Turning Point
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MONASH University
MONASH ADDICTION RESEARCH CENTRE

SUBMISSION TO THE *INQUIRY INTO THE HEALTH IMPACTS OF ALCOHOL AND OTHER DRUGS IN AUSTRALIA*

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About

Turning Point is a national addiction treatment centre, dedicated to providing high quality, evidence-based treatment to people adversely affected by alcohol, drugs, and gambling, integrated with world-leading research and education. Turning Point is part of Eastern Health and is formally affiliated with Monash University. Turning Point reduces the harms caused by alcohol, drugs and gambling and promotes recovery through integrated activity that: increases access to support and evidence-based practice using innovative technologies; delivers high quality evidence-based practice and supports health care professionals nationally and internationally to do the same; educates and trains the workforce to deliver programs to a broad range of populations; and underpins policy and practice relevant research and the provision of key national population level data that informs expert comment and policy advice to state and federal governments.

The **Monash Addiction Research Centre (MARC)** brings together world-leading expertise from across Monash University and the sector to provide solutions to the challenges of addiction. MARC draws on the multidisciplinary strengths and capabilities of researchers across the University to develop and test novel, scalable prevention and treatment approaches. MARC's mission is to provide national solutions to addiction, leveraging expertise in basic and social science, clinical, and epidemiological research to develop new knowledge to shape government policy and evidence-based approaches.

1. Summary of recommendations

Turning Point, Eastern Health and the Monash Addiction Research Centre welcome the opportunity to contribute to this important and timely *Inquiry into the health impacts of alcohol and other drugs in Australia* by the Australian Parliament's Standing Committee on Health, Aged Care and Sport.

Alcohol and other drug (AOD) harms place a significant and increasing burden on the health and wellbeing of Australians, with 1 in 4 Australians struggling with AOD use at some point in their lifetime.[1] Unintentional fatal alcohol and other drug overdoses have increased by more than 71% in the past two decades,[2] while alcohol was associated with 188,327 hospitalisations in 2021-22 (515 hospitalisations each day or 21 every hour).[3]

AOD-related stigma is pervasive and profound, resulting in significant delays in help-seeking. For example, the median time to first treatment for alcohol use disorder is an astonishing 18 years.[4] Such lengthy help-seeking and treatment delays mean AOD harms escalate, and people become more complex and costly to treat due to higher rates of co-occurring physical and mental health disorders, as well as social, occupational, and financial complications.

As AOD harms and treatment demand continue to escalate, an already stretched health system and budget is under increasing pressure. Addiction is associated with substantial health and economic costs, with a recent report finding the annual cost to the Australian community is $80 billion, and as much as $174 billion in the value of lives lost in 2021 when considering their potential contributions in the future.[5]

Every dollar invested in AOD treatment saves up to $23,[6] and every dollar invested in harm reduction saves up to $27.[7] Yet total AOD investment by all Australian jurisdictions remains imbalanced across the three pillars of the *National Drug Strategy*, with 34.1% invested in

[1] Timothy Slade et al, *The Mental Health of Australians - Report on the 2007 National Survey of Mental Health and Wellbeing* (Report, No 2, 2014) 5 <https://www.researchgate.net/publication/236611613_The_Mental_Health_of_Australians_2_Report_on_the_2007_National_Survey_of_Mental_Health_and_Wellbeing>.
[2] Penington Institute, *Australia's Annual Overdose Report* (Report, 2024) 3 <https://www.penington.org.au/australias-annual-overdose-report-2024/>.
[3] Agata Chrzanowska et al, *Trends in Drug-Related Hospitalisations in Australia, 2002-2022* (Report, 17 June 2024) 9 <https://www.unsw.edu.au/research/ndarc/resources/trends-drug-related-hospitalisations-australia-2002-2022>.
[4] Cath Chapman et al, 'Delay to First Treatment Contact for Alcohol Use Disorder' (2015) 147 (February) *Drug and Alcohol Dependence* 116, 118.
[5] Rethink Addiction and KPMG, *Understanding the Cost of Addiction in Australia* (Report, 2022) 4 <https://www.rethinkaddiction.org.au/the-cost-of-addiction>.
[6] Alexandra Voce and Tom Sullivan, *What are the Monetary Returns of Investing in Programs That Reduce Demand for Illicit Drugs?* (Report, No 657, 8 September 2022) 8 <https://www.aic.gov.au/publications/tandi/tandi657#>.
[7] National Centre in HIV Epidemiology and Clinical Research, *Return on Investment 2: Evaluating the Cost-Effectiveness of Needle and Syringe Programs in Australia* (Report, 2009) 8 <https://www.acon.org.au/wp-content/uploads/2015/04/Evaluating-the-cost-effectiveness-of-NSP-in-Australia-2009.pdf>.

AOD treatment and prevention (i.e., demand reduction) and only 1.6% for harm reduction, compared to 64.3% spent on law enforcement (i.e., supply reduction).[8]

This inquiry presents an opportunity to rethink how we respond to AOD harms, and this submission outlines three key action areas to do so. Section 2 discusses the need to re-establish AOD sector inclusive national governance arrangements, section 3 focusses on the need for effective national strategies supported by implementation plans, and section 4 emphasises the importance of national AOD strategies/plans backed by coordinated joint Commonwealth and state/territory investment mechanisms to support evidence-based initiatives known to generate significant returns. To that end, we make the following recommendations:

1. Re-establish an AOD sector-inclusive national governance framework to improve coordination of sustainable AOD policy and practice change. Proposed actions (see section 2) include:
    a. Review existing national governance arrangements with a view to embedding and increasing the representation of clinical, policy, lived experience, and research expertise, enhancing cross-agency collaboration and stakeholder engagement, and supporting the renewal of national AOD strategies and ensuring their targets are being met, actions are being implemented, and outcomes are being measured.
    b. Consider whether the Department of Health and Aged Care's Alcohol & Other Drugs Branch, currently nested under the Population Health Division, is adequately resourced and appropriately located/profiled within the Department's organisational structure.
    c. Establish an inter-departmental AOD committee to improve cross-portfolio communication and coordination of AOD-related policy and practice change.
2. Develop effective national AOD strategies that:
    a. Balance investment across the national strategy's pillars (see section 3.1.3) in accordance with Recommendations 2 and 3 of the report from the *Inquiry into Australia's illicit drug problem: Challenges and opportunities for law enforcement*;
    b. Include short-, medium-, and long-term outcomes and set measurable targets to track progress, including stigma reduction and improved quality of life pillars and targets (see section 3.2.2); and
    c. Are supported by joint Commonwealth and state/territory agreements and implementation plans to ensure jurisdictional buy-in and coordination of

[8] Alison Ritter et al, The Australian 'Drug Budget': Government Drug Policy Expenditure 2021/22 (Monograph, No 36, 4 June 2024) 11 <https://apo.org.au/node/327038>.

shared investment priorities across AOD prevention, treatment and harm reduction (see section 3.3), workforce (see section 3.4), research and data (see section 3.5), and any other relevant initiatives (see section 4.1 for an outline of current investment mechanisms).

3. Provide sustainable investment in system enablers to put downward pressure on AOD harms, reduce associated costs, and build a more sustainable, effective, and efficient AOD system. Options include:

    a. A whole-of-health approach to tackling AOD harms (see section 4.2.1).
    b. A range of public health, prevention, early intervention and harm reduction initiatives to prevent AOD harms from escalating and becoming more complex and costly to manage (see section 4.2.2).
    c. A national digital AOD service model to overcome stigma and geography as access barriers, promote early help-seeking and intervention, improve system navigation, and reduce demand on the broader health system (see section 4.2.3).
    d. An updated national AOD workforce strategy that invests in a range of initiatives to enhance the capacity and capability of the AOD workforce so it can deliver now and into the future (see section 4.2.4).
    e. National coordination and monitoring of the *National Quality Framework for Drug and Alcohol Treatment Services* so it is fully implemented across and within states and territories (see section 4.2.5).
    f. Adequate (5-year) timeframes, indexation, timely renewal notices (at least six months prior to expiry) and resourced evaluations of new programs in funding agreements with AOD services (see section 4.2.6).

2. Re-establish inclusive national AOD governance arrangements

2.1. Governance context

Since the dissolution of the Intergovernmental Committee on Drugs and the National Drug Strategy Committee and its subgroups, as well as the disbanding the Council of Australian Governments and the Ministerial Drug and Alcohol Forum in 2020, Australia no longer has a coherent national governance structure that facilitates dialogue between the AOD sector, law enforcement, different levels of government, funding and commissioning bodies, and intersecting sectors and systems.

The disbanding of national AOD governance structures has resulted in a fragmented approach to the implementation of effective drug policy with limited opportunities for

federal, state, and territory information sharing, collaboration, and learning. This limits Australia's capacity to deliver a nationally consistent approach to prevent and minimise AOD harms, improve access to treatment and harm reduction, and ensure equitable health and justice outcomes across jurisdictions. It also hinders efforts to effectively monitor trends, track progress against the *National Drug Strategy*, identify best practice, and ensure policymaking is contemporary and evidence based.

On this background, the Australian National Advisory Council on Alcohol and Other Drugs (ANACAD) was established to provide confidential advice to the Minister for Health on current and emerging drug and alcohol issues. However, this channel alone cannot adequately represent and leverage the breadth of the AOD sector's clinical, policy, lived experience and research expertise, and there is a need to return to more inclusive national AOD governance arrangements to provide adequate stakeholder engagement and expert-informed, evidence-based decision-making.

As noted by the Australian Alcohol & Other Drugs Council in its 2024-25 pre-budget submission, "In years gone by, national governance structures such as the Ministerial Council on Drug Strategy, the Intergovernmental Committee on Drugs and the National Indigenous Drug and Alcohol Committee were integral to the development and implementation of National Drug Strategies. They ensured a better coordinated approach to system development and funding for the AOD sector at both Commonwealth and State/Territory levels. National governance structures remain in place for other sub-sectors within the Health portfolio (such as in the Blood Borne Viruses and Sexually Transmissible Infections sub-sector) and reinstating such a structure for the AOD sector is seen as critical for the ongoing development and advancement of coordinated priorities for the AOD service sector across Australia."[9]

2.2. Enhanced national governance options

Re-establishing more inclusive national governance arrangements will support coordination, innovation and implementation in relation to AOD priorities and investment. Enhanced governance, including embedding and increasing the representation of clinical, policy, lived experience, and research expertise, would enhance collaboration and stakeholder engagement, and support the successful implementation of national AOD strategies, targets, actions, and outcomes.

The National Mental Health Commission is currently being folded into the Department of Health. Given this restructure, it would be timely to consider whether the Department of Health and Aged Care's Alcohol & Other Drugs Branch, currently nested under the Population Health Division, is adequately resourced and appropriately located within the

[9] Australian Alcohol & Other Drugs Council (AADC), *2024-25 Pre-Budget* (Submission, 25 January 2024) 5 <https://aadc.org.au/resources/>.

Department's organisational structure to enable it to effectively engage with the AOD sector and support delivery of national AOD strategies.

The impact of alcohol and drug harms across the community is broad and substantial, and individuals experiencing AOD harms often face compounded challenges due to social disadvantage, such as poverty, unemployment, and unstable housing. It is therefore timely that the present inquiry also seeks to address how a range of portfolios can better address AOD harms and effectively support treatment and recovery pathways. Interdepartmental communication and coordination of AOD-related policy and practice change across portfolios could be improved through multiple mechanisms, including establishment of an interdepartmental committee. Indeed, there are many examples of interdepartmental committees serving as a common governance body for cross-agency work, including on Closing the Gap and gender equality.

