NADA
network of alcohol and other drugs agencies

Submission to the Special Commission of Inquiry into the Drug 'Ice'

Response to the Issues Papers

May 2019

The Network of Alcohol and other Drugs Agencies (NADA) is the peak organisation for the non government alcohol and other drugs sector in NSW. We represent close to 100 organisational members that provide a broad range of alcohol and other drugs services including health promotion and harm reduction, early intervention, treatment and continuing care programs. Together, we work to reduce the harms related to alcohol and other drugs use across the NSW community.

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ABOUT NADA

The Network of Alcohol and other Drugs Agencies (NADA) is the peak organisation for non government alcohol and other drugs services in NSW. We advocate for, strengthen and support the sector. As a member driven peak body, NADA's decisions and actions are informed by the experiences, knowledge and concerns of its membership.

We represent close to 100 organisational members that provide a broad range of alcohol and other drugs services including health promotion and harm reduction, early intervention, treatment and continuing care programs. Our members are diverse in their structure, philosophy and approach to alcohol and other drugs service delivery.

Together, we work to reduce the harms related to alcohol and other drugs use across the NSW community.

NADA has award level accreditation under the Australian Services Excellence Standards (ASES), a quality framework certified by Quality Innovation and Performance (QIP).

To learn more, visit www.nada.org.au.

PREPARATION OF THIS SUBMISSION

The comments provided in this submission have been prepared by NADA as part of the NSW non government AOD peak body role in representing the view of its members. The work in this submission draws largely on the work that has been done on this issue by NADA for previous government Inquiries and Parliamentary Committees as well as input from the membership and key content experts.

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SUBMISSION OVERVIEW COMMENTS

NADA is supportive of the NSW Government *Special Commission of Inquiry into the Drug 'Ice'*. NADA supports the establishment of the Commission of Inquiry. NADA believes the NSW Government's Commission should also consider the recommendations, strategies and initiatives from the Final Report of the National Ice Taskforce (2015), the Australian Government Response, and the Council of Australian Governments' National Ice Action Strategy (2015).

NADA remains concerned that the Commission's Issues Papers simplistically focus on the single drug methamphetamine (though we note that the more appropriate term 'amphetamine type stimulants' is used throughout). Applying a single drug lens makes comment difficult as we know that for many people experiencing issues with substance use, the challenges they face are shaped by their biology, mental state and social circumstances. It may also be the case that a person is using more than one substance, and therefore their experiences produce behavioural responses that cannot be simply attributed to a single drug 'ice' in a direct causal relationship.

It is therefore not helpful to ask questions about one drug 'ice' in relation to a whole host of personal, family, geographic or whole of community set of issues without taking into consideration the other drugs used and the personal/social circumstances of people with drug problems. It is with a broader lens that NADA will be making its responses to the key questions asked throughout the Issues Paper's topic areas.

ISSUES PAPER 1: USE, PREVELENCE AND POLICY FRAMEWORK

1.1.1 How prevalent is ATS use in NSW? How is prevalence of ATS determined? Are there ways to improve the way in which prevalence is determined?

NADA is satisfied with the data in the Issues Paper that describe prevalence of use and we don't have any additional data to add to this. However, it is well known that only a subset of people who use amphetamines (including methamphetamines) seek treatment from both government and non government services. McKetin et al (2005) used data from the National Minimum Data Set (NMDS) and determined that a multiplier of 5.5 can be reasonably applied to this treatment data to estimate dependent methamphetamine users. NADA's own NMDS data shows that roughly between 30% and 35% of all closed NMDS treatment episodes are for primary methamphetamine as the principle drug of concern.

McKetin et al (2005) applied a multiplier-benchmark technique to estimate the number of regular and dependent methamphetamine users in Sydney, NSW and Australia, 'The benchmark data sources were drug treatment data, hospital separation data and arrest data, which were derived for Sydney, New South Wales and Australia. The treatment multiplier holds the greatest promise for monitoring the size of the dependent methamphetamine using population in Australia, because of its simplicity, and specificity to dependent methamphetamine use, which is most likely to be predictive of treatment seeking and other methamphetamine-related harms. Only one in ten methamphetamine users reports receiving treatment for their methamphetamine use in the past year'.

1.1.2 Can current prevalence estimates be improved through any particular kinds of systematic analyses of available drug use datasets? What is best practice in other jurisdictions for such analyses?

NADA would defer to our research partners in NSW National Drug and Alcohol Research Centre (NDARC), Drug Policy Modelling Program (DPMP), Centre for Social Research in Health (CSRH) and National Centre for Clinical Research on Emerging Drugs (NCCRED) in relation to this question.

1.1.3 Can wastewater analysis (in combination with other data sources) reliably identify geographic locations of ATS use in NSW? If not, why not?

NADA remains concerned that wastewater testing, a grossly simplified indicator, is used in other contexts—for example, the Federal government's recent Social Services Legislation Amendment (Welfare Reform) (Drug Testing Bill) 2018—to identify regions with presumed high drug use on the basis of its results. It is concerning that proposals for wastewater testing may progress despite it being well known that the necessary drug testing technologies and treatment capacity in certain regions across NSW are simply not there. This use of wastewater testing data was widely criticised by the AOD sector nationally.

NADA believes that significant issues will arise due to the lack of suitable and available testing technology, treatment facilities places, appropriately trained staff, and/or the distance from services for some clients. On these grounds alone, NADA would be concerned if funding was allocated to service provision based on this type of sentinel testing.

1.1.4 What is considered to be harmful or problematic ATS use, having regard to impacts on individual mental and physical health, employment, family and social functioning, or other indicators?

NADA argues that these issues are similar for all substance dependencies and a focus on ATS alone is not helpful for identifying and resourcing an appropriate AOD treatment response. NADA members in their provision of treatment would apply the same comprehensive biopsychosocial assessment to all people accessing services and treatment; these would be matched according to the needs identified by the individual, including support for any areas of their lives impacted by their substance use, as a part of holistic care.

1.1.5 Does the current data enable a distinction to be made between people who use ATS in NSW in a harmful way from those whose use is not harmful? Is drawing this distinction necessary? Could this distinction improve NSW's response to ATS use?

