

Evaluation of the National Drug  
Strategy Aboriginal and Torres Strait  
Islander Peoples Complementary  
Action Plan 2003-2009

Prepared for the Department of Health and Ageing

Final Report

May 2009

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# Evaluation of the Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003- 2009 (CAP)

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Health and Ageing

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**Rationale for using the term Indigenous Australians**

Aboriginal and Torres Strait Islander peoples have diverse languages, cultures and communities, and live in urban, rural and remote settings.

Many of these groups seek to maintain their particular cultural identity and preferred names as distinct from others. For the purposes of this resource, and in recognition of this diversity we have chosen the term Indigenous Australians as a way of acknowledging all Australian Aboriginal and Torres Strait Islander groups.

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<b>Executive Summary .....</b>	<b>i</b>
<b>1 Introduction and methodology .....</b>	<b>1</b>
1.1 Background to the CAP .....	1
1.1.1 The National Drug Strategy (NDS).....	1
1.1.2 The Complementary Action Plan (CAP).....	3
1.1.3 This evaluation .....	4
1.2 Methodology .....	5
1.2.1 Update of the Background Paper .....	5
1.2.2 Mapping of CAP programs and activities .....	5
1.2.3 Regional workshops .....	6
1.2.4 Key stakeholder consultations.....	6
1.2.5 Presentations to the Evaluation Reference Group and IGCD.....	7
1.3 Key challenges with the evaluation .....	7
1.3.1 Getting people to workshops.....	7
1.3.2 Stakeholder consultations .....	7
<b>2 The CAP as a policy framework.....</b>	<b>8</b>
2.1 The role of the CAP as a policy framework.....	8
2.1.1 The CAP as a national framework.....	8
2.2 The CAP in relation to State/Territory plans.....	11
2.3 The CAP in relation to service delivery .....	12
2.4 The CAP in relation to other strategies and frameworks.....	12
2.4.1 Closing the Gap.....	13
2.4.2 National Indigenous Health Equality Summit and the Indigenous Health Equality Targets..	14
2.4.3 National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013: Australian Government Implementation Plan 2007-2013 (NSFATSIH) .....	15
2.4.4 National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being (2004-2009) .....	17
2.4.5 National Preventative Health Strategy .....	17
2.4.6 Social Inclusion Agenda .....	18
2.5 Summary .....	18
<b>3 CAP program outcomes .....</b>	<b>19</b>
3.1 CAP program funding.....	19
3.1.1 ICI .....	19
3.1.2 Capacity Building in Indigenous Communities Initiative (CBIC).....	20
3.2 Programs linked to the CAP .....	20
3.2.1 CAP programs receiving funding.....	20
3.2.2 Programs related to the CAP .....	21
3.2.3 Programs that reported against or were aligned with CAP KRAs.....	21
3.3 Annual IGCD reporting .....	22
3.3.1 The nature of programs reported, and alignment with NDS reporting and the CAP KRAs ..	23
3.3.2 Adherence to the CAP performance indicators.....	25
3.4 Summary .....	26
<b>4 Monitoring the performance of the CAP .....</b>	<b>27</b>
4.1 Key Result Areas (KRAs) .....	27
4.2 Performance indicators.....	28
4.3 Reporting .....	29

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4.4	Effectiveness of the CAP .....	29
4.5	Efficiency of the CAP .....	30
4.6	Summary .....	30
<b>5</b>	<b>Conclusions and recommendations .....</b>	<b>31</b>
5.1	Reviewing the CAP .....	31
5.2	Implementing the CAP .....	32
5.3	Monitoring the CAP .....	33
 <b>APPENDICES:</b>		
Appendix A	List of organisations consulted.	
Appendix B	Interview guide for stakeholder consultations.	
Appendix C	IGCD survey.	
Appendix D	Matrix of programs in alignment with the CAP or receiving funding under ICI or CBIC.	
 <b>FIGURES:</b>		
	Figure 1 – Situation of the CAP within the NDS .....	8
 <b>TABLES:</b>		
	Table 1 – Organisations consulted in stakeholder interviews. ....	7

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## List of acronyms

ANCD	Australian National Council on Drugs
ATOD	Alcohol, tobacco and other drugs
CAP	Aboriginal and Torres Strait Islander Peoples Complementary Action Plan
CBIC	Capacity Building in Indigenous Communities Initiative
DoHA	Commonwealth Government Department of Health and Ageing
FaHCSIA	Commonwealth Government Department of Families, Housing, Community Services and Indigenous Affairs
ICI	Indigenous Communities Initiative
ICLO	Indigenous Community Liaison Officer
IGCD	Intergovernmental Committee on Drugs
KRAs	Key Result Areas (of the CAP)
MCDS	Ministerial Council on Drug Strategy
NCETA	National Centre for Education on Training and Addiction
NDS	National Drug Strategy
NGOs	Non-government organisations
NDRI	National Drug Research Institute
NDARC	National Drug and Alcohol Research Centre
NDLERF	National Drug Law Enforcement Fund
NIDAC	National Indigenous Drug and Alcohol Committee
OATSIH	Office for Aboriginal and Torres Strait Islander Health
VACCHO	Victorian Aboriginal Community Controlled Health Organisation

## Executive Summary

Urbis was commissioned by the Department of Health and Ageing to conduct an evaluation of the *Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009 (CAP)*. The aim of this evaluation was to determine the knowledge and use of the CAP as a policy framework by both government and non-government organisations; and assess the outcomes of programs which had been developed in line with the CAP, in addressing the misuse of alcohol and other drugs by Aboriginal and Torres Strait Islander peoples.

The evaluation involved: updating the CAP Background Paper; mapping CAP programs and activities through analysis of relevant documentation, strategies, policies, reviews of reports and stakeholder consultations; eight workshops conducted across the country with a range of stakeholders from Commonwealth and state/territory governments, Indigenous community service providers, local councils and research fellows; 36 key stakeholder consultations and administration of a survey to the Intergovernmental Committee on Drugs (IGCD); and presentations to the Evaluation Reference Group and the IGCD.

The CAP was found to be well regarded as a policy document by those who are familiar with it, and used regularly by a relatively small number of people working in a policy context. A wider group of people were only vaguely familiar or unfamiliar with the CAP and amongst this group people generally considered the existence of such a document as the CAP was valuable in itself as a public statement of nationally agreed good practice. In addition, the presence of a national framework was felt by many to provide a benchmark for improving services or developing new initiatives, and that the CAP provided validation for efforts to develop new services which address the needs of Aboriginal and Torres Strait Islander people for culturally appropriate drug and alcohol services.

Informants attributed great weight to the CAP's consultative beginnings and the fact that it was developed at a time when such a national framework, specifically for Aboriginal and Torres Strait Islander communities to use in addressing drug and alcohol issues, did not exist. Since that time, many other national initiatives have been developed which include a focus on Aboriginal and Torres Strait Islander well-being, including some of the policy directions discussed in this report. It seems, however, that maintaining a specific Aboriginal and Torres Strait Islander focus within the NDS is important, and this was reiterated by a majority of informants.

The evaluation has led to the following recommendations:

**Recommendation 1:** That the CAP be retained within the NDS as a separate entity but that its links to the other strategies be increased.

**Recommendation 2:** That the CAP key result areas (KRAs) be reviewed, through a process of culturally appropriate consultation, and revised to include specific high priority result areas, with accompanying measurable performance indicators.

**Recommendation 3:** That the CAP is developed in a more concise format, and perhaps in more than one format, which can be easily accessed and is user-friendly. The statements of principles and current KRAs (which are considered to be good practice principles) could be shared across policy areas to tie the CAP more closely to other initiatives.

**Recommendation 4:** That processes of monitoring are improved to ensure that reporting against the CAP occurs for funding under the Indigenous Communities Initiative (ICI) and the Capacity Building in Indigenous Communities Initiative (CBIC).

**Recommendation 5:** That a hierarchy of outcomes model be used in developing the performance indicators, and that clear processes of responsibility for monitoring and data collection are identified.

# 1 Introduction and methodology

The following report presents findings of an evaluation of the *Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009* (CAP). This is the first evaluation of the CAP since its development in 2003. The CAP is one of six elements of the *National Drug Strategy 2004-2009* (NDS), and provides a targeted action plan for addressing Aboriginal and Torres Strait Islander drug misuse.

The project was commissioned by the Department of Health and Ageing as part of their wider evaluation of the NDS. The objectives of this research were to:

- determine how the CAP is currently operating as a policy framework that can be used by governments, NGOs and service providers;
- analyse the outcomes of programs that have been developed in line with the CAP; and
- assess whether there have been improvements in outcomes for Aboriginal and Torres Strait Islander peoples in line with current performance indicators.

The research methodology for this project involved extensive consultation with policy makers, research fellows, managers and CEOs of Indigenous health and community services; as well as those involved with the development, monitoring and oversight of the CAP.

This report provides an assessment of the value of the CAP in addressing drug and alcohol misuse among Aboriginal and Torres Strait Islander people. Findings from this report suggest recommendations for the future operation of the CAP within the NDS, as well as within a wider policy context. Recommendations concerning program outcomes as well as monitoring and reporting under the CAP are also provided.

## Structure of this report

This report has been structured in accordance with the three components of the evaluation brief, which were to:

- **Evaluate the CAP as a policy framework:** examine the role of the CAP as a successful and useable policy framework for Commonwealth, state and territory governments and key non-government organisations (NGOs) and assess use of the CAP to influence the approach of stakeholders in providing services. This should include an assessment of how the CAP operates in relation to other Indigenous health and wellbeing frameworks and strategies.
- **Evaluate the CAP program outcomes:** identify programs which have been established by Commonwealth and state and territory governments to support the key result areas (KRAs) of the CAP, and assess the extent to which they have been successful in contributing to each KRA.
- **Evaluate how the performance of the CAP is monitored:** identify how outcomes for Aboriginal and Torres Strait Islander peoples are improved and reported against the CAP; and assess whether the CAP performance indicators have been appropriately applied, useful and/or relevant. Provide advice on potential alternative performance indicators where relevant and options for the future direction and composition of the CAP.

The final section summarises the findings and provides recommendations for the future development of the CAP.

## 1.1 Background to the CAP

### 1.1.1 The National Drug Strategy (NDS)

The NDS is an integrated policy framework designed to guide the efforts of Commonwealth and state/territory governments and non-government organisations (NGOs) in preventing the uptake of harmful drug use and reducing the damaging effects of licit and illicit drugs in Australia. The NDS is the

umbrella document for national action plans on tobacco, alcohol, illicit drugs and school-based drug education. This originally included the *Aboriginal and Torres Strait Islander Peoples Complementary Action Plan (CAP)*, the *National School Drug Education Strategy*, the *National Tobacco Strategy*, the *National Action Plan on Illicit Drugs*, and the *National Alcohol Strategy*. The *National Amphetamine-Type Stimulant Strategy 2008-2011* was endorsed in May 2008 and follows the model used for the *National Alcohol and Cannabis Strategies*. The NDS is the successor to the *National Drug Strategic Framework 2003-2004* and preceding national strategies.

The NDS provides a framework for a coordinated and integrated response to reducing drug-related harm in Australia. The NDS follows the principle of harm minimisation, which has been the centrepiece of Australia's approach to drug use since the 1980s. Harm minimisation comprises a comprehensive approach to drug abuse, taking into account: the individuals and communities involved; their social, cultural, physical, legal and economic environment; and the drug itself. A harm minimisation approach does not condone drug use, but rather facilitates the development of policies and programs aimed at reducing drug-related harm. Harm minimisation involves a wide range of strategies including:

- Supply-reduction strategies designed to disrupt the production and supply of illicit drugs.
- Demand-reduction strategies designed to prevent the uptake of harmful drug use, including abstinence-oriented strategies to reduce drug use.
- Strategies to reduce drug-related harm to individuals and communities.

The NDS coordinates its harm minimisation approach through:

- developing and implementing national strategies
- promoting community understanding of drug-related harms
- building partnerships, including partnerships between governments, affected communities and service providers
- implementing the key action areas of the CAP
- coordinating outcomes through complementary integrated Commonwealth, state and territory structures, and internationally where appropriate.

Harm minimisation is one of four facets to which the NDS attributes its success. The other three include: the comprehensiveness of the approach; the promotion of partnerships between health, law enforcement and education agencies, affected communities, business and industry; and a balanced approach across all levels of government.

The current NDS has eight priority areas for future action:

1. prevention
2. reduction of supply
3. reduction of drug use and related harms
4. improved access to quality treatment
5. development of the workforce, organisations and systems
6. strengthened partnerships
7. implementation of the CAP
8. identification and response to emerging trends.

Progress against these priority areas is reported annually by the Intergovernmental Committee on Drugs (IGCD) to the Ministerial Council on Drug Strategy (MCDS).

## The NDS Governance Framework

The NDS is the responsibility of the MCDS, the peak decision-making body on drug policy. The role of the MCDS is to determine national policies and programs intended to reduce drug-related harm within the Australian community. The MCDS is comprised of Australian Government and state and territory ministers responsible for health and law enforcement, as well as the minister responsible for education. The objectives of the MCDS are to facilitate regular consultation between ministers and promote a consistent and coordinated national approach to policy development and implementation.

The MCDS is supported by the IGCD and the Australian National Council on Drugs (ANCD), which provide state/territory and expert input into activities carried out under the NDS. Both bodies have ongoing consultation and liaison with one another.

The IGCD plays a key role in providing policy advice to ministers, and is also responsible for implementation of the National Drug Strategic Framework. The IGCD produces annual reports on the state of progress of NDS priorities to the MCDS. These include an overview of activities undertaken by all jurisdictions with a particular focus on the interventions undertaken by government agencies to reduce the supply, demand and harms associated with drug use across sectors. Reporting is done in consultation with the National Drug and Alcohol Research Centres: the National Drug Research Institute (NDRI), the National Centre for Education on Training and Addiction (NCETA), and the National Drug and Alcohol Research Centre (NDARC); as well as the National Drug Law Enforcement Fund (NDLERF).

The ANCD was developed to provide a non-government voice to facilitate enhanced partnerships between the government and community sectors in the development and implementation of policies and programs to redress drug-related harms. The ANCD has a diverse membership who has a wide range of experience and expertise on various aspects of drug policy. The National Indigenous Drug and Alcohol Committee (NIDAC) is one such group that has been formed by the ANCD to ensure particular issues relating to the use of alcohol and other drugs in Indigenous communities are addressed.

Secretariat support to the MCDS and IGCD is provided through the Drug Strategy Branch of the Australian Government Department of Health and Ageing (DoHA).

### 1.1.2 The Complementary Action Plan (CAP)

The CAP was developed in 2003 after extensive national consultation with Aboriginal and Torres Strait Islander peoples, and recognition of the need for deliberate action to address the specific needs of Indigenous people affected by alcohol and drugs.

The CAP complements all other national action plans under the NDS, but is specific to dealing with alcohol and drug harms experienced by Aboriginal and Torres Strait Islander peoples. Like the other national action plans, its purpose is not to define detailed implementation strategies, but to provide national direction for communities, non-government organisations, Aboriginal and Torres Strait Islander community-controlled organisations and all levels of government, to pursue strategies that are specifically relevant to Indigenous peoples' needs and appropriate to their circumstances.<sup>1</sup>

The CAP follows the harm minimisation principle, providing guidance through: supply reduction measures; demand reduction measures; measures to provide effective treatment; and a range of other harm reduction strategies.

The CAP consists of a boxed package which includes two action plans (one for Aboriginal peoples and one for Torres Strait Islander peoples), an extensive literature review (the Background Paper), a glossary and a summary. An overriding principle in the development in the CAP is acknowledgement of the social, cultural and economic factors affecting the health and wellbeing of Indigenous Australians. This is reflected in the CAP's six key result areas (KRAs):

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<sup>1</sup> Ministerial Council on Drug Strategy, 'Aboriginal and Torres Strait Islander Peoples Complimentary Action Plan 2003-2009: Background Paper', 2003.

- Enhanced capacity of individuals, families and communities to address current and future issues in the use of alcohol, tobacco and other drugs, and promote their own health and wellbeing.
- Whole-of-government effort in collaboration with non-government organisations to implement, evaluate and improve comprehensive approaches to reduce drug-related harm.
- Substantially improved access to the appropriate range of health and wellbeing services that play a role in addressing alcohol, tobacco and other drugs issues.
- A range of holistic approaches from prevention through to treatment and continuing care that is locally available and accessible.
- Workforce initiatives to enhance the capacity of community-controlled and mainstream organisations to provide quality services.
- Increased ownership and sustainable partnerships of research, monitoring, evaluation and dissemination of information.

Monitoring the progress of the CAP is based on specific national performance indicators (outlined in each action plan):

- an increase in the capacity to report nationally on improvements for the Torres Strait and Northern Peninsula area population in meeting the mainstream performance indicators specified by the substance-specific national action plans
- the number of regional health plans developed under the partnership agreements that incorporate the alcohol, tobacco and other drugs (ATOD) strategies that are listed in the CAP
- evidence that all appropriate workforce, research and evaluation and monitoring actions that arise from funding for the substance-specific action plans are developed in line with the intentions of the CAP to improve capacity and to promote holistic models of intervention.

In 2004, a report produced by the MCDS following consultation with states and territories and non-government organisations, documented the following national priority areas for implementing the CAP<sup>2</sup>:

- Implementation of a National Smoking Cessation Program for Indigenous Communities.
- Development of an Indigenous Alcohol Management Plan.
- Improvement of Indigenous Data Collection.
- Improvement of outcomes for Indigenous Communities as a result of the policing response to illicit drugs and other substances.

Progress against the CAP is documented in IGCD's annual reporting on the NDS priority areas (as detailed above).

### 1.1.3 This evaluation

The evaluation of the CAP began in August 2008 and was timed to coincide with the wider evaluation of the NDS.

Essentially, the evaluation of the CAP has involved a review of the CAP documents – specifically, identifying what the Commonwealth, states and territories are doing at both program and policy levels to address drug and alcohol misuse through reference to the CAP, and the extent to which these activities reflect the KRAs and performance indicators of the CAP. The evaluation has also involved extensive consultation with policy makers and drug and alcohol service providers in all states and territories.

The evaluation's terms of reference include the following:

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<sup>2</sup> IGCD Executive and Secretariat, 2007, 'Annual Report July 2005-June 2006 to the Ministerial Council on Drug Strategy'.

- how the CAP has operated as a successful and useable policy framework for governments, NGOs and service providers, including the interrelationship between the CAP and other Indigenous health and wellbeing frameworks and strategies
- what programs and projects have been established by Commonwealth and state/territory governments to support the six key result areas of the CAP, and the extent to which these have been successful
- how outcomes for Aboriginal and Torres Strait Islander peoples have changed over time, and whether the current performance indicators are appropriate and sufficient.

## 1.2 Methodology

The evaluation methodology consisted of the following components:

- Update of the CAP Background Paper
- Mapping of CAP programs and activities
- Eight workshops conducted across the country
- Key stakeholder consultations and IGCD survey
- Presentations to the Evaluation Reference Group and the IGCD.

These components are discussed in more detail below.

### 1.2.1 Update of the Background Paper

The Background Paper forms part of the original CAP package and was developed in 2003. Part of the evaluation involved updating, where possible: current data on the prevalence of Indigenous drug and alcohol use and misuse; recent interventions (including supply control, demand management, harm reduction, early intervention and treatment) across the range of substances; and policy and program responses of Australian governments. A priority was placed on including research from 2003 onwards.

A number of search strategies were employed in the review. They included:

- Key databases accessible on the internet, such as: the Australian Drug Information Network; the Aboriginal Drug and Alcohol Council of South Australia (ADAC); the National Drug and Alcohol Research Centre (NDARC); Australian Indigenous HealthInfoNet; Australian Drug Information Network; National Drug Research Institute; and the EBSCO suite of databases including Medline, Academic Search Complete, SocINDEX with full text, and the Australia/New Zealand Reference Centre..
- Academic journals including (but not limited to): the Drug and Alcohol Review, the Australian and New Zealand Journal of Public Health, Addiction, The Medical Journal of Australia, the Australian Journal of Rural Health, Australian Psychiatry and the Australian Institute of Criminology.
- Current policy documentation and information available on Commonwealth and state/territory department websites, as well as other related strategy documents and frameworks.
- National surveys conducted by the Australian Government – most notably the *National Drug Strategy Household Survey 2007* (AIHW 2007) and *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2008* (ABS & AIHW 2008).

### 1.2.2 Mapping of CAP programs and activities

A number of activities were conducted in order to assess the role of the CAP in Indigenous drug and alcohol programs and activities. This was not a discrete task, but was rather built into other areas of the methodology, including analysis of relevant documentation, strategies, policies, reviews of reports and stakeholder consultations.

Activities included the following:

- Review of reporting documents and evaluations conducted for programs funded under the CAP (as part of both the Indigenous Communities Initiative (ICI) and Capacity Building in Indigenous Communities Initiative (CBIC)) and the development of a matrix for reporting against the CAP's KRAs and performance indicators.
- Review of programs listed in stakeholder telephone interviews and the IGCD survey according to the CAP's KRAs and performance indicators.
- Review of related strategies and frameworks for comparison with the CAP.
- Review of data received through the regional workshops.

### 1.2.3 Regional workshops

A series of eight workshops were conducted across the country from October to December 2008 in the following locations:

- Canberra
- Perth
- Alice Springs
- Darwin
- Thursday Island
- Melbourne
- Sydney
- Adelaide.

A total of 79 people participated in the workshops. The number of participants attending workshops varied in size from 4 participants (in Thursday Island) to 23 (in Perth).

Workshop participants consisted of a range of stakeholders who had had various levels of exposure to the CAP. They included: state/territory government departments (including health, human services and police), NGOs, state/territory Indigenous drug and alcohol-related health and community service providers and council members; as well as personnel from the Department of Health and Ageing (DoHA), the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), the Attorney General's Department, the Australian Federal Police and representatives from various state/territory law enforcement agencies. A list of organisations consulted can be found at Appendix A.

### 1.2.4 Key stakeholder consultations

DoHA provided Urbis with lists of potential stakeholders in the course of organising the workshops, and all stakeholders who did not attend a workshop were emailed or telephoned over a period of two months with requests to participate in the evaluation through a telephone interview. Follow-up phone calls were also made. In total, 36 stakeholders participated in telephone interviews over the period of December 2008 to February 2009.

Interviews were approximately 30-45 minutes in length. An interview guide was developed in consultation with the Department, and this was provided to all participants (see Appendix B). Areas covered by the discussion guide included: awareness and use of the CAP; programs that had been developed using the CAP and whether they reported against the KRAs; opinions on various areas of the CAP including KRAs, performance indicators, the summary document and Background Paper; perceived links between the CAP and other NDS strategies; and potential improvements that could be made to the CAP.

The majority of telephone interviews were conducted with managers and CEOs of Indigenous health and community service providers. Other stakeholders included policy makers, research fellows as well as members from IGCD, the CAP Evaluation Group, and NIDAC. The list of stakeholders consulted is included in Appendix A.

### *IGCD survey*

A separate survey was developed in consultation with the Department, in an effort to gather additional quantitative and qualitative data on use of the CAP (see Appendix C). The survey included a mix of scaled questions, multiple response items and open ended responses, and was sent by email in November 2008 to all IGCD members, and 10 were returned. Other IGCD members had participated in workshops or interviews, and so did not complete the survey.

## 1.2.5 Presentations to the Evaluation Reference Group and IGCD

Presentations were given to the Evaluation Reference Group in January and the IGCD in February, which outlined progress and findings to date.

## 1.3 Key challenges with the evaluation

The following key challenges were encountered during the evaluation.

### 1.3.1 Getting people to workshops

There was some difficulty in getting people to attend the workshops. The lack of response may have been due to several reasons such as: sending the invitation in some instances to organisational email addresses rather than to named people; lack of funding for people from community agencies to attend; workload; the CAP being unknown to people or not being 'core business'; and unforeseen circumstances arising on the day.

Efforts were made to increase numbers of participants. In the case of the Northern Territory workshops, follow up calls were made by Urbis to workshop invitees who had not responded to an earlier email invitation from the Department. Many explained that they had not received the original email, which was then forwarded to them again. This was initially successful in boosting numbers for these workshops, however in the end only half of those who said they would attend the Alice Springs workshop did so.

### 1.3.2 Stakeholder consultations

There was some difficulty in scheduling telephone interviews with stakeholders. This was due to the following reasons: changes in personnel in some departments with those new to the position having little knowledge or experience with the CAP; no knowledge or use of the CAP; and stakeholders not returning calls or emails. Overall, 36 telephone interviews were conducted.

The following chapters provide details on findings from the research.

## 2 The CAP as a policy framework

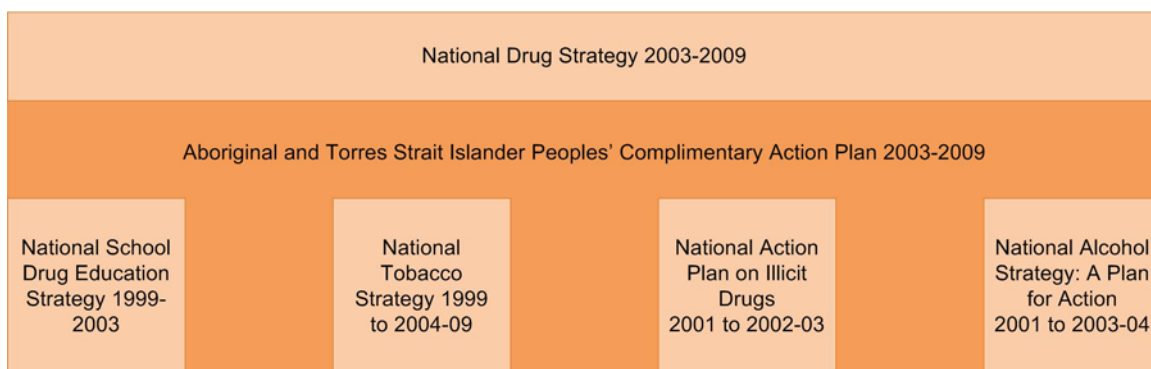
### 2.1 The role of the CAP as a policy framework

This chapter reports stakeholder perceptions of the CAP as a policy document, and explores the relation of the CAP to other Indigenous health policy frameworks.

#### 2.1.1 The CAP as a national framework

The CAP was developed to *complement* the other strategies under the National Drug Strategy and conceptually sits between the NDS and the National School Drug Education Strategy, the National Tobacco Strategy, the National Action Plan on Illicit Drugs and the National Alcohol Strategy (see figure 1 below – this diagram was developed before the addition of the amphetamine-type stimulants strategy).

Figure 1 – Situation of the CAP within the NDS



Overall, there is very strong support for the existence of a national Indigenous framework to address substance misuse issues. It was clear that the CAP plays an important symbolic function in signalling that Indigenous drug and alcohol issues were being taken seriously, and that there is an agreed broad national approach. As one participant noted:

*A national framework is important, that it's not just state/territory based, but is part of a bigger picture. It's expanding the knowledge of Indigenous communities, through the recognition that the document is there – it complements mainstream policy.*

Even amongst those who knew little about the CAP, the existence of an articulated national commitment was highly significant. Another important symbolic factor was that the existence of a CAP highlights drug and alcohol issues within other Indigenous health topics, and highlights Indigenous drug and alcohol needs within mainstream drug and alcohol services. A number of stakeholders felt that while documents such as the CAP existed, Indigenous drug and alcohol issues had less chance of being 'lost'. The existence of the CAP was also seen as having promoted momentum in addressing Indigenous drug and alcohol abuse.

*Its real value is symbolic. There's a benefit in having a document that reminds jurisdictions that they have to be sensitised to the needs of Aboriginal and Torres Strait Islander populations.*

*The CAP represents Aboriginal involvement in their own health care – it has a symbolic role.*

*The process of putting it together was important; it identified key issues and priorities.*

*The CAP is like a magnet, it attracts other things to it.*

Beyond the symbolic function (about which there was general agreement), perceptions of, and evidence for, the degree of influence the CAP has had on state/territory policy and program development varied considerably. At one end of the scale, the CAP has shaped the development of one state's Indigenous drug and alcohol plan; at the other end, the CAP was unfamiliar even within key government departments in another state. Somewhere in between, the CAP has been acknowledged or referenced in numerous drug and alcohol and/or Indigenous health plans, but was not viewed as having been instrumental in shaping state/territory policy in relation to Indigenous drug and alcohol issues. Rather, state/territory policy was viewed as being *consistent with* the approach taken by the CAP.

Nevertheless, the CAP was seen as being a laudable and significant document, which has a number of strengths in the approach it promotes within Indigenous health. In particular, the CAP:

- *Provides excellent background information on Indigenous drug and alcohol misuse.* The background document was thought by many stakeholders including policy makers, departmental staff and service providers to provide high quality and useful information that was not available elsewhere to the same degree. Some reservations were expressed in relation to a perceived predominance of Northern Territory and remote-based research findings, and the converse lack of focus on urban Aboriginal and Torres Strait Islander populations.
- *Provides a good framework for addressing Indigenous drug and alcohol misuse.* Through its emphasis on a holistic concept of health, the CAP promotes whole-of-government approaches to policy development, with the need to involve a range of stakeholders such as police, corrections, education, employment, Indigenous health service providers, and other mainstream health services. As one stakeholder commented, *'the CAP demands that policy makers be more sophisticated in dealing with [Indigenous drug and alcohol] issues rather than using a silver bullet approach'*. The CAP is also seen as an important articulation of national direction:

*If we didn't have the CAP we wouldn't know that we were veering off into different directions (through the Intervention). It highlights the tension in the NT and how far we've gone from what should be happening.*

- *Provides a reference point for policy makers, funders and service providers.* At Commonwealth and state/territory levels, high level statements have been made to 'hang off' the CAP and support the approach Commonwealth departments or state/territory governments have taken place. In some instances it was reported that the CAP has provided guidance to the allocation of funds through the development of selection criteria. At a service level, whilst knowledge of the CAP is less common, the document has been used to strengthen proposals for drug and alcohol services, and has provided services with 'a tool' for dealing with governments.
- *Highlights key priority areas for the development of jurisdictional strategic documents without prescribing specific actions.* The 'one size fits all' approach had both supporters and critics amongst participating stakeholders. On the one hand, it was thought that national documents necessarily need to focus on the 'lowest common denominator' and allow states/territories to determine how that is implemented. On the other hand, the CAP's lack of prescription was thought by some to be its weakness as it created too much 'wiggle room' for states and territories to avoid addressing key Indigenous drug and alcohol issues.
- *Represents good practice in implementing culturally appropriate approaches to Indigenous drug and alcohol misuse.* The six principles (see below), identified in the CAP as critical in any response to issues of drug and alcohol misuse within Indigenous communities, were widely seen as being key aspects of good practice not only in drug and alcohol, but in Indigenous health more broadly. As one stakeholder commented:

*"The philosophy of the CAP is what I do all the time [in terms of research, work with elders, clinical practice]. You could use it for everything because what it really describes is good practice".*

### Principles

- Use of alcohol, tobacco and other drugs must be addressed as part of a comprehensive, holistic approach to health that includes physical, spiritual, cultural, emotional and social wellbeing, community development and capacity building.
- Local planning is required to develop responses to needs and priorities set by local Aboriginal and Torres Strait Islander communities.
- Culturally valid strategies that are effective for Aboriginal and Torres Strait Islander peoples must be developed, implemented and evaluated.
- Aboriginal and Torres Strait Islander peoples must be centrally involved in planning, development and implementation of strategies to address the use of alcohol, tobacco and other drugs in their communities.
- Aboriginal and Torres Strait Islander communities must have control over their health, drug and alcohol and related services.
- Resources to address the use of alcohol, tobacco and other drugs must be available on the basis of need, and at the level required to reduce disproportionate levels of drug-related harm by Aboriginal and Torres Strait Islander peoples.

- *Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009, p.4*

Whilst the CAP was overwhelmingly viewed as an important document that needs to exist, a number of criticisms were raised. These are summarised below.

- The CAP is not an *action plan* because it does not provide an adequate guide to action. It is not directive enough to be an action plan because it does not identify action or priority areas that are specific enough. In its current form it should rather be re-termed a *framework*, because it provides a structure and a general approach from which action plans can be developed. Some stakeholders felt that calling it an *action plan* erroneously raises expectations because people expect the document to provide direction. Another recurring comment was that without direct funding attached to it, the CAP cannot really be conceived of as an *action plan*.
- If the CAP were to try to exist as an *action plan*, there was a need to further unpack the KRAs and articulate more specific areas of action, linked to specific performance measures. As it stands, several stakeholders commented that it was difficult to identify where one fits or where one's efforts should go. The most critical viewed the CAP merely as a series of 'motherhood statements'. Others argued against further specificity within the KRAs, and thought these were best left to state/territory and even regional plans to address. For the latter, the CAP was most effective as a *framework* that articulates a national direction.
- Whilst the CAP is generally known within the policy spheres of the drug and alcohol sector, it is less familiar even within other sections of health departments, and less well known outside of health. Critics argued that the philosophy of the CAP is about holistic, cross-jurisdictional approaches, yet it had largely failed to penetrate beyond the health sector. Consequently, the CAP is largely seen as a 'health' document. However, there was clear evidence that the CAP had been used within law enforcement jurisdictions, so perhaps it is best stated that the knowledge of the CAP is variable across health and other jurisdictions.
- The mechanism for measuring CAP outcomes is inadequate. Firstly, the CAP lacks clear and measurable performance indicators, let alone indicators that link to existing data sets. Secondly, the system for reporting CAP outcomes is weak, and states and territories have not been made accountable to report against the KRAs. It was argued by some stakeholders that it was difficult to create accountability for a strategy that has no direct funding attached to it; others disagreed, saying that the issue was not funding, but rather clarity around what is expected and commitment to the initiative. The issue around measurement and reporting of outcomes is discussed in greater detail in chapter 4.
- The CAP is now seen by many to be out of date, as a number of critical developments have occurred over the past five years that impact on how Indigenous drug and alcohol issues are, and can be, addressed. These include the Northern Territory Intervention, COAG initiatives such as

Murdi Paaki, and the National Indigenous Health Summit. It was thought that the CAP needed to be reviewed and the approaches now being taken in Indigenous drug and alcohol incorporated into a revised CAP.

## 2.2 The CAP in relation to State/Territory plans

Where states and territories have developed Indigenous drug and alcohol plans (post-2003), the CAP has been referenced. Generally the reference is made in the introductory sections which identify links to other documents. In most cases, this is where the link to the CAP ends.

Six state/territory level plans were identified that included the CAP document more thoroughly and incorporated the principles and approaches, as described below.

### *Strong Spirit Strong Mind: Western Australian Aboriginal Alcohol and Other Drugs Plan (AAOD) 2005-2009.*

*Strong Spirit Strong Mind* makes reference to the NDS and specifically the CAP – crediting the CAP as a guide to its development. WA consultations confirmed that the CAP was the model used to develop *Strong Spirit Strong Mind*, and it is the strongest example of a state/territory plan developed from the CAP framework. Like the CAP, *Strong Spirit Strong Mind* uses a holistic approach and addresses Indigenous drug and alcohol in terms of prevention and early intervention; supply and control; harm reduction; support and treatment. Performance indicators are linked to the CAP KRAs, namely capacity building; working together; access to information and services; and workforce development. The Drug and Alcohol Office (DAO), OATSIH and the Office of Aboriginal Health (OAH) have developed a partnership to implement *Strong Spirit Strong Mind* involving regular meetings.

### *Tasmanian Drug Strategy (TDS) 2005-09*

The TDS was developed by the Tasmanian Department of Health and Human Services. The TDS identifies the NDS and the CAP as having played a significant role in defining the scope and context in which the TDS operates, and lists the implementation of the CAP as a key objective to improving access to quality treatment. The CAP is also identified in related action plans developed under the TDS: an Alcohol Action Plan (currently being developed); further development of the Tasmanian Action Plan; and plans to target the use of illicit drugs (all identified as areas for immediate action)<sup>3</sup>. Specific reference is given to the CAP in the *Tasmanian Tobacco Action Plan 2006-2010*, in tailoring initiatives for disadvantaged groups. The Plan's recommended actions include review and implementation of the tobacco components of the CAP.<sup>4</sup> The *Tasmanian Psychostimulants Action Plan (TPAP) 2007-2009* lists the CAP in one of its three priority areas - 'improved access to quality and treatment services' - with the aim of improving access to services for Aboriginal and Torres Strait Islander people through implementation of initiatives such as the CAP.

The CAP is also embedded in Tasmania's framework funding agreements with the Commonwealth.

### *Aboriginal Health – Everybody's Business*

This state-wide plan was developed by the South Australian Aboriginal Health Partnership (SAAHP). Along with other national frameworks (the National Strategic Framework for Aboriginal and Torres Strait Islander Health (2003), and National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing (2004-09)) as well as other South Australian frameworks, the CAP has been used specifically in the creation of guiding principles in developing the state Substance Misuse Strategy. The aim of the strategy is to assist in the development of regional and organisational implementation plans addressing the misuse of legal and illegal substances in South Australia. These guiding principles include: cultural respect; community control; holistic approach; local planning; partnerships; recognition of diversity; and capacity building and accountability. All of these principles are in alignment with the CAP.

