
# Submission in response to the draft *South Australian Alcohol and Other Drug Strategy 2024 - 2030.*

**Submitted to Preventive Health SA**

**Email:** PreventiveHealthSA.AlcoholTobaccoandOtherDrugs@sa.gov.au

**July 2024**

## About SACOSS

The South Australian Council of Social Service (SACOSS) is the peak non-government body for health and community services in South Australia, and has a vision of justice, opportunity and shared wealth for all South Australians.

Our mission is to be a powerful and representative voice that leads and supports our community to take actions that achieve our vision, and to hold to account governments, businesses, and communities for actions that disadvantage vulnerable South Australians.

SACOSS aims to influence public policy in a way that promotes fair and just access to the goods and services required to live a decent life. We undertake research to help inform community service practice, advocacy and campaigning. We have 75 years' experience of social and economic policy and advocacy work that addresses issues impacting people experiencing poverty and disadvantage.

SACOSS wishes to acknowledge the range of organisations involved in policy reform and advocacy work in the interests of reducing the harms of alcohol and other drugs, with whom we have collaborated. These include, amongst others, the South Australian Network of Drug and Alcohol Services (SANDAS), FARE Australia, the Aboriginal Drug and Alcohol Council (ADAC), the Alcohol and Drug Foundation (ADF), and the other community sector members of the SA Consumer and Business Services' Alcohol Harms Reference Group.

## Acknowledgement

We acknowledge the traditional lands of the Kaurna people and acknowledge the Kaurna people as the custodians of the Adelaide region and the Greater Adelaide Plains, and also acknowledge the traditional custodians of lands beyond Adelaide and the Adelaide Plains. We pay our respects to Elders past and present.

We acknowledge and pay our respects to the cultural authority of Aboriginal and Torres Strait Islander communities, organisations and colleagues and recognise the cultural expertise that they represent.

We underscore the importance of Aboriginal-led responses to address the needs and rights of children, and for the embedding and realisation of the Aboriginal and Torres Strait Islander Child Placement Principle in legislation and practise.

Title: *Submission in response to draft South Australian Alcohol and Other Drug Strategy 2024-2030*

Published by the South Australian Council of Social Service, July 2024.

47 King William
Road Unley, SA, 5061 Australia
Ph (08) 8305 4222
Email: sacoss@sacoss.org.au
Website: www.sacoss.org.au

**Contact:** For further information, please contact Dr Rebecca Tooher: RebeccaT@sacoss.org.au

# Table of Contents

Acknowledgement ..... 2

About SACOSS ..... 2

1. Introduction and overview ..... 4

2. Summary of recommendations ..... 4

3. SACOSS commentary on the Strategy ..... 7

Social Determinants of Health, Aim of the Strategy, and Priority Populations ..... 7

Priority Area 1: Health promotion and prevention ..... 9

Priority Area 2: Disruption and supply reduction ..... 9

Priority Area 3: Early and targeted interventions ..... 10

Priority Area 4: The recognition of the need for treatment and support ..... 11

Priority Area 5: Engaging with communities ..... 12

System enablers and measuring success ..... 13

4. Conclusion ..... 14

# 1. Introduction and overview

The South Australian Council of Social Service (SACOSS) welcomes this opportunity to respond to Preventive Health SA's draft *South Australian Alcohol and Other Drug Strategy 2024-2030,* and we look forward to the further development and refinement of the Strategy.

There are many aspects of this Strategy that we support, including attention being given to the social determinants of health, health promotion and prevention, disruption and supply reduction, early and targeted interventions, the recognition of the need for treatment and support, and the importance of engaging with communities. We are also encouraged by the cross-referencing of this Strategy with a range of relevant international, national and state policies, legislation and other strategies to guide a more strategic response.