3. Effective national AOD strategies

3.1. Policy context

3.1.1. Rising AOD harms and costs

The growing demand for AOD treatment, care, and support is directly and significantly fuelled by the harms of alcohol and other drugs. In Australia, unintentional alcohol and drug-induced deaths have risen by 108% between 2002 and 2022, with the total number of deaths (including drug-induced suicides) exceeding 38,000 lives lost over this period.[10] Alcohol remans a leading cause of injury, chronic disease, and mortality in Australia and globally, with chronic consumption a causal factor for over 200 diseases and conditions, spanning cancers, liver and cardiovascular disease, mental disorders and suicide.[11] In 2021-22, there were 188,327 hospitalisations where an alcohol-related diagnosis (principal or additional) was recorded, equating to 515 hospitalisations per day or 21 hospitalisations per hour.[12]

Increasing AOD harms and the associated burden contribute to significant and rising health system costs. AOD-related healthcare costs were conservatively estimated to be around $4.6 billion in 2021, with roughly $513 million attributable to ambulance and emergency services, and a further $831 million incurred by hospital inpatient services.[13] And it's not just the health system under pressure. AOD harms are contributing to increasing costs related to the welfare, homelessness, and criminal justice sectors, as well as being a major driver of

[10] *Australia's Annual Overdose Report* (n 2) 7.
[11] Jürgen Rehm et al, 'The Relation Between Different Dimensions of Alcohol Consumption and Burden of Disease - An Overview' (2010) 105(5) *Addiction* 817, 821.
[12] Chrzanowska et al (n 3).
[13] Unpublished Turning Point analysis.

reduced productivity. Indeed, the annual cost of addiction in Australia is estimated to be $80 billion.[14]

3.1.2. The need for coherence across national AOD strategies

This inquiry, alongside the consultation process currently underway for the *National Drug Strategy*, presents an opportunity to consider how the current mix of national strategies could be reimagined and re-energised through engagement with the AOD sector.

There are currently eight national AOD strategies. The *National Drug Strategy 2017-2026* identifies national priorities relating to alcohol, tobacco, and other drugs. It presents three pillars of harm minimisation (supply reduction, demand reduction, and harm reduction) and identifies priority actions (e.g., enhanced access to evidence-informed, effective and affordable treatment), priority populations (e.g., Aboriginal and Torres Strait Islander peoples), and priority substances (e.g., methamphetamines and other stimulants). It aims to measure progress by reviewing and reporting against several indicators, including the number of people reporting recent drug use and drug-related burden of disease.

The *National Drug Strategy 2017–2026* serves as an overarching document, with several strategies sitting below it, namely the:

- *National Alcohol Strategy 2019–2028* (and its subsidiary *National Foetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018–2028*);
- *National Aboriginal and Torres Strait Islander Peoples Drug Strategy 2014-2019*;
- *National Alcohol and Other Drug Workforce Development Strategy 2015–2018*; and
- *National Ice Action Strategy 2015*.

Other standalone strategies include the *National Quality Framework for Drug and Alcohol Treatment Services*, and the *National Tobacco Strategy 2023–2030*. States and territories also have their own AOD strategies.

Three of the national strategies are currently out of date,[15] and the remaining five strategies work to timeframes and outcomes that are not aligned, with little coherence between or coordination across them. And despite international evidence that changes in drug markets have been the largest driver of exponentially increasing overdose deaths in North America,[16] none of the current strategies are reflective of rapidly changing international drug markets or inclusive of responses required to mitigate resulting harms; more

[14] Rethink Addiction and KPMG (n 5).
[15] These are the *National Aboriginal and Torres Strait Islander Peoples Drug Strategy 2014-2019, National Alcohol and Other Drug Workforce Development Strategy 2015–2018*, and *National Ice Action Strategy 2015*.
[16] Daniel Ciccarone, 'The Triple Wave Epidemic: Supply and Demand Drivers of the US Opioid Overdose Crisis' (2019) 71 (September) *International Journal of Drug Policy* 183.

specifically, none address the growing threat of highly potent synthetic opioids like fentanyl and nitazenes.[17]

There have been positive outcomes resulting from the *National Foetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan*, such as the development of a national FASD awareness campaign[18] and the introduction of pregnancy warning labels on alcohol products,[19] which were listed actions in the plan. This example shows the benefit of supporting action/implementation plans with clear actions and dedicated resourcing (see section 3.1.4).

3.1.3. Imbalance of investment across the Strategy's pillars

The National Drug Strategy places equal emphasis on the three pillars of supply, demand, and harm reduction, however, investment in the initiatives is unevenly spread. Almost two thirds (64.3%) of the total combined drug budget across all Australian jurisdictions is spent on law enforcement (i.e., supply reduction). Less than a third is spent on treatment (27.4%) and 6.7% on prevention (i.e., demand reduction). And only 1.6% on harm reduction.[20]

Recommendations 2 and 3 of the *Inquiry into Australia's illicit drug problem: Challenges and opportunities for law enforcement* call for the Australian Government to review resourcing for the three pillars of the Strategy in consultation with state and territory governments, and to consider increasing investment in demand and harm reduction measures should the relative difference in investment still be substantial.

3.1.4. The importance of national agreement and state/territory buy-in

The "national direction, jurisdictional implementation" approach repeated throughout national AOD strategies results in an ad hoc, uncoordinated approach to investment in different initiatives (see section 4.1) that limits learning and the adoption of evidence-based policy and practice. A nationally coordinated approach requires all jurisdictions to collaborate more closely to plan action in ways that meet local needs while working toward nationally agreed goals, outcomes, and targets. This could be achieved by linking updated national AOD strategies and associated implementation plans into agreements, such as:

- an expanded whole of health National Health Reform Agreement as recommended by the Huxtable review (see sections 4.1.3 and 4.2.1);
- updated bilateral mental health agreements between the Commonwealth and each state and territory (see section 4.1.4);

[17] Victorian Alcohol and Drug Association (VAADA), 'Victoria Needs a Potent Synthetic Opioids Plan' (Media Release, 8 July 2024) <https://www.vaada.org.au/vaada-and-harm-reduction-victoria-press-release-victoria-needs-a-potent-synthetic-opioids- plan/>.
[18] 'National FASD Program', *Foundation for Alcohol Research and Education* (Web Page, 2024) <https://fare.org.au/fasd-program/>.
[19] 'Together We Won a Long-Fought Campaign to See Mandatory, Visible Pregnancy Health Warnings on All Alcohol Products in Australia and New Zealand', *Foundation for Alcohol Research and Education* (Web Page) <https://fare.org.au/labelling-campaign/>.
[20] Ritter et al (n 8).

- establishing standalone bilateral AOD agreements between the Commonwealth and each state and territory (see section 4.1.4); or
- a national AOD agreement with jurisdictional implementation plans, such as occurs for Closing the Gap arrangements (see section 4.1.5).

Formal agreements ensure buy-in from stakeholders through shared investment and clearly outline Commonwealth and state/territory government responsibilities, which are often blurred in our federated system of government.

Whatever form they take, future AOD strategies should work to reduce stigma and discrimination (see section 3.2), invest in prevention, treatment and harm reduction to reduce AOD harms (see section 3.3), grow the workforce so it can deliver now and into the future (see section 3.4), and use research and data to improve treatment and service/system planning and outcomes (see section 3.5).

3.2. Reduce stigma and discrimination

3.2.1. Types and impact of stigma

Addiction is one of the most stigmatised health conditions globally, with stigma occurring at three levels:

- **Self / internalised stigma** refers to the negative thoughts and feelings people have about themselves when they identify with a stigmatised group, which can manifest in feelings of unworthiness or embarrassment.[21]
- **Public / social stigma** describes stereotypes and negative attitudes held by others that lead to prejudice and discrimination towards a stigmatised person or group.
- **Structural / institutional stigma** occurs at the macro level and is experienced through the enactment of rules, policies, and practices that negatively affect or constrain the opportunities and resources of the stigmatised person or group, such as by limiting access to healthcare.[22]

Examples of structural stigma include the inequitable allocation of resources for demand and harm reduction, which results in Australians facing greater barriers to accessing appropriate care for AOD harms than they do for other health needs, despite its prevalence and societal impact. Unlike other areas of health, stigma often restricts consumer involvement in policy and program development, while language written into policies can uphold discriminatory practices and legitimise unfair treatment and restrictive treatment policies (e.g., reluctance to provide Opiate Agonist Treatment [OAT] within many health and custodial settings). Institutional and government policies and funding that result in a lack of

[21] Ali Cheetham et al, 'The Impact of Stigma on People with Opioid Use Disorder, Opioid Treatment, and Policy' (2022) 13 (January) *Substance Abuse and Rehabilitation* 1, 2 <https://doi.org/10.2147/SAR.S304566>.
[22] Ibid; Mark Hatzenbuehler, 'Structural Stigma and Health' in Brenda Major, John Dovidio and Bruce Link (eds), *The Oxford Handbook of Stigma, Discrimination, and Health* (Oxford University Press, 2018) 105, 106.

coordination between AOD and other health services also reinforce stigma by fragmenting care, as well as limiting opportunities to expand the availability of evidence-based treatment options.

It is therefore not surprising that the high rates of stigma and discrimination experienced by people living with AOD-related harms negatively impacts their quality of life and opportunities, and delays help-seeking due to shame and fear of judgement. For example, the median time to first seek help for an alcohol use disorder is an astonishing 18 years.[23] The combination of public stigma and existing structural barriers means many individuals do not seek help until they are experiencing acute harms related to their use (e.g., withdrawal complications, infection, injuries, overdose, psychosis). This results in a resource-intensive, costly, and highly inefficient approach to AOD harms that is disproportionately reliant on emergency services, including both ambulance and police. Indeed, in Victoria alone during 2022, research utilising the National Ambulance Surveillance System (NASS) identified more than 50,000 AOD-related ambulance attendances, of which 33% involved police co-attendance.[24] Such presentations also represent a significant proportion of emergency department attendances, as well as hospitalisations including admissions to both intensive care and acute psychiatric beds.

It is also important to highlight that some communities, for example, First Nations and LGBTIQ+ communities, are disproportionately impacted by AOD harms because they experience multiple, compounding forms of stigma and discrimination such as racism and homophobia, which further limit timely access to health and support services, as well as opportunities for recovery.

3.2.2. Leverage national mental health strategies and plans to progress AOD initiatives

There is a pressing need for public education and awareness campaigns that tackle addiction-related stigma by using humanising, strengths-based narratives, as well as targeted campaigns that promote social inclusion, the importance of early help-seeking, and the effectiveness of treatment. Anti-stigma campaigns have been used internationally to tackle mental health-related stigma and have proven highly cost-effective.[25]

Embedding addiction medical and nursing specialist teams in hospitals,[26] and expanding primary care and hospital-based pharmacotherapy delivery through initiatives such as prescriber education and low-threshold opioid pharmacotherapy initiation in hospital

[23] Chapman et al (n 4).
[24] Turning Point, *National Ambulance Surveillance System* (Data Set, 2022).
[25] Rebecca Collins et al, 'Social Marketing of Mental Health Treatment California's Mental Illness Stigma Reduction Campaign' (2019) 109(53) *American Journal of Public Health* s228, s230; Sara Evans-Lacko et al, 'Economic Evaluation of the Anti-Stigma Social Marketing Campaign in England 2009–2011' (2013) 202(55) *The British Journal of Psychiatry* s95, s99.
[26] Suzanne Nielsen and Dan Lubman, 'Time to Address Addiction Treatment Inequality in Hospital Settings' (2022) 7(1) *The Lancet Public Health* e6, e6.

emergency departments, may also help to normalise appropriate care and reduce experiences of stigma within such service settings.[27]

In 2020, the National Mental Health Commission began developing a *National Stigma and Discrimination Reduction Strategy*. As part of this process, the Commission held public consultation and engaged people with lived experience of mental illness (including those with addiction), trauma, distress, or suicidality, as well as families, carers and support people, other stakeholders in the sector, and the broader community. The final *National Stigma and Discrimination Reduction Strategy,* delivered to the government in June 2023, is yet to be made publicly available,[28] however it provides one possible avenue for developing initiatives and targets to address addiction-related stigma.