<sup>3</sup> Tasmanian Department of Health and Human Services, 2007, 'Tasmanian Psychostimulants Action Plan 2007-2009', [http://www.dhhs.tas.gov.au/\\_data/assets/pdf\\_file/0015/25503/Tasmanian\\_Psychostimulants\\_action\\_plan\\_2007-2009.pdf](http://www.dhhs.tas.gov.au/_data/assets/pdf_file/0015/25503/Tasmanian_Psychostimulants_action_plan_2007-2009.pdf).

<sup>4</sup> Tasmanian Department of Health and Human Services, 2006, 'Reducing Smoking in Tasmania – A Framework for Action: Tasmanian Tobacco Action Plan 2006-2010'.

### *Central Australian Eight Point Plan*

The Eight Point Plan is a tri-state (Queensland, Northern Territory and Western Australia), cross-government strategy for addressing petrol sniffing. Whilst a direct link between the Eight Point Plan and the CAP is not made, the two frameworks share a similar holistic, multi-faceted approach. The comment was made during the consultations that, rather than a direct correlation between the two documents, the CAP influenced thinking about how to address substance abuse in Indigenous communities.

In NSW and Victoria, Indigenous drug/alcohol plans are currently being developed, and briefly described below.

### *Draft NSW Aboriginal and Torres Strait Islander Substance Misuse Plan*

At the time of writing this plan was not yet released and so details were unavailable. However, stakeholders from NSW Health indicated that the CAP is referenced in the plan and that the priorities and approaches are consistent with the CAP.

### *Koori Alcohol Action Plan*

The Koori Alcohol Action Plan is identified for development under *Victoria's Alcohol Action Plan 2008-2013*. The Koori Alcohol Action Plan will build on the Koori Alcohol and Drug Plan 2003-2004, which itself reflected the priority areas of the CAP through its focus on workforce issues, capacity building and families.

## 2.3 The CAP in relation to service delivery

In general terms, the CAP appears to be known best within policy making circles, but is considerably less well known at a service delivery level. During consultations, a number of service delivery stakeholders were looking at the CAP for the first time and a number were surprised they had not seen it before. It should be acknowledged, however, that the CAP was intended to be first and foremost a policy framework.

Nevertheless, some ad hoc examples of service providers using the CAP were uncovered during the consultations. One South Australian Aboriginal Health Service, for example, had used the CAP's principles to structure a hepatitis C health worker education program. This service had found the CAP information and framework for thinking about the issues invaluable and have specifically targeted 2 to 3 of the KRAs:

*The CAP has been a vital resource to us. It's been influential right across the organisation. And the information is not just filtering down, it's filtering up too.*

## 2.4 The CAP in relation to other strategies and frameworks

One of the terms of reference for this evaluation is to examine the relationship between the CAP and other Indigenous health and wellbeing frameworks/strategies.

Increasing attention has been directed to the need to take direct action for improving Indigenous health through the introduction of *Closing the Gap* and other targets, as well as other Indigenous physical and mental health implementation plans and strategies (described below). All of these current initiatives share the common goal of improving the welfare of Indigenous peoples through health and wellbeing. However in the context of the CAP evaluation, they are conspicuous by their lack of reference to or articulated alignment with the CAP, despite clear overlaps in key areas and monitoring and reporting.

It has been argued that much has occurred in terms of Indigenous drug and alcohol since the CAP was developed and therefore the priorities set out in the CAP are out-of-date, and this is why the CAP may have been omitted. Another argument was that the CAP was under-promoted and therefore many key policy makers were not aware of it.

## 2.4.1 Closing the Gap

The Closing the Gap campaign stemmed from the 2005 Social Justice Report in which Tom Calma (Aboriginal and Torres Strait Islander Social Justice Commissioner who is also current Chair of the Closing the Gap committee) called for a nation-wide commitment to achieving Aboriginal and Torres Strait Islander health and life expectancy equality within 25 years.<sup>5</sup>

On 20 December 2007, the Commonwealth of Australian Governments (COAG) agreed to a partnership between all levels of government to work with Indigenous communities to achieve the target of 'closing the gap' on Indigenous disadvantage; and notably, to close the 17-year gap in life expectancy within a generation, and to halve the mortality rate of Indigenous children within ten years. The Campaign culminated in the National Indigenous Health Equality Summit in Canberra in March 2008, where the Rudd Government signed a historic Close the Gap Statement of Intent to be reached by 2030.<sup>6</sup>

The following six targets were established to close the gap (as set out in the 2008-09 Budget)<sup>7</sup>:

- To close the 17-year life-expectancy gap between Aboriginal and Torres Strait Islander people and other Australians within a generation.
- To halve the mortality gap between Aboriginal and Torres Strait Islander children and other children under age 5 within a decade.
- To halve the gap in literacy and numeracy achievement between Aboriginal and Torres Strait Islander students and other students within a decade.
- To halve the gap in employment outcomes for Aboriginal and Torres Strait Islander people within a decade.
- To at least halve the gap in attainment at Year 12 schooling (or equivalent level) by 2020.
- To provide all Aboriginal and Torres Strait Islander four-year-olds in remote communities with access to a quality preschool program within five years.

COAG formally adopted these targets at the end of 2007, and in turn identified a number of strategic platforms or 'building blocks' from which to achieve them, including: healthy homes; safe communities; health; early childhood; schooling; economic participation; and governance and leadership.<sup>8</sup> Since then, progress has been made in establishing a national Aboriginal and Torres Strait Islander representative body to give Indigenous Australians a voice in national affairs, which will be guided by a national workshop of Indigenous leaders in March 2009.<sup>9</sup> Whilst these targets are broad in nature, dealing with drug and alcohol issues plays a crucial underlying role in addressing the 'gap', however there are currently no linkages with the CAP.

In terms of funding, a sum of \$49.3 million was allocated over four years to Close the Gap in the 2008-09 Budget in response to COAG's commitment to support substance and alcohol rehabilitation and treatment services across Australia, particularly in remote areas (a funding commitment that was built on COAG's investment of \$49.3 million over four years announced in July 2006, to address drug and alcohol use in Aboriginal and Torres Strait Islander communities).<sup>10</sup> In addition, \$14.5 million was announced in the 2008-09 Budget for a new Indigenous Tobacco Control Initiative.<sup>11</sup> This is in line with the Government's current focus on addressing licit drugs. Whilst Closing the Gap and the CAP operate

<sup>5</sup> Close the Gap website, <http://www.closethegap.com.au/index.php>, developed by ANTaR on behalf of the Close the Gap coalition

<sup>6</sup> Ibid

<sup>7</sup> Australian Commonwealth Government, 'Budget 2008-09', [http://www.budget.gov.au/2008-09/content/ministerial\\_statements/html/indigenous-03.htm](http://www.budget.gov.au/2008-09/content/ministerial_statements/html/indigenous-03.htm),

<sup>8</sup> Close the Gap website, <http://www.closethegap.com.au/index.php>, developed by ANTaR on behalf of the Close the Gap coalition

<sup>9</sup> Australian Commonwealth Government, 'Closing the Gap on Indigenous Disadvantage: The Challenge for Australia', Canberra, 2009, [http://www.fahcsia.gov.au/indigenous/closing\\_the\\_gap/closing\\_the\\_gap.pdf](http://www.fahcsia.gov.au/indigenous/closing_the_gap/closing_the_gap.pdf).

<sup>10</sup> Ibid

<sup>11</sup> Indigenous Measures – new and redirected funding following the 2007 Election and 2008-09 Budget Measures, [http://www.budget.gov.au/2008-09/content/ministerial\\_statements/html/indigenous-08.htm](http://www.budget.gov.au/2008-09/content/ministerial_statements/html/indigenous-08.htm)

under two different funding streams, the Closing the Gap agenda has the potential to reframe and enhance drug and alcohol policy programs particularly tobacco control and alcohol policy interventions – two areas in which the CAP could be given reference.

#### 2.4.2 National Indigenous Health Equality Summit and the Indigenous Health Equality Targets

The National Indigenous Health Equality Summit took place as part of the Closing the Gap Campaign, and included the signing of the Close the Gap Statement of Intent by Prime Minister Kevin Rudd. Part of the Rudd Government's commitment to Closing the Gap involved the measuring, monitoring and reporting on joint efforts in accordance with a range of supporting sub-targets and benchmarks in an effort to set concrete targets. The Indigenous Health Equality Targets (as they are now known) are the responsibility of the reformulated Indigenous Health Equality Council.<sup>12</sup> Many of these targets are in alignment with the KRAs of the CAP:

##### *Partnership Targets to improve access to quality health care (complementary with KRAs 1,3,6)*

- A commitment to ensuring the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs.
- Establishment of national framework agreements to secure the appropriate engagement of Aboriginal and Torres Strait Islander peoples and their representative bodies in the design and delivery of accessible, culturally appropriate and quality health services.

##### *Health status Targets to close the divide in health outcomes and life expectancy between Indigenous and non-Indigenous Australians (complementary with KRAs 3,4, and issues raised in the Background Paper).*

- Maternal and child health – reduce low birth weight, control infections particularly gastroenteritis and respiratory, maternal education, dedicated services for mothers and babies.
- Chronic disease – secondary prevention of chronic disease (risk identification and management including health checks); acute care (reduce time to admission and implementation of care guidelines for CVD, diabetes, chronic kidney disease); tertiary prevention (services for cardiac rehabilitation, chronic kidney disease, stroke).
- Mental health and emotional and social well-being – reduce the impact of loss, grief and trauma; reduce the disparity in suicide rates and mental health disorders including depression and psychosis; improve mental health outcomes and reduce adverse events for Indigenous patients including Indigenous people with chronic disease, substance abuse or in custody.

##### *Primary Health Care and other Health Services Targets (complementary with KRAs 1,3,4,6).*

- Supporting and developing Indigenous community-controlled health services in urban, rural and remote areas; achieving improved access to, and outcomes from, mainstream services for Indigenous people; respecting and promoting the rights of Indigenous peoples ensuring that health services are available, appropriate, accessible, affordable and of good quality.
- A Capacity Building Plan – for Indigenous primary health care services to provide comprehensive care to an accredited standard to meet the level of need.
- Mainstream health services to improve access to MBS/PBS, AHCA, GP Divisions, specialist outreach.
- Specific Programs for: mothers and children (national coverage of maternal and child health services, rheumatic fever/rheumatic heart disease, home visits, nutrition); chronic diseases

<sup>12</sup> Aboriginal and Torres Strait Islander Social Justice Commissioner and the Steering Committee for Indigenous Health Equality, Human Rights and Equal Opportunity Commission, 'Close the Gap: National Indigenous Health Equality Targets, Outcomes from the National Indigenous Health Equality Summit Canberra, March 18-20, 2008'

(implementation of the National Chronic Disease Strategy and National Service Improvement Framework); prevention (smoking, alcohol and substance misuse, physical activity and nutrition; mental and social-emotional well-being (mental health, men's health including suicide prevention); other (men's health, oral, environmental, vaccine preventable, communicable disease).

*Infrastructure Targets – with the aim of measuring, monitoring and reporting on joint efforts in accordance with benchmarks and targets (complementary with KRA 5).*

- Involves: workforce training plans for Indigenous people; capital works and equipment; engagement of Indigenous communities; housing; environment; health information and data.

*Social Determinants Targets – involves working collectively to systematically address the social determinants that impact on achieving health equality (complementary with KRAs 3,4).*

- Includes: education; community safety; employment; community development; culture/language; criminal justice system review and reform.

The Close the Gap Steering Committee continues to work with COAG and Australian governments to progress the adoption of the targets and their integration with a variety of monitoring frameworks, including, but not limited to the following<sup>13</sup>:

- the National Strategic Framework for Aboriginal and Torres Strait Islander Health and the Aboriginal and Torres Strait Islander Health Performance Framework
- the Productivity Commission's Overcoming Indigenous Disadvantage framework, which measures the total impact of Australian government activities on a range of Indigenous socio-economic indicators, including health
- the targets developed by the Building the Evidence sub-group of the COAG Working Group on Indigenous Reform
- the social inclusion performance framework developed by the COAG Health and Ageing Working Group and the National Health and Hospital Reform Commission in relation to the Australian Health Care Agreements
- the Prime Minister's annual report to Parliament on closing the gap, announced at the National Apology to Australia's Indigenous Peoples.

The Close the Gap report suggests that these and other policy frameworks and indicators are linked to benchmarks and targets in order to address the overarching aims of reaching Indigenous health equality. It would make sense to link the CAP with the Close the Gap campaign or at least provide cross-referencing as a means of providing a consistent response to dealing with Indigenous drug and alcohol abuse.

#### 2.4.3 National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013: Australian Government Implementation Plan 2007-2013 (NSFATSIH)

The *Australian Government Implementation Plan 2007-2013* was developed by the Department of Health and Ageing in consultation with all relevant government agencies and the (then) National Aboriginal and Torres Strait Islander Health Council. The Plan has a strong emphasis on a whole-of-government approach, and is committed to strengthening access to culturally sensitive health care services for Aboriginal and Torres Strait Islander people, with a particular focus on primary health care – a key area of focus within the CAP. The Plan also has an increased emphasis on addressing the social and environmental determinants of health. Included in the eight priority areas of the plan that are of particular relevance to the CAP, are:

- smoking, nutrition, alcohol, physical activity, overweight and obesity

<sup>13</sup> Ibid

- social and emotional wellbeing, including substance use and mental health.

The National Strategic Framework for Aboriginal and Torres Strait Islander Health recognises that concerted action is required both across and beyond the health sector, in order to address the complex and inter-related factors contributing to health problems amongst Indigenous people. In 2004, the Australian Government changed its approach to Indigenous affairs through the abolition of ATSIC and ATSIIS, resulting in Indigenous programs being administered by mainstream agencies under a whole-of-government approach.

There are opportunities for greater alignment with the CAP within these current arrangements. The Plan currently operates through Indigenous Coordination Centres (ICCs), who are responsible for local engagement with Indigenous Australians and the coordination of programs at local and regional levels. Department of Health and Ageing officials in the ICCs are called Health Solution Brokers. Arrangements are made through Shared Responsibility Agreements and State and Regional Partnership Agreements. Engagement with state NACCHO Affiliates and state and territory governments in the development of specific responses occurs through the state/territory Health Partnership Forums in each jurisdiction according to the Framework Agreements.

As required under the National Strategic Framework, the Australian Government produces a qualitative report to AHMC on health portfolio progress against this implementation plan every year and on the contribution of all portfolios every two years. A report against the Aboriginal and Torres Strait Islander Health Performance Framework is also produced every two years (the last of which was in 2008). Use of the CAP in program and portfolio development could potentially provide a link between frameworks, and it would be useful to include the CAP in reporting.

There are nine key result areas against which progress is reported, many of which complement the CAP's KRAs:

1. Community controlled primary health care services.
2. Health system delivery framework (including enhanced provision of comprehensive primary health care through increased coordination and the establishment of partnerships and collaborative linkages between Aboriginal community controlled health services and general mainstream services; mainstream services that are better equipped to be responsive to the needs of Indigenous peoples; increased participation in planning and managing health services by Indigenous peoples).
3. A competent health workforce.
4. Social and emotional wellbeing – through population health approaches to reduce the prevalence and impact of harmful alcohol, drug and substance use on Indigenous individuals, families and communities; coordination of policy, planning and program development between mental health, social and emotional wellbeing and drug and alcohol agencies that provide services to individuals and families with mental health conditions and comorbidities; a workforce that is resourced, skilled and supported to address mental health, social and emotional wellbeing and substance use issues across all Indigenous settings.
5. Environmental health.
6. Wider strategies that impact on health.
7. Data, research and evidence.
8. Resources and finances.
9. Accountability.

#### 2.4.4 National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being (2004-2009)

The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004-2009* was developed under the auspices of the National Mental Health Working Group and the then National Aboriginal and Torres Strait Islander Health Council (which has since been reformulated as an Indigenous Health Equality Council). It complements the *National Mental Health Plan 2003-08* and sits within the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013 (NSFATSIH)*. Monitoring and reporting has been undertaken through the overall monitoring process, established by the Australian Health Ministers' Advisory Council (AHMAC) for the whole health system approach to implementing the NSFATSIH.

Like the CAP, the Framework operates to provide a separate basis from which to address Indigenous drug and alcohol problems. The Mental Health and Social and Emotional Well Being Framework operates on the premise that Indigenous people have different cultures and histories, and in many instances different needs, which must be acknowledged and addressed by locally developed, and culturally specific strategies.<sup>14</sup> The Framework also acknowledges that partnerships need to be developed between Indigenous and mainstream health services so that coordinated responses can be given to achieving better health outcomes for Indigenous peoples. In addition, recognition is also given to the fact that health and wellbeing requires a holistic and whole-of-life view of health, and is synonymous with the social, emotional and cultural wellbeing of the whole community.<sup>15</sup> All of these factors are in line with the principles of the CAP yet there is no cross-referencing with the CAP.

Each jurisdiction develops its own implementation plan for the Framework. At the state and territory level the Framework therefore provides for the development and implementation of social and emotional well being components for these implementation plans. Unlike the CAP however, consistency is maintained through forums for mental health planners, by ensuring the key priorities from this Framework, the *National Mental Health Plan 2003-08* and existing state and territory social and emotional well being plans. If the CAP were to be more closely aligned with the Social and Emotional Wellbeing Framework, inclusion in these forums would be a useful means of establishing a coordinated response to Indigenous health, as well as keeping the CAP 'alive' as a referral document in coordination with other Indigenous health-focused strategies.

#### 2.4.5 National Preventative Health Strategy

The National Preventative Health Strategy has been implemented to combat chronic disease in Australia, by reaching the following targets by 2020:

- Halt and reverse the rise in overweight and obesity.
- Reduce the prevalence of daily smoking to 9% or less.
- Reduce the prevalence of harmful drinking for all Australians by 30%.
- Contribute to the 'Close the Gap' target for Indigenous people, reducing the 17-year life expectancy gap between Indigenous and non-Indigenous people.<sup>16</sup>

The National Preventative Health Taskforce was created in April 2008 initially for a three-year period, and will produce the National Preventative Health Strategy in June 2009, focusing on the primary prevention of obesity, tobacco and harmful consumption of alcohol – the blueprint for preventative health reform. Other important areas of preventative health such as mental health, injury, immunisation,

<sup>14</sup> Social Health Reference Group for National Aboriginal and Torres Strait Islander Health Council and National Mental Health Working Group, 'Social and Emotional Well Being Framework: a National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004-2009, Canberra, prepared by the; endorsed by the Australian Health Ministers' Advisory Council, 2004

<sup>15</sup> Ibid

<sup>16</sup> National Preventative Health Taskforce, 'Australia the Healthiest Country by 2020: A discussion paper', Canberra, Commonwealth of Australia, 2008

sexual and reproductive health and illicit substance use will be considered in the next phase of the Taskforce's work in 2009.<sup>17</sup> The CAP could potentially play a significant role in meeting Indigenous drug, smoking and alcohol targets, and could assist in 'closing the gap' between Indigenous and non-Indigenous health and wellbeing more broadly.

