Chapter 3

At-risk communities, people with children and workplace initiatives

3.1 The committee's first report identified a number of at-risk communities within Australia that are more prone to developing problematic crystal methamphetamine use.[1] This chapter considers treatment and support initiatives available to two of these at-risk communities: regional and remote communities, and Aboriginal and Torres Strait Islander peoples.

3.2 This chapter also discusses support services for people with children, particularly women, seeking to undergo alcohol and other drug (AOD) treatment; and initiatives aimed at workplaces with a high-risk of employees using crystal methamphetamine.

3.3 The National Ice Taskforce (NIT) and the National Ice Action Strategy (NIAS) developed a number of strategies specifically aimed at addressing crystal methamphetamine use in at-risk communities, families and workplaces. The NIT's final report recommended the following:

- Governments to develop online toolkit to provide information and support to families and communities to better respond to problems caused by crystal methamphetamine use (Recommendation 1).[2]
- Provide additional funding to communities to develop locally-based solutions to crystal methamphetamine use and other AOD issues (such as the Good Sports Program) (Recommendation 2).[3]
- Governments working with accreditation associations and training organisations to ensure health professionals (such as general practitioners, regional and remote health professionals, and Indigenous health workers) receive relevant education and training on crystal methamphetamine and other psychostimulant use (in both urban and regional and remote settings) (Recommendation 5).[4]
- Governments develop 'workforce development pathways and career options for more Indigenous Australians' in the AOD sector and 'strategies to ensure the workforce is appropriately supported and sustainable over the long term' (Recommendation 8).[5]

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1 See Parliamentary Joint Committee on Law Enforcement (PJCLE), *Inquiry into crystal methamphetamine (ice): First Report*, September 2017, pp 21–30.

2 National Ice Taskforce (NIT), *Final Report*, p. vii.

3 NIT, *Final Report*, p. vii.

4 NIT, *Final Report*, p. vii.

5 NIT, *Final Report*, p. vii.

- Develop specific crystal/methamphetamine resources for regional and remote communities that inform teachers, parents, families and students (Recommendation 9).[6]
- Develop a comprehensive, evidence-based two-year prevention communication plan that includes targeted activities for people living in regional and remote areas, Indigenous communities, young people and lesbian, gay, bisexual, transgender, queer or questioning, and intersex (LGBTQI) people. This plan should be evaluated after two years and used to inform future communication strategies (Recommendation 10).[7]
- Governments and industry groups develop a pilot workplace program for high-risk industries (Recommendation 11).[8]
- Governments should agree to a whole-of-government approach to AOD prevention with a specific focus on vulnerable populations (including Indigenous Australians) that works with vulnerable communities and groups to address risk factors that lead to drug misuse, and roll-out of parenting and early childhood programs that developed resilience in young children in disadvantaged communities (Recommendation 12).[9]
- Governments to further invest in specialist AOD treatment services that specifically target regional and remote areas (Recommendation 18).[10] And,
- Governments, in consultation with Aboriginal Community Controlled Organisations and communities, to improve access to integrated, evidence-based, culturally appropriate services for Indigenous Australians (Recommendation 22).[11]

3.4 These recommendations informed the strategies in the NIAS.[12]

3.5 Some submitters and witnesses raised concerns about treatment options and support services for some at-risk groups and communities. These are discussed in the following sections.

Regional and remote communities

3.6 Regional and remote communities face unique challenges in regard to crystal methamphetamine use. The committee's first report showed that methamphetamine use in regional and remote areas is high, especially in Western Australia (WA) and

6 NIT, *Final Report*, p. viii.

7 NIT, *Final Report*, p. viii.

8 NIT, *Final Report*, p. viii.

9 NIT, *Final Report*, p. ix.

10 NIT, *Final Report*, p. x.

11 NIT, *Final Report*, p. xi.

12 Council of Australian Governments (COAG), *National Ice Action Strategy (NIAS)*, pp 24–25.

South Australia (SA).[13] Illicit drug use in these communities is further compounded by social disadvantage, lack of employment opportunities and limited access to AOD treatment services.[14] The committee heard evidence that called for improved data collection and AOD treatment services to regional and remote communities.

Improved data collection

3.7 A consistent concern expressed to the committee was the lack of data and a poor understanding of methamphetamine use in regional and remote communities. Although the National Wastewater Drug Monitoring Program (wastewater program) provides valuable insight into illicit drug use at selected testing sites, the committee heard that gaps remain.

3.8 The National Drug and Alcohol Research Centre (NDARC) submitted that there is a lack of understanding 'about the nature of methamphetamine use amongst rural and regional populations'.[15] This poor understanding extends to the 'supply chains and market routes which would inform strategic policing' in regional and remote communities.[16]

3.9 The Alcohol, Tobacco and other Drugs Council Tasmania (ATDC) similarly highlighted the need for better data on regional and remote areas. The ATDC argued that current policