Queensland Network of Alcohol and Other Drug Agencies Ltd

3 February 2022

Mental Health Select Committee

Parliament House

George Street

Brisbane QLD 4001

Dear Mental Health Select Committee Members

Thank you for the opportunity to provide a submission to the *Inquiry into opportunities to improve mental health outcomes for Queenslanders*. The Queensland Network of Alcohol and other Drugs (QNADA) submission is attached.

QNADA represents a dynamic and broad-reaching specialist network within the non-government alcohol and other drug (NGO AOD) sector across Queensland. We have more than 50 member organisations, representing the majority of specialist NGO AOD providers. This submission is made following consultation with QNADA members.

QNADA is pleased to provide further information and would welcome the opportunity to discuss any aspect of this submission with the Committee. Please don't hesitate to contact me at [redacted] or by calling [redacted]

Yours sincerely

Rebecca Lang

CEO

Post: Level 20, 300 Queen St,Brisbane, 4000 Ph: 07 3023 5050 Web: www.qnada.org.au Email: info@qnada.org.au ABN: 68 140 243 438

Submission to the *Inquiry into the opportunities to improve mental health outcomes for Queenslanders*

February 2022

Summary

This submission has been prepared by the Queensland Network of Alcohol and Other Drug Agencies (QNADA). Its' content is informed by our regular engagement with member organisations providing treatment and harm reduction services across Queensland, as well as a review of relevant research and reports.

Our submission addresses the Terms of Reference for the *Inquiry into the opportunities to improve mental health outcomes for Queenslanders* (the Inquiry) in three distinct, but inter-related parts. Good practice examples, case studies and identified areas for improvement are also highlighted throughout this submission.

Part A: Services

This section discusses the following areas of the Committee's Terms of Reference:

- *the current needs of, and impacts on, the alcohol and other drugs service system in Queensland*. We note that while most people who use alcohol and other drugs don't require treatment around their use, for those that do there are insufficient specialist services available. Challenges associated with an ageing workforce and limited educational pathways specific to alcohol and other drugs are also discussed, with positive shifts seen at a state level over the past five years to improving planning and increase the investment in alcohol and other drug treatment and harm reduction services in Queensland.
- *opportunities to improve the economic and social participation of people who are experiencing problematic substance use* through comprehensive, coordinated and aligned services (including both specialist and generalist services) across the care continuum. This extends to a consideration of the importance of incorporating lived experience perspectives in all aspects of program and policy development.
- *service safety and quality, workforce improvement and digital capability* are also touched upon with positive examples provided of existing resources and partnerships that are helping to drive quality improvements across publicly funded alcohol and other drug treatment and harm reduction services in Queensland.

Challenges still exist at a national level however, with less stable funding arrangements which can impact state funded services, as well as issues in relation to unregulated private residential facilities. Future opportunities also exist to improve access to services through fully realising the potential of telehealth models (particularly with respect to improving access to opioid treatment prescribers, and for people in custody).

Part B: Policy

This section discusses the following areas of the Committee's Terms of Reference:

- *relevant national and state policies* and the associated need to improve system governance and leadership outside of the health system at both a state and Commonwealth level; to better drive cross-system partnerships and reforms.
- *current funding models*, and how evidence informed investment by the Queensland Government and other levels of government can enhance outcomes for Queenslanders, although longer-term funding is required to reduce disruption to critical health services.
- *opportunities to better consider the perspectives of people with a lived experience* of drug use in future policy and planning reform activities.

In particular, opportunities to expand evidence based harm reduction initiatives, improve access to information services for people who use drugs, and to recommit to the implementation of policy reform regarding diverting people who use drugs from the criminal justice system, are identified.

Part C: Systems

This section provides a broad overview of the economic and societal impacts of alcohol and other drug use in Queensland, and notes that the significant harms associated with this use can often be a result of our policy and legislative response to alcohol and other drug use, rather than the use in and of itself.

Also discussed are opportunities for greater whole of system collaboration and partnerships across the criminal justice, child protection and youth justice systems, as well as opportunities to better understand the intersections between alcohol and other drugs problems and mental health.

Finally, the need to refocus our approach to those that focus on addressing the social, cultural and structural determinants of health is also identified, in line with clear evidence that shows that to achieve a meaningful improvement in outcomes we need to collaborate across the government and non government sectors to address complex social issues.

Contents

QNADA members delivered over 20,000 episodes of care to more than 14,000 Queenslanders in 2020-21, from over 100 service locations across Queensland.

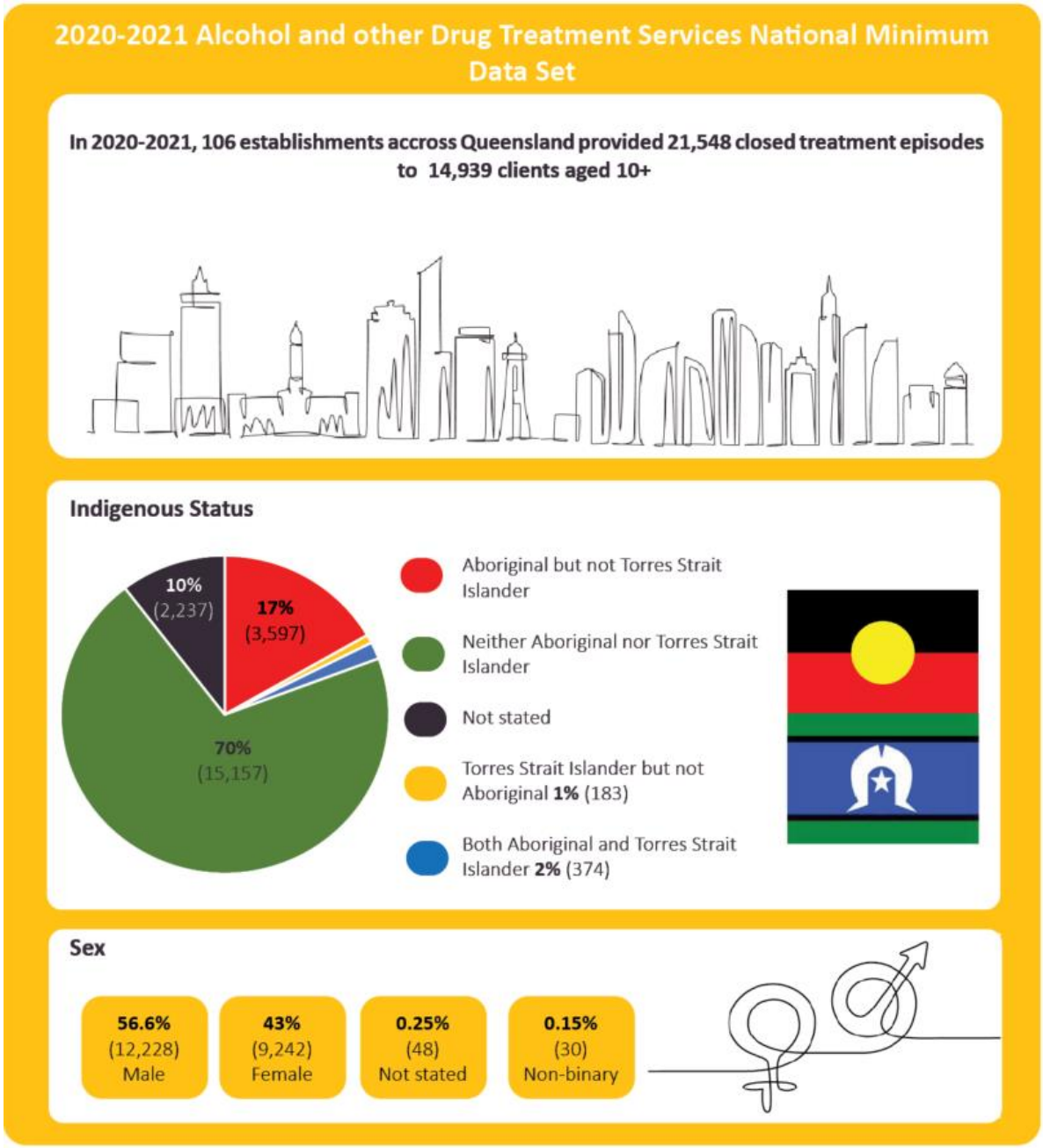
About QNADA and its' members

QNADA is the peak organisation for the non-government (NGO) alcohol and other drug treatment and harm reduction sector in Queensland. We are committed to supporting our member organisations to deliver high quality, evidence informed alcohol and other drug treatment and harm reduction services to individuals, families, and communities in Queensland.

We have over 50 member organisations, representing the majority of specialist non-government alcohol and other drug services operating across the state. Our members provide a range of services including rehabilitation (residential and non-residential), withdrawal management (detox), psychosocial interventions, medication assisted treatment, and harm reduction services. QNADA actively engages and supports staff working at member organisations across all levels recognising that it is every part of an organisation that contributes to the quality of services provided.

QNADA also engages our members, key stakeholders, the broader alcohol and other drug sector and other social and community sectors in activities designed to enhance workforce and sector capacity to respond to issues related to substance use.

Our strong connection to treatment providers, combined with our understanding of the Queensland context has meant we are well placed to identify the work that needs to be done; contribute to knowledge development and the translation of policy and research into practice; and to test the relevance, feasibility, and generalisability of our solutions to improve the health and wellbeing of Queenslanders.



Data interpretation notes: The data is limited to those NGO AODTS who submit through QNADA, including statewide residential treatment services. Data from AODS or similar government services is not included. Please note, in some cases, agencies may not submit data to QNADA.

Client type

4.4% (944) Other's drug use

95.6% (20,604) Own drug use

Most episodes were provided to clients for their own drug use.

Main treatment type

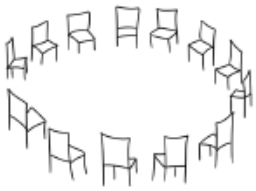
Counselling was the most accessed treatment type followed by **rehabilitation**, and **support and case management**.

Assessment only: **11%** (2,303)

Case management: **15%** (3,172)

Rehabilitation: **16%** (3,396)

Counselling: **50%** (10,823)



Delivery setting

Non-residential treatment facility was the most common delivery setting.

Other: **1%** (192) - usually refers to phone setting

Home: **1%** (202)

Residential: **14%** (3,055)

Outreach: **20%** (4,347)

Non-residential: **64%** (13,752)

Withdrawal management (detoxification) made up 5% of total episodes (1,022) and **information and education** made up 3.6% (762).

Part A: Services

This section discusses the following areas of the Committee's Terms of Reference:

- *the current needs of, and impacts on, the alcohol and other drugs service system in Queensland*. We note that while most people who use alcohol and other drugs don't require treatment around their use for those that do, there are insufficient specialist services available. Challenges with an ageing workforce and limited educational pathways specific to alcohol and other drugs are also discussed, with positive shifts seen at a state level over the past five years to improving planning and investment in alcohol and other drug treatment and harm reduction services in Queensland.
- *opportunities to improve the economic and social participation of people who are experiencing problems related to substance use* through comprehensive, coordinated and aligned services (including both specialist and generalist services) across the care continuum. This extends to a consideration of the importance of incorporating the lived experience perspectives in program and policy development.
- *service safety and quality, workforce improvement and digital capability* are also touched upon with positive examples provided of existing resources and partnerships that are helping to drive quality improvements across publicly funded alcohol and other drug treatment and harm reduction services in Queensland.

Challenges still exist at a national level however, with less stable funding arrangements which can impact state funded services, as well as issues in relation to unregulated private residential facilities. Future opportunities also exist to improve access to services through fully realising the potential of telehealth models (particularly with respect to improving access to opioid treatment prescribers, and for people in custody).

Effective Responses to Alcohol and other Drug Use

Effective responses to alcohol and other drug use, like other health interventions, are evidence informed and matched to the needs of individuals based on the level of harm experienced, and intensity of use.

What constitutes an effective intervention will be different from one person to another, however all effective interventions are flexible, realistic, and culturally responsive.

Effective treatment and harm reduction services tend to also be publicly funded, accredited, informed by scientific evidence, and delivered by appropriately skilled and qualified professionals. There are a range of treatment (e.g. counselling, rehabilitation) and harm reduction (e.g. needle and syringe programs, drug checking) service approaches and settings, which have good quality evidence for their effectiveness, regardless of a person's drug/s of concern.

In Queensland, the alcohol and other drugs treatment and harm reduction service system is made up of public, non-government and private providers, delivering the range of treatment responses identified in Figure 1 below.

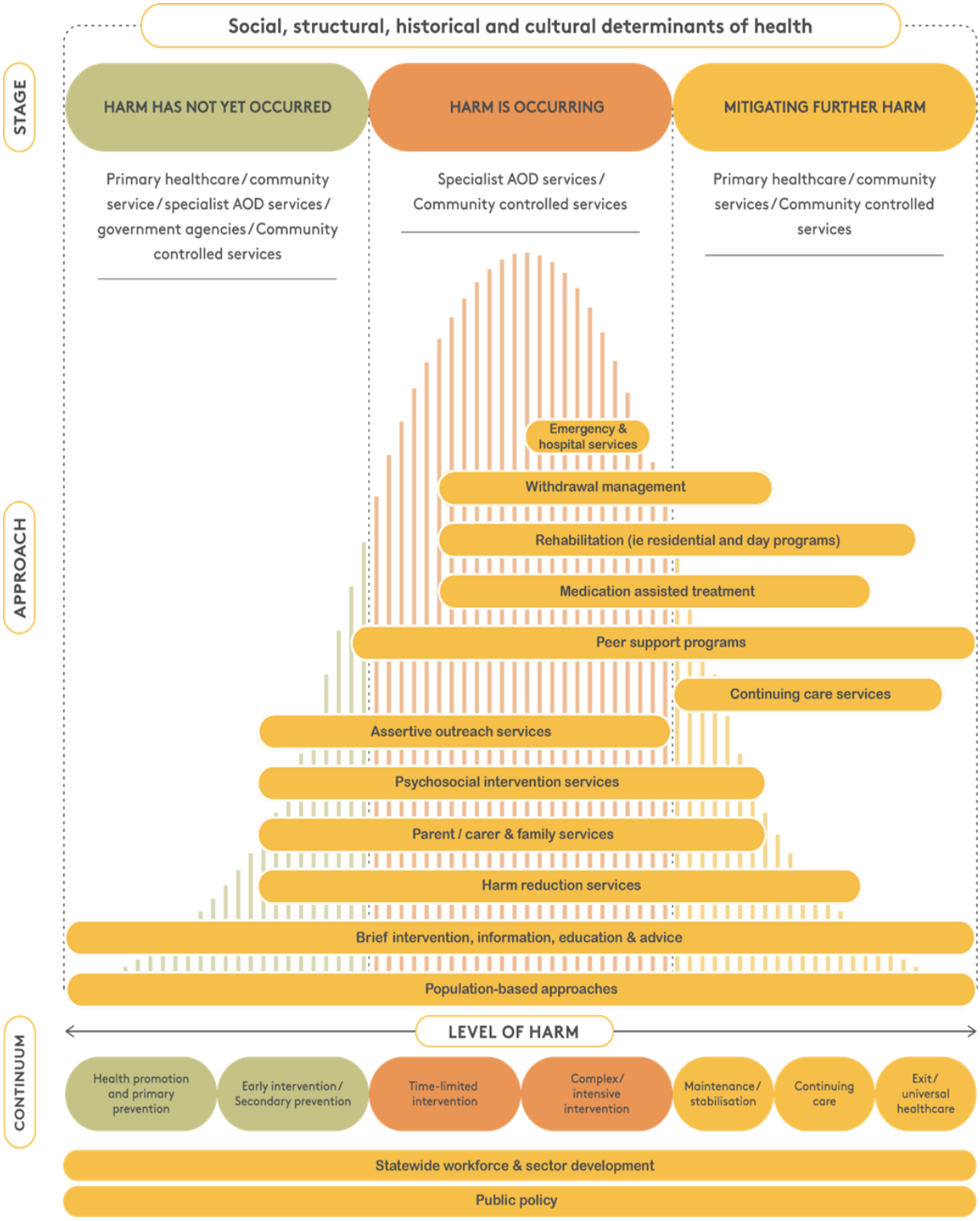


Figure 1: Alcohol and other drugs treatment and harm reduction services[1]

[1] Queensland Alcohol and Other Drugs Sector Network. (2022). Queensland Alcohol and other Drug Treatment Service Delivery Framework (draft update to the 2015 version). Brisbane: Author.

At the outset, it is important to note that the vast majority of people who use alcohol and other drugs do so occasionally and without issue and don't require any form of intervention from services. Instead, they are primarily interested in accessing accurate and timely information to protect their safety and wellbeing in relation to their use.

The notion that policy should be informed by the people it most directly affects is widely considered an important ethical consideration for public health and policy development[2]; however the voices of people who use drugs, have traditionally been marginalised from policy debate.

"We need to value and incorporate the voices of those who use drugs into both research processes and policy processes. Indeed, it has been said that one way of responding to stigma is to involve marginalised individuals in the policy-making process (Lancaster, Ritter & Stafford, 2013)."[3]

"Despite the fact that [even] the broader criminological literature has demonstrated the need for offenders' views to be heard in policy and practice, most of the responses to drug-related overdose, drug-related crime, family breakdown, drug treatment, etc., have been developed in isolation to people who use illicit drugs. People who use drugs, as the community most directly affected by policy responses, should have their views represented in policy deliberation (a position widely held in the international drug policy community). [4]"

Global research indicates that **88%**[5] of people who use illicit drugs do not experience dependence or require treatment intervention.

More than **2** in **5** Australians have used an illicit drug in their lifetime, most commonly cannabis. More than 1 in 10 Australians have used cannabis in the last 12 months.[6]

Smoking rates increase with socio-economic disadvantage, but rates of illicit drug use are highest in the most advantaged areas.

[2] Organisation for Economic Co-operation and Development (OECD), Engaging citizens in policy-making: information, consultation and public participation, in OECD Public Management Policy Brief No. 10. Organisation for Economic Co-operation and Development (OECD): Paris. 2001. quoted in Kari Lancaster, Alison Ritter, and Jennifer Stafford, "Public Opinion and Drug Policy in Australia: Engaging the 'Affected Community'," *Drug and Alcohol Review* 32(1) (2013).

[3] Alison Ritter, Kari Lancaster, and Monica Barratt, "Researcher Engagement with People Who Use Drugs," *Drug and alcohol Research Connection* (2016), http://connections.edu.au/opinion/researcher-engagement-people-who-use-drugs.

[4] Latkin, C. and Friedman, S., Preface. Substance Use & Misuse, 2012. 47(5): 461 quoted in Lancaster, Ritter, and Stafford, "Public Opinion and Drug Policy in Australia: Engaging the 'Affected Community'."

[5] United Nations Office on Drugs and Crime, "Global Overview of Drug Demand and Supply," in *World drug report 2021* (Vienna: United Nations, 2021).

[6] Australian Institute of Health Welfare, "National Drug Strategy Household Survey 2019," (Canberra: AIHW, 2020).

Only a very small proportion of people who use alcohol and other drugs require treatment (the United Nations Office on Drugs and Crime estimates 11-12 percent)[7]. Experiencing problems with alcohol and other drugs is often predicated by experiences of trauma and influenced by social, cultural, historical, and structural determinants of health.

This means alcohol and other drugs treatment can be psychologically and socially complex, with the effectiveness of counselling reinforced by case management support, particularly for young people (as outlined in the case study below). Needs related to statutory system engagement or income support may require prioritisation in order to support engagement with counselling interventions.

People may also transition between approaches in an ordered way (e.g. withdrawal management to rehabilitation), or in a more episodic way (e.g. periodically accessing counselling or case management support in times of crisis).

In this way, alcohol and other drugs treatment can be said to address the social, cultural, and structural issues that can influence whether a person is likely to experience further harm related to their alcohol and other drug use. The more protective/positive factors in a person's life (e.g. healthy integration of traumatic events, stable housing, connection to community and culture), the less likely a person is to experience ongoing problems with their use.

QNADA is committed to supporting our members to reap the benefits of engaging with people with a lived experience, which include better outcomes for people using the service/system, improvements to workforce morale, and service, system and policy responses that are in line with community attitudes and expectations. In 2017, QNADA worked with our colleagues at the Qld Alliance for Mental Health and Enlightened Consultants to develop the Stretch2Engage framework (supported by funding from the Qld Mental Health Commission). The Stretch2Engage framework is founded on values that acknowledge that meaningful engagement of people, their families and friends is a human right, fundamental to citizenship and recognises that this requires those who engage to think and act differently.

In 2020, we worked with the same partners to pilot the Stretch2Engage framework in 7 AOD and mental health services across public, private and non-government sectors. This work focused on building the capacity of organisations to think differently about engagement and supported them to design engagement activities which recognised that the responsibility for engagement is with the organisation, rather than with the people seeking help.

[7] United Nations Office on Drugs and Crime, "World Drug Report Booklet 2: Global Overview of Drug Demand and Supply: Latest Trends, Cross-Cutting Issues," World drug report 2018 (Vienna: United Nations, 2018).

An independent evaluation of the pilot project showed that the framework and associated capacity building work with organisations led to an increased capacity for those organisations to undertake meaningful engagement with people who use their services which in turn led to an increase in engagement activity. In addition, it revealed multiple positive impacts for stakeholders including improved service delivery and collaboration, improved staff morale, benefits for people using services and their families and friends through improved feedback mechanisms and better services, and increased organisational efficiencies through reduced absenteeism and more streamlined service provision.

The Stretch2Engage framework continues to be utilised in a variety of settings in the AOD and mental health sector to inform and develop engagement/consultation approaches. However, increasing resourcing and other strains on services make it difficult to prioritise engagement activity. Given the challenges and importance of engaging with people who use drugs in Queensland, more work is required to support services, systems and policy makers to realise the potential of Stretch2Engage framework to ensure that we leave behind the traditional representative and sometime tokenistic approaches to engagement in favour of more genuine and authentic approaches.

Case Study: Daisy's Story

Daisy was a 17 year old young woman who was referred by Child and Youth Mental Health Services (CYMH) to access case management support from QNADA member organisation YETI (Youth Empowered Towards Independence). During intake and assessment, it was identified that she was experiencing challenges relating to her alcohol and other drug use, mental health concerns, intimate partner and familial relationships, as well as disconnection from education and employment.

