Review of the Aboriginal and Torres Strait Islander Alcohol, Tobacco and Other Drugs Treatment Service Sector: Harnessing Good Intentions

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June 2014

Preventing harmful drug use in Australia

The National Drug Research Institute at Curtin University is supported by funding from the Australian Government under the Substance Misuse Prevention and Service Improvement Grants Fund

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Acknowledgments

First, we would like to thank the representatives of Aboriginal and Torres Strait Islander community controlled health and alcohol, tobacco and other drug services, non-Indigenous non-government service providers, and Australian and state and territory government agencies who participated in the project on which this report is based. All of those we were able to interview gave freely of their time and insights and we are grateful to them. The project was part of a wider review of drug and alcohol prevention and treatment services conducted by the National Drug and Alcohol Research Centre at the University of New South Wales with funding from the Australian Government Department of Health. The National Drug Research Institute at Curtin University is supported by funding from the Australian Government under the Substance Misuse Prevention and Service Improvement Grants Fund.

Executive Summary

Substance use disorders and treatment

- Substance use disorders are chronic relapsing conditions usually embedded in a web of other health and social problems.
- For this reason, treatment strategies should: be broader than clinical responses; include the provision of social support services; and, focus on long-term provision of services in a seamless manner.

Need and demand for treatment services

- Data of sufficient detail are not available to precisely quantify either the need or demand for alcohol tobacco and other drug (ATOD) services among Aboriginal and Torres Strait Islander people.
- Data that are available show that among Aboriginal and Torres Strait Islander people ATOD related problems are at least twice as prevalent as in the non-Indigenous population.
- Due to the complex nature of the problems they face, there is a need for greater intensity of treatment service provision for Aboriginal and Torres Strait Islander people.
- Measurable levels of ATOD-related harm and the experience of service providers indicate that there is a considerable level of demand that is not currently being met.

Treatment services: gaps and priorities

- In addition to alcohol, there is concern to address increased levels of cannabis and amphetamine type stimulant use.
- Gaps in ATOD treatment service provision include: gaps in access to a full range of services in some regions; lack of culturally appropriate services; limited range of gender specific services and services for families and young people; and a paucity of on-going support and relapse prevention services for those completing intensive treatment.
- The gaps in treatment service provision are unevenly distributed and the priorities arising from them are not necessarily the priorities of particular communities.
- In some cases, services are provided as a result of historical funding decisions or recent availability of targeted program funds rather than current priorities.

- The uneven geographical distribution of ATOD services and lack of correlation between service provision and population levels and indicators of harm is evidence that there has been little planning of service provision.
- Service provision is fragmented and often not coordinated resulting in less than optimal effectiveness.

Organisational issues

- The delivery of effective ATOD treatment services is dependent upon effective organisational structures and procedures.
- Culturally appropriate treatment results in better outcomes. The most effective means of ensuring treatment is culturally appropriate and secure is through Aboriginal and Torres Strait Islander control of services.
- Among some service providers, there is concern that community control is being undermined by top-down planning, exclusion from decision-making processes, and contracting of service provision to non-Indigenous organisations.
- To enable organisations to provide more effective services, there is a need to continue up-skilling organisational boards to enable them to better manage service provision.
- Up-skilling and expansion of the ATOD workforce is a priority. As well as providing much needed services and contributing to the reduction of ATOD-related harm, this can provide real employment opportunities and has a flow-on economic benefits.
- There is a need for support for a body that can more directly represent the views of local Aboriginal and Torres Strait Islander service providers and work in partnership with governments to the end of achieving improved outcomes.

A model for the delivery of treatment services

- To address fragmentation and poor coordination of services a clear model for the effective provision of services needs to be articulated.
- Whether they present specifically for them or not, most people with ATOD-related problems are likely to attend an Aboriginal and Torres Strait Islander health service (ACCHS). This presents an opportunity for screening and engaging potential clients in treatment.
- A large percentage of ACCHS provide specialist ATOD and social and emotional wellbeing services in addition to the primary health care (PHC) services they provide.
- There have been calls since the late-1980s for the better integration of ATOD and PHC services.
- The number of ACCHS and their location around the country, the ATOD services many already provide, and the networks they have through the National Aboriginal

Community Controlled Health Organisation (NACCHO) make ACCHS the logical hub for the provision and coordination of ATOD treatment services.

- Coordination between ACCHS and other Aboriginal community controlled organisations (ACCOs) providing specialist ATOD treatment services could be facilitated by means of service agreements linked to funding contracts.
- If such an ACCHS-PHC centred model of service provision could be negotiated between key stakeholders, NACCHO and its state and territory affiliates could provide an already existing means of representing the views and interests of the broader Aboriginal and Torres Strait Islander ATOD service sector (as NACCHO affiliates in two states or territories do already).

Treatment service planning

- The *National Drug Strategy* (*NDS*) and the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan* (*CAP*) (soon to be replaced by the *National Aboriginal and Torres Strait Islander Peoples Drug Strategy*) provided the broad strategic planning framework for the provision of ATOD treatment services.
- While the *CAP* was based on extensive consultation, stakeholders were of the view that it was largely aspirational and has become a 'top-down' document.
- Evaluation of the *CAP* found it was largely endorsed by stakeholders, but the key result areas were far too broad, it lacked performance measures and, monitoring of outcomes was poor.
- Providers expressed concerns that planning is largely limited to development of broad strategy and focuses too heavily on resource allocation at the expense of operational planning.
- An essential element missing from *CAP* and the state and territory strategies based on it, is a clearly articulated and agreed upon organisational framework through which the strategy is to be implemented.
- Stakeholders were concerned that the goals of the *CAP* have been poorly translated into technical plans, which were perceived to be ad hoc and not driven by community need. A consequence of this was seen to be less than optimal outcomes.
- While supportive of planning, stakeholders generally felt that: governments had a poor understanding of service gaps and priority areas; there was a lack of consultation and involvement in decision making processes; a narrow definition of 'treatment' was employed; and, there was a lack of flexibility in allocation of resources.
- Key informants from all sectors generally agreed that services developed with community consultation and engagement are more likely to be successful. Technical planning will produce a better return on investment when informed by communities.

- Giving local ACCHS and ACCOs greater input into decision making process requires a structure or structures to facilitate this. If the ACCHS-PHC centred model of service provision could be successfully negotiated and agreed upon by stakeholders, NACCHO might provide part of that structure.
- A clearly articulated model for the provision of ATOD-treatment services – such as the ACCHS-PHC centred model – could provide a more effective focus for the planning and provision of ATOD treatment services and help to ensure effective use of resources and improved outcomes for the clients of ATOD service providers.

Funding

- Funding of ATOD services is an investment that contributes to the reduction of ATOD-related costs, including those of: disruption to child-development and education; unemployment; and high levels of violence and incarceration.
- None of the key informants interviewed, none of the submissions made as part of the consultations conducted for development of the *National Aboriginal and Torres Strait Islander Peoples Drug Strategy*, nor any of the published reports on this area indicate that, across-the-board, levels of funding for ATOD treatment services are adequate.
- Generally, grants are too small to enable organisations to support the demand for services placed upon them. This leads to organisations chasing smaller addition grants. resulting in inefficient administrative and reporting burdens.
- Given the fragmented nature of ATOD treatment service provision, efficiencies are likely be achieved by increased coordination of services. Due to their numbers and geographic spread, ACCHS are best placed to facilitate such coordination.
- In light of the need for greater integration of PHC and specialist ATOD treatment services transfer of funding for Aboriginal and Torres Strait Islander ATOD treatment services from the Australian Government Department of Health to the Department of the Prime Minister and Cabinet, while well intentioned, is a retrograde step. It fragments funding sources and is likely to impose additional administrative burdens.
- Aboriginal Hostels' funding for bed places in residential treatment facilities should be consolidated under treatment grants funding.
- A potential advantage of an ACCHS-PHC centred model of ATOD treatment service provision is the opportunity for increased access to Medicare funding for such services as screening and brief interventions and improved treatment under mental health and chronic disease care packages.
- Across Australia, Aboriginal and Torres Strait Islander people have established and selected their own preferred service providers. They are well-established have no 'competitors' and have had historically-based funding agreements. In these circumstances there is no advantage in competitive tendering and these organisations are best funded by means of individually negotiated agreements.

- In the Aboriginal and Torres Strait Islander context, the continued provision of funds through block grants is the most practical option for the foreseeable future. However, there need to be clearly defined criteria for the basis of such funding, including assessments of need and the costs of service provision.
- It is clear that inadequate levels of funding limit the ability of ACCHS and other ACCOs to meet the need for ATOD-treatment services among Aboriginal and Torres Strait Islander people. If funding for such services is not increased in the immediate future and better systems put in place to enhance the capacity of ACCOs to respond to ATOD problems, those problems will only get worse and they will ultimately become more expensive to address.

Summary

- The current system for the provision of ATOD services is fractured. A model for the provision of treatment services needs to be negotiated between service providers and governments, preferably a ACCHS-PHC centred model.
- Once agreed upon, the model needs to be supported by: improved service planning; organisational and community development; and, consolidated funding allocated on the basis of need.
- Within Aboriginal and Torres Strait Islander communities, among service providers and within government there is widespread concern to address substance use disorders among Aboriginal and Torres Strait Islander people and their actions to do so are clearly based on good intentions. What is needed is to more effectively harness those good intentions to reduce harmful levels of ATOD use in the Aboriginal and Torres Strait Islander population.

Introduction

Higher levels of alcohol, tobacco and other drug use (ATOD) among some sections of the Aboriginal and Torres Strait Islander population are a consequence of and contribute to social inequality.[1–3] They contribute to: a significant proportion of the burden of physical and mental ill-health; have a negative impact on the capacity of individuals for employment; disrupt the early development and education of children; contribute to higher levels of breakdown in inter-personal relationships; violence and other crime; and, higher levels of incarceration.[4–8]

In order to reduce Aboriginal and Torres Strait Islander inequality, community action and government programs to reduce ATOD-related problems have been and continue to be of high priority. It is important to note, however, that – because of the complex web of social problems within which ATOD-related problems are embedded – on their own strategies to reduce harmful ATOD use will be circumscribed in their effectiveness.

Research evidence shows that to effectively reduce ATOD-related harm, a multi-faceted approach is required. This evidence is the basis of Australia's *National Drug Strategy* which is based on the principle of harm minimisation and the pillars or sub-strategies of demand, supply and harm reduction.[9] Treatment is an important element of demand reduction and, again, a wide range of evidence-based treatment strategies is available.

This review of the Aboriginal and Torres Strait Islander alcohol, tobacco and other drug (ATOD) treatment services sector was conducted as part of a wider review of alcohol and other drug prevention and treatment services.[a] The objectives of the wider review were to achieve:

- clarity as to the range of services currently funded, their distribution and the demographic groups targeted by these services;
- a common understanding amongst governments and the sector of current and future service needs and where there may be service gaps, either in relation to service type, geographic area and/or demographic groups;

a. The wider review excluded tobacco treatment. However, it has been included in this review as: it is psychoactive substance like alcohol and illicit drugs; individuals who are dependent on tobacco often use alcohol or other drugs; such use should be addressed concurrently; and, the organisations that provide treatment for alcohol and other drug dependence (such as primary health care services) also provide treatment for tobacco dependence.

- clarity as to the type and timing of drug and alcohol funding activities undertaken by governments; and
- the development of a resource/tools to help focus future government funding activities to ensure existing levels of resources (and any growth funding) are used as efficiently and effectively as possible to deliver quality, sustainable drug and alcohol services that respond to the needs of individuals, families and communities.

The findings of the review will identify ways for governments to work collaboratively and better plan for the future delivery of drug and alcohol services and improved treatment outcomes (Commonwealth of Australia 2013).[10]

The larger review was conducted by the National Drug and Alcohol Research Centre (University of New South Wales),[11] which contracted the National Drug Research Institute at Curtin University to:

Provide a report which collects and analyses data from stakeholders across the Aboriginal and Torres Strait Islander community – including primary health care services, community-based organisations, residential rehabilitation services, and inclusive of Aboriginal peak bodies (e.g. the National Aboriginal Community Controlled Health Organisation and its affiliates) which covers:

- identification of gaps in current service provision;
- areas of unmet need;
- priority groups;
- service planning processes;
- funding models/funding arrangements and contracting issues; and,
- strengths, weaknesses and challenges across these areas.

Methods

A synthetic, qualitative approach was used to meet objectives of the study. Semi-structured key informant interviews were conducted with:

- representatives of peak organisations representing residential, community-based and primary health care services providing ATOD treatment services (Aboriginal and Torres Strait Islander community-controlled organisations, other NGOs, and government agencies)[b] – or, in jurisdictions where there are no such peak organisations, representatives of particular organisations providing such services;

b. We use the abbreviation ACCHS to refer specifically to Aboriginal and Torres Strait Islander primary health services (or Aboriginal medical services). The abbreviation ACCOs is used in two ways, which will be obvious from the context in which they are employed: to refer to other Aboriginal and Torres Strait Islander community controlled organisations (usually specialist ATOD service providers); and to refer to all Aboriginal and Torres Strait Islander community controlled organisations including ACCHS. The abbreviation NGO is used to refer to non-Indigenous non-government organisations.

- employees of Australian Government and state/territory agencies funding Aboriginal and Torres Strait Islander ATOD treatment services, referred to as employees rather than representatives as, often, they expressed views based on their own experiences in the field and not simply the views of the agencies by which they were employed; and,
- members of the National Indigenous Drug and Alcohol Committee (NIDAC) and others with expertise in the issues under consideration.

Within the constraints imposed by the project budget, a total of 28 Aboriginal and Torres Strait Islander and 25 non-Indigenous people were interviewed, either individually or in small groups, in nine locations in all state and territory jurisdictions except Tasmania.

To flesh-out the information obtained from interviews and to provide a broader context, we also reviewed both the NIDAC report on consultations for the new *National Aboriginal and Torres Strait Islander Peoples Drug Strategy* and the written submissions made as part of that consultation.[12,13] We also reviewed previous reports and other publications addressing: treatment services; broader provision of ATOD services; primary health care services; and, general issues pertaining to service delivery among Aboriginal and Torres Strait Islander people. Among the most salient of these were: an Australian National Council on Drugs (ANCD) report on 'areas of greatest need' in the provision of Indigenous-specific alcohol and other drug services;[14] a NIDAC statement on the funding of Indigenous-specific alcohol and other drug services;[15] and, a review of contracting for the provision of primary health services.[16] Information from other sources is discussed in the body of the report.

The qualitative data from these various sources were subject to thematic analyses within the structure provided by the objectives of the review. These analyses were also guided by the experience of the authors who collectively have extensive involvement in ATOD research, ATOD and primary health care service provision, and ATOD and health policy (see Appendix 2 for more detail).

The project was conducted within the framework of the NHMRC's *Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*,[17] and the Curtin University Human Research Ethics Committee gave approval for the project (Protocol Approval NDRI-05-2013).

Treatment Services: Needs, Gaps and Priorities

A clear understanding of the nature of substance use disorders and the effectiveness of treatment strategies is fundamental to addressing harmful ATOD use in the Aboriginal and Torres Strait Islander population. First, substance use disorders are chronic relapsing conditions akin to problems such as hypertension and diabetes that occur on a spectrum of severity. While a 'cure' in the form of abstinence resulting from treatment may be desirable and attainable by some, it is difficult to achieve. A more realistic outcome of treatment, at least in the short-term, is extending periods between episodes of relapse and – in accord with the objective of the *National Drug Strategy* – minimising the harm caused to self and others as well as the associated social and economic costs.[9] Importantly, there is strong evidence for the effectiveness of treatment for substance use disorders.[18–22]

Second, among individuals, substance use disorders do not occur in isolation. They often occur in conjunction with various mental and physical health problems, dysfunctional familial and social relationships, and a range of social challenges and disadvantages, including homelessness and involvement with the criminal justice system. Treatment of substance use disorders in isolation from these other problems is likely to be limited in effectiveness. For this reason, treatment needs to be conceptualised more broadly than the simple provision of clinical services such as screening, withdrawal management, medical management, counselling and residential services. It needs to encompass social support, including advocacy and links to other services, such as housing and welfare support. As substance misuse disorders are primarily health problems, they need to be addressed in the broader context of health care and not in isolation from preventive and harm minimisation strategies.[23–26]

Third, treatment needs to be person-centred. Rather than being based on the priorities of organisations funding or providing services; it needs to address – in as seamless a manner as possible – the inter-related needs of clients and their families. That is, it needs to be holistic. Importantly, this entails the integration of service provision both within and between organisations. Furthermore, a review of the evidence shows that treatment results in better outcomes if it is provided in a manner that is culturally safe and appropriate.[27]

The need and demand for treatment services

Given the diversity among Aboriginal and Torres Strait Islander peoples, to effectively provide treatment for ATOD related harm among them we need to know – at a local, or at least at a regional level – what are the patterns and levels of ATOD consumption, what are the consequence of those patterns and levels of use, what services are available to address them, what additional services are needed, if any, and what are the priorities for intervention based upon both epidemiological data and those articulated by particular communities.

Epidemiological data of sufficient detail are not available to quantify either the need or the demand for ATOD treatment clinical services, nor the specific level of resourcing that should be allocated to them. Nevertheless, at the population level, ATOD-caused deaths, hospital admissions and emergency presentations for ATOD-caused conditions, and survey data all indicate that the level of harmful ATOD use is *at least twice*, and probably greater, among Aboriginal and Torres Strait Islander people than in the non-Indigenous population.[4–7] Furthermore, work done as part of development of the *Drug and Alcohol Service Planning Model for Australia* indicates that there is a need for greater intensity of service provision for Aboriginal and Torres Strait Islander people undergoing treatment.[28,29] While it is difficult to measure the demand for treatment services among Aboriginal and Torres Strait Islander people, both the levels of measurable ATOD-related harm and the comments of service providers indicate that there is a considerable level of demand that is not being met.

Apart from isolated studies, below the national level systematic data on patterns and levels of consumption – apart perhaps for smoking rates – are either not available or are not reliable.[30–32] Data on health-related harms such as hospital admissions data are not available for all states and territories or if they are, such as mortality data, the numbers are too small at the local level to be reliable or they are out-dated. For this reason, among others, it is important for there to be organisational structures in place which provide information from regional and local communities about ATOD use and its impact.