This draft Strategy is being developed at a critical time of increasing harms resulting from alcohol consumption, in particular. The following statistics highlight the extent of the crisis: In 2022, across Australia, there was a 9.1% increase in the alcohol-induced death rate since 2021. This is the highest rate per 100,000 people in the ABS' 10-year time series.[1] In 2022-2023, alcohol was the most common drug of concern for which people received treatment; 42% of young adults aged 18 – 24 were at risk of alcohol-related disease or injury; 31% of people aged 14 years and over consumed alcohol in ways that put their health at risk. In 2021-22, alcohol accounted for 59% of drug-related hospitalisations – in SA, nearly 1 in 4 ED presentations for injuries are estimated to be attributed to alcohol. Between 2015 and 2023, the highest rates of alcohol and other drug-elated ambulance attendances were related to alcohol intoxication.[2]

The response and action that the South Australian Government takes can make a considerable difference to the health and wellbeing of people across the state, and would have an impact on reducing the pressure on hospital emergency departments and ambulance ramping. This makes it all the more urgent that this Strategy provides an appropriately cogent and targeted response.

Our commentary follows the structure of the draft Strategy document. Where appropriate, we provide proposals to strengthen or re-frame specific aspects outlined in the document.

# 2. Summary of recommendations

In summary, our key recommendations are set out below following the Strategy's structure of introductory sections, priority areas, system enablers and measures of success. They include further attention being given to the following:

**Social Determinants of Health, the Aim of the Strategy, and Priority Populations**

- Expand the focus of the Strategy to include not only social but also cultural and commercial determinants of health – particularly in relation to recognising Aboriginal and

[1] Australia Bureau of Statistics – Causes of death: https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release

[2] AIHW Alcohol, tobacco & other drugs in Australia (10 Jul 2024) https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/drug-types/alcohol

Torres Strait Islander People's cultural knowledges and practices; and the effects of the commercial vested interests of alcohol companies and their lobbyists
- Consider the nexus between accessing AOD treatment and the threat of the involvement of child protection services
- Give attention to the use of language, specifically, the Strategy's description of drinking alcohol at 'risky levels', which implies that there are 'zero-risk levels'. The preferred term is 'use alcohol at high-risk levels'. In addition, attention should be given to addressing stigma and stigmatising language about AOD use and people affected by it.
- Recognise women as a priority population in the Strategy, noting that 36.4% of South Australian AOD treatment clients were women
- Include children and young people who are criminalised and subjected to the youth justice system as a priority population, noting the link with their AOD use and treatment.

**Priority Area 1: Health promotion and prevention**

- Include a priority action to improve access to the screening, assessment and diagnosis of Foetal Alcohol Spectrum Disorder (FASD)
- Move away from the individualisation of responsibilities to effecting structural reforms – much of the Strategy's focus on health promotion and prevention is weighted towards individual behavioural change and health literacy, with less attention given to specific and concrete reforms that will challenge problematic causal enablers at a structural level
- Strengthen the intention and implementation of proposed priority actions and supporting activities in order to make these more explicit, directed and practical.

**Priority Area 2: Disruption and supply reduction**

- Explore options and take decisive action to regulate alcohol promotions, including ensuring that provisions regarding take away and online alcohol sales are incorporated into the *Liquor Licencing Act 1997* and associated Regulations**.**
- Support the measures outlined in the body of this submission regarding a review of online liquor sales and delivery regulations, in general, but also with specific reference to reducing the risk of domestic and family violence.

**Priority Area 3: Early and targeted interventions**

- Increase the focus on early and targeted interventions that include the use of harm reduction strategies such as drug checking/pill testing, needle and syringe programs, outreach to alcohol and drug users who have engaged but not yet experienced harm, and positive modelling of healthy practices in schools, workplaces, licenced premises, sporting and social clubs and in online environments. These will necessitate the intention and willingness to fund early intervention and early prevention activities.

**Priority Area 4: The recognition of the need for treatment and support**

- Implement a health-in-all-policies approach, which requires explicitly viewing AOD treatment and support services as responses to a health condition, and that clients/patients are entitled to a full range of health interventions for their condition
- Wherever possible, avoid operating on the assumption that the justice system needs to be involved as the entry pathway into people accessing treatment – the treatment of people

with substance use disorders including co/multi-morbidities should, in the first instance, be through health services, irrespective of the person's engagement with the justice system.