Tragically, 7784 Australians have died by alcohol and drug-induced suicide between 2002 and 2022.[29] The *National Suicide Prevention Strategy for Australia's Health System: 2020–2023* notes that "suicide prevention is also more effective when integrated with broader, cross-sectoral responses that address the social and cultural determinants of poor health and wellbeing, including… alcohol and other drug misuse."[30] Importantly, the risk of suicidal behaviour is particularly elevated in those diagnosed with an alcohol or drug use disorder; conditions which were responsible for almost one-fifth of global suicide-related disability-adjusted life years in 2010, with alcohol use disorders alone accounting for 13.3% of this burden[31] and associated with a 223% increase in suicide risk.[32]

In addition to leveraging national mental health strategies and plans to progress AOD initiatives that reduce stigma and promote help-seeking, consideration could also be given to how measures to reduce stigma and improve quality of life could be incorporated into national AOD strategies. Stigma reduction and quality of life improvement targets have been used successfully in strategies that address other highly stigmatised conditions such as HIV (e.g., the PozQol indicator),[33] however, there is a need to first develop and validate a stigma indicator to track reductions in experiences of AOD-related stigma over time, and to adopt a nationally consistent approach to AOD quality of life (and other) data collection (see section 3.5.2).

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[27] Cheetham et al (n 21).
[28] 'National Stigma and Discrimination Reduction Strategy', *National Mental Health Commission* (Web Page, 26 August 2024) <https://www.mentalhealthcommission.gov.au/projects/stigma-and-discrimination-reduction-strategy>.
[29] *Australia's Annual Overdose Report* (n 2) 26.
[30] Department of Health and Aged Care, *National Suicide Prevention Strategy for Australia's Health System: 2020–2023* (Strategy, 30 June 2020) 7 <https://www.health.gov.au/resources/publications/national-suicide-prevention-strategy-for- australias-health-system-2020-2023?language=en>.
[31] Alize Ferrari et al, The Burden Attributable to Mental and Substance Use Disorders as Risk Factors for Suicide: Findings From the Global Burden of Disease Study 2010' (2014) 9(4) *PLoS ONE* e91936, e91936.
[32] Jason Isaacs et al, 'Alcohol Use and Death by Suicide: A Meta-Analysis of 33 Studies' (2022) 52(4) *Suicide and Life-Threatening Behavior* 600, 607.
[33] 'About PozQol', *PozQol* (Web Page, 22 July 2024) <https://www.pozqol.org/about-pozqol/>.

3.3. Invest in prevention, treatment, and harm reduction to reduce AOD harms

3.3.1. Opportunities to prevent AOD harms and intervene earlier

Alcohol is a harmful, addictive product responsible for more than 3,500 cancer cases in Australia each year,[34] yet many Australians remain unaware of the link between alcohol and cancer.[35] Alcohol use is also associated with family violence (see section 3.5.6), increased risk of suicide,[36] unintentional drownings,[37] and it is a leading cause of fatal road crashes.[38] Despite the significant harms associated with alcohol products, their relatively loose regulation coupled with the normalisation of heavy drinking in Australian culture, remains a recipe for increasing alcohol harms. In light of a recent commitment from all states and territories to strengthen their liquor laws and regulations to address alcohol-involved family violence, it would be timely for the Committee to recommend the consistent, Australia-wide adoption of evidence-based measures known to prevent and minimise alcohol harms, such as:

- Delayed dispatch of home deliveries by remote sellers of alcohol and limits on delivery hours, to reduce rapid and late night deliveries that are known to be a key driver of alcohol-involved assaults, family violence, and suicide.[39]
- Requiring Responsible Service of Alcohol training on responding to sexual harassment.
- Limits on licensee trading hours and density, as late night trading and high licence density are associated with increased alcohol harms.[40]
- Strengthened advertising and marketing standards that 1) prohibit excessive alcohol discounts by retailers, as well as inducements such as the sale of alcohol being linked with any benefit, coupon, voucher, or reward scheme, and 2) limit the exposure of children and young people to alcohol advertising through social media and physical media such as billboards and bus shelter advertising.[41]

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[34] 'Alcohol and Cancer', *Cancer Council Australia* (Web Page, 2018) <https://www.cancercouncil.com.au/1in3cancers/lifestyle-choices-and-cancer/alcohol-and-cancer/>.
[35] Foundation for Alcohol research and Education (FARE), *Annual Alcohol Poll: Attitudes and Behaviours* (Report, 2020) 22 <https://fare.org.au/wp-content/uploads/ALCPOLL-2020.pdf>.
[36] Isaacs et al (n 32).
[37] Tuulia Pajunen et al, 'Unintentional Drowning: Role of Medicinal Drugs and Alcohol' (2017) 17(388) *BMC Public Health* 1, 1.
[38] Lisa Wundersitz and Simon Raftery, *Understanding the Context of Alcohol Consumption Before Driving For Crash-Involved Drivers* (Case Report, No 129, November 2019) 14 <https://casr.adelaide.edu.au/casrpubfile/2080/CASR129.pdf>.
[39] 'Dangerous Practices of On-Demand Alcohol Delivery Companies Place Victorian Children and Vulnerable People at Risk of Harm', *Alcohol Change Vic* (Web Report, 2021) <https://www.alcoholchangevic.org.au/our-work/research>; Suzanne Briscoe and Neil Donnelly, *Temporal and Regional Aspects of Alcohol-Related Violence and Disorder* (Alcohol Studies Bulletin, No 1, May 2001) <https://www.ojp.gov/ncjrs/virtual-library/abstracts/temporal-and-regional-aspects-alcohol-related-violence-and- disorder>; Shane Darke, Johan Duflou and Michelle Torok, 'Toxicology and Circumstances of Completed Suicide By Means Other Than Overdose' (2009) 54(2) *Journal of Forensic Science* 490; Shane Darke et al, 'Characteristics, Circumstances and Toxicology of Sudden or Unnatural Deaths Involving Very High-Range Alcohol Concentrations' (2013) 108(8) *Addiction* 1411.
[40] Claire Wilkinson, Michael Livingston and Robin Room, 'Impacts of Changes to Trading Hours of Liquor Licences on Alcohol-Related Harm: A Systematic Review' (2016) 26(4) *Public Health Research & Practice* 1, 4; Debbie Scott et al, 'Alcohol Accessibility and Family Violence-Related Ambulance Attendances' (2021) 37(13-14) *Journal of Interpersonal Violence* NP10661.
[41] Alcohol Change Vic, *Harmful Advertising and Promotions of Alcoholic Products* (Position Paper, 23 March 2023) 6 <https://www.alcoholchangevic.org.au/our-work/position-statements/harmful-advertising-and-promotions-of-alcoholic-products>.

- Minimum unit pricing, which is supported by the World Health Organisation,[42] and was implemented in the Northern Territory in 2018 – where it resulted in a 50% reduction in per capita consumption of cheap cask wine in the year after its introduction,[43] while also having no negative impact on the Northern Territory alcohol industry or economy.[44]
- Improving the uptake and use of alcohol screening tools and effective brief interventions for alcohol harms, as well as pharmacotherapies for alcohol dependence within primary care through funding for GP AOD training placements, and improving pathways and access to AOD services and addiction medical specialist support.[45]

School education prepares young people for healthy, fulfilling adult lives, with comprehensive drug education a key component of the school curriculum. Effective drug education assists students to understand AOD harms and complexities around substance use, as well as the influence of societal attitudes, social media, and peers, and the importance of assertive communication, help-seeking, and values that promote health and safety. The *Principles for School Drug Education* provides a broad conceptual tool to inform the planning, implementation, and review of school drug education programs, policies, and practices.[46] The Principles were last updated in 2004, and Turning Point is currently leading a consortium of key prevention, education, and addiction experts in updating these guidelines for NSW Health. Preliminary consultations with teachers and schools have identified that the previous *Principles* are neither widely known nor utilised, and that schools would welcome greater guidance and support to identify and implement evidence-based programs. Investment is needed to scale the updated *Principles* so they have national reach, including resources to support schools to deliver effective drug education across the country.

There is a robust literature highlighting the importance of early intervention programs that reduce the number of young people who progress to regular or harmful use, and support those currently using to reduce risky patterns of use and seek help early.[47] However, young people are often reluctant to seek help, preferring to rely on informal sources of support such as peers, over formal sources such as health professionals. Indeed, our research has found adolescents are often reluctant to seek professional help for AOD harms, and also

[42] World Health Organization Regional Office for Europe, *No Place for Cheap Alcohol: The Potential Value of Minimum Pricing for Protecting Lives* (Report, 20 June 2022) 9 <https://www.who.int/europe/publications/i/item/9789289058094>.
[43] Nicholas Taylor et al, 'The Impact of a Minimum Unit Price on Whole-Sale Alcohol Supply Trends in the Northern Territory, Australia' (2021) 45(1) *Australian and New Zealand Journal of Public Health* 26, 26, 29.
[44] Yarning and Frontier Economics, *Evaluation of Minimum Unit Price of Alcohol in the Northern Territory* (Report, 6 July 2022) 13-14 <https://health.nt.gov.au/__data/assets/pdf_file/0010/1146448/evaluation-mup-alcohol-nt.pdf>.
[45] Amy Pennay, Dan Lubman and Matthew Frei, 'Alcohol: Prevention, Policy and Primary Care Responses' (2014) 43(6) *Australian Family Physician* 356, 359.
[46] Lois Meyer and Helen Cahill, *Principles for School Drug Education* (Report, 2004) <https://apo.org.au/node/33720>.
[47] Dan Lubman et al, 'Intervening Early to Reduce Developmentally Harmful Substance Use Amongst Youth Populations' (2007) 187(S7). *Medical Journal of Australia* S22.

lack the necessary knowledge, confidence, and skills to effectively intervene with their peers.[48] As such, there is an urgent need for accessible, sustainable, and evidence-based school programs such as MAKINGtheLINK,[49] that build adolescents' substance use literacy and help-seeking skills, as well as their confidence and capacity to support their peers.

3.3.2. Improve access to treatment and support services

Roughly 500,000 Australians who need help for an alcohol or other drug use disorder don't receive care due to access issues or fear of judgement.[50] While AOD treatment demand has increased by 27% over the last decade (from 171,093 treatment episodes in 2013-14, to 217,303 in 2022-23),[51] we know many Australians are not seeking help early due to stigma and misconceptions about the effectiveness and availability of treatment. At the same time, presentations to emergency services and other parts of the health system for AOD harms and complications are substantial. To meet this growing demand for AOD treatment, care, and support, a more balanced approach to investment across the Strategy's pillars (see section 3.1.3) and investment mechanisms to support a sustainable AOD service system are needed (see section 4).