#### 2.4.6 Social Inclusion Agenda

The Social Inclusion Agenda has been established by the Australian Government as a means of mainstreaming the task of building social inclusion so that all Australians are able to share in the nation's prosperity.<sup>18</sup> Early priorities of the agenda include the following:

- addressing the incidence and needs of jobless families with children
- delivering effective support to children at greatest risk of long term disadvantage
- focusing on particular locations, neighbourhoods and communities to ensure programs and services are getting to the right places
- addressing the incidence of homelessness
- employment for people living with a disability or mental illness
- closing the gap for Indigenous Australians.

There is scope for the CAP to assist in the closing the gap process by addressing Indigenous drug and alcohol abuse.

### 2.5 Summary

The consultations and the review of a wide range of national and state/territory policies have clearly indicated that while the CAP has made an impact in some areas of policy development, its identifiable impact to date has been limited both within and beyond the health sphere. There are a number of reasons for this, including a lack of promotion of the CAP, a lack of accountability, and a lack of understanding about how the CAP could be used.

Nevertheless, the achievements of the CAP must not be undervalued. It is widely viewed as having an important symbolic function as leading the national direction on Indigenous drug and alcohol matters and elevating these issues within the health agenda and beyond. The holistic approach promoted by the CAP is consistent with current thinking and directions in Indigenous health and has the potential to influence drug and alcohol planning at state/territory and regional levels, as the approach taken in Western Australia has demonstrated.

While the CAP operates as a separate Indigenous-focused stream under the NDS in isolation to other strategies, despite a common national goal to address Indigenous drug and alcohol abuse, it is clear that it has the potential to operate within the broader national policy context, generating greater exposure, and providing a more coherent and consistent effort to addressing Indigenous drug and alcohol misuse on a national, multi-faceted front.

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<sup>17</sup> Ibid

<sup>18</sup> Social Inclusion website, <http://www.socialinclusion.gov.au/>.

## 3 CAP program outcomes

This chapter discusses the documented extent of CAP-related programs and projects, and analyses the evidence of program outcomes.

### 3.1 CAP program funding

The CAP itself has no direct funding source with which to support Indigenous drug and alcohol services. Drug and alcohol service providers are able to apply for project funding under two initiatives – the Indigenous Communities Initiative (ICI) and the Capacity Building in Indigenous Communities Initiative (CBIC). In order to receive funding, programs must report against the KRAs of the CAP. The IGCD defines these projects as having the potential to:<sup>19</sup>

*...enhance capacity of Aboriginal and Torres Strait Islander individuals and communities to address current and future issues relating to alcohol and other drugs, as well as workforce initiatives to strengthen Aboriginal and Torres Strait Islander community controlled and mainstream organisations to provide quality services.*

Both of these initiatives are managed by the Drug Strategy Branch of the Mental Health and Chronic Disease Division within DoHA. Both initiatives were considered as ongoing in the 2008-2009 Budget.

#### 3.1.1 ICI

The ICI was implemented to assist Indigenous communities in developing local solutions to drug and alcohol abuse. The initiative received \$10.5 million in funding over four years in 2003-04, and a further \$14.6 million was allocated in 2007-08. The initiative complements other initiatives by Australian state/territory governments that address different aspects of the problem - across health and welfare, law enforcement, training, education and employment.<sup>20</sup>

The ICI funds proposals that are either sourced directly or received on an ad-hoc basis by the Drug Strategy Branch; proposals are reviewed and are funded at the discretion of the Department. ICI-funded programs tend to focus on addressing alcohol and inhalant use, and their links to violence; recent examples include the creation of education resources and capacity building projects. Projects are able to receive funding over a number of years.

An evaluation of ICI was conducted by (then) Urbis Keys Young in 2006 to examine the achievement of goals and objectives and the effectiveness of the Initiative. The review found that the ICI had facilitated:

- substantial development/enhancement of quality, evidence-based and culturally-based resources
- the implementation of new resources which in turn had provided a focus for engaging new service providers and service networks to better meet the needs of Indigenous clients and communities
- a significant improvement in the identification of resources
- an increased identification of 'need' for health, welfare and community development workers, and Indigenous drug and alcohol abuse service providers
- new service delivery, early intervention and community capacity building projects
- the development of linkages and networks that specifically supported a nationally coordinated Indigenous Train the Trainer program

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<sup>19</sup> Intergovernmental Committee on Drugs *National Drug Strategy 2004-2009 Annual Report July 2006-June 2007* to the Ministerial Council on Drug Strategy, 2008, [http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/27AF519ECBC5D3FFCA25752300112355/\\$File/igcd-annrep2007.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/27AF519ECBC5D3FFCA25752300112355/$File/igcd-annrep2007.pdf)

<sup>20</sup> Ibid

- increased engagement of national drug and alcohol research centres and universities in culturally relevant Indigenous research projects
- the development and enhancement of programs which assist Indigenous people with drug and alcohol issues seeking employment in key Indigenous employment areas (eg mining).

Overall the ICI was found to fund effectively targeted interventions which had significant 'value adding' potential in addressing Indigenous drug and alcohol abuse.

### 3.1.2 Capacity Building in Indigenous Communities Initiative (CBIC)

The CBIC was developed to complement the ICI in assisting Aboriginal and Torres Strait Islander communities to address problems related to alcohol and other drugs. In 2005-06 the CBIC was funded \$8 million over four years. This was reprioritised in 2008, with \$3 million transferred across to the Indigenous Tobacco Control Initiative. The first projects under this initiative were commenced in 2006-07.

CBIC project proposals are sourced from Health Solution Brokers in the Indigenous Coordination Centres (ICCs) and, as is the case with the ICI, proposals are reviewed by an Advisory Group and are funded at the discretion of the Department. CBIC funded programs are characterised as community grants programs.

No evaluations of the CBIC have been conducted to date.

## 3.2 Programs linked to the CAP

All programs that were reported to be linked to the CAP (either through funding, or alignment with the CAP's principles) have been entered into a matrix which can be found at Appendix D. Programs are listed according to whether they operate at a national or state/territory level; where information has been available, the matrix provides details on funding source and alignment with CAP KRAs. Of the 115 programs listed in the matrix:

- 54 programs were funded under the ICI or CBIC
- 61 programs were reported by stakeholders to be related to the CAP in some way.

Of these, 69 programs reported against, or could be identified as in alignment with, the CAP KRAs.

### 3.2.1 CAP programs receiving funding

The Department provided a list of all programs that had, or were to receive funding under the ICI or CBIC funding initiatives. These current, completed and potential programs are included in the matrix in Appendix D along with funding details. Altogether 54 projects have received or will be receiving funding under either the ICI or CBIC. These include:

- 7 programs currently funded under ICI
- 10 programs proposed to be funded under ICI
- 19 completed programs that were funded under ICI
- 22 programs currently funded under CBIC
- 5 proposed programs to be funded under CBIC
- 3 completed programs that were funded under CBIC

The Department was able to provide Urbis with reports for 11 of the 54 programs. It is understood that this was due to the fact that: it was not feasible to send through all progress reports for programs that reported periodically (due to the sheer number of reports). Few recent program evaluations have been conducted, and many program reports were not otherwise available.

The reports were analysed according to whether they reported against the CAP KRAs or whether they were aligned with the CAP principles in general. Overall it was found that of the 11 projects:

- All projects were complementary to the CAP, however only 2 made direct reference to the document.
- Only 1 project reported specifically against the CAP KRAs.
- None of the reports made reference to the KRAs in determining future direction or improving outcomes.
- There was very little consistency in reporting generally – 3 reports made use of a DoHA progress report template; 3 made use of a Queensland Department of Health progress status report; and the remainder of the reports were presented in a variety of formats.

### 3.2.2 Programs related to the CAP

During consultations, stakeholders were asked to detail any programs, strategies or initiatives that were developed according to the principles of the CAP; reported specifically against the CAP; or reflected the CAP KRAs.

Altogether, stakeholders reported a total of 61 programs that were related to the CAP in some way. These programs are listed in the matrix and are distinguished by a blue diamond symbol, as funding details were not provided during consultations. Details are also provided as to whether each program was reported by stakeholders to be aligned with/or report against specific KRAs.

It is important to note that in this instance, the matrix **does not**:

- reflect every program in existence that has some link to the CAP, only those mentioned by stakeholders who were consulted or that were documented in reports
- comprehensively reflect reporting against CAP KRAs as in the great majority of cases evaluation reports were not provided – current reporting details were gathered only through consultations
- provide comprehensive funding details for programs not funded under either the ICI or CBIC.

### 3.2.3 Programs that reported against or were aligned with CAP KRAs

Of the 115 programs listed in the matrix, 69 were reported by stakeholders to report against, or to be in alignment with, one or more of the CAP KRAs. This figure includes 8 programs funded under either the ICI or CBIC that were noted in stakeholder consultations.

The following table provides a count for each KRA with data available (a more detailed matrix can be found at Appendix D). Note that figures for the 'total number of programs' and 'programs funded under the ICI and CBIC', include multiple reports against KRAs. KRAs with the most number of mentions included KRA 4 (22 programs), closely followed by KRA 3 (19 programs) and KRA 1 (17 programs). A state by state breakdown of programs reported by stakeholders shows that Western Australian programs are most likely to report against the CAP KRAs (with KRAs reported in 31 instances). Whilst this table is not an accurate reflection of the number of programs currently operating under the CAP, New South Wales and the Australian Capital Territory were reported by stakeholders to have the least number of programs aligned with KRAs.

Table 1 – Programs reported against or in alignment with, the CAP KRAs

CAP KRA	Total number of programs	Location									Programs funded under ICI/CBIC
		National	NSW	ACT	VIC	TAS	SA	WA	NT	QLD	
KRA 1: Enhanced capacity of Indigenous individuals, families and communities to address current and future issues in the use of alcohol, tobacco and other drugs and promote their own health and wellbeing.	17	-	-	-	5	1	2	3	6	-	3
KRA 2: Whole-of-government effort and commitment, in collaboration with community-controlled services and other non-government organisations to implement, evaluate and continuously improve comprehensive approaches to reduce alcohol, tobacco and other drug issues.	14	-	-	-	2	1	3	5	3	-	3
KRA 3: Substantially improved access for Indigenous people to the range of services, programs and interventions that play a role in addressing alcohol, tobacco and other drugs.	19	-	-	-	2	-	5	8	1	3	4
KRA 4: A range of holistic approaches from prevention through to treatment and continuing care, that is locally available and accessible.	22	-	1	1	2	-	3	9	2	5	6
KRA 5: Workforce initiatives to enhance the capacity of Indigenous community-controlled and mainstream organisations to provide quality services.	14	-	-	1	2	-	3	5	1	2	5
KRA 6: Sustainable partnerships among Indigenous communities, government and non-government agencies in developing and managing research, monitoring, evaluation and dissemination of information.	13	-	-	-	4	-	3	1	4	1	4
<b>Total</b>	<b>99</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>17</b>	<b>2</b>	<b>19</b>	<b>31</b>	<b>17</b>	<b>11</b>	<b>25</b>

### 3.3 Annual IGCD reporting

Annual Reports are submitted by the IGCD to the MCDS which detail the Commonwealth and state and territories' progress against the NDS. These reports provide information on the current state of key drug related issues affecting Australia and the various interventions undertaken by government agencies to address these. Reporting is conducted in consultation with the National Drug and Alcohol Research Centres (NDARC), the National Drug Research Institute (NDRI) and the National Centre for Education on Training and Addiction (NCETA); as well as the National Drug Law Enforcement Fund (NDLERF).

Progress against the eight NDS priorities is a particular focus of these reports, which includes implementation of the CAP. These priority areas are:

- prevention
- reduction of supply
- reduction of drug use and related harms
- improved access to quality treatment
- development of the workforce
- organisations and systems
- strengthened partnerships
- implementation of the CAP
- identification and response to emerging trends.

An analysis of four of the Annual Reports since implementation of the CAP – the 2003-2004 Report, 2004-2005 Report, 2005-2006 Report and 2006-2007 Report - demonstrated changes in programs under the NDS that had an Indigenous drug and alcohol component, and programs specifically developed under the CAP. A specific focus of the analysis was the number of Indigenous-focused programs operating since implementation of the CAP; the nature of these programs and alignment with CAP KRAs and the NDS priority areas; and adherence to the CAP performance indicators.

### 3.3.1 The nature of programs reported, and alignment with NDS reporting and the CAP KRAs

#### Programs reported

The number of Indigenous drug and alcohol-focused programs reported in the IGCD Annual Reports increased steadily over the life of the CAP. This is presented in the table below:

Table 2 – Indigenous drug and alcohol programs reported in annual IGCD reports

Reporting period	Indigenous-specific programs	Programs with an Indigenous component
2003-2004	10	4
2004-2005	33	5
2005-2006	46	5
2006-2007	57	15

It is evident that there has been a recent rise in the number of mainstream programs with an Indigenous component (although these figures are open to interpretation, as program details were not always clear). Whilst it could be assumed that this rise is due to a heightened awareness of the CAP, the reports do not provide evidence as to whether this is the case. However it seems reasonable that growth in both sets of program could be attributed to an increased awareness of Indigenous drug and alcohol problems and their health and social consequences, and the need to include the Indigenous population in mainstream measures. These in turn might be attributed, if only indirectly, to the existence of the CAP and the diffuse dissemination of its key principles.

#### Reporting against the NDS

An analysis of the Annual Reports shows that as reporting has progressed, Indigenous drug and alcohol programs have increasingly come to feature in reporting against the other 7 key priority areas of the NDS, thus gaining prominence in reporting against the NDS overall. This is particularly so in the

areas of workforce development, organisations and systems, and strengthened partnerships; and more recently in the 2006-07 Report, reduction of drug use and related harms. Each of these areas are discussed in detail below.

### *Development of the workforce, organisations and systems*

Inclusion of Indigenous drug and alcohol programs in this area has primarily centred around the development of training initiatives for Indigenous health care workers. In 2004-2005, programs included (as documented in the 2004-2005 Report): induction and foundation programs for Aboriginal drug and alcohol workers managed by TAFE New South Wales in conjunction with AHMRC; the development of *Smokecheck* by New South Wales Department of Health which involved a training and education resource to support health workers working with Aboriginal communities; Koori training initiatives under the *Victorian Alcohol and Other Drugs Workforce Development Strategy*; a new training model developed in Western Australia for supporting Indigenous health workers on Blood Borne Virus (BBV); and *Quit* groups offered in workplaces in the Top End Northern Territory, as well as the delivery of the national pilot of the Certificate III Alcohol and Drugs to Indigenous workers.

In 2005-2006, the following additional programs were reported: development of a New South Wales Family and Carers Training Kit for Aboriginal and Torres Strait Islander families and carers; development of an Aboriginal Dual Diagnosis Case Management Certificate funded by the New South Wales Department of Health and managed by the AHMRC; continuation of the *Indigenous National Alcohol and Other Drugs Workforce Development Program* led by the Western Australian Drug and Alcohol Office, which delivers nationally recognised training to the Aboriginal and Torres Strait Islander alcohol and other drug workforce; training provided to Indigenous health care workers and midwives in smoking cessation in the Northern Territory.

In 2006-2007 the programs listed above were noted as ongoing. It was also reported that Australian Capital Territory Policing employed an Indigenous Community Liaison Officer (ICLO).

### *Strengthened partnerships*

A number of programs with an Indigenous focus were reported throughout the 4-year period to have demonstrated strong partnerships between stakeholders. Partnerships were strengthened on a number of levels:

- between state/territory governments and local Indigenous communities, such as: a partnership between the Victorian Premier's Drug Prevention Council and the local Koori community to develop information and resources for Indigenous health workers to address the incidence of Fetal Alcohol Spectrum Disorder in Indigenous communities; the use of Liquor Accords in New South Wales to foster closer links between licensed premises and the local Indigenous community as a means of dealing with alcohol-related problems;
- between Commonwealth and state/territory government departments, such as: a partnership agreement established in Western Australia for the funding of alcohol and other services between the Western Australian Drug and Alcohol Office, the Western Australian Office of Aboriginal Health and OATSIH in 2004 to improve the coordination in the planning and funding of Aboriginal drug and alcohol services;
- between state/territory governments and non-government Indigenous services providers, such as: an Implementation and Evaluation Group established under the *Australian Capital Territory Alcohol, Tobacco and other Drug Strategy 2004-2008* with membership from Indigenous government and non-government organisations; the use of diversion initiatives by the Victorian Department of Human Services which included partnership with the Ngwala Willumbong Cooperative to improve reporting and recording of practices, and improved partnerships between the Victorian Department of Justice and Koori alcohol and other drug services to ensure linkages for Koori offenders into appropriate Aboriginal or generalist drug treatment services.

### *Reduction of drug use and related harms*

A number of Indigenous drug and alcohol-related programs were documented in the 2006-2007 Report. Examples show that these ranged both in nature and context: in New South Wales the Heroin Overdose Prevention Strategy enabled the Red Cross to work with families of drug dependent people,

including that from Indigenous communities; the New South Wales Correctional Centre Release Treatment Scheme provided post-release linkage and support to 56 Indigenous released offenders in 2006-07 who had drug problems; *Chopped Liver*, an innovative Indigenous theatre show was developed in collaboration with the Theatre Co-Operative, VACCHO and the Victorian Hepatitis C Council addressing the social implications of Hepatitis C; and in 2006-07 the South Australian Drug Court Program at the Adelaide Magistrates Court engaged the Aboriginal Sobriety Group to deliver support services for Indigenous participants.

### Reporting against the CAP KRAs

Whilst it was not possible to determine from the IGCD Annual Reports specifically which CAP KRAs each program addressed (as program details were very brief and did not include reporting specifics), the programs, as highlighted above, indicate general alignment with the CAP KRAs. This is particularly so with:

- KRA 2: Whole-of-government effort and commitment (through the development of state and territory policy frameworks and collaboration with other community-controlled services),
- KRA 5: Workforce initiatives (through the development of educational resources for health care workers, and specialised training for Indigenous drug) and
- KRA 6: Sustainable partnerships (at a community, NGO, Commonwealth and state/territory government level).

### 3.3.2 Adherence to the CAP performance indicators

The IGCD Annual Reports were reviewed with regard to the CAP performance indicators, specifically:

- whether there had been an increase in the capacity to report nationally on improvements for Indigenous people against mainstream performance indicators specified in the substance-specific national action plans
- whether regional health plans incorporated Indigenous drug and alcohol strategies listed in the CAP
- whether workforce, research, and evaluation and monitoring actions that arise from the substance-specific action plans are developed in line with the intentions of the CAP.

Whilst it was not possible to determine whether there had been an increase in the capacity to report nationally on improvements for Indigenous people against mainstream performance indicators for the substance-specific national action plans, there was evidence of increased reporting against the NDS priority areas (as discussed above). This suggests that increasing acknowledgement is being given to the need to incorporate Indigenous-focused components in mainstream programs addressing drug and alcohol abuse. It is also evident through programs documented in the Annual Reports that workforce, research, and evaluation and monitoring actions arising from the NDS (rather than the substance-specific action plans) are increasingly giving consideration to the CAP principles.

In relation to the development of regional health plans incorporating Indigenous drug and alcohol strategies listed in the CAP, the Annual Reports documented a number of state/territory Indigenous drug and alcohol abuse strategies or mainstream strategies that had an Indigenous component:

- *VIC Koori Alcohol and Drug Plan 2003-2004*
- *Indigenous Drug Action Team* trial as part of SA's *Aboriginal Health – Everybody's business* developed in 2003-2004
- *WA Strong Spirit Strong Mind: Aboriginal and Other Drugs Plan* developed in 2004-2005
- *Tasmanian Aboriginal and Torres Strait Islander Complementary Action Plan* developed in 2004-2005 and *Aboriginal Health and Wellbeing Strategic Plan* developed in 2005-2006.

Finally, while there is little evidence of any direct link, it does appear that such workforce, research, and evaluation activities which do take place often incorporate elements of the 'good practice' outlined by

the CAP. As discussed above, this seems to occur more by accident than design, although it does provide evidence that the CAP principles themselves are sound as they are complementary to a great number of service providers' operations.

The performance indicators are discussed further in chapter 4 in the context of performance monitoring.

### 3.4 Summary

It appears that the CAP has had some influence on program development through the funding provided under the two CAP-related Commonwealth funding streams. However, the inconsistency in reporting makes it difficult to ascertain the extent of the CAP's influence. Likewise, there has been an increase in programs addressing Indigenous drug and alcohol misuse as evidenced in annual IGCD reporting, as well as state and territory level reporting. However, due to a lack of consistent and clear reporting, conclusions cannot be drawn about the outcomes of programs funded by ICI or CBIC, or aligned with the CAP. Requiring a greater level of reporting against the CAP, as well as consistency of reporting, will assist in evaluating the impact of the CAP in the future.

## 4 Monitoring the performance of the CAP

This chapter examines the contribution of the KRAs and performance indicators to monitoring the performance of the CAP.

### 4.1 Key Result Areas (KRAs)

The six KRAs were developed through a consultation process with Indigenous communities. They are as follows:

- Enhanced capacity of individuals, families and communities to address current and future issues in the use of alcohol, tobacco and other drugs, and promote their own health and wellbeing
- Whole-of-government effort in collaboration with non-government organisations to implement, evaluate and improve comprehensive approaches to reduce drug-related harm
- Substantially improved access to the appropriate range of health and wellbeing services that play a role in addressing alcohol, tobacco and other drugs issues
- A range of holistic approaches from prevention through to treatment and continuing care that is locally available and accessible
- Workforce initiatives to enhance the capacity of community-controlled and mainstream organisations to provide quality services
- Increased ownership and sustainable partnerships of research, monitoring, evaluation and dissemination of information.

In general terms, these KRAs were viewed as being appropriate by most stakeholders. The emphasis on holistic approaches, collaboration, capacity building and workforce development were widely applauded as being key issues of concern in relation to Indigenous drug and alcohol.

Nonetheless, several issues were raised in relation to the usefulness and the measurement of the KRAs. These are outlined below.

- *The KRAs are very broad.* Stakeholders were divided about whether this was a positive or a negative characteristic. Many stakeholders argued that as a national level document, it was the job of the CAP to provide broad strategic direction without the specificity of identified actions. Broad result areas allowed states and territories to adapt the CAP to match the needs, priorities and resources of their own jurisdictions.

*It is broad enough to allow flexibility for localised protocols and procedures that are implemented and applied within that framework.*

On the other hand, critics argued that “*without specifics, no one does anything*”. They felt the CAP had the capacity to be ‘braver’, to identify action areas and set targets. “*There’s too much wiggle room for the states [and territories]*” commented one stakeholder. A stakeholder referred to the changed political climate since Labor’s election to Federal Government and said, “*There are things that we are doing now that would have been unthinkable ten years ago. If we can’t give it a go now, there will never be a better time.*” Several people felt the KRAs provided little more than ‘motherhood’ statements.

- *The KRAs lack performance measures.* Following on from the previous point, opinion was divided about whether targets should be set at the KRA level of the CAP, although there was widespread agreement that the CAP lacked adequate performance measures as a whole. A strong argument was made by a number of stakeholders, including many at state/territory level, that the KRAs and the sub-objectives are meaningless unless linked to performance indicators. Furthermore, it was argued that it is important that the performance indicators link to data that is readily available, and is aligned with other key indicator documents such as FaHCSIA’s Overcoming Disadvantage indicators, rather than requiring jurisdictions to ‘reinvent the wheel’.

- *The KRAs need to be updated.* It was particularly felt that the KRAs should be reviewed in light of more recent developments such as the Northern Territory Intervention and the National Indigenous Health Summit and income management strategies. It was suggested by one stakeholder that the current focus of the KRAs on workforce issues was appropriate in 2003, but that workforce issues had moved on since then and other issues might need to be prioritised.
- *The Action Plan and KRAs are somewhat repetitive.* Some stakeholders felt the Action Plan document was overly long, dense, repetitive and confusing. In particular the KRAs and Key Action Areas were thought by these stakeholders to be repetitive:

*"It tries to cover everything off under each KRA. It makes it hard for people to see where they should put their efforts"*

*[The CAP] can at times be overwhelming to people – overwhelmed with every KRA, with objectives, key action areas etc. It needs to get across that its all important with a particular focus on certain areas.*

One critic suggested that the repetitiveness within the KRAs decreased the level of accountability, with governments able to 'tick off' that they have made progress against each KRA with little effort.

- *The KRAs could be constructed in a different way.* Some stakeholders commented that the existing KRAs were difficult to align with activities because they did not provide sufficient direction. It was suggested that the CAP could usefully look at the way other strategies have constructed their objectives. For example, the Central Australian Eight Point Plan was suggested as having more practical objectives that enabled stakeholders to see clearly where they fit.

## 4.2 Performance indicators

The CAP sets out the performance indicators for the National Tobacco Action Plan, the National Alcohol Action Plan and the National Illicit Drug Action Plan, in addition to three specific national indicators for the CAP, as follows:

- An increase in the capacity to report nationally on improvements for Aboriginal and Torres Strait Islander populations in meeting the mainstream performance indicators specified by the substance-specific national action plans.
- The number of regional health plans developed under the partnership agreements that incorporate ATOD strategies listed in the CAP.
- Evidence that all appropriate workforce, research, and evaluation and monitoring actions that arise from funding for the substance specific action plans are developed in line with the intentions of the CAP to improve capacity and to promote holistic models of intervention.

Stakeholders generally felt that these were not helpful performance indicators. For one thing, there was no benchmark so it was impossible to measure them in a meaningful way. Secondly, whereas the indicators for the other strategies identify clear and measurable areas of evidence (eg number of deaths caused by smoking, percentage of women smokers, costs of alcohol use, incidence of hepatitis C diagnoses attributable to injecting drug use), the CAP indicators are of an entirely different order and it is not clear how they would or could be measured.

Another major criticism was that these indicators are insufficient measures by which to evaluate the progress of the CAP. Critics argued that effectiveness of the CAP could not be measured simply by whether: mainstream measures include Indigenous populations better; counting regional health plans that overlap with the priorities set out in the CAP; and checking that initiatives under the other drug strategies reflect the CAP priorities. It was argued that firstly, the CAP represents much more than these indicators suggest; and secondly, that such global measures cannot adequately evaluate the CAP; rather, measures at the KRA or objective level need to be developed in order to build evidence for the CAP's progress through a 'hierarchy of outcomes'. This lack of sophistication was thought by many to be a significant flaw in the approach to measuring outcomes of the CAP.

The performance indicators were also criticised for their lack of connection to real data. It was reported that NIDAC, which was made responsible for monitoring CAP outcomes, had been given an impossible task because there is no dedicated mechanism for collecting the data required for the three CAP performance indicators. It was suggested that the performance indicators be redrafted taking into consideration existing data sets (eg ABS, AIHW, state health data) and existing performance frameworks of relevance (eg Overcoming Indigenous Disadvantage indicators) to ensure that indicators are aligned with collected or collectible data.

### 4.3 Reporting

It was anticipated at the outset of the CAP that each state and territory government would report on the three CAP performance indicators to the IGCD. However, it is evident that no clear or effective mechanism was established to ensure that this happened, nor with any kind of regularity.

Consultations with a number of state/territory stakeholders have raised several problematic issues regarding reporting, including:

- The difficulty of locating or accessing the necessary data – often the data required are simply not collected.
- CAP reporting is not mandated. Failure to report has little consequence (in contrast to a funded initiative which risks losing its funding). Agencies are likely to prioritise reporting on mandated initiatives.
- The performance indicators do not clearly indicate what types of data are required.

It is clear that if states and territories are to take CAP reporting seriously, an effective reporting mechanism needs to be established with articulated timeframes, revised performance indicators and consequences for non-compliance.

### 4.4 Effectiveness of the CAP

A number of examples have also been given in this report of ways in which the CAP has been used by policy makers, program funders and service providers to guide decisions or structure programs. Where this has occurred, the CAP may be viewed as having been an effective tool.

To the extent that the CAP has raised the profile of Indigenous drug and alcohol issues on the health agenda, the CAP may also be viewed as having succeeded. By its very existence, the CAP has become a reference point to ensure that Indigenous drug and alcohol issues are not 'lost' in the mainstream or amongst other Indigenous health issues.

The extent to which the CAP has driven or influenced the development of local policy or programs is difficult to determine. In many instances, stakeholders reported that their activities appear to be in line with the CAP because their projects are based on good practice principles. On closer scrutiny of the CAP, many confirmed that their initiatives align with the priorities and/or the approaches set out in the CAP, even though they were developed with little or no knowledge of the CAP. In other words, people are often able to see their own work falling within the CAP's KRAs, rather than the CAP being used to shape new policy and programs.

Where the CAP has been less effective, it has largely been because people have not known about it. While it was envisaged that the CAP would be adopted and adapted by each state/territory, this process was not driven in all states/territories equally. The jurisdictions that have actively embraced and progressed the CAP priorities tended to have had a 'driver' – some person or people with an investment in the CAP and a willingness to drive the process in their state/territory. Conversely, the jurisdictions where the CAP has made little impact tend to be characterised by a lack of a driver or champion, and a lack of ownership by key agencies.

It is important to acknowledge, however, that the CAP has suffered from a lack of promotion, but is winning new 'fans' all the time. As one stakeholder commented,

*The problem is with promotion rather than the document itself, which is good. People just haven't heard about it, but when I put them on to it, they're always really grateful that they've found it.*

This highlights the importance of recognising that multiple factors determine the successful implementation and effectiveness of a policy or program. It is not enough for a strategy to be a good document – it also needs to be promoted, driven, and monitored.

## 4.5 Efficiency of the CAP

Evaluation of the efficiency of the CAP requires an assessment of outcomes relative to outlays. The CAP as an initiative has involved the development of the action plan documents, relatively small pools of funding for projects, and evaluation. Considering the initiative has occurred on a 'shoestring' budget, its achievements may be considered to be remarkable.

However, that is not to say that the approach taken in implementing the CAP was the most satisfactory. Achievement of CAP outcomes has undoubtedly been hampered by a lack of promotion (there has been a significant element of 'word of mouth'), of monitoring, and of reporting. A particularly inefficient aspect has been the monitoring of CAP outcomes. As discussed earlier in this section, it appears that the problems began with the performance indicators, which have been noted to be not very useful, and were exacerbated by an unclear reporting process.

## 4.6 Summary

In short, monitoring the performance of the CAP has been impossible for the following reasons:

- The performance indicators themselves are not measurable without benchmark data
- The data required are not available
- There are few funding initiatives which require reporting against the CAP, and within those the reporting standards are variable
- There is little direct funding available which relates to the CAP
- The CAP has not been widely promoted and therefore has not been used to its full potential

Monitoring of the CAP could be distinctly improved by developing revised and appropriate indicators, requiring greater standards of reporting against the CAP, and aligning the CAP more closely to funding streams. These ideas are discussed further in chapter 5.

## 5 Conclusions and recommendations

This evaluation has reviewed documentary evidence and reported consultations with stakeholders who are familiar with the CAP or who work within Aboriginal and Torres Strait Islander drug and alcohol services. In general, the research team has found that the CAP itself is well regarded as a policy document by those who are familiar with it, and that it is used regularly by a relatively small number of people working in a policy context. A wider group of people were only vaguely familiar or unfamiliar with the CAP; amongst this group, people generally considered that the existence of such a document as the CAP was valuable in itself as a public statement of nationally agreed good practice. In addition, the presence of a national framework was felt by many to provide a benchmark for improving services or developing new initiatives, and that the CAP provided validation for efforts to develop new services which address the needs of Aboriginal and Torres Strait Islander people for culturally appropriate drug and alcohol services.

Informants attributed great weight to the CAP's consultative beginnings and the fact that it was developed at a time when such a national framework, specifically for Aboriginal and Torres Strait Islander communities to use in addressing drug and alcohol issues, did not exist. Since that time, many other national initiatives have been developed which include a focus on Aboriginal and Torres Strait Islander well-being, including some of the policy directions discussed in this report. It seems, however, that maintaining a specific Aboriginal and Torres Strait Islander focus within the NDS is important, and this was reiterated by a majority of informants.

It was felt that the CAP had not been utilised to its full potential, largely because of a lack of promotion of the document, and the fact that it was not tied to any funding pool which might require greater attention to the CAP as a criterion for funding. It was also noted that the other NDS strategies are not cross-referenced to the CAP, and it was felt that tying the CAP more closely to other strategies within the NDS would assist with highlighting the need to provide culturally appropriate services within mainstream drug and alcohol services as well.

**Recommendation 1: That the CAP be retained within the NDS as a separate entity but that its links to the other strategies be increased.**

### 5.1 Reviewing the CAP

Findings from this evaluation indicate that the CAP has had a clear but limited impact on policy and program development. This is due to a number of reasons, including a lack of promotion of the CAP, and a lack of understanding about how the CAP might be used at a service provider level.

As discussed in chapter 4, whilst the KRAs are holistic in approach, emphasising collaboration, capacity building and workforce development, they need to be reviewed through a process of consultation with Aboriginal and Torres Strait Islander people to ensure that the key result areas from 2009 onward are contemporary with current needs. Some specific comments which were received from informants include the following.

- **The practicality of the KRAs**

*The KRAs are currently too broad in nature. Whilst a degree of generalisation is needed to provide broad and strategic direction, the current action plans do not provide clear courses of action as much as they provide general guidelines for approaching drug and alcohol problems. Currently it is very difficult to determine how effective the CAP has been in guiding program activity. Whilst initiatives were found to be in alignment with the CAP KRAs (as well as best practice approaches in general), it is not always the case that initiatives have been developed specifically with the CAP in mind.*

- The KRAs also need to be measurable, and tied to meaningful performance indicators which can demonstrate individual and community benefits.
- The KRAs are largely focussed on organisation of services – workforce, collaboration, etc. – and some informants suggested that it would be more useful to develop KRAs which identified

key areas where results are desired, such as youth involvement with licit and illicit drugs, mental health and comorbidities, and the influence of drug use on domestic violence and other crime.

- **Consistency with other key developments in Indigenous drug and alcohol sector**
  - The KRAs need to be updated in line with recent developments in Indigenous drug and alcohol policy frameworks and strategies. Specifically, the KRAs need to be reviewed in light of the Northern Territory Intervention and the National Indigenous Health Summit and income management strategies to provide ideas which take into account the changes in Australia since 2003. Whilst the CAP is consistent with current thinking and directions in Indigenous health, it is not linked in any way with other policy frameworks and initiatives, potentially hindering opportunities for future dissemination and uptake. The CAP, with its focus on drug and alcohol issues, has great potential to contribute within the broader national policy context, by being linked more tangibly with other policy initiatives while maintaining its focus on a topic of great social, health and economic concern.
- **Revision of the Action Plan**
  - The CAP is seen by a large number of stakeholders not as an *action plan* but rather as a *framework*, as it does not provide clear direction for program and policy development. In order to function more effectively as an action plan, greater emphasis needs to be placed on identifying specific points of action or activity (through the KRAs) and providing measurable indicators against which to monitor progress. Tying the CAP to current funding available might also improve monitoring through requiring reporting against the KRAs.

**Recommendation 2: That the CAP KRAs be reviewed, through a process of culturally appropriate consultation, and revised to include specific high priority result areas, with accompanying measurable performance indicators.**

## 5.2 Implementing the CAP

One reason that the CAP has not been widely used is the lack of promotion since its initial development. As is evident in annual IGCD reporting, uptake of the CAP has been slow. Changes of staff and the general activity in offices means that original copies of the CAP may be missing, and those who were first informed of the CAP are no longer in that place of employment. Continuous dissemination and promotion is needed to keep the CAP fresh in the minds of current and potential stakeholders.

- **Promotion of the CAP**
  - It would be useful to identify ‘champions’ in each jurisdiction with enthusiasm for the CAP, to ensure local engagement with the document.
  - Providing a more ‘user-friendly’ guide to implementing the CAP, perhaps through the use of examples or best practice case studies which detail how the CAP was used in the development of programs and how key reporting criteria were tailored specifically to the CAP KRAs. Currently the boxed package of the CAP is quite a weighty policy tool, and has not been demonstrated to have been used much at the service provider level where time is short and people are looking for active ideas rather than theoretical or policy statements. Providing a more concise document, preferably online, might make the CAP more accessible to a wider range of stakeholders.
- **Uptake of the CAP**
  - At the same time, the current policy-based format was found useful by policy makers and those writing grant applications, who wished to retain the background paper in any future iteration of the CAP.

- The statements of principles, and the current set of KRAs, were both felt to be foundational elements of good practice. Retaining these, and perhaps publicising these in alternative formats, or sharing them with other policy initiatives, might increase the uptake of the CAP framework. For instance, Closing the Gap initiatives might benefit from having access to these statements and using them in developing services which address both policy areas – drug and alcohol, and closing the gap.

**Recommendation 3: That the CAP is developed in a more concise format, and perhaps in more than one format, which can be easily accessed and is user-friendly. The statements of principles and current KRAs (which are considered to be good practice principles) could be shared across policy areas to tie the CAP more closely to other initiatives.**

### 5.3 Monitoring the CAP

Whilst there is evidence of the dissemination of the CAP and use of the document as a reference and supporting document as well as a foundation for many Indigenous drug and alcohol programs, there is currently very little evidence of effectiveness in the outcomes of these programs. This is due in particular to lack of reporting against the CAP KRAs.

As discussed in chapter 3, there are over 50 programs that have received or are due to receive funding in alignment with the CAP. However, whilst funding is allocated according to a program's ability to report against the CAP KRAs, evidence available to the research team has shown that this is not necessarily occurring. Whilst programs could very well be adhering to the CAP KRAs, there is currently no consistency in reporting for programs to provide details which might provide evidence for the impact of the CAP.

At the same time, drug and alcohol services often receive funding from several sources and increasing reporting requirements will not be desirable or feasible for many services. Consideration might be given to streamlining reporting requirements across the NDS, or across funding streams (such as OATSIH funding which is tied to its own sets of indicators, and the ICI or CBIC). The following additional factors also need to be addressed:

- Ensure the consistent use of a reporting template or reporting guidelines in order to benchmark achievements against the KRAs and the CAP more broadly. Without these it has not been possible to determine the impact of the CAP.
- Establish and clearly articulate a regular reporting process, including who to report to, how often, in what format and the consequences for non-compliance. Currently, failure to report has little consequence, and agencies are far more likely to report on mandated initiatives. Consideration however needs to be given to the current reporting requirements that agencies face, and that additional reporting against the CAP could be onerous. It seems more appropriate to add CAP indicators to existing service reporting requirements than to require an entirely separate reporting process. For that reason, ensuring the CAP indicators are clear and measurable, and tying them closely to funding, appears to be the best way of ensuring that the CAP is used.
- The performance indicators do not clearly indicate what types of data are required. There needs to be development of performance indicators within a 'hierarchy of outcomes' model which is tied closely to the revised KRAs, that take into consideration the data sets that are readily available or obtainable. For instance, linkages could be made with the latest Indigenous drug and alcohol use data from the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS), and other key Indigenous health performance frameworks such as FaHCSIA's Overcoming Indigenous Disadvantage indicators. Developing performance indicators which can be monitored at a national and state/territory level rather than at the service level might ensure that monitoring of the levels of misuse of licit and illicit drugs within Aboriginal and Torres Strait Islander communities takes place, although it would not be able to demonstrate that these improvements took place because of the CAP.

**Recommendation 4: That processes of monitoring are improved to ensure that reporting against the CAP occurs for funding under the ICI and the CBIC.**

**Recommendation 5: That a hierarchy of outcomes model be used in developing the performance indicators, and that clear processes of responsibility for monitoring and data collection are identified.**

# Appendix A    List of organisations consulted.

Table 3 – List of organisations consulted throughout the life of the research project

Organisation	Affiliation	Stage of consultation
DoHA	IGCD, CAP Evaluation Reference Group, NIDAC	Stakeholder telephone interview, workshops
Attorney General's Department	IGCD, CAP Evaluation Reference Group, NIDAC	Stakeholder telephone interview, workshops
NSW Department of Health	IGCD	Stakeholder telephone interview. NSW workshop
NSW Police Service	IGCD	NSW workshop
VIC Police Service	IGCD	Stakeholder telephone interview
WA Police Service	IGCD	Stakeholder telephone interview, WA workshop
SA Police Service	IGCD	Stakeholder telephone interview
TAS Department of Health and Human Services	IGCD	Stakeholder telephone interview, VIC workshop
NT Department of Health and Community Services	IGCD	Stakeholder telephone interview
Australian Federal Police	IGCD	IGCD survey
Australian Customs Service	IGCD	IGCD survey
VIC Department of Human Services	IGCD	IGCD survey, VIC workshop
VIC Police Service	IGCD	IGCD survey
Drug and Alcohol Office, WA Department of Health	IGCD	IGCD survey, WA workshop
QLD Police Service	IGCD	IGCD survey
QLD Department of Health	IGCD, NIDAC	IGCD survey, Stakeholder telephone interview
Drug and Alcohol Services of South Australia (DASSA)	IGCD	IGCD survey, SA workshop
NT Police Service	IGCD	IGCD survey, Darwin workshop
TAS Police Service	IGCD	IGCD survey
FaHCSIA	CAP Evaluation Reference Group	ACT workshop
ANCD	NIDAC	Stakeholder telephone interview
QADREC	NIDAC	Stakeholder telephone interview

SA Aboriginal Drug and Alcohol Centre (ADAC)	NIDAC	Stakeholder telephone interview
Australian National Council on Drugs (ANCD)	NIDAC	Stakeholder telephone interview
NIDAC	NIDAC	Stakeholder telephone interview, ACT workshop
Australian Indigenous Doctors Association (AIDA)	NIDAC	Stakeholder telephone interview
ACT Department of Health		ACT workshop
ACT Police Service		ACT workshop
WA Department of Health		WA workshop
WA Department for Communities		WA workshop
WA Department of Education and Training		WA workshop
Department of Corrective Services		WA workshop
WA Department of Premier and Cabinet		WA workshop
Curtain University of Technology		WA workshop
SA Department of Premier and Cabinet		SA workshop
Country Health SA		SA workshop
QLD Police Service		Thursday Island workshop
James Cook University		Thursday Island workshop
Torres Strait Regional Authority		Thursday Island workshop
Danila Dilba	Indigenous drug and alcohol service	Stakeholder telephone interview
Benelong's Haven Ltd	Indigenous drug and alcohol service	Stakeholder telephone interview
Weigelli Centre Aboriginal Corporation	Indigenous drug and alcohol service	Stakeholder telephone interview
Ray Thorne Substance Misuse Rehabilitation Centre	Indigenous drug and alcohol service	Stakeholder telephone interview
Marrin Weejali Aboriginal Corporation	Indigenous drug and alcohol service	Stakeholder telephone interview

Ngaimpe Aboriginal Corporation (The Glen Centre)	Indigenous drug and alcohol service	Stakeholder telephone interview
Namatjira Haven	Indigenous drug and alcohol service	Stakeholder telephone interview
Aboriginal Medical Service Co-operative Ltd	Indigenous drug and alcohol service	Stakeholder telephone interview
Illawarra Aboriginal Medical Service Aboriginal Corporation	Indigenous drug and alcohol service	Stakeholder telephone interview
Katungul Aboriginal Corporation Community and Medical Services	Indigenous drug and alcohol service	Stakeholder telephone interview
Oolong Aboriginal Corporation Inc	Indigenous drug and alcohol service	Stakeholder telephone interview
Aboriginal Health and Medical Research Council	Indigenous drug and alcohol service	Stakeholder telephone interview
Aboriginal Health, North Sydney and Central Coast Area Health Services	Indigenous drug and alcohol service	Stakeholder telephone interview
Midwest Community Drug Service Team	Indigenous drug and alcohol service	Stakeholder telephone interview
Goldfields Midwest Community Drug Service Team	Indigenous drug and alcohol service	Stakeholder telephone interview
Great Southern Midwest Community Drug Service Team	Indigenous drug and alcohol service	Stakeholder telephone interview
Kimberley Midwest Community Drug Service Team	Indigenous drug and alcohol service	Stakeholder telephone interview
Pilbara Midwest Community Drug Service Team	Indigenous drug and alcohol service	Stakeholder telephone interview
Tangentyere Council, Central Australian Youth Link Up Service (CAYLUS)	Indigenous drug and alcohol service	Alice Springs workshop
Mt Theo Program	Indigenous drug and alcohol service	Alice Springs workshop
Drug and Alcohol Services (DASA)	Indigenous drug and alcohol service	Alice Springs workshop
Central Australian Aboriginal Alcohol Programme Unit (CAAAPU)	Indigenous drug and alcohol service	Alice Springs workshop
NPY Women's Council	Indigenous drug and alcohol service	Alice Springs workshop
Barkly Region Alcohol and Drug Abuse Advisory Group (BRADAAG)	Indigenous drug and alcohol service	Alice Springs workshop

Council for Aboriginal Alcohol Program Services (CAAPS)	Indigenous drug and alcohol service	Darwin workshop
Geraldton Regional Aboriginal Medical Service	Indigenous drug and alcohol service	WA workshop
Ngwala Willumbong Cooperative	Indigenous drug and alcohol service	VIC workshop
Nunkawarrin Yunti	Indigenous drug and alcohol service	SA workshop
Directions ACT	Drug and alcohol service	ACT workshop
AER Foundation	Drug and alcohol service	ACT workshop
Cyrenian House	Drug and alcohol service	WA workshop
Western Australian Substance Users Association (WASUA)	Drug and alcohol service	WA workshop
Western Australian Network of Alcohol and other Drug Agencies (WANADA)	Drug and alcohol peak body	WA workshop
Rosella House	Drug and alcohol service	WA workshop
Salvation Army	Social service network	SA workshop
Hepatitis C Council of South Australia		SA workshop
East Arnhem Shire Council		Darwin workshop

# Appendix B    Interview guide for stakeholder consultations.

# Aboriginal and Torres Strait Islander Complementary Action Plan

## Introduction

Introduce yourself and Urbis.

Check that this is a convenient time to talk.

Assure the person that what is said is confidential, and that they will not be named (although their organisation will be identified as participating).

Ask if they have any questions before you start.

## Consultation questions

1. Are you aware of the National Drug Strategy Aboriginal and Torres Strait Islander Complementary Action Plan?
2. Does your organisation use the CAP in order to plan its programs or policies?
3. If yes, in what way does your organisation use the CAP?  
If no, why not?
4. Do you think it's a good idea to have a national framework? What do you think it should cover?  
***(If they don't know about the CAP and don't use it, then thank the person for their time and end the interview.)***
5. The CAP package includes a summary document, a background paper, two action plans (one for Aboriginal peoples and one for Torres Strait Islander people) and a glossary of terms. Which parts of the CAP have been most helpful to you? Which have been least helpful?
6. Can you identify programs in your organisation which have been developed using the CAP? If so, do these programs link back specifically to the key result areas in the CAP?
7. How does your organisation assess the success of programs to minimise harms of alcohol and drug use for Aboriginal and Torres Strait Islander peoples?
8. In what ways has the CAP been helpful in developing your programs? How are the programs operating now?
9. Do you find the CAP key result areas helpful? What is good about them? What could be improved? (The key result areas are listed on page 3)
10. Do you find the CAP performance indicators helpful? What is good about them? What could be improved?

11. In what ways does the CAP assist other (ie State) frameworks for the health and well being of Aboriginal and Torres Strait Islander peoples?
12. In your view, how does the CAP link to the other strategies under the National Drug Strategy? (these are: the National School Drug Education Strategy, the National Tobacco Strategy, the National Action Plan on Illicit Drugs, and the National Alcohol Strategy)
13. In what ways could the CAP be improved?
14. Is there anything else you would like to add?

## Conclusion

Ask if they have any questions or want to add anything else.

Reassure them regarding the process: that we will be collecting information from a lot of people and will put it all together in a report which will go back to the Department of Health and Ageing. All their information will be confidential and they will not be identified.

Thank them for their time.

## Key result areas

### Key result area 1: Enhanced capacity

Enhanced capacity of Aboriginal and Torres Strait Islander individuals, families and communities to address current and future issues in the use of alcohol, tobacco and other drugs and promote their own health and wellbeing.

### Key result area 2: Whole-of-government effort and commitment

Whole-of-government effort and commitment, in collaboration with community-controlled services and other non-government organisations to implement, evaluate and continuously improve comprehensive approaches to reduce alcohol, tobacco and other drug related harm.

### Key result area 3: Substantially improved access

Substantially improved access for Aboriginal and Torres Strait Islander peoples to the range of services, programs and interventions that play a role in addressing alcohol, tobacco and other drug issues.

### Key result area 4: Holistic approaches

A range of holistic approaches, from prevention through to treatment and continuing care, that is locally available and accessible.

### Key result area 5: Workforce initiatives

Workforce initiatives to enhance the capacity of Aboriginal and Torres Strait Islander community-controlled and mainstream organisations to provide quality services.

### Key result area 6: Sustainable partnerships

Sustainable partnerships among Aboriginal and Torres Strait Islander communities, government and non-government agencies in developing and managing research, monitoring, evaluation and dissemination of information.

# Appendix C IGCD survey.

# Survey of members of the Intergovernmental Committee on Drugs (IGCD)

## Introductory notes

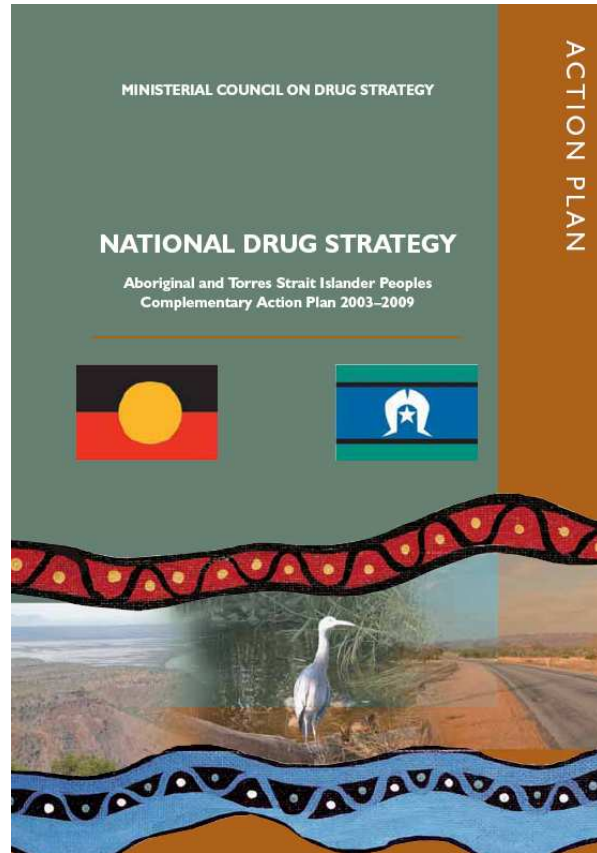
**This survey is part of** the national evaluation of the National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan (the CAP).

**The Complementary Action Plan** is a boxed set of five documents which produced by the Department of Health and Ageing in 2003. The CAP can be viewed online at <http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/indigenous-drug-strategy-lp>

**This survey is for members of the Intergovernmental Committee on Drugs**, which supports the National Drug Strategy and provides State/Territory and expert input into activities carried out under the National Drug Strategy.

**The survey results will be used internally** to analyse the extent to which current drug and alcohol programs are aligned with the key result areas of the CAP. The survey results will also assist in providing an assessment of the range and type of activities carried out under the CAP in each State/Territory.

**All responses are confidential** and will only be seen by independent research consultants (Urbis) and reported as aggregated findings.



## How to respond to this survey

This questionnaire is designed to be completed in Microsoft Word and emailed back. (It will be easier in 'normal' view rather than 'print layout'). This will hopefully make it easy for you to complete, and to consult with your team (if necessary).

**1. Save this document** to your desktop (or somewhere else easy to find) before you start, and keep saving the document as you complete it.

**2. Complete the survey:** tick the boxes by clicking in them, and type your comments in the boxes provided.

**3. Once you're finished**, please email it to [lkurti@urbis.com.au](mailto:lkurti@urbis.com.au); by **Wednesday 3 December**.

**If you'd rather fill it in as a hard copy**, you can post it to Urbis, Level 21, 321 Kent St Sydney 2000.

**Any questions about this survey** or the evaluation can be directed to Dr Linda Kurti at Urbis (02 8233 9900 or [lkurti@urbis.com.au](mailto:lkurti@urbis.com.au)).

## Part A – Awareness and use of the Complementary Action Plan

**A1 How familiar are you (personally) with the Complementary Action Plan? (Select one).**

- 1  Very familiar
- 2  Fairly familiar
- 3  Not very familiar
- 4  Not at all familiar

**A2 To the best of your knowledge, how has your agency used the Complementary Action Plan? (Select all that apply).**

- 1  To help with policy formation
- 2  To inform decisions about funding allocation
- 3  As a basis for research
- 4  In other ways (please briefly outline below)
- 5  None of the above – we have not used the Plan
- 6  Not sure, can't say

Other ways your agency has used the Plan:

*If your agency **has used** the plan → go to Part B*

*If your agency **has not used** the plan → answer A3*

**A3 (If your agency has not used the plan)  
 Please outline any reasons why your agency has not used the Complementary Action Plan. Remember that your answers are confidential.**

*If your agency **has not used** the plan → now go to Part C*

## Part B – Usage of the Complementary Action Plan

**B1 How would you rate the extent to which your agency has used the Complementary Action Plan? (Select one)**

Occasional/ minor references only		Highly integrated into agency programs			Not sure, can't say
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

**B2a How useful has your agency found the Complementary Action Plan to be OVERALL? (Select one)**

- 1  Very useful
- 2  Fairly useful
- 3  Not very useful
- 4  Not at all useful
- 5  Not sure

**B2b Why do you say that? Remember that your answers are confidential.**

**B3 How useful has your agency found each of the sections of the Complementary Action Plan?**

*(Select one response for each section.  
 If your agency has not used a section of the Plan, select Not Applicable)*

	Very useful	Fairly useful	Not very useful	Not at all useful	Not sure how useful we found it	Not applicable: section not used
a) Background Paper	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
b) Summary	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
c) Glossary	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
d) Aboriginal Action Plan	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
e) Torres Strait Islander Action Plan	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

**B4 If applicable, please describe ways in which your programs or policies have been influenced by the Complementary Action Plan.**

**Part C – Alternatives and improvements**

**C1a Are you aware of any OTHER Aboriginal and/or Torres Strait Islander drug and alcohol policy frameworks that have influenced your programs?**

- 1  Aware of other influential policy frameworks → Go to C1b
- 2  Not aware of any other influential policy frameworks → Go to C2

**C1b (If aware of other influential policy frameworks)  
 Please list up to three frameworks and briefly describe why and how they were influential.**

Framework	Comments about why and how this framework was influential
1.	
2.	
3.	