Through support and referrals offered by YETI, Daisy has received collaborative support from a range of service providers which has seen a massive improvement in her wellbeing, motivation for change and self-efficacy. This includes:

- *Safety:* Daisy was supported to develop safety plans to maintain her safety. Her partner was also offered access to supports but declined. She later nominated to leave the relationship and is now safe.
- *Disconnection from family*: Daisy reports that her involvement in pro-social activities such as school have had an immensely positive impact on her relationship with her mother and conflict has been resolved.
- *Risk of homelessness:* Daisy was initially referred to Youth Link supported accommodation program, however due to resolved family conflict young person was supported to return to her family home.
- *Mental health:* Daisy's engagement with CYMHs has been maintained through transport and emotional support from YETI. At times YETI has also provided financial assistance for mental health medication and supported her with budget development to self-manage this expense. YETI has also supported Daisy to develop emotional regulation and impulse control skills. Through working with YETI and CYMHS this young person's self-harming behaviours have continued to decline.
- *Alcohol and Other Drug Use:* Daisy successfully engaged in harm minimisation strategy development regarding substance use and successfully attained her substance reduction goals.
- *Disconnection with employment and education:* Daisy was supported to enrol in Busy Schools and is still engaged. Daisy has now commenced job seeking with her YETI case manager.
- *Identification*: Daisy was supported to attain identification to enable school enrolment.

Case Study: Jane's story

Jane is a 46-year-old mother with seven children who presented to QNADA member organisation the Qld Injectors health Network (QuIHN) for support with managing her alcohol use and maintenance of cessation of prior methamphetamine use.

Jane had ceased using methamphetamine during pregnancy. Her son was removed from the hospital following birth with the primary reason being a voluntary 30-day order due to homelessness (rough sleeping) and no other reason cited (with respect to her capacity to care and protect).

Jane was discharged from hospital without being offered follow up care, no accommodation, no referrals, or transport vouchers were offered. She slept in a public toilet that evening. Her partner and father of her child has a current protection order in place.

At the time of Jane's discharge from hospital he was outside of the same hospital waiting for support from Mental Health services. He was presenting as agitated and asking for his long acting medication to be administered by Depo injection (which was not provided for six weeks). In the meantime, the Hospital Social Worker attempted to link him in with Homeless Health Outreach Team however outreach treatment was refused due to his violent behaviour.

Both parents remained homeless for six months post- birth. Child Safety invoked a 2-year order, although Jane had been advised that a voluntary order could be entered into. She is now dealing with extremely severe anxiety (as evidenced by Psychometric testing) associated with feeling guilty about '*giving up a child*', having to prove her ability to care for him, as well as ongoing trauma from his removal shortly after giving birth.

This is exacerbated by advice that she is unable to be re-unified with her baby until she has secured housing, however she cannot secure supported housing as a single woman without a child. Communication from child safety officers had also been confusing and stressful. For example, the client was advised that her baby was unwell and asked to present to the hospital to support him. While facing financial difficulties and highly stressed about her son's health she was then advised upon arrival that she was not allowed to attend due to COVID-19 restrictions and she had to leave without seeing him.

There are significant attachment and bonding issues. For example, no photos and/or recording of her son's milestones were given to Jane until he was six months of age. She also been unable to regularly see him due to COVID-19 lockdowns; child safety closing over public holidays; with no opportunity for makeup sessions provided.

Jane has complied with abstinence from substances and routine hair follicle testing. However, she was recently prescribed medical marijuana to manage her severe anxiety from a GP. Child Safety will not acknowledge this prescription and has taken the positive test as evidence of illicit cannabis use. The alcohol and other drug service is continuing to support Jane with maintaining cessation of her (previous) methamphetamine use, managing stress, anxiety, and trauma and referrals to access supported housing and her experiences of domestic and family violence.

Although only a relatively small proportion of people who use alcohol and other drugs experience problematic use, there is insufficient supply of specialist alcohol and other drugs treatment and harm reduction services to meet demand[8]. QNADA has worked productively with Queensland Health (through the Mental Health, Alcohol and Other Drugs Branch) over a number of years to quantify this gap and support planning processes to address the identified shortfall in Queensland.

Over the past five years this gap has begun to be addressed by the Queensland Government through additional funding allocations, primarily in the non government part of the system. There are also promising signs for service growth in 2022, with three new State funded residential rehabilitation services under development and a solid consultation process to update the *Queensland Drug and Alcohol Services Planning Model* (QDASPM) to inform the next Statewide services plan.

However, growth plans for the specialist alcohol and other drug treatment sector are moderated by the need to continue to develop a specialist workforce, and new service models to improve access for vulnerable populations. This includes an under-supply of withdrawal management (particularly inpatient), family units and non residential specialist services for young people

[8] Alison Ritter et al., "New Horizons: The Review of Alcohol and Other Drug Treatment Services in Australia," in *Final Report* (Sydney: University of New South Wales, 2014).

This means there is still much to be done before we can say that the supply of services meets the demand from Queenslanders.

In an environment of an under supply of specialist services, it is important to develop and contemporise our shared understanding of when and how other sectors and services should respond to alcohol and other drug use to help better manage issues when they arise.

A review of the differing philosophies and approaches across sectors is required to establish a solid foundation for collaboration and coordination between alcohol and other drugs specialists and other services or systems who come into contact with people who use alcohol and other drugs.

For example, recent research commissioned by QNADA in collaboration with the Brisbane North Primary Health Network shows that primary care practitioners consider that they have limited knowledge and/or confidence to deliver basic alcohol and other drug assessments and brief interventions.[9]

People who use alcohol and other drugs, whether occasionally/socially or dependently, also feel unsafe to talk about their substance use in primary care settings. Limited specialist alcohol and other drugs service availability and support at a local level can also increase the reluctance of primary care

[9] Queensland Network of Alcohol & Other Drug Agencies (QNADA), "Submission to the Inquiry into the Provision of Primary, Allied and Private Health Care, Aged Care and Ndis Care Services and Its Impact on the Queensland Public Health System," (Brisbane2021).

practitioners to explore alcohol and other drug issues due to limited referral pathways and/or longer waiting times to access more intensive treatment.

Case Study: Delivering system improvements

We know that people who use drugs experience a range of barriers in attempting to access appropriate treatment and support in the health system, which are rooted in stigma and discrimination. QNADA members have regularly raised the issue of stigma and discriminatory practices experienced by their clients over many years (e.g. via statewide surveys, routine member contact, and targeted consultations). We've represented our members' experiences and the best available evidence regularly to the State and Commonwealth governments as well as various departments and commissions throughout Queensland through written submissions, systems advocacy on behalf of the alcohol and other drug treatment and harm reduction system, as well as providing expert advice to the community sector for use in developing their workforces.

As part of this work, we first raised the issue of stigma and discrimination of people who use alcohol and other drugs with the Queensland Mental Health Commission in 2014. This led to the Commission including an action related to better understanding what we can do to reduce stigma and discrimination in their first whole of government action plan. The Drug Policy Modelling Program (DPMP) were subsequently commissioned to undertake research and produce a report - *Reducing stigma and discrimination for people experiencing problematic alcohol and other drug use* – which then informed the options for reform outlined in *Changing Attitudes, Changing Lives: Options to reduce stigma and discrimination for people experiencing problematic alcohol and other drug use* (2018). In addition to a range of other options for reform, these reports identified that increasing the availability of alcohol and other drug treatment responses in primary care settings had the potential to reduce stigma and facilitate specialist treatment access. QNADA sought to further develop our understanding of the structural issues affecting primary care access for people who use alcohol and other drugs by engaging the DPMP in 2019 to work with us to develop 15 practical recommendations for the Brisbane North PHN to increase primary care responses to people who use alcohol and other drugs in the Brisbane region.

These recommendations were informed by Brisbane-based general practices, people who use alcohol and other drugs and had experienced system access issues, and a comprehensive policy and literature review. Importantly, the recommendations moved beyond simple training initiatives and focused on system issues that impact on practice decisions to identify and work with people who use alcohol and other drugs.

The recommendations spanned three broad areas:

- initiatives to improve knowledge of, and linkages to, existing supports and services for GPs
- initiatives that involve new models or greater expansion of existing models in Brisbane North PHN to provide additional support to GPs and/or people who use alcohol and other drugs
- addressing gaps in policy, guidelines, and training.

QNADA's work with DPMP and Brisbane North PHN has generated interest from other PHNs in Queensland and we are now conducting a trial of in Western Queensland, with the support of the local PHN. Recognising that in many parts of Queensland, specialist treatment services are sparsely dispersed across regions, being able to see a primary care practitioner regarding alcohol and other drug issues is particularly important.

The trial in Western Queensland aims to safely challenge stigmatising beliefs and discriminatory attitudes held about alcohol and other drug use and to provide practical support for primary care providers to maximise the impact that primary health care services can have in delivering effective assessment, brief intervention and referral.

We anticipate our work will lead to increased knowledge and confidence of practitioners regarding evidence-based prevention, care, treatment and referral options for people experiencing alcohol and other drugs issues, increased use of evidence-based screening and assessment tools and improved likelihood of people receiving alcohol and other drugs support and assistance from primary care providers. As part of this work we are establishing sustainable service level networks and providing tailored coaching and support for primary care services in the region.

Workforce capacity and current funding arrangements

There are a number of key workforce pressures faced by alcohol and other drug treatment and harm reduction services across the state. We have an ageing alcohol and other drugs workforce,[10] limited professional educational offerings with a focus on alcohol and other drugs, and so there is the worrying potential for loss of experience and skill that could occur as older workers retire.

These issues are exacerbated by cyclical short-term funding arrangements, particularly from the Commonwealth government, which impacts the capacity of services to effectively plan, develop and retain their workforce. At the time of writing, long-term funded and established services have not been advised of Commonwealth funding beyond 30 June 2022, with only verbal assurances provided that funding will be continued. QNADA has had limited capacity to influence improvements in the process due to the opaqueness of Commonwealth decision making. This impacts State funding effectiveness, particularly for residential services, as most are funded through a mix of State and Commonwealth contracts.

> Alcohol and other drug services *'attract around a tenth of the funding of mental health services. Forty one per cent of full time alcohol and other drug workers earn less than the average Australian income. It's difficult to attract and retain qualified professionals to a sector that is so chronically underfunded, which makes it difficult to improve specialisation.'*
>
> Lee, N. and Allsop, S. (2020)

Stop-start funding arrangements and last minute contract renewals impact the ability of services to develop and maintain a skilled and available workforce and ultimately creates a range of quality, safety, and treatment access issues for people seeking advice and assistance. This can lead to detrimental outcomes as when people are unable to access the necessary support, it can also reduce the likelihood of future help-seeking. It also increases pressures in other parts of the system (e.g. mental health services, emergency departments) contributing to:

- coordination and collaboration issues, meaning people can fall through the gaps;
- limitations in information and knowledge sharing which impacts the capacity of services to provide holistic and coordinated care;

[10] Skinner, McEntee, and Roche, "Australia's Alcohol and Other Drug Workforce: National Survey Results 2019-2020."

- a varying appetite for risk between systems which may result in punitive responses when people disclose their use; and
- unhelpful and outdated system responses and philosophies that can perpetuate stigma and discrimination.

As noted above, work has been undertaken to improve planning and contracting arrangements for specialist alcohol and other drugs services in recent years. For example, the Qld Drug and Alcohol Services Planning Model (QDASPM) has been developed and is based on epidemiological data, contextualised by expert input. It provides an estimate for the number of full time equivalent positions required across alcohol and other drugs professions and treatment types per 100,000 people, calculated by unpacking the components of each type of treatment provided.