The ATOD treatment needs of individuals reflect the diversity of communities in which they reside and treatment should be targeted to meet those diverse needs. As indicated above, treatment of substance use disorders requires a comprehensive and integrated range of options that address the social, emotional and physical wellbeing of individuals and their families. In this regard, key informants for this study reported a

number of gaps in this range of options. In the following sections, we discuss these and priorities arising from them and compare them to those identified in a study of gaps and needs conducted for the ANCD for the 2006–2007 financial year.[14]

There is a wide range of Aboriginal and Torres Strait Islander community-controlled, non-Indigenous NGOs, and government organisations providing ATOD treatment services. These organisations include primary health care (PHC) providers, home and community visitors, withdrawal management facilities, and non-residential and residential treatment providers. The mix of such organisations and the services they provide varies considerably by state and territory and regions within them. Effective coordination between providers is exists in some locations but in others is fragmented or non-existent.

Substances of concern

Historically the primary drug of concern in the Aboriginal and Torres Strait Islander community has been alcohol. This continues to be the case, with most community-based informants saying that alcohol remains the drug that causes the most harm.

> … alcohol is the big one. (A recent survey) … asked what is the biggest issue confronting Aboriginal people in South Australia? Far and away the topic that was mentioned most – people were asked to mention three topics – but the one that was mentioned more than employment, education, any other health issue was alcohol. (Representative NACCHO affiliate)

> From a Queensland community perspective, alcohol is still certainly a significant contributor to that space for us. We see that in our primary health care data as well, that the number of people that are consuming alcohol at above average rates is still significantly higher than what it is in mainstream populations. Alcohol is certainly one of the biggest (problems). (CEO NACCHO affiliate)

The provision of ATOD services reflects this concern with alcohol. In 2006–07, 72 per cent of all Aboriginal and Torres Strait Islander-specific substance use intervention projects and 34 of 38 residential treatment services, primarily targeted alcohol.[14]

Despite historical and current concerns about the impact of alcohol, cannabis use has become of increasing concern. Data from the 2002 and 2008 National Aboriginal and Torres Strait Islander Social Surveys (NATSISS) found 23.5 and 22.5 percent of respondents reported using cannabis in the previous 12 months.[6] However, for methodological reasons this is likely to be an under-estimate.[32] Key informants from ACCOs in all jurisdictions, cities, large towns and remote areas nominated cannabis as the second major drug of concern.

> I think there is a social acceptance of gunja (cannabis), you know what I mean? It's an illicit drug but socially we accept it, so therefore it's okay, everybody does it. (CEO ACCHS)

> The other (major drug of concern), obviously, is bloody yarndi – marijuana – and that's still a fairly big contributor (to the problems we see). … Marijuana and alcohol are the biggest issue for us. (Representative NACCHO affiliate)

> I have major concerns about the growth and the encroachment of drugs like cannabis into our Aboriginal worlds. I've seen it grow and emerge into a major drug of concern. (Representative urban ACCHS)

The other category of drugs that is of concern is amphetamine type stimulants (ATS). The 2008 NATSISS reported that a little over 10 per cent reported ever using ATS and five per cent that they had done so in the previous 12 months.[6,31] Again, this is likely to have been an under-estimate. Of particular concern has been the use of methamphetamines. A qualitative research project conducted for the Australian Government Department of Health (AGDH)[c] at about same time as the 2008 NATSISS found that:

> While the research is unclear with regards to the prevalence of methamphetamine use in Indigenous communities, especially remote and regional communities, it is clear that it is an issue of increasing significance.[33]

This view of increasing significance appears to have been borne out and, although there is still an absence of quantitative data on ATS use, key informants from ACCOs reported increasing use and injecting of methamphetamines and harms arising from this – particularly in urban areas but also rural and remote towns, as also reported by police in some locations such as the Kimberly.[34]

> The heavier drugs are getting up there (in terms of use and impact). So the heavier drugs are slowly increasing amphetamines and that. (CEO ACCO)

> I think amphetamines in our community have caused so much problems around domestic violence and family and community violence. (CEO ACCHS)

Concern about observed increases in methamphetamine use prompted NACCHO and NIDAC to conduct a survey on ATS issues among workers in the ATOD field.[35] The report cautioned that it was not a representative sample survey, but 88 per cent of respondents reported observing a recent increase in ATS use among their clients.

c. For convenience and to avoid confusion, we refer to the Australian Government of Health by its current name – rather than previous names such as the Australian Government Department of Health and Ageing – and use the abbreviation AGDH.

A key issue in addressing both cannabis and ATS use is that, while ATOD service providers are skilled in treating alcohol related problems, fewer have the skills to address the issues arising from illicit drug use. The impact of cannabis has been recognised by key stakeholders and the National Cannabis Prevention and Information Centre (NCPIC) has funded the National Drug Research Institute to develop a cannabis intervention – 'Could it be the Gunja?' – for use in PHC settings.[36] Resources have been developed but additional funding is required to roll-out the intervention.

Similarly some peak organisations such as the Victorian Aboriginal Community Controlled Organisation (VACCHO) are taking the initiative with regard to methamphetamine use.

> We have held several forums focusing on methamphetamine use and feedback through evaluation forms indicates that there is a need for information and skill in best practice management of clients with methamphetamine addictions. Another need is for practical family support for those dealing with family members with methamphetamine dependence. For instance, parents and children, through active counselling services or phone advice lines, not through passive pamphlets or flip charts. (VACCHO, NIDAC consultations).

The initiatives being taken with regard to cannabis and methamphetamine use are important but, as indicated by key stakeholders, more work is required in these areas.

Population groups

Service providers stressed the need for services which address the needs of Aboriginal and Torres Strait Islander communities as a whole. However, there was clear recognition that in many areas this goal was not being achieved. In particular, it was recognised that there were gaps in the provision of specialist treatment services for youth, both men and women, and families.

> One of the questions I have – I was talking about the availability of a spectrum of services. Are there adequate services across all age groups, and for men and women? Not at all. No! (Representative NACCHO affiliate)

It is generally recognised that there is a paucity of specialist ATOD treatment services for young people. However, as the Aboriginal and Torres Strait Islander population is significantly younger than the non-Indigenous population,[37] this lack of services is exacerbated. Concerns about this were reflected in comments by key informants.

> We don't have a youth rehab here (in our state at all). We have so many spokes off the wheel (of comprehensive service provision) here it's not funny. It's so frustrating. (Representative NACCHO affiliate).

> If you look at the onset of substance misuse at an early age, you really need to have a whole lot of better interventions and engagement programs in that early phase and they just don't. (CEO, NGO peak body)

The paucity of specific youth treatment services results in referrals from far distant communities to places where those services that do exist.

> Because there's a lack off of youth specific drug and alcohol agencies around Australia and in the NT we're getting young people from Yirrkala, Beswick, Katherine, Darwin constantly and interstate. (CEO NGO youth program)

This entails significant additional costs but also limits the amount of on-going care that can be provided. The needs of youth are not just for treatment services but other support such as housing, education, and employment.

> It's no proper housing, it's no work at the end of schooling, it's not all sorts of things like that. (Representative, NACCHO affiliate)

The paucity of ATOD treatment services which cater specifically for the needs of women has previously been identified.[14] Concern about this was reflected among ACCO and NGO service providers in the present study, but was also more broadly contextualised in the need for male-specific services as well.

> Although children, youth and women need to be better supported – there are similar needs in relation to men. (AMSANT NIDAC consultations)

> Men are the greatest perpetrators of alcohol-related violence in our communities and we need programs to help them address this. (ACCO representative)

While there are high rates of harmful alcohol use among Aboriginal and Torres Strait Islander women (as among non-Indigenous women) their participation in treatment programs – particularly residential programs is markedly lower.[38] A major reason for this is that women are often primary care-givers to children, and do not have the option to leave them for the significant periods of time required to undertake residential treatment programs. Also, ATOD-related problems are often suffered by both partners in a relationship. If, as is usually the case, residential service providers require partners to enter treatment individually and if couples have children, this requires one partner to remain out of treatment, causing even more stress on relationships and family units. For these reasons, key informants also emphasised the need for the provision of more family-specific residential services or resourcing of present facilities to enable them to cater for families.

> There's no sense in trying to fix up somebody with a drug or alcohol problem if you're not going to be able to work with the whole family around addressing that person's needs. At the end of the day the person becomes isolated, alienated from the family and

> either has to pack up roots and move because they can't come back to that environment or you've got to encourage the family. (CEO ACCHS)

On-going care

One of the gaps in service provision most commonly identified was that of on-going care (also referred to as after-care, continuing care, or maintenance) These are services that provide support following the intensive stage of treatment.[19] They consist of more than simple practitioner follow-up and among other things they might include on-going management of co-morbid physical and mental health problems, support group meetings, counselling sessions, advocacy and linking to other services and facilitation of integration back in to communities for those completing periods of residential treatment. Provision of on-going care should be an essential component of a treatment program. It has been shown to significantly reduce relapse rates and the associated costs of providing additional intensive clinical services and thus, protects initial investment in such expensive services.[14,19,20,39,40]

A number of stakeholders acknowledged the importance of extended, on-going care as part of treatment.

> Really people need an intensive 12 months follow-up. Like you'll be an alcoholic for life, so however long it (on-going care) takes. (NGO service provider)

> … anybody who knows anything about addictions knows that the first three months is actually relatively easy. It's the next year and a half to two years to keep people off it, that's the really hard part. (Senior medical practitioner)

> The gap is post-treatment aftercare, an on-going program. It just defeats the purpose of putting them (clients) into those treatment centres, if they're going in there, having their three month, or whatever period of time that they're going to spend in those centres and then get released. (CEO NACCHO affiliate)

In 2006–2007, only four on-going care programs for Aboriginal and Torre Strait Islander people were specifically funded for that purpose.[14] Most such care was provided using funds from other sources. Given that there were 52 non-residential and 38 residential treatment services at that time, this was a significant gap. Since that time, more attention has been paid to the provision of on-going care services, but given the comments of key informants there is still some way to go in filling this particular gap.

The provision of on-going care is a particular problem for residential treatment services where clients' usual places of residence are in other, often distant communities.[41] In such situations, a practical solution is the implementation of service agreements in

which local ACCHS or other PHC providers take responsibility for on-going service provision.

Other gaps

In addition to the issues discussed above, other gaps in service provision identified by key informants included: the lack of coordinated care for clients with co-morbid mental health problems; the lack of resources available for providing or linking into social support services for clients and for case management; and, treatment services in correctional institutions or as an alternative to incarceration. [42,43]

Summing many of these concerns one stakeholder stated:

> … these patients have really complex problems, mental health issues, housing issues, corrections issues. There's no system it's very piecemeal… . We can make those systems internally, which is what we've tried to do in (named location). But then it's the external referrals – especially in remote rural areas – that you can't do … There are all these other links that you need. (Representative NACCHO affiliate)

It is important to recognise that these gaps and the priorities accorded to addressing them vary both locally and regionally and that different strategies are available to address them. For this reason, it is important that local ACCOs and peak bodies are involved in developing strategies to address their priorities and that funding is flexible enough to accommodate those strategies.

Culturally safe services

The need for ATOD treatment programs to be culturally appropriate and culturally safe was a recurrent theme in the interviews conducted with key informants. In particular they emphasised the need for clients to feel engaged with both the organisations and people providing services. A key element in this the employment of Aboriginal and Torres Strait Islander staff and ACCOs acknowledged that one of their strengths lay in their staff. Informants from the ACCO, NGO and government sectors all made the point that a less credentialed Aboriginal or Torres Strait Islander person who was part of the community and familiar with local culture and community was generally more effective in providing treatment than a more highly qualified non-Indigenous person.

The importance of cultural awareness for all treatment service providers was emphasised. However, ACCO staff regarded much cultural awareness training – particularly in the NGO sector – as superficial and ineffective. As one said:

> (Cultural awareness) is more than just a three-hour session and putting some Aboriginal posters on the wall. (ACCHS representative)

The CEO of a NACCHO affiliate made the point that the most effective way of ensuring the cultural safety of ATOD and other health care interventions was through community control of services. He and others recognised the that NGOs have an important role to play in service provision, but where they do so they should work in partnership to ensure that the capacity of local Aboriginal and Torres Strait Islander communities is developed to the stage that they can take control of service provision.

Distribution of treatment services

Key informants identified a range of specific gaps in treatment service provision. However, under-pinning the discussion of those gaps were general concerns about the overall availability and distribution of ATOD services.

The most recent report to comprehensively document the range of Aboriginal and Torres Strait Islander specific ATOD intervention services was prepared for NIDAC and the ANCD covering the 2006–2007 financial year – a report which replicates an earlier one for the 1999–2000 financial year.[14,44] A key result area of the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009* (the CAP) was:

> A range of holistic approaches from prevention through to treatment and continuing care that is locally available an accessible.[45]

However, the ANCD report – which mapped all Aboriginal and Torres Strait Islander specific ATOD interventions by the Australian Bureau of Statistics' Indigenous regions – found that:

- there were considerable gaps in terms of the range of services available at the regional level – there was a small group regions which were well provided for, but others in which the range of available services was limited;
- there was no relationship between the range of services provided at the regional level and the size of regional populations;
- the amount of funding allocated for ATOD services at the regional level was not related to the size of regional populations; and,
- *the distribution of services provided evidence of the limited planning of service delivery* (emphasis added).[14]

There has been no similar documentation of either ATOD services in general or treatment services in particular since the ANCD report was published. However, as far as

we have been able to ascertain from interviews with key informants, while there have been some increases in the provision of treatment services and while some regions are reasonably well serviced, the situation with regard to the comprehensive provision of services remains much the same. However, it is important to note that it is not just the quantum of services which is of concern. As the AMSANT submission to the NIDAC consultations for the NATSIPDS made clear, in some communities it is not necessarily the absence of services that is an issue, rather there is an absence of co-ordination, collaboration, and consultation, with money being spent on poorly integrated services achieving poor outcomes.

> AMSANT and our members are very concerned about the lack of access to AOD services in most remote communities in the NT despite the high need. Access to mental health services in most remote communities is also patchy and complex with a reliance on visiting services that often communicate poorly with both the Aboriginal PHC service and the other visiting mental health services. … the need is high for mental health services, with high and rising suicide rates (and with many being in the setting of alcohol of other drug intoxication). Some communities have too many services visiting them but with poor communication between them, and some communities have very little support from visiting agencies. (AMSANT NATSIPDS consultation)

The issue of service fragmentation or lack of integration of services was raised in another jurisdiction.

> A lot of it (treatment) is compartmentalised. … What we haven't worked out in that patient continuum is to know now who is responsibility for it. If there's a gap in services, how do we – what are we doing or how are we influencing government and others to make sure that that gap's being picked up? (CEO NACCHO affiliate)

Organisational issues

The delivery of effective ATOD treatment services is dependent upon efficient and effective organisational structures and procedures – among service providers themselves and the organisations that support and fund them. It has long been recognised that Aboriginal and Torres Strait Islander control of their own health and ATOD services is essential to provision of service that meets local community needs and ensures provision of culturally safe services; and, other factors being equal, results in better outcomes. Recognition of this is endorsed in both the *National Aboriginal and Torres Strait Islander Peoples Drug Strategy* and the *National Aboriginal and Torres Strait Islander Health Plan*.[13,58] It is also important to recognise that a strong ACCO sector provides 'employment, economic independence and higher levels of education'.[46]

Governance

As indicated by funding agency employees in different jurisdictions – despite common perceptions – most Aboriginal and Torres Strait Islander ATOD service provider organisations are well governed. However, there are some which have been poorly governed resulting in poor quality service provision and, in some instances, to defunding. As both service providers and funding agency employees pointed out, one of the more common problems is poor financial control by boards of management – often arising because members have limited expertise or interest in financial management. Issues also arise because board members may be enthusiastic about addressing ATOD problems but, again, have little knowledge of current best practice. Governments have attempted to address the first of these problems by providing basic governance training to board members. However, in the view of one senior funding agency employee, while this provides members with an understanding of their responsibilities it does not provide the level of expertise required to effectively govern an organisation. To ensure better treatment outcomes, there is need for funding agencies to make available to the boards of Aboriginal and Torres Strait Islander ATOD treatment services, where required, training and resources to strengthen governance procedures. Of their own volition, some organisations have moved to the appointment of board members with specific areas of expertise, for example, clinical services and financial management – with varying voting rights arrangements – in addition to elected members without undermining the principle of community control. Organisations that were cited by participants as taking a lead in this regard were the Institute for Urban Indigenous Health and Central Australian Aboriginal Congress. This is a positive move that should be further encouraged and one that could possibly be advocated by a peak organisation.

Workforce issues

ATOD treatment strategies are only effective if there is a skilled workforce to deliver them. However, despite being identified as a priority and funds being specifically allocated for workforce development and capacity building, workforce issues have been and continue to be identified as an impediment to the delivery of effective ATOD treatment services.[14,47] Among the issues identified by service providers – all of which lead to high staff turnover – were: shortages of skilled workers at all levels; low levels of remuneration, particularly for Aboriginal ATOD workers; limited career development pathways, especially in small organisations; and, limited staff support. If improved outcomes are to be achieved, up-skilling and expansion of the ATOD workforce is seen as a priority, particularly by service provider representatives.

Importantly, ATOD treatment workforce development and expansion should not be viewed simply as a cost. As well as providing much needed services and contributing to the reduction of ATOD-related harm, it can provide real employment opportunities in Aboriginal and Torres Strait Islander communities with flow-on effects in reducing dependence on the social security system and providing support and improved living conditions for the families of such workers.

NGO service provision

The focus of this report has been on the provision of ATOD treatment services by Aboriginal and Torres Strait Islander community controlled organisations. This does not mean we think that Aboriginal and Torres Strait Islander people should not have the choice of using mainstream service providers or that NGOs do not have a role to play in the provision of ATOD treatment services specifically for Aboriginal and Torres Strait Islander people. In the first instance, mainstream service providers should provide their services on the same basis they do for non-Indigenous clients with the proviso that, as for all clients, their services should be culturally safe.

There was recognition by Aboriginal participants that in some instances, although there is a need for Aboriginal and Torres Strait Islander specific services, there may not be community-controlled organisations that are able or wish to take on provision of those services. However, there was a strong view that where non-Indigenous organisations are successful in tendering for services specifically funded for the benefit of Aboriginal and Torres Strait Islander people, a condition of their funding contracts should be a requirement to negotiate with local communities regarding service planning, local community employment, and capacity building, based on clear recognition of cultural differences. Most importantly, they should be required to develop plans for the transfer of services to community control within a specified time-period. Aboriginal Peak Organisations Northern Territory (APONT) has developed a set of guidelines for such engagement which have been negotiated with non-Indigenous organisations including the Australian Council of Social Service.[48] Guidelines such as these, when adhered to, have the potential to reduce the likelihood of inappropriate service delivery which contributes to clients discontinuing treatment and ultimately to further gaps in service provision.

The role of government

Organisational impediments to the efficient and effective delivery of ATOD treatment services for Aboriginal and Torres Strait Islander people do not only occur within ACCOs. Such impediments are also found in the administration of government

programs. Government programs for Aboriginal and Torres Strait Islander people are aimed at alleviating disadvantage and providing equal opportunity to fully participate in Australian society. However, a view expressed by some service providers is that such aims are over-shadowed by departmental concerns with their roles as fund administrators and funding contract managers. While acknowledging that financial accountability is important, they felt that – with some notable exceptions – many contract managers knew little about the organisations they were funding and they provided little support in terms of meeting broad program objectives. Without 'micro-managing' or over-planning, government agencies can play a greater role in ensuring consistency of expectations between service providers and funders, supporting organisational capacity and being flexible and responsive to community expressions of need.

Representation and peak organisations

As well as bodies such as the National Aboriginal Drug and Alcohol Committee and the National Health Leadership Forum, there is a need for a representative body that can more directly speak for other ACCOS that provide ATOD services (which currently have no such body) and to work in partnership with governments to the end of providing improved outcomes. Again, it would need to be negotiated with and between Aboriginal and Torres Strait Islander organisations, yet the most efficient means of providing such representation for ATOD-specific services is through NACCHO and its affiliates. As precedents for this, participants cited examples of the Aboriginal Medical Services Alliance Northern Territory (AMSANT) opening its membership to ATOD treatment services, and the Queensland Aboriginal and Islander Health Council (QAIHC) incorporating the Queensland Substance Misuse Council (QISMC) which represents residential treatment service providers. If some variation on these models could be negotiated across all jurisdictions, not only would it be an efficient way to provide representation, it would provide organisational support for the integrated, ACCHS-PHC centred model of ATOD treatment service provision discussed below and facilitate improved service planning as discussed in the following chapter.

A model for the delivery of treatment services

There is a need for a clearly articulated model or framework for the delivery of ATOD-treatment services to Aboriginal and Torres Strait Islander people – one that would provide better integration of services and a more rational model for funding. Development of this would need to be negotiated between representatives of Aboriginal and Torres Strait Islander organisations, non-Indigenous service providers, and

governments – with their roles and responsibilities clearly defined. However, the basis of such a model should be the provision of ATOD treatment services by, or facilitated by, ACCHS – a view reflected by most, but not all, service providers and some funding agency employees.

Participants favouring an ACCHS-PHC centred approach made the following points. For a large proportion of the population, ACCHS are the first point of contact with the health care system. While many of those with substance use disorders may not present because of those problems, such contacts provide the opportunity for service providers to screen for them, provide opportunities for engagement in treatment, and where necessary provide referrals to specialist providers either within or external to their organisation. ACCHS also have opportunity to assess and address other health-related problems associated with substance use disorders. These views about the centrality of PHC in the treatment of ATOD-related problems are congruent with those expressed by the National Aboriginal Health Strategy Working Party in the late 1980s and by more recent reviews.[49,23,24]

Many, but not all, ACCHS also provide specialist ATOD social and emotional well-being services. There are clear advantages to this as such services can be provided either on-site or through outreach visits and can be coordinated with PHC service provision. Further ACCHS are in a position to provide – and support non-Indigenous organisations to provide – culturally safe treatment services. Participants pointed to Central Australian Aboriginal Congress' 'Safe and Sober Support Service' as providing an example that could be the basis of such an approach. This program – originally known as 'Grog Mob'[50] – provides coordinated care in three streams (medical, counselling and social) from within the Congress with referrals to more specialist services if needed.[51]

Where there are no ACCHS, or where ACCHS are not in a position to provide specialist ATOD services, there is need for other non-residential ATOD service providers. However, to the end of providing integrated client care, to the extent possible, the services provided by those organisations should be integrated with those provided by ACCHS or other PHC providers. To facilitate compliance with this, service agreements could be included as a provision of funding contracts.

To overcome the fragmentation of service provision, links between residential treatment service providers and ACCHS also need strengthening and formalising. While such links are relatively strong in some locations, the relationships are poorly articulated in others and – as between non-residential ATOD service providers and ACCHS – these should be the subject of formal service agreements. ACCHS are best able

to efficiently provide health services to the clients of residential facilities and, because of their wider geographical spread, are best able to provide on-going care services to clients discharged from residential facilities. Importantly, however, as service providers stressed, agreed-upon arrangements for the provision of services may need to be resourced as it cannot simply be assumed that this can be achieved within existing staffing and other resource allocations. For example, additional costs may be incurred in the provision of case coordination, practitioner visits to off-site specialist treatment services, and on-going care beyond regular clinical follow-up.

It is important to note that this argument for an ACCHS-PHC centred approach to the provision of ATOD treatment services is not an argument for the de-funding of other ACCOs providing such services. Like ACCHS, other ACCOs were established in response to needs perceived by Aboriginal and Torres Strait Islander communities and are a manifestation of the wishes of communities to control their own services. The approach we are suggesting is aimed at ensuring greater levels of cooperation between organisation, more effective use of limited resources, and most importantly ensuring that the provision of service to clients is as seamless as possible.

Summary

The wide range of Aboriginal and Torres Strait Islander community-controlled, non-Indigenous non-government, and government organisations providing ATOD treatment services has previously been documented.[14] These organisations include primary health care (PHC) providers, home and community visitors, withdrawal management facilities, and non-residential and residential treatment providers. The mix of such organisations and the services they provide varies considerably by state, territory and region. As some service providers themselves pointed out, coordination between organisations exists in some locations but in others is fragmented or limited.

Participants – particularly service providers – identified various gaps in the provision of treatment services. These gaps – which continue to reflect gaps identified in previous research[14] – include: gaps in access to a full range of services in some regions; lack of culturally appropriate services; limited range of gender-specific treatment services and services for young people; and, generally a paucity of on-going support and relapse prevention services for those completing intensive treatment. The latter services are crucial for, without them, investment in clinical services may be lost.

The gaps in treatment service provision are unevenly distributed and, as representatives of some community controlled organisations pointed out, the priorities arising from

them are sometimes not the priorities of local communities. Furthermore, in some cases, the services that are provided are provided as a result of historical funding decisions or the recent availability of program funds for particular services rather than current community priorities.

Generally, the current system for the delivery of ATOD treatment services for Aboriginal and Torres Strait Islander people is fragmented. There is no clearly articulated model or framework underlying the delivery of such services and limited opportunity for local community input into decisions about service provision – with the result that outcomes are less than optimal.

Planning for More Effective Treatment Service Provision

Planning is a critical component in the delivery of services aimed at reducing the harms associated with ATOD use in Aboriginal and Torres Strait Islander communities. ATOD treatment services are impacted upon by planning occurring at the national, state, local and agency level, and the quality of that planning impacts, both positively and negatively, across the field – most importantly upon those seeking help and those working in front-line services. The uneven distribution and fragmentation of ATOD treatment services for Aboriginal and Torres Strait Islander people is a concrete reflection of both the historically-specific development of services and the limited degree of service planning.[14] These concerns about planning are not new. A report prepared for the Australian National Council on Drugs stated:

> There is increasing emphasis on the need for rational and equitable planning in the delivery of services to Indigenous communities. ... However, the random distribution of projects and resources indicates that, to some extent, their growth has not been part of coordinated planning processes.[44]

A useful review of 'Planning processes for alcohol and other drug treatment in Australia' has been prepared by Ritter *et al.*[52] As they point out, there are various definitions of health care planning but they fall into two broad categories. On the one hand, there are those who view planning primarily as a process for the allocation of scarce resources. On the other, are those who take a more contextual view – emphasising goals, competing values and the political environment in which planning occurs. Among the representatives of ACCOs and NGOs we interviewed – either explicitly or implicitly – the latter was the predominant view. While by no means rejecting the latter view, employees of government agencies were more inclined to emphasise the centrality of resource allocation – not unsurprisingly, given that for some this is a key part of their work. These differences are important to recognise as they can be a source of tension between the funders and providers of services.

Even where there is agreement that planning should be goal oriented, as Ritter *et al.* caution, the goals themselves are not typically clearly articulated, leading to mismatched expectations.[52] Indeed, ACCO and NGO representatives who participated in the current study frequently expressed concern about the lack of clarity around planning decisions – emphasising that the goal and purpose of planning should be openly discussed and understood by those participating in, and affected by, planning decisions.

Any discussion of planning should not be limited to a discussion of how resources are allocated but should consider how they are applied.

Another distinction made by Ritter *et al.* which is salient to our discussion is that between strategic and operational planning.[52] Strategic planning is the high level national planning in which the vision, direction and objectives are set. It guides the general direction of service delivery and the development of the overall framework and principles. Some have defined technical planning narrowly as 'the systematic approach to the distribution of scarce resources' and the explicit allocation of resources.[52,53] While this view predominates, others have described technical and operational planning as the translation of strategic objectives into a concrete sequence of activities involving the allocation of budgets and resources, the provision of facilities, equipment and staff and the organisation of services.[52,54] Importantly, this second conceptualisation includes not only the allocation of resources but the implementation and organisation of services. Emphasis is given to both to both in this report. The report considers planning for ATOD service provision for Aboriginal and Torres Strait Islander people from national, state, local and service provider levels. Critical to all of this is a clearer understanding of what services are needed and what services are available.

Strategic planning

The primary strategic planning document for reduction of ATOD-related harm in Australia is the *National Drug Strategy 2010–2015* (the *NDS*).[9] The *NDS* aims 'to build safe communities by minimising alcohol, tobacco and other drug related health, social and economic harms' and encompasses the three pillars of demand reduction, supply reduction and harm reduction. As with previous iterations of the strategy, the *NDS* was developed consultatively in a process overseen by the Intergovernmental Committee on Drugs (IGCD) and endorsed by the Ministerial Council on Drugs. Importantly, the *NDS* specifies that is underpinned by commitments to partnerships across sectors, good governance (including partnerships and consumer participation), building the evidence base, evidence informed practice and innovation, monitoring performance and developing a skilled workforce. The *NDS* is not prescriptive, instead it provides a framework to guide similar state and territory strategic plans.

In recognition of the particular needs of Aboriginal and Torres Strait Islander people and a more focussed approach, the *NDS* has been supplemented by the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan* (the *CAP*).[45] The *CAP* which initially covered the period 2003–2006, was subsequently extended to cover the period 2003–2009 and has remained in place pending its

replacement by the *National Aboriginal and Torres Strait Islander Peoples Drug Strategy 2015–2018*.[13] The *CAP* was developed following extensive community consultation. It emphasised a holistic approach to understanding and addressing ATOD issues and a recognition of the need for culturally appropriate services. The *CAP* identified six Key Result Areas (KRAs) covering issues such as workforce development, treatment accessibility, and collaboration.

Initially, the IGCD established the Aboriginal and Torres Strait Islander Peoples National Drug Strategy Advisory Group to provide some oversight of the implementation of the *CAP*. When it was proposed to abolish this Advisory Group, along with a number of other IGCD advisory groups, the Australian National Council on Drugs (ANCD) successfully lobbied for the establishment of the National Indigenous Drug and Alcohol Committee (NIDAC) to replace it. NIDAC was established in 2004 and continues in that role.

An evaluation of the *CAP* found that it was largely supported and endorsed by stakeholders. However, it also found: the KRAs were far too broad; it lacked performance measures; and, monitoring of outcomes aligned to the *CAP* were poor.[55] The evaluators reported that beyond the symbolic function of the *CAP* its utility as a guide to assist development of planning at the national, state and local level was typically poor. It was reported that many did not see the *CAP* as an action plan as it did not guide action effectively and its influence was increasingly diluted with distance from centres of policy making – with many treatment providers not knowing of its existence. In summary, while the review found the *CAP* had not been utilised to its full potential – largely because it was not tied to a funding pool and not cross-referenced with the *NDS* – it emphasised its importance and it recommended that a *CAP* continue to accompany the *NDS* into the future. The on-going need for a plan such as the *CAP* was clearly articulated by participants in our review. However, the delay in the yet to be released replacement strategy – the *National Aboriginal and Torres Strait Islander Peoples Drug Strategy* – was widely criticised and seen by some as reflecting a low level of commitment.

In discussions with key informants and in the submissions to NIDAC, there was general support for the objectives of the *NDS* and the *CAP* and the commitments under-pinning them. However, there was some concern that this did not translate into effective technical planning and that the goals of the both remain largely aspirational.

A concern of key informants from the ACCO and NGO sectors was that decisions affecting Aboriginal and Torres Strait Islander people, were often made outside the

framework provided by the *NDS* and *CAP* – including decisions made at the Australian Government level which have a significant impact on strategic planning and ultimately technical and operational planning. For example, participants expressed concerns that the recent decision to transfer responsibility for Aboriginal and Torres Strait Islander AOD treatment services from the AGDH to the Department of Prime Minister and Cabinet (PM&C) was not consultative, its rationale was poorly communicated and it would impact negatively on planning for holistic service provision.

As indicated above, the *NDS* and related documents were developed cooperatively in a consultative process which involved the (now defunct) Ministerial Council on Drug Strategy and the Intergovernmental Committee on Drugs (comprised of officials from state/territory health and police departments and the Australian Government departments of health, police and customs). Although endorsed by the Australian and all state and territory governments, the *NDS* is not prescriptive. Rather, it sets the broad parameters of strategy. The specific implementation of these broad strategies is the prerogative of state and territory governments in accord with their specific needs and priorities.

Within this framework, all states and territories have their own strategic plans or frameworks aimed at the minimisation of ATOD-related harm. These may highlight particular substances of concern and priority groups and most have specific plans to address ATOD-related harm among Aboriginal and Torres Strait Islander people. For example the West Australian Government has both a *Drug and Alcohol Strategic Framework* and an *Aboriginal Drug and Alcohol Framework*.[56,57] The latter is particularly well regarded: it was closely aligned to the principles in the *CAP* and is presented in a clear framework that can be easily understood and utilised across the sector. The utility of the document is a particular strength.

Similar to their national counterparts, the state policy documents outline strategic directions and identify broad key result areas. However, key informants from ACCOs, were less likely to feel consulted in development of these plans. As with the *CAP*, state level plans tend to contain aspirational targets and poorly operationalised terms which can be overlooked when it comes to technical planning. For example, it is common across documents which express the importance of holistic treatment but – whilst there is some explanation of the term 'holistic' either as meaning across the whole of health or encompassing broader social emotional and spiritual wellbeing – there is little clear articulation that ATOD service providers should provide, or provide access to, the social support services needed to complement clinical services. In the Western Australian plan, for example, the statement that 'A holistic approach may need to consider other

areas' gives neither sufficient emphasis to, or guidance in the provision of such services.[58] As with national plans, state and territory level strategic plans are clearly well-intentioned but they are poorly operationalised and tend to be neglected and ignored when it comes to technical planning at the community level.

The *CAP* and the various state and territory Aboriginal and Torres Strait Islander ATOD strategies have provided a broad framework in which goals, key priorities and strategies to address them are identified. However, an essential element missing from them is a clearly articulated and agreed upon organisational framework through which the strategy is to be implemented. A consequence of this is the failure to harness the good intentions expressed throughout the *CAP*.

At the community level there is no consistent approach to the strategic planning of ATOD treatment services for Aboriginal and Torres Strait Islander services.. Whilst there is some concern that strategic planning is less suited to the community level – because it may provide little additional benefit if it is unrelated to funding and resource allocation – many key informants clearly articulated the importance of such an approach and the advantages flowing from it. These advantages are two-fold. First, it enables planners and providers to engage with local communities, to identify their priorities, and reflect them in service provision and coordination. Second, community-based plans have the potential to feed into the state/territory and national planning processes and hence their responsiveness to the needs of clients 'on the ground'.

Key challenges to developing and sustaining strategic planning for ATOD treatment services at the local level are: human resources, individuals with adequate skills and experience in planning, financial resources; and, active support from the various levels of government. The framework presented in the preceding chapter, which embeds ATOD treatment within ACCHS, provides a model in which effective community level planning occurs providing the benefits described above whilst minimising the risk of over-planning or planning untied to any realistic funding base.

Agency level strategic planning is critical in the delivery of quality services and in developing and maintaining a quality workforce to deliver those services. However, the use of strategic planning varies greatly across the ACCO and NGO sectors, with some agencies utilising strong methods of strategic planning and other agencies operating largely in a reactive manner – this being closely related to the strength of agency boards and organisational governance.

A key challenge to strategic planning at the agency level is balancing the priorities of communities and those of funders – priorities which may not be in accord. A number of key informants also discussed the challenges in planning when they are reliant on short term funding cycles which can limit the capacity of agencies to hold long term strategic plans. As one ACCO representative said, 'Our planning is limited by our funded arrangements'. Smaller agencies with limited funding sources are particularly at risk of developing planning procedures which focus more on the needs of funders than the communities they service.

Technical planning

As indicated above, key informants generally felt positively towards the goals of the *NDS* and the *CAP*. Nevertheless, within the ACCO and NGO sectors, there was concern that these goals were poorly translated into technical planning which – at both the national and state-territory levels and with some variation – was generally perceived to be ad hoc and not driven by community need. A consequence of this was seen to be less than optimal outcomes. As noted by Ritter *et al.*, there has been a lack of an evidence-based approach to planning methodology[52] and this is partially reflected in the gaps in service provision for Aboriginal and Torres Strait Islander people. Technical planning for the provision of effective ATOD services constitutes a significant challenge and, in interviews with key informants, a number of themes around this challenge emerged.

Poor understanding of service gaps and priority areas

As noted earlier, there is limited epidemiological data that can be used to quantitatively identify key priority areas for service needs. As a consequence, some decisions about service funding and resourcing are made without adequate consideration of gaps and resources are allocated in an ad-hoc and reactive manner – particularly at the state and territory level.

> Even the gap analysis seems to be reactive rather than proactive. (CEO Peak representative)

Participants expressed concern that, in the absence of data to inform planning processes, some government agencies were relying on the opinions of prominent but unrepresentative individuals, headline grabbing topics identified in the popular media, or areas identified by public sector employees who are not adequately grounded in community consultation and knowledge.

Lack of consultation

Following on from the above, a general feeling among key informants was that there is a lack of community consultation and engagement in technical planning. While a state government employee in one jurisdiction spoke positively about cooperation between state and Commonwealth agencies in determining funding allocations, there was no Aboriginal involvement in the process. A submission to the NIDAC Consultations from another jurisdiction commented on similar arrangements:

> Whole of government efforts through COAG have often totally excluded the voice of the community and have been imposed in a top down manner. (AMSANT, NIDAC Consultation)

Community voices should always be part of planning decisions but, in the absence of epidemiological and service data to inform planning, the weight of such voices is particularly important. Limited consultation can lead to failure to address gaps in service provision, but also to resourcing of initiatives that may be in effective. An example of the latter is illustrated in the quote in the previous section relating to the establishment of a residential treatment facility in the Anangu Pitjantjatjara Yankunytjatjara Lands. As the informant went on to say:

> Every piece of advice from the community was that this isn't going to work. It was another case of the government not listening to the people and that's a really difficult thing. That's a real barrier (CEO NGO peak).

Key informants from all sectors generally agreed that services developed with community consultation and engagement are more likely to be successful. Technical planning will produce a better return on investment when informed by communities.

> Need an Aboriginal world view of what service delivery should look like and what the needs of the people are. That its Aboriginal owned and driven. (State government employee)

> Decisions about funding should be driven by Aboriginal organisations (CEO NACCHO affiliate)

> Idea comes to us from community. We review the past. What's been done? What works? What can we do? How much does it cost? Does it fit with our agency philosophy and the evidence? And *then* we micro plan. (CEO NGO)

While there was agreement on this point, a key barrier is the absence of structures through which it can be better facilitated.

Narrow definition of treatment

Concern has been expressed that ATOD treatment service planning – including the new *Drug and Alcohol Service Planning Model for Australia*[29] – tends to focus on medical

and counselling services and does not address the need for the social support services which are critical for long term treatment success. A key theme in participants' responses was that planning fails – and ultimately services fail their clients – when it does not take into account the complexity of ATOD and whole-of-life issues.

> The problem with government is that when they fund services they look at the therapeutic end. But frequently, what people need is good support services and that doesn't have to be high level clinical services stuff. That just needs a regular presence, help, support with shopping, housing, lawyers that sort of stuff. (CEO NGO peak)

> … there are very high levels of comorbidity between AOD problems and mental health issues. Therefore it makes sense to provide integrated (Social and Emotional Wellbeing) services that will address both AOD and mental health problems in a holistic and integrated way using therapists and Aboriginal mental health/AOD workers who have the appropriate skills to deal with these problems. We believe that the money to provide an integrated and comprehensive service is already in the system but is being spent on vertical, poorly integrated services. (AMSANT, NIDAC Consultation)

> Treatment success is limited by (failure to address) basic welfare needs. (CEO ACCO)

Basing planning on narrow definitions of treatment ultimately means many of the services required by individuals seeking help will not be adequately funded, thereby making even greater the challenge of providing effective ATOD treatment.

The need for flexibility in allocating resources

Many participants discussed the need for flexibility in planning and allocation of resources to enable providers to adjust service provision to meet the changing needs of their clients and the community.

> [Let *us* review] what's working, what's not working and *we'll* fine tune it. … The community should have the flexibility to address and put in place some strategies. (CEO NACCHO affiliate)

Even with good quality data, flexibility to respond to changing circumstances at the local level is important, but, in the absence of such data, flexibility is even more important. Supporting the capacity of funded agencies to adapt services to the needs of communities facilitated by collaborative relationships between funders and service providers may result in more effective programs and ultimately savings.

> We were given funding for the positions so I went and did community consultation looking at how they saw these positions and the thing that came out of it was the community didn't want more nurses, they wanted local people for these positions, they wanted local people trained up. With that I wrote back to the Commonwealth and they agreed to do that and one of the successes of that was that part of the agreement was these positions got a house so it didn't matter if you were Aboriginal, nurse, allied health you were entitled to get the house with the position. (Government employee)

In this example the mechanism by which an outcome was achieved was altered as a result of community consultation.

> What we've advocated is at the state level is the contract management process would have two meetings a year where they come out twice a year and sit down with people. (CEO NGO peak)

Challenging policy circumstances

Several participants also discussed the challenges of technical planning associated with policy shifts that were not in line with agency priorities or with current evidence. For example, key informants reported that the introduction of mandatory treatment in the NT became a challenge for a number of organisations as the technical planning around ATOD services shifted suddenly and not in line with what communities perceived as need or best practice. As a consequence of this poor technical planning, further unplanned services were required for which adequate funding or support were not provided.

> … it became clear that aftercare or on-going care was required for people once they had left treatment centres, however this wasn't resourced and existing organisations in the sector were requested to this without any increase in funding. (CEO NACCHO affiliate)

Planning and expectation mismatch

Many key informants reported described that a negative consequence of poor technical planning was a mismatch between expectation and level of funding. Smaller ACCOs with less experienced personnel reported struggling with the consequences of decisions – under pressure from both government and communities – to take on service activities that were not adequately funded. This contrasts with some larger organisations, representatives of which reported turning down funding for the provision of services which were poorly planned.

> … if it's under resourced your execution will be poor because you don't have the resources to execute it. I mean we don't just accept money, we will say no we can't do it for that. (CEO ACCHS)

In another example of such a mismatch, the CEO of a large ACCO made the point that on-going care requires proper operationalization and funding. Whereas among funders there was an expectation that it simply happens because it is 'best practice'.

Planning which facilitates best practice

Following on from the above there was some discussion among participants regarding the commitment to best practice and culturally safe practice at the planning level. A key focus of the *NDS* and the *CAP* has been the importance of evidence based practice. Resources and planning are often directed toward piloting treatment practices or approaches ('There have been that many pilot projects you'd think we were an airport') to be followed by broad dissemination into existing services. However, such dissemination is typically poorly planned with scant attention paid during technical planning to the feasibility of implementing best practice and measure required to ensure they are adapted to suit local cultural needs.

Integrated technical planning

A primary theme from key informants in relation to planning is the need for integrated technical planning that includes national, state, and local agencies. When planning is not integrated it impacts on service providers and presents challenges meeting the needs of all funders. There is also the risk of over servicing some areas and underservicing others. For example:

> In one year [in named location] all these problems came up and they just chucked money in there. It's been highly un-coordinated money and the services don't talk to each other. … There's resource duplication, people can have 14 agencies working with them (CEO NGO peak)

Another risk of poorly integrated planning is the competition that can develop within communities. One service provider stated that 'Limited funding can set up an adversarial relationship between one organisation and another' with further negative flow on effects. However, if planning is integrated and supported this can be minimised and collaborative projects can be developed.

The previously cited quote about Australian and state funding agencies forming a partnership group to cooperatively decide on the allocation of funding to avoid duplication and fill gaps was a step in the right direction but it did not include ACCO representatives. It important to note that this partnership did not survive because the structure was not institutionalised.

A key point made by informants was the need to incorporate not only multiple government agencies but that peak bodies play a crucial role to provide local voices. Whilst it is important that all Aboriginal and Torres Strait Islander people should have the right to choose if they wish to attend an ACCO or not, the majority of respondents emphasised the need for ACCOs to have the strongest voice in articulating need and in

technical planning. The importance of peak bodies cannot be underestimated. When properly resourced they can ensure the technical planning is appropriately managed from the perspectives of funders and also community. Consequently, it is important to ensure that peak bodies have a place at the table during technical planning activities and are able to play an active role in those activities.

In the absence of peak body involvement, there is a difficulty in communities and services advocating in a coordinated and positive fashion. It is important to include local voices to ensure that planning is responsive and appropriately flexible. However, as Ritter *et al*. caution that if there is a too great a focus on small local units in planning then planning becomes too cumbersome and there is a risk of over-planning.[52]

> The NATSIPDS can act as a balance to this trend by actively promoting proactivity and not reactivity, and strongly advocating for the central position of process in proposing or informing solutions. In particular, the NATSIPDS can provide a valuable launching point for the re-emphasis on community development as key principle and design feature of any AOD initiatives. (South Australian Network of Drug and Alcohol Services, NATSIPDS Consultation)

Support for planning

It is important to note that the majority of key informants who participated in this project felt that planning in ACCO treatment services was vitally important 'if you fail to plan, you plan to fail'. Improved planning of treatment services is necessary if those with ATOD problems are to be provided with a level of care that will achieve the best outcomes and if resources are to be efficiently used in accord with the principle of community control. At present planning processes are less than optimal and if they are to be improved additional support is required. Summarised below are areas of opportunity which, if supported, will improve the quality of planning in ATOD service delivery.

Planning and resources

To adequately support planning and improve outcomes a shift in resources is required. Importantly, several key informants commented that within government there is often both a lack planning expertise and resourcing for the planning process itself.

> Government requires people with technical knowledge to support planning. There's a lack of technical planning expertise in government.

> I'd like to see a well-developed strategic policy and planning unit, and work to continue to work out our policy planning and initiatives. It needs that leadership. (Government agency employee)

As recommended by Ritter *et al.* formal governance around planning is required, with more structured processes for this to occur.[52] Planning itself needs to be adequately resourced, funded and evaluated. This is particularly important when it is related to management of finite resources to a resource intensive sector. In this regard, there are some who might argue that allocation of resources to planning diverts them from the provision of services. This might be true but the amount required is not necessarily great and the investment will be re-paid in more efficient and effective service provision.

Data quality and planning

A prerequisite for any planning is data. Ritter and *et al.* provide an extensive, but not exhaustive, list of data that may be utilised in planning, including socio-demographic data, epidemiological data, treatment utilisation data, resource availability and case mix information.[52] Informants interviewed by Ritter *et al.* were aware of the lack of data adequate to inform planning, but also noted the lack of data use in planning. They noted the lack of data meant it is difficult to identify gaps and that there is a disconnect between data and decision making.

The concerns expressed by Ritter *et al.* about the quality for ATOD planning in general are exacerbated in the Aboriginal and Torres Strait Islander context. The paucity and lack of timeliness in regard to ATOD-related harm among Aboriginal and Torres Strait Islander people and the availability of resources and services to address this has long been recognised.[14] Some data, such as self-reported ATOD consumption data and ATOD-related hospital admissions data, are available at the national level or state and territory level.[5,6] While these data are useful for providing a 'broad-brush' picture they are less useful for planning purposes at the state-territory and regional levels where the available data suggest that there is considerable variation in levels of consumption and key indicators such as alcohol-related mortality.[4,14]

Concern about the lack of data and the need to develop robust data for planning were recurrent themes in discussions and documents considered for the current study. In a submission to the NIDAC consultations for the *National Aboriginal and Torres Strait Islander Peoples Drug Strategy*, the NACCHO affiliated Victorian Aboriginal Community Controlled Health Organisation wrote:

> A barrier to providing drug and alcohol treatment services in Victoria is that little data is recorded and need can be difficult to understand and establish.

In a similar vein, the Kirby Institute submission to the NIDAC consultations stated:

> Surveillance of AOD use among Indigenous Australians could do with much improvement. One such improvement could be to increase the Indigenous sample for the National Drug Household Survey (which currently excludes people in prison). The new National Aboriginal and Torres Strait Islander Peoples Drug Strategy should propose a way in which measuring of AOD use among Indigenous Australians can be improved.

Participants expressed concern that the lack of data was resulting in poor service planning, including adequate identification of need in some areas and over-servicing others. Participants also suggested that – in the absence of quantitative data – there is a need for planners to consider other sources of information including qualitative data and extensive consultation, in particular the recognition of the knowledge Aboriginal and Torres Strait Islander people have of their own communities.

> Indigenous people's understanding of their communities and the issues they face because of drug and / or alcohol use means that resources and services can be targeted to best address the need of Aboriginal drug users. (Anex, NIDAC Consultations)

> There should be equal consideration given to qualitative data and reporting (South Australian Network of Drug and Alcohol Services, NIDAC Consultations)

As well as concerns about the paucity of data and the need to make more use of qualitative data and consultation, there was a general feeling among participants from the ACCO and NGO sectors that available data are poorly utilised and that many planning decisions were made without consideration of data or research evidence and with little or no consultation. The introduction of the *Alcohol Mandatory Treatment Act* in the NT, and the establishment of a residential rehabilitation centre in the Anangu Pitjantjatjara Yankunytjatjara Lands in South Australia were cited as examples.

> The Wran Government, built a rehab centre on the (APY) lands – $4 million. 'Build it and they'll come. Four people! They were the four most rehabilitated Aboriginal people in the world I think. They got in there and nobody else came. So that whole lack of process is problematic. (CEO NGO)

Planning methods

As noted by Ritter *et al.*, there has been lack of an evidence-based approach to planning methodology.[52] A recent effort to address this has been the development of the *Drug and Alcohol Service Planning Model for Australia* – sometimes referred to as DA-CCP, the acronym for the project on which it was based.[29] The *Drug and Alcohol Service Planning Model* is a technical planning tool that uses demand-based projections derived from epidemiological data which can be used to systematically identify gaps and assist in the allocation of resources. It is important to note, however, that the *Drug and*

Alcohol Service Planning Model focuses on the demand for clinical services and does not include the range of support services that are essential to the provision of effective treatment. It is also important to note that the estimates of demand produced by the *Drug and Alcohol Service Planning Model* provide only a technical solution, which can inform, but not prescribe, final planning decisions which must be negotiated with key stakeholders and through the political process.

While for the broader Australian population, the *Drug and Alcohol Service Planning Model* has the potential to quantify the demand for ATOD clinical services, there is currently insufficient epidemiological data to apply the model to estimate demand for use in Aboriginal and Torres Strait Islander ATOD service planning. Nevertheless, work currently being undertaken to adapt care packages aimed at individuals with particular ATOD problems (of different degrees of severity) for application to Aboriginal and Torres Strait Islander people has the potential to inform planning for the quality of services to be provided if not the quantum.

Planning structures

To support the methods described above there is a clear need to integrate the voices and expertise of community. Key informants from the ACCO and NGO sectors in particular stressed the role that Aboriginal and Torres Strait Islander peak bodies can potentially play, not only in representing the views of member organisations to government, but as a partners in planning processes. NACCHO represents over 150 ACCHS and, as indicated previously, all provide PHC services to people with ATOD problems and many these also provide specialist ATOD treatment and support services.

There is no national peak body similar to NACCHO which represents ACCOs providing ATOD specialist services. In South Australia the Aboriginal Drug and Alcohol Council (ADAC) represents 17 organisations at the state level. In the NT ATOD treatment providers are eligible to become members of the Aboriginal Medical Services Alliance of the NT (AMSANT) – although not all have done so. In Queensland Aboriginal and Islander ATOD services are eligible for membership of the Queensland Aboriginal and Islander Health Council (QAIC) and within it have a subsidiary body, the Queensland Indigenous Substance Misuse Council (QISMC). Supporting and funding agencies such as these will provide a clear pathway for Government agencies to plan effectively with the sector (not for the sector).

Summary

At the national level, the *National Drug Strategy* provides the strategic framework for addressing ATOD-related harm. Subsidiary to this has been the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009* (the *CAP*);[45] soon to be replaced by the *National Aboriginal and Torres Strait Islander Peoples Drug Strategy* (NATSIPDS).[13] These plans are not prescriptive, but provided a framework to guide similar state and territory strategic plans, such as Western Australia's 'Strong Spirit Strong Mind' plan.[57] The national, state and territory plans have been based on varying degrees of consultation with Aboriginal and Torres Strait Islander people. However, at the regional and local level there are varying degrees of familiarity with these plans – as found in the evaluation of the *CAP*.[55] Among those interviewed for this project, and those who participated in the NIDAC consultations for the development of the *National Aboriginal and Torres Strait Islander Peoples Drug Strategy*, there was general endorsement of the plans' broad aspirational goals. However, representatives of community-controlled organisations were critical of limited local participation in service planning and it was clear that at the technical and operational levels planning is not optimally effective.

While positive examples exist, service providers expressed a number of concerns about the planning of ATOD treatment services for Aboriginal and Torres Strait Islander people. Among these concerns are that planning is: largely symbolic and limited to the development of broad strategy; driven from the top, reactive and undermines community-control; constrained by the poor quality of available data; not directed at clear goals; not coordinated and integrated; not adequately consultative of local communities about their needs; and, focuses too heavily on the allocation of funding at the expense of operational planning.

Poor planning – the failure to provide the right service, at the right place at the right time – affects the sector in four key ways. First, and most importantly, it means that those seeking treatment are unable to obtain it and that they and others around them will experience on-going harm. Second, it impacts on the stability and effectiveness of the ATOD workforce and the opportunity build capacity. Third, it affects the organisations that provide services which may become ineffective and may ultimately fail. Finally, it results in misallocated resources and potential waste.

A missing element in strategic planning for the provision of ATOD treatment services for Aboriginal and Torres Strait Islander people has been a clearly articulated organisational model or framework through which such service are most efficiently

provided. An ACCHS-PHC centred model has the potential to provide a more effective focus for the planning and provision of ATOD treatment services and is consistent with the broad strategies articulated in both the *National Drug Strategy*, the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Drug Strategy* and the *National Aboriginal And Torres Strait Islander Health Plan 2013–2023*.[9,45,58]

To be effective, a sharpened, coordinated focus on the planning of ATOD treatment services requires the structures and resources to support it. As articulated by service providers, these include: improved data collection; the strengthening of Aboriginal and Torres Strait Islander peak bodies and their state and territory affiliates to enable them to canvass and represent the views of regional and local communities; forums, with decision-making roles, which bring together on a regular basis representatives of ACCOs, other service providers, and governments which can provide more flexible responses to ATOD-related problems. Such forums would not need to meet more than annually and could probably be 'piggy-backed' on to other activities. While there are some cost implications of this, these are not necessarily great and would yield benefits in the more effective and efficient delivery of services.

Funding for Treatment Services

The funding of ATOD services for Aboriginal and Torres Strait Islander people is something that is paramount in the minds of both funders and service providers. Among the challenges are how to: garner resources equal to the magnitude of ATOD problems in a time of budgetary constraint; deploy existing resources to best effect; achieve efficiencies without sacrificing effectiveness; and, do these things without undermining Aboriginal and Torres Strait Islander community-control.

Sources of funding

Virtually all funding for the provision of Aboriginal and Torres Strait Islander ATOD services is provided by Australian, state and territory governments. Within these governmental jurisdictions, funds are provided by different agencies managing various funding programs. The Australian Government began providing specific funds for the improvement of Aboriginal and Torres Strait Islander health through the (then) Department of Aboriginal Affairs (DAA) in the 1970s. Most of this money was allocated to the provision of housing and health infrastructure, with a lesser amount being provided to support PHC services and a small amount to support residential alcohol treatment services. In the same period, the Australian Government Department of Health established an Aboriginal Health Branch, which also provided funding for some PHC services. In the 1980s, these various health programs were consolidated within DAA – which later became the Aboriginal and Torres Strait Islander Commission (ATSIC). In subsequent years, concern grew that the amount of funding for health and ATOD services was limited under this arrangement and in 1995, following much lobbying, these funds were transferred to the newly created Office for Aboriginal and Torres Strait Islander Health Services (later to become OATSIH, the Office for Aboriginal and Torres Strait Islander Health).[59] It is important to note that although PHC and specialist ATOD services were located under one broad umbrella in both ATSIC and OATSIH, they were administered largely as separate entities. This was despite the fact that, in 1989, the National Aboriginal Health Strategy Working Party called for the integration of PHC and ATOD services.[60]

Within the AGDH, OATSIH remained the largest funder of Aboriginal and Torres Strait Islander ATOD services until 2011.[14] At that time, the AGDH consolidated 159 funding programs into 18 ‘flexible funds’. One of the latter was the Substance Misuse Delivery

Grants Fund (SMSDGF) – administered by the Mental Health and Drug Treatment Division. The SMSDGF incorporated the following programs previously administered by either the Mental Health and Drug Treatment Division or OATSIH:

- COAG Mental Health - Improved Services for People with Drug and Alcohol Problems and Mental Illness
- National Illicit Drugs Strategy – Community Education and Information Campaign
- National Illicit Drug Strategy – Indigenous Programs
- National Tobacco Campaign – More Targeted Approach
- Substance Use: Base Funding; COAG Substance Use 06 Program; COAG Substance Use 07 Program; Opal Fuel Rollout.[61]

The objective of the SMSDGF was:

> … to better promote and support treatment services across Australia to provide better outcomes for individuals and communities affected by alcohol and drug misuse.

The program had six priority areas:

- Supporting non-government drug and alcohol treatment services to deliver quality, evidence based services and build capacity to effectively identify and treat coinciding mental illness and substance misuse;
- Assisting Indigenous communities to provide service delivery in alcohol and other drug treatment;
- Supporting those services targeting Aboriginal and Torres Strait Islander people to increase the effectiveness of, and access to, drug and alcohol treatment and rehabilitation services;
- Reducing the prevalence and impact of petrol sniffing by continuing to support the supply of low aromatic fuel;
- Supporting people from culturally and linguistically diverse backgrounds; and,
- Supporting the development and implementation of a range of social marketing campaigns.[62]

The SMSDGF is largely a competitive grants program. However, within the program, the AGDH also has the option providing funding through other mechanisms, including targeted grant rounds, one-off unsolicited proposals, and procurement of work consistent with the program objective. Of the 184 organisations funded under the SMSDGF in 2013, 28 were ACCHS, 34 were other ACCOs, and the remainder were NGOs, some of which submitted proposals for the delivery of services to Aboriginal and Torres Strait Islander people.

Alongside the SMSDGF, the Substance Misuse and Indigenous Wellbeing Program Branch of the AGDH also administered the Non Government Organisation Treatment

Grants Program (NGOTGP) – a more specifically treatment-focused program. Originally established in 1997, the aim of the NGOTGP is to:

> … increase treatment places and improve service outcomes and quality as well as reduce drug-related harm to individuals, families and communities.[63]

The NGOTGP is a competitive funding program. In 2013, 124 organisations were funded under the program and, of these, three were ACCHS and eight were other ACCOs.

In March 2008, the Australian Government introduced the three year, $14.5 million Indigenous Tobacco Control Initiative. Its purpose was to trial innovative approaches to reduce smoking levels among Indigenous peoples and communities. Eighteen projects – driven by Aboriginal and Torres Strait Islander communities – were funded including the Miwatj Tackling Smoking Project in East Arnhem Land and the Maari Ma smoking cessation project in the west of New South Wales. It was anticipated that lessons learned from the pilot projects would inform the implementation of the $100.6 million Indigenous Tackling Smoking measure funded under the COAG Closing the Gap in Indigenous Health National Partnership. Under the measure an evaluation component was included to monitor progress in reaching the COAG National Healthcare Agreement target of halving the prevalence of smoking among Aboriginal and Torres Strait Islander people by 2018.

While OATSIH's ATOD funding was transferred to the Mental Health and Drug Treatment Division, administration of PHC funding remained the responsibility of OATSIH – which subsequently became the Indigenous and Rural Health Division. An effect of this was to further emphasise the administrative separation of PHC and ATOD funding programs.

In 2013, Australian Government announced a new 'Indigenous Advancement Strategy' to be administered by the Department of the Prime Minister and Cabinet (PM&C) to take effect from the 1st July 2014. This strategy – aimed at streamlining administrative arrangements – has five priority areas:

- Jobs, Land and Economy
- Children and Schooling
- Safety and Wellbeing
- Culture and Capability
- Remote Australia Strategies

consolidating over 150 individual programs and activities.[64]

The third of these priority areas, the 'Safety and Wellbeing Programme':

> … is about ensuring the ordinary law of the land applies in Indigenous communities, and that Indigenous people enjoy similar levels of physical, emotional and social wellbeing enjoyed by other Australians. The programme will fund a range of activities including those that support:
> - Health, social and emotional wellbeing
> - Drug, alcohol and substance misuse prevention
> - Community safety and violence prevention
> - Legal services and access to justice, including interpreter services
> - Diversionary programmes.[64]

As part of this initiative, responsibility for the 'Petrol Sniffing Prevention', 'Social and Emotional Wellbeing' and 'Substance Use' Programs has been transferred from AGDH to PM&C. The latter includes three of the priority areas from the SMSDGF:

- Assisting Indigenous communities to provide service delivery in alcohol and other drug treatment;
- Supporting those services targeting Aboriginal and Torres Strait Islander people to increase the effectiveness of, and access to, drug and alcohol treatment and rehabilitation services; and,
- Reducing the prevalence and impact of petrol sniffing by continuing to support the supply of low aromatic fuel.

The AGDH funds a limited proportion of ATOD treatment services, provided by both ACCHS and private practitioners, through the Medical Benefits and Pharmaceutical Benefits Schemes.[65] In addition, the Australian Government funds bed-day costs in many residential treatment facilities through Aboriginal Hostels Limited (AHL). It is important to note that organisations have accessed, and do access, funding through more than one of the Australian Government's funding sources. In 2013, 11 organisations accessed funds from both the SMSDGF and the NGOTGP, the 30 ACCHS accessing these funds also accessed PHC funding, and the residential treatment services accessed the AHL funding in addition to AGDH funds. Also, because many of the ACCHS and other ACCOs provide more than treatment services, some access funds from other Australian Government sources such as the Attorney-General's Department. However, overall, for over a decade, the AGDH has provided about half of all direct funding for Aboriginal and Torres Strait Islander ATOD intervention services.[14,44]

In addition to the funds for Aboriginal and Torres Strait Islander ATOD treatment services provided directly by the Australian Government, most other funding for such services is provided by the state and territory governments. In 2012–13, for example, of the 228 organisations receiving funding from the SMSDGF and the NGOTGP, about 70 per cent were also receiving funds from state or territory health departments. However, much of this funding was provided to the states and territories by the Australian Government through National Partnership payments.[65] The range of funding sources

provided by state and territory governments for Aboriginal and Torres Strait Islander specific ATOD services varies by jurisdiction and includes funding from justice agencies for diversion and treatment programs. It is beyond the scope of this paper to review these arrangements. Suffice it to say, however, that they add significant complexity to the funding and reporting web. As highlighted by Dwyer *et al.* with regard to PHC services, such complexity contributes to:

> … fragmentation and duplication in relation to the purposes, reporting and monitoring of funds and their application to service delivery and corporate support functions.[16]

At the national level, the AGDH's introduction of the flexible funding programs and the later consolidation of Aboriginal and Torres Strait Islander programs in PM&C, is generally to be applauded. However, with regard to ATOD services the latter initiative is likely to be less than optimally effective. As we and others have argued, addressing ATOD-related problems in Aboriginal and Torres Strait Islander communities is an essential component of PHC and as such should be integrated with the services provided by ACCHS.[23,24,60,66] Such integration has not yet been achieved and the continued administrative separation of ATOD and PHC programs will remain an obstacle to the end of minimising ATOD-related harm in Aboriginal and Torres Strait Islander communities. This position was summed up by a representative of a state NACCHO affiliate who stated:

> I think that problem (of separating ATOD and PHC services) is continuing and if you look at the structures now within the Commonwealth Health Department, funding for primary health care services continue with the Commonwealth Health Department with the new Indigenous and Rural Health Division. Alcohol and drugs have moved from the Health Department across to Prime Minister and Cabinet and so that's probably going to exacerbate that separation.

In the same vein, the CEO of another NACCHO affiliate said:

> I don't know whether or not it's going to be a good thing for us because there's no real thinking around integration into the health system and other bits and pieces. It's another department.

Funding levels

As discussed previously, there is insufficient data to estimate levels of either un-met need or demand for ATOD treatment services among Aboriginal and Torres Strait Islander people. Nevertheless, as indicated previously, epidemiological data on ATOD-related mortality and morbidity indicate that levels of both need and demand for ATOD treatment services are *at least* twice those in the non-Indigenous population. Work by NIDAC indicates that managing ATOD-related problems among Aboriginal and Torres

Strait Islander people also requires greater intensity of service provision.[67] This raises the question 'Are ATOD services for Aboriginal and Torres Strait Islander people funded at level adequate to meet the need?' We do not have the data available to answer this question in quantitative terms but – based on what those interviewed for this study have reported and a previous ANCD report[14] – the answer is 'No'.

Nationally, between 1999–2000 and 2006–2007, funding for all Aboriginal and Torres Strait Islander specific ATOD interventions, in real terms, rose by 34 per cent from $236 to $316 per person aged ≥15 years.[14] We are not aware of any similarly detailed studies of expenditure on Aboriginal and Torres Strait Islander ATOD services, but various reports indicate that since 2007 there have also been increased allocations. Nevertheless, none of the key informants we interviewed, none of the submissions made as part of the consultations conducted for development of the *National Aboriginal and Torres Strait Islander Peoples Drug Strategy*, nor any of the published reports on this area indicate that, across-the-board, levels of funding for ATOD treatment services are adequate to address documented levels of harm. Speaking specifically about funding, a senior public servant in a state/territory jurisdiction said:

> For the size of the problem and the particular sort of difficulties of the problem, there's still a lot more that needs to be done.

Particularly among service providers and representatives of peak bodies, but also among some government agency employees, there was a high level of agreement that funding levels in general are inadequate. Among the consequences, they highlighted inability to either undertake new initiatives or expand existing programs to address the gaps identified in the second chapter of this report. Organisations often face community expectations that they respond to need and provide a full range of services. However, limited resources constrain their ability do to so. Some also felt that funding agencies have unrealistic expectations about what can be achieved with available levels of funding.

> People (in the community and funding agencies) are often disappointed by what they think we should be doing and what we can do, and it comes down to resources really. There's not enough funding in the sector. (CEO ACCO)

At a second level, for some organisations inadequate funding constrains the ability to provide clients with the intensity of support or the range of services they require, or to link clients to such services. Speaking of the lack of resources to provide the broader range of services needed to support clients, an ACCO service provider said:

> You can't just address the addiction. That's just the physical thing. You know what I mean? There's all the emotional stuff that goes with it. There's all that behavioural stuff around what created the addiction in the first place.

Reflecting on the constraint imposed by limited funding, an ACCHS employee said this made it necessary to:

> … pick and choose what you concentrate on when you're working in an inadequately resourced primary health care service and you're dealing with people with a complex array of problems.

Particularly for representatives of residential treatment facilities, but also for other service providers, short-falls in funding were in part related to historically determined arrangements under which funding agencies fail to take account of growth in the demand for services and the real cost of providing services. Several issues were raised in this latter context, including the high costs of: service provision in remote areas; recruitment and turnover of staff; and, providing on-going care to clients from highly mobile populations. Specifically with regard to residential facilities, the CEO of one said:

> We provide a 24-hour a day service but we're only funded from nine-to-five. We don't have the dollars to put on enough staff after-hours. This puts staff at risk and it puts clients at risk and it exposes … (the organisation) to risk.

Another issue of concern for residential treatment facilities is the short-fall in the cost of funding and maintaining bed-places. As indicated above, AHL has for a long period funded bed-places in many residential treatment facilities – a purpose for which its program was not originally designed. As highlighted by residential treatment service staff, these funds are based on occupancy rates. These do not take into account the recurrent component of costs of maintaining those beds, whether occupied or not, and thus under-fund the cost of providing the service.

In a period of tight fiscal restraint, there is no simple solution to the problem of funding that is insufficient to provide optimal levels of ATOD treatment. Given the fragmented nature of the present system of service provision, efficiencies are likely to be achieved by increased coordination between service providers. Given the need for integration between PHC and ATOD-specific services, and their numbers and geographic spread, ACCHS are best placed to facilitate such coordination. However, it is important that such arrangements be negotiated and not imposed. It is also important to note that service coordination and coordinated case management are not cost-free and that investment in these – supported by service and funding agreements – will be necessary to achieve longer term funding efficiencies and improve the quality of care.

An advantage of a an ACCHS-PHC centred model of ATOD treatment service provision is the potential for increased access to funding under the Medical Benefits Scheme for services such as screening and brief interventions, and improved treatment under mental health and chronic disease care packages which several of those interviewed said are currently under-utilised. Such funding could also support provision of care to clients of residential treatment services – either where organisations have part-time medical staff or, more importantly, where they have service agreements with ACCHS. While some saw this as a panacea for current funding short-falls, an experienced medical practitioner with an ACCHS cautioned:

> Medicare money would just fund the GP and the psychologist, nothing more. There'd be no profit from it to fund other aspects of the service. It wouldn't work without a residential grant strand. Then, Medicare can complement that. The core has to come from a grant.

Another ACCHS service provider pointed out that it is unrealistic for smaller ACCOs to believe Medicare would immediately and substantially boost income. It takes time to establish the client-base needed to generate this income and the positions must first be funded and then filled by suitably qualified staff. As discussed elsewhere, attracting and retaining quality staff is an obstacle facing many organisations. An ACCO peak representative also expressed concern about Medicare generated income, stating that a reliance on Medicare income may change the way health services are delivered in the PHC sector from:

> a team based, multidisciplinary, community, comprehensive primary health care … to much more of a GP-centric fee-for-service kind of thing.

In the context of broader cuts to government spending – given the well documented disadvantage faced by the Aboriginal and Torres Strait Islander population and the under-funding of current ATOD service provision – an important measure that could be taken is to quarantine or partially quarantine from future cuts ATOD programs targeted at Aboriginal and Torres Strait Islander people. Such quarantining could apply not just to specific programs such as those now administered by PM&C, but also to components of the SMSDGF and the NGOTGP. This would be a measure in the interests of equity of health outcomes – rather than the simple equal treatment of unequal people entailed in across-the-board cuts.

Another issue to be considered is the potential for reducing administrative costs incurred by the Australian Government in providing grants to state and territory governments which then purchase services from ACCOs. While there is certainly a need

for a coordinated approach to service planning between the Australian and state and territory governments, and ACCO representatives, this does not necessarily entail the multiple handling of funds. This issue was raised by representatives of a large ACCHS in the NT. They highlighted the example of a program conducted by the NT Government with Australian Government funds, to coordinate ATOD workers in PHC services. In their view, with the same amount of funding, more could have been achieved and coordination could have been enhanced if the funds had been directly paid to AMSANT to administer rather than to the NT Government.

There is a need for additional funding if we are to respond adequately to the higher levels of harmful ATOD use in the Aboriginal and Torres Strait Islander population and governments need to be working to that end. In this context it is important to note that the funding of ATOD services should not be regarded as a cost to government and taxpayers. Such funding is an investment that contributes to the reduction of ATOD caused costs, including those of: disruption to child-development and education; unemployment; high levels of inter-personal violence; and, incarceration.

Purchasing ATOD treatment services

The gaps identified in the provision of ATOD treatment services for Aboriginal and Torres Strait Islander people, the uneven distribution of services, and the lack of correlation between service provision and population and available indicators of harm are indicative of a less than optimal approach to planning for the reduction of ATOD-related harm.[14] However, purchasing services in consultation with key Aboriginal and Torres Strait Islander stakeholders on the basis of an agreed-upon model of service provision provides the opportunity to have a significant impact upon outcomes. An ACCHS-PHC centred model is the one most likely to achieve this. As stated previously, this is not an argument for all ATOD services to be provided by ACCHS, or for other ACCOs or non-Indigenous NGOs to be de-funded or to have their services cut-back. However, it is and argument that when purchasing ATOD services funders require organisations to demonstrate how their services: address local priorities; fit within the framework of a broader level of client-centred service provision linked to PHC services; and how those services are to be integrated. That is – within the broad parameters set by the *National Aboriginal and Torres Strait Islander Peoples Drug Strategy* – at the regional or local level there should be room for flexibility in the specification of objectives, but the strategies for achieving them should be executed with an evidence-based integrated framework.