**C2 How important is it to have a national policy framework for Aboriginal and Torres Strait Islanders such as the Complementary Action Plan? (Select one)**

- 1  Very important
- 2  Fairly important
- 3  Not very important
- 4  Not at all important
- 5  Not sure

**C3 How (if at all) would you like to see the Complementary Action Plan improved as a source of information / guidance for your agency? (Select all that apply)**

- 1  Increase the amount of information in the CAP
- 2  Decrease the amount of information in the CAP
- 3  Change the physical lay out of the CAP
- 4  Make the key result areas more specific
- 5  Make the performance indicators more specific
- 6  Increase requirements for jurisdictional strategies to be tied to the CAP
- 7  In other ways (please briefly outline below)
- 8  None of the above – there is no real room for improvement
- 9  Not sure, can't say

Other ways you would like to see the CAP improved:

**C4 Please use the space below to add any other comments you would like to make about the CAP**

## Part D – Complementary Action Plan alignment

We are interested in learning about the specific ways the Complementary Action Plan is linked to the types of programs your agency has developed.


**Below is a table listing the 6 Key Result Areas of the CAP. Please list any of your programs that relate to each specific Key Result Area.**

Key Result Area	Your agency's programs which link to this Key Result Area
<b>Key Result Area 1</b> Enhanced capacity of individuals, families and communities to address current and future issues in the use of alcohol, tobacco and other drugs, and promote their own health and wellbeing.	
<b>Key Result Area 2</b> Whole-of-government effort in collaboration with non-government organisations to implement, evaluate and improve comprehensive approaches to reduce drug-related harm.	
<b>Key Result Area 3</b> Substantially improved access to the appropriate range of health and wellbeing services that play a role in addressing alcohol, tobacco and other drugs issues	
<b>Key Result Area 4</b> A range of holistic approaches from prevention through to treatment and continuing care that is locally available and accessible	
<b>Key Result Area 5</b> Workforce initiatives to enhance capacity of community-controlled and mainstream organisations to provide quality services	
<b>Key Result Area 6</b> Increased ownership and sustainable partnerships of research, monitoring, evaluation and dissemination of information	


THIS IS THE END OF THE SURVEY.  
Please follow the instructions on page 1 to return the survey to [lkurti@urbis.com.au](mailto:lkurti@urbis.com.au).

## Appendix D Matrix of programs in alignment with the CAP or receiving funding under ICI or CBIC.


State	Program	Program details	Reports reflect KRA 1	Reports reflect KRA 2	Reports reflect KRA 3	Reports reflect KRA 4	Reports reflect KRA 5	Reports reflect KRA 6	Funded under CAP? (ICI or CBIC)
National	Alcohol Treatment Guidelines for Indigenous Australians reprinting and dissemination	Update and reprint sections in the Alcohol Treatment Guidelines for Indigenous Australians to be in line with the new Alcohol Treatment Guidelines due to be release in early 2009.	NA	NA	NA	NA	NA	NA	ICI
	Indigenous National Alcohol and other Drug Workforce Development Program – Stage 3	IGCD agreed to a cost share funding the continuation of the Indigenous National Alcohol and Other Drug (AOD) Workforce Development Program in Queensland, Northern Territory, South Australia, New South Wales and the ACT.	NA	NA	NA	NA	NA	NA	ICI
	Evaluations – various	A number of projects under the Initiative will require an independent evaluation over the next three years. The Department has agreed to fund these evaluations separately to the funds required for each project in the official orders.	NA	NA	NA	NA	NA	NA	ICI
	Printing – Various	There are currently a number of Indigenous specific educational resources that will require updating and reprinting.	NA	NA	NA	NA	NA	NA	ICI
	Indigenous Psychostimulants Comic (Proposed)	Development of an Indigenous health promotion comic to address binge behaviour of young Aboriginal people who are drawing large incomes on the mines and experimenting with psychostimulants, when returning to main towns.	NA	NA	NA	NA	NA	NA	CBIC
	Aboriginal Men's Health Promotion Comic (Proposed)	Development of comic that promotes Indigenous men's health through positive role modelling, exhibiting Aboriginal men enjoying their culture and family life without violence or alcohol.	NA	NA	NA	NA	NA	NA	CBIC
	Indigenous Foetal Alcohol Spectrum Disorder Comic (Proposed)	Development of an Indigenous health promotion comic that addresses Fetal Alcohol Spectrum Disorder.	NA	NA	NA	NA	NA	NA	CBIC
	Project Evaluations (Proposed)	The Department of Health and Ageing (DoHA) has entered into a number of Funding Agreements which are due to end on 30 June 2009. The Schedule to each Funding Agreement states that an independent evaluation will be conducted and funded in 2009 by the DoHA.	NA	NA	NA	NA	NA	NA	CBIC
	Enhancing the Management of	The project will identify gaps in the evidence base for the	NA	NA	NA	NA	NA	NA	CBIC

NA Reporting not available/accessible at the time  Data on funding not available/accessible.

State	Program	Program details	Reports reflect KRA 1	Reports reflect KRA 2	Reports reflect KRA 3	Reports reflect KRA 4	Reports reflect KRA 5	Reports reflect KRA 6	Funded under CAP? (ICI or CBIC)
	Alcohol-related Problems Among Indigenous Australians Project Stage 2 - National Drug Research Institute	effective management of alcohol-related problems among Indigenous Australians and commission and fund five research projects to fill some of those gaps. This is to identify ways of making them more effective and acceptable to Indigenous people.							
NSW	Supporting Young People and Families, Bathurst SRA program - NSW Department of Housing as auspice for the SRA	The Shared Responsibility Agreement will use the funds to employ a full-time Family Wellbeing Coordinator (FWC) to provide a range of education, prevention and diversion activities on at 'risk nights' at the Kelso Community Centre to improve health and wellbeing of the Bathurst community, particularly youth located in the Kelso area.	NA	NA	NA	NA	NA	NA	CBIC
	Coonamble Family Wellbeing project – Dubbo Plains Division of GP	The project will employ a family wellbeing facilitator, case manager with Drug and Alcohol experience and a coordinator in Dubbo and the surrounding area to develop a range of family centered strategies to address an interconnected set of issues including drug and alcohol misuse and family violence issues that negatively impact upon families, individuals and communities in the region. Such strategies include developing models of care and coordinating community responses to ensure that problems are addressed in an appropriately multifaceted, community-wide and consistent manner, and improving the overall service capacity in the area.	NA	NA	NA	NA	NA	NA	CBIC
	Making Tracks to Cultural Strengths – The Oolong Aboriginal Corp.; and Making Tracks feasibility study	The project focuses on holistic healing of Aboriginal people who experience problems relating to the misuse of alcohol and other drugs. Sessions will be run on cultural training by a cultural skills service provider. The cultural program will be run in conjunction with the existing Oolong Aboriginal corporation therapeutic program. Clients enrolled in the therapeutic program will have the option of participating in the cultural program, in recognition that culture forms a large part of the recovery process for the client.	NA	NA	NA	NA	NA	NA	CBIC
	Clarence Valley Aboriginal Community Capacity Building project – Bulgarr Ngaru Aboriginal Medical Service	The Project will increase positive health outcomes for local Aboriginal youth and their families by helping them to address AOD related issues. The Project also aims to reduce the target group's involvement in the criminal justice system and build the capacity of the individual, family and community by encouraging them to sustain a healthy lifestyle by providing case management support, skill development opportunities, advocacy and referral to	NA	NA	NA	NA	NA	NA	CBIC

NA Reporting not available/accessible at the time  Data on funding not available/accessible.

State	Program	Program details	Reports reflect KRA 1	Reports reflect KRA 2	Reports reflect KRA 3	Reports reflect KRA 4	Reports reflect KRA 5	Reports reflect KRA 6	Funded under CAP? (ICI or CBIC)
		other services where appropriate. Two Indigenous Project Officers will be recruited to case manage 12-25 year Indigenous youths identified as 'at risk' residing in the Clarence Valley area.							
	Safety Anytime – Durri Aboriginal Corp. Medical Service	This project will provide a safe haven within the Aboriginal community for children and young people to go to when they are feeling unsafe in their home environment due to the impacts of drugs or alcohol on a caregiver. Ten Safety Anytime carers (local Aboriginal members) will be recruited and trained, and their homes set up in accordance with Occupational, Health and Safety standards. Durri ACMS will identify and assist families requiring further support to address AOD and other related issues.	NA	NA	NA	NA	NA	NA	CBIC
	Strong Together – Muloobinba Aboriginal Corp.	The project will provide healthy lifestyle choices for Aboriginal people in the Hunter Region aimed at reducing harm caused by alcohol and other drugs and focus on improving social and emotional well being. This will be delivered through a holistic day program facilitated two days per week in six, six week blocks for 15 participants at a time, (90 participants in total) The program will also provide education sessions at schools and community groups and offer one-on-one counseling sessions for existing and new clients.	NA	NA	NA	NA	NA	NA	CBIC
	NSW Aboriginal Women's & Children's Rehabilitation Service feasibility study – South Coast Medical Service Aboriginal Corp.	The project is a feasibility study to inform the development of an effective and culturally appropriate residential service delivery arrangement for Aboriginal women experiencing drug and alcohol issues in NSW. In particular, this project will focus on women whose needs are too serious for help to be provided effectively within the Community setting, given the impact of Aboriginal historical, social and cultural realities.	NA	NA	NA	NA	NA	NA	CBIC
	Clean Air Dreaming Project - Aboriginal Medical Services on the South Coast of NSW	Culturally appropriate promotion prevention, early intervention and treatment programs relating to nicotine use will be delivered to Aboriginal communities on the Illawarra, South and Far South Coast of NSW.	NA	NA	NA	NA	NA	NA	CBIC
	Social Re-engagement Program	Examine the effectiveness of a social re-engagement program aimed at reducing the number of Aboriginal clients from Griffith revolving through drug and alcohol rehabilitation services	NA	NA	NA	NA	NA	NA	ICI
	Evaluation of <i>Sniffing and the Brain</i>	Cultural and Indigenous Research Centre Australia conducted an				✓			ICI

NA Reporting not available/accessible at the time  Data on funding not available/accessible.

State	Program	Program details	Reports reflect KRA 1	Reports reflect KRA 2	Reports reflect KRA 3	Reports reflect KRA 4	Reports reflect KRA 5	Reports reflect KRA 6	Funded under CAP? (ICI or CBIC)
	Flipchart	evaluation of the Sniffing and the Brain educational resource covering the appropriateness, effectiveness, future need and opportunities for development of the flipchart.							
ACT	Youth Diversion Project - Winnunga Nimmitjiah Aboriginal Health Service	A project to divert Indigenous adolescents residing within the ACT and outer regions away from Alcohol and Other Drugs, and crime. The project will engage youth (15 to 19 years of age) in education and training and subsequent employment options to reduce substance misuse and contact with the criminal justice system.				✓	✓		CBIC
	Adolescent Fathers and Drug Use project	The Australian Institute of Aboriginal and Torres Strait Islander Studies has been engaged to complete research to develop a holistic model of health and wellbeing interventions for Aboriginal and Torres Strait Islander adolescent fathers, with a particular focus on drug use.	NA	NA	NA	NA	NA	NA	ICI
VIC	Koori community AOD workers	Based in Aboriginal Community Controlled Health Organisations and some mainstream community health organisations.	✓				✓	✓	◆
	Koori community AOD Resource Services	Managed through Aboriginal Community Controlled Health Organisations.	✓						◆
	Healthy Pregnancies Healthy Babies Resource Kit and Training	Developed, produced and delivered by Victorian Aboriginal Community Controlled Health Organisation.	✓						◆
	Koori Families and Young Fellas Connecting and Sharing (FACES)	Developed by the VIC Department of Human Services.	✓						◆
	Victorian Police Indigenous trained roles	The Aboriginal Community Liaison Office (ACLO) program employs Aboriginal people working in areas of high indigenous population. The ACLOs, Youth Resource Officer (YROs) and Police Aboriginal Liaison Officer (PALOs) foster relationship building and conduct programs for youth and other Indigenous people in an atmosphere free from alcohol and drugs.	✓				✓		◆
	The Development of the Koori Alcohol Action Plan, and Other Drug Healing Services	VIC Department of Health		✓		✓		✓	◆
	Aboriginal Advisory Unit (AAU) case management	Individual case management of chronic alcoholics and the ongoing care is a function currently undertaken in partnership with the Aboriginal Advisory Unit (AAU) (VIC Police). Also involves ACLO, PALO and ACJP programs.		✓		✓		✓	◆

NA Reporting not available/accessible at the time ◆ Data on funding not available/accessible.

State	Program	Program details	Reports reflect KRA 1	Reports reflect KRA 2	Reports reflect KRA 3	Reports reflect KRA 4	Reports reflect KRA 5	Reports reflect KRA 6	Funded under CAP? (ICI or CBIC)
	Koori Drug Diversion workers	Work with clients in the justice system and with the Koori Court process.			✓				◆
	Cross-organisational activities	The Aboriginal Advisory Unit currently work in partnership with case workers and the Victoria Police Custodial Medicine Unit to manage Aboriginal individuals suffering chronic alcoholism			✓				◆
	Indigenous Drug Prevention Research Stock-take and Gap Analysis	Victorian Premier's Drug Prevention Council						✓	◆
	The Australian Secondary Students' Alcohol and Drugs (ASSAD) 2008 extension project – The Anti Cancer Council of Victoria	The project involves the extension of the ASSAD Survey 08 and the production of the national report which incorporates analysis of the ASSAD Extension project with the national level results of secondary students' use of tobacco, alcohol, and over-the-counter and illicit drugs. The extension will increase the number of students participating in the ASSAD survey to include students in year levels 7 to 10 who reside in regional remote areas of Victoria, Queensland, South Australia, Northern Territory and Western Australia. Data for this report will draw on appropriate data from Indigenous students participating in the main ASSAD study and the extension study. The report will detail prevalence of tobacco smoking, alcohol use and use of different illicit substances among Indigenous students participating in these studies. Prevalence estimates for male and female students in age group 12 – 13 years and 14 – 15 years will be able to be determined.	NA	NA	NA	NA	NA	NA	CBIC
SA	Friendz 2 Comic – Aboriginal Health Council of South Australia	The project will follow on from the "Wiltanendi Indigenous Peer Promotion Comic" Friendz Comic project. This project will involve the development and production of another comic by Aboriginal young people in Adelaide to raise awareness about the impacts of negative peer relationships, increase knowledge about relationships and the associated skills pathways to leading a healthy and stable life.	NA	NA	NA	NA	NA	NA	CBIC
	Substance Misuse Community Resilience project - Kura Yerlo Council Inc	The project will deliver community education, led by Aboriginal Elders (Grannies Group) who will provide a framework for working with individuals linking them to the services which can help them deal with the effects of substance misuse, as well as providing them with ongoing support. The project aims to create an awareness of drug issues and support a community approach to resolving issues through education, training and mentoring to ensure individuals and services recognise the important role of the family in building resilience.	✓	✓	✓	✓	✓	✓	CBIC

NA Reporting not available/accessible at the time ◆ Data on funding not available/accessible.

State	Program	Program details	Reports reflect KRA 1	Reports reflect KRA 2	Reports reflect KRA 3	Reports reflect KRA 4	Reports reflect KRA 5	Reports reflect KRA 6	Funded under CAP? (ICI or CBIC)
	Illicit Drug Diversion program	Run by SA Police. Each of the local areas operating this program work with local service providers to tailor options to fit the area. Evaluated by SA Office of Crime and Statistics.	✓						◆
	APY Lands Substance Misuse Treatment Facilities	FaHCSIA and South Australian Government.		✓					◆
	Aboriginal Substance Abuse Day Centres in rural and remote areas of SA	Drug and Alcohol Services South Australia (DASSA).		✓					◆
	Aboriginal Substance Misuse Connection Program	Drug and Alcohol Services South Australia (DASSA).			✓				◆
	Remote Aboriginal Tobacco Control Project	Drug and Alcohol Services South Australia (DASSA).			✓				◆
	Smoke-free Pregnancy Project for Aboriginal women	Drug and Alcohol Services South Australia (DASSA).			✓				◆
	Nunkawarrin Yunti's (NWY) Hepatitis C program	Nunkawarrin Yunti (NWY)			✓				◆
	Statewide Aboriginal Men's Camp	Collaboration between AOD organisations, AMS and SA Government.				✓			◆
	Corka Yarnin Radio and Television Program	Drug and Alcohol Services South Australia (DASSA).				✓			◆
	'Smokecheck' tobacco brief intervention training program	Queensland Health.					✓		◆
	Indigenous Alcohol and Other Drug raining program	National Indigenous Alcohol and Other Drug worker Training Program Certificate III Community Services work (Strong Spirit, Strong Mind)					✓		◆
	Memorandum of Understanding	Drug and Alcohol Services South Australia (DASSA) and the Aboriginal Health Council South Australia (AHCSA) have signed a Memorandum of Understanding to work collaboratively across the State to provide drug and alcohol services to Aboriginal people.						✓	◆
	Alcohol Treatment Guidelines for Indigenous Australians	Drug and Alcohol Services South Australia (DASSA).						✓	◆

NA Reporting not available/accessible at the time ◆ Data on funding not available/accessible.