NADA, through the online client database used by its members (NADAbase), can only refer to those people that have sought treatment for their ATS use and therefore can make little comment on those who deem their use not to be 'harmful'. The collection of Client Outcomes Measures (COMS) routinely collected by NADA members can provide insights into the severity of harm as perceived by people accessing treatment and is used to monitor improvements in health and wellbeing. However, there are no current investigations that NADA is aware of that has explored unharmful ATS use.

In using NADAbase COMS and NMDS data, a distinction between dependent and nondependent would be particularly useful if we could analyse this by 'age', 'main treatment type' and 'service setting'. However, this function is not currently possible due to the data rules of the system. If this was to be made available, it would indeed be helpful in terms of overall treatment planning.

NADA can be confident that via comprehensive biopsychosocial assessments conducted by NADA members, people are matched to treatment according to the severity of harm. However, demand for treatment still significantly exceeds availability for those who would identify their ATS use as harmful.

1.1.6 What are the harms associated with the illicit use of licit ATS? Is this a significant problem in NSW?

NADA could not comment with confidence on this issue and would encourage the Commission to speak directly to NADA members regarding their experience in this specific area.

1.1.9 Who are the at-risk populations for harmful ATS use? Are there geographical differences? What is the evidence that supports the identification of these populations as being at-risk populations?

Drawing on research literature, NSW hospital data and member feedback—Aboriginal and Torres Strait Islander people have experienced significant harm associated with ATS and we are also aware that people in

certain rural and regional centres have expressed concerns regarding their communities. In this regard we know that treatment options and resourcing for Aboriginal Community Controlled Organisations (ACCHOs) are less than optimal and would encourage funders to prioritise funds to these organisations.

Treatment data, that NADA has access to, can be confusing when considering who is more at risk given that different definitions that are used to identify problematic use across data sets, there can be issues with the consistency of data collection and the way it is analysed. For example:

- McKetin (2005) uses regular vs. dependent user
- National Drug Strategy Household survey uses 'frequency of use' which ranges from daily to once or twice a year
- NMDS will tell us about the setting where treatment is provided, by age, by usual residential postcode (postcode is possibly unreliable since it is often entered into NMDS when the patient first receives treatment, but it's not regularly updated).

In responding to this question NADA would defer to our member knowledge and experience, in addition to our research partners NDARC, DPMP, CSRH and NCCRED. There are several NADA members who work with specific target populations such as Aboriginal and Torres Strait Islander people, young people, people from the LGBTI community and women/women with their children all have raised considerable concerns about the impact of ATS. However, attributing the harms to the substance use alone is simplistic given the unique experiences of each individual.

1.1.10 How prevalent is methamphetamine related self-harm, intentional or accidental suicide in NSW? How can data on this be better obtained?

NADA notes the presentation by Dr Shane Darke, NDARC, UNSW from the November 2018 NDARC Symposium. His study looked at eight years' worth of coronial data for 15-44-year-olds and found evidence that even small doses of ATS can be fatal for some individuals. This data tells us about the deaths, but not the near misses, for example those who died with haemorrhagic stroke vs. those who live with morbidity/residual symptoms. Abstract at https://onlinelibrary.wiley.com/doi/abs/10.1111/1556-4029.14056

NADA would again defer to our research partners regarding the best approach to improving data collection to increase understanding around links between self-harm and suicide and ATS use. However, we take the position that greater access to AOD treatment and the potential hope this provides people concerned about their ATS use may assist in the identification of suicidal ideation and the supports to alleviate these experiences.

ISSUES PAPER 3: HEALTH AND COMMUNITY

3.1.1 What is the experience of ATS users and their families of the individual impacts of ATS use-physically, mentally and socially.

NADA members and NADA staff with clinical experience believe that having a working knowledge and understanding of the effects and nature of ATS use on an individual's physical and psychological health, such as sleep deprivation, sensitivity to paranoia and potential for psychosis and other negative impacts on mental health is essential to effective treatment provision. Furthermore, there is a need to appreciate the high levels of stigma and discrimination experienced by those who use ATS resulting from the often alarmist health campaigns over the last 10 years—which has kept people *away* from treatment and make families more concerned about this drug and its harmful effects over other drugs.

In our experience in working with AOD service providers across our membership, and in terms of our working partnerships with specialist organisations like Family Drug Support, Sydney Drug Education and Counselling Centre and Holyoake, NADA would argue that there are no dramatic differences between ATS users and users dependent on heroin or alcohol and poly drug use in terms of negative impacts on families.

There is also some evidence to suggest that those who experience problematic ATS use do consider themselves as requiring specialist AOD treatment and that identified clinics that either promote themselves as being ATS specific or are perceived to have specialist knowledge in the treatment of ATS use are attractive to people seeking support.

3.1.2 What is the link between ATS use and the physical, psychological and social impacts often associated with ATS use?

See our comments in 3.1.1.

3.1.3 What issues arise for individuals from the comorbidities and negative social impacts frequently associated with ATS use?

See our comments in 3.1.1

3.1.4 What is the experience of individuals (including those with multiple needs) in navigating the service system in relation to their ATS use?

NADA prefaces the response to this question by stating that navigating the AOD treatment service system and gaining access to services is challenging and difficult for all illicit drug users irrespective of their principle drug of concern. The issue of navigating access to AOD health services is a broad and complex one, highlighting the fact that there are never enough resources to meet the total population's demand for health services. This is especially true for AOD treatment services where the issue of the inadequacy of the funding base for these services is particularly critical. It is well accepted across the AOD specialist field that demand exceeds availability of treatment places. The recent study by the DPMP estimated 'that between 200,000 and 500,000 more people would be in treatment if demand were to be fully met. This means that current met demand may vary between 26% and 48% of all people who will seek, and are appropriate for, AOD treatment'[1]. This study demonstrated the need for increased funding of AOD treatment to meet the needs of the Australian population.

As a result of a demonstrably underfunded sector, waiting lists are common and prioritising clients in need is a challenge. Referrals to non government AOD treatment services occur through the following ways:

- self-referral
- referral from a relative or friend
- referral from one treatment or other service provider to an AOD treatment provider
- referral from the criminal justice system, either through a formal court diversion program or from probation and parole/community corrections
- referral from Family and Community Services.

