MENTAL HEALTH SELECT COMMITTEE

Members present:
Mr JP Kelly MP—Chair
Ms AJ Camm MP
Mr RI Katter MP (virtual)
Ms AB King MP
Mrs MF McMahon MP
Mr R Molhoek MP
Mr BL O'Rourke MP
Dr CAC Rowan MP

Staff present:
Dr A Beem—Acting Committee Secretary
Ms M Westcott—Assistant Committee Secretary

PUBLIC HEARING—INQUIRY INTO THE OPPORTUNITIES TO IMPROVE MENTAL HEALTH OUTCOMES FOR QUEENSLANDERS

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 16 FEBRUARY 2022

Brisbane

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The committee met at 2.02 pm.

CHAIR: Good afternoon. I declare open this public hearing of the Mental Health Select Committee. Welcome. I respectfully acknowledge the traditional custodians of the land on which we meet today and pay our respects to elders past and present. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander people, whose lands, winds and waters we all share.

I would like to introduce the members of the committee. I am Joe Kelly, member for Greenslopes and chair of the committee. With me are Mr Rob Molhoek, who will be with us momentarily, the member for Southport and deputy chair; Dr Christian Rowan, the member for Moggill; Ms Ali King, the member for Pumicestone; Mrs Melissa McMahon, the member for Macalister; Mr Barry O'Rourke, the member for Rockhampton; and Ms Amanda Camm, the member for Whitsunday.

The purpose of today's proceedings is to assist the committee in its inquiry into the opportunities to improve mental health outcomes for Queenslanders. This is a proceeding of the parliament and is subject to the Legislative Assembly standing rules and orders. Only the committee members and invited witnesses may participate in the proceedings. Witnesses are not required to give evidence under oath or affirmation, but I remind witnesses that intentionally misleading the committee is a serious offence.

These proceedings are being recorded and broadcast live on the parliament's website. Media may be present and are subject to the committee's media rules and the chair's direction at all times. You may be filmed and photographed during the proceedings and images may also appear on the parliament's website or social media pages. Please turn your mobile phones off or switch them to silent mode. I remind everybody that face masks are to be worn at all times. Witnesses and committee members may only remove their masks to speak during the proceedings. As the chair, I reserve the right to keep my mask off because I have to speak at frequent times without warning.

LANG, Ms Rebecca, Chief Executive Officer, Queensland Network of Alcohol and Other Drugs Agencies Ltd

POPE, Ms Sue, Deputy Chief Executive Officer, Queensland Network of Alcohol and Other Drugs Agencies Ltd

POPOVICH, Mr Sean, Director, Policy and Systems, Queensland Network of Alcohol and Other Drugs Agencies Ltd

CHAIR: I would like to welcome representatives of the Queensland Network of Alcohol and Other Drugs Agencies. I would like to say that the committee welcomes the opportunity to spend some time focusing on AOD services. It has become very clear in the early parts of this committee process that we need to consider carefully the issues around AOD in relation to their interactions with mental health services. We are very pleased to spend some time on this today and it will no doubt continue to come up through the inquiry. I would like to invite you to make a brief opening statement, after which members of the committee will have some questions for you.

Ms Lang: Thank you very much. I would like to add my acknowledgement of the custodians of the lands on which we meet and acknowledge that Aboriginal and Torres Strait Islander people, whilst using substances at lower rates than the rest of the population, experience more significant harms, particularly the harms through the criminal justice system.

QNADA is the peak organisation for the non-government alcohol and drug sector in Queensland. We have around 55 to 60 member organisations operating across the state, from the Torres and cape region all the way down to here in the south-east corner and as far west as Roma, Charleville and up through the western corridor. Our member organisations provided around 20,000 episodes of (inaudible) to around 15,000 clients. Most of these episodes of care are single

episodes of care. The double-up can mostly be accounted for through connected treatment episodes—for instance, withdrawal management, going to residential rehab or moving from case management into counselling services.

Through research, we know that for the vast majority of people who use substances they do so without problem. Alcohol is the best example of that. Eighty per cent of the Australian population consumes alcohol. Most people do so in moderation and in the context of a larger productive life. The same is sometimes surprisingly true for people who use other types of substances, but the occurrence of that use is much lower in the community than for alcohol. The most commonly used illicit substance is cannabis. Around 15 per cent of the population in any given year will be using cannabis, but nearly 50 per cent of people will try it at some point in their life.

While not everyone who uses drugs has a problem, for the group that does experience dependence or significant issues, they find it difficult to access treatment. Sometimes that is about what they think treatment is. A lot of people assume that treatment is residential treatment and is the only option that is available to them. They approach the nearest residential rehab to them, which is almost invariably full, with a waiting list, and they are best offered some waitlist support while they are working through the issues. Often there are issues around medical assessments or accommodation, loved ones, pets—there are things to be organised before people can just walk straight into a residential rehab.

The most recent investment from the federal government in treatment went out through the primary health networks. One of the unforeseen benefits of that process was that the investment was not enough to invest in residential services so we saw a growth in outclient counselling services. It has changed the way some of our members look at providing residential treatment. They will first put someone in a non-residential group to prepare for residential treatment because obviously it is very intensive, but also, for some people, once they get into that outclient counselling they realise they can manage this quite well.

The other part of this where people have problems—not exclusively but often—is where we bump up against the mental health system. There is the concept of self-medication, which I do not find a very useful concept myself, but people are using substances to cope with the after-effects of post-traumatic stress disorder, for instance, or have experienced significant adverse childhood experiences like abuse or domestic violence.

Often we find that when people come to treatment it is not as simple as removing the substance from their life and then everything goes back to a reset. There are significant issues around the physical health, social health, economic health of people, and you need to work with them to develop coping strategies that are not substance dependent before you can remove the substance. Professor Steve Allsop, an expert in this field, describes it as: if you consider yourself hanging off a cliff, most people have a range of ropes that are holding them, stopping them from falling—employment, relationships at home, housing and all of those types of things. If you think about someone in serious drug dependence, often the drug is the only coping mechanism they have, so asking for them to just give that up and trusting that everything else will be better is a pretty big ask. For that group of people, we know that substance use problems can be a chronic relapsing disorder. We sometimes talk about developing a more chronic disease focused model where people can dip in and out of treatment, with different varying intensities depending upon their needs at the time.

The other thing we notice is that the social and cultural determinants of health become a really important factor. For Aboriginal and Torres Strait Islander peoples, the lasting legacy of colonisation and dispossession from land can be tied up with substance use issues. I would note the work of QNADA member organisation Gindaja, in the discrete community of Yarrabah, as providing a really great example of how cultural healing is integrated with drug treatment to great effect.

The issues our members are raising with us include the need for more treatment. We have a process in place with Queensland Health which we have been working on. One of the benefits of being associated with mental health is that we have a more regular planning process where we see some of the opportunities that this committee might pick up relate to the cross-systems work that our members have raised with us over a number of years—for instance, the way that Child Safety manages people in their system who have alcohol and drug use issues, the way that the youth justice system responds to young people's substance use and then also the adult justice system and some of its approaches to substance use where people appear before. That is a whistlestop tour of our submission. I am pleased to answer any questions you may have.

CHAIR: Before we do that, with the agreement of the other members of the committee, I would like to start by having about 10 or 15 minutes of a private hearing with members of QNADA.

Proceedings suspended from 2.12 pm to 2.27 pm.

CHAIR: In your submission you talk about the need to incorporate voices of marginalised individuals in the policymaking processes. From a practical perspective, how would we go about that?

Ms Lang: I will throw to Sue for this one. We did some work on this in 2020.

Ms Pope: We did a piece of work right at the beginning of the pandemic. We had hoped to be able to do this face to face. Hampered by the pandemic, we set out to consult with a large group of people in Queensland who use drugs to hear about what their representation needs might be. You would be aware, I am sure, that in Queensland we have no funded representation body for people who use drugs. Recently I would note the creation of the body in Queensland for people with mental health issues. Hearing the voices of people who use drugs in Queensland is incredibly difficult because of the stigma and discrimination that they experience and fear of disclosure. There is a whole raft of issues that make hearing those voices incredibly difficult.

We heard from over 400 people across Queensland. We learnt a couple of things. The first was that the community of people who use drugs in Queensland is incredibly diverse, but one thing they all agreed on is that they would like for there to be an opportunity for their voices to be heard in relation to the development of policy, system reform and service improvement. We have also had a little bit of experience developing a framework to support services to better engage with people with lived experience of using alcohol and other drug and mental health services. That was funded by the Queensland Mental Health Commission—the development of the framework—and then piloted very successfully. The issue that we heard very clearly through our consultation was that it is very important for people who use drugs to have a voice in the development of policy, systems and service delivery, and currently there is no avenue for that voice to be heard in Queensland. The report from that piece of work did not come up with a firm recommendation.

As I said, there a number of organisations. QuIVAA is an organisation in Queensland that operates on a voluntary basis that represents and advocates for people who use drugs across Queensland. As you know, there are a number of organisations that advocate for and represent people from other communities including LGBTQIA+ communities, culturally and linguistically diverse communities and Aboriginal and Torres Strait Islander communities, to name a few.

Something very important to consider when you are thinking about what a good model might look like is that people have a range of diverse experiences, but often that can be associated with other communities that they recognise themselves as a part of, so sometimes it goes to that notion of intersectionality. Sometimes the experiences of people of discrimination and marginalisation can be exacerbated. None of those other representative organisations are resourced to work specifically with people who use alcohol and other drugs. I think that is a really large gap in Queensland. Other states and territories have funded organisations that do fabulous work in this space.

I do not think we particularly have a position on the model—correct me if I am wrong, Bec—but there are lots of things to consider and I think the first place to start would be by doing some more consultation with people who use drugs to help work up some models that may work for them.

Ms Lang: And possibly also some capacity work with those existing groups that are working with those communities so that they move beyond the stereotypes of what substance use looks like. Multicultural communities often start from a place of 'our community do not use drugs', but that does not bear up to any type of scrutiny for the most part.

Dr ROWAN: I would like to ask a question of Rebecca Lang as the CEO of QNADA. In the submission of QNADA, it is highlighted that reviews in the past decade have consistently called for greater collaboration and coordination across systems to prevent Queenslanders with alcohol and/or drug dependency conditions from falling through the gaps. I would really like to get a sense of how well Queensland is going when compared with other state jurisdictions and what more needs to be done in relation to publicly funded services, whether that be detoxification beds or rehabilitation services within hospital and health services, not only in the acute hospital sector but also in the community sector in regions across Queensland.

Ms Lang: The sad truth is that whether you fall through the gaps depends very much on where you are in the state. More than that, it also depends upon the service you access or the statutory officer who is before you. We highlighted in our submission a couple of child safety instances—one where there was great collaboration between child safety officers and the treatment service that was supporting the person, so that the safety of the child was kept front and centre without impacting the treatment rapport. The confidentiality of that space is that people need to feel safe to make disclosures and sometimes those statutory systems lean on our system to give them information, because they think more information is better without necessarily balancing that with you impacting the effectiveness of the intervention by intervening in that relationship.

New South Wales has done some reasonably good work of late with empowering workers in the AOD sector to have an escalation pathway if they feel like the child safety officer that one of their clients is seeing is not applying best practice. What we have is a situation where most of the rest of the country is grappling with this at the same time. I have asked the question on a number of occasions to anyone who will listen to me: I do not understand at what point a young person ceases to be at risk of harm in their family and needs to be removed into the care of the state and becomes a youth offender that the community needs to be protected from by virtue of detention. There is a really strong correlation between kids who have been removed from their families or have had child safety intervention in their families who have substance use issues and then go on to be subject to detention, in some of the worst cases just for drug possession—like several different instances of drug possession. There is a young woman who volunteers with the Youth Advisory Council for the Queensland Family and Child Commission whose story is horrifying. She is now doing a social work degree and is a mother herself and has come through that remarkably well, but at the same time I think she is the exception, not the rule.

I think sometimes the issue is that we do an inquiry and then we set up a project team within a department to implement the recommendations that are accepted by government. It is a finite period of time. No-one else in the department thinks that what the project team is doing affects their day-to-day. At some point that project finishes and we have made an assumption that we have embedded that change into the system when if we have learned anything from behaviour change science over the last 20 years it is that old habits are hard to break, new habits are hard to form and coaching, support and focus are what changes behaviour in the longer term.

In our own minds, we think there should be some type of ongoing structure that is about systems improvement, not dissimilar to the kinds of quality improvement cycles that have been required in service provision land for a really long time now. The hospitals have been doing it for 30 years and our sector has been doing it for 15 years. There should be constant reflection and review on practice and collecting the right types of data to really get good metrics about how well we are performing. For instance, at the moment if you present at an emergency department with an injury that was clearly related to your intoxication, your broken leg will be the thing you get put into the system as being there for, and maybe the person will write in the notes, 'They fell over because they were drunk.' That makes it hard to even quantify the size of the problem.

My understanding is that Child Safety data shows that, while they can say that 60 per cent of their removals involve substance use, what they cannot tell you is whether that is current substance use or previous substance use. I think that is a pretty important distinction to make for child safety. I would be much less concerned about previous substance abuse than current substance use. Then we want to have a conversation about all the whys, the wheres and the whats of that—like, how often and what amount and 'are you arranging care for your child while you are using substance?' All of these things are relevant but are not necessarily front of mind for people working in that system.

We do a lot of work with our member organisations and other community services around capacity building. We provide forums, fact sheets and guidance around, 'This is what the science says about alcohol and other drugs interventions. We would love to talk to you about what that looks like in your part of the world,' because we do not know everything about what are the pressures in the child safety system or the youth justice system. I think bringing people together is the way to solve some of these problems.

Ms KING: Thank you so much for being here and for the work that you do with organisations all over the state to bring about improvements in people's lives and in their experiences. I wanted to ask you to speak specifically about some of the issues that are outlined in a number of the case studies you put forward in your submission. In particular I was struck by the statement about Jane, whose prescription use of medical marijuana led to adverse outcomes in child safety settings. Rather than specifically talking to you just about that, though, I wanted to ask you about the intersectionality of people who experienced adverse scenarios from alcohol and drug use with various aspects of various systems which you talked about. Are there any other particular issues you would want us to know about when it comes to making recommendations? That is a glaring one to me.

Ms Lang: Yes.

Ms KING: Is there anything else you want to flag with us?

Ms Lang: The same service that provided this case study talks to us about how women who use substances avoid antenatal care because they know that that is an automatic report for a doctor. We introduced medicinal cannabis maybe four or five years ago now. It took a while for the green light to turn into products available and doctors available to prescribe it. We have noticed a real acceleration in that industry's establishment over the last 18 months, and we hosted a forum on this

topic with our members because the issues are broad as police have no real guidance around how to tell the difference between what is medicinal cannabis that has been prescribed versus what is illicit cannabis that has been put into a prescription box or a bag. There was some confusion early on that if you were not also carrying a vape pen then what you were doing was not legal. There was some thinking that you could not remove it from the packaging. In fact, there was, I understand, an effort to tighten laws around that which would have had the unintended consequence of making Webster-paks illegal. We do that with other medications all the time—divide them up into what you need to use on any given day. That seems to me to be a really great example of how we make a change and we think the various systems will figure it out on the way through. I think we can be more intentional about supporting that behaviour change. It seems ludicrous to me that a child safety officer thinks medicinal cannabis would not show up on a drug screen. That speaks to the lack of understanding about what medicinal cannabis is or is not.

The other side of that is that amongst our members we have had a conversation about: if there is a proportion of the public's cannabis use that is self-medication, what proportion of that group should we be supporting to access medicinal cannabis to get them out of at least the illegal market? At this point, access to medicinal cannabis is limited by your income as well because accessing the legal substances is significantly more expensive, as is reported to us, than accessing it on the unregulated market, which obviously comes with increased risk of harm because it is not labelled; you do not know what it is precisely you are getting in terms of psychoactive substance mix.

Mr MOLHOEK: I wanted to ask some questions around rehabilitation and detox services—there are residential and non-residential—probably more about the residential services. In terms of, say, over the last decade, has there been any significant increase in the number of services or beds available in the system? What are the models of rehab work and which are the most effective? I have, I think, three in my electorate and there has been no expansion of any of them since the eighties, basically. One of the groups actually wanted to acquire a new property—it was a backpackers lodge—but they were not allowed to because under the new housing standard everyone has to have an ensuited room, not shared bathrooms. I am interested to understand which rehab models work and what has happened with supply and demand of services and how effective they are.

Ms Lang: That is a good question. In 2015 a study on demand and availability suggested that the entire country was about 50 per cent underdone when it came to specialist treatment services. Since that report was produced, the federal government has funded non-residential services through the National Ice Action Strategy but only for four years. That funding is currently only confirmed to 30 June this year. That could be $12 million from the system that just disappears on 1 July. We are assured it is in the March budget, but I would have been more comfortable if it was announced at the end of last year.

We have seen an increase in new services. The federal government before the last election invested in a new service in Caboolture and a new service in Far North Queensland. At our last state election the state government committed to three new services. There is one in Ipswich, which—the department can confirm—comes with something like 28 or 30 residential beds and an additional eight withdrawal management beds. That should help quite a lot to smooth the flow in as you do not have to go to someone else to get your withdrawal management service and then try to get them to coordinate; you can just go to the one place.

The real issue, and one that we have raised with Queensland Health consistently over the past five years, is exactly the one you raise: there is no expansion of existing services; there is only tendering for new services. Residential services suffer in that environment because obviously those new services come with new buildings and no-one is investing in the existing services. In terms of the service infrastructure, our members rely generally on either catching the ear of a minister or a local member who is interested in helping out or applying to things like the federal Building our Regions program for their infrastructure funding. For instance, Logan House at Chambers Flat has enormous space to expand but is also in ageing buildings. The buildings are more than 30 years old and have been patched up a number of times. Some investment to refresh the infrastructure would be very welcome.

I hope that we can work towards a situation where every single residential rehab in the state has its own withdrawal capacity. That also increases the clinical capacity of the service generally because you bring, usually, nurses in to oversee people's withdrawal and have a visiting doctor to do the prescribing, but that nurse is then able to also help out with the other physical health needs of residents.

When it comes to models, it is a little bit of a 'how long is a piece of string?' question. There is a range of models. Therapeutic communities have a good evidence base for them. They are particularly good for people who have significant social disability as well, because you live in a

community and learn healthy relationships in the residential service. Newer models tend to focus on shorter programs with more intense psychological therapy content. I would point to that in the private sector. Really, you are limited by your budget. There are some really great services in Queensland that can offer in-house psychiatric support as well as individual psychological counselling as well as a very nice place to stay while you sort through your issues.

Then there is the problem of there being no regulation of who says they are a residential rehab provider. The public system is effectively regulated through contracts with government and requirements for quality improvement, staffing levels and all of those sorts of things. In the private sector, if it is outside of a hospital setting you cannot claim private health insurance for it. People pay out of pocket for sometimes very expensive services that do not come with very expensive professionals attached. That has been highlighted in Victoria as a particular problem, particularly with services that encourage people to access their superannuation in order to access treatment. I think that is something we definitely do not want happening in Queensland.

Mr O'ROURKE: Thank you for your detailed submission. With regard to page 21 concerning workforce capability and current funding arrangements—you touched on it in a previous response around the federal funding being through to June 2022. What does that actually mean on the ground for organisations? Is there a requirement within that funding agreement; for example, three months out you need to start looking at transitioning your staff into other employment?

Ms Lang: It is not a requirement of the contract, but it is definitely what people are doing. Most of our members are either incorporated associations or companies limited by guarantee. Their directors have rules around responsible risk management. The other part of this—and perhaps the bigger part of it—is individual staff voting with their feet. People have mortgages and school fees to pay. They have professional development needs of their own. It takes quite a lot of resilience to walk right up to the end date of a contract and hope that you will have another one so that you still have a job the following week. There are financial impacts for services whereby if they have not made people redundant before the end of the contract they wear the cost of that redundancy, which obviously impacts their ability to deliver, but that money cannot be used to then deliver services.

Perhaps the most significant impact is that it holds back the development of our workforce, which we know we have a shortage of, because people leave to go and work in more secure sectors and then we have to start training from the baseline again. There is not a program in this country that produces job-ready graduates for alcohol and drug services. They require further training—not so much psychologists but social workers and nurses. It is a specialised field. It would make the world of difference to have funding stability. I note the public system has that funding stability. I am sure there is a downside to working in the public system, but workforce stability is not the problem for them.

Mr O'ROURKE: What would be the ideal, if we can influence the federal government around that? Should they be re-calling tenders 12 months out?

Ms Lang: The department did start this process 12 months ago. It seems as though with the federal government's contracting arrangements nothing happens in less than 18 months. They have just extended some of their contracts for 12 months and they say they are going to tender them, and I am saying to them, 'You don't have time. You are not going to be able to get it done.' It would be better to see rolling contracts but better performance management within that contract environment. If you have concerns about the quality of service provided, you use that as your mechanism for withdrawing funding from a provider and placing it somewhere else. The rest of the health system does not contract on fixed-term contracts and hope that this is still a priority.

We have not solved drug dependence. We are not going to solve drug dependence in the next five years. This is somewhere the Queensland government is actually moving in a really good direction, though. Our non-residential members are just coming to the end of their first five-year contracts. They had contact from the department in the second half of last year to advise them of the process for renewing those contracts. Similarly with our residential contracts, that process started in January 2021 and has now advanced to the point where individual negotiations are going on. That process itself gives providers comfort that another contract is coming and that if they do good work they will be rewarded with ongoing work. That is a model the Commonwealth could look to and learn from.

CHAIR: I acknowledge that the member for Traeger has joined us. Welcome, member. I go back to the issues you raised in your submission around the need to regulate providers of alcohol and drug services, particularly around residential services. Are we looking there at regulation of individual practitioners or are we looking at more of a service-level regulation?

Ms Lang: We would point to something like the current process for licensing day hospitals as a good model—something that means there is someone who actually has a list of criteria that says, 'If you are going to call yourself a residential rehab then you need to have this baseline staffing capacity, connection to the evidence' or whatever it might be, and then that is reviewed on a regular triennial basis.

CHAIR: That would assist consumers to determine which services have validity?

Ms Lang: Absolutely. The difficulty is: because of the stigma people experience, they do not know how to tell whether the service they are accessing is of a quality compared to other services, because they have only really accessed the one they could manage to get into. Sometimes that is okay. Sometimes it is fine. We have a number of church based, sober house style unfunded services across the state. If you are a person of faith and have a drug issue, they work really well. The problem really comes where generally enterprising folks with their own lived experience of recovery who are active in a fellowship want to take that out to the world and share that experience with others. That is not a problem in and of itself, but when they start charging the sorts of prices you would expect to see of a place that has psychiatrists and psychologists working in it—the price tag does not match the service delivered.

CHAIR: In terms of the residential programs and the day programs, do you see an important role for peer support workers? Should they be part of a regulatory process to be required to be part of the services?

Ms Lang: One of the things we found in talking with people who use drugs across the state is that in the mental health system you have people in identified peer worker roles. They are highlighted as people with a lived experience so that people coming to access that service know that someone has empathy for what they have been through. In the alcohol and drug space, a significant proportion of people working in therapeutic communities have lived experience but are not in an identified lived experience role.

We have been talking with the primary health networks around how we might do some work to identify what we mean about peer workforce in our alcohol and drug space, because obviously in the harm reduction space, particularly in needle and syringe programs, it is not unusual to have people who are themselves current illicit drug users. There are obviously specific risks that need to be managed in that environment to keep them safe in that environment. It becomes a little easier to manage in the residential setting where you have people on their own recovery journey, have recovery capital and can share that with people in the service. The answer is: yes, we want more empathy in all of our service systems, and giving prominence to lived experience in those services is one way to do that.

CHAIR: We have talked a lot about people who need that high-end support and therapeutic response. I am interested also in the very low end of people who might have a pre-alcohol and drug problem and whether there is more we can do in that space. We seem to have a lot of public health messaging around safe levels of alcohol consumption, good marking on most drinks that come from Australia and confusing messaging from the media every other day telling me I can have a glass of wine, it is good for me, or I cannot have a glass of wine, it is bad for me. I am interested in that interaction in the primary health network around GPs. Are there models of systems that actually help people do a real and valid assessment of their alcohol consumption and whether they need to be starting to take steps to think about their relationship with alcohol?

Ms Lang: Yes.

Mr Popovich: There are a few issues in the primary healthcare space. One of the biggest issues—and it goes without saying—is stigma experienced by people who use drugs and alcohol in disclosing their use in a primary health setting. The first thing that we really need to do is identify those primary healthcare practices that would benefit from learning a bit more about alcohol and other drugs and the people they would be seeing in that process.

What I would take us back to is what we have in our submission—that the United Nations Office on Drugs and Crime reports that around 88 to 89 per cent of people do not experience problems requiring treatment. If our primary health-care services were well aware of that, they would also recognise that the people they are seeing in terms of particularly illicit drugs are the people who are already attending their practices. We are not asking those practices to see different people; we are asking them to ask the question of whether or not your relationship, as you put it, with alcohol and other drugs could be safer or healthier. There is some work to do in reducing that stigma around use.

In terms of the models, I actually do not think it is super complicated. We have got the rollout currently happening of the ASSIST, which is an assessment tool in primary health practices that helps primary health practitioners identify alcohol and other drugs issues. Speaking specifically to alcohol, we have also had for a long time the audit in place. It really is a matter of asking the question in the first instance and then building the knowledge of those practitioners of what services are currently available and what services can be called upon for secondary consultation in instances where it might become a bit more complicated. We also have ADCAS in Queensland—which is a clinical advisory service for GPs in the state—that can be called upon by those services. We actually have a range of things in place. The bigger question is how do we get people to start using them.

CHAIR: Do you connect in well with the PHNs?

Mr Popovich: Yes. We have good relationships with all seven PHNs across the state. We are currently doing some work with those PHNs on this very issue in both North Queensland and Western Queensland.

Dr ROWAN: Ms Lang touched on the importance of infrastructure that is needed, and we talked about beds earlier. I have been involved in the sector in various clinical professional capacities. I want to come to the workforce specifically and getting doctors, nurses and allied health professionals who are going to be providing the services into the next generations and beyond—whether it is addiction medicine specialists, addiction psychiatrists, nurse practitioners, pharmacists, social workers or psychologists. Is there any advice that QNADA could give to this committee as to what needs to happen with respect to workforce for the AOD sector? The committee has heard a lot of testimony as to what needs to happen in mental health services, but I am interested in what also needs to happen in alcohol and other drug services.

Mr Popovich: That is a great question. We have a really diverse workforce, as you are aware. One of the issues that we experience is that very little education happens in tertiary settings around alcohol and other drugs in undergraduate degrees. I think Bec touched on this earlier. The problem is that we have to assume someone already has an interest in alcohol and other drugs to go on and do postgraduate in that space and there is no other way to get a taste of that setting. One of the things that I am big on—this is just my personal opinion—is offering things like majors in undergraduate degrees in this space. I think that is a simple solution to give people a taste of what the sector is about and what it is like.

The other issue we have to be cognisant of is that we have people in the sector with 30-plus years of experience who currently do not have degrees but are excellent practitioners. We have to be really careful when we are professionalising the workforce that we do not disregard the expertise of people who have been in the workforce for 30-plus years. I note that Victoria had some issues with implementing a mandatory certificate IV in alcohol and other drugs, where people were required to go back and do that after they had all of that experience or they were also qualified as well as, for example a psychologist in the space. Forgive my way of putting it, but it was a bit of a kick in the teeth in some respects. There are certainly solutions that can be implemented but we just have to be careful about those issues as we move along.

Mrs McMAHON: One thing I want to touch on, and it has been raised in earlier hearings, is how the alcohol and other drug space looks for our younger people and children. We have been told that a lot of these specialist treatments only kick in from a certain age onward and are not considered earlier. Could you give us a snapshot of the alcohol and drug issue in our under-18 space in terms of percentage of use, where the problem use is and what the drug of choice is? What are the options for a parent who is dealing with a child with a drug use problem? What services are currently available to children?

Ms Lang: We need to divide up that group of young people a little more finely than just under-18. For the most part, the under-10s are not using in a way that would be the primary issue. Generally speaking, with the very young kids, a diversion is what you need to do—not like literally the police diversion, but to actually take those kids and give them something else to do and engage them in more pro social activity.

If someone is under 10 and they are using, they generally would be using something like inhalants, such as deodorants. It is literally about availability. Butane is available on most supermarket shelves. We moved spray paints to behind the counter 20 years ago. There is some resistance. I note there is an article in the *Courier-Mail* today about Coles in the CBD moving their deodorants into a locked cabinet, which has caused some stir from adults who are wondering why that might happen. Generally speaking, the drug use in the very young cohort is not the problem; there are life problems.

We have a series of youth services. I would note two in particular that are very good at delivering alcohol and drug work within the context of a generalist youth service. There is one here in Brisbane called Brisbane Youth Service and there is one in the Far North in Cairns called Youth Empowered Towards Independence that does a lot of work with young Aboriginal and Torres Strait Islander people who are often disengaged from school, who are maybe not living at home with their folks for some reason or who are in other unsafe living circumstances.

If you move beyond the littlies and into the pre teens and early teenage years, it again is about helping kids get interested in going back to school. There are some alternative schools. One of the case studies talks about reconnecting a young woman with schooling which then resolved her issues with her parents so she could go back to living at home. That meant child safety did not need to find a placement for her, which is a really great outcome. Those types of services could help the young person to deal with identification issues, to get them back into schooling or to deal with Centrelink if they are having issues with them. Those are the types of services the young person will talk to about their substance use once they have developed some trust.

Occasionally, we see older people preying upon young people who are in those circumstances and using substances. They provide them with substances as a way to draw them into very unhealthy situations. Again, the existence of those non-residential youth services can be really good for helping young people to develop the skills to identify when they are being preyed upon and to stand up for themselves and get out of those situations.

This has been a bone of contention for some time in Queensland because we are soon to have our first youth residential rehab. We have not had a dedicated one. Mirikai on the Gold Coast focuses on younger people. There is a bit of flexibility if someone is 17 or nearly 17 and the current cohort in the rehab is not at the older end of the spectrum so they can bring those people in.

There is a 10-bed facility that is being developed currently. We are working with the Aboriginal and Islander Health Council in Queensland Health on the development of that model of service. I know there is some interest in a New South Wales service which is a three-month program. I suspect given the high rates of engagement with youth justice and child safety for this particular cohort that a longer term safe space for them might be required. We will not really know until we open the doors and see who selects it. We do have a short-term program here in Queensland called Clarence Street attached to the Mater Hospital, but it focuses itself as a withdrawal program. It is an 11-day program.

There is more we could be doing for young people. Young people is really where we need to be investing our prevention efforts. For the most part, their patterns of use are sporadic, they are not dependent and they are opportunistic as well—that is, they might go for weeks without using and then be with someone who is using inhalants and be like, 'I'll get onto that,' or be offered cannabis or other drugs by people with income who can access those substances. It really is tied up tightly with the social determinants.

There are a lot of parents out there who are not quite sure how to have this conversation with their children. Certainly, our school based education programs have not met the mark for a very long time. People think that scaring children is going to work or that telling them to just say 'no' is going to work. There is an enormous body of evidence internationally to show that for every child who is deterred from substance use by that approach there is another who becomes curious about it after hearing the approach because they were not even thinking about it until it was raised. Then there is a group of kids who use it as an opportunity to say, 'Well, I'm a bit different to everybody else. I'm going to do the thing they told me not to do.' When we focus those efforts on the most extreme versions of harm that people can experience, there is always someone in the room who says, 'I've got a mate who did that once and that didn't happen to him' so they discard the entire message.

A really great example of this is that the federal government finally saw sense and withdrew the funding for Harold the giraffe to tell the kids not to use drugs a few years ago. Young people themselves, through Triple J, mounted a campaign so that the Department of Health withdrew the funding but the Department of Education reinstated it. We have to fight against this counterintuitive thinking. It is not about whether young people come across substances or use them; it is about how well they can protect themselves in that moment—so refusal skills, being able to stand up to their peers and say, 'Actually, I don't want to do that,' or at least knowing that if someone does use and they get into trouble they should call an ambulance really fast because they are not going to get in trouble.

These are the kinds of messages that we know are best delivered by trusted agents—that is, your existing teacher—and not some police officer or someone like me who comes in for the day and has a chat to them about it but they never see them again. This is about transparency in relationships with kids. That is where they need to feel safe to come and talk about it, and they need to know that they will be met with non-judgemental support if they do disclose use.

Mrs McMAHON: The next question I want to ask is that intersectionality between alcohol and drug use and criminality. I spent many years working as a first responder as a police officer. We would be called out to a job, often by a parent because they could no longer control the situation and what was happening—there was violence, there was property destruction. As you have pointed out, there are probably a whole range of other issues as well in terms of mental health or other stressors and it manifests itself in excessive drug use.

I understand that when a person has an addiction there are often small windows of opportunity where they are open to treatment and open to break the addiction. What often has a lot of parents pulling their hair out is the inability to get them into somewhere in that small timeframe before they disappear, they go off the rails again and they are not seen for another couple of months and the parents do not know where they are during that time. We have spoken in earlier hearings that it is not just about the number of beds but about having them at the right time when the person is in the right frame of mind to enter into it willingly—as opposed to the involuntary care.

Could you tell us, in those moments of crisis where is the best resource for those who have addiction problems and there is a window of opportunity when they themselves are willing to seek rehabilitation? Do we have enough beds? What sort of program does that look like during the middle of the crisis? From the point of view of a police officer, we would take them to hospital and do a referral and that would be it. That is the job done from the criminal justice perspective, unless there are criminal matters that have to be dealt with. A lot of mental health and addiction issues do get to that crisis point where all the other government departments are involved. Where is the best use of those resources to get that person ready to better themselves?

Ms Lang: If I could solve that one—

Mrs McMAHON: That is what we are here for.

Ms Lang:—I think I would deserve some sort of medal. There is a lot in that. We know that hospital is not a great place for people who are intoxicated. They get very agitated very quickly and the staff at the hospital do not appreciate you bringing them in because they have enough things to deal with. There is the concept of safe spaces. We have had sobering-up services in Queensland. There are a few left. They mostly came out up out of the Royal Commission into Aboriginal Deaths in Custody.

Mrs McMAHON: Murri House.

Ms Lang: Yes. That is a model that I think we underutilise in Queensland. There is no good reason, for the most part, that an intoxicated person needs to be in a hospital. Most often what they need is to be observed to ensure that their condition does not deteriorate and they could be taken to hospital if that happened.

In terms of getting people into beds instantly, I would note that there is not really another specialist service where there is an expectation that as soon as you are ready to go there will be something available to you. In that instance what you would be doing is having someone held in a safe space and medically monitored. Then when they were sober you would have the conversation about change. It would be drawing upon, 'Last night didn't go so well, did it?' That can be a really important hinge point for getting people to be honest about how bad things really are, because people cope all the way up until the moment that they are no longer coping.

There are new models we could be looking at—not new models. We could be expanding existing models that we have applied in Aboriginal and Torres Strait Islander policy in the broader policy. Up until a number of years ago, we had the Youth at Risk initiative that had sobering-up spaces for young people. Generally, if police came across a young person who was at risk and clearly intoxicated, instead of taking them to the watch house or the hospital they would take them to these spaces. Maybe we had a cross systems issue because, when the review of youth programs happened maybe back in 2016, that initiative was folded into generalist youth work and we lost that particular resource. Mostly, this is families dealing with this stuff at home quietly, hoping that no-one will notice.

The tricky part of this is that when the crisis occurs your cognitive functioning and logic are not what is driving you. If you do not have an existing understanding of the service system, how are you supposed to know who to call or how to get help? I cannot tell you the number of times I have had conversations where people have decided that the issue is if we just had a better service directory people would be able to find a service. We maintain a service directory on our website and we update it every six months because we do not want anyone to take a number from our website but when they call it no-one answers.

The stop-start funding of our system means that we have good examples of practice but we do not necessarily have a clear pathway for scaling up once we know an intervention works. Until recently we did not have a service growth plan at the state level. *Connecting care to recovery* changed that

for us and the process of developing our understanding about where our next best buys are fills me with a lot of hope that our next plan will be even better again. If we educated the community about the softer end of it and we got general practice to do better work, maybe fewer people would be at the point of, 'I'm tearing my hair out and I have no alternative but to call the police to protect me from my own child.' That is horrifying.

Ms CAMM: In closing your opening statements you referenced a chronic disease model of treatment. Could you expand upon that? Obviously there is an intersection between alcohol and drug use and mental health, which in significant cases is also a chronic disease. What did you mean by that? What are some of the policy settings or integrations that may need to occur or recognitions by government and decision-makers to achieve that?

Ms Lang: The chronic disease model we talked about is about having a primary physician who is across all of the physicians that you are working with, and generally that would be your general practitioner. They would refer you to specialists as you need them. Take diabetes as an example. You might need a podiatrist, you might occasionally need a stay in hospital, there might be amputations and those sorts of things that need to happen. But at the core of it you have a medical professional who is able to keep track of where you are up to with all of the things and can say to you, 'You've put on a little extra weight in the past six months and that will be a problem down the track. Let's talk about managing that.'

It is getting to a place where someone coming out of residential treatment is referred back to a general practitioner or to an alcohol and drug service that is able to keep them on the books so that they get prioritised for re-entry if they have a slip-up. There are a lot of services that do the best they can with that. The state government invested in some after-care services or continuing-care services with our resi services maybe five years ago. It is not just an exit of the residential treatment and then you are on your own; it is a much more supported re-entry into community.

For people who are injecting drug users, obviously there are increased risks around physical health issues. We definitely would want to get those people onto opioid substitution therapy. In a sense it is a type of chronic disease management model because usually you have a primary addiction medicine specialist who is overseeing your dose rates and reviewing your case. There are some restrictions around that program that I think the pandemic started to show us were probably more about stigma or discrimination rather than being essential. For instance, takeaway doses sometimes are really hard to get a hold of, but when people were not able to get out because they were in lockdown they were provided with greater leniency around takeaway doses for their opioid substitution therapy and, for the most part, did really well with that. There is a range of different models but I think it is about collaborative care.

Dr ROWAN: Coming back to the three pillars of alcohol and drug policy across Australia and Queensland: supply reduction, demand reduction or harm minimisation. From the submission of QNADA it is clear that investing in harm minimisation—whether it be drug diversion initiatives, enhanced education or improved and expanded community health services—would be of significant benefit. Is there an idea of the quantum of investment, whether that is from the Queensland state government or the federal government, needed in Queensland to improve the health and wellbeing of people who are suffering with any form of alcohol and/or drug dependency?

Ms Lang: Tracking our investment is difficult because in the public system in the mental health and alcohol and drug service we cannot see how much of that is alcohol and drugs and how much is mental health. It is kind of just a lump. The department does collect an FTE count of AOD workers so you could do the maths and work it back.

When that study was done in 2015, nationally they said across primary care, hospitals and community services we spend about $1 billion a year in alcohol and drugs treatment. The burden of disease caused by alcohol and other drug issues is generally recognised at around two per cent of the burden on the health system. They said that that was an argument for doubling the investment.

In Queensland when we started at that point we had around $120 million or $130 million invested in both the public system and in the non-government part of the system. If you use that as your baseline, since then we have had some slippage in the public system, I would think. We have lost some of that investment and workforce. It has been repurposed as mental health. In the non-government sector we have had an increase in our investment; probably about half of what we originally had. We are not talking hundreds and hundreds of millions of dollars. I think to build an alcohol and drug treatment system that is big enough to support the needs of Queensland we would be looking at somewhere in the region of an additional $50 million to $60 million per annum.

The difficulty with these types of services, though, is that in specialist services our workforce is not just sitting around waiting to be offered a job. There is not a latent workforce. We have to train them up. I think the federal Partners in Recovery program a few years back neatly demonstrated this point: you cannot really dump a bunch of money in and expect the standard of service to stay the same or the specialisation of the workforce to stay the same. We argue a planned approach over a number of five-year plans that has a workforce component with it so we grow our workforce as we grow our service system.

I think there are amazing opportunities for regional employment through that as well. We know that access to psychological services, for instance, in Central Queensland is not great and in Far North Queensland as well. In fact, at the moment access to psychological services anywhere in the country is virtually impossible. Those things will have impacts down the track.

How do we incentivise kids who are in grade 12 this year to choose psychology when they go to uni next year, or social work or counselling? How do we tell them that we exist over here and our jobs are really rewarding so that we bring those young people into our workforce and we can kind of 'steady as she goes' grow our system—not forgetting that it is not just about new stuff; it is also about topping up existing things sometimes as well.

CHAIR: Perhaps we need a really good Netflix show.

Ms Lang: There have been a few. Patrick Melrose is one I would recommend.

CHAIR: I will keep an eye out for it.

Ms KING: I am interested in hearing from you about the pointy end of the system, that is, the delivery of alcohol and other drug services in conjunction with mental health services in the correctional system. What are the areas of biggest need? What perhaps are the low-hanging fruit of things that could be done that would make a difference in those systems?

Ms Lang: The Corrective Services system has done a bit of work in commissioning non-government services to deliver alcohol and drug groups inside correctional facilities. At the moment they are trialling a through-care model that connects people with services as they are leaving prisons, and hopefully usually it is the same service provider they have grown to know. There is definitely scope for more. We have issues around people being held on remand rather than people who have been sentenced and then the differences in program access. I guess the trick with remand is that you do not know how long it is going to last so it makes it difficult to plan. That is why it would be good to have a service provider in the custodial facility who can also provide services if someone is released on bail or is found guilty, sentenced to time served and then is in the community. While we know that drug and alcohol use does not cause crime amongst the people who are in our justice system, substance use contributes to the circumstances under which crime is committed so there definitely are opportunities to do more there.

The low-hanging fruit in our corrective services system is harm reduction. We are not far away from eliminating hepatitis C in the community. We have a really effective treatment. It has few side effects. It is actually really acceptable to people. We no longer require people who are no longer injecting drug users to access it. We are within sight of custodial facilities becoming the place where people can contract hepatitis C, which then has all of the liver issues down the track. Unfortunately, the things we need to do to eliminate hepatitis C in prisons are not things that people who work in prisons are particularly amenable to. The things that we would offer in the community to do this work would be needle and syringe programs, we would be encouraging people to use condoms if they are sexually active, we would be connecting them with treatment. There are examples internationally of systems where needle and syringe programs have been implemented. It is a long road. One thing we could be doing straightaway is condoms as the easier thing to do. You get trapped in that kind of loop of, are we condoning illicit sexual activity? From our perspective, it is already happening so we are not creating a problem; we are merely seeking to address the problem.

We have been working with two of our member organisations—Hepatitis Queensland and the Injectors Health Network—to work with corrective services because they do have a drug and alcohol strategy that acknowledges these things should be investigated. Again, there is no lack of goodwill for understanding that these services would benefit people in prisons, but it is the sort of thing that people have a lot of risk concerns about if people found out we were offering this. We are the only jurisdiction in Australia that does not offer condoms in prisons, which I think is an indictment on us all.

Mr MOLHOEK: There are so many questions I want to ask. On page 20 of your submission you talk about the trial that you are conducting in Western Queensland. I would be interested to understand a little more about what that is and what it is hoping to achieve and how you are actually conducting that.

Ms Pope: Thank you. I was hoping we would get an opportunity to talk about this piece of work. It follows on from some of the things that Sean was talking about in relation to general practice and their role in talking to their patients about their substance use, recognising in Western Queensland that there is a significant lack of specialist AOD services and also recognising the incredible burden that is on general practices in the Western Queensland region and in lots of other regions throughout Queensland.

We are working with the PHN to build the capacity of the primary healthcare services out there—the community controlled services, as well as the private general practices and the hospital and health service primary healthcare services. We are working with them to identify what their goals might be around how they could improve responding to their patients with substance use concerns and providing some quite tailored coaching and support to those practices to help increase their confidence and their skills and their knowledge around just asking the question, as Sean mentioned earlier, and then having the capacity to respond in case someone discloses and is interested in talking further within their primary healthcare setting about their substance use issues.

We are at the beginning of this project. Even given COVID and the increased workload on general practice at the moment, we have had a lot of interest. We have done some quite significant work in the electorate of Traeger, in Mount Isa and also in Normanton. It is particularly relevant to regional, rural and remote Queensland but also there is a lot of work to be done in the more urban settings. In the urban settings in Queensland there is a lot more referral options to specialist treatment than there is in some of our more regional, rural and remote areas of Queensland.

CHAIR: Thank you for that. There have been no questions taken on notice. There being no further questions today from the committee, I would like to thank you all for coming along. Members may send additional questions via the secretariat after the hearing. We will now take a short break and resume the hearing at 3.45 pm.

Proceedings suspended from 3.33 pm to 3.45 pm.

LALOR, Dr Erin, Chief Executive Officer, Alcohol and Drug Foundation (via videoconference)

MILNE, Mr Martin, State Manager, Queensland, Alcohol and Drug Foundation (via videoconference)

NORMAN, Mr Richard, Clinical and Service Development Manager, Drug ARM Queensland

YOUNG, Dr Dennis AM, Chief Advocate, Drug ARM Queensland

CHAIR: Thank you very much for your participation this afternoon. I invite each organisation to make a brief opening statement.

Dr Lalor: I note that the inquiry is very well timed in addressing issues that are of significant concern for Queenslanders. We have recently conducted a survey that showed that 54 per cent of people in Queensland are reporting mental health as being the social issue of greatest concern to them. Over half of Queenslanders report being more concerned about alcohol and drug related harms now than before the pandemic. We know that the relationship between alcohol and drug use and mental health is complex and biodirectional. Use of alcohol and drugs, either episodically or over an extended period, can lead to or exacerbate a mental health condition and people with mental health conditions can turn to alcohol and drugs as a coping strategy in response to their symptoms.

AOD use can also contribute to other life stressors such as challenges with employment, finances, housing and maintaining relationships. Tragically, there are very strong links between alcohol and drug use and suicide. We know that AOD use is the second and third leading modifiable risk factors for suicide and self-inflicted injury in men and the third and fourth modifiable risk factors for the same in women. We have noted in our submission that investing in prevention initiatives to reduce these harms is more important now than ever before. Through COVID-19 we witnessed how critical it is to reduce the pressure on our health systems. Supporting Queenslanders to avoid, stop or reduce their alcohol and drug use will contribute to reducing AOD related harms as well as the incidence of mental ill health. This, in turn, will relieve the pressure on the health systems and make it much easier to respond to future crises.

We have noted in our submission that responding to alcohol and drug use as a health issue in Queensland will continue to improve outcomes for individuals and society as a whole and it will reduce the pressure on other systems like emergency services, law enforcement and the justice system. Really, adopting a multipronged approach will yield the best results. That means working proactively through prevention initiatives, providing access to early intervention in primary health care—and I know you have been speaking about the role that GPs can play in helping alcohol and drug management strategies to reduce mental health issues—increasing funding to treatment services and shifting to a health-based approach to AOD use will all be really important. Thank you again for the time to present and contribute to the inquiry.

CHAIR: Dr Young or Mr Norman?

Mr Norman: Firstly, I would like to offer the apologies of Jody Wright, our executive director, who is unavailable this afternoon to do this brief presentation. I thank the committee for the opportunity to speak around this important issue and for this inquiry. I want to start by acknowledging, too, people for whom this inquiry holds a lot of significance, that is, the people with lived and living experience of both mental health and alcohol and other drug issues and also their families and carers and the professional workforce that supports them. Over the past few days and right now, no doubt, you have heard a number of specialists share with you the reality about alcohol and other drugs, mental health and of course suicidality having a combined greater impact than other health conditions.

Significant work has been done in this area over the past number of years which we have seen on the frontline and that is great. We have seen expansion in rural and regional support. But the reality is there is a long way to go and we have a lot to learn, particularly more recently in seeing the move towards lived and living experience input into how services are developed and delivered. Over half of Australians will experience a mental health condition at some point in their life. Research shows that right now about one-quarter of those are experiencing mental health issues. However, not all alcohol and other drug users experience mental health issues. As you just heard, some in fact use drugs and alcohol to self-medicate their mental health issues. Some may end up with a mental health issue as a result of their drug and alcohol use, yet there are still others who use drugs and alcohol problematically but have no mental health issues resulting.

In terms of harms from alcohol and drug, we acknowledge that alcohol is still the most harmful substance and the toll of drug overdose is still worse than the road toll. Rural areas are seeing the highest growth in unintentional overdose deaths. The harms from alcohol and other drugs, which are really quite separate in some respects to mental ill health, have a significant impact on health. If we go into some of the stats, they are quite staggering. What we at Drug ARM believe we need is a cross-sector approach as opposed to a systems integration. The alcohol and drug sector, while interfacing with mental health as a specialist, is unique not just in terms of its nature of issues dealt with but also in screening, assessment, treatment approach, theoretical approach and the broader way it touches and intersects with multiple services within the community. A collaborative and unsiloed cross-sector planning approach, while retaining sector independence and planning responses, would work particularly for the benefit of persons experiencing their help-seeking journey with either drug and alcohol or mental health.

Workforce development is a pressing issue across the sector, particularly with the increasing client complexity that we are seeing today. It is important that any workforce development planning is done in a collaborative way with state, Commonwealth and non-government organisations. The commissioner noted that it is estimated that between 28 and 48 per cent of people today are receiving services for AOD issues. An increased investment in the supply of specialist alcohol and other drug services is required to meet the demand across the continuum from prevention right through to brief intervention treatment to address what we are experiencing, which is long waitlists. If you have a complex issue and you are on a waitlist then that is a risk place to be.

Currently there are several different funding models in place, including block funding, activity based, outcome and fee-for-service models. While a mix may be necessary, block funding certainly provides an optimum model in its ability to adequately cost resources and ability and form long-term planning and create that stable financial environment required to achieve service outcomes.

Stigma is the missing piece. Often, particularly with mental health as with drugs and alcohol, it is a significant barrier for people to access, thus restricts access, and also impacts the outcomes of services. Adequately funded stigma reduction initiatives can work. We have seen this work in the mental health sector over the past 15 years.

Finally, to achieve this a dedicated Queensland alcohol and other drug plan stated commissioning process is really required to help drive a cross-sector approach. Drug ARM's written submission highlights what we believe would work to create a robust response to alcohol and other drug issues as they relate to mental health in the context of this inquiry. I thank the committee for the opportunity to speak today and assert our commitment to getting the best outcomes we can for the people with lived and living experience, their families and their carers.

CHAIR: You touched on the planning issues. I will ask a question of the Alcohol and Drug Foundation. Dr Lalor and Mr Milne, this mission suggests a role for Health and Wellbeing Queensland in the planning and commissioning of AOD services. There is no commissioning in the Mental Health Commissioner's role but there is a planning element. It seems to me that to go down this path would be doubling up on the work being done by the Mental Health Commission. Why are you suggesting that approach?

Mr Milne: We were talking specifically about prevention. If you look at the role that Health and Wellbeing Queensland has in the preventive space, they commission a range of programs—such as My health for life—that address other chronic conditions while aiming to prevent people developing those chronic conditions. The Mental Health Commission and Queensland Health do not fund preventive programs in this area outside of health messaging and publicity campaigns. We see in other jurisdictions except Queensland the state government funding community organisations like ourselves and others to deliver community based AOD harm reduction and preventive programs to try to stop people developing AOD issues and also to intervene early with people who are developing AOD issues.

Dr Lalor: To add a response to the point you made about the duplication of services, at the moment there is not a funding source for prevention activities around alcohol and drug related harm. In conversations we have had in Queensland around where that might sit, there is not great clarity around which body might actually do that. It would not be duplicating it as it does not currently exist in Queensland.

CHAIR: Either group can answer this follow-up question. That is interesting. From the perspective of preventive programs, are we talking about broad population health programs or targeted programs aimed at specific at-risk populations—or both?

Dr Lalor: If we were talking from the alcohol and drug perspective, we would say both. The prevention programs that have the greatest evidence for impact in the alcohol and drug space are often place-based approaches where a local community will develop their own action and deliver that action at a local level to target their need in the demographic within their community that is most at risk. We have programs like the Local Drug Action Team program. We also have programs like the Good Sports program that have had impact, but there are also opportunities, we believe, for earlier intervention through primary care, through things like screening, brief interventions and referral to treatment, and also targeted campaigns at particular cohorts. We know that younger men, 18 to 30, are high users of alcohol and drugs. Some will continue to develop problematic use of alcohol and drugs. There are very specific targeted activities for that cohort, and then using tools that individuals can use for behaviour change would also be a strategy that we would recommend.

Dr Young: Drug ARM used to be funded through Queensland Health for a fairly large prevention group of workers across Queensland. Once the PHNs came in, there seemed to be a state and federal government arrangement where Queensland would do more of the treatment and the PHNs would do more of the prevention. When we have tried to access prevention funding, we have been told to go and see the feds at the PHNs. That is where I think some of the prevention programs in Queensland started to drop off. Drug ARM still runs one and I will hand over to Richard to talk about Breakthrough for Families, which we get funded to do across Queensland.

Mr Norman: Breakthrough for Families is an initiative where there is a public presentation of facts around drugs and alcohol designed to target specifically families that may have a loved one who is experiencing a drug and alcohol issue. It supports that person and family through the process of getting help or helping that person or simply supporting that family. It is that prevention program and early intervention as well. Within our circumstance we have a library, which is a public library, dedicated to alcohol and other drug use through which we do drive a lot of our prevention initiatives.

Dr Young: Unfunded.

Mr Norman: Yes. It would be wonderful to see, as we heard about, a place base; being able to respond in the many different small communities throughout Queensland that have specific needs, and unique needs sometimes, and where a targeted prevention response is required.

CHAIR: I am a bit confused because you do see ads that are aimed at reducing smoking and educating people around alcohol, but not so much about illicit substances. Where are those messages funded from and who is pushing those in the community? Is that done more at a federal level? I know there is a huge campaign going on at the moment around drink-driving, but that is the state.