Stigma hinders opportunities for early intervention across the health system. Research has consistently found low rates of screening for AOD harms within primary care due to a range of systemic barriers,[52] while a recent review of Headspace, which is ideally placed to offer early intervention for young people presenting with mental health and/or AOD concerns, found AOD services made up less than 1% of Headspace services delivered.[53]

When people do seek help, they often present with complex needs and/or physical or mental health comorbidities. For example, the association between trauma and substance use is well known,[54] with the prevalence of co-occurring substance use and post-traumatic stress disorder estimated to be between 25–49%.[55] Limited capacity to deliver holistic care, especially in terms of embedded mental health and medical expertise, can lead to many people bouncing between services, or having to travel long distances to access care if they

[48] Dan Lubman et al, 'Australian Adolescents' Attitudes and Help-Seeking Intentions Towards Peers Experiencing Symptoms of Depression and Alcohol Misuse' (2017) 17 (August) *BMC Public Health* 1, 4-6.
[49] Dan Lubman et al, 'Twelve-Month Outcomes of MAKINGtheLINK: A Cluster Randomized Controlled Trial of a School-Based Program to Facilitate Help-Seeking for Substance Use and Mental Health Problems' (2020) 18 (January) *EClinicalMedicine* 1.
[50] Alison Ritter, Jenny Chalmers and Maria Gomez, 'Measuring Unmet Demand for Alcohol and Other Drug Treatment: The Application of an Australian Population-Based Planning Model' [2019] (18) *Journal of Studies on Alcohol and Drugs, Supplement* 42, 47.
[51] 'Alcohol and Other Drug Treatment Services in Australia: Early Insights', *Australian Institute of Health and Welfare* (Web Report, 16 April 2024) Figure AODTS PDOC.1 <https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol- other-drug-treatment-services-aus/contents/key-findings/drugs-of-concern>.
[52] Pennay, Lubman and Frei (n 45).
[53] KPMG, *Evaluation of the National Headspace Program* (Report, June 2022) 71 <https://www.health.gov.au/resources/publications/evaluation-of-the-national-headspace-program?language=en>.
[54] Kathleen Brady, Sudie Back and Scott Coffey, 'Substance Use and Posttraumatic Stress Disorder' (2004) 13(5) *Current Directions in Psychological Science* 206.
[55] Michel Bonin et al, 'Drinking Away the Hurt: The Nature and Prevalence of PTSD in Substance Abuse Patients Attending a Community-Based Treatment Program' (2000) 31(1) *Journal of Behavior Therapy and Experimental Psychiatry* 55, 60; Martin Driessen et al, 'Trauma and PTSD in Patients with Alcohol, Drug, or Dual Dependence: A Multi–Center Study' (2008) 32(3) *Alcoholism: Clinical and Experimental Research* 481, 484; Nele Gielen et al, 'Prevalence of Post-Traumatic Stress Disorder Among Patients With Substance Use Disorder: It is Higher Than Clinicians Think It Is' (2012) 3(1) *European Journal of Psychotraumatology* 1, 5.

are from rural and remote areas. Even in urban settings, funding constraints and long waiting lists limit the availability of addiction treatment. In Victoria alone, data collected in June 2024 shows more than 4600 people are on a waiting list for AOD treatment on any given day, a 93% increase compared to waitlist numbers in September 2020.[56]

The often siloed nature of AOD service delivery within the health system and fragmented patient pathways has resulted in a growing focus on models that address these limitations and improve continuity of care.[57] These include the need to fund "stepped care models (in which the least intrusive and costly treatment likely to be effective is used initially, with progressively more intensive treatment used if this approach is insufficient in obtaining a positive outcome), integrated care models (in which AOD services are coordinated horizontally, such as between withdrawal services, counselling and residential rehabilitation, and vertically, through different levels of health care), and care coordination (i.e., the coordinated delivery of individual services across multiple sectors)."[58] Delivering a more coordinated, integrated system requires greater investment in data-driven AOD service planning (see section 3.5.3), workforce capacity (see section 3.4), and a whole of health approach to service investment (see section 4.2.1).

Funding for Australia's AOD treatment system is typically focussed on short-term discrete treatment episodes, resulting in those with more complex presentations lacking the continuity of care required to address their needs, which is further exacerbated by limited investment in an experienced addiction specialist (e.g., addiction medical specialists, nurse practitioners, senior allied health clinicians) and peer workforce. Offering person-centred, tailored approaches based on individual needs and preferences increases treatment engagement, retention, and success. It will also lead to greater efficiency in the treatment system, particularly in terms of throughput and access, including reduced treatment drop-out and averted readmissions.

Australia's national outcome studies demonstrate that treatment is effective,[59] but we are yet to fully understand what works, when, and for whom. A national routine outcome monitoring program would enable these insights to be realised, leading to clearly defined treatment pathways and models of care (see section 3.5.2). Further investment in research is also needed to optimise integrated AOD treatment pathways across the health system as

[56] Victorian Alcohol and Drug Association (VAADA), 'Treatment Delayed is Treatment Denied' (Press Release, 25 September 2024) <https://www.vaada.org.au/treatment-delayed-is-treatment-denied/>.
[57] Dan Lubman, Victoria Manning and Ali Cheetham, *Informing Alcohol and Other Drug Service Planning in Victoria* (Report, 2 May 2017) 63 <https://www.turningpoint.org.au/research/impact/service-planning>.
[58] Ibid.
[59] Christina Marel et al, 'Patterns and Predictors of Heroin Use, Remission, and Psychiatric Health Among People with Heroin Dependence: Key Findings from the 18–20-Year Follow-Up of the Australian Treatment Outcome Study (ATOS)' (2023) *International Journal of Mental Health and Addiction* (advance); Rebecca McKetin et al, 'Treatment Outcomes For Methamphetamine Users Receiving Outpatient Counselling From the Stimulant Treatment Program in Australia' (2013) 32(1) *Drug and Alcohol Review* 80, 83; Victoria Manning et al, 'Substance Use Outcomes Following Treatment: Findings from the Australian Patient Pathways Study' (2017) 51(2) *Australian & New Zealand Journal of Psychiatry* 177, 181.

well as the development of innovative treatment options (see section 3.5.4).

There is also a need to ensure recovery pathways are in place and people are adequately supported to engage with treatment and peer support. People experiencing addiction are more likely to experience insecure housing, homelessness, social isolation, and other forms of disadvantage.[60] The *National AOD Strategy* recognises that AOD-related harms cut across health, social, and economic domains, and are associated with social determinants of health including discrimination, unemployment, homelessness, poverty, and family breakdown. To this end, it recognises the need to work collaboratively with agencies responsible for AOD policy and service delivery. However, investment in programs that meet the social determinants of health and provide wraparound support, like investment in treatment services, currently suffers from an ad hoc, uncoordinated approach (see section 4.1), meaning Australians receive different levels of treatment and support based on where they live rather than their levels of need.

Finally, the criminalisation of the possession and use of certain drugs also means that instead of receiving help and support, many people experiencing drug-related harms are met with legal sanctions. A criminal record makes it difficult to find employment,[61] limiting and delaying opportunities for recovery. Moreover, while 33% of people are homeless upon entry to prison, 54% of people expect to be homeless upon being released from prison.[62] Australia needs a health-led approach to AOD harms that addresses social determinants of health and limits unnecessary engagement with the criminal justice system by: (i) decriminalising the personal possession and use of small quantities of all illicit drugs by either removing criminal penalties from the law or replacing them with civil penalties or administrative sanctions; and (ii) harmonising and expanding access to diversion programs so they are accessible and consistent across all Australian jurisdictions.[63]

3.3.3. Re-establish Australia as a global leader in harm reduction

Australia was a world leader in the 1980s, with the adoption of "harm minimisation" as its official national drug policy, the rollout of needle and syringe programs, regular national campaigns and surveys, and the establishment of a Ministerial Council on Drugs.[64] There is now a wealth of international evidence that encompasses a broad range of cost-effective,

[60] Christian Schütz, 'Homelessness and Addiction: Causes, Consequences and Interventions' (2016) 3 (July) *Current Treatment Options in Psychiatry* 306, 307; Isabella Ingram et al, 'Loneliness Among People With Substance Use Problems: A Narrative Systematic Review' (2020) 39(5) *Drug and Alcohol Review* 447, 478.
[61] Human Rights and Equal Opportunity Commission, Discrimination in Employment on the Basis of Criminal Record (Discussion Paper, December 2004) 6-7 <https://humanrights.gov.au/our-work/human-rights-discrimination-employment-basis- criminal-record>.
[62] 'The Health of Australia's Prisoners 2018', *Australian Institute of Health and Welfare* (Web Page, 30 May 2019) <https://www.aihw.gov.au/reports/prisoners/health-australia-prisoners-2018/summary>.
[63] Turning Point and the Monash Addiction Research Centre, Submission No 32 to Joint Committee on Law Enforcement, *Australia's Illicit Drug Problem: Challenges and Opportunities for Law Enforcement* (January 2023) 21.
[64] Alex Wodak, 'Australia's Drug Policy Led the World 30 Years Ago. Now Politics Holds Us Back', *The Guardian* (online, 2 April 2015) <https://www.theguardian.com/commentisfree/2015/apr/02/australias-drugs-policy-led-the-world-30-years-ago-now- politics-holds-us-back>.

life-saving harm reduction initiatives, however, without a nationally coordinated approach, there has been inconsistent implementation across the country.

Naloxone is a life-saving medicine that reverses the effects of an opioid overdose. The Australian Government has invested $19.6 million over 4 years from 2022-23 in the take home naloxone program, which makes naloxone available for free, without a prescription at participating pharmacies across Australia.[65] With a federally funded supply and a national system, Australia now has a national naloxone program that would be the envy of many parts of the world. However, the state-based approach to implementation has resulted in some states being further ahead than others.

Overdose prevention services (i.e. medically supervised injecting facilities) are a proven and highly effective harm reduction measure that have been used in Australia and internationally for almost four decades, with more than more than 100 currently operating across Europe and North America.[66] Despite clear evidence indicating medically supervised overdose prevention services save lives, improve public amenity, reduce demand on emergency services, and result in fewer people injecting drugs and discarding needles in public spaces,[67] only two currently operate in Australia, at King's Cross in Sydney and North Richmond in Melbourne.

Drug checking services are a proven and highly cost-effective harm reduction measure that have been used internationally for more than three decades,[68] are supported by a majority of Australians,[69] and result in many people discarding drugs or limiting their use.[70] Results are available in as little as 20 minutes and can indicate the type and strength of substances. Drug checking services are currently only available in the Australian Capital Territory and Queensland, with Victoria in the process of establishing its service.

Opioid agonist treatment (OAT) (with methadone or buprenorphine) is a highly cost-effective intervention that has become more affordable following the Australian Government making these medications available on the Pharmaceutical Benefits Scheme in 2023.[71] However, the *National Guidelines for Medication-Assisted Treatment of Opioid*

[65] 'About the Take Home Naloxone Program', *Department of Health and Aged Care* (Web Page, 23 July 2024) <https://www.health.gov.au/our-work/take-home-naloxone-program/about-the-take-home-naloxone-program>.
[66] Leo Beletsky et al, 'The Global Health and Equity Imperative For Safe Consumption Facilities' (2018) 392(10147) *The Lancet* 553, 553.
[67] Ibid; John Ryan, *Review of the Medically Supervised Injecting Room: Key Findings and Recommendations* (Final Report, 21 February 2023) 12 <https://www.health.vic.gov.au/publications/review-of-the-medically-supervised-injecting-room-2023>; Allison Salmon, John Kaldor and Lisa Maher, *Sydney Medically Supervised Injecting Centre: Evaluation of Service Operation and Overdose-Related Events* (Evaluation Report, No 4, June 2007) 7-8 <https://www.kirby.unsw.edu.au/sites/default/files/documents/EvalRep4SMSIC.pdf>;
[68] Monica Barratt et al, *Global Review of Drug Checking Services Operating in 2017* (Bulletin, 2018) 1 <https://idpc.net/publications/2018/03/global-review-of-drug-checking-services-operating-in-2017>.
[69] 'Alcohol, Tobacco & Other Drugs in Australia', *Australian Institute of Health and Welfare* (Web Report, 23 April 2024) <https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/harm-minimisation/harm-reduction>.
[70] Anna Olsen et al, *CanTEST Health and Drug Checking Service Program Evaluation* (Final Report, 17 July 2023) 42 <https://www.health.act.gov.au/about-our-health-system/population-health/pill-testing>; Fiona Measham and Gavin Turnbull, 'Intentions, Actions and Outcomes: A Follow Up Survey on Harm Reduction Practices After Using and English Festival Drug Checking Service' (2021) 95(September) *International Journal of Drug Policy* 1, 4.
[71] 'Opioid Dependence Treatment Program', *The Pharmaceuticals Benefit Scheme* (Web Page, 1 July 2024) <https://www.pbs.gov.au/browse/section100-md>.