> Historically funding for alcohol and drug services for Aboriginal people has been quite separate from funding for primary health care. So it's meant that what funding has been

> available has generally gone into specific Aboriginal alcohol and drug programmes. It hasn't been incorporated. There hasn't been sufficient recognition that alcohol and drug treatment services are just a crucial part of primary health care for Aboriginal people which does need sufficient funding. (NACCHO affiliate representative)

As indicated above, the argument for an ACCHS-PHC centred approach to the provision of ATOD treatment services is also not an argument against the provision of such services by non-Indigenous NGOs. As we noted in the previous chapter, in cases where an ACCO does not operate in a particular area or is not in a position to provide a service on their own, partnership-centred models may be appropriate. A partnership-centred approach is principled around 'strengthening and rebuilding an Aboriginal controlled development and service sector'.[48]

> Those non-government organisations, we can't do without them, we need their support because they obviously have expertise in some of the gaps that the Aboriginal organisations will have. So, we're not saying we're going to cut the cord and let you go immediately. We do need that partnership, that collaboration with the non-government sector, but the decisions and the funding and all that sort of stuff needs to be driven by the Aboriginal organisations (CEO NACCHO affiliate)

A key element in an ACCHS-PHC centred model of ATOD service delivery is the provision of integrated case management to ensure that: services are not duplicated; clients are not buffeted from one service provider or practitioner to another; and clients do not 'fall through cracks' between services or providers. Although not extensive, there is evidence for the efficacy of case management in non-Indigenous settings.[20,69] However, when service providers are carrying heavy workloads, case management is difficult to implement. It has to be resourced – a fact that needs to be recognised by service providers themselves as well as funders.

> (Case management) is a luxury and it's a cost and governments don't recognise the cost. If I'm down in (rural town) and I tendered for a service and I won that tender, I may not have factored in the fact that it costs me $20 in petrol and the labour to drive two hours to a case conference in (neighbouring town) or something like that. That's where the costing of these services has to be better. But it has to be acknowledged by government too. (NGO peak body representative)

In this regard, in a non-Indigenous setting, McLellan *et al.* have written:

> Essential elements for successful implementation included extensive training to foster collaboration; and pre-contracting of services to assure availability.[68]

While particular interventions may be well designed, they may be compromised if the organisations contracted to provide them do not have the capacity to do so. The need to build the capacity of Aboriginal and Torres Strait Islander organisations to deliver

services was recognised in the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan* and in the soon to be released *National Aboriginal and Torres Strait Islander Peoples Drug Strategy*.[13,45] The AGDH has provided funds for this purpose but, as attested by service providers themselves, there is a need for further investment – including funds for continuous quality improvement programs and service accreditation. As a representative of an ACCHS stated:

> Some people might say why spend money on that (quality improvement and accreditation) when we need to get services on the ground; but you're better off having fewer good services than more services that aren't getting the results.

'Selection' of providers and provision of funds

The question of mechanisms by which funding is allocated for the provision of ATOD treatment services is a vexed one from an ACCO perspective. When it comes to the 'selection' of providers of ATOD services for Aboriginal and Torres Strait Islander people, there is a need for a flexible approach by funding agencies. In the first instance, over much of rural and remote Australia, the funder-provider model is a distortion of reality. In effect, local communities have established and selected their own preferred service providers, that is ACCHS and other ACCOs. Where there is more than one ACCO in a location, they generally provide complementary (although not necessarily coordinated) services and are not in competition to provide the same suite of ATOD-related services. A large proportion of these services have been long established and have had historically-based individually negotiated agreements with various funding agencies. In this situation, for funders to implement a competitive tendering system – as has been the case with the NGOTGP – provides no advantage and imposes unnecessary administrative burdens on both funders and providers (particularly the latter) and creates uncertainty within provider organisations. For these reasons, these organisations are best funded by means of individually negotiated agreements.

It is worth noting that some ACCO representatives were critical of 'historical' funding arrangements. However, essentially, their concerns were not about the lack of transparency in such agreements. Rather, they had to do with the fact that existing funds are largely committed to established organisations, which are unevenly distributed geographically, and in the absence of new funds it is difficult to establish and attract funds for new organisations.

While tendering processes create a burden in situations such as those described above, they are more problematic in situations where new services are to be introduced. That is where no ACCO is currently providing services. It is in such situations that local ACCOs

are most likely come into competition with non-Indigenous NGOs, or are excluded from tendering at all by their inability to compete with larger NGOs. It was widely perceived by ACCO representatives that the ability to win an open tender is related to the capacity of, and resources available to, an organisation rather than on the basis of which organisations are best able to provide services appropriate and acceptable to particular Aboriginal and Torres Strait Islander communities. Such concerns have previously been reported among ACCO treatment services in Queensland.[41]

Concerns about the competitive edge that non-Indigenous NGOs have and their encroachment into the provision of ATOD services for Aboriginal and Torres Strait Islander people is not unfounded. Between 1999–2000 and 2006–2007 the percentage of all Aboriginal and Torres Strait Islander specific ATOD interventions provided by non-Indigenous NGOs rose from 6% to 17%.[14] As NIDAC has pointed out, funding non-Indigenous NGOs to provide ATOD treatment services to Aboriginal and Torres Strait Islander people undermines the Australian Government's commitment to provide opportunities for Aboriginal and Torres Strait Islander people to own and be responsible for the delivery of ATOD services in their communities.[15]

As indicated above, there was recognition by representatives of ACCOs that there is a role for non-Indigenous NGOs to play in the provision of ATOD-treatment services for Aboriginal and Torres Strait Islander people. However, such participation should be in partnership with ACCOs. As Lowe *et al.* have written, funding models that emphasise and provide incentives for cooperation rather than competition can be an effective way of enhancing organisational capacity to meet the complex needs of clients.[69] However, challenges to delivering services through partnerships between NGOs and ACCOs have previously been noted and for a partnership-centred model to be effective, it needs to be guided by principles of trust, respect for cultural values and knowledges, and a genuine commitment to improve the outcomes for Aboriginal and Torres Strait peoples.[48,70,71] In these circumstances the most appropriate way of selecting service providers is through invitation of consortia to tender for the provision of services.

The use of individually negotiated agreements and invitation of consortia to tender for service provision has some implications for open tender funding programs such as SMSDGF and NGOTGP. In order for ACCOs to maintain or increase funding levels, consideration should be given to quarantining some further proportion of those funds currently administered by the AGDH.

As Ritter *et al.* have discussed in the non-Indigenous context, at this point in time there are difficulties in applying unit pricing, capitation and payment for outcomes in the

ATOD treatment sector.[11] Thus, in the Aboriginal and Torres Strait Islander context, the continued provision of funds through block grants is the most practical option for the foreseeable future. However, there needs to be clearly defined criteria for the basis of such funding, including assessments of need and the costs of service provision.

Contracting issues

Much of the discussion in this chapter has related to the major ATOD treatment programs administered by the AGDH and PM&C. However, it is important to note that service providers are dependent upon a plethora of grants, and the issues raised by key informants do not apply, or do not apply equally, to all funding contracts or the agencies administering them. Nevertheless, representatives of various ACCOs raised three key issues relating funding contracts that had a negative impact on the abilities of their organisations to provide quality treatment services. These were the short-term length of funding contracts, the burden imposed by reporting requirements, and the lack of flexibility in contractual agreements. These concerns are not new and they have been raised in other reports. While some steps have been taken to address these issues they nevertheless remain of concern.

The length of funding contracts

The amounts of the individual grants that most ATOD treatment service providers receive are insufficient to enable them to meet the demand for their services. For this reason they are dependent upon multiple grants. More recent detailed analysis is not available, but a study conducted for the 2006–2007 financial year found that 224 organisations conducting a broad range of ATOD interventions received a total of 494 separate grants. While this was a mean of 2.2 grant per organisation, the distribution was skewed. Many small organisations received only one grant, yet for those organisations providing complex treatment programs the mean was 4.1 grants with one organisation having 17 grants. Many of these were small one-off grants and the median grant was $114,000.[14] These data alone explain or partially explain two of the three issues highlighted above – short-term funding and the burden of reporting.

> Look, it's still a bit of a minefield because there's budget allocations that come from a range of different sources. It's still not necessarily streamlined and there had been some work happening at a federal level through OATSIH, where they were looking at streamlining into single contracts which has worked to an extent and having separate schedules from different areas in government. So that's taken a bit of the burden away. How that changes now that the department with primary responsibility for drug and alcohol services is the Indigenous Affairs, it fits inside the Prime Minister and Cabinet, how that's going to affect us. I'm not too sure yet. I think it may certainly still have some impact. But certainly from a state government perspective, you had Health, we've had Justice and Attorney General, Corrective Services and others who have been providing

> bits and pieces of money to organisations where you're then having to develop ten different reports to go to all the different places. That becomes a significant issue. (CEO NACCHO affiliate)

Gray *et al.* have previously highlighted how the short-term and non-recurrent nature of much ATOD funding leads to uncertainty on a number of levels for service providers and to a stop-start pattern to service delivery.[14] Even where funding contracts are of longer duration, this negatively affects the ability of service providers to develop sustainable programs, and to attract and retain qualified staff. A senior manager in a large ACCHS reported:

> … we've have two, two-year lots of funding (for an ATOD treatment program) and each time at the end of the two years – like right now we've lost most of our professional staff again. We can't even recruit because it runs out in June. So two year block funding is a big problem.

A senior employee of another ACCO said:

> Funding. Re-signing every year. They take just too much out of us. We've been here for 40 years and we continue to do well so the recurrent funding is something that we need.

Rightly or wrongly, some participants believed that funding agencies do not understand the impact of their decisions on ACCOs. These decisions reverberate through whole organisations, with the addition or subtraction of a program affecting an organisation's focus, level of service provision and relationships with communities. It is demoralising to listen to service providers go over these issues again and again. Although, in the end it is a political decision, in the interests of more effective service provision, pressing for longer-term funding with decreased reliance on small grants should be a priority.

Reporting requirements

ACCOs have long complained about the administrative burden of reporting requirements. For organisations with limited administrative personnel, it is sometimes necessary to withdraw staff from service delivery to undertake the task of reporting. Commenting only half-seriously on this, one of those interviewed said:

> You've got more people sitting around in the back offices than you have people delivering the services, which they were originally set up to deliver. They can't get out and deliver that service because they're obligated to do all this bloody reporting stuff. (NACCHO affiliate representative)

This burden arises from two sources: the multiplicity of funding programs on which service providers are dependent and the reporting requirements of particular funding programs and the agencies administering them. There are two solutions to problems

raised by the multiplicity of funding programs. The first of these is to reduce the number of programs. This is most easily realised by reducing the number of programs administered within a particular agency. The AGDH took this approach in 2011 when it reduced 159 funding programs to 18 'flexible funds'. This is less easily achieved between agencies within a particular jurisdiction and even less easily achieved between agencies from different jurisdictions. In these latter cases, the issue can be addressed by the pooling of resources by funding agencies – an approach which was suggested by some of those we interviewed and which has been tried in some locations but not widely adopted. The second approach to the problem of reliance on multiple funding programs is to increase the amounts by which service providers are funded under particular programs. This obviates the need to seek additional funds from other sources. In the present fiscal climate this is unlikely to happen but it seems to us to be the more rational approach and one that should be pursued.

The second source of the burden of reporting arises from the reporting requirements themselves. Of these, Dwyer *et al.* have written:

> The funding and regulatory practices of Australian governments are complex and fragmented, and bring a heavy burden of acquiring, managing, reporting and acquitting funding contracts to both sides of the funding relationship.[16]

The AGDH has attempted to address this by reducing the number of funding programs and by its 'Single Desk Trial', under which contracts for funding from various programs is combined in a single schedule with a single grant manager.[72] This is a significant step in reducing the administrative burden and should be commended.

Service providers we interviewed acknowledged the necessity of reporting and accountability. However, most thought reporting systems could be more user-friendly, less burdensome, and provide their organisations with data that could facilitate improved service delivery. To this end it was suggested that service providers and funding agency staff could work together to design more efficient reporting systems,

Service providers also expressed frustration at having to report the same information to different agencies in different formats. One service provider commented:

> That reporting. What we're saying is the AHL and the financials, and what we report to Territory Health, and how we report to OATSIH, and how we report to FaHCSIA are all very different. All wanting the same information but on very different templates. … I mean how many times do you have to dress it? It's in one audit report, you just need to be able to read it.

In this context, some participants also raised the issue of trust and accountability – with some believing that Aboriginal and Torres Strait Islander organisations are over-scrutinised by funding bodies and are managed on a 'high risk management, highly compliant funding arrangement' (ACCO peak representative). According to NIDAC, risk assessment processes have added to the burden faced by organisations.[15] It was apparent that service providers understood the need for strong organisational accountability, but often capacity within organisations to meet frequent and varying reporting requirements proved challenging. Rather than contract management supporting struggling organisations, the tendency is for non-compliance with reporting obligations to result in payments being deferred or in funding being withdrawn. As the CEO of an ACCO said:

> Funding is contingent on meeting the milestones. So if you don't meet the milestone, you don't get your next quarterly payment. That's been really difficult to manage because of the number of small grants that make up the whole.

As indicated above, the issues raised with regard to contract management are not new and they impact negatively on the ability of organisations to efficiently and effectively deliver ATOD treatment services to members of Aboriginal and Torres Strait Islander communities. Some positive steps have been taken to address these issues but, from the perspective of those 'on the ground', there is still a considerable way to go.

Flexibility

The third concern raised by ACCO representatives is that their ability to respond to changing circumstances and priorities and community expectations is hampered by lack of flexibility in some funding contracts. The combination of 'strings-attached' funding, 'bucket funding' and short-term funding cycles that encourage a pattern of stop-start service delivery, results in ACCO's having to operate according 'to external priorities and plans' which goes against the grain of community control.[48]

> (Funding arrangements) are quite specific at times so they can only be used for that particular activity or that particular head count. So it might be a small grant that's actually for the people to do certain things and that's not negotiable because that's what it was actually applied for. If it's not for salaries, you can't use it for anything else. So it's restrictive at times. (CEO ACCO)

An alternative approach suggested by service providers was for government agencies to provide flexible funding. Having provision for the flexible use of funds in agreements between funders and service providers would allow for local leadership and decision making.[41,48,73]

> If we want to encourage community leadership, organisational leadership, creativity, innovation, all that sort of stuff, we've got to have the funding agreements that suit. (NACCHO affiliate representative)

Summary

As discussed in the second chapter of this report, there are significant gaps in the provision of ATOD treatment services for Aboriginal and Torres Strait Islander people and services are fragmented. There is a need for a model or framework for the provision of ATOD which can better integrate service provision. Given the number of ACCHS and the central role they play in the health system, the most rational way to achieve such integration is through an ACCHS-PHC-centred approach. If used judiciously, and in consultation with key Aboriginal and Torres Strait Islander stakeholders, funding arrangements can play a key role in providing a more effective response to harmful ATOD use. Given the ACCHS-PHC centred approach we are advocating, there is a need for ATOD and PHC funding programs to be administered under the same umbrella.

In essence, across Australia, Aboriginal and Torres Strait Islander people have established and selected their own preferred service providers. They are well-established have no 'competitors' and have had historically-based funding agreements. In these circumstances there is no advantage, and there is a potential disadvantage, in competitive tendering and these organisations are best funded by means of individually negotiated agreements. Where new services are to be funded the most appropriate means of doing so is through invitation of consortia to tender for the provision of services. Block grants are the most appropriate means of providing funding, but with clearly defined criteria for the basis of such funding, including assessments of need and the costs of service provision.

Service providers identified three key issues relating to funding contracts that had a negative impact on the abilities of their organisations to provide quality treatment services. These were the short-term length of funding contracts, the burden imposed by reporting requirements, and the lack of flexibility in contractual agreements. The first two of these are explained in part because major grants are generally insufficient to enable organisations to meet the demand for their services – with the consequence that they must chase and report on multiple small short-term grants.

It is clear that inadequate levels of funding limit the ability of ACCHS and other ACCOs to meet the need for ATOD-treatment services among Aboriginal and Torres Strait

Islander people. If funding for such services is not increased in the immediate future and better systems put in place to enhance the capacity of ACCOs to respond to ATOD problems, those problems will only get worse and they will ultimately become more expensive to address.

Summary

Higher levels of alcohol, tobacco and other drug use (ATOD) among some sections of the Aboriginal and Torres Strait Islander population are a consequence of and contribute to social inequality. They contribute to a significant proportion of the burden of physical and mental ill-health, reduce the capacity of individuals for employment, disrupt the early development and education of children, contribute to higher levels of breakdown in inter-personal relationships, violence and other crime, and higher levels of incarceration.

In order to reduce Aboriginal and Torres Strait Islander inequality, community action and government programs to reduce ATOD-related problems have been and continue to be of high priority. However, it is important to note that, because of the complex web of social problems within which ATOD-related problems are embedded, on their own strategies to reduce harmful ATOD use will be circumscribed in their effectiveness.

Research evidence shows that to effectively reduce ATOD-related harm, a multi-faceted approach is required. This evidence is the basis of Australia's *National Drug Strategy* which is based on the principle of harm minimisation and the pillars or sub-strategies of demand, supply and harm reduction. Treatment is an important element of demand reduction and, again, a wide range of evidence-based treatment strategies is available.

A clear understanding of the nature of substance use disorders and the effectiveness of treatment strategies is fundamental to addressing harmful ATOD use in the Aboriginal and Torres Strait Islander population. First, substance use disorders are chronic relapsing conditions akin to problems such as hypertension and diabetes that occur on a spectrum of severity. While a 'cure' in the form of abstinence resulting from treatment may be desirable and attainable by some, it is difficult to achieve. A more realistic outcome of treatment, at least in the short-term, is extending periods between episodes of relapse and minimising the harm caused to self and others and the associated social and economic costs.

Second, among individuals, substance use disorders do not occur in isolation. They often occur in conjunction with various mental and physical health problems, dysfunctional familial and social relationships, and a range of social challenges and

disadvantages, including homelessness and involvement with the criminal justice system. Treatment of substance use disorders in isolation from these other problems is likely to be limited in effectiveness. For this reason, treatment needs to be conceptualised more broadly than the simple provision of clinical services. It needs to encompass social support, including advocacy and links to other services, such as housing and welfare support.

Third, treatment needs to be person-centred. Rather than being based on the priorities of those organisations funding or providing services, it needs to address – in as seamless a manner as possible – the inter-related needs of the client and his or her family. That is, it needs to be holistic. Furthermore, the evidence shows that treatment results in better outcomes if it is provided in a manner that is culturally safe.