We are supportive of the QDASPM being used to plan for specialist treatment services in the future and the continuation of the collaborative approach taken to update this model for use in Queensland. In addition, Queensland Government's move to longer term (5 year) contracts has contributed to increased stability for services. However, delays at a national level in Commonwealth funding flowing to PHNs and then decision making by individual PHNs has had a negative impact on service provision. For example, last financial year several QNADA members' reported they had to stand-down staff due to late contract renewals and with the delays in announcements related to Commonwealth funding beyond 30 June 2022, it seems likely this situation will be repeated.

Further, inexperience with alcohol and other drug services and treatment approaches has resulted in one PHN trialling funding by outcomes despite clear evidence that this is an ineffective approach and counterproductive to increasing system stability and service quality. Thankfully we were able to bring this to their attention prior to the arrangements being established and the approach was ultimately discontinued.

In an already stretched and under-resourced system, with known workforce pressures, we should be looking to increase stability and predictability in order to facilitate access to treatment for those who need it, through the continuation of block-funding as the preferred model of funding for the alcohol and other drugs system (as outlined in Table A).

Funding mechanism	How it works	Our perspective
Block funding	Known level of payment for provider and purchaser, regular lump sum, routine reporting of activity and outcomes, performance managed via regular contracting and review	Predictable, stable, increases workforce sustainability
Activity-based funding	Payment based on level of activity or episodes of care, varying levels of payment, seeks to manage performance by incentivising efficiency	Difficult to determine appropriate units of activity due to complexity of alcohol and other drug system, open to 'cherry picking' less difficult clients in order to increase activity, less stable
Funding by outcomes	Payment based on performance (e.g. client health outcomes), seeks to manage performance by incentivising results	Potential outcomes vary based on individual and treatment approach, very difficult to determine given the complexity of people's lives, open to 'cherry picking' less difficult clients to show better results

Table A: Commonwealth and state approaches to funding[11]

Service safety and quality

QNADA has supported the Qld AOD Sector Network since 2012, which provides an informal forum for collaboration in supporting and developing the specialist sector in Queensland. The group includes representation from the Queensland Health (Mental Health, Alcohol and other Drugs Branch), Queensland Mental Health Commission, Queensland Aboriginal and Islander Health Council, the Australasian Professional Society for Alcohol and other Drugs, Metro South Hospital and Health Service, Insight and Dovetail.

The group has been highly productive in establishing a shared understanding on sector governance across the public and non-government sectors. For example, in 2015, the group hosted a Statewide

[11] Alison Ritter et al., "New Horizons: The Review of Alcohol and Other Drug Treatment Services in Australia," in Final Report (Sydney: University of New South Wales, 2014).

convention of more than 100 service managers, policy makers and sector leaders from across the government and non-government alcohol and other drug sector in Queensland, which resulted in the development of the *Queensland Alcohol and Other Drug Treatment Service Delivery Framework*. One of the aims of this framework is to act as a benchmark against which to assess new or alternative treatment approaches to determine whether they are consistent with what is commonly accepted as good practice.[12]

An update to the framework is underway and nearing completion at the time of writing.

The group also led the process to develop the *Queensland Treatment and Harm Reduction Outcomes Framework*, which 'describes the way Queensland alcohol and other drugs treatment and harm reduction services can measure their impact. It suggests a series of outcome indicators that, when measured and considered in the context of each other and specific treatment types, help to inform service quality'[13].

Both frameworks have become embedded in system governance, and informed commissioning and contracting arrangements in the non-government sector, as well as practice in the public sector across the state. The Queensland Treatment Service Delivery Framework has also inspired other jurisdictions to adapt the framework for their context and ultimately resulted in the Commonwealth commissioning the Drug Policy Modelling Program to develop the *National Framework for Alcohol, Tobacco and other Drugs Treatment 2019-29*, which was adopted by the (now defunct) Ministerial Drug and Alcohol Forum (MDAF) in December 2019.

QNADA was also significantly involved in the development of the National Treatment Framework's companion, the *National Quality Framework for Drug and Alcohol Treatment Services,* which was also developed under the now defunct MDAF arrangements, in response to the National Ice Taskforce report, after the Taskforce identified the '*need for a national mechanism to ensure continuous quality improvement to assist services to build their capacity to deliver effective treatment and ensure the sector is best-placed to respond effectively to emerging issues and trends[14]'.*

This national quality framework recognises that the majority of alcohol and other drugs treatment providers are accredited to a range of service standards relevant to their setting. For example, services provided through Hospital and Health Services are accredited through the Australian Council on Safety and Quality in Health Care and non-government services are accredited through internally recognised

[12] MacBean, Rebecca, Jeff Buckley, Kate Podevin, Linda Hipper, Dion Tatow, and Eddie Fewings. "Queensland Alcohol and Other Drug Treatment Service Delivery Framework." Brisbane, 2015.
[13] Queensland Alcohol and Other Drugs Sector Network. (2019). Queensland Alcohol and other Drug Treatment and Harm Reduction Outcomes Framework. Brisbane: Author.
[14] Department of Health, "National Quality Framework for Drug and Alcohol Treatment Services," (Department of Health, 2019).

schemes such as International Standardization Organization (ISO)[15] and Quality Innovation Performance (QIP)[16]. The national quality framework was released in 2019 and requires all providers to be accredited to an acceptable standard by November 2022.

It is intended to apply to all providers, including those '*specifically providing treatment to address alcohol and other drug dependence, or one that describes or promotes itself as a service that provides such treatment that does not receive government funding. A provider not receiving government funding may receive funding from other sources such as philanthropy, client fees and private hospitals'.*[17]

While there are high levels of compliance with the national quality framework among funded providers in the public and non-government sectors, the status of providers not receiving government funding is more difficult to establish, as there is no mechanism requiring them to be licenced to provide treatment, outside those required by professional bodies regulated by (as monitored by the Australian Health Practitioner Regulation Agency, or APHRA).

Since the NQF's release, QNADA has been advocating for the Queensland Government to proactively regulate private providers of residential services to ensure there is effective oversight of service quality and safety. This is particularly critical in Queensland, as the current lack of access to publicly funded services has left a gap in the market which has contributed to a rise in the number of unregulated private organisations claiming to provide specialist alcohol and other drug residential treatment, with costs up to $1,000 per day.

[15] ISO is a non-governmental, international standard-setting body composed of representatives from various national standards organisations.
[16] QIP is a not-for-profit health promotion charity with more than 20 years' experience offering accreditation services against a variety of standards.
[17] Department of Health, "National Quality Framework for Drug and Alcohol Treatment Services."

Submission to the Mental Health Select Committee Page 25 of 51

Area of improvement 1: regulation of private residential rehabilitation services

While there are a number of reputable and accredited private organisations offering high quality residential treatment options, there is an ongoing issue with some who are unable to demonstrate either quality treatment nor how their high cost reflects the services provided, (such as by individual access to clinical psychology services, or access to onsite medical support). These organisations are in effect, if not intention, exploiting people who are desperate to access alcohol and other drugs treatment but have been unable to do so due to the under resourcing of the publically funded system (both public health and non-government services), or because they don't know a publicly funded system exists.

Workforce improvement

QNADA regularly engages with our member services to consult on and deliver workforce improvement activities, (funded by the Commonwealth Government) which complements our sector development work, (funded by the State Government).

QNADA maintains local sector networks in Toowoomba, Ipswich, Brisbane South, Brisbane North, Townsville, Cairns and Western Queensland. We also participate in a Hospital and Health Services supported sector network on the Sunshine Coast.

This engagement informs our workforce support activities which have recently included:

- The *Harm reduction information for health professionals*, 132 resources describing the interactions between commonly used mental health medications and alcohol and other drugs.
- The development and maintenance of Qld's first statewide, online *AOD service finder*.
- The *Adis social media campaign*, a campaign targeting the 4 regional PHNs encouraging people to seek help for themselves or a family member or friend by accessing the ADIS 24/7 telephone support and counselling service.
- The *Alcohol and other drugs treatment fact sheet*, a resource for non-alcohol and other drugs services.
- The *Working with AOD clients who experience mental health issues fact sheet*, and the *Working with AOD clients experiencing housing issues & homelessness fact sheet*, resources for the AOD sector.

- The *Getting started in the AOD sector resource*, a sector induction resource for on-boarding new workers.
- The *Clinical/practice supervision for alcohol and other drug practitioners guide*, a guideline for organisations to implement clinical/practice supervision in their services.
- The *Clinical/practice supervision in alcohol and other drugs settings e-learning*, a package of supervision training and resources.
- The *LGBTIQ+ sistergirl & brotherboy cultural awareness for the AOD sector e-learning*, an LGBTIQ+ training package for the AOD workforce.
- The *AOD issues in refugee and asylum seeker background communities e-learning*, the *Helping asylum seeker and refugee background communities with problematic AOD use guide*, and the *Multicultural drink drug driving resources*; resources for working with AOD issues in refugee and asylum seeker communities.

Alcohol and other Drugs treatment services also play a role in developing the workforce, through placements, in house training programs and through conference presentations. The capacity of the non government sector to contribute to workforce development is limited only by available resources.

Case study - community and family support service

Working in the AOD sector requires not only knowledge and competencies but special attributes to work with a marginalised and often stigmatised group in our community. In responding to this, Drug Arm's Community and Family Support Service (CAFSS) serves as a good example of a quality workforce development program and sector capacity building strategy.

CAFSS delivers time limited counselling sessions to people dealing with their own or others mild to moderate substance misuse issues. It uses evidenced based responses and interventions delivered by an intern workforce overseen by experienced AOD clinicians.

Interns are final year social work, psychology or counselling undergraduates seeking to undertake their final placement as an AOD specialisation. They are required to commit to a minimum of six (6) month placement and are introduced to the key features of an AOD treatment service, including understanding the application of the harm minimisation and recovery frameworks using a psychosocial approach. During their placement, and building on theories studied during their tertiary studies, interns learn how to put that theory into practice.

Counselling is provided using a co-counsellor model of an observer and lead counsellor. This is achieved by the intern demonstrating a range of structured learning outcomes that allows them to move through three competency levels. Beginning at the 'Developing' level where there is no client contact and a focus on administrative and clinical practice, they move through to 'Intermediate' where the intern acts in an observer counsellor role, through to the 'Advanced' level where the intern acts as a lead counsellor. The co-counselling model also provides learnings about work within a multi-disciplinary approach as interns are often paired between the disciplines they have studies. Clinical supervision and professional development are provided and clinical audits are under taken to monitor and address any clinical practice issues.

"The group supervision sessions held daily with the team provided a safe space to discuss/receive advice regards case formulations, provided myself with education regards interventions and helped build my confidence to interact and provide support

CAFSS provides a real world learning experience that equips emerging graduates with additional skills and knowledge, as well as an understanding of the important attributes, that are optimal in their transition to an entry level workforce capable of delivering quality AOD services. CAFSS is indeed recognised by the sector for its quality learning outcomes, with many interns immediately recruited into positions within the sector.

CAFSS is an efficient, effective and recognised program that is only limited by the investment level made towards quality workforce development in the AOD sector. This is particularly pertinent when considering the need to address the significant present and emerging workforce gaps.

"My time at CAFSS built confidence in my ability as a counsellor"

Digital Capability

Queensland's specialist alcohol and other drugs services rapidly and successfully shifted to telehealth (e.g. online and telephone) responses as required throughout the course of the COVID-19 pandemic. The uptake of telehealth services during the pandemic demonstrated that these models are feasible and effective for groups who would otherwise have limited access to services - particularly for those in regional, rural and remote areas.