State	Program	Program details	Reports reflect KRA 1	Reports reflect KRA 2	Reports reflect KRA 3	Reports reflect KRA 4	Reports reflect KRA 5	Reports reflect KRA 6	Funded under CAP? (ICI or CBIC)
	Substance Misuse Community Resilience Program	Kura Yerlo Council Incorporated is the auspice organisation for the Grannies Group. The Grannies Group is a network which supports grandmothers, grandfathers and families with substance misuse issues affecting their children, grandchildren and community. Its members include key Elders from across South Australia. The Grannies Group's work has highlighted the damage and family dysfunction caused by substance misuse within Indigenous communities.	NA	NA	NA	NA	NA	NA	ICI
	Indigenous Playing Cards	The Australian Drug and Alcohol Council (SA) developed playing cards with culturally appropriate health promotion messages targeting a range of issues.	NA	NA	NA	NA	NA	NA	ICI
	Rural and Remote Indigenous Alcohol and Other Drug Workers' Stress, Burnout and Wellbeing Project - The National Centre for Education and Training on Addiction (NCETA)	A research project to identify the key signs and consequences of stress, burnout and wellbeing among Rural and Remote Indigenous and non Indigenous AOD workers. The project will examine coping mechanisms used by staff to overcome stress and burnout with their organisation. The project will include the development of an information base and a range of tools (e.g. report, literature review) to inform strategies to improve worker wellbeing and improve stress and burnout.	NA	NA	NA	NA	NA	NA	CBIC
TAS	Tasmanian Police Aboriginal Strategic Plan		✓						◆
	Tasmanian whole-of-government drug and alcohol-related strategies	Includes the development of the Tasmanian Drug Strategy 2005-2009 and the Tasmanian Psychostimulant Action Plan 2007-2009. The Tasmanian Alcohol Action Plan and the Tasmania Police Alcohol Action Plan has also been informed by the CAP.		✓					◆
	Youth / Community Support Worker - South East Tasmanian Aboriginal Corporation	The project aims to enhance the capacity of Aboriginal and Torres Strait Islander People, families and communities to address current and future issues in the use of alcohol and other drugs to promote and take control of their own health and well being. A Youth and Community Support Worker will establish a mentoring system with local Elders, deliver activities and develop formal partnerships with mainstream service providers. Young people at risk will be engaged through cultural activities such as mentoring programs, camps and art and craft activities to educate and improve knowledge of issues relating to drug use. Education and information programs will be provided to Aboriginal families. Aboriginal Elders will provide support to young people at risk by highlighting the importance of culture.	NA	NA	NA	NA	NA	NA	CBIC

NA Reporting not available/accessible at the time ◆ Data on funding not available/accessible.

State	Program	Program details	Reports reflect KRA 1	Reports reflect KRA 2	Reports reflect KRA 3	Reports reflect KRA 4	Reports reflect KRA 5	Reports reflect KRA 6	Funded under CAP? (ICI or CBIC)
	Aboriginal Drug & Alcohol Training	The project will provide Certificate IV Indigenous Drug and Alcohol Training with a local Indigenous Component for Indigenous and non-Indigenous Workers working with Indigenous Drug and Alcohol Clients through TAFE Tasmania.	NA	NA	NA	NA	NA	NA	CBIC
	The Yowarling Out Family Project - Women's Health Care Association (WHCA)	The project aims to increase the capacity of Indigenous Australians to deal with problems related to alcohol and other drug misuse. Two Indigenous Project Officers and one Indigenous Child-Care Worker will receive supervision and training to deliver a program to Indigenous families residing in Perth with a parent misusing alcohol and other drugs. The program will incorporate early intervention and prevention strategies, with a particular focus on supporting pregnant women and parents with children under the age of four.	NA	NA	NA	NA	NA	NA	CBIC
WA	Alcohol and Other Drug Programs and Projects for Indigenous Australian	The NDRI undertook an update of Australian National Council on Drugs research papers 4 and 8 and made a comparison of changes over time to substance use funded activities.	NA	NA	NA	NA	NA	NA	ICI
	Enhancing the management of alcohol-related problems among Indigenous Australians (Stage one)	The National Drug Research Institute (NDRI) identified gaps in the evidence base for the effective management of alcohol-related problems among Indigenous Australians. The intention was not to develop new interventions, but to focus on interventions that are known to be effective in other populations and to identify ways of making them more effective and acceptable to Indigenous Australians.	NA	NA	NA	NA	NA	NA	ICI
	Strong Spirit, Strong Mind	WA alcohol and other drugs plan (Drug and Alcohol Office, WA Department of Health)	✓	✓					◆
	Local alcohol management plans in partnership with local communities; targeted alcohol and other drug prevention initiative in the Fitzroy Valley; and an Annual WA Aboriginal AOD Worker Forum	Drug and Alcohol Office, WA Department of Health	✓						◆
	Local partnerships with non-government organisations for the delivery of services, such as Aboriginal residential beds	Drug and Alcohol Office, WA Department of Health		✓					◆

NA Reporting not available/accessible at the time ◆ Data on funding not available/accessible.

Aboriginal AOD Worker Network	Western Australian Network of Alcohol and other Drug Agencies (WANADA)			✓						◆
Establishment of Aboriginal residential beds at Palmerston Farm and Cyrenian	Drug and Alcohol Office, WA Department of Health					✓	✓			◆
Establishment of Next Step Aboriginal Withdrawal Unit - 4 beds	Drug and Alcohol Office, WA Department of Health					✓	✓			◆
Aboriginal Drug and Alcohol Workers to support the Withdrawal Unit	Drug and Alcohol Office, WA Department of Health					✓				◆
Creation of Aboriginal Diversion worker positions across the State	Drug and Alcohol Office, WA Department of Health					✓				◆
Expansion of services in remote areas with Aboriginal staff in the community drug service teams across the state to allow for greater service delivery to outlying communities	Drug and Alcohol Office, WA Department of Health					✓				◆
Funding for additional Aboriginal workers within NGOs and community controlled sector	Drug and Alcohol Office, WA Department of Health					✓				◆
Aboriginal Youth Mentor program	Established to engage and deliver culturally secure Alcohol and Drug Services for Aboriginal families and young people. Drug and Alcohol Office, WA Department of Health.					✓				◆
Development of a range of evidence based resources to support AOD workers to provide culturally secure drug and alcohol information, screening, brief intervention, counselling and referral services to Aboriginal people	Drug and Alcohol Office, WA Department of Health.						✓			◆
Community Drug Service Teams	Operate in remote areas with Aboriginal staff. Drug and Alcohol Office, WA Department of Health.						✓			◆
Brief intervention in WA public hospitals	Plans have been introduced to roll out brief intervention practices in all WA public hospitals. The training and roll out is supported by DAO. WA Department of Health.						✓			◆

Sobering up centres	A state-wide network of 12 sobering up centres predominantly staffed by Aboriginal people. Drug and Alcohol Office, WA Department of Health.					✓			◆
Alcohol and Drug Information Service (ADIS)	Post treatment support is available through the Alcohol and Drug Information Service (ADIS). Country callers are able to access the service via a toll free number. Drug and Alcohol Office, WA Department of Health.					✓			◆
The Indigenous Diversion Program	Drug and Alcohol Office, WA Department of Health.					✓			◆
Development and delivery of cultural awareness and culturally secure clinical and community development support training for Aboriginal and non-Aboriginal workers	Drug and Alcohol Office, WA Department of Health.						✓		◆
Development of career pathways for Aboriginal Alcohol and other Drug Workers	Drug and Alcohol Office, WA Department of Health.						✓		◆
All service agreements for DAO funded activities include a requirement for services to provide a qualitative report on the development and implementation of Aboriginal health workforce strategies to improve the recruitment, retention and development of Aboriginal alcohol and other drug workers	Drug and Alcohol Office, WA Department of Health.						✓		◆
Indigenous National Alcohol and other Drug Workforce Development Program – Stage 3	Further funding to continue a national coordination role for the Indigenous National Alcohol and Other Drug (AOD) Workforce Development Program in Western Australia to increase the capacity and sustainability of partner jurisdictions to deliver training to the Indigenous AOD workforce.	✓ (As reported in evaluation report)	✓ (As reported in evaluation report)				✓ (As reported in evaluation report)		ICI
Alcohol and other drug component of the Australian Indigenous HealthInfoNet (website)	The Edith Cowen University (ECU) (through a contract with OATSIH) is funded to maintain four web pages (alcohol, inhalants, illicit drugs and other drugs) on behalf of DSB on the Indigenous HealthInfoNet until June 2009. Further funding will be dependent on an evaluation in 2009.	NA	NA	NA	NA	NA	NA	NA	ICI
Pilbara Drug & Alcohol Program (SRA)	As a result of an independent evaluation continue funding three Social Health Teams to deliver drug and alcohol related services to Indigenous people, including outreach services, in the Western		✓	✓	✓	✓	✓	✓	ICI

NA Reporting not available/accessible at the time ◆ Data on funding not available/accessible.

		Australia Pilbara region.								
	Aboriginal Men & Alcohol Comic – Central Australian Aboriginal Congress	The project will develop an 'Indigenous Men & Alcohol' comic that showcases responsible Aboriginal men living without alcohol, empowered by close connections to their families. The aim of the comic is to highlight the negative effects of alcohol on Indigenous individuals, families and culture, and promote healthy, alcohol free lifestyles, family and cultural ties.	NA	NA	NA	NA	NA	NA	NA	CBIC
	Indigenous Outreach Trainee Program - The Drug and Alcohol Services Association Alice Springs Inc (DASA)	Two Indigenous trainees will participate in an Indigenous Outreach Training Program. The program based in the DASA Sobering up Shelter will provide a training pathway for Indigenous people wanting to work in the Alcohol and Other Drugs (AOD) area. The project will provide participants with hands on experience, as well as the opportunity to complete a Certificate III and IV in Community Services AOD.	NA	NA	NA	NA	NA	NA	NA	CBIC
NT	Commencement of the Nguui Community Project	The project is designed to gather information on the amount and types of alcohol sold as well as alcohol related harm from various sources, and assessing the impacts since changes to the community's license conditions came into effect. Information will then be presented in ways that are suitable for the local committee, licensing commission and for people in the local community (ie the local women's centre, schools and sports clubs).						✓		◆
	Clinical Practice Guidelines	Currently being developed to support the <i>Volatile Substance Abuse Prevention Act</i> to ensure competency in risk identification and risk management of people under a treatment order process.					✓			◆
	Alcohol and Other Drugs Program (AODP)	Provides education, prevention and intervention strategies including brief intervention, promotion and education in the new Indigenous Alcohol Treatment Guidelines		✓			✓			◆
	Development of the Aboriginal Cultural Security policy	Commitment that services provided by the Department of Health and Families will respectfully combine the cultural rights and values of Aboriginal people with the best health and community service systems available. Involves: identifying elements of culture that affect health delivery; reviewing service delivery practices; acting to modify service delivery practices where necessary; monitoring service activity to ensure services meet standards.					✓			◆
	Alcohol Management Plans	Development of Alcohol Management Plans in each regional centre with government, non-government and community organisations, by Local Alcohol Committees. Addresses harm reduction, demand reduction and supply reduction.	✓	✓						◆

NA Reporting not available/accessible at the time ◆ Data on funding not available/accessible.

Borroloola Army Aboriginal Community Assistance Program (AACAP)	The Council for Aboriginal Alcohol Program Services (CAAPS) provided the alcohol and other drug mentoring and leadership component of the training program associated with the AACAP, in line with the needs of the people taking part in the program.	NA	NA	NA	NA	NA	NA	NA	ICI
Smoking Cessation Program	The Menzies School of Health Research ran a trial program to assess requirements to implement sustainable and continuing intervention programs to support Indigenous people in NT's 'Top End' to quit smoking tobacco and/or cannabis.	✓	NA	NA	NA	NA	NA	✓	ICI
Gender specific inhalant abuse flipcharts	The Menzies School of Health Research developed gender specific flipcharts similar to <i>Sniffing and the Brain</i> . The male flipchart addresses issues relating to violence and effects on family, community and personal relationships of petrol sniffing. The female flipchart explains the effects of inhalant abuse on unborn children and the dangers women can place themselves in while under the influence of inhalants.	NA	NA	NA	NA	NA	NA	NA	ICI
Review of the Youth Wellbeing Project	The Cultural and Indigenous Research Centre Australia (CIRCA) reviewed the Youth Wellbeing Program in the Top End region of Northern Territory to evaluate the effectiveness, appropriateness and efficiency of the Program.	NA	NA	NA	NA	NA	NA	NA	ICI
Mt Theo/Yuendumu Substance Misuse Program	Mt Theo/Yuendumu Substance Misuse Aboriginal Corporation is funded to continue two positions (Coordinator and Outstation Worker) of the Mt Theo/Yuendumu Substance Misuse program.	NA	NA	NA	NA	NA	NA	NA	ICI
Remote Area Drug Strategy and Substance Abuse Intel Desk (SAID)	Run by Northern Territory Police. Low level strategies also run by police in local communities such as the Groote Eylandt and Nhulunbuy alcohol management plans	✓							◆
Permit System	Permit system in areas where alcohol can be consumed by permits local police have direct input, with the Dept of Justice, Health and local stakeholders.	✓	✓						◆
Indigenous AOD workforce development program Certificate III Development (soon to be a Certificate IV)	Wendy Casey's work on drug treatment training.						✓		◆
Drug and alcohol research	NT Police initiated key pieces of research via the NDLERF fund and have also sponsored another piece of work around transient/long grass movement of Indigenous people. We routinely contribute information to a very wide selection of academic bodies and researchers on Alcohol and drug issues.							✓	◆

NA Reporting not available/accessible at the time ◆ Data on funding not available/accessible.

	Alcohol and other drugs Indigenous communities project	The project assists with the reduction of the health and social harms associated with volatile substance misuse in the Palmerston Indigenous Village and other town camps in Darwin and related communities in the Top End region of the NT	NA	NA	NA	NA	NA	NA	ICI
	Ewenpar Atwatye (Hidden Valley) Community Centre Project	Funding to Tangentyere Council Incorporated will allow the continued funding of two existing positions (Coordinator and Male Outreach/Caseworker); the creation of an additional position (Female Outreach/Caseworker); and support services at the Hidden Valley Community Centre (an Alice Springs town camp).	NA	NA	NA	NA	NA	NA	ICI
	Wugularr, Sunrise Health Service Aboriginal Corporation (SRA)	DoHA funding as part in the SRA would contribute to salary, on costs medical/health services to maintain the 'Youth at Risk' project which addresses inhaling volatile substances in North west NT and setup the project in Ngukurr and Bulman or Minyerri.	NA	NA	NA	NA	NA	NA	ICI
	Alcohol and Other Drugs (AOD) Strategic Intervention Project	Amity Community Services has been engaged to continue and expand the services provided under the Retailers Responsible Sale of Volatile Substances pilot project. Negotiations are currently underway to continue funding an expansion of this project.	NA	NA	NA	NA	NA	NA	ICI
	Yarrenyty Altere (Larapinta Valley) Learning Centre	The Tangentyere Council Incorporated is funded to continue three positions (Coordinator, male Drug & Alcohol Outreach/Case Worker and female Drug & Alcohol Outreach/Case Worker) at the Larapinta Valley Learning Centre in Alice Springs.	NA	NA	NA	NA	NA	NA	ICI
	Event Support Program	Provides support and small grants to Indigenous communities across the state to assist with the implementation of smoke-free sporting and cultural events. Managed by Queensland Health.	✓						◆
	"Weed it Out"	A multi-faceted project involving independent research by JCU to identify the extent of the use of cannabis and the associated harms using local people to assist in research. Supported by DoHA, Australian Federal Police, Customs, Qld Health, Qld Dept of Communities, Local Government Authorities and community groups.	✓					✓	◆
<b>QLD</b>	'SmokeCheck' Tobacco Brief Intervention program	Queensland Health.			✓				◆
	Champions' Program and Negotiations Tables process	Focus on alcohol demand reduction and child safety initiatives, and ensuring that outcomes from negotiation tables are actioned in a timely and effective manner. Queensland Health.				✓			◆
	Enhanced Model of Primary Health Care for remote communities to	Promotes health through a person's life, and prevents and detects the main risk factors which lead to chronic diseases, including alcohol consumption and smoking. Queensland Health.				✓			◆

NA Reporting not available/accessible at the time ◆ Data on funding not available/accessible.

Alcohol and Other Substances Demand Reduction Program (DRP)	\$4.3M has been approved for 56 projects servicing the 19 communities eligible for funding. Queensland Health.				✓				◆
29 new Indigenous Alcohol, Tobacco and Other Drug clinical and prevention positions in non-government organisations and mainstream Queensland Health services established over 2005/06 to 2008/09	Established under the Queensland Chronic Disease Strategy and Indigenous Health funding packages. Queensland Health.					✓			◆
Indigenous Risk Impact Screen (IRIS) & Brief Intervention State-wide Implementation Project	The Centre for Drug and Alcohol Studies, run by Queensland Health and Queensland Alcohol and Drug Research and Education Centre, will implement IRIS and the brief intervention tool state wide through health, justice and police and non-government agencies over two to three years.			✓	✓	✓			ICI
Woorabinda Boundary Riders Program	Following an independent evaluation provide six month funding to Central Queensland Indigenous Development (through OATSIH) to continue the program which reduces alcohol and other substance misuse in young Indigenous people in the Woorabinda community.	NA	NA	NA	NA	NA	NA	NA	ICI
Cape York and Torres Strait Cannabis reduction project	The project will research to implement a multiple-component Indigenous community intervention that aims to reduce cannabis use in Cape York and Torres Strait communities and to evaluate its effectiveness.	NA	NA	NA	NA	NA	NA	NA	ICI
Cape York and Torres Strait Cannabis reduction project (Proposed)	The project will research to implement a multiple-component Indigenous community intervention that aims to reduce cannabis use in Cape York and Torres Strait communities and to evaluate its effectiveness.	NA	NA	NA	NA	NA	NA	NA	CBIC
Volatile Substance Misuse: a review of interventions	The James Cook University updated the publication 'Petrol sniffing in Aboriginal communities: A review of interventions', incorporating information regarding chroming. This publication was renamed 'Volatile Substance Misuse: a review of interventions'.	NA	NA	NA	NA	NA	NA	NA	ICI
Health (IT) Project (HIT) phase 2	The University of Queensland developed and implemented an interactive, narrative multimedia module based on the AUDIT alcohol consumption tool. The module was uploaded into 4 touch screens in the Indigenous Cape York Communities.	NA	NA	NA	NA	NA	NA	NA	ICI

NA Reporting not available/accessible at the time ◆ Data on funding not available/accessible.

Barambah Community Support Project - South Burnett CTC Inc	The project aims to reduce the number of incarcerated adult and adolescent Indigenous Australians in the Murgon Watchhouse by assisting individuals to address the common causes for incarceration, which are a range of alcohol and other drugs-related offences, and for outstanding fines. Community Support Officers will provide support to Indigenous persons coming in contact with police support services; including educational, awareness and recreation programs to divert them from drugs and alcohol and the provision of general awareness programs to Indigenous adults in the community.			✓	✓		✓	CBIC
Which Way – Youth Link	This project is part of a five phase, four year project aiming to reduce adverse mental health effects of cannabis use, reduce criminality relating to cannabis trafficking and build community resilience against uptake of cannabis and other illegal drugs. This funding is provided for one year to maintain a police presence in the community to facilitate training in the harms associated with cannabis and other drugs use, promote healthy lifestyle choices and to recognise the important role of the family and community in building resilience to improve the overall social and emotional wellbeing of community members. Cannabis use prevalence is endemic in some remote Indigenous communities in far North Queensland and a significant contributor to many problems.	NA	NA	NA	NA	NA	NA	◆