Epidemiological data of sufficient detail are not available to quantify either the need or the demand for ATOD treatment clinical services, nor the specific level of resourcing that should be allocated to them. Nevertheless, at the population level, ATOD-caused deaths, hospital admissions and emergency presentations for ATOD-caused conditions, and survey data all indicate that the level of harmful ATOD use is *at least twice*, and more probably greater, among Aboriginal and Torres Strait Islander people than in the non-Indigenous population. Furthermore, work done as part of development of the *Drug and Alcohol Service Planning Model for Australia* indicates that there is a need for greater intensity of service provision for Aboriginal and Torres Strait Islander people undergoing treatment. While it is difficult to measure the demand for treatment services among Aboriginal and Torres Strait Islander people, both the levels of measurable ATOD-related harm and the observations of those working in the field indicate that there is a considerable level of demand that is not being met.

There is a wide range of Aboriginal and Torres Strait Islander community-controlled, non-Indigenous non-government, and government organisations providing ATOD treatment services. These organisations include primary health care (PHC) providers, home and community visitors, withdrawal management facilities, and non-residential and residential treatment providers. The mix of such organisations and the services they provide varies considerably by state and territory and regions within them. Effective coordination between providers is exists in some locations but in others is fragmented or non-existent.

In broad terms, there are a number of gaps in the provision of treatment services. These include: gaps in access to a full range of services in some regions; lack of culturally appropriate services; limited range of treatment services for women and young people;

and generally a paucity of on-going support and relapse prevention services for those completing intensive treatment. The gaps in treatment service provision are unevenly distributed and the priorities arising from them are not necessarily the priorities of particular communities. Furthermore, in some cases the services that are provided are provided as a result of historical funding decisions or the recent availability of program funds for particular services rather than current priorities.

The delivery of effective ATOD treatment services is dependent upon effective organisational structures and procedures – among service providers themselves and the organisations that support and fund them. There is evidence that, other factors being equal, community control of services produces better outcomes. Among some ATOD service providers, however, there is concern that community-control is being under-mined by top-down planning, exclusion from decision-making processes, and contracting of service provision to non-Indigenous organisations. In part, these concerns arise because there is no peak body to represent Aboriginal and Torres Strait Islander treatment service providers – as the National Aboriginal Community Controlled Health Organisation (NACCHO) and its state and territory affiliates do for ACCHS.

There is a need for a body that can represent the views of Aboriginal and Torres Strait Islander service providers and to work in partnership with governments to the end of providing improved outcomes. Again, it would need to be negotiated with and between Aboriginal and Torres Strait Islander organisations, but the most efficient means of providing such representation for ATOD-specific services is through NACCHO and its affiliates. There is precedent for this with the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) opening its membership to ATOD treatment services and the Queensland Aboriginal and Islander Health Council (QAIHC) incorporating the Queensland Substance Misuse Council (QISMC) which represents residential treatment service providers. If some variation on these models could be negotiated across all jurisdictions, not only would it be an efficient way to provide representation, but it would provide organisational support for the integrated, ACCHS-PHC-based model of treatment service provision which we have proposed.

Despite common perceptions, most Aboriginal and Torres Strait Islander ATOD service provider organisations are well governed. However, there are some which have been poorly governed resulting in poor quality service provision and in some instances to defunding. One of the more common problems arises because of poor financial control by boards – often because members have no expertise or interest in financial management. Issues also arise because board members may be enthusiastic about

addressing ATOD problems but, again, have little knowledge of current best practice. Governments have attempted to address the first of these problems by providing basic governance training to board members. However, while this provides members with an understanding of their responsibilities it does not provide the level of expertise required to effectively govern an organisation. Of their own volition, some organisations have moved to the appointment of board members with specific areas expertise – with varying arrangements around voting rights – in addition to elected members without undermining the principle of community control. This is a positive move that should be further encouraged and one that could possibly be advocated by a peak organisation.

ATOD treatment strategies are only effective if there is a skilled workforce to deliver them. However, despite being identified as a priority and funds being specifically allocated for workforce development, workforce issues continue to be identified as an impediment to the delivery of effective ATOD treatment services. Among the issues identified are shortages of skilled workers at all levels, low levels of remuneration (particularly for Aboriginal ATOD workers), limited career development pathways (especially in small organisations), and limited staff support – all of which lead to high staff turnover. Particularly by service provider representatives, up-skilling and expansion of the ATOD workforce is seen as a priority if enhanced outcomes are to be achieved.

Importantly, ATOD treatment workforce development and expansion should not be viewed simply as a cost. As well as providing much needed much needed services and contributing to the reduction of ATOD-related harm, it can provide real employment opportunities in Aboriginal and Torres Strait Islander communities and has a flow-on effect in reducing dependence on the social security system and providing support and improved living conditions for the families of such workers.

The focus of this report has been on the provision of ATOD treatment services by Aboriginal and Torres Strait Islander community controlled organisations. This does not mean, however, that we do not think that Aboriginal and Torres Strait Islander people should not have the choice of using mainstream service providers or that non-Indigenous organisations do not have a role to play in the provision of ATOD treatment services specifically for Aboriginal and Torres Strait Islander people. In the first instance, mainstream service providers should provide their services on the same basis they do for non-Indigenous clients with the proviso that, as for all clients, their services should be culturally safe.

There is recognition by communities and their representatives that in some instances although there is a need for Aboriginal and Torres Strait Islander specific services there may not be community-controlled organisations that are able or wish to take on provision of those services. However, where non-Indigenous organisations tender for such services using funds allocated by governments for the benefit of Aboriginal and Torres Strait Islander people, as a condition of their funding contracts they should be required to negotiate with communities regarding service planning, local community employment and capacity building and the transfer of services to community control within a specific time period. The Aboriginal Peak Organisations Northern Territory (APONT) has produced a set of guidelines for such engagement (which usefully could be more widely circulated) and member organisations have successfully negotiated with non-Indigenous service providers on the basis of them.

Organisational impediments to the efficient and effective delivery of ATOD treatment services for Aboriginal and Torres Strait Islander people do not only occur within community controlled organisations. Such impediments are also found in the administration of government programs. Government programs for Aboriginal and Torres Strait Islander people are aimed at alleviating disadvantage and providing equal opportunity to participate Australian society. However, a view expressed by some service providers is that such aims are over-shadowed by departmental concerns with their roles as fund administrators and funding contract managers. While acknowledging that financial accountability is important they felt that – with some notable exceptions – many contract managers knew little about the organisations or services they were funding and provided little support in terms of meeting broad program objectives. Without 'micro-managing' or over-planning, government agencies can play a greater role in ensuring consistency of expectations between service providers and funders, supporting organisational capacity and being flexible and responsive when community expressions of need.

There is a need for a clearly articulated model or framework for the delivery of ATOD treatment services to Aboriginal and Torres Strait Islander people – one that would provide better integration of services and a more rational model for funding. Development of this would need to be negotiated between representatives of Aboriginal and Torres Strait Islander organisations, non-Indigenous service providers, and governments; with their roles and responsibilities clearly defined. However, the most appropriate basis of such a model should be the provision of ATOD treatment services centred on ACCHS and PHC. For a large proportion of the Aboriginal and Torres Strait Islander population ACCHS are the first point of contact with the health care system. While many of those with substance use disorders may not present because of those

problems, such contacts provide the opportunity for service providers to screen for them, to provide opportunities for engagement in treatment, and where necessary provide referrals to specialist providers either within or external to their organisation. ACCHS also have opportunity to assess and address other health-related problems associated with substance use disorders.

Many, but not all, ACCHS also provide specialist ATOD social and emotional well-being services. There are clear advantages to this, as such services can be provided either on-site or through outreach visits and can be coordinated with PHC service provision.

Where there are no ACCHS or where ACCHS are not in a position to provide specialist ATOD services, there is need for other non-residential ATOD service providers. However, to the end of providing integrated client care, to the extent possible, the services provided by those organisations should be integrated with those provided by ACCHOs or other PHC providers. To facilitate compliance with this, such agreements could be included as a provision of funding contracts.

To overcome the fragmentation of service provision, links between residential treatment service providers and ACCHS also need strengthening and formalising. While such links are relatively strong in some locations, the relationships are poorly articulated in others and – as between non-residential ATOD service providers and ACCHS – these should be the subject of formal service agreements. ACCHS are best able to efficiently provide health services to the clients of residential facilities and, because of their wider geographical spread, are best able to provide on-going care services to clients discharged from residential facilities. Importantly, however, agreed upon arrangements for the provision of services may need to be resourced – it cannot simply be assumed that this can be achieved within existing staffing and other resource allocations.

The uneven distribution of ATOD treatment services is a concrete reflection of historically specific development of services and the limited degree of service planning. At the national level, the *National Drug Strategy* provides the strategic framework for addressing ATOD-related harm. Subsidiary to this has been the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009* (the CAP); soon to be replaced by the *National Aboriginal and Torres Strait Islander Peoples Drug Strategy*. These plans are not prescriptive, but provided a framework to guide similar state and territory strategic plans. The national and state and territory plans have been based on varying degrees of consultation with Aboriginal and Torres Strait Islander people. At the regional and local level there are varying degrees of

familiarity with these plans and among those who have knowledge of them there is general endorsement of the plans' broad aspirational goals. However, at the technical and operational levels planning is not optimally effective.

While positive examples exist, service providers expressed a number of concerns about the planning of ATOD treatment services for Aboriginal and Torres Strait Islander people. Among these concerns are that planning is: largely symbolic and limited to the development of broad strategy; driven from the top, reactive and undermines community-control; constrained by the poor quality of available data; not directed at clear goals; not coordinated and integrated; local communities are not adequately consulted about their needs; and focuses too heavily on the allocation of resources at the expense of operational planning.

Poor planning affects the sector in four key ways. First, and most importantly, it means that those seeking treatment are unable to obtain it and that they and others around them will experience ongoing harm. Second, it impacts on the stability and effectiveness of the ATOD workforce and the opportunity build capacity. Third, it affects the organisations that provide services which may become ineffective and may ultimately fail. Finally it results in misallocated resources and potential waste.

A clearly articulated model for the delivery of ATOD-treatment services to Aboriginal and Torres Strait Islander people, such as that advocated above, is consistent with the broad strategies articulated in the *National Drug Strategy*, *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Drug Strategy* and the *National Aboriginal And Torres Strait Islander Health Plan 2013–2023* and could provide a more effective focus for the planning and provision of ATOD treatment services.

To be effective however, a sharpened, coordinated focus on the planning of ATOD treatment services needs the structures and resources to support it. These include: improved data collection; the strengthening of Aboriginal and Torres Strait Islander peak bodies and their state and territory affiliates to enable them to canvass and represent the views of regional and local communities; forums, with decision-making roles, which bring together on a regular basis representatives community controlled organisations, other service providers and governments which can provide more flexible responses to ATOD-related problems. Such forums would not need to meet more than annually and could probably be 'piggy-backed' on to other activities. While there are some cost implications of this, these are not necessarily great and would yield benefits in the more effective and efficient delivery of services.

The funding of ATOD services should not be regarded as a cost to government and taxpayers. Such funding is an investment that contributes to the reduction of ATOD caused costs, including those of: disruption to child-development and education; unemployment; high levels of violence and incarceration. While recognising the restrictions imposed by budgetary constraints on funding for ATOD treatment services, given the magnitude of the problem and the inequities faced by Aboriginal and Torres Strait Islander people, current funding levels should be maintained (with Government departmental cuts being absorbed by other program areas).

There have been modest increases in the level of funding for Aboriginal and Torres Strait Islander ATOD treatment services and some individual organisations have been well-resourced – it being obvious that, generally, better resourced organisations produce better outcomes. However, none of the key informants we interviewed, none of the submissions made as part of the consultations conducted for development of the *National Aboriginal and Torres Strait Islander Peoples Drug Strategy*, or any of the published reports on this area indicate that, across-the-board, levels of funding for ATOD treatment services are adequate. That is, they are not funded on the basis of need – as committed to in the *National Aboriginal and Torres Strait Islander Peoples Drug Strategy*.

In the light of this, there is a need for a thorough analysis of the funding needs of the sector both to determine what additional funds might be needed and how current funds can be more effectively employed. However, as funding levels are contingent upon the model of care underpinning the provision of ATOD treatment, such a review should be postponed until a clear, broad model of care is agreed upon.

The inefficiencies of multiple funding programs and the administrative burdens they place on both funder and service provider has long been highlighted. The AGDH has attempted to address this by reducing the number of funding programs and its Single Desk Trial under which funding under various program is combined in a single schedule with a single grant manager. This is a significant step and should be commended. However – given the need for a holistic approach to the delivery of ATOD treatment services and that the most efficient way of delivering those services is through ACCHOs – the separation of ATOD treatment funding from PHC funding resulting from the transfer of Aboriginal and Torres Strait Islander treatment services from the AGDH to PM&C is a retrograde step. It again fragments funding sources, is likely to impose additional administrative burdens on both departments and on service providers and is a barrier to the development of an integrated ACCHS-PHC centred model of ATOD treatment service provision.

Australian Government funding for ATOD treatment services is not only provided by the Departments of Health and Prime Minister and Cabinet. Aboriginal Hostels Limit funds bed places in some residential treatment facilities. These funds are based on occupancy rates which do not take account of the recurrent component of costs of maintaining those beds, whether occupied or not, and thus under-fund the cost of providing the service. Furthermore, reporting requirements are onerous. As such costs are more akin to the provision of hospital, rather than hostel, beds the Aboriginal Hostels' funding should be transferred and consolidated under treatment grants funding.

A potential advantage of an ACCHS-PHC centred model of ATOD treatment service provision is the opportunity for increased access to Medicare funding for services such as screening and brief interventions and improved treatment under mental health and chronic disease care packages. Such funding could also support provision of care to clients of residential treatment services – either where organisations have part-time medical staff or more importantly where they have service agreements with ACCHOs.

The issue of competitive tendering for grants to support the provision of ATOD treatment services to Aboriginal and Torres Strait Islander people is a vexed one from the perspective of community-controlled organisations. There is a strong view that such tenders are won by those organisations that best have the capacity to prepare grant applications rather than on the basis of which organisation is best able to provide a service appropriate and acceptable to particular Aboriginal and Torres Strait Islander communities. While it is recognised that non-Indigenous organisations have role to play in the provision of ATOD treatment services, here is also concern that open tendering has the potential to undermine the principal of community control when such organisations successfully tender for the provision of services to Aboriginal and Torres Strait Islander people.

The current system of treatment service provision is fractured. A model for the provision of treatment services needs to be negotiated between service providers and governments – preferably an ACCHS-PHC centred model. Once agreed upon, the model needs to be supported by improved service planning, organisational and community development, and consolidated funding allocated on the basis of need. Within Aboriginal and Torres Strait Islander communities, among service providers, and within government there is widespread concern about the need to address substance use disorders among Aboriginal and Torres Strait Islander people, and their actions to do so are clearly based on good intentions. What is needed is to more effectively harness

those good intentions and to reduce harmful levels of ATOD use in the Aboriginal and Torres Strait Islander population.

Appendix 1: List of Abbreviations

ACCHS	Aboriginal community controlled health service
ACCO	Aboriginal community controlled organisation
AGDH	Australian Government Department of Health (and as it was previously known the Australian Government Department of Health and Aging)
AHL	Aboriginal Hostels Limited
AMSANT	Aboriginal Medical Services Alliance Northern Territory
ANCD	Australian National Council on Drugs
APONT	Aboriginal Peak Organisations Northern Territory
ATOD	Alcohol, tobacco and other drugs
ATS	Amphetamine type stimulants
CAP	National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan
CEO	Chief Executive Officer
COAG	Council of Australian Governments
IGCD	Intergovernmental Committee on Drugs
MCDS	Ministerial Council on Drug Strategy
NACCHO	National Aboriginal Community Controlled Health Organisation
NATSIPDS	National Aboriginal and Torres Strait Islander Peoples Drug Strategy
NDRI	National Drug Research Institute
NDS	National Drug Strategy
NGOTGP	Non Government Organisation Treatment Grants Program
NIDAC	National Indigenous Drug and Alcohol Committee
OATSIH	Office for Aboriginal and Torres Strait Islander Health
PHC	Primary Health Care
PM&C	Australian Government Department of the Prime Minister and Cabinet
QAIHC	Queensland Aboriginal and Islander Health Council
QISMC	Queensland Indigenous Substance Misuse Council
SEWB	Social and emotional wellbeing
SMSDGF	Substance Misuse Delivery Grants Fund
VACCHO	Victorian Aboriginal Community Controlled Health Organisation

Appendix 2: The Authors

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Professor Dennis Gray is a Deputy Director at the National Drug Research Institute at Curtin University, and a leader of the Institute's Aboriginal Research Program and has a long history of conducting collaborative research with Aboriginal community-controlled organisations on alcohol, tobacco and other drug issues. His research has had demonstrable outcomes at the national, state/territory and regional and local levels. He is a member of the National Indigenous Drug and Alcohol Committee, and his research team was awarded the 2006 National Alcohol and Drug Award for Excellence in Research. In 2010, in recognition of his significant contribution to the alcohol and other drugs field, he was named on the National Drug and Alcohol Honour Roll.

Annalee Stearne BA Grad Dip Post Grad Dip

Annalee Stearne – a Nyungar from Western Australia – has been working in the National Drug Research Institute's Aboriginal Australian Research Program since 2001. She has been involved in numerous evaluations of Aboriginal Australian substance misuse interventions in the Northern Territory, Western Australia and South Australia. Between September 2005 and November 2008, while located in Alice Springs she worked closely with Tangentyere Council's Research Hub. In 2006, she was a member of the research team that won the National Drug and Alcohol Award for Excellence in Research, and a Curtin University Vice-Chancellor's Award for Excellence. Currently she sits on the board of Palmerston Association. Ms Stearne was awarded the 2012 First People's Award for Excellence in Science and Research by the Australasian Professional Society on Alcohol and other Drugs.

Matthew Bonson LLB

Matthew Bonson is an Aboriginal Australian from the Northern Territory. He holds a law degree and he has practiced as a solicitor with the Northern Territory Legal Aid Commission. From 2001–2008 he was the Member for Milner in the NT Legislative Assembly and served as the Minister for Sport and Recreation, Minister for Corporate and Information Services, Minister for Senior Territorians, Minister for Young Territorians, Minister Assisting the Chief Minister on Multicultural Affairs, and Government Whip. From 2008–13, he was the Chief Executive Officer of the Council for Aboriginal Alcohol Program Services – the NT's largest Alcohol and other Drug Rehabilitation Centre in the NT. He is also a member of the National Indigenous Drug and Alcohol Committee.