However, the full potential of telehealth is not yet realised. There are opportunities to use telehealth to improve cross-system coordination, collaboration, and connectedness, but this would require adequate planning, workforce development and resourcing.

For example, telehealth models have been shown to be able to facilitate access to specialist treatment while people are in custody and ensure people continue to be supported when they enter the community. They can also facilitate access to opioid treatment prescribers in regions where there are

none and can enable specialist treatment access for people who would traditionally be unable to travel due to issues such as distance, cost, and time.

While telehealth is not a substitute for face-to-face services, QNADA is supportive of continuing to grow the digital capability of the service system to support increased access to specialist alcohol and other drugs treatment.

Part B: Policy

This section discusses the following areas of the Committee's Terms of Reference:

- *relevant national and state policies* and the associated need to improve system governance and leadership outside of the health system at both a state and Commonwealth level; to better drive cross-system partnerships and reforms.
- *current funding models*, and how evidence informed investment by the Queensland Government and other levels of government can enhance outcomes for Queenslanders, although longer-term funding is required to reduce disruption to critical health services.
- *opportunities to better consider the perspectives of people with a lived experience* of drug use in future policy and planning reform activities.

In particular, opportunities to expand evidence based harm reduction initiatives, improve access to information services for people who use drugs, and to recommit to the implementation of policy reform regarding diverting people who use drugs from the criminal justice system, are identified.

Current policy environment

As outlined in Figure 2, the current policy context for alcohol and other drugs in Queensland includes an interrelated mix of state and national policies and frameworks which sit under, or are aligned with, the broader national drug strategic framework.

The *National Drug Strategy 2017-26* is founded on the core principle of harm minimisation, supported by the delivery of a range of actions across the pillars of harm, demand and supply reduction. While the national drug strategy is intended to provide an overarching policy framework, its successful implementation relies on joint collaboration and shared responsibility at a state and national level (across health, police, justice, education, child protection and community/social services). It provides flexibility for individual jurisdictions to determine how they adopt agreed actions, with the actual details of implementation intended to reflect local priorities alongside this broader national commitment. The extent to which this is occurring in Queensland, outside the treatment and harm reduction service system, is variable.

Significantly, there has been no dedicated AOD plan for Queenslanders since 2017 (through the Alcohol and other Drug Action Plan 2015-17).

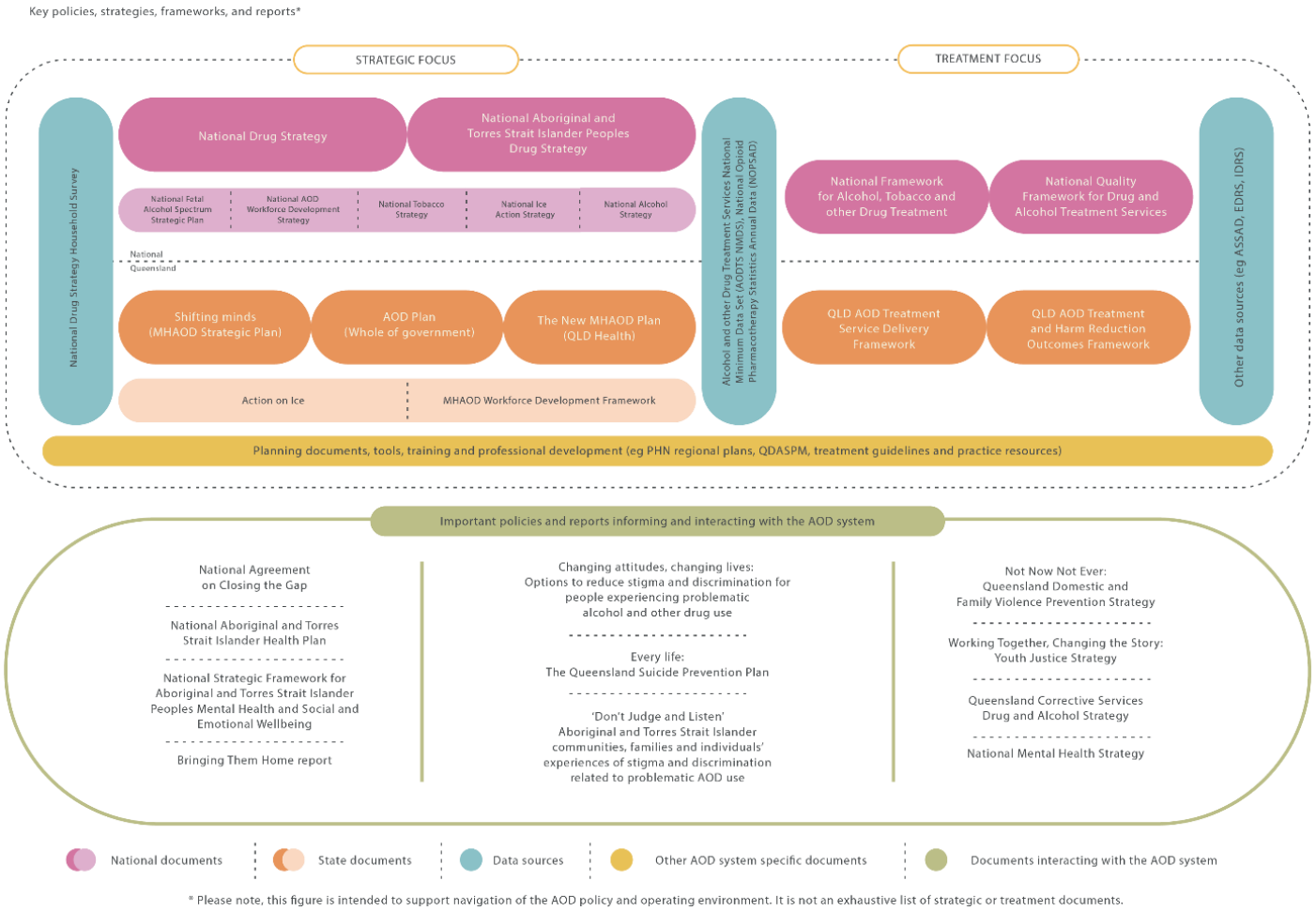


Figure 2 Relevant state and national policies and strategies[18]

[18] Queensland Alcohol and Other Drugs Sector Network. (2022). Queensland Alcohol and other Drug Treatment Service Delivery Framework (draft update to the 2015 version). Brisbane: Author.

Queensland has been without a dedicated, cross-system plan or strategy for AOD for five years[19]. Delays have also been experienced with the development of previous state strategies[20], and while there have been higher level plans for the mental health and alcohol and other drug sector more broadly; these have been developed with the intention that they would be supported by a specific plan for alcohol and other drugs in recognition of the different responses required.

For example, while the Queensland Mental Health Commission has undertaken multiple planning and consultation processes since 2018 to develop a renewed approach as part of commitments within the *Queensland Mental Health Alcohol and Other Drugs Strategic Plan 2018-23* (Shifting minds), there have been continued delays in its release over the last 18 months, with the latest delay related to the calling of this Inquiry [21].

The lack of a clear public plan, endorsed by government, has the effect of stifling leadership for, and the prioritisation of, system reform related to alcohol and other drugs outside of the health system. It also impacts on agencies' understanding of their roles and responsibilities in delivering or supporting agreed state and national priorities and commitments; and means that there is no overarching mechanism in place to drive action across the criminal justice, domestic and family violence, youth justice, child protection, education, and community sectors.

While the Queensland Mental Health Commission is nominally assigned a role in coordinating these systems to drive reform, it appears to have been unable to achieve this in any meaningful way with respect to alcohol and other drug policy since its establishment (almost ten years ago). This appears to be for a number of reasons, foremost our tendency to consider alcohol and other drugs issues during periods of crisis (such as that which precipitated both the Qld and National Ice Action Strategies in 2015 - 2016), but also perhaps related to structural impediments including the Commission's location within the health portfolio, issues relating to the types of work they invest in and their engagement approach, how they conceptualise system reform work and their ability to deliver timely outcomes, as well as the usual challenges associated with the prioritisation of alcohol and other drug system reform when it is coupled with mental health system reform (discussed in more detail in Part C).

[19] This excludes *Action on Ice (2018)* which was specifically developed by the Queensland Government to address crystal methamphetamine use only.

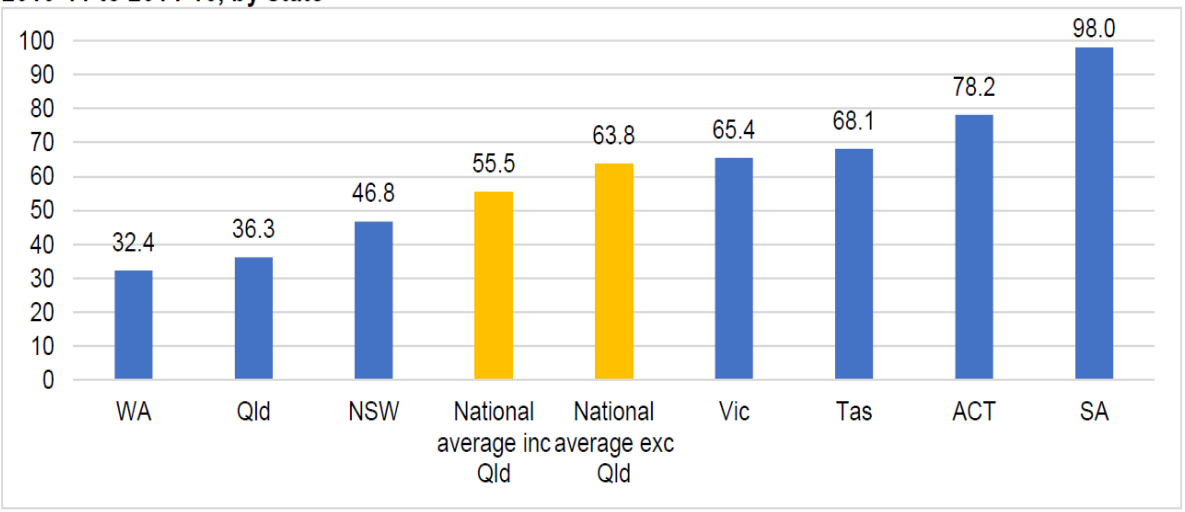
[20] For example, this plan was preceded by the *Queensland Drug Strategy 2006-2010,* and the *Queensland Drug Action Plan 2011-12* (representing a three year gap between plans).

[21] Developed in 2018 by the Queensland Mental Health Commission outlines a commitment to develop a whole-of-government AOD approach to support Queensland's commitments under the *National Drug Strategy 2017–2026*. Queensland priorities include system-wide integration and the development of multiagency responses to meet the needs of individuals and groups with complex needs.

An example of where this leadership is needed can be found in our current practice around diversion from the criminal justice system for possession offences, in an environment where this is publicly supported by both Queensland Health and the Queensland Police Service Commissioner.

Queensland is more than twenty years behind the rest of the nation in that we limit the Police Drug Diversion Program to cannabis possession. Recent analysis of the first twenty years of diversion conducted by the Drug Policy Modelling Program found inter-jurisdictional learning had reduced over time and alarmingly that Queensland provides the lowest rate of diversion per 100 000 people in the nation.[22] The rate is so low that it noticeably shifts the national proportion of people with a principal offence of use/possession given a police drug diversion, as shown in the figure below:

Proportion of offenders with a principal offence of use/possession given a police drug diversion, 2010-11 to 2014-15, by state [3]



Specifically, this report found that '*Queensland accounted for the largest increase in people detected for use/possession in Australia and the highest rates of offenders being sentenced to prison for use/possession alone'*.