- Noting that children and young people (more especially those with substance use concerns, FASD or associated disabilities) should not be criminalised and incarcerated, it is critical that they are given appropriate therapeutic care and treatment, as highlighted in recent reports by the Guardian for Children and Young People and Community Visitor[3]
- Increase and optimise available treatment and support services by appropriately funding these services.

**Priority Area 5: Engaging with communities**

- Include and involve people with lived experience of AOD – either due to substance use themselves or being affected by those around them – in the actual co-design and development of this Strategy. This will contribute to ensuring that it is informed by the people who are directly affected and who can share their experiences of what does and does not work. The development of a peer-informed or lived experience model needs to be identified as a key priority in the Strategy.
- Establish community-based peer support groups and harm-reduction networks, to contribute to prevention and to supporting substance users and other affected groups of people, particularly in terms of connecting them with outreach health and support services.
- Establish an independent representative body for people who use alcohol and other drugs – noting that, with the exception of the Northern Territory, a representative service exists in every other jurisdiction in Australia.

**System enablers and measuring success**

- Value the inclusion and involvement of communities of practice, to enable more interactive engagement with the health system and the intentions of this Strategy, and to include evaluation and the implementation of continuous improvement strategies.
- Include NGO representation on the Alcohol and Other Drug Strategy Steering Group, noting the sector's significant role and contribution in providing preventive programs, treatment, support services and community advocacy.
- Actively engage and include ACCHOs, primary health care organisations, NGOs and local governments in the Steering Group, beyond participating in partnerships.
- Enable more inclusion and direct representation from people who use drugs, bringing their experience and expertise to inform system improvement.
- While acknowledging a role for police, correctional services and emergency services in the Steering Committee, there is a need to correct the weighting given to these representatives, more so in the absence of others, as outlined above. This weighting may give rise to an increased focus on the policing, law enforcement, criminalising and risk management aspects of the Strategy's implementation, rather than a health-in-all-policies approach focusing on the social, cultural and commercial determinants of health and wellbeing, and positive health and treatment outcomes.

[3] Office of the Guardian for Children and Young People. *Training Centre Visitor. Annual Report 2022–23* https://gcyp.sa.gov.au/wordpress/wp-content/uploads/2023/11/Training-Centre-Visitor-2022-2023-Annual-Report.pdf

- In addition to monitoring and evaluating the Key Performance Indicators to measure the Strategy at a population level, it would be important to include regular monitoring and public reporting on progress with the Priority Actions and Supporting Activities. This would enable us all to learn from the outcomes of the Strategy and what is effective, for whom and under what conditions.

# 3. SACOSS commentary on the Strategy

## Social Determinants of Health, Aim of the Strategy, and Priority Populations

***Social, cultural and commercial determinants of health***

We support the Strategy's focus on the social determinants of health and the adoption of a population health approach, which addresses determinants of health and the distribution of health in the population, and calls for whole-of-government strategies. However, we recommend that the principle of taking a 'social determinants of health' approach be expanded to include 'cultural' and 'commercial' determinants of health.

*Cultural determinants*

We note that the iteration of the Strategy is designed to complement associated strategies, including *South Australia's Implementation Plan for the National Agreement on Closing the Gap*, and 'supporting the capacity of Aboriginal Community Controlled Organisations (ACCOs) to expand their provision of services to their respective communities' (p. 2). Aside from including ACCOs, Aboriginal Community-Controlled Health Organisations (ACCHOs) also need to be identifiably included, and that these organisations and their expertise need to be integrated in ways that go beyond 'supporting their capacity'. If we are to reform our health system in ways that reduce health inequities and challenge racism, it is essential that this Strategy includes a focus on the cultural determinants of health (CDoH), through demonstrating a recognition of the knowledges and cultural authority held and practiced by Aboriginal and Torres Strait Islander Peoples. For more detailed information, this article provides a useful overview: *Implementing the cultural determinants of health: our knowledges and cultures in a health system that is not free of racism.*[4]

*Commercial determinants of health*

The inclusion of commercial determinants of health will necessitate addressing and regulating the inherent conflicts of interest of alcohol companies and their lobbyists regarding:

- political and policy access and influence, for example, excluding the alcohol industry from all alcohol policy development processes and advisory groups, and banning alcohol industry political donations;
- promotions and marketing, through introducing and extending more comprehensive government regulation of alcohol marketing; and

[4] Parter, C & Murray, D. et al (2024) *Implementing the cultural determinants of health: our knowledges and cultures in a health system that is not free of racism* accessed at https://apo.org.au/sites/default/files/resource-files/2024-07/apo-nid327478.pdf

- the regulation of the rapid increase of alcohol availability, particularly through online sales and the delivery of alcohol.

***The nexus between accessing AOD treatment and involvement of child protection services***

While the Strategy highlights links between AOD use and its impact on children and young people, it is important to also register levels of resistance to taking up AOD support services and access to treatment as a result of the interaction between service responses to alcohol use and the child protection system – parents/carers who use alcohol and other drugs tend to avoid accessing treatment or social supports for fear of their children being removed and placed in out-of-home-care.[5] Besides the stigma associated with harmful levels of alcohol and other drug use deterring people from accessing supports, the nexus between accessing AOD treatment/support services, and the threat of the involvement of child protection services compounds the problem.

***Use of language and terms***

In addition, we recommend further attention being given to the use of language throughout the strategy – this specifically relates to the description of drinking alcohol at 'risky levels'. Using the expression 'risky levels' implies that there are 'zero-risk levels'. The preferred term is to 'use alcohol at high-risk levels'. This would accord with the National Health and Medical Research Council's (NHMRC) *Australian guidelines to reduce health risks from drinking alcohol* to not use the expression 'risky drinking' or 'risky levels'.

As a general comment on language usage, more so towards addressing stigma and stigmatising language about AOD use and people affected by it, the Strategy could indicate ways in which anti-discrimination language, terminology and attitudes could be enforced and legislated, with a particular emphasis on the role of media communications.

***Priority Populations***

*Women:*
The list of priority populations is silent on the incidence and treatment needs of women. The AIHW data for 2022-2023 indicates that 36.4% of South Australian AOD treatment clients were women.[6] Interestingly, over half of all people who received treatment for someone else's alcohol or drug use were women (54%) – thereby indicating the impact and implications of AOD for women, and the importance of recognising women as a priority population in the Strategy.

*Children and Young People with experience of the Youth Justice System:*
While children and young people in general are listed as a priority group, and the rates of people (unspecified age) in the criminal justice system are stated, it would be important for the Strategy to include a recognition of the link between children and young people who are criminalised and subjected to the youth justice system and an increased likelihood of AOD use. The overlap between alcohol and other drug treatment services and youth justice supervision is significant – when compared with the age-equivalent Australian population, those (aged 10–17) who had

[5] Lawrie, A. (2024) Commissioner for Aboriginal Children and Young People South Australia. *Holding on to Our Future, the Final Report of the Inquiry into the application of the Aboriginal and Torres Strait Islander Child Placement Principle in the removal and placement of Aboriginal Children in South Australia*, p. 69. https://cacyp.com.au/wp-content/uploads/2024/06/CACYP-Inquiry_Final-Report_14052024.pdf
[6] AIHW (July 2024) *Alcohol and other drug treatment services in Australia annual report* https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-australia/contents/state-and-territory-summaries/south-australia

youth justice supervision were 30 times as likely to have an alcohol and other drug treatment service, and those who received an alcohol and other drug treatment service were 30 times as likely to have youth justice supervision.[7]

## Priority Area 1: Health promotion and prevention

***Preventing Foetal Alcohol Spectrum Disorder (FASD)***

While the Strategy indicates an aspiration that, by 2030, health providers will have appropriate screening, assessment and referral tools to aid in the diagnosis and support for FASD (p. 8), there is no explicit priority action or supporting activity indicated, besides '…increasing community knowledge and awareness about the harms and consequences of drinking during pregnancy or when planning a pregnancy' (p. 8).