NSW NMDS data show that the vast majority of referrals to non government AOD treatment services occur through client self-referral (39%).

[1] New Horizons: The review of alcohol and other drug treatment services in Australia (2014). DPMP, UNSW.

The management of client waiting lists is governed by each individual non government treatment organisation and is largely shaped by the need to respond to priority populations (Aboriginal Australians, pregnant women, women with children, young people, and people living with HIV are some examples). However, other considerations may include:

- the continued increase in demand for residential treatment being experienced by residential treatment providers across NSW
- mental health, homelessness and/or potential for physical health risks
- residential services may require proof of detoxification—3–7 days substance free for example
- some services may require regular contact from prospective clients while waiting for a place to become available.

NADA recommends that work is done in consultation with the sector to establish definitions, and standards in relation to the management of waiting lists to ensure consistent monitoring and review.

In terms of meeting the demand for AOD treatment services in NSW, NADA argues that significant new resources are required for those non government specialist AOD treatment providers. We are quite certain, based on the feedback from our regional, rural and remote members, that waiting lists are a more significant issue for these services as there are far fewer options for referral to other treatment services in rural NSW. NADA argues that it should be a priority for significantly enhanced funding to be made available for NSW non government AOD treatment services to assist with meeting demand for services.

3.1.5 Are services able to provide integrated and holistic care and support for ATS use and associated comorbidities such as mental Health? How can service models be improved to better address comorbidities?

NADA and its membership of specialist AOD treatment organisations has acknowledged for the past two decades that co-occurring mental health and AOD disorders are common, and to be expected and screened for as part of standard practice in AOD treatment settings. It is also well understood and accepted in the field that people living with both these disorders typically also experience multiple other challenges and social issues that significantly impact on their lives. This is regardless of the illicit substance used but may be more acute for people with primary ATS use/dependence. While there are high levels of staff expertise in working with clients with co-morbidities in the specialist non government AOD treatment sector, the main obstacle to providing greater specialist co-morbidity care is the lack of financial resources available for the engagement of more skilled psychologists, social workers and psychiatrists within AOD treatment agencies. Also, access to Local Health District (LHD) mental health teams is critical but mainly unavailable to our member services.

NADA believes that a 'community of practice' approach be adopted to working collaboratively as organisations rather than as a simple interagency approach. This includes the wide spectrum of services: hospital, policy and planning agencies, LHDs, police, ambulance, mental health, and AOD service providers. The process needs to be based on in-depth collaboration between all players. This should be followed up with the development and implementation of an accountability tool (outcomes/quality/capacity) to inform the clinicians and service providers within the system and assist with regular public discussion of the results.

To be able to continue to attract and inspire highly qualified people to long term careers in our community based AOD and mental health services, we need the funding system to be enhanced and made more sustainable. Our sector needs funding security and an opportunity to plan for the long term; this means having minimum four to five-year funding contracts that are costed at an appropriate market level. Additionally, the community mental health and AOD sectors must be recognised and remunerated appropriately to attract new staff and retain existing skilled staff.

The role and experience of the non government sectors must be recognised in moving towards greater integration of the government and non government service systems, with more equal value placed on services provided to clients by different agencies for staged and holistic care.

There needs to be increased flexibility in the system to work across NSW Health LHDs; clients do not easily fit into geographical boundaries, and often access services across boundaries in order to receive the care they need. A range of services needs to be available that address the spectrum of needs from health promotion and early intervention to tertiary services, with an investment in resources and services that have a genuine client and recovery focus.

Improved client health and wellbeing outcomes could be achieved with a commitment to mechanisms that facilitate cross sector partnerships with housing, employment, education and other services essential for building strong community resilience, in addition to genuine and appropriate engagement with carer and consumer support networks. Key to this is comprehensive discharge and transition planning, and implementation of best practice treatment rather than the basic 'pills and pillows' approach that characterises a lot of current one-off mental health interventions.

An overarching Alcohol and other Drug Services Plan that provides strategic direction for the sector is required that also incorporates AOD prevention, early intervention and treatment. Following on from this, a specific drug and alcohol plan for NSW is required that provides futures directions based on the most available evidence that aligns with national policy and incorporates mental health. Coordinated efforts between state and federal governments is required to reduce duplication, provide mutual support and guidance for the service system.

3.1.7 Are there groups of people within NSW experiencing unique or particular impacts of ATS use that have not yet been identified?

We have no reliable evidence of this at this time. However, we would encourage further consultation with our NADA members for their input.

3.1.8 Are high-risk population groups disadvantaged by current service delivery models and location of services?

NADA would argue that all clients of current AOD services are high risk and that the biggest disadvantage high risk AOD users face is the lack of available services and the social stigma they face in the mainstream health settings.

3.1.10 Are outreach models sufficient in servicing rural/regional locations, particularly in areas of high prevalence use? If not, why not?

NADA would argue that outreach models, while useful for accessing people who are not in treatment, are not in and of themselves sufficient to address high risk population needs. This is because outreach models can only provide brief interventions and cannot provide the high level intensive inpatient care or intensive outpatient care and support needed by people with problematic AOD use and complex health and social issues. Outreach is one important part of a comprehensive treatment system.

3.1.12 Are existing services meeting the needs of populations with specific needs, such as those set out above?

As discussed in responses above, we stress that the specialist non government AOD treatment sector endeavours to meet the needs of all clients who access treatment but are limited in this regard by the inadequate funding levels from both the state and federal government AOD health funders.

3.1.13 To what extent do populations with specific needs require specialised or targeted needs?

It is our position that people with ATS use issues who require active treatment interventions are effectively treated within the existing non government AOD treatment sector. The main problem is the adequate resourcing of these treatment services and the active service linkages with appropriate specialist health services to meet their broader needs as described above in Q 3.1.5. This will require significant new financial, human and infrastructure resources and holistically linked services planning by both the state and federal governments.

ATS use and Families

3.2.1 What current services or programs available to support families in NSW affected by ATS use? Are they adequate?

NADA would argue that specialist services and programs for families are extremely limited in NSW, with Family Drug Support being the main specialist family AOD support service. Many residential rehabilitation services provide family support services to their existing client base but are not generally available for families not connected to their services through clients in treatment. NADA suggests that NSW Health undertake an audit of appropriate services to support families struggling with AOD dependence in NSW and that a planning process follow this audit.