The DPMP went on to note that such a finding reflects the longer term upward trend in Queensland, as evidenced by a recent analysis by the Queensland Sentencing Advisory Council that showed the number of offenders sentenced for possessing dangerous drug offences as their most serious offence more than doubled between 2005-06 to 2015–16 (Queensland Sentencing Advisory Council, 2017)[23]

[22] Caitlin Hughes et al., "Monograph 27: Criminal Justice Responses Relating to Personal Use and Possession of Illicit Drugs: The Reach of Australian Drug Diversion Programs and Barriers and Facilitators to Expansion," *Drug Policy Modelling Program* (2019).
[23] Ibid.

This significant increase in convictions came despite our stated policy being to divert people from the criminal justice system.

As far back as 2011-12, the Queensland Drug Action Plan noted *'early intervention and diversion programs, which help prevent people apprehended for drug use from getting caught up in the criminal justice cycle and divert them to treatment, have become an established and successful part of Queensland's response to drug issues'.*[24]

At the national level, the dissolution of the Council of Australian Governments has also impacted alcohol and other drugs governance, as the Ministerial Drug and Alcohol Forum (MDAF) was one of the committee's disbanded. This has had the immediate effect of disrupting efforts to implement the *National Framework for Alcohol, Tobacco and other Drugs Treatment 2019-29* and the *National Quality Framework for Drug and Alcohol Treatment*, which had been led by the Commonwealth Department of Health and included representation from each of the States and Territories, as well as two representatives from peak bodies for the non-government alcohol and other drugs sector, reporting through to the MDAF.

QNADA, in collaboration with our colleagues in the State and Territory AOD Peaks Network, have developed a consensus position on a new draft national governance framework, which has been provided to all State and Territory Health Ministers, as well as the Federal Minister for Health.

This Peak's network proposed governance framework is inspired by the new governance arrangements for Closing the Gap and are intended to provide an effective and efficient structure to coordinate the response to AOD issues across state, territory and federal governments. A key task of the framework, and associated governance bodies, is to oversee the implementation of the National Drug Strategy (NDS) and sub strategies and to guide the future development of national alcohol and other drug strategies.

In response to receiving the proposed new framework, the Federal Health Minister has indicated a willingness to consider new governance arrangements as part of the mid-term review of the National Drug Strategy, which is due to be undertaken in 2022.

[24] Queensland Health, "2011-2012 Queensland Drug Action Plan," (Brisbane2011).

While Minister D'Ath has similarly responded supportively of considering governance matters as part of the upcoming mid term review of the national drug strategy, we note the lack of a governance mechanism to oversee the review presents a significant impediment to progress.

Service planning and investment that values effective responses to AOD use

While the vast majority of people who use alcohol and other drugs never require treatment or come into contact with services around their use, we know that for those that do, services are not always available, accessible, or acceptable. This is problematic as the efficacy and effectiveness of treatment has been well-established and we know that early intervention is critical in achieving the best outcomes.

Effective treatment has been shown to reduce consumption, improve health status, improve psychological wellbeing, and improve community participation. Additionally, savings are accrued by governments from alcohol and other drug treatment including future (reductions in) health care costs and productivity gains.[25]

It is also accepted that there is insufficient investment in alcohol and other drug treatment to meet community need and we congratulate the Queensland government for its efforts to address the availability of services through *Connecting Care to Recovery 2016-21;* which set the direction and highlighted priorities for action and investment across state-funded mental health, alcohol and other drug service system.

Estimating population level treatment needs, and the right mix of services is challenging but not insurmountable.

The QDASPM (discussed early in Part A) provides guidance for policy makers to inform planning and investment in specialist alcohol and other drug treatment services in order to meet demand.[26] We note the recent service planning process undertaken by the Mental Health, Alcohol and other Drugs Branch in Queensland Health included consideration of this data and express our hope that the next Statewide services plan continues to commit to expanding access to high quality, evidence based services in the non government sector.

At the Commonwealth level, planning for growth in AOD treatment places is less structured, with the most recent increase in investment provided through the *National Ice Action Strategy* in 2016. Funding tends to be provided in time limited tranches, with the current investment committed to 30 June 2022

[25] Susan L Ettner et al., "Benefit–Cost in the California Treatment Outcome Project: Does Substance Abuse Treatment "Pay for Itself"?," *US National Library of Medicine National Institutes of Health* 41 (2006)., quoted in Alison Ritter et al., "New Horizons: The Review of Alcohol and Other Drug Treatment Services in Australia," in *Final Report* (Sydney: University of New South Wales, 2014).
[26] Queensland Network of Alcohol & Other Drug Agencies (QNADA), "Effective Responses to Drug Use Position Paper," (Brisbane2019).

Submission to the Mental Health Select Committee Page 36 of 51

and no public announcements made about the future of this funding beyond this point. As outlined above in Part A, this has significant planning and program implications for services and impacts staff retention.

While we know that there is a substantial return on investment for alcohol and other drug treatment, funding is only about half of what is required to meet demand. The right amount of funding in the right place is critical for good treatment outcomes. New investment should also prioritise protective responses rather than punitive responses to alcohol and other drug use and include a diversity of treatment options including harm reduction strategies. These options should include responses that are amenable to families, as well as residential and non-residential treatments available to those on remand and in prison.

Area of improvement 2: Elimination of Hepatitis C from Qld correctional centres

The Qld Hepatitis C Action Plan 2019 – 2022 seeks to make significant progress towards eliminating Hepatitis C as a public health threat, by increasing access to treatment and taking action to reduce transmission.

Correctional Centres are a significant source of Hepatitis C transmission. While treatment is now available in every Qld Correctional Centre, and access to opioid substitution therapy is being rolled out across Centres, the evidence supports further action to reduce transmission by providing access to condoms and reducing the transmission risk posed through sharing injecting equipment by providing access to needle and syringe programs.

Evidence informed approaches to drug policy

Collated by the Australian Institute of Health and Welfare, the National Drug Strategy Household Survey has been conducted every few years since 1985. It collects information about alcohol and tobacco consumption, and illicit drug use, as well as people's attitudes and perceptions about this use.

The most recent *National Drug Strategy Household Survey 2019*[27] shows us that the patterns of, and attitudes towards, alcohol and other drug use are changing in Australia. Specifically, they found that Australians are increasingly supportive of legalising cannabis use, most support drug-checking (pill-testing) and there has been a decline in support for policies aimed at reducing problems associated with excessive alcohol use (such as reduced trading hours)[28].

The voices of people with a lived experience in Queensland express similar sentiments. In 2020, in collaboration with the Queensland Injectors Voice for Advocacy and Action (QuIVAA) and the Queensland Aboriginal and Islander Health Council (QAIHC), QNADA's undertook a statewide consultation process to understand the representative needs of people who use drugs in Queensland. The *Peer Peak Body Scoping project* (2020)[29] heard from around 400 Queenslanders and found that:

- nearly a third of respondents reported that they hadn't experienced any challenges as a consequence of their substance use.
- representation for people who use drugs in Queensland should include people who use illicit, licit and have previously used drugs, and that there should be particular attention paid to the people who experience significant harms including frequent experiences of discrimination in the community.
- representation activities should include advocacy for changing drug laws and policy, activity which creates positive outcomes with a focus on the health, happiness and human rights of people who use drugs and work to end stigma and discrimination.
- The population of people who use drugs in Queensland is heterogeneous. Whilst similar perspectives exist amongst sub groups, such as those who inject substances, for other groups, such as Aboriginal and Torres Strait Islander people, people who identify as LGBTQIA+ and people from culturally and linguistically diverse backgrounds, differences in particular harms and reports of discrimination emerged.

[27] Australian Institute of Health and Welfare 2020. National Drug Strategy Household Survey 2019. Drug Statistics series no. 32. PHE 270. Canberra AIHW.
[28] See more here
[29] Queensland Network of Alcohol & Other Drug Agencies (QNADA), "Peer Peak Body Scoping Project Report," (Brisbane2020).

Area of improvement 3: Enhancing the input of lived experience in policy and system design

The heterogeneous nature of the population of people who use drugs makes it unlikely that one organisation will be able to represent the breadth of experiences amongst people who use drugs. An approach that sought to build representative capacity around substance use in existing organisations for specific populations (such as Aboriginal and Torres Strait Islander peoples and the LGBTIQA+ community), as well as resourcing the existing drug user organisation (QuIVAA) is likely to yield the best outcomes.

This would ensure expertise in engagement with a broad range of people and allow specificity in representation, as well as serve to amplify the common experiences across the population of people who use drugs, including those that identify as peers and those that have utilised the AOD treatment system, as well as those who don't identify as peers and have highlighted criminal justice system risks as their primary risk of substance related harm.

So too, is the evidence of what works in responding to alcohol and other drug use and related harms changing. It is important that our system and policy responses are designed taking into account lived experience perspectives and continue to evolve alongside this shift in community expectations and the growing evidence base.

Illicit drug use amongst Queenslanders is relatively common. Almost half of Queenslanders (44.3 per cent) over the age of 18 have used illicit drugs in their lifetime (AIHW 2017c). This means that as of

2018, around 1.7 million Queensland adults (aged 18 and older) had used illicit drugs, with 15.9 per cent or 611,000 reporting recent use (in the last 12 months).[30]

Remembering that most people who use don't experience problems, we note the World Health Organisation identifies illicit drug dependence as the most stigmatised health concern in the world[31]. As outlined in more detail within *Changing attitudes, changing lives* (2018) experiences of stigma and discrimination are common for people who use drugs in Queensland, and these experiences result in reluctance to seek help, compounding social disadvantage, social isolation, and negative impacts on a person's mental and physical health.

The way in which legislation, legal practices, rules, definitions, and processes are implemented and operationalised can also enable the development and establishment of certain stereotypes about people who use drugs[32]. A clear example of this can be seen with current approaches to drug law enforcement, despite significant evidence internationally that more effective and less harmful policy solutions exist.

In Queensland, people who use illicit drugs are almost nine times more likely than dealers or traffickers to find themselves facing action in the criminal justice system (39,099 and 4,385 respectively in 2016-17).[33]

Criminalisation of some drugs has created significant costs and unintended harms. While the current approach has been in place for many decades, it has proven largely ineffective at significantly reducing the consumption of illicit drugs and has not achieved anything like sustained reduction in supply. In Australia, ecstasy, cocaine, methamphetamines and opioids are significantly more expensive than in other western countries (Martin et al. 2018, p. 102), and this also does not appear to have strongly deterred Australian users—rates of illicit drug use in Australia are relatively high internationally. Criminalisation has also helped to create an illegal market worth at least $1.6 billion per annum[34], which introduces the known risk of violence associated with unregulated markets generally, makes

[30] Queensland Productivity Commission, "Inquiry into Imprisonment and Recidivism," (Brisbane: Queensland Productivity Commission, 2019).
[31] Robin Room et al., "Cross-Cultural Views on Stigma, Valuation, Parity, and Societal Values Towards Disability," in *Disability and Culture: Universalism and Diversity*, ed. Faculty of Social Sciences Stockholm University, Centre for Social Research on Alcohol and Drugs (SoRAD) (Seattle: Hogrefe & Huber Publishers, 2001).
[32] Lancaster, K., Seear, K., & Ritter, A. (2017) *Reducing stigma and discrimination for people experiencing problematic alcohol and other drug use*, Drug Policy Modelling Program, National Drug and Alcohol Research Centre: University of New South Wales
[33] Australian Criminal Intelligence Commission. Illicit Drug Data Report 2016-17. (2018).
[34] ibid

the quality of supply uncertain (resulting in increased morbidity and mortality), and impedes access to treatment.