We recommend that an action be included to improve access to the screening, assessment and diagnosis of FASD, particularly across the health, education, child protection and criminal justice sectors.

***Move from individualisation of responsibility to effecting structural reforms***

Much of the focus of health promotion and prevention throughout the Strategy is weighted towards individual behavioural change and health literacy, with less attention given to specific and concrete reforms that will challenge problematic causal enablers at a structural level, such as challenging the sale and promotion of online alcohol sales and unregulated delivery.

***Strengthen the intention and implementation of proposed actions and activities***

While noting inclusions under Priority Area 2, and supporting the Priority Actions and Supporting Activities under Priority Area 1, we believe that points 5, 9 and 10 could be significantly strengthened and the proposed actions made more explicit and practical. For example, it is insufficient to indicate that supporting activities will include 'Work across sectors to develop and implement initiatives that *highlight the risks of supplying alcohol to children and young people* (point 9 on p. 8)' – the emphasis here should go beyond 'highlighting' and should aim to halt and block the supply of alcohol to children and young people. Similarly, rather than just 'examining data and evidence on the most effective alcohol and other drug regulations to promote public health and safety', the emphasis should be on actively introducing and implementing effective regulations under the *Liquor Licencing Act 1997.*

## Priority Area 2: Disruption and supply reduction

We note that no reference is made to the online sale and delivery of alcohol. This may be because the Strategy document was drafted prior to the COVID-19 pandemic, when online sales and home deliveries became ubiquitous.

We recommend that an action be included to adequately address the sale of off-licence or take away alcohol and the promotion of the online delivery of alcohol including marketing on digital platforms – with the internet being explicitly identified as a 'point of sale outlet'. For example, the

[7] AIHW (2018) *Overlap between youth justice supervision and alcohol and other drug treatment services* https://www.aihw.gov.au/reports/youth-justice/overlap-youth-justice-supervision-and-aodts/summary

Strategy could indicate steps to ensure that alcohol is not promoted to people through online shopping sites for general groceries.

In addition to the monitoring and re-introduction of wholesale alcohol sales data, current regulations relating to online sales and the delivery of alcohol must be reviewed. Online alcohol sales and home delivery have created a significant increase in alcohol availability. This has meant that existing liquor licensing laws are insufficient to regulate the damaging impacts and emerging health and safety risks of this type of alcohol supply. There is clear Australian evidence that alcohol delivery is associated with increased high-risk levels of alcohol use in the home.[8]

We support the measures set out below – as highlighted elsewhere by organisations such as the South Australian Network of Drug and Alcohol Services (SANDAS), FARE Australia, the Aboriginal Drug and Alcohol Council (ADAC), the Alcohol and Drug Foundation (ADF), and SACOSS and the other members of the SA Consumer and Business Services' Alcohol Harms Reference Group. These proposed measures have formed part of our response to reviewing online liquor sales and delivery regulation, in general, but also with specific reference to reducing the risk of domestic and family violence:

- No rapid (less than two-hour) deliveries
- No late-night deliveries
- Effective online ID check and age verification
- Ban predatory marketing
- Better training and protections for delivery staff.

Linked to this set of recommendations we continue to advocate for:

- an increase in funding of AOD treatment and support services and an increase in the workforce to meet the significant investment gap and the increasing number of episodes
- a review and, if necessary, to amend the available expertise constituting relevant liquor advisory bodies – to ensure adequate representative expertise in health and the effects of alcohol.

SACOSS recommends that the Strategy explores options and sets out decisive actions to regulate alcohol promotions, including ensuring that provisions regarding take away and online alcohol sales are incorporated into the *Liquor Licencing Act 1997* and associated Regulations.