Dependence have not been updated for over a decade,[72] despite the introduction of new long-acting formulations, resulting in differences in OAT implementation and policies across jurisdictions. There also remain significant ongoing issues around the sustainability of OAT delivery due to an ageing workforce and failure to integrate this evidence-based treatment into standard medical practice. Governments need to do more to address the ageing OAT workforce and improve uptake of OAT, in particular in primary care, hospitals, and mental health and pain services. One successful international example of addressing gaps in OAT provision through telehealth is the *Virtual Opioid Dependency Program* in Alberta, Canada that supports people to commence pharmacotherapy for opioids within 24 hours.[73]

There is also a need to improve access to OAT and naloxone in custodial settings and post-release,[74] with the risk of overdose particularly high in the weeks following release.[75] A recent meta-analysis found alcohol and drug poisoning to be the leading cause of death among recently released prisoners worldwide,[76] while an Australian study that tracked 400 people released from Victorian prisons found 27 (6.8%) died of fatal overdose and a further 47 (12%) experienced a total of 70 non-fatal overdose incidents.[77]

3.4. Grow the workforce so it can deliver now and into the future

3.4.1. National AOD Workforce Development Strategy

The *National AOD Workforce Development Strategy 2015-2018* was "developed to support the National Drug Strategy at the request of the Intergovernmental Committee on Drugs in recognition of the need for a national focus on workforce development activities for the AOD workforce. The Strategy development process was guided by a Project Working Group appointed by the Intergovernmental Committee on Drugs. It followed an extensive consultation process involving forums held in each jurisdiction, a written submission process and key informant interviews."[78]

[72] Linda Gowing et al, *National Guidelines for Medication-Assisted Treatment of Opioid Dependence* (Guidelines, April 2014) <https://www.health.gov.au/resources/publications/national-guidelines-for-medication-assisted-treatment-of-opioid-dependence?language=en>.
[73] 'Addiction and Mental Health - Virtual Opioid Dependency Program', *Alberta Health Services* (Web Page) <https://www.albertahealthservices.ca/findhealth/Service.aspx?id=1078559&serviceAtFacilityID=1122401#>.
[74] Australian Alcohol & Other Drugs Council (AADC), 'Recent Overdose Deaths Raise Fears For People in Prison – Naloxone Must Be Made Available to Save Lives' (Media Release, 15 July 2024) <https://aadc.org.au/media-releases/>.
[75] Elizabeth Merrall et al, 'Meta-Analysis of Drug-Related Deaths Soon After Release From Prison' (2010) 105(9) *Addiction* 1545, 1549.
[76] Rohan Borschmann and Stuart Kinner, 'Rates and Causes of Death After release from incarceration among 1 471 526 people in eight high-income and Middle-Income Countries: An Individual Participant Data Meta-Analysis' (2024) 403(10438) *The Lancet* 1779, 1784.
[77] Michael Curtis et al, 'Non-Fatal Opioid Overdose After Release From Prison Among Men Who Injected Drugs Prior to Their Imprisonment: A Prospective Data Linkage Study' (2022) 218(2) *The Medical Journal of Australia* 94, 94.
[78] Intergovernmental Committee on Drugs, *National Alcohol and Other Drug Workforce Development Strategy 2015-2018* (Strategy, July 2014) iv <https://www.health.gov.au/resources/publications/national-alcohol-and-other-drug-workforce- development-strategy-2015-2018?language=en>.

The Strategy had two goals:

- To enhance the capacity of the Australian AOD workforce to prevent and minimise alcohol and other drug-related harm across the domains of supply, demand, and harm reduction activities.
- To create a sustainable Australian AOD workforce that is capable of meeting future challenges, innovation, and reform.

The Strategy also had twelve outcomes and proposed a range of suggested actions under the heading "actions could include." The lack of state and territory buy-in, however, meant that many of these actions were never implemented.

The need for national coordination of the AOD workforce has not subsided in the years since the national workforce strategy lapsed. Indeed, the goals and many of the outcomes of the workforce strategy remain unrealised, and the need to work toward them has arguably never been greater.

The *National AOD Workforce Development Strategy* needs to be renewed, and consideration given to mechanisms that could ensure national coordination and buy-in from all jurisdictions (see section 3.1.4). This could potentially include linking it to a new workforce Schedule under the National Health Reform Agreement (see section 4.2.4).

3.4.2. Workforce capacity and capability

The *National AOD Workforce Development Strategy* warned several years ago that "as a result of an ageing population, demand for workers in health care and social assistance in Australia will outstrip all other sectors over the next few years, which will increase pressure on AOD services to attract and retain suitable staff [and that this] will be particularly relevant for medical practitioners and nurses."[79] It also noted significant jurisdictional differences in workforce profiles between government and non-government organisations, partly due to "alternative service delivery models, different funding levels and different client groups;"[80] and significant disparities between wages and conditions offered by public sector and NGO agencies, with NGO employees generally paid considerably less as a result of different funding arrangements and awards.[81]

Under the current funding context (see section 4.1) AOD services continue to experience recruitment and retention challenges,[82] stretching the AOD service system and leaving

[79] *National Alcohol and Other Drug Workforce Development Strategy* (n 78) 12-13.
[80] Ibid 12; Ann Roche and Ken Pidd, *Alcohol and Other Drugs Workforce Development Issues and Imperatives: Setting the Scene* (Report, 2010) <https://www.drugsandalcohol.ie/18264/>.
[81] Roche and Pidd (n 80) 7.
[82] Kylie Bailey et al, *Workforce Recruitment and Retention: Alcohol and Other Drug Services* (Rapid Review, October 2019) 21 <https://www.saxinstitute.org.au/wp-content/uploads/20.11_-Workforce-recruitment-and-retention-alcohol-and-other-drug-services.pdf>.

people waiting longer for treatment.[83] It is therefore imperative to ensure that the AOD workforce is sustainable by supporting appropriate training pathways as well as addressing barriers to retention, including funding to support a career pathway in the AOD sector (AOD contracts typically fail to fund a specialist workforce comparable to other areas of health). Delays in help-seeking mean that when many people do eventually seek help they can be more complex to treat. However, limited data-driven planning (see section 3.5.3) and under-investment in the AOD workforce (see section 4.2.4) means the pipeline, capacity, and retention of addiction medical specialists and senior AOD nursing and allied health practitioners is not sufficient to meet demand for the resulting care needs.

Given the prevalence of AOD harms it is also essential to build the capability of the generalist health workforce,[84] which should include ensuring undergraduate and postgraduate curricula in the health disciplines provide a firm foundation of addiction knowledge and skills. In addition, the *National AOD Workforce Development Strategy* identified the need to improve "linkages and coordination between AOD services and other specialist, primary care, and welfare services to enhance the capacity of generalist workers to identify, intervene, and refer individuals experiencing AOD harm."[85]

The emerging lived experience workforce also needs to be supported through nationally accredited peer worker training. The Certificate IV in Mental Health Peer Work is a nationally recognised mental health qualification designed for people with lived experience of mental health conditions, but there is no equivalent nationally recognised vocational education training dedicated to AOD peer work. Peer workers support complex clients with a range of needs and would benefit from more formal training that helps them better understand and respond to these complexities while ensuring their own physical and mental wellbeing.

3.5. Use research and data to improve treatment and service/system planning

Despite a range of AOD research and data collection initiatives (see section 3.5.1), there remains a lack of treatment and health outcomes data, meaning there are no nationally consistent treatment outcomes to enable benchmarking of patient outcomes (see section 3.5.2), and a lack of data-driven service planning (see section 3.5.3). There also remains a need for greater investment in research to develop AOD treatment options (see section 3.5.4), and to bridge gaps in AOD harms data (see sections 3.5.5 and 3.5.6).

[83] For example, the Victorian Alcohol and Drug Associated (VAADA) estimated that the AOD workforce in Victoria would need an additional 243 EFT workers to meet current demand for services. Mental Health Victoria, *Strategy, Stability, Support Submission to the Victorian State Budget 2023–2024 Government* (Budget Submission, December 2022) 28 <https://www.mhvic.org.au/images/MHV-003-Budget_RGB_v2.pdf>.
[84] *National Alcohol and Other Drug Workforce Development Strategy* (n 78) 4.
[85] Ibid 27.

3.5.1. Current AOD data collection and research initiatives

Australia collects AOD-related data through a range of initiatives, including:

- The National Drug Strategy Household Survey collects self-reported information on alcohol, tobacco, and illicit drug use among the general population and also captures people's attitudes and perceptions in relation to these drugs. It is conducted approximately every three years.[86]
- The Australian Institute of Health and Welfare maintains the Alcohol and Other Drug Treatment Services National Minimum Data Set, which tracks all publicly funded AOD treatment services (including Primary Health Network-commissioned services) that have reported, across Australia's 31 PHNs.[87]
- The Australian Institute of Health and Welfare also reports on the National Ambulance Surveillance System, a world-first public health monitoring system that monitors trends in AOD ambulance attendances across Australia.[88]
- The Australian Criminal Intelligence Commission publishes annual illicit drug data reports on drug use, arrests, and seizures.
- The National Wastewater Drug Monitoring Program collects wastewater samples every two months in capital city sites and every four months in regional sites to acquire population level data on the use of 13 illicit and licit drugs.[89]
- The Illicit Drug Reporting System[90] and Ecstasy and Related Drugs Reporting System[91] collects self-reported information on drug use and related harms annually from individuals in Australian capital cities who regularly inject drugs or who use ecstasy and other stimulants.
- The Drug Use Monitoring in Australia program collects quarterly criminal justice and drug use information from police detainees through interviewer-assisted self-report surveys and voluntarily provided urine samples that are tested for licit and illicit substances.[92]

Australia is a recognised global leader in AOD research despite its small population and relatively modest research budget. There are major clinical, epidemiological, and social research groups across the country largely funded through nationally competitive grants. There are also currently five Commonwealth funded national centres across four

[86] 'National Drug Strategy Household Survey', *Australian Institute of Health and Welfare* (Web Page, 20 July 2022) <https://www.aihw.gov.au/about-our-data/our-data-collections/national-drug-strategy-household-survey>.
[87] 'Alcohol and Other Drug Treatment Map, 2018–19 to 2022–23', *Australian Institute of Health and Welfare* (Web Page) <https://maps.arcgis.aihw.gov.au/portal/apps/dashboards/dad5fb08627e448093aeac6f5bde0b5e>.
[88] Dan Lubman et al, 'The National Ambulance Surveillance System: A Novel Method For Monitoring Acute Alcohol, Illicit and Pharmaceutical Drug Related-Harms Using Coded Australian Ambulance Clinical Records' (2020) 15(1) *PLoS ONE* 1.
[89] 'National Wastewater Drug Monitoring Program Reports', *Australian Criminal Intelligence Commission* (Web Page, 26 October 2022) <https://www.acic.gov.au/publications/national-wastewater-drug-monitoring-program-reports>.
[90] 'The Illicit Drug Reporting System (IDRS)', *National Drug & Alcohol Research Centre* (Web Page, 2022) <https://ndarc.med.unsw.edu.au/project/illicit-drug-reporting-system-idrs>.
[91] 'The Ecstasy and Related Drugs Reporting System (EDRS)', *National Drug & Alcohol Research Centre* (Web Page, 2022) <https://ndarc.med.unsw.edu.au/project/ecstasy-and-related-drugs-reporting-system-edrs>.
[92] 'Drug Use', *Australian Institute of Criminology* (Web Page, 2022) <https://www.aic.gov.au/statistics/drug-use>.

jurisdictions (i.e., the National Drug Research Institute (WA), National Centre for Education and Training on Addiction (SA), National Drug and Alcohol Research Centre (NSW), National Clinical Centre for Research on Emerging Drugs (Consortium of St Vincent's plus NDRI, NCETA and NDARC), and the National Centre for Youth Substance Use Research (QLD)). The inquiry presents an opportunity to further boost Australia's international AOD research reputation and impact by reviewing the mix and composition of the current national centres, including their scope, geographic coverage, and coordination, to fully maximise research and translational outcomes, collaboration, and capability across the country.