NADA does have some members who are skilled in providing whole of family support where young people and/or children are involved. However, NADA and its members recognises the need for greater family/significant other support and inclusion within AOD treatment. There has been some intensive workforce development support provided by NADA, in partnership with Family Drug Support and LHDs which has identified an ongoing need for up-skilling workers who are already stretched.

3.2.3 How could the therapeutic and practical support to families of ATS users be improved?

NADA has worked with its membership over the past decade on enhancing work with families in AOD treatment. Earlier work in this area by the then, Mental Health and Drug and Alcohol Office (MHDAO), NSW Department of Health, included funding to NADA to deliver the 'Mental Health and Drug and Alcohol Family and Carer Project' (Family and Carer Project) over three years. The project included four project elements:

1. the development of a resource toolkit, *Tools for Change: A new way of working with families and carers*[1]
2. a seeding grants program: grants to 22 member agencies to further develop family inclusive practice
3. practice development workshops (with The Bouverie Centre, La Trobe University)
4. the 'Single Session Work with Families' (SSW) training program (with The Bouverie Centre, La Trobe University).

The independent project evaluation[2] found that NADA had 'clearly made a significant contribution to the development of practice, knowledge and resources within agencies, and in supporting the ongoing shift of the sector to embrace family inclusive practice'. However, the evaluation and associated needs analysis in the same report provided recommendations to support the workforce to continue this important work. The NSW Ministry of Health funded NADA to develop training for the AOD sector and other primary health contacts to

[1] Network of Alcohol & other Drugs Agencies, (2009). Tools for Change: A new way of working with families and carers, Department of Health, NSW

[2] Argyle Research, (2011). Family inclusive practice in NSW non government alcohol and other drug agencies. Sydney: Network of Alcohol and other Drugs Agencies

build the capacity of workers to better support families who are impacted by someone else's substance use. The training developed aimed to increase workforce capacity to support families and significant others impacted by substance use through:

- building better links across specialist AOD services, both non government organisations and LHDs, primary health and generalist services to support families and significant others
- increasing knowledge and application of approaches that support families and significant others impacted by the AOD use of another
- promoting resources and services that specialise in supporting families and significant others impacted by the AOD use of another NADA has delivered this training from May 2018 to June 2019.

Findings from the training (May 2018–November 2018)

The *Engaging with families and significant others in the AOD sector* workshops were held in seven LHDs and across nine locations. Funding was provided to NADA to deliver seven training workshops, however due to the identified needs of two LHDs, NADA delivered an additional two workshops within two LHDs. All training locations were determined based on the advice of each LHD. Across the nine workshops, 290 participants attended. All workshops included a mixture of participants from NSW Health, NADA member services, ACCHOs and a mix of other non government organisations from mental health, housing, family support and domestic family violence (DFV).

This kind of collaborative workforce development needs to continue to ensure that not only AOD workers are better equipped to support families and significant others who support someone else experiencing problematic substance use—but that other service providers such as FaCS are more engaged.

3.2.4 Does family support improve treatment outcomes for those with problematic ATS use and is it a protective factor against relapse?

It is NADA's position that the inclusion of family and any significant support person caring for someone experiencing issues with their substance use is an essential part of AOD treatment and improves the outcomes for all.

ATS use and Family Violence

3.2.6 What evidence is there of a link between ATS use and DFV? 3.2.7 Has ATS use changed the nature and/or prevalence of DFV? If so, how?

The link between DFV and substance use, including amphetamine type substances is complex. Research shows the use of AOD is a risk factor for DFV and can contribute to more frequent and higher levels of aggression by perpetrators[2]. However, it is important to note that the use of AOD does not cause DFV. DFV comes in different forms, and is not only physical abuse, but can include emotional, psychological, physical, verbal, social, financial and sexual abuse[3]. DFV perpetration is a highly complex behaviour and is reinforced through multiple social learning influences at many levels[4]. It is a gendered problem. While NADA acknowledges that

[2] Phillips, J & Vandenbroek, P 2014, 'Domestic, family and sexual violence in Australia: an overview of the issues', Parliamentary Library Research Paper Series 2014 – 2015, Commonwealth of Australia, Canberra.
[3] NSW Government, Family and Community Services 2018, *About domestic and family violence, https://www.facs.nsw.gov.au/domestic-violence/about*
[4] Vlais, R 2017, 'Family violence perpetration and AOD services', NADA Advocate, https://www.nada.org.au/wp-content/uploads/2018/07/nada_advocate_2017_june.pdf

some men are hurt by DFV, the evidence overwhelmingly shows that DFV is committed most frequently by men against women and that gender inequality is a key determinant of DFV[5].

Men who perpetrate DFV make choices to use violence against family members[6]. DFV is often minimised with suggestions that the perpetrator lost control or being related to their drug use or mental health issues. However, it is unusual for the perpetrator to use violence in other situations, such as work. Examples of the intentional and deliberate nature of DFV can include the perpetrator only hitting the partner in places where bruises will not show[7]. Minimising, denying or excusing DFV is referred to as 'violence-supporting narratives'. Linking ATS or any other drug with DFV, gives a perpetrator and our society a narrative to minimise or justify their use of violence because of their drug use.

Discussing ATS use and links with DFV is not helpful for changing this massive issue in our community. Nor is implementing initiatives targeted specifically at addressing DFV associated with ATS as it oversimplifies this complex problem and takes away from addressing the fundamental issues that relate to DFV regarding gender inequality and the tactics of power and control used by perpetrators. Greater resourcing in accredited men's behaviour change programs is useful for the whole community.

3.2.9 How can DFV services that deal with ATS use be improved?

To improve the way DFV and other services deal with people experiencing problematic AOD use including ATS, greater resourcing is needed to enhance capacity building across all human service sectors. All sectors including AOD, housing, health and children services need resource to build capacity to respond to DFV. NADA acknowledges that DFV services are the specialists in DFV, but it is not only their responsibility to respond to this issue. With greater cross-sector training the different sectors can develop skills in other disciplines to respond to the presenting problem. For example, greater resources for DFV services to build capacity in AOD, and resources for AOD services to build capacity to respond to DFV. This does not retract from each sector continuing to be the specialists in their area but to best respond to DFV, ATS and other drug use, greater skills and knowledge is required across the sectors.

Housing and Homelessness

3.2.14 What evidence is there of a correlation between inadequate housing and homelessness and ATS use?

Homelessness is one of the co-occurring issues commonly experienced by people with problematic AOD use[8]. The Australian Government (2016) reported in 2016–17, around 6% of clients who sought assistance from specialist housing services reported AOD issues their main concern[9]. According to the Australian Institute of Health and Welfare (2018) the homeless population experience additional complexities[10]. Social determinants such as discrimination, unemployment, poverty, lack of social supports and lack of housing are just some of

[5] Domestic, family and sexual violence in Australia: an overview of the issues', Parliamentary Library Research Paper Series 2014 – 2015

[6] 'Family violence perpetration and AOD services', NADA Advocate.

[7] Department for Child Protection 2013, 'Perpetrator Accountability in Child Protection Practice: A resource for child protection workers about engaging and responding to perpetrators of family and domestic violence', Perth Western Australia: Western Australian Government.

[8] Community Sector Consulting (2011) NGO Practice Enhancement Program: Working with Complex Needs Initiative Literature Review and Member Consultation, NADA: Sydney.

[9] Australian Institute of Health and Welfare 2018, Alcohol, tobacco and other drugs. Reviewed from: https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia.

[10] Australian Institute of Health and Welfare 2018

the associated factors with problematic AOD use[11]. Therefore, as discussion in other sections of this submission, to best address ATS use and inadequate housing and homelessness, a collaborative approach is required across all human services sector that does not single out one substance from another.

3.2.15 *Do the housing needs of ATS users vary for specific populations, such as Indigenous people and those coming out of custody or within particular geographical areas?*

Data shows that a higher proportion of Indigenous Australians (27%) are homeless who also experience AOD issues[12]. People exiting custody also experience greater rates of homelessness and it is accurate that some geographical areas are impacted more than others. However, to address the housing needs for these populations, a broader approach is required than one that responds specifically to ATS use within these cohorts.

Social, economic and environmental impacts of ATS

3.2.20 *Can any or all of the current social and economic impacts from ATS in NSW referred to above be quantified? If so, what is the quantification of these costs?*

NADA would defer to our research partners in relation to the quantification of the social and economic impacts of ATS in NSW—acknowledging that it is only through data linkage that these kinds of estimates can be made. At present each health and social service collects data that often has similar areas of inquiry and yet is completely siloed from the other, the Australian Institute for Health and Welfare has begun exploring the integration of large data sets. However, more needs to be done to reach agreements across the myriad health and welfare agencies of how to best share data to be able to answer these complex questions.

Current health service models, barriers to treatment and stigma

3.3.1 *Are service delivery models of care in NSW matched to population need and best practice evidence?*

While there is some investment in improving service delivery models of care in NSW, there is still much to be done—particularly in relation to the continued siloing of AOD and mental health service provision. Mental health issues are a common experience for people who use ATS frequently and for a prolonged period of time, which makes collaboration between AOD and mental health services essential. However, currently there are ongoing barriers for accessing mental health care where ATS use continues, outside of specialist clinics. Best practice in support for ATS and other drug use, indicates service delivery models that have collaborative approaches to mental health and AOD care whatever the treatment goals of the individual.

It is NADA's position that improvements need to be made to service delivery models of care in NSW that have people who use drugs are refused access to the care they need based on the fact that they may continue to use drugs.

3.3.3 What NSW system-wide planning arrangements for treatment services are necessary?

There is currently no comprehensive approach to planning AOD services in NSW. There are some mechanisms that support planning, such as the Ministerial Drug and Alcohol Forum, National Drug Strategy Committee and the NSW Ministry of Health's Drug and Alcohol Program Council. However, these forums do not enable a

[11] Commonwealth Department of Health 2017, The National Drug Strategy 2017-2026. Reviewed from: http://www.nationaldrugstrategy.gov.au/
[12] Australian Institute of Health and Welfare 2018.

coordinated approach to planning, with the non government sector often being disconnected from these processes.

NADA has been advocating for the application of the DASPM in the NSW for the past two to three years. Whilst we appreciate that this tool alone is not the solution to effective planning, it should play a critical role, that also includes consultation with those most impacted, such as funders, treatment providers and treatment service users.

The NSW Legislative Council commissioned a review into the provision of rehabilitation services in regional, rural and remote NSW. The Portfolio Committee No.2 (Health and Community Services) Report 49 was made public in August 2018 and made a series of recommendations. Recommendation 1 is 'That the NSW Ministry of Health implement, as a matter of urgency, a population based planning tool, such as the Drug and Alcohol Service Planning model, to ascertain what rehabilitation services and how many beds are required throughout NSW, and in which regions'. In response, NADA commissioned DPMP, UNSW to run the DASPM for this purpose. The modelling found the need to double the number of beds available in NSW[13].

Whilst there has been progress to move to a more planned approach to AOD treatment, both at the federal and state levels, more needs to be done. The Journal of Studies on Alcohol and Drugs has recently provided a supplement issue on *Global Research on Needs-Based Planning for Substance Use Treatment Systems: Principles, Progress, and Prospects* (Supplement 18, January 2019), which includes research from both Australia and internationally. NADA suggests that this supplement should be reviewed by the Commission in preparing its recommendations.

The current draft NSW Drug and Alcohol plan is sufficient enough to meet the current needs of the sector. However, should the Commission see the need for the development of a new plan or the current one to be revised, we would suggest that a revised plan include how the NSW Ministry of Health plans for AOD treatment. We would advocate for the inclusion of the DASPM as part of a comprehensive approach to planning, that also includes consultation with the sector more broadly to ensure that DASPM tool triangulates with feedback from those on the frontline of service provision. Additionally, we would also suggest alignment with the National Treatment Framework and National Quality Framework that are currently pending with the Australian Government Department of Health.

3.3.2 Is the current amount of NSW government funding adequate to support delivery of treatment and support services to ATS users ….

AOD treatment works when people can access the right kind of care at the right time, with clinical and social support tailored to what is best for the individual. Historic under-investment, stigma, uneven distribution of services, poor integration with other clinical and social services, and a lack of population based state-wide planning have limited the size and effectiveness of the AOD sector in NSW. As a result, too many people and their families experience long delays, and limited choice in a system that is fragmented and difficult to navigate.

This means that the time when people access treatment is often many months or even years later than when they should. Long delays lead to greater harm, increased health care costs, and potentially less successful treatment. Poorly designed funding systems have compounded this effect, undermining service improvement, evaluation and growth. There is broad agreement across both the government and specialist non government AOD sector in NSW that we are only able to provide access to treatment for one in four of all people who are seeking and would benefit from treatment.

[13] Modelling bed numbers for NSW using the Drug and Alcohol Service Planning Model (DASPM) https://www.nada.org.au/wp-content/uploads/2019/03/NADA-Submission-attachment_DPMP-Modelling-bed-numbers-for-NSW-using-DASPM_Feb19.pdf

NADA has been advocating for a comprehensive review of the funding models for non government delivered AOD service provision for the past five years at both the state and federal levels. We have formally submitted position papers to the NSW Government during this time. Based on these, NADA suggests:

- The following funding benchmarks for residential and withdrawal management beds as follows, based on a recent exercise undertaken by NADA for the NSW Health Minister[14].
    1. Funding benchmark for residential rehabilitation services for the adult population: $224.95
    2. Funding benchmark for residential rehabilitation servicing women and children, and pregnant women: $306.85
    3. Funding benchmark for residential rehabilitation services treating complex needs patients (mental health, physical comorbidities and inpatient pharmacotherapy service provision. These costs should also include services for Aboriginal and Torres Strait Islander people and rural service provision): $310.81
    4. Funding benchmark for inpatient withdrawal management: $613.50

- The tier 2 clinic, drug and alcohol specialist rate be applied to out-client pricing for specialist AOD non government organisations. The ABF classification for non-admitted care is the tier 2 clinic classification. There is currently a tier 2 clinic identifier, number 40.30, for drug and alcohol care. A service event for the purposes of this classification is defined by the AIHW as an interaction between a health care provider and a non-admitted patient for the purposes of providing a therapeutic intervention. This is a definition easily met by non government AOD providers. A service event in the tier 2 clinic classification for care type 40.30 'drug and alcohol' without any special population weightings attract an NWAU of 0.0362. At the current NSW efficient price of $4563.00, this equates to a payment of $165.18 per contact or session of treatment.

- An independent costing study be commissioned which identifies appropriate price structures for all AOD treatment types, that considers those currently included in the DASPM, and involves extensive consultation with the NSW non government AOD sector.

- The National Disability Insurance Agency reasonable price model be applied to pricing of welfare support services provided through non government AOD providers.

This will lead to the conclusion that the NSW government will need to significantly increase the AOD budget in NSW. An immediate doubling of the NSW alcohol and other drugs budget would go a long way to ensuring improved access to all treatment types and could be utilised to attract and retain a suitable workforce. This immediate increase in budget would be able to be absorbed within the existing service infrastructures of both the government and non government sectors so would effectively be utilised within a very short timeframe. In the longer term, DASP planning should be undertaken to determine the appropriate population based funding formula for the sector and planned budget increases applied over a five to ten year timeframe with an appropriate capital works budget allocation applied to support the new service infrastructures required.

3.3.4 Are the performance measurement approaches to drug treatment in the health system appropriate to deliver the best health outcomes? Can KPIs be changed to promote better practice….?

There is currently no standardised approach to performance measurement in AOD treatment services in Australia. In NSW, there are almost 90 non government services that receive funding to provide AOD treatment episodes to almost 14,000 annually on behalf of multiple funders. Within multiple funding agreements, providers have numerous and differing performance measures and outcome expectations for the provision of the same type of treatment. For example, one organisation that has up to five different funders

[14] https://www.nada.org.au/wp-content/uploads/2019/03/NADA-Submission_-NSW-AOD-Beds_120319.pdf

could have in excess of 100 performance indicators. The absence of a standardised approach to performance measurement in the AOD field has resulted in a lack of clarity and consistency in accountability expectations, differing approaches to addressing the quality of the AOD service system, as well as a burden on reporting for providers with multiple data collection systems.

The Australian Health Performance Framework[15] provides a conceptual framework for performance measurement of heath care in Australia. The mental health sector has used this Framework to establish performance measures for public mental health services in Australia, though this does not include non government organisations.

NADA sees this as a significant issue for the NSW non government AOD treatment sector and has recently commenced a study with the University of NSW that is seeking to reach consensus on a finite list of performance measures for NSW non government AOD treatment that has input from funders of AOD treatment, treatment providers and treatment service users. The development of these measures will use the conceptual framework in the Australian Health Performance Framework, as well as align with the National Drug Strategy. The Strategy has an action to 'develop and share data and research, measure performance and evaluate outcomes' (Commonwealth of Australia, 2017, p18). They suggested that this is to be undertaken with 'robust evaluation processes to effectively measure impact or outcome of work undertaken, including consistent monitoring and reporting of treatment outcomes'.

NADA does not believe that specific performance measures are required for ATS users. The current Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) already collects primary and other drugs of concern as part of mandatory data collection. This enables both providers, funders and planners to understand the treatment being provided to ATS users. Where there needs to be is improvement on how we better understand and report on treatment outcomes, however this issue is not specific to ATS users that access treatment and is described in more details below.

The current system for the measurement of performance of AOD treatment is primarily focused on measures of output. We know from the literature that there needs to be a range of measures that include outcome measures, as well as structural measures, that assess the capacity of an AOD service to provide quality services (e.g. skilled workforce, program content, facilities). Additionally, access measures, that assess whether a person who needs care is able to access it.