## Priority Area 3: Early and targeted interventions

In order to strengthen the stated priority actions and supporting activities, SACOSS proposes that early and targeted intervention should include the use of harm reduction strategies such as drug checking/pill testing, needle and syringe programs, outreach to alcohol and drug users who have engaged but not yet experienced harm, and positive modelling of healthy practices to support disease prevention and health promotion in schools, workplaces, licenced premises, sporting and social clubs and in online environments. The latter would include exploring new models of early intervention, such as evidence-based education in schools; the delivery of training to employers of apprentices and new entrants to the workforce on the need for good practices in relation to

[8] FARE (2020) *Annual Alcohol Poll: Attitudes and Behaviours*. http://fare.org.au/wp-content/uploads/ALCPOLL-2020.pdf
VicHealth (2020) *On-demand alcohol delivery services and risky drinking*. https://www.vichealth.vic.gov.au/media-andresources/publications/alcohol-delivery-risky-drinking

workplace drinking; and the engagement with sports and social clubs in providing education and support to members in relation to safer use of alcohol and other drugs.

With reference to Supporting Activity 24 (p. 12), which aims to integrate referral pathways, it will be essential to ensure that sufficient and appropriate services are in place to receive and respond to these referrals. It is noted that, at a national level, the need/demand for treatment is two to three times the current available treatment on offer,[9] with South Australia having seen a significant decline in the number of people able to access treatment since 2014.[10]

The above proposals will necessitate the intention and willingness to fund early intervention and early prevention activities. However, a consideration of government expenditure indicates a significant mis-direction of funding away from early intervention and prevention. In 2021/2022, across Australia, governments spent nearly $5.5 billion on illicit drug countermeasures but less than 10 per cent went towards strategies aimed at preventing use and reducing negative consequences. As indicated in Figure 1 below, more is spent on law enforcement in illicit drug policy than treatment, prevention and harm reduction combined.[11]

The proportion spent on prevention, such as in-school education programs, decreased since the last report in 2009/10, down from 9.5 per cent to 6.7 per cent in 2021/22. Spending on harm reduction also decreased from 2.2 per cent to just 1.6 per cent. Spending on law enforcement remained relatively stable, slightly down from 64.9 per cent to 64.3 per cent of expenditure. However, spending on drug treatment services rose from 22.0 per cent to 27.4 per cent.[12]

## Priority Area 4: The recognition of the need for treatment and support

In order for this Strategy to implement a health-in-all-policies approach, it is essential to explicitly view and identify AOD treatment and support services as a response to a health condition, and that clients or patients are entitled to a full range of health interventions for their health condition.

In response to Priority Area 28, there is a need to include a commitment to increase service delivery across the board, in addition to focusing on increasing the number of residential and rehabilitation beds.

Regarding Supporting Activity 37, we are concerned that this activity may imply that the justice system is a legitimate and sufficient entry pathway into treatment. The treatment of people with substance use disorders including co/multi-morbidities should, in the first instance, be through health services, irrespective of the person's engagement with the justice system.

Supporting Activity 47 commits to 'developing and implementing innovative treatment models in the SA youth justice system' (p.14). While noting that children and young people (more especially

[9] Ritter, a. et al (2014) *New Horizons: The review of alcohol and other drug treatment services in Australia Final Report* https://www.unsw.edu.au/content/dam/pdfs/unsw-adobe-websites/arts-design-architecture/ada-faculty/sprc/Alcohol-and-other-drug-treatment-services-review-New-Horizons-Final-Report-July-2014.pdf

[10] AIHW (2024) *Alcohol and other drug treatment services in Australia annual report.* https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-australia/contents/state-and-territory-summaries/south-australia

[11] Ritter, A., Grealy, M., Kelaita, P. & Kowalski, M. (2024) The Australian 'drug budget': Government drug policy expenditure 2021/22. *DPMP Monograph No. 36*. Sydney: Social Policy Research Centre, UNSW. https://doi.org/10.26190/unsworks/30075

[12] Ibid.

those with substance use concerns, FASD or associated disabilities) should not be criminalised and incarcerated, and while it would be preferable to implement constructive approaches to therapeutic care and treatment, it is critical that foundational care and health-in-all-policies are applied and met, before we aspire to new 'innovative treatment models' – more particularly in light of the recent reports by the Guardian for Children and Young People and Community Visitor, which highlight the lack of appropriate treatment and therapeutic supports available to children and young people in Kurlana Tapa and the youth justice system.[13]

As indicated previously, there is a need to increase and optimise available treatment and appropriate support services – there is therefore an urgent need to focus on the funding made available for these services.