3.5.2. Lack of treatment and health outcomes data

Of Australia's five national AOD research centres, none currently have research activity focussed on optimising treatment and recovery or reducing harms across the health system. Australia lacks national-level AOD treatment and health outcomes data, including longitudinal data, to guide best practice care, and monitor and improve treatment outcomes. The absence of such data means that policymakers and healthcare providers lack critical insights into the trajectories and associated outcomes of people with AOD harms. This includes understanding how and when individuals are most likely to seek help, the barriers they face in accessing treatment, and critical points at which early intervention could be most effective. Without this information, efforts to improve service delivery and reduce the burden on acute care systems are severely limited.

NSW has introduced a routine outcome monitoring system (NADABase) for the Network of Alcohol and other Drugs Agencies (NADA) members, which provides comprehensive client data collection and reporting, including outcomes data.[93] This secure online client treatment system can be used to inform benchmarking, practice, and decision-making at the organisational level, and is available for research purposes to indicate treatment effectiveness.[94] NADAbase includes national and state minimum datasets and client outcomes measures, including the Australian Treatment Outcomes Profile (ATOP), which has been designed to be incorporated into routine clinical care in AOD treatment settings.[95] The ATOP has been an integrated component of the electronic medical records of government AOD services in NSW since June 2016.[96]

3.5.3. Progress toward data-driven service planning

In 2009, the Inter-Governmental Committee on Drugs provided funding to develop a national population-based model for AOD service planning.[97] The subsequent development

[93] "What We Do', *Network of Alcohol and Other Drug Agencies* (Web Page) <https://nada.org.au/about/what-we-do/nadabase/>.
[94] Peter Kelly et al, 'Routine Outcome Measurement in Specialist Non-Government Alcohol and Other Drug Treatment Services: Establishing Effectiveness Indicators for the NADAbase' (2021) 40(4) *Drug and Alcohol Review* 540, 541.
[95] 'Australian Treatment Outcomes Profile', *South Eastern Sydney Local Health District* (Web Page) <https://www.seslhd.health.nsw.gov.au/australian-treatment-outcomes-profile>.
[96] Emma Black et al, 'Substance Use, Socio-Demographic Characteristics, and Self-Rated Health of People Seeking Alcohol and Other Drug Treatment in New South Wales: Baseline Findings from a Cohort Study' (2023) 219(5) *The Medical Journal of Australia* 218, 218.
[97] Lubman, Manning and Cheetham (n 57) 59.

of the Drug and Alcohol Clinical Care Package, based on an earlier NSW mental health planning model,[98] and now known as the Drug and Alcohol Service Planning Model (DASPM),[99] is a model that includes all drugs except tobacco, and all AOD services (including prevention and treatment) across a range of sectors and service types.[100]

DASPM's aim is to "provide more contemporary planning figures and contribute to a better distribution of treatment resources and improved access for those seeking alcohol or other drugs treatment."[101] A key feature of DASPM is nationally shared descriptions of units of service (i.e., care packages) "which specify the care for an individual with specific needs over a 12-month period… [and outline] packages of care for clients with a standard presentation (i.e., one with low co-morbidity) and with a complex presentation (i.e., one with high co-morbidity)... [with] many care packages in the model, differentiated on the basis of frequency and duration, as well as location (i.e., care in the community versus at a treatment facility)." The Committee should consider ways to further build on DASPM's success.

We also need to enhance national AOD-related datasets to drive data-driven responses that reduce AOD harms by promoting allocative efficiency for health service investment. For example, the Victorian Government has invested in *AODstats*, a statistical and epidemiological resource and monitoring tool for policy planners, AOD service providers, health professionals and other key stakeholders.[102] *AODstats* provides data on a range of AOD (i.e., alcohol, illicit and pharmaceutical drug use) harms including AOD-related ambulance attendances, hospital admissions, serious road injuries, and deaths. Turning Point successfully piloted a national *AODstats* a number of years ago for the Commonwealth Department of Health and Aged Care, demonstrating its potential for national scale-up.

3.5.4. More research needed to improve health service responses and develop new treatment options

The Commonwealth invests in AOD research through competitive National Health and Medical Research Council and Medical Research Future Funding. While this funding is welcome and important, stigma also plays a role in limiting research investment in this area, resulting in a relatively small pool of funded academic roles across universities (as compared to other health conditions of similar health burden) and limited philanthropy and community support.

In other areas of health (e.g., cancer, stroke, and mental health) there have been successful,

[98] Jane Pirkis et al, 'International Planning Directions for Provision of Mental Health Services' (2007) 34(4) *Administration & Policy in Mental Health* 377, 385.
[99] 'Drug and Alcohol Services Planning Model (DASPM)', *University of New South Wales: Social Policy and Research Centre* (Web Page) <https://www.unsw.edu.au/research/sprc/our-projects/drug-and-alcohol-services-planning-model-daspm>.
[100] Namely: outpatient, community based treatments; residential rehabilitation services; inpatient, hospital based treatments; inpatient, community based treatments; and primary care services (eg. GPs).
[101] 'Drug and Alcohol Services Planning Model' (n 99).
[102] 'AODstats - Victorian Alcohol and Drug Statistics', *AODstats* (Web Page) <https://aodstats.org.au/>.

large-scale efforts to conduct population-level research that includes mapping of care trajectories, associated health outcomes, and economic evaluations. These efforts have been instrumental in understanding the burden of these conditions, optimising healthcare responses, and improving patient outcomes. For example, in cancer care, Australia has developed robust population-level research platforms that track patient healthcare utilisation, outcomes, and costs across the country. The Australian Cancer Database and the National Cancer Control Indicators provide comprehensive data that informs policy, guides resource allocation, and supports the development of targeted interventions. Similarly, in mental health, initiatives like the *National Mental Health Service Planning Framework* offer detailed insights into the needs and service usage of people with mental health conditions, enabling better planning and service delivery.

Given the human and economic cost of AOD harms to the Australian community, there is an urgent need for greater targeted investment (through the National Health and Medical Research Council, Medical Research Future Fund and other mechanisms) for a broader program of health services research, as well as the development and implementation of new evidence-based AOD treatments.

3.5.5. Illicit substance surveillance gaps

The illicit drug market is continuously evolving with the emergence of a range of novel and potent substances. It is therefore critical that Australia stays at the forefront of identifying and responding to emerging drug-related threats, including timely alerts to government agencies, health services, and consumers to limit and appropriately respond to AOD harms.

One way to ensure the timely collection of data on illicit substances is by linking emergency department (ED) surveillance data with other data on illicit drugs (e.g., police/customs data) to support a more coordinated approach to national drug monitoring and public health / prevention responses, and to ensure ED drug surveillance is backed by ongoing investment.

One example of an ED surveillance system is the Emerging Drugs Network of Australia, which is active across 5 jurisdictions, and is currently supported by a National Health and Medical Research Council grant.[103] Patients aged 16 years and over who present to a network ED with a suspected illicit drug-related toxicity have blood samples taken for comprehensive toxicological analysis by specialised forensic services, with results informing public drug alerts and health interventions.[104]

Drug checking services also present an opportunity to inform life-saving drug alerts through the data they collect on illicit substances that have higher purity and risk of overdose than

[103] Daniel Fatovich et al, *Emerging Drugs Network of Australia: A Coordinated Toxicosurveillance System of Illicit Drug Use in Australia to Enable Rapid Detection and Harm Reduction Responses Via an Early Warning System* (Project Web Page, 2024) <https://research-repository.uwa.edu.au/en/projects/emerging-drugs-network-of-australia-a-coordinated-toxicosurveil>.
[104] Rebekka Syrjanen et al, 'The Emerging Drugs Network of Australia – Victoria Clinical Registry: A State-Wide Illicit Substance Surveillance and Alert Network' (2023) 35(1) *Emergency Medicine Australasia* 82, 83.

usual, or that have toxic and dangerous additives. As noted earlier, drug checking services are currently only available in the Australian Capital Territory and Queensland, with Victoria in the process of establishing its service.

3.5.6. Incorporating data to effectively respond to alcohol harms Australia-wide

This inquiry presents an opportunity to support the harmonisation of liquor laws across Australia, so they are consistent and effectively minimise alcohol-involved family violence and other alcohol-related harms.

As part of the federal government's new $4.7 billion gendered-based family violence package, states and territories have committed to review their liquor laws and regulations with a view to harmonising and improving them in ways that help to tackle alcohol-involved family violence.[105] Alcohol and other drug use plays a large part in domestic and family violence, with women most often the victims. Between 24–54% of domestic and family violence incidents reported to police in Australia are alcohol-related, while 1–9% of incidents involve other drugs.[106] This is consistent with international evidence showing substance use occurs with domestic and family violence in 25–50% of cases.[107]

It is an object of the Australian Capital Territory's, New South Wales', Queensland's, South Australia's and Victoria's liquor laws to minimise harm *including harm arising from violence*.[108] However, while the Northern Territory, Tasmania, Western Australia also have liquor laws that seek to minimise harm, they do not include a definition of harm that explicitly refers to alcohol-involved violence including domestic/family violence.[109]

The ability of liquor regulators to give due regard to harm minimisation,[110] consistent with the statutory definition of harm, and exercise their powers and functions to effectively minimise harm, depends on the development of robust data systems that provide timely location-based data on AOD harms including AOD-involved violence.

Turning Point and MARC are actively leading work in this space aimed at understanding how different liquor licence types affect alcohol-related harms. Our research is identifying the times, places, situations, and developmental life stages that elevate alcohol risks, and linking harms that are mapped in the National Ambulance Surveillance System (NASS) with other datasets at the state and Commonwealth level. This work is focussing on developing and validating an alcohol harm indicator, which could be used by policymakers and liquor

[105] Anthony Albanese, 'Press Conference - Canberra', *Prime Minister of Australia* (Transcript, 6 September 2024) <https://www.pm.gov.au/media/press-conference-canberra-15>.
[106] Peter Miller at al, *Alcohol/Drug-Involved Family Violence in Australia: Key Findings* (Monograph, No 68, 2016) 2 <https://www.aic.gov.au/sites/default/files/2020-09/monograph68-key-findings.pdf>.
[107] Larry Bennett and Patricia Bland, *Substance Abuse and Intimate Partner Violence* (Report, May 2008) 2 <https://vawnet.org/sites/default/files/materials/files/2016-09/AR_SubstanceRevised.pdf>.
[108] *Liquor Act 2010* (ACT) s 10(c); *Liquor Act 2007 No 90* (NSW) s 3(2)(a); *Liquor Act 1992* (Qld) s 3(a)(i); *Liquor Licensing Act 1997* (SA) s 1(a)(e); Liquor Control Reform Act 1998 (Vic) s 3.
[109] *Liquor Act 2019* (NT) s 3; *Liquor Licensing Act 1990* (Tas) s2A(1); *Liquor Control Act 1988* (WA) s 5, see also s 152NB(1) which refers to harm and adverse effects on the safety or welfare of people, but only in relation to protected entertainment precincts.
[110] For example, *Liquor Control Reform Act 1998* (Vic) s 4(2).

regulators to aid decision making to reduce alcohol harms and promote the health of everyday Australians.