Mr Milne: As I have said, there are preventive measures so there are publicity campaigns around it, but all the evidence shows that awareness campaigns can only do so much if they are not supported by on-the-ground interventions such as community-based prevention. Queensland Health runs awareness campaign around the dangers of ice, but there is no funding for on-the-ground interventions in communities. For us, we think that is the missing piece.

Dr Lalor: I think your point around the tobacco campaigns, quit campaigns and those sorts of things is valid and correct. There is and has been historically good investment in tobacco and we have seen some real benefits from that. We know from what has been done in the tobacco space that the right sort of messaging can change behaviour.

The road safety ads are about road safety. They have an alcohol message. They are about drinking and driving. They are not about reducing risky drinking per se. We have done a number of campaigns over the past couple of years through COVID that have really worked to reduce risky drinking, not illicit drug use. We are talking with people around how we might be able to do something in that space.

In the risky drinking space, it is partly getting people to understand what a standard drink is, what the recommendations are around low-risk use of alcohol and then getting people to think about behaviour change if they need to change that behaviour. As Martin said, it is a comprehensive campaign approach that differs from the road safety sorts of messages, which are really about making sure that people do not drink and get behind the wheel of a car as opposed to not drinking riskily in the first place. That behaviour change component of it does require investment, consideration and activity and I think we can learn a lot from the tobacco space.

CHAIR: You could almost argue that the drink-driving ads encourage three people to drink heavily and one person to be sensible.

Dr ROWAN: I want to follow on from your line of questioning, Chair, and be explicit. This question is to either organisation and it is around the population health programs or the targeted prevention ones that we are talking about. This is about looking forward compared to what is happening at the moment.

If there was to be a fundholder for those programs to be delivered via various organisations across Queensland, what would you advise or recommend as to whether that is Health and Wellbeing Queensland, the Queensland Mental Health Commission, the Department of Health? What government entity should be the fundholder to distribute the funds for those targeted interventions at either a population health level or a targeted prevention level, understanding the coordination that needs to happen with individual hospital and health services and also the primary health networks and the other programs that are delivered via various levels of government, whether that be the federal level of government or even some councils or local government areas that are delivering their own programs as well?

Dr Young: At the moment you have a number of Queensland Health districts all with their own priorities. When the structure came in we were advocating to the minister of the day that the health minister should retain some policy direction or control over each of those districts because we found that district A might be very committed and will invest but district B, which might have a more serious problem, does not see it as a serious problem and there is no investment. It is hard to get an even roll of financial flow. We have no issue with strengthening the commission's role. I would not mind having a bit of a chat about that later. I will hand over to Richard because he is the gentleman who deals with all of these various funding bodies all the time. He knows how difficult it is.

When I was on the National Council on Drugs—I was on that for 11 years—we ran a number of national campaigns for alcohol and illicit drugs and things like that. It was much easier from a national point of view because you could run it out through all the state jurisdictions. With the states you have the same issue: you have to have a process so if the parliament or the government view an issue as a serious policy issue then there has to be a mechanism to roll it out across all of the health districts and not just the ones that see it.

Mr Norman: One of the things from a service delivery point of view is really seeing the continuity from prevention, early intervention, brief intervention and right through to treatment. To fragment that with different funding sources could potentially silo prevention to one side. To have that ability to be able to have continuity of services offered from within the sector would be advantageous to the people we service. Where that actually sat I think is a matter for discussion, but, yes.

Mr MOLHOEK: In your submission you refer to some work being done by VicHealth. I think the heading is The art of community alcohol management guide. I am sorry: that is the A&DF. Could you tell us a little bit about that and what it is?

Dr Lalor: In Victoria we have been working with VicHealth, the health promotion agency in Victoria, to strengthen the capacity of local governments to be able to support prevention of alcohol, tobacco and other drug harm in their community. We started that process by doing a prevention capacity index survey. We partnered with a group from Sweden that has been doing this internationally, measuring the capacity of local governments around the world to support through policy, through practice, through funding, through skills enhancement. In Victoria they have the health and wellbeing plans that this was feeding into. We did the survey, we did the indexing for the local government areas in Victoria and then we developed a handbook, a guide, to help them do that. It had templates of policies they could use, business cases for delivering prevention activities and guidelines on the best way to prevent alcohol, tobacco and drug harm in their local areas. Then we held a number of forums with local governments to help them build that capacity. We had some of our senior community development officers who work on the ground with our local drug action teams working with the local governments that are members of local drug action teams to help them start to build their capacity and push that out into community.

Mr MOLHOEK: What sort of things would they be doing at the practical end of it, in terms of the capacity in developing it? What would the council actually be doing? What programs would they be running?

Dr Lalor: Some of them might be running activities for children that allow children in their local area to participate in structured supervised extra-curricula activities that strengthen protective factors in that demographic. They might be developing guidelines for alcohol-free events in their local area. They might be putting in place policies that limit the use of alcohol in some of their local areas or within their own workforce. They might be funding prevention officers. Some of them have started to invest in dedicated positions that work with that local community to do the sorts of activities that we

have referred to in our submission around that sort of place-based approach that really strengthen the protective factors within the community, particularly with young people, and reduce the risk factors that are likely to increase alcohol and drug use.

Mr MOLHOEK: Did the councils push back on that a bit in terms of it being a cost-shifting exercise and saying, 'That is really the job of VicHealth and the feds'?

Dr Lalor: The councils love it. They actually really enjoy it. We have had really positive feedback from the councils that have participated in the program. They are doing health and wellbeing activities. They are doing this work already. They do not have the skills within their workforce to really understand alcohol and drug prevention. The tools, the resources, the support we give them makes it easier for them to do things they are already investing money in.

Mr Milne: It is also a harm-reduction approach because we know that AOD misuse can lead to antisocial behaviour and vandalism. It also impacts other social harms such as domestic violence that councils are concerned about. One of our senior community development officers and I attended the LGAQ conference in Mackay last year. We were blown away by the number of councils that wanted to talk to us about the work that they could do with us. All that was missing was funding for us to adapt the Victorian guide into a Queensland guide that would be more suitable to Queensland councils. We have already enlisted 20 councils in Queensland that want to work with us in this area.

Mr MOLHOEK: I had a look at the material online. You would be forgiven for thinking that it also has some role to play within town planning policy.

Mr Milne: Yes.

Dr Lalor: That is correct.

Mr MOLHOEK: They are adopting policies around their planning and approval processes—would that be a fair assumption—on what can and cannot go somewhere?

Mr Milne: Yes.

Dr Lalor: That is right.

Mr MOLHOEK: In a conversation with Fair Canberra, they talked about the predatory behaviour of some of the major chains in establishing liquor outlets right in the middle of some of the most socially disadvantaged suburbs. I have seen examples of that here in South-East Queensland where even the old corner store in a housing estate has disappeared but there is a branded liquor outlet that is open until 10 o'clock at night, seven days a week or whatever. Is that the sort of thing that this program looks at in terms of trying to limit some of that sort of behaviour?

Dr Lalor: You are absolutely right: there is certainly predatory behaviour around targeting alcohol sales into the segments of community or individuals who are most likely to use alcohol. We have seen over COVID an explosion in the online delivery of alcohol, very targeted marketing to people who are heavy users of alcohol and the placement of more and more outlets in communities that are already at high risk.

The challenge we have is that often decisions about liquor licences are not made by local government so they are left to respond to a decision that is often outside of their control. One of the things that we do in some jurisdictions is work with local governments to help them respond to liquor licence applications or to help their community respond to liquor licence applications. We had a huge amount of work happening in New South Wales where we really upskilled communities to respond with community impact statements around liquor licence applications to either stop new outlets being placed there because there were already many there or to respond to an extension of trading hours, which is also associated with increased alcohol related harm. Whilst local governments do not make decisions about whether licences can be awarded in their local area, they can certainly respond to that and they can manage the harm that might arise from additional licences being made available.

Mr MOLHOEK: They could possibly also exercise their powers around material change of use and impact assessment though. They would have to change their planning tables to make it implicitly clear at the outset that that was not an appropriate location for those services. I would love to keep going, but I had better go back to the chair.

CHAIR: We will go to the member for Rockhampton for a question.

Mr O'ROURKE: My question is to Drug ARM Queensland, which seems to cover most of Queensland. Are there challenges in providing services in regional, rural and remote communities? How could the government assist to overcome those issues and challenges?

Dr Young: That is a Richard question. We have a couple of services in your electorate.

Mr Norman: We do, yes. I guess the first thing to say is that they are complex in responding in that each individual community needs to be approached with a unique, consultative, collaborative, co-designed type approach. There needs to be consideration around and consultation with the community in terms of what kind of funding model is assigned to that community. There are examples we have experienced where we have an identified community that has drug and alcohol issues and a clinical treatment approach has been taken, with some lesser degree of effectiveness. It is looking, in that particular community, at what type of funding model would be more effective. It may be more along the early intervention/information providing approach.

Within many of those communities the workers talked about having time to build connection with the community. That is absolutely vital. They cannot be seen as workers who sit in an office and counsel clients. They have to get out to the community events. Even though they might be clinical or treatment workers, they also have to put on a prevention cap and get out and join in the community and get the message out there. Some innovative funding models would be really helpful around those communities.

Dr Young: It also depends on where the region is. For us to locate suitably qualified staff is also a significant challenge the further you get away from Brisbane.

Mr O'ROURKE: This is something that I bring up quite often: to what extent is insecure housing or homelessness a factor for people who use your services?

Mr Norman: We actually have a service dedicated to reaching the homeless and to supporting people who are in circumstances where they need to be on the street. Looking at it from the other end, one of the issues in terms of being an alcohol and drug worker is that we work at every level and intersect. We know that if we can get people into stable accommodation, we can get them into stable employment, we can get them connected again with their community and then we are going to have better outcomes. It is not just about the hour of counselling in which we work with them; it is dealing with the whole person and their full circumstances.

Ms CAMM: My question is to the Alcohol and Drug Foundation and, in particular, it is around trends and whether there is data or evidence—feel free to take this question on notice—in regards to the impacts of the COVID-19 pandemic. We have heard anecdotally evidence of a significant increase in retail alcohol sales during lockdowns et cetera. My second question is around evidence and research. I come from a regional community that is heavily reliant on the mining industry. We see a rotational roster of seven on, seven off or a fly in, fly out workforce. I have heard from the Queensland Police Service that when they pull people over to do drug and alcohol testing it is actually positive drug testing that is becoming far more prevalent. The statistics are scary. Is there data there where you have seen a changing trend around usage? That may be pertinent across different parts of our nation, but is there data and evidence there? Coupled with that is the significant increase in serious drugs like ice, which we are seeing in my local community as well.

Dr Lalor: Certainly we can send through some more data after this. In response to the first part of your question around what has happened during COVID, we have quite a lot of data. In the first year—it is a bit sad that we are talking about the 'first' year and not the 'only' year. In the first year of the pandemic we did see a really sudden shift in alcohol use. You have reflected on the increased alcohol sales and Fair Canberra released a report today that shows that that increase in retail sales of alcohol has continued to climb. It is significantly higher. The amount of alcohol that is being sold in Australia is significantly higher than it was at the beginning of the pandemic.