According to Ritter et al. (2024),[14] and indicated in Figure 1 below, the national allocation for drug treatment from the total Australian 'drug budget' was 27.4% (less than half that allocated to law enforcement at 64.3%).

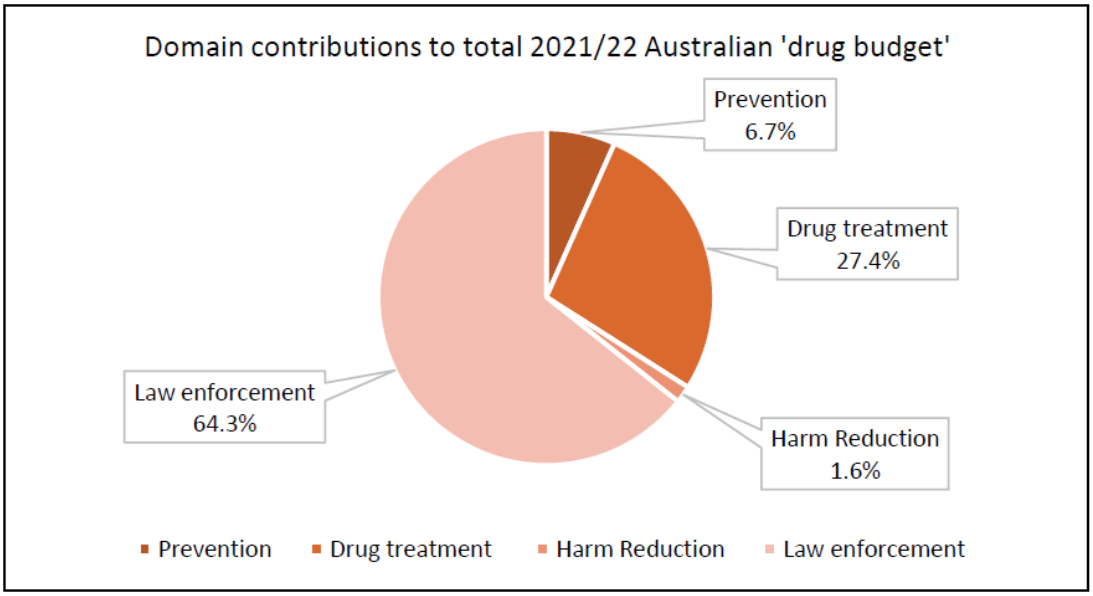


**Figure 1: Government expenditure estimates (proportion) across four policy domains**

## Priority Area 5: Engaging with communities

While the Strategy indicates that 'engaging communities in alcohol and other drug initiatives is important for increasing understanding of AOD harms, and ultimately promoting the health and wellbeing of individuals and populations', and the importance of communities' 'involvement in planning and implementing health policies and services', there appears to be a lack of involvement of people with lived experience of AOD – either due to substance use themselves or being affected by those around them – in the actual co-design and development of this Strategy itself. While the Strategy indicates that 'co-designing services supports a more flexible service

[13] Office of the Guardian for Children and Young People. *Training Centre Visitor. Annual Report 2022–23* https://gcyp.sa.gov.au/wordpress/wp-content/uploads/2023/11/Training-Centre-Visitor-2022-2023-Annual-Report.pdf

[14] Ritter, A., Grealy, M., Kelaita, P. & Kowalski, M. (2024) The Australian 'drug budget': Government drug policy expenditure 2021/22. *DPMP Monograph No. 36*. Sydney: Social Policy Research Centre, UNSW. https://doi.org/10.26190/unsworks/30075

provision', it needs to go beyond participation in service design and begin with the actual co-design of this Strategy, to ensure that it is informed by the people who are directly affected and who have much to share about their experiences of what does and does not work. Moreover, the section of the Strategy outlining collaboration and partnerships (p. 7) does not indicate the active engagement or involvement of people with lived experience in the development or co-design of this Strategy.