There is a movement by government, both internationally and in Australia, to outcomes based funding and reporting to demonstrate health outcomes resulting from funded treatment. As part of consultations for the New Horizons report referred to earlier, Ritter et al (2014) consulted with both funders and providers in the AOD sector. They reported that whilst there is an appetite to move to outcomes based reporting, reaching a consensus on the development of suitable measures was described as 'fraught', in particular deciding what is a good outcome and for whom—funder, provider, service user. This is further challenged by the impact on co-funded services by two levels of government and the ability to attribute outcomes to funding. These issues were raised in an earlier study by Copeland et al[16] in scoping the establishment of an outcome monitoring report system in NSW. They similarly reported the issue that treatment providers usually receive funds from multiple funding sources, meaning that funders may only be contributing to part of the service, but may receive outcomes data relating to all clients of the service, making attribution to a particular funding source difficult.

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[15] The National Health Information and Performance Principal Committee (2017). *Australian Health Performance Framework*. Retrieved from https://www.coaghealthcouncil.gov.au/Portals/0/OOS318_Attachment%201.pdf

[16] Copeland, J., Rush, B., Reid, A., Clement, N., Conroy, A. (2000). Alcohol and other drug treatment: Predictors of outcome and routine monitoring. National Drug and Alcohol Research Centre Monograph No.45. Sydney, Australia, University of New South Wales.

Whilst this is a challenge, NADA and its members are engaged in a process of working with funders on how we demonstrate performance with outcome measures. We hope the study referred to above will guide us towards having a range of measures to assess performance of AOD treatment.

3.3.10 What research and development initiatives are required to improve available treatment options?

It is NADA's position that a greater emphasis on research that can be easily translated into practice is required to improve treatment. Treatment-related research frequently focuses on research trials that are not compatible with 'real-world' settings or client complexity. Furthermore, limited government investment into workforce development and/or remuneration in the AOD treatment sector has meant that suitably qualified/skilled staff are not attracted or retained—which impacts on the treatment available.

Increases in resourcing to encourage evaluation of treatment being conducted in the AOD sector would lead to improvements in the available treatment options and assist in identifying best practice that could be expanded across the state. Already there is evidence of good practice among NADA members that have undergone independent evaluations with university partners and if more programs like this were sufficiently funded, could be made available in more areas.

Stigma

3.3.14 What is the nature of any stigma associated with ATS use and the impact that stigma has upon ATS users – the Inquiry is particularly interested in hearing directly from ATS users.

NADA is a strong advocate of consumer participation and would encourage the enquiry to invest signifyingly in gaining feedback from consumers across NSW.

People who use illicit drugs, particularly those who inject drugs, can experience significant stigma. They are very often considered as not part of 'normal' society and are commonly labelled as deviants, diseased, unemployed, uneducated, and criminals[17]. Stigma involves processes of labelling, stereotyping, social ostracism, exclusion, and extrusion and are all essential ingredients for discrimination. Experiencing stigma, over any time period can have devastating effects[18].

3.3.15 What is best practice for choice of language and messaging in order to avoid stigmatising ATS users?

Language is powerful, especially when discussing AOD and the people who use them. For information about best practice for choice of language around substance use please refer to the *Language Matters* resource (Attachment 1). This resource was developed by NADA and NUAA, in consultation with non government AOD workers and people who use drugs.

3.3.18 Are there reporting standards for the media in relation to the coverage of drug use and drug users generally? If not, should there be? If reporting standards do exist, are there opportunities to strengthen them?

The Australian Press Council with support from the now defunct Australian National Council on Drugs (ANCD) strengthened advisory guidelines (originally developed in 2004) for the responsible reporting of issues relating to AOD and the users of these substances in 2014. This is of particular relevance as research has found that

[17] Australian Injecting and Illicit Drug Users League (AIVL) 2015, We Live With it Almost Every Day of Our Lives - An AIVL Report into Experiences of Stigma & Discrimination, Canberra, Australia.

[18] Australian Injecting and Illicit Drug Users League (AIVL) 2015.

most of the broader community do not know anyone who uses illicit drugs, and that their major source of information and education is through the media (AIVL, 2010). Of significance to this submission are the guidelines relating to the reporting on the *public debate about drug use and addiction responsibly* and that *the harmful effects of any particular drug should not be either exaggerated or minimised*. Unfortunately, AIVL found in 2005 that few journalists and editors were aware of the advisory guidelines and/or were resistant to using them.

It could well be argued that the media has created a 'drugs crisis' through reporting of inaccuracies, unnecessary dramatisation of issues, and stereotypical representations of illicit drug users. Headlines such as 'Our Ice Epidemic,' Western Australian, 5 April 2018; 'Ice Hits Schools: Our Ice Scourge,' Herald Sun, 18 January 2015; and 'Ice Plague: Victorian-First, Tests Reveal Alarming Spread of Deadly Drug,' Herald Sun, 3 September 2014 all reflect a manufactured drama which conflicts with evidence.

The advisory guidelines are not mandatory, and it has been suggested that the media are reluctant to consider them, if they are aware of them at all. Opportunities do exist to strengthen the guidelines and these include the development and active endorsement of media kits on journalistic best practice in relation to reporting on drugs and drug users, which could include the guidelines and other resources such as language guides, epidemiological data and reference points to key representatives in the AOD sector.

Prevention strategies including education

3.4.1 How effective are current prevention strategies at achieving their intended outcome? How are the effectiveness of such measures measured?

3.4.2 How important is education as a preventative strategy, compared to other prevention approaches?

NADA believes that broader based public education about AOD, the reasons why people use substances and the settings in which they consume them would be valuable in terms of encouraging more useful public discussion of AOD issues. Furthermore, education needs to include the effectiveness of treatment options should people feel concerned about their use—there is very little community knowledge about the treatments available and where people can go to access information and support.

Primary education and prevention initiatives, delivered through school based education or broader community messages need to be factual and suitable for a broad audience and age appropriate. Secondary and tertiary education and prevention strategies (for those people already using substances) should be harm reduction based and best delivered as psychosocial education within a treatment setting e.g. community based counselling settings and residential treatment settings.

3.4.3 What is the current distribution of resources and activity across primary, secondary and tertiary prevention measures? Does this need to be rebalanced?