The Qld Productivity Commission estimates expenditure on the enforcement of drug laws costs Queensland around $500 million per year.

The Queensland Productivity Commission made a compelling economic argument for decriminalisation for low harm drugs within their *Inquiry into Imprisonment and Recidivism* (2020)[35] finding that:

- illicit drugs policy has failed to reduce supply or harm and was found to be a key contributor to rising imprisonment rates; with drug offences contributing to 32% of the increase since 2012.
- current illicit drugs policy results in significant unintended harms, through supporting a large criminal market and incentivising the introduction of more harmful drugs.
- evidence suggests that legalising lower harm drugs and decriminalising other drugs is likely to provide net benefits to Queensland of at least $2.8 billion by 2025 and is unlikely to increase drug use.
- targeted community-level interventions and greater use of diversionary approaches are alternative approaches to the criminal justice system (and are significantly less expensive).

While the Queensland Government noted within their public response to this report that they have no intention of altering any drug laws in Queensland, they provided no indication of how this decision was made. They did however positively highlight their commitment to '*further develop health-based approaches to illicit drug use within current legislative and policy frameworks'*, including through progressing:

- the development of a therapeutic health and rehabilitation model for the new Southern Queensland Correctional Precinct prison;
- the delivery of appropriate Alcohol and Other Drug screening, assessment, referral pathways, and treatment programs for offenders referred from the criminal justice system;
- the continuation of the foundation initiatives included in the *Action on ice plan*; and
- supporting additional investment in alcohol and other drug treatment services.[36]

[36] Queensland Government, "Queensland Productivity Commission Inquiry into Imprisonment and Recidivism: Queensland Government Response," (Brisbane: Queensland Government2020).

There are a number of additional opportunities to further develop health based approaches within our current legislative and policy frameworks that are in place internationally. QNADA calls on the government to introduce the following as a matter of priority:

- Interventions to eliminate Hepatitis C infection in correctional settings;
- Expand police diversion to all substances;
- Fixed site and mobile drug checking (pill testing) services;
- Cannabis cautioning;
- Real time monitoring of overdose injuries and deaths;
- Wide spread distribution of take home naloxone;
- Implementation of the findings of the 2020 Inhalant's roundtable; and
- Resourcing work to progress hearing the voices of lived experience across the heterogenous population of people who use drugs in Queensland.

Area of improvement 4: Criminalisation approaches to drug possession

Evidence supports the removal of criminal penalties for possession (decriminalisation) as a prudent strategy which reduces the investment required over time to process people through the criminal justice system.

While Queensland's overarching Mental Health, Alcohol and other Drug Strategic Plan 2018-23, *Shifting minds* called for an informed and evidence-based debate about the benefits and challenges to the approach to decriminalisation taken by Portugal, this has not occurred to date in Queensland.

Taking into account the Queensland Productivity Commission's recent findings, now is the time to independently and robustly assess this approach for the Queensland context, which should include the perspectives of people with a lived experience, leading academics and peak bodies.

Part C: Systems

This section provides a broad overview of the economic and societal impacts of alcohol and other drug use in Queensland, and notes that the significant harms associated with this use can often be a result of our policy and legislative response to alcohol and other drug use, rather than the use in and of itself.

Also discussed are opportunities for greater whole of system collaboration and partnerships across the criminal justice, child protection and youth justice systems, as well as opportunities to better understand the intersections between alcohol and other drugs problems and mental health.

Finally, the need to refocus our approach to those that focus on addressing the social, cultural and structural determinants of health is also identified, in line with clear evidence that shows that to achieve a meaningful improvement in outcomes we need to collaborate across the government and non government sectors to address complex social issues.

Global research shows that the vast majority of people who use alcohol and other drugs do so infrequently and without problems.[37] For example, the 2019 National Drug Household Survey found that among people who used meth/amphetamines, 17% used weekly or more often. In addition, the report estimates that only 7.5% of users were at risk of harm.[38] For the significant majority the risk of harm to both themselves and the community is increased primarily as a result of the social, policy and legislative responses to their use, rather than the substance itself.

This includes through associated harms such as contact with the criminal justice system, or as a result of broader experiences of stigma and discrimination which can have

Understanding 'harm' within the context of AOD use

The *National Drug Strategy 2017-2026* outlines a range of health, social and economic harms associated with AOD use; and highlights the importance of a progressive, balanced, and comprehensive approach in the way that we address these harms across the *spectrum of use* (as per Figure !).

There is however not always a direct causal relationship between some of the identified harms, and AOD use itself. With some harms noted such as mental health issues, intergenerational trauma, child protection issues, and violence perpetration found to be associated with a range of other risk and protective factors in a persons' life.

Engagement with the criminal justice and child protection systems, healthcare and law enforcement costs, and reinforcement of marginalisation and disadvantage are also identified as key harms, but these are often a result of our current policy and legislative responses to AOD use, and not the use in and of itself.

[37] United Nations Office on Drugs and Crime, "Global Overview of Drug Demand and Supply: Latest Trends, Cross-Cutting Issues," *World drug report 2018* (Vienna: United Nations, 2018), quoted in (QNADA), "Effective Responses to Drug Use Position Paper."
[38] Australian Institute of Health Welfare, "National Drug Strategy Household Survey 2019."

detrimental effects for people over the longer term (such as through restricting access to employment and community participation).

It is estimated that only approximately 11-12% of people who use alcohol and other drugs experience problematic use, meaning they may experience dependence and/or require treatment. This corresponds to a prevalence of drug use disorders of 0.7% globally among people aged 15 to 64[39]. It is this smaller cohort who are more likely to experience greater harms associated with their use and would benefit from accessing treatment.

System alignment to reduce alcohol and other drug related harm

Queensland's *Mental Health, Alcohol and Other Drugs Strategic Plan 2018-23* (Shifting Minds) highlights the importance of collective leadership and responsibility across all policy, funding, program development and service delivery to achieve common outcomes and collective benefits. As also highlighted within Shifting Minds, reform cannot be achieved through the actions of any one agency alone; with an identified need to strengthen and integrate cross-sectoral approaches. To deliver this across systems and sectors, focused, coordinated, and sustained activities are required to build sector capacity and deliver workforce development activities.

However, there is no entity in Queensland who has primary responsibility for, and a dedicated focus on, effectively influencing, driving and coordinating this change within the context of alcohol and other drug policy and planning. As outlined in Part B this has resulted in prolonged delays with the release of a dedicated plan for alcohol and other drugs in Queensland.

In early 2021, in response to member feedback, QNADA launched its' self-funded *Responsive Systems* project which aims to improve cross-agency collaboration and partnerships and support more effective system responses to individuals, families and communities affected by alcohol and other drug use outside of the health sector. To better understand the scope and focus of current reform initiatives and how they may impact or intersect with members and their clients a rapid desktop review of relevant inquiries, reports and strategies was undertaken.

Of the 50 inquiries, reports and strategies over the past ten years in Queensland identified as relevant to the scope of the rapid review, 449 recommendations and actions were identified as falling in scope of the review criteria. The largest proportion of recommendations aimed to improve pathways to services or interventions, and/or develop or expand programs (35%) followed by those that aimed to enhance workforce capacity and training (16%). The areas where the fewest relevant recommendations were identified related to governance and strategy (6%), theory (3%),

[39] Crime, "Global Overview of Drug Demand and Supply."

infrastructure (2%) and tools (1%). While these findings need to be considered within the broader context of Queensland's response to alcohol and other drug use and related harms overall, and the respective scope of the reports included in the review, it is interesting to note that these latter domains tend to be the enabling ones, which provide structure and system accountability.

Responsibility for the implementation of recommendations and actions were generally assigned to individual agencies, multiple agencies, or the Queensland Government as a whole. Queensland Health was the agency assigned responsibility for the largest percentage of recommendations (29%) which positively reflects a recognition of the importance of health focussed responses to people who use alcohol and other drugs. This was followed by the Department of Justice and Attorney-General (24%), which can largely be accounted for by a continued focus on diversion and drug court (Queensland Court Services) as well as on reducing alcohol-related harms within night-time entertainment precincts (Office of Liquor, Gaming and Regulation).

Queensland Corrective Services (QCS) was also responsible for a significant percentage of recommendations (15%) which reflects the ongoing reforms occurring across this agency as a result of the *Parole System Review* (2016), and other follow-up reports; as well as their dedicated focus on responding to alcohol and other drug use through the *QCS Drug and Alcohol Strategy* and related Action Plan. These results highlight the diversity of agencies involved in delivering reforms relevant to alcohol and other drug sector, and the need for overarching coordination, outside of the health sector.

Feedback from a range of agencies across the criminal justice, child protection and youth justice systems has been overwhelmingly positive to this project, indicating a need for these types of collaborative partnerships outside of the health sector, between the government and non government sectors.

Refocusing responses within these broader systems to increase understanding of patterns of alcohol and other drug use, including to support the enhanced identification of key points where a referral to treatment is indicated, will also strengthen protective factors, and minimise the need for any further interactions with these entities.

QNADA will continue to prioritise work to improve responses across systems as resources become available. We are currently establishing a partnership with the University of Queensland to explore opportunities to reduce stigma and discrimination for people who use drugs in contact with the criminal justice system and identify approaches for supporting safe and meaningful consumer participation and engagement within this system.

We have also commenced scoping work to explore improved system responses for both young people and parents engaged with the Child Safety system, and on improving responses to both victim/survivors and perpetrators of family and domestic violence.

Case Study: Beth's Story

Beth had wrap around and intensive involvement from Child Safety due to specific and quite extreme circumstances. These circumstances stemmed from having a child removed, who then gone on to experience significant harms while in foster care.

Beth was working directly with a Child Safety Senior Team Leader who was generally active and responsive in their communication with other services. In conversations over the phone between the clinician and Child Safety, the Child Safety worker demonstrated an understanding of the challenges that Beth was facing and seemed to be attuned to the demands being placed on Beth through Child Safety's involvement and how this might be a stressor for Beth which affect likelihood of using.

Additionally, the Child Safety worker demonstrated understanding of Beth's substance use contextually – i.e., was able to see Beth's substance use relative to past traumas and current stressors and was able to differentiate between different causes and types of substance use. This worker's nuance in their approach to Beth's substance use meant that she had much more buy-in with the worker and the broader process. Additionally, this facilitated communication between the QuIHN therapist and Child Safety, who were able to work more collaboratively on client-centered goals. Further it meant that therapy sessions involved less problem solving and processing around Child Safety, which can take up a lot of therapy time when there are less productive relationships and greater stigma.

Overall, it assisted Beth in working towards her goals and minimising her substance use by fostering an atmosphere of support and understanding for Beth, and co-ordination and collaboration (rather than opposition and secrecy) amongst the care team.

Case Study: Michael's Story

Michael is a young TI man; who's life can only be described as volatile. Michael started using substances at the young age of 11 years. He started his criminal behaviour at this time and was remanded in custody for most of his teenager years. When Michael was in community his substance use would increase and he would rarely be at home, couch surfing with peers.

Before Michael turned 18 years he was remanded in custody at Lotus Glen Correctional facility (LGCF) for serious offences. It was when he was remanded the first time, he found out he was going to be a father.