Engaging with communities and involving people in co-design processes should not be treated as an 'after-the-fact' exercise once a strategy or series of priorities and actions have already been developed and designed. The development of a peer-informed or lived experience model needs to be identified and practised as a priority in the development and implementation of the Strategy.

We are concerned that there is a disconnect between the aspirations – by 2030, for co-design processes, equity in service provision, harm minimisation, and cultural safety and competency – and the priority actions as set out. We are not sure that 'embedding routine client experience measures' and a number of the other proposed actions are sufficiently linked or enable the realisation of Priority Area 5's stated vision and commitment. This probably calls for a more in-depth and comprehensive engagement with affected communities.

Establishing community-based peer support groups and harm-reduction networks can make a significant contribution to prevention and to supporting substance users and other affected groups of people, particularly in terms of connecting people with outreach health and support services. [15]

In addition, it would be important to include a priority action to establish an independent representative body for people who use alcohol and other drugs – noting that, with the exception of the Northern Territory, a representative service exists in every other jurisdiction in Australia.

## System enablers and measuring success

This submission does not include substantive commentary on the system enablers, other than to indicate the value of including the involvement of communities of practice and that this should be envisaged in a more interactive and comprehensive manner than that set out in Supporting Activity 55. The establishment of these communities of practice would enable more interactive engagement with the health system and the intentions of this Strategy, and could extend beyond promoting the Drug and Alcohol Clinical Advisory Services (Support Activity 57), to include evaluation and the implementation of continuous improvement strategies.

SACOSS is concerned that there does not appear to be NGO representation on the Alcohol and Other Drug Strategy Steering Group (p. 19). Given the significant role and contribution of the NGO sector in providing preventive programs, treatment, support services and community advocacy, we encourage the inclusion of NGO representatives in the Steering Group. In addition, we would like to see a more active inclusion of ACCHOs, primary health care organisations, NGOs and local

[15] For further information on the value of peer support and lived experience expertise, see for example:

- Iryawan AR, Stoicescu C, Sjahrial F, Nio K, Dominich A. The impact of peer support on testing, linkage to and engagement in HIV care for people who inject drugs in Indonesia: qualitative perspectives from a community-led study. Harm Reduct J. 2022 Feb 11;19(1):16. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8832667/
- Treatnet: International Network of Drug Dependence Treatment and Rehabilitation Resource Centres. (2008) *Community Based Treatment – Good Practice* http://www.unodc.org/treatnet

government in the Steering Group, beyond being viewed as participating in 'strong partnerships'. We also re-state our point that there should be more inclusion and direct representation from people who use drugs, bringing their experience and expertise to inform system improvement.

While there is, of necessity, a role for police, correctional services and emergency services in the Steering Committee, we are concerned by the weighting given to these representatives, more so in the absence of others, as outlined above. This weighting may give rise to an increased focus on the policing, law enforcement, criminalising and risk management aspects of the Strategy's implementation, rather than a health-in-all-policies approach that focuses on the social, cultural and commercial determinants of health and wellbeing, and positive health and treatment outcomes.

In addition to monitoring and evaluating the Key Performance Indicators to measure the Strategy at a population level, it would be important to include regular monitoring and public reporting on progress with the Priority Actions and Supporting Activities. This would enable us all to learn from the outcomes of the Strategy and what is effective, for whom and under what conditions.

## 4. Conclusion

While we have raised a number of concerns about issues in the Strategy, we appreciate the work that has gone into preparing and compiling its content. Noting the relatively short turn-around time for providing feedback on the document, we trust that there will be further opportunities and scope for the non-government health and community services sector to contribute to the Strategy's further development. Thank you for the opportunity to provide feedback and SACOSS looks forward to engaging with the process and the Strategy's implementation.