4. Sustainable investment in system enablers

4.1. Funding context

The Commonwealth invests in AOD services and responses through multiple channels, including direct AOD service funding, Primary Health Network grants, the National Health Funding Pool, Medicare Benefits Schedule items, and initiatives under bilateral mental health agreements with states and territories and Closing the Gap implementation plans.

4.1.1. Direct investment

State and territory governments provide the majority of direct investment in AOD services. The 2024/25 federal budget included $41.6 million over two years to continue work supporting the prevention, treatment, and reduction of alcohol and other drug related harms by:

- "implementing activities that align with the objectives of the *National Drug Strategy 2017–2026* and its sub-strategies, including the *National Alcohol Strategy 2019–2028* and the *National Tobacco Strategy 2023–2030.* This includes delivering health promotion and education activities to support smoking and nicotine cessation and prevention, to raise awareness of the Australian guidelines to reduce health risks from drinking alcohol, and the risks of drinking alcohol while pregnant and breastfeeding
- investing in quality AOD treatment services consistent with the National Quality and Treatment Frameworks
- supporting expansion of tobacco and e-cigarette control program activities through investment in tobacco and e-cigarette control research and evaluation."[111]

As the Australian Alcohol & Other Drugs Council noted in its submission to this inquiry, "some Commonwealth funding to AOD treatment services is currently also partially supplemented through three different, time-limited budget measures. These are currently the Drug and Alcohol Treatment Services Maintenance (DATSM) program, Wage Cost Indices (WCI) and Community Sector Organisation (CSO) payments, the broad purpose of which are to address issues such as compliance with 'modern' awards, pay rate increases in line with awards and lack of consistent contract indexation to cover increasing service costs over time. These payments are also subject to varying timelines for expiry, requiring services

[111] Department of Health and Aged Care, *Portfolio Budget Statements 2024–25: Budget Related Paper Health And Aged Care Portfolio* (Budget Paper, No 1.9, 14 May 2024) 22, 63 <https://www.health.gov.au/resources/publications/budget-2024-25-health -and-aged-care-portfolio-budget-statements>; Australian Treasury, *Budget Measures* (Budget Paper, No 2, 14 May 2024) 121 <https://budget.gov.au/content/bp2/index.htm>.

to divert resources away from core business to administer their management and advocate for their renewal, separate to their 'core' contracts."[112]

4.1.2. Primary Health Networks

The Australian Government announced its response to the National Ice Taskforce's Final Report On 6 December 2015, with the related *National Ice Action Strategy* endorsed by the Council of Australian Governments on 11 December 2015.[113] The response included establishing a role for Primary Health Networks (PHNs) to reduce AOD harms through the planning and commissioning of AOD treatment services. This was initially supported by a $241.5 million investment under the *National Ice Action Strategy* over the forward estimates to assist PHNs in achieving these objectives, as part of a $412.1 million investment under the Australian Government's *Drug and Alcohol Program*,[114] which supported the PHNs to commission and administer additional funding to existing services until 30 June 2019. In 2022, the Australian Government committed $315 million to extend investment under the *National Ice Action Strategy* for another four years,[115] and $236 million in current AOD PHN funding is in place for the 2024/25 and 2025/26 financial years.

While previous investments are welcome, given the overall lack of investment in AOD services relative to demand, it is critical that this funding pool is not lost. However, there is an opportunity to review whether funding is well targeted, addresses clear local needs, appropriately complements existing state funding, and whether outcomes and learnings are shared nationally.

4.1.3. National Health Funding Body and Pool

The Commonwealth provides significant investment for local hospital networks through the *National Health Reform Agreement* (hereafter the Agreement),[116] but it is not clear how much if any goes toward AOD services,[117] and with its focus on tertiary care, there are

[112] Australian Alcohol & Other Drugs Council, Submission No 45 to Standing Committee on Health, Aged Care and Sport, *Inquiry Into the Health Impacts of Alcohol and Other Drugs in Australia* (30 Sep 2024) 14. DATSM and WCI apply to services funded by PHNs and the Department of Health and Aged Care, whereas CSO only applies to services funded by the Department of Health and Aged Care.
[113] Department of Health and Aged Care, *A2 – Drug and Alcohol Treatment Services* (Annexure, 1 February 2016) <https://www.health.gov.au/resources/publications/primary-health-networks-phn-grant-program-guidelines?language=en>.
[114] 'Data – Primary Health Network', *Australian Institute of Health and Welfare* (Web Page, 14 June 2024) <https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-australia/contents/data-primary-health-network>.
[115] Greg Hunt, 'Continued Funding to Tackle Scourge of Methamphetamines' (Media Release, Department of Health and Aged Care, 21 March 2022) <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/continued-funding-to-tackle- scourge-of-methamphetamines>.
[116] The Administrator of the National Health Funding Pool is an independent statutory office holder. The *National Health Reform Act 2011* (Cth), along with common provisions in State and Territory legislation, sets out the functions of the Administrator. All Commonwealth, state and territory governments have to agree to the Administrator's appointment. The Administrator is supported to oversee payments under the Agreement by the National Health Funding Body, an independent agency that – along with the Administrator of the National Health Funding Pool – was established through the Agreement. The National Health Funding Body operates as a Commonwealth non-corporate entity under the *Public Governance, Performance and Accountability Act 2013* and is funded as a small agency by the Commonwealth Department of Health and Aged Care.
[117] The National Health Funding Pool's Annual Report notes AOD services are out of scope for activity based funding in New South Wales, South Australia, Tasmania, and Victoria, but does not mention whether this is the case for other states and territories. The National Health Funding Body tracks *activity based* funding investment across five categories: emergency department services; acute admitted services; admitted mental health services; sub–acute and non–acute services; and non–admitted services. The National Health Funding Body also

limited funds available for public health initiatives through the National Health Funding Pool.

As shown in Figure 1, the National Health Funding Pool was established to receive all Commonwealth (activity based and block funding) and State and Territory (activity based funding only) local hospital network funding. The Commonwealth also contributes a small amount of *public health* funding to the Pool ($0.5B or 1.7% of total Commonwealth investment). Each state and territory have a State Managed Fund to manage state and territory block funding, which Commonwealth block funding from the National Health Funding Pool is also funnelled through.

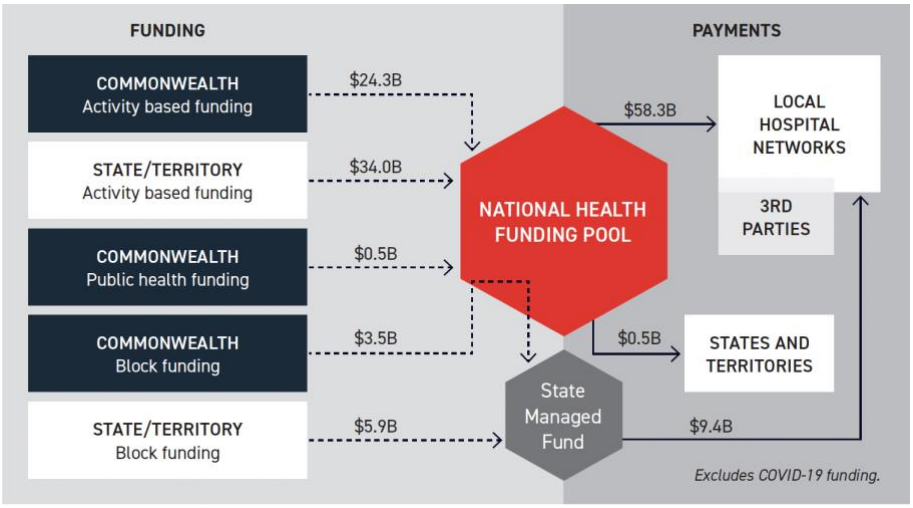

Figure 1: 2023-24 Public hospital funding payment flows. Source: *National Health Funding Body Corporate Plan 2024-25* p.19.

The final report from the *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* prepared by Rosemary Huxtable AO PSM (hereafter the Huxtable review) was released on 24 October 2023 and recommended a single, collaborative, whole of health system Agreement to support its goal of driving health system performance and sustainability and a better-connected health system.[118]

National Cabinet noted in December 2023 that "Australians rightly want a whole-of-system approach to healthcare, where primary care and hospitals are connected and able to provide optimal models of care in the right place and the right time" and that health ministers will work through the "renegotiation of the National Health Reform Agreement

tracks *block* funding across five categories: teaching, training and research; small rural hospitals; non-admitted mental health; non-admitted home ventilation; other non-admitted services; highly specialised therapies. Administrator, National Health Funding Pool, *Annual Report 2022-23* (Report, 22 December 2023) 81, 108, 180, 204 <https://www.publichospitalfunding.gov.au/publications/national-health-funding-pool-annual-report-2022-23>.

[118] Rosemary Huxtable, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023) 1 <https://apo.org.au/node/325261>.

(NHRA) Addendum to embed long-term, system-wide structural health reforms, including considering the NHRA Mid-Term Review findings."[119]

4.1.4. Bilateral mental health agreements

The Huxtable review identified nearly 80 health related agreements as at 30 August 2023 that currently operate outside the National Health Reform Agreement. Among them is the *National Mental Health and Suicide Prevention Agreement*, which consists of bilateral agreements between the Commonwealth and each state and territory government, all due to expire on 20 June 2026.

These agreements outline Commonwealth and state/territory responsibilities and resourcing arrangements for a range of agreed mental health initiatives, however, the agreements with Victoria and Western Australia are the only two that are inclusive of AOD initiatives. In short, existing mental health agreements between the Commonwealth and states and territories do not adequately address the needs of the AOD services, nor are they linked to national AOD strategies and agreed implementation plans.

The Huxtable review noted that "a pressing priority is to assign functions and actions for mental health within the National Health Reform Agreement. Currently the Agreement acknowledges a shared commitment to improve mental health outcomes (Clause 6), but agreed actions are in the separate and subsequent *National Mental Health and Suicide Prevention Agreement*. The National Health Reform Agreement should reference the actions that the parties will take to improve mental health outcomes across the health system, integrating mental health strategies into optimal models of care, financing, innovation and performance elements of a new Agreement."[120]

Accordingly, recommendation 3 of the Huxtable review calls for the Agreement to "reaffirm the commitments to improving mental health outcomes through the separate *National Mental Health and Suicide Prevention Agreement*, utilising the mechanisms agreed through the National Health Reform Agreement, including models of care, financing, innovation and performance monitoring, to progress agreed actions in the area of mental health."[121] This effort, if undertaken, should clearly include AOD services and outcomes either through expanded bilateral mental health agreements or standalone bilateral AOD agreements.

4.1.5. National Closing the Gap Agreement

Under the *National Agreement on Closing the Gap*, every Australian jurisdiction has its own implementation plan. The *Commonwealth 2024 Implementation Plan* provides $66 million for the *Strengthening Aboriginal and Torres Strait Islander Alcohol and Other Drugs*

[119] Anthony Albanese, 'Meeting of National Cabinet – the Federation Working for Australia' (Media Release, Prime Minister of Australia, 6 December 2023) <https://www.pm.gov.au/media/meeting-national-cabinet-federation-working-australia#>.
[120] Huxtable (n 118) 62.
[121] Ibid 5.

Treatment Services Initiative to "support improved outcomes for First Nations people and communities impacted by harmful substance use."[122] State and territory implementation plans are also inclusive of a range of AOD initiatives.