Edward Wilkes AO BA

Associate Professor Ted Wilkes is a Nyungar man from Western Australia. His professional background includes working for the Western Australia Museum, the Centre for Aboriginal Studies at Curtin University, and sixteen years as the Director of the Derbarl Yerrigan Aboriginal Health Service in Perth. He is currently employed at the National Drug Research Institute at Curtin University where he is a leader of the Aboriginal Research Program and plays an active role in Aboriginal capacity building, and research and its application. Professor Wilkes is a member of the Australian National Council on Drugs, is Chair of the National Indigenous Drug and Alcohol Committee, and provides advice and expertise to a wide range of other committees at state, national and international levels. In 2014 Professor Wilkes was made an Officer of the Order of Australia 'for distinguished service to the Indigenous community as a leading researcher in the area of public health and welfare, to youth in Western Australia, and to the provision of legal support services'.

Julia Butt BSc MClinPsych PhD

Dr Julia Butt is Senior Research Fellow at the National Drug Research Institute. Dr Butt has worked as both a clinical psychologist and researcher in a range of community controlled and government agencies. She has a commitment to working collaboratively with Aboriginal communities on projects involving substance related harms and the development and evaluation of interventions. Dr Butt has been involved in a number of projects investigating youth alcohol and drug use and in assessing the impact of emerging substances on culturally diverse communities. Her most recent work has focussed on cannabis interventions and the translation of research findings into practice through effective models of dissemination. Dr Butt is currently the Western Australian representative on the Australasian Professional Society of Alcohol and Drugs.

Mandy Wilson BA PhD

Dr Mandy Wilson is a Research Fellow on the Aboriginal Research Team at the National Drug Research Institute. An anthropologist, she took up her present position in 2008. She currently works on a variety of projects which reflect her interests in Aboriginal health. In particular, her research involvement includes projects exploring offender health, substance use issues and violence, with a particular focus on women and young people. Dr Wilson has sat on the West Australian Corrective Service's Research and Evaluation Committee since 2012 and was appointed to the Department's Youth Justice Board in 2014.

References

1. Wilkinson RG, Marmot M (eds). *Social Determinants of Health: the Solid Facts*, 2nd edn. Copenhagen: World Health Organization, Regional Office for Europe, 2003.
2. Marmot, M. Social determinants and the health of Indigenous Australians. *Medical Journal of Australia* 2011; 194 (10): 512–513.
3. Gray D, Saggers S, Stearne A. Indigenous health: the perpetuation of inequality. In Germov J (ed) *Second Opinion: An Introduction to Health Sociology*, 5th edn. Melbourne: Oxford University Press, 2014; 147–162.
4. Chikritzhs T, Pascal R, Gray D, Stearne A, Saggers S, Jones P. Trends in alcohol-attributable deaths among Indigenous Australians, 1998–2004. *National Health Indicators Bulletin* No. 11. Perth: National Drug Research Institute, 2007.
5. Australian Institute of Health and Welfare. *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander People: An Overview 2011*. Cat. no. IHW 42. Canberra: AIHW, 2011. Available at: http://www.aihw.gov.au/publication-detail/?id=10737418989 (accessed May 2014)
6. Australian Institute of Health and Welfare. *Substance Use Among Aboriginal and Torres Strait Islander People*. Cat. no. IHW 40. Canberra: Australian Institute of Health and Welfare, 2011.
7. Steering Committee for the Review of Government Service Provision. *Overcoming Indigenous Disadvantage: Key Indicators 2011*. Canberra: Productivity Commission, 2011.
8. Weatherburn D. *Arresting Incarceration: Pathways Out of Indigenous Imprisonment*. Canberra: Aboriginal Studies Press, 2014.
9. Ministerial Council on Drug Strategy. *The National Drug Strategy 2010–2015: A Framework For Action on Alcohol, Tobacco, and Other Drugs*. Canberra: Australian Government Department of Health and Ageing, 2011.
10. Commonwealth of Australia, Department of Health and Ageing. Request For Tender: Review of the drug and alcohol prevention and treatment services. RFT No. DoHA/105/1213. Canberra: Department of Health and Ageing, 2013.
11. Ritter A, Berends L, Chalmers J, Hull P, Lancaster K, Gomez G. *New Horizons: The Review of Alcohol and Other Drug Treatment Services in Australia. A Report Commissioned by the Australian Government Department of Health*. Sydney: National Drug and Alcohol Research Centre, University of New South Wales, 2014.
12. National Indigenous Drug and Alcohol Committee. Report on Consultation to Inform the Development of the National Aboriginal & Torres Strait Islander Peoples Drug Strategy 2013–2018. Canberra: National Indigenous Drug and Alcohol Committee, 2013.
13. Intergovernmental Committee on Drugs. *National Aboriginal and Torres Strait Islander Peoples Drug Strategy 2015–2018*. Canberra: Australian Government Department of Health, in press.
14. Gray D, Stearne A, Wilson M, Doyle MF. *Indigenous-specific Alcohol and Other Drug Interventions: Continuities, Changes and Areas of Greatest Need*. ANCD Research Paper 20. Canberra: Australian National Council on Drugs, Canberra, 2010.

15. National Indigenous Drug and Alcohol Committee. Funding of Alcohol and Other Drug Interventions and Services for Aboriginal and Torres Strait Islander People. NIDAC Position Paper. National Indigenous Drug and Alcohol Committee: Canberra, 2013.

16. Dwyer J, O'Donnell K, Lavoie J, Marlina U, Sullivan P. *The Overburden Report: Contracting for Indigenous Health Services*. Darwin: Cooperative Research Centre for Aboriginal Health, 2009.

17. National Health and Medical Research Council. *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*. Canberra: National Health and Medical Research Council, 2003.

18. Gowing L, Proudfoot H, Henry-Edwards S, Teeson M. *Evidence Supporting Treatment: The Effectiveness of Interventions for Illicit Drug Use*. ANCD Research Paper 3. Canberra: Australian National Council on Drugs, 2001.

19. United Nations International Drug Control Programme. *Contemporary Drug Abuse Treatment: A Review of the Evidence Base*. New York: United Nations, 2002.

20. Proude E, Lopatko O, Lintzeris N, Haber P. *The Treatment of Alcohol Problems: A Review of the Evidence*. Canberra: Australian Government Department of Health and Ageing, 2009.

21. Haber P, Lintzeris N, Proude E, Lopatko O. *Quick Reference Guide to the Treatment of Alcohol Problems: Companion document to the Guidelines for the Treatment of Alcohol Problems*. Canberra: Australian Government Department of Health and Ageing, 2009.

22. Australian Government Department of Health and Ageing. *Alcohol Treatment Guidelines for Indigenous Australians*. Canberra: Department of Health and Ageing, 2007.

23. Gray D, Saggers S, Atkinson D, Strempel P. *Substance Misuse and Primary Health Care Among Indigenous Australians.* Aboriginal and Torres Strait Islander Primary Health Care Review: Consultant Report No 7. Canberra: Australian Government Department of Health and Aging, 2004.

24. Gray D, Saggers S, Atkinson D, Wilkes E. Substance Misuse. In Couzos S, Murray R (eds). *Aboriginal Primary Health Care: An Evidence-Based Approach,* 3rd edn. Melbourne: Oxford University Press, 2008; Ch 20: 755–787.

25. Wilkes E, Gray D, Casey W, Stearne A, Dadd L. Harmful substance misuse and mental health. In Dudgeon, Milroy H, Walker R. (eds.) *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*, 2nd edn. Perth: Telethon Institute for Child Health Research/Kulunga Research Network, 2014.

26. Gray D, Wilkes E. Addressing and preventing harmful alcohol and other drug use. Resource sheet no. 3 produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare and Australian Institute of Family Studies, 2010.

27. Smith TB, Rodriguez MD, Bernal G. Culture. *Journal of Clinical Psychology* 2011; 67(2): 166–175.

28. National Indigenous Drug and Alcohol Committee. Report on the modification to the National Drug and Alcohol Clinical Care and Prevention (DA-CCP) project packages. Canberra: National Indigenous Drug and Alcohol Committee, 2012.

29. New South Wales Ministry of Health. *Drug and Alcohol Service Planning Model: Final Report to the Intergovernmental Committee on Drugs (IGCD) on the Development of a Population Based Planning Tool for Australia.* Sydney: New South Wales Ministry of Health, 2013.

30. Australian Institute of Health and Welfare. *2010 National Drug Strategy Household Survey Report*. Drug statistics series no. 25. Cat. no. PHE 145. Canberra: Australian Institute of Health and Welfare, 2011.

31. Australian Bureau of Statistics. *National Aboriginal and Torres Strait Islander Social Survey 2008*. Canberra: Australian Bureau of Statistics, 2010. Available at: http://www.abs.gov.au/ausstats/abs@.nsf/mf/4714.0/ (accessed May 2014).

32. Chikritzhs T, Brady M. Fact or fiction? A critique of the National Aboriginal and Torres Strait Islander Social Survey 2002. *Drug and Alcohol Review* 2006; 25 (3): 277–287.

33. Blue Moon Research & Planning. *Patterns of Use and Harms Associated with Specific Populations of Methamphetamine Users In Australia: Exploratory Research*. Sydney: Blue Moon Research & Planning, 2008.

34. Collins B. The rise of methamphetamine use in Aboriginal communities. ABC Kimberley, 10th June 2014. Available at: http://www.abc.net.au/local/stories/2014/06/10/4022280.htm (accessed 15th June 2014).

35. National Drug and Alcohol Committee. *National Indigenous Drug and Alcohol Committee and National Community Controlled Health Organisation Survey on Amphetamine Type Stimulants Use*. Canberra: National Drug and Alcohol Committee, in press.

36. Howard J, Butt JCM, Wright T, Norberg MM, Copeland J, Wilkes, E. Raising awareness about cannabis, its use and impact on health and wellbeing among Indigenous Australians. Bulletin Series 14, Feb2012. Sydney: National Cannabis Prevention and Information Centre, 2012. Available at: http://ncpic.org.au/ncpic/publications/bulletins/article/bulletin-14-raising-awareness-about-cannabis-its-use-and-impact-on-health-and-wellbeing-among-indigenous-australians (accessed 27th May 2014).

37. Australian Bureau of Statistics (ABS). *Australian Demographic Statistics*. ABS cat No. 3101.0, Canberra: Australian Bureau of Statistics, 2013 (ABS). Available at: http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/AA5F9A950A217EA7CA257CA7000DCBB4/$File/31010_Sep%202013.pdf (accessed 27th May 2014).

38. Australian Institute of Health and Welfare. *Alcohol and Other Drug Treatment Services in Australia 2011–12*. Drug treatment series 21. Cat. no. HSE139. Canberra: Australian Institute of Health and Welfare, 2013.

39. McLellan AT, Woody GE, Metzger D, McKay J, Alterman AI, O'Brien CP. Evaluating the effectiveness of treatments for substance use disorders: reasonable expectations, appropriate comparisons. *Milbank Quarterly* 1996: 74(1): 51–85.

40. McLellan AT. Have we evaluated addiction treatment correctly? Implications from a chronic care perspective. *Addiction* 2002: 97(3): 249–252.

41. Gray D, Green M, Saggers S, Wilkes E. *Review of the Aboriginal and Torres Strait Islander Community-Controlled Alcohol and Other Drugs Sector in Queensland*. Brisbane: Queensland Aboriginal and Islander Health Council, 2009.

42. National Indigenous Drug and Alcohol Committee (NIDAC). *Bridges and Barriers: Addressing Indigenous Incarceration and Health*, revised edn. Canberra: Australian National Council on Drugs (ANCD), 2013. Available at: http://www.nidac.org.au/images/PDFs/NIDACIpublications/revised_bridges_and_barriers.pdf (accessed 27th May 2014)

43. Deloitte Access Economics. *An Economic Analysis for Aboriginal and Torres Strait Islander Offenders: Prison verses Residential Treatment*, ANCD Research Paper 24. Canberra, Australian National Council on Drugs, 2013.

44. Gray D, Sputore B, Stearne A, Bourbon D, Strempel P. *Indigenous Drug and Alcohol Projects: 1999–2000*. ANCD Research Paper 4. Canberra: Australian National Council on Drugs, 2002.

45. Ministerial Council on Drug Strategy. *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009*. Canberra: Department of Health and Ageing, 2006.

46. Alford K. *Economic Value of Aboriginal Community Controlled Health Services*. Canberra: National Aboriginal Community Controlled Health Organisation, 2014.

47. Duraisingam V, Roche, AM, Trifonoff A, Tovell A. *Indigenous AOD Workers' Wellbeing, Stress, and Burnout: Findings from an Online Survey*. Adelaide: National Centre for Education and Training on Addiction (NCETA), Flinders University, 2010.

48. Aboriginal Peak Organisations Northern Territory. Principles for a Partnership-Centred Approach for NGOs Working with Aboriginal Organisations and Communities in the Northern Territory. Darwin: Aboriginal Peak Organisations Northern Territory, 2013. Available at http://apont.org.au/index.php/ngo-partnerships.html (accessed May 2014).

49. National Aboriginal Health Strategy Working Party. *A National Aboriginal Health Strategy*. Canberra: Australian Government Printer, 1989.

50. d'Abbs P, Togni S, Rosewarne C, Boffa J. The Grog Mob: lessons from the evaluation of a multi-disciplinary alcohol intervention for Aboriginal clients. *Australian and New Zealand Journal of Public Health* 2013; 37: 450–6.

51. Stearne, A. *Central Australian Aboriginal Congress Safe & Sober Support Service Final Evaluation Report*. Perth: National Drug Research Institute, 2012.

52. Ritter A, Hull P, Berends L. Chalmers J. *Planning Processes for Alcohol and Other Drug Treatment in Australia*. Sydney: Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW, 2014.

53. Green, A. *An Introduction to Health Planning for Developing Systems*. Oxford: Oxford University Press, 2007.

54. Eagar, K, Green J, Lago L, et al. *Cost Drivers and a Recommended Framework for Mental Health Classification Development: Final Report for Stage B of the Definition and Cost Drivers For Mental Health Services Project*, Volume 1. Brisbane: University of Queensland, 2013.

55. Urbis. *Evaluation of the Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003 – 2009*. Canberra: Urbis, 2009.

56. Drug and Alcohol Office. *Drug and Alcohol Interagency Strategic Framework for Western Australia 2011–2015*. Perth: Drug and Alcohol Office, Government of Western Australia, 2011.

57. Drug and Alcohol Office. *Strong Spirit Strong Mind Aboriginal Drug and Alcohol Framework for Western Australia 2011–2015*. Perth: Drug and Alcohol Office, Government of Western Australia, 2011.

58. Australian Government Department of Health and Ageing. *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*. Canberra: Australian Government Department of Health and Ageing, 2013.

59. Grant M, Wronski I, Murray RB, Couzos S. Aboriginal health and history. In Couzos S, Murray R. *Aboriginal Primary Health Care: An Evidence-based Approach*, 3rd edn. Melbourne: Oxford, 2007; Ch 1: 1–28.

60. National Aboriginal Health Strategy Working Party. *A National Aboriginal Health Strategy*. Canberra: Australian Government Printer, 1989.

61. Australian Government Department of Health and Ageing. *Annual Report 2011–2012*. Canberra: Australian Government Department of Health and Ageing, 2012.

62. Australian Government Department of Health. Substance Misuse Service Delivery Grants. Canberra: Australian Government Department of Health. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/drugtreat-fund (accessed 26th May 2014).

63. Australian Government Department of Health. Non Government Treatment Grants Program. Canberra: Australian Government Department of Health. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/drugtreat-NGOTGP (accessed May 2014).

64. Australian Government Department of the Prime Minister and Cabinet. Indigenous Affairs: Indigenous Advancement Strategy. Available at: http://www.dpmc.gov.au/indigenous_affairs/index.cfm (accessed 26th May 2014).

65. Chalmers J, Ritter A, Berends L. Alcohol and Other Drug Treatment Financing in Australia: Funding Flows. Working Paper No. 3. Sydney: National Drug and Alcohol Research Centre, University of New South Wales, 2013.

66. Aboriginal Medical Services Alliance of the Northern Territory (AMSANT). A model for integrating alcohol and other drug, community mental health and primary health care in Aboriginal Medical Services in the Northern Territory. Darwin: Aboriginal Medical Services Alliance of the Northern Territory, 2008.

67. National Indigenous Drug and Alcohol Committee. Report on the modification to the National Drug and Alcohol Clinical Care and Prevention (DA-CCP) project packages. Canberra: National Indigenous Drug and Alcohol Committee, 2011.

68. McLellan AT, Hagan TA, Levine M. et al. Does clinical case management improve outpatient addiction treatment? *Drug and Alcohol Dependence* 1999: 55(1–2): 91–103.

69. Low J, Gray D, Allsop S, Wilkes E, Garrison E. *Enhancing the Management of Alcohol-Related Problems Among Indigenous Australians: Implementation Plan*. Perth: National Drug Research Institute, Curtin University, 2013.

70. Secretariat of National Aboriginal and Islander Child Care (SNAICC). *Opening Doors Through Partnerships: Practical Approaches to Developing Genuine Partnerships That Address Aboriginal and Torres Strait Islander Community Needs*. North Fitzroy: Secretariat of National Aboriginal and Islander Child Care, 2012.

71. Taylor K, Bessarab D, Ukich V, Hunter L, Thompson S. Aboriginal-mainstream partnerships: exploring the challenges and enhancers of a collaborative service arrangement for Aboriginal clients with substance related issues. *BMC Health Service Research* 2013; 13(12). Available at: http://www.biomedcentral.com/1472-6963/13/12 (accessed May 2014).

72. Australian Government Department of Health and Ageing. *Annual Report 2012–2013*. Canberra: Australian Government Department of Health and Ageing, 2013.

73. Eagar K. Gordon R. *Access and Equity: The Funding Required to Close the Gap in Aboriginal and Islander Health in Far North Queensland*. Wollongong NSW: Centre for Health Service Development, University of Wollongong, 2008.