NADA would argue that primary, secondary and tertiary prevention measures are grossly underfunded and in terms of best practice prevention strategies, not funded as a coherent strategy within the state and federal government AOD strategies. Given this, we believe the question of the distribution of resources across the three areas is mute. NADA recommends a fundamental reassessment of the role and place of properly planned and resourced education and prevention strategy needs to be undertaken as a priority by the Ministry of Health.

3.4.4 Are priority populations receiving adequate and appropriate information about ATS and related harm? If not, how can this be improved?

NADA argues that a statewide education and prevention strategy for the whole AOD program needs to be developed as a companion strategy to the NSW drug and alcohol strategy which we have noted has still not been approved by the NSW Health Minister. This education and prevention companion strategy needs to be planned on the basis of a whole of population and priority populations data, available evidence in relation to best practice methods for the development and delivery of appropriate education and prevention strategies and funded adequately over the life of the overall state strategy.

3.4.5 Is the information currently being disseminated about ATS accurate, up to date and appropriate? Is the information currently being disseminated contributing to stigma associated with ATS use in any way?

Information from within the non government sector is that quality and accuracy of information varies enormously and there is still a lot of misinformation about ATS and related substances. In relation to the second part of this question, the feeling is yes, current information continues to contribute to stigma and media hysteria and it is believed reduces options to access treatment for people or even discuss e.g. with peers due to the use of loaded and discriminatory language. Furthermore, there is research evidence that clearly indicates that people who use ATS and have experienced harms have delayed accessing treatment longer than seen for people using other substances.

3.4.6 Are the websites that have been developed by the Commonwealth and NSW Government to provide information about ATS related issues adequate? If not, why not?

Resources targeting workers and consumers such as 'Cracks in the Ice' and 'Ice: Online training for Frontline Workers' are considered by NADA members to be useful resources.

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ISSUES PAPER 4: DATA, RESOURCES AND FUNDING

4.1.1 Is there a need for a prospective data plan that identifies knowledge gaps and seeks to develop datasets to address those gaps?

Yes, current data sets need to be reviewed and updated to improve our knowledge and understanding of what is happening for those seeking drug treatment and for accessing those who aren't. A prospective data plan could bring together the knowledge and experience of people in the field that are already aware of the gaps in current datasets and can identify what we can learn from global examples.

4.1.2 *What new datasets need to be developed to inform appropriate policy development in relation to ATS use*

The following datasets would better inform appropriate policy development and planning in relation to treatment:

- more real-time monitoring of ED presentations and toxicology reporting that can be applied in practice to respond to changes in ATS drug types, including early warning systems that can reduce harm
- datasets that identify the barriers people face in reaching out and accessing treatment would inform planning and policy development

- datasets that focus on client/patient feedback on the effectiveness of treatment and the measuring of therapeutic alliance assisting in informing the treatment as it happens rather than after a client has ceased to attend.

4.1.8 How well do current funding and governance structures for AOD and ATS research enable coordination across national and jurisdictional bodies, and are the models sustainable to allow forward research planning?

NADA strongly believes that there are major gaps between research institutions and treatment service providers and that more needs to be done to have research conducted in 'real-world' settings. NADA would like to see improvements to funding for research partnerships and translation of research into practice.

4.2.14 How should funding be allocated across NSW for ATS-related services?

One way in which funding could be allocated across NSW for ATS-related services is via use of the Drug and Alcohol Service Planning Model (DASPM). This population based service planning model for AOD is a useful 'decision support tool' and can assist in targeting the level and mix of services (community based services, residential rehabilitation services, and hospital services) required across different geographical areas of NSW.

4.2.15 What action has the NSW Government taken to implement the recommendation of the 2018 NSW Parliamentary Inquiry into Drug Rehabilitation to use a population-based planning model such as the DASP model?

NADA is aware that action has been taken outside of NSW regarding the implementation of the DASPM.

On 7 September 2017 at the Commonwealth level an 'order for the production of documents' regarding the Drug and Alcohol Services Planning Model (DASPM) which has previously been described as the Drug and Alcohol Clinical Care and Prevention (DA-CCP) Project was made in the senate. These DASPM documents are now publicly available on the Australian Parliament website. The Royal Australasian College of Physicians (RACP) welcomed the release of the modelling tools, which are more easily accessed via the College's media release. See https://www.racp.edu.au/docs/default-source/default-document-library/20170918-racp-welcomes-release-of-modelling-tools-on-drug-and-alcohol-services.pdf?sfvrsn=0.

NADA is also aware that Western Australian Mental Health Commission used the DASPM in their Mental Health, Alcohol and Other Drug Services Plan 2015–2025, which is publicly available at https://walga.asn.au/getattachment/Policy-Advice-and-Advocacy/Community-Development/Health-and-Wellbeing/Western-Australian-Mental-Health-Alcohol-and-Other-Drug-Services-Plan-2015-2025.pdf.aspx?lang=en-AU

4.2.16 Would the implementation of a population-based planning model beyond residential rehabilitation services improve ATS treatment planning and funding more broadly? If yes, how would it assist and which agencies should use it?

Yes, the implementation of a population based planning model beyond residential rehabilitation services would improve ATS treatment planning and funding more broadly. As a 'decision support tool' the DASPM can assist in targeting the level and mix of services (community based services, residential rehabilitation services, and hospital services) required across different geographical areas of NSW.

Several NADA members were represented on the DASPM Expert Reference Group which built the model between 2010–2012. Making the Excel based DASPM tool easier to use and providing training to use the tool would be an important first step.

NADA is aware that a similar 'decision support tool' is used in planning national mental health services. This tool is the National Mental Health Strategic Planning Framework (NMHSPF). Publicly available information shows that the Commonwealth Department of Health funded NSW Ministry of Health, and Queensland Health to develop this initial mental health population based service planning tool. See https://nmhspf.org.au/about-the-nmhspf/.

NADA is aware that training to use the mental health planning tool in now provided by a university. From May 2017 the University of Queensland commenced training mental health planning staff from within Primary Health Networks and State and Territory jurisdictions to use the NMHSPF. A similar approach to increasing uptake of the DASPM via an external training provider could be considered for NSW.

Harm reduction measures—MSIC, NSPs and substance testing

As a member driven network, NADA is supportive of its member agencies' submissions and values and respects their expertise in this areas outlined in Issues Paper 3.