We also know that about one in four people who was using alcohol before the pandemic is drinking more alcohol now. We have surveyed at various times over the past two years, once we saw the first year ending and restrictions lifting, to see whether people are reverting back to pre-pandemic levels of alcohol use and we did not. About half of the people who had increased alcohol use continued to drink at elevated levels. That might be drinking earlier in the day, drinking every day of the week or drinking more in one sitting.

There were some demographics that were more likely to have increased their alcohol use and that varied. During lockdowns, parents in particular were impacted. We saw increased alcohol use in parents for reasons I am sure we all appreciate. We also saw alcohol use drop off in some demographics. That was largely related to the loss of the ability to drink in social settings. As lockdowns started to lift or when they did not exist very much at all, the group that had reduced alcohol use very quickly reverted back to the alcohol that they were drinking before in many instances.

In terms of illicit drugs, we saw illicit drug use changing as well. There have been a number of great surveys on that and we can send through that data. Some of the drugs that we saw an increasing usage of were cannabis and benzodiazepines. We saw reductions in some of the drugs

like cocaine and MDMA. Again, it shifts all the time. Getting data on illicit drug use is slightly more challenging than getting data on alcohol use. Stigma plays a big part in whether people will talk about their alcohol and drug use, even in an anonymous environment, but the illegal nature of drugs makes it quite difficult to get data on that. There have been some great studies out of some of the centres of research excellence in Australia that we can share.

Over time, when you refer to ice, crystal methamphetamine, certainly the National Drug Strategy Household Survey data that is published by the Australian Institute of Health and Welfare tells us that methamphetamine use is reducing and so we are seeing some changes in that. The next drug strategy survey will be done in another couple of years so we will be able to see what has happened during the pandemic around ice use.

Yes, we have also heard from the police that they are seeing more instances of driving with drugs in the system. I would point out that the correlation between drugs in the system and impairment is not as clear-cut as alcohol in the system and impairment from alcohol. Some people may have illicit drugs in their system and not be impaired in their driving, which makes it rather complicated. But we are hearing that there are more instances of drug driving than there have been before but, as Drug ARM has mentioned, alcohol is still the most prevalent and the most harmful drug.

Dr Young: Can I make one comment on that, too, but it is not a criticism so, elected members, please do not take it as a criticism. I will be interested to see how the harms from alcohol increase over the next few months and 12 months. The federal government is talking about reducing the tax on alcohol so it will be cheaper. We know that alcohol can be price sensitive. Some of the state jurisdictions, of course, have increased the availability of where they can obtain alcohol. Those two issues may combine to see an increase in harm in the weeks, months and years ahead. I know it is speculative, but one would assume that that is possibly a positive outcome from these policies. I can understand why governments do it, because we are trying to come out of a pandemic and we want all the businesses to be successful and maintain and keep employment. It is one of those catch 22 issues, but it may become a serious issue in the alcohol and drug area in the future.

Dr Lalor: I would add and extend to that to reiterate the importance of price as a driver of harm: the cheaper alcohol is, the more harm we see. We have seen some great examples internationally and in the Northern Territory of a minimum unit price or a floor price. When they introduced a floor price of $1.30—so one standard drink cannot be sold for less than $1.30 in the Northern Territory—they saw really marked reductions in harm. That is something that we have been urging state governments to consider and implement, because it is entirely within the jurisdiction of a state government to put a floor price on alcohol.

Dr Young: That is on our bucket list as well: minimum unit pricing. I believe it has proved its success in other state jurisdictions.

CHAIR: Is that standard pricing across different types of alcohol? Often we have talked about tax per unit of alcohol, which obviously has bigger implications for, say, wine and spirits than it does for beer.

Dr Lalor: It is a pretty simple measure, really. It is a minimum price for one standard unit of alcohol so it applies across all alcohol. It might be 100 mL of wine and a 30 mL nip of spirits. It applies to retail packaged liquor only. It also applies to on-premise alcohol, but typically those prices are already above the floor price. At $1.30, which is a relatively low floor price, a bottle of wine is around $10, as an example. That is the minimum price that you can sell that bottle of wine for.

Dr Young: Under the minimum unit pricing, some alcohol will increase in price and some of the others may actually reduce in price as they standardise it across the sector.

CHAIR: We have had a request that you take that question on notice and provide more detail, particularly in relation to the Northern Territory. I think that would be the most relevant.

Ms KING: Thank you all for being here and submitting before us today. I want to turn to workforce issues. Throughout this inquiry we have heard about challenges around securing a suitably skilled workforce into the future. Could both organisations comment on whether there are any particular programs or approaches that are proving successful in helping to build the alcohol and other drugs workforce in other jurisdictions or if there are any particular areas of reform that you would recommend? Perhaps we could go to Drug ARM first.

Mr Norman: A primary focus of ours has been workforce development. We have a program that has been running for quite a number of years now called the Community and Family Support Program. It addresses workforce development and also client need at a low to moderate complexity level. The program recruits university students in their final year. They come to do a placement of up

to six months with us and they work with clients face to face. It develops from theory to practise in those particular students. Around 60 per cent of those students are retained in the AOD sector. It has been a very successful program that we have run for quite some time now. It gives those students the ability to hone their skills.

Ms KING: I think one of our other organisations contributed at some length on the CaFS Program. Is that scalable, in your view? Is there room for expansion?

Mr Norman: Absolutely. We have more students applying than we can have placement for.

Dr Young: It was one of the very first home visitation and support programs introduced. When I sought funding from the very initial NGO TGP funding grant, probably 15 years ago, we based it on the maternal and child welfare nurses. There was such a lot of positive research based on the interventions the nurses did, both before the birth and after the birth, that it encouraged us to try that with alcohol and drugs. That program has been very successful right through. As Richard said, we can train up to about 45 or 46 students every six months. A lot of the workforce in other agencies in Queensland have gone through our training programs because after six months with us they usually pick up a full-time job in one of the other organisations.

Ms KING: Perhaps we could hear from the Alcohol and Drug Foundation?

Dr Lalor: In relation to the treatment workforce, I think Drug ARM and QNADA are probably best placed to respond to that. Our area of focus really is prevention. Having said that, we really do recognise the importance of having no wrong door. Having mental health practitioners and alcohol and drug practitioners who can manage those with dual diagnosis without moving them between the systems would be important.

From a prevention perspective, there has actually been some great work done in Europe where they have developed programs and training curriculum to create dedicated community prevention workers in the alcohol and drug space. We know that if the work in community is not evidence based it can be harmful. It can increase alcohol and drug use, particularly amongst young people. It can increase stigma and do the things that we do not want to see happen. A lot of the work that the Alcohol and Drug Foundation does with the communities we work with in Queensland is supporting them to make sure that they are using evidence based approaches. We have been watching and exploring with interest the work they are doing in Europe, because it enables more capacity in a community to have greater impact by developing that alcohol and drug prevention workforce.

Dr ROWAN: This question is to both organisations. Are there any challenges that you see in Queensland in incorporating the voices of people with lived experience of problematic alcohol and/or other drug use in public policy as well as program and clinical service design? If you do see that there is a problem there, what solutions would you recommend?

Mr Norman: That is a very good question. My first response is 'appetite for risk'. We have engaged people with lived and living experience at multiple levels within the organisation and their contribution has been and is still valuable. We need a lot of work around how to support them within organisations, how they develop as workers, when they start as perhaps a person with lived experience, where they move on and do not live in that title forever. Those kind of support mechanisms need to be developed. My first call is the appetite for risk within the organisations to start to really listen and put in place some of the recommendations and the ideas that people have. We have lived experience people on our internal clinical governance committee, which decides how and looks at and reviews all our clinical approaches.

Dr Young: As you know, there is still stigma attached if someone comes out and says, 'I have had lived experience with alcohol and drugs', because there is still a lot of negative feeling out there in the community unfortunately. We need to do better in reducing stigma.

Dr ROWAN: Is there any comment from the Alcohol and Drug Foundation?

Mr Milne: On the point about stigma, there is a great deal of stigma attached, particularly to illicit alcohol use, which is not necessarily the case for people with lived experience or with mental health issues. I think that involving people with lived experience in the co-design of services is vital. There is lots of evidence to show that services that are co-designed in part by end users will benefit more and will have more impact.

Dr Lalor: The other thing I would add is that, when we talk about people with lived experience in the alcohol and drug space, we often, without explicitly saying it, refer to people who have a substance use disorder or problematic use of alcohol and drugs. The reality is that there are many people who use alcohol and illicit drugs without harm and without any illness. We have been doing some work to develop harm-reduction messaging and harm-reduction campaigns into those groups where they are not using it in a problematic way but they have insights that are incredibly powerful in

crafting messages and interventions that help keep people healthy and well. I would encourage you, when you think about people with lived experience in the alcohol and drug space, not just to think about people with lived experience who access treatment services but also the people who use alcohol and drugs who can help us understand a better way to prevent harm in that community.

Mrs McMAHON: I have a question for each organisation, but first I want to clarify something. We were talking earlier about the increase that we are seeing in drug driving. I want a bit of context in relation to whether drug driving is happening more frequently or whether Queensland police and other organisations now have more tools at their disposal to detect it. Some 15 years ago it needed a blood test taken at a hospital if someone exhibited indicia, but now it can be random and/or targeted. Has the amount of drug driving remained unchanged but we are able to catch it more; does anyone have any comments on that?

Dr Young: All I can refer to is conversations I have had with serving police officers. Quite often on their random breath testing stations, someone displaying all the symptoms and not testing positive on the breathalyser—they seem to be getting far more of those than perhaps the old drink-driving ones so some of the police officers report that it has gone up. But to answer your question properly, I do not think you would be able to establish that because it would be just too difficult. If you talk to police officers, they will say that the drug driving is on the increase and a lot of the media does, too. I have not necessarily seen the research. A&DF may have. I will hand over to them.

Dr Lalor: We can certainly send through some more information. It is an excellent question. I think it is a bit of both. There are some research studies that have looked at, or some data that has been reported, on the drugs in the system of people involved in fatal and non-fatal accidents. As I understand it, that has increased. We will find the research and send it through to you.

CHAIR: I note that that is a question taken on notice and we will receive that information in due course.

Mrs McMAHON: Looking at the Alcohol and Drug Foundation submission in relation to the value of prevention, I want to know more about the Good Sports program. There are a lot of sporting organisations in my community. For our young people, one of the biggest social groups that they have is their sporting club. It is also one of the big groups, when there is suicide or when there is a mental health issue, that has the ability to impact a large number of young people. Can you outline a little bit about what the Good Sports program is and perhaps how we could look at improving it, if there is room for improvement in a program such as that?