YETI workers discussed Men's program "healthy relationships" however Michael did not want to participate. While on remand Michael participated in emotional regulation and impulse control (ERIC) groups and harm minimisation groups and a YETI worker supported Michael with his transition from prison to community.

Michael was released from custody and was supported to engage with probation and parole. Michael was referred to mental health and was eventually diagnosed with schizophrenia. A YETI worker supported Michael to engage with the mental health team and supported Michael to engage with NDIS.

Understanding the intersections between alcohol and other drugs and mental health systems

Understanding the intersections of the alcohol and other drugs and mental health systems requires familiarity with:

- The current level of alcohol and other drugs system coordination and planning with the full range of other systems a person may be involved with (eg housing, corrections, mental health)
- The extent of alcohol and other drugs service collaboration co-location, and coordination both within and outside the sector
- Issues around practice based coordination and treatment planning
- The impact of previous attempts to integrate governance and funding for AOD and mental health systems
- Tensions arising from differing treatment system philosophies and processes. [40]

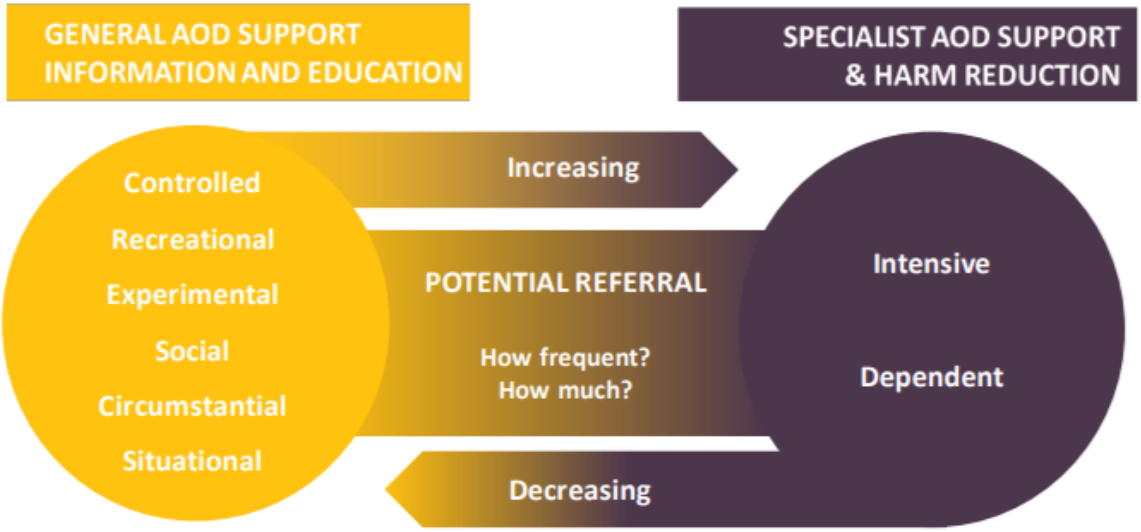
[40] Claire D Clark et al., "Providers' Perspectives on Program Collaboration and Service Integration for Persons Who Use Drugs," *Journal of Behavioral Health Services & Research* 44, no. 1 (2016).

While the co-occurrence of substance use concerns alongside mental health concerns is relatively common in alcohol and other drugs treatment settings, it's important this is understood in relation to the variety of substance use and mental health treatment scenarios:

- No substance use and good mental health – no treatment
- Uses substances (no issues) and good mental health – no treatment, may benefit from information to manage risks
- Uses substances (no issues) and mental health concerns – mental health treatment, may benefit from information to manage risks
- Substance use concerns (low, moderate, severe) and good mental health – substance use treatment
- Substance use concerns (low, moderate, severe) and mental health concerns (low, moderate, severe) – coordinated treatment with a lead agency based on severity and where the person presents.

Where there is high severity issues in both alcohol and other drugs and mental health domains, QNADA supports the implementation highly specialised 'dual-diagnosis' services. In our systems integration thinking, this group is often the focus of concern across systems because it's the hardest to solve. However, in the majority of cases coordinated and collaborative care approaches are most effective, and the number of organisations involved is less important than the quality of the coordination and collaboration.

It is also important to note that it's equally as common for people who access substance use treatment to be experiencing issues in a range of other life domains (eg physical, housing, financial, social, relationships). This high degree of psychosocial complexity means there needs to be a high degree of coordination and collaboration between systems to address these various areas of concern. It also requires that each specialist area has a basic level of skill across fields of expertise in order to identify when specialist expertise is required. For example, the figure below conceptualises when a referral to specialist alcohol and other drugs treatment may be required based on a person's pattern of use.



We also know that:

- There are a range of reason's that a person's pattern of AOD use might shift in intensity.[41]
- Moderate - severe substance use problems can sometimes generate or exacerbate mental health problems
- Moderate - severe mental health problems can generate or exacerbate problematic substance use.
- Because of this complexity many people 'fall through gaps' in the health system. This means their needs are not met, and it also elevates the likelihood they may experience compounding harms.[42]

Exploring the place of alcohol and other drug services in the mental health system (2020) found that across both systems, models that support holistic care are preferential and that future approaches would benefit from maintaining specialisation; improving internal capability across both sectors to respond; increasing external collaboration (including with other areas of health); and providing adequate funding and accountability measures to ensure funding is having an impact on services' ability to appropriately respond.

Alcohol and other drugs treatment models of care tend to be holistic in nature with the ability to respond to the range of issues a person may be experiencing as demonstrated by Daisy's case study in Section A of this submission. This allows for the identification, planning, referral, and coordination of care with other specialist services where required. However, QNADA members continue to report

[41] Phil Crane, Jeff Buckley, and Cameron Francis, *Youth Alcohol and Drug Practice Guide 1: A Framework for Youth Alcohol and Other Drug Practice, ed.* Phil Crane (Brisbane: Dovetail, 2012),
[42] Nicole Lee and Steve Allsop, "Exploring the Place of Alcohol and Other Drug Services in the Mental Health System," (Melbourne2020).

instances where they've assessed a person as experiencing moderate to high severity mental health concerns, or observed escalating self harm and attempted to refer to mental health services for additional support, and the person has been denied a service.

We believe more needs to be done to skill mental health specialists in responding to people experiencing alcohol and other drugs issues. While the alcohol and other drugs system has achieved gains in its understanding of mental health responses through investment in sector capacity building (via the State and Territory AOD Peak Bodies) in the non-government treatment sector, the same has not occurred in the mental health system. A similar investment in the public and non government mental health system is likely to contribute to improved outcomes for people who use alcohol and other drugs accessing that system and improve collaboration and coordination across systems.

Area of improvement 5: Strengthened system planning and governance

Alcohol and other drug policy and planning has cross-sectoral implications beyond the health system. While it has been a key focus area in many recent inquiries across the criminal justice, child protection and youth justice system, there is currently limited dedicated system leadership to support effective cross-sectoral coordinated planning and ensure alignment with agreed national initiatives. This is perhaps most evident with the prolonged delays associated with the development and release of (successive) cross-sectoral AOD strategies in Queensland over the past 15 years.

A strong governance mechanism is also required to ensure cross-agency leadership and collaboration to drive meaningful change over the longer term, which includes senior representatives from all government agencies and relevant peak bodies.

An important priority area moving forward should also be improved reporting and data collation to better measure any unintended consequences associated with broader system reforms which may intersect with the non-government AOD treatment and harm reduction sector.

System responses that address the social, cultural and structural determinants of health

> The social determinants of health and the non-medical factors that influence health outcomes, such as education, employment, food security, housing, social inclusion and non-discrimination.
>
> Research shows that they can be more important than health care or lifestyle choices in influencing health and addressing them is fundamental to reducing health inequity and improving health.
>
> World Health Organisation, 2022

QNADA's Strategic Plan 2021-23 outlines our vision of a system that values responses which aim to address the social, cultural, and structural determinants of health. The evidence is clear in showing that while we continue to address complex social issues in isolation from each other, we will never achieve the change we want to see.

A myriad of inquiries and reports over the last ten years, across the criminal justice system, child protection and youth justice systems in Queensland, have been clear in highlighting the need to prioritise health responses to alcohol and other drug use, and that a longer term approach which addresses the broader social, economic, and cultural determinants of health is required.

While treatment works for people experiencing problematic use, and harm reduction strategies are essential to supporting safe use for others, our policy and legislative responses across the broader service system tend to be targeted towards addressing the greater harms experienced by a relatively small, but highly visible, part of the community. This often results in a focus on more punitive, crisis oriented responses, which provide limited benefits over the longer-term, fail to achieve the desired, deterrent effect and are increasingly misaligned with broader community expectations.

Queensland Network of Alcohol and Other Drug Agencies Ltd

6 April 2022

Mental Health Select Committee
Parliament House
George Street
Brisbane QLD 4001

Dear Mental Health Select Committee Members

Thank you for the opportunity to provide an addendum submission to the Mental Health Select Committees' *Inquiry into opportunities to improve mental health outcomes for Queenslanders*, in relation to current investment in alcohol and other drug treatment and harm reduction services in Queensland.

As per the attached table, total investment in alcohol and other drug services by both the state and federal government was almost $196 million during the 2020-21 financial year. This accords with state government investment information outlined by Queensland Health (Submission 150) which demonstrates that, in total, the Queensland Government expended $139 million dollars on alcohol and other drug services throughout 2020-21. This was inclusive of 61% ($85.4 million) spent on treatment services delivered though Hospital and Health Services (HHS); and a further 36% ($49.7 million) in services delivered by the non-government sector.

The attached advice also seeks to clarify information included in the Queensland Mental Health Commission's submission which outlines that state government funding for non-government organisations was $50.7 million in 2019-20. While this section broadly touches on funding for alcohol and other drug services it fails to make clear that the stated investment of $50.7 million relates to mental health services only; and is not inclusive of investment in non-government alcohol and other drug services (Submission 151; page 10).

Information on funding provided by the federal government has been sourced directly from our colleagues at the Australian Government Department of Health, Alcohol, Tobacco and other Drugs Strategy Branch. This investment is placed with non government alcohol and other drug services, either commissioned directly by the federal government, or by Primary Health Networks. I would be pleased to provide further information on this addendum submission if required, and can be contacted at [redacted] or by calling [redacted]

Yours sincerely

Rebecca Lang

CEO

Queensland Government		
Fund administrator	Fund description	2020-2021 financial year
Queensland Health	Alcohol and other drugs treatment provided by Hospital and Health Services (HHSs)	$85 400 000
	Alcohol and other drugs treatment provided by non-government providers	$49 700 000
Queensland Corrective Services	Alcohol and other drugs treatment for people in custody and transitioning from custody to the community	$3 700 000
	Total Qld Government:	$138 800 000
Australian Government		
Department of Health	Drug and Alcohol Program provided to non-government residential rehabilitation and withdrawal management providers.	$13 945 633
	PHN Core treatment funding (PHN commissioned services from non-government providers)	$10 395 835
	National Ice Action Strategy funding: PHN Commissioned alcohol and other drugs treatment provided by non-government and Aboriginal and Torres Strait Islander Community Controlled health services)	$16 084 063
National Indigenous Australians Agency	Indigenous Advancement Strategy funding for alcohol and other drugs treatment for First Nations peoples	$17 500 000
	Total Australian Government:	$57 925 531
	Total Qld and Australian Governments:	$196 725 531