4.2. Sustainable investment options

4.2.1. A whole of health approach

The Huxtable review (see section 4.1.3) found "there was a general view that the National Health Reform Agreement did not operate as a health system agreement, but as a technical hospital financing agreement and, while it has had success in this area, its broader aspiration to take a system-wide approach and drive innovation and integration has not been realised in practice."[123] In particular, while "the Agreement has been successful in improving the technical efficiency and transparency of public hospital funding through the operation of activity based funding with nationally consistent classification and pricing systems and funding flows, it has been less successful in delivering the right care in the right place at the right time (allocative efficiency) to respond to the needs of an ageing population and one with higher rates of chronic and complex conditions, to incentivise high value care and optimal patient outcomes."[124]

The Huxtable review recommended that "a future Agreement should be reshaped as a single collaborative health system Agreement that recognises that all elements of the health system need to work effectively together to improve patient outcomes, is performance-focused, predicts and prepares for future challenges and is clear on shared and individual accountabilities."[125]

In the absence of this Huxtable review recommendation being adopted or in the interim, the Commonwealth and states and territories should adopt other shared agreement/financing arrangements with implementation plans to support a comprehensive, coordinated uplift in AOD investment across Australia's primary, secondary and tertiary care systems.

4.2.2. A greater focus on public health, prevention, early intervention, and harm reduction

Greater investment in initiatives that prevent and minimise AOD harms presents an opportunity to reduce the growing costs of escalating AOD harms and generate significant returns. For example, every dollar invested in AOD counselling saves up to $23,[126] and every dollar invested in harm reduction saves up to $27.[127] Opportunities to promote earlier

[122] Huxtable (n 118) 17.
[123] Ibid 1.
[124] Ibid 4.
[125] Ibid 1.
[126] Alexandra Voce and Tom Sullivan, *What are the Monetary Returns of Investing in Programs That Reduce Demand for Illicit Drugs?* (Report, No 657, 8 September 2022) 8 <https://www.aic.gov.au/publications/tandi/tandi657#>.
[127] National Centre in HIV Epidemiology and Clinical Research, *Return on Investment 2: Evaluating the Cost-Effectiveness of Needle and Syringe Programs in Australia* (Report, 2009) 8 <https://www.acon.org.au/wp-content/uploads/2015/04/Evaluating-the-cost-effectiveness-of-NSP-in-Australia-2009.pdf>.

intervention and improve access to AOD treatment should therefore be a priority, and could include enhancing the availability and scope of AOD digital services (see section 4.2.3), as well as effective prevention and harm reduction initiatives (see sections 3.3.1 and 3.3.3).

The Commonwealth and states and territories should adopt shared agreement/financing arrangements to support an uplift in public health, prevention, early intervention, and harm reduction initiatives that will help to put downward pressure on AOD harms, thereby reducing the frequency, severity, and costs of responding to AOD-related presentations, and taking pressure off an increasingly stretched emergency and tertiary health workforce.

One such shared agreement/financing arrangement that could be leveraged is the National Health Reform Agreement and National Health Funding Pool. The Huxtable review called for "A pricing model that shapes demand by funding services outside the hospital and earlier in the pathway to slow the demand for acute care. This can involve establishing incentives and payments for health services to focus on early intervention and care to reduce downstream acute care demand and provide flexibility to fund services in non-hospital settings (primary, aged and disability care) best placed to meet the health needs of individuals."[128]

Recommendation 33 proposes that "a renewed focus on prevention activities should be set out in the Agreement which directly addresses the rising burden of chronic disease in the community, complements the *National Preventive Health Strategy 2021-2030* and work of the Australian Centre for Disease Control and provides a shared program of action, with clear accountabilities, funding and milestones."

Notably, the *National Preventive Health Strategy 2021-2030* includes reducing AOD harms as a focus area. Consistent with this recommendation, a dedicated program of work in AOD prevention and early intervention should be urgently undertaken to slow down rapidly escalating AOD harms and health system costs.

4.2.3. Digital health

Digital health responses have become an important part of the health service landscape. Recognising their value in ensuring people can access support when and where they need it at no cost to the client, Commonwealth investment in mental health digital health services has made it easier for Australians experiencing mental health concerns to access care. This is supported by a *National Digital Health Strategy 2023-2028* and the *Strategy Delivery Roadmap*, with the Strategy recognising "policy and regulatory settings that cultivate digital health adoption, use and innovation" as a key change enabler.[129] Australia should likewise prioritise digital responses to reduce AOD harms.

[128] Huxtable (n 118) 79.
[129] Australian Digital Health Agency, *National Digital Health Strategy 2023-2028* (Strategy, 2023) 5 <https://www.digitalhealth.gov.au/national-digital-health-strategy>.

National data shows that only one in five (22.4%) Australians with an AOD use disorder seek help.[130] Barriers to accessing treatment include service availability (e.g., hours of operation), geography (e.g., restricted transport options and scarcity of services in regional/rural areas), stigma, and concerns about anonymity. Due to demand on publicly-funded treatment services, there are also limited early intervention options for the many Australians with lower levels of complexity, who are unlikely to seek treatment.

AOD telephone and online services help overcome stigma and geography as barriers to equitable treatment access, however greater investment is needed to realise the full potential of a digital health approach. Evidence from the tobacco cessation field has shown quitlines that offer comprehensive in-depth counselling and support programs are highly effective in helping people to stop smoking,[131] and are widely used across the Australian community, with growing evidence from recent trials of telephone-delivered AOD interventions, delivered within helpline settings, showing they are also effective in reducing AOD harms.[132]

While over 65% of Australians contacting the national online AOD service, *counsellingonline.org.au*, are seeking help for the first time, the service is currently funded to only provide single session counselling, meaning there are few follow-up options available apart from providing callers with contact numbers for local AOD intake services. This is a missed opportunity to assertively engage with callers over time, support those who are reluctant or unable to seek face-to-face care, as well as offer digital interventions (e.g., self-help, peer support, navigation, telehealth, and virtual care) that reduce further escalation of AOD-related harms and demand on an already overstretched AOD treatment system.

Consistent with the *National Digital Health Strategy 2023-2028*, there is an opportunity to improve the adoption, reach, and interoperability of innovative digital AOD services as a key system enabler. Current AOD digital offerings could be leveraged and scaled to form an integrated AOD national digital service model (a Connected Care system) that could effectively: (i) remove geographical barriers to access to tackle inequities in regional & remote Australia; (ii) improve service system navigation by providing easily accessible pathways to care; (iii) enable efficient and agile workforce models that reduce current workforce pressures; (iv) remove stigma-related access barriers to enable individuals to receive treatment earlier and without fear of judgement; (v) reduce fragmentation of

[130] Maree Teesson et al, 'Prevalence and Correlates of DSM-IV Alcohol Abuse and Dependence in Australia: Findings of the 2007 National Survey of Mental Health and Wellbeing' (2010) 105(12) *Addiction* 2085, 2090.
[131] Lindsay Stead et al, 'Telephone Counselling for Smoking Cessation' (2006) 12(8) *Cochrane Database of Systematic Reviews* 1, 19-20.
[132] Jasmin Grigg et al, 'Ready2Change: Preliminary Effectiveness of a Telephone-Delivered Intervention Program For Alcohol, Methamphetamine and Cannabis Use Problems' (2022) 41(2) *Drug & Alcohol Review* 517, 522; Dan Lubman et al 'Effectiveness of a Stand-alone Telephone-Delivered Intervention for Reducing Problem Alcohol Use A Randomized Clinical Trial' (2022) 79(11) *JAMA Psychiatry* 1055, 1058.

services by providing integrated virtual care models; and (vi) support a digital stepped care model, offering Australians in need the right digital solution, at the right time.

Recommendation 40 of the Huxtable review noted that "a future Agreement should include an explicit commitment to progress digital health as a key enabler to improving the health system, as an additional Schedule" and that "the Schedule should reflect support and incentivisation for a digitally enabled healthcare system, including integrated funding for evolving models of care."[133] We strongly support this recommendation.

With the Commonwealth having already allocated $588 million over eight years from 2024–25 for online services that allow people struggling with mental health concerns to access free, low intensity online appointments without a referral,[134] there is scope to enhance AOD digital services without delay.

4.2.4. Workforce

Commonwealth investment that supported Australian medical schools to implement AOD education in the 1990s ceased over a decade ago. Today, a lack of funded AOD-related academic positions across health disciplines (who are able to advocate for and teach into health curricula), as well as insecure career pathways (i.e., lack of publicly funded training and specialist positions) is limiting Australia's ability to train and retain the next generation of addiction specialists to meet even the current demand.[135]

The Huxtable review recommends a dedicated workforce schedule be added to the National Health Reform Agreement,[136] and that key national workforce strategies should be incorporated.[137] If this recommendation is adopted, an updated *National AOD Workforce Strategy* should likewise be included. However, in the interim, the Commonwealth, states, and territories should adopt other shared agreement/financing arrangements linked to an updated *National AOD Workforce Strategy* to support Australia's AOD workforce to deliver now and into the future (see section 3.4).

4.2.5. Service quality and safety

In their submission to this inquiry, the Australian Alcohol & Other Drugs Council recommended that the Australian Government "work with State and Territory Governments to fund and monitor the implementation of the *National Quality Framework for Drug and Alcohol Treatment Services* to drive a nationally coordinated approach to AOD service regulation, and reduce the risk of people in need of AOD treatment accessing unsafe services which operate without an evidence-based treatment model."[138]

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[133] Huxtable (n 118) 40.
[134] Australian Treasury, *Budget Measures* (Budget Paper, No 2, 14 May 2024) 116 <https://budget.gov.au/content/bp2/index.htm>.
[135] Dan Lubman, Witness Statement WIT.0002.0041.0001 to the *Royal Commission into Victoria's Mental Health System* (2020) 17.
[136] Huxtable (n 118) 61.
[137] Ibid 111.
[138] Australian Alcohol & Other Drugs Council (n 112) 5-6.

Due to increasing demand for AOD treatment, there has been significant growth in private operators offering rehabilitation services. Australians should expect that the treatment offered by such operators is evidence-based, appropriately accredited, and supported by credentialed professional staff. However, while many of these services are appropriately accredited, and are covered by private health insurance, there are still private operators that prey on vulnerable individuals, delivering programs that are not effective or supported by evidence. This highlights the need to fully implement the *National Quality Framework for Drug and Alcohol Treatment Services* across states and territories, and will require implementation funding, national coordination, and ongoing monitoring.

4.2.6. Funding security

In their submissions to this inquiry, the Australian Alcohol & Other Drugs Council (AADC) and Alcohol and Drug Foundation among others noted the current insecure Commonwealth funding arrangements for AOD services.

In particular, the AADC noted "the lack of consistent indexation on Commonwealth funding contracts since 2012 and, where it has been applied, indexation has often been at rates significantly below those applied by State and Territory Governments."[139] It further noted that the Drug and Alcohol Treatment Services Maintenance (DATSM) "program funding measure will expire on 30 June 2025 and to date there has been no guarantee from the Australian Government of its renewal. This leaves $17.3 million in sector funding unsecured past the end of the current financial year. The removal of the DATSM component from Commonwealth funding for AOD sector services would therefore obviously have a significant impact on current sector capacity and threaten the viability of many services."[140]

We support the AADC recommendation that the Australian Government "increase core funding to the AOD sector to deliver enhanced capacity to meet current demand/need for specialist, quality services. This should include sensitivities to the costs of service delivery in regional, rural and remote areas to ensure equity across geographic locations."[141]

To ensure the sustainability of AOD services, funding agreements with AOD services should include adequate (5-year) timeframes, indexation, timely renewal notices (at least six months prior to expiry), and resourced evaluations of new programs.

[139] Australian Alcohol & Other Drugs Council (n 112) 14.
[140] Ibid 15.
[141] Ibid 5.