Mr Milne: In Queensland we have over 1,100 clubs that are part of the Good Sports program. They are community sporting clubs. The program is about trying to ensure a healthier environment with reduced AOD harm in clubs. We know that in sport alcohol is often linked to both success and failure: you celebrate when you win; you drown your sorrows when you lose. In particular, we try to develop healthier attitudes inside the clubs through policies, for example, ensuring staff working behind bars have RSAs. There are also safe transport policies, coming back to the drink-driving example. That might be ensuring that there are non-alcoholic drinks on sale that are cheaper than the cheapest alcohol they could drink. They may also have safe transport with a minibus to take people home or a designated driver program. We also have a particular focus on young people, trying to make the clubs safer for junior athletes. That is about things like ensuring that when the juniors are playing the bar is shut and people are not drinking nearby. When juniors are in the changing rooms, there is no alcohol in the changing rooms. It is things like that.

In one of our clubs, for example, they were gifted a set of rugby post covers that had a prominent alcohol brand on them. As part of the program, some of the mums sewed covers that could be put over the top of it so that when the juniors were playing there was no alcohol advertising around them. It is things like that.

We have recently expanded the program to include some mental health elements to work with clubs to improve that, but there is a lot more that we could do if we were funded. One of the things we have explored is the idea of providing mental health first-aid training to coaches and senior players so that they can help club members who may be experiencing mental health distress. Part of the program is about tackling illicit drugs, so having those conversations about why illicit drugs are dangerous. I think as QNADA said, often those messages are best delivered by people you trust. People trust the sports coach, people trust senior players. They are often role models. If we equip them with the ability to have those conversations around drink and alcohol, that is very useful.

We know that sport is an incredible protective factor. The longer young people continue to play organised sport, the later they are likely to start drinking and the more likely they are not to develop risky drinking later in life. One of the benefits of the program is that it increases junior participation. It

increases female participation as well because the club is more welcoming. There is a lot more that we could do. I already talked about the mental health model. In some other jurisdictions we have dedicated safe transport models that work to expand the range of the drink-driving and drug driving messages that we can deliver.

In Queensland we have been approached by Toowoomba Together, which is a longstanding community campaign against domestic violence. They have a 'Not in our club' campaign around domestic violence. They would like to see us try to incorporate that into our Good Sports program in that area. If we had funding, we would like to innovate to see if we could develop that into a module that is part of the Good Sports program that we could spread across Queensland.

Mrs McMAHON: This question is for Drug ARM. We were talking about stigma. Your submission talks about stigma reduction. Interestingly, we were talking about councils and planning. In my area we have a pharmaceutical rehabilitation service in the main street. All we hear are voices saying that we should not have this service in the main street because it attracts people with drug problems to the city, to the point where the council is now looking at rezoning it so it moves the service on. As a community and as a government, how do we really address the stigma around addiction? I am trying to get an idea of what kind of programs really do work in stigma reduction.

Mr Norman: Certainly education. Basically stigma exists because of a lack of understanding sometimes. Sometimes it is there because there is misunderstanding around what is involved. Certainly, information and education to the general public are effective. One of the most effective ways we have found that is known to deliver this message is people telling their stories about their journey and what they find in terms of stigma. Certainly, it is about looking at bringing people onboard and understanding drug and alcohol use, understanding why people perhaps may use drugs and alcohol, and that they can recover from drugs and alcohol use.

Mrs McMAHON: In my conversations with the service providers, a fair amount of people using this service are not who people would traditionally consider to be people with a drug issue.

Mr Norman: That is right.

Mrs McMAHON: They are usually people with an opioid addiction following rehabilitation injuries that went wrong. Is there a role in myth busting to really try and get down to who is using these services?

Mr Norman: Yes and no. Yes, it would be great to bust some of those myths. We all have a kind of picture of what a typical person who is dependent on substances should look like. The fact is that that is not correct; it affects multiple levels of our society. Certainly to get that message across to others would be a really effective way of dealing with it.

Dr Young: Some of those services, if they were on the continuum. We ran a needle supply program in South Australia. When they came there, there was the opportunity for them to be referred to some of our other programs, if they were seeking support, rather than just coming, getting their needles and going. The needle supply program is probably a good one. When that was first introduced, I am sure most of the committee members will remember the local government did not want to have a bar of it. They did not want to have a needle program in their town anywhere, but you hardly hear a word of it these days because it has become accepted and it will be a while, I think, before we get some of those other chemical-type programs accepted I would think. We do need to work more and have a continuum of things. You do not just go there and get your Naltrexone; you do not go there and get that. If you wanted more, if we could afford it, it would be good to offer them a range of support services as well.

Dr Lalor: I completely agree and echo the statement around getting people who use drugs to tell their stories—that very human centred focus. We published a research report into stigma a number of years ago to guide the work that we do in this space. One of the things that we are acutely aware of is that much of the stigma that we see in the community relates to the way that people with illicit drugs are used by the system. It is an argument for considering the importance of a health response to drug use for those who need it, rather than reinforcing the image that they are dangerous people. I think that is one thing to consider as you are considering responses to stigma. We have also done some work looking at values based messaging and how we can change the messages that we use around drug use to influence the attitudes and behaviours of people towards people who use drugs.

CHAIR: Many years ago as a nurse I did rapid detox programs in an intensive care setting and we were really only there managing the ventilator part of the process. I would read the charts and the histories of the patients. One of the things that struck me at that time was that often the social situations of these folks who were seeking detox services and the way that they approached heroin

or other types of drugs were fairly similar to the way my family might approach Gold beer—you know, you drop around to see your mum and dad on a Sunday and have a Gold beer—whereas you talk to these folks and they would drop around and have a shot of heroin together. It struck me that while we could detox these people rapidly and probably help them to break that particular habit, if you are putting them back into an environment where society is still engaging in those behaviours it would seem to me that your chances of long-term success are limited. What do your organisations, if anything, do about that sort of notion of trying to not just deal with the person who is seeking help in front of you but also the broader networks around that person?

Mr Norman: Absolutely, and that is a really key issue. Obviously different complexity and different levels of severity will be triaged to different interventions and for some people the reality is if they need detox they may need residential treatment. Treatment does not finish when they leave residential treatment and I think that is a message we are trying to get across quite strongly as well. It is not about after-care; it is about continuing care. Somebody who may have been through detox and may have been fortunate enough to get into residential rehab then needs ongoing support in the community to be able to reassign some of those relationships, reconnect with other more positive people around them perhaps and build those connections again. Things like training, education, housing et cetera become really critically important. Detox will not work on its own, in my opinion, and residential rehab treatment will not work on its own; it is that continuum of care for individuals.

CHAIR: I go to the member for Pumicestone for a follow-up question on that particular point.

Ms KING: I hear what you are saying about the continuum of care, which in other mental health contexts often seems to be referred to as wraparound services.

Mr Norman: Wraparound, coordinated care, yes.

Ms KING: Can you comment on whether there is a gap in service availability, which in other mental health contexts is often referred to as the missing middle? It might be step-up, step-down facilities, those kinds of things. I would love to hear your thoughts.

Mr Norman: Absolutely in regional areas that is an issue. There are not the support services that we can build into continued care for individuals. Certainly in the city areas that is more easily done, but once you get out into community et cetera that can be a difficult space to navigate. That is where we find a worker who may be assigned as a clinical worker but who is also giving and trying to connect with as much support as is possible within that area. There is a gap, yes.

Dr Lalor: I would add to that that when we talk about alcohol and drugs we often focus on the people who are needing treatment—an important gap. There is not enough treatment to meet current demand. However, when you look at the National Drug Strategy Household Survey, they used the ASSIST-Lite for the first time in the last survey. It highlighted that about 1.9 million Australians who use alcohol have what could be classified as a dependence, but 4.7 million are using it in a harmful, hazardous way. It is that group that we do miss out on. They are the group that are not yet seeking treatment because their problems are not considered to be significant enough, or they might be having problematic use of alcohol but the social norms around alcohol use mean that that has not crystallised for that individual, or their family or their friends yet.

We have done a lot of work with family and friends to understand how they can support the individual who might need help and also how they can get support themselves. When we talk about stigma, a lot of it comes from our family and friends. We are doing a lot of work to think about the best way to stop people who are at risk of developing substance use disorders from developing them so that they do not need treatment. That is why we talk about the importance of primary care, screening, brief interventions and referral to treatment for those who need it. But if you think about the vast number of people who are using alcohol in a risky way, and the same in the illicit drug space, there is huge opportunity to intervene early in that group in a much more cost-effective way to avoid the need for treatment and all of the social issues that arise for people when they may have a substance use disorder going forward.

Ms KING: To clarify, that number that you mentioned is something like one in five or one in six Australians who are using alcohol in a risky way and did I hear you say 7.9 million?

Dr Lalor: I do not have the figures in front of me. I think it is 1.9 million are classified as having an alcohol dependence and 4.6 million are using at moderate levels of risk. We will send you the data from the National Drug Strategy Household Survey.

CHAIR: You can take that on notice. The submission notes that there are 54 LDATs in Queensland. Can you take this on notice and send us a list of those LDATs? Can you also outline what an LDAT is, who is on an LDAT, how they coordinate themselves and what they do?

Mr Milne: They are local drug action teams. Basically, each of the 54 teams has a lead organisation, which can vary. In some cases the QPS is the lead agency and in other cases it might be a community controlled health service in an Indigenous community, it may be a local youth group or it may be the PCYC. They identify AOD risk in their area and AOD harm in their area. Then we work with them to develop a program that can challenge and address that AOD harm. Often it is about increasing the protective factors, particularly among young people. I think Bec from QNADA earlier on said that often, for young people, diversion—and not criminal diversion—can give them a sense of connection to either family, community, education or, in the case of Indigenous young people, to country. It can be a really powerful protective factor that can stop them either experimenting with drugs or developing AOD issues.

We have a wide variety of programs. One of them, for example, is the Blue EDGE program where police work with a group of schoolchildren who have become disengaged with education. They will do a fitness based activity first thing in the morning. You will have teenagers competing with a local police officer to see who can do an assault course the quickest or a competition, a war of engagement. Then there may be a guest speaker or a conversation about AOD, or maybe about family or country, or about other social issues. Then they might finish with breakfast. Because those young people are together and are engaged, and often the event takes place at their school, they are much more likely to then go to school that day and continue to engage in education.

We have had programs for people who have finished the program. Young people who were on the verge of dropping out of education recommenced education and actually went on to become police officers. We have seen examples of that. We also have an Indigenous group who have done camps on country, which is where they have taken Indigenous young people who are disengaging from their culture and their family and are beginning to exhibit risky behaviours. They go away with elders onto their country, re-establish that link to their country and to their community, and we have seen really positive outcomes from that. Those are just a couple of examples. Each of the 54 LDATs probably delivers the program in slightly different ways, but it is about communities deciding what the risk is in their area and how best to address that using tool kits and resources that we provide, and we fund them to deliver that program.

CHAIR: Thank you very much for that. There are no further questions from the committee. There were a number of questions taken on notice. We would ask you to please provide responses to the secretariat by the close of business on 25 February. Please be aware that members may choose to send some additional questions to both your organisations following this hearing. I would like to thank our Hansard reporters and our secretariat staff for today. A transcript of today's briefing will be available on the committee's web page in due course. I declare this public hearing closed.

The committee adjourned at 4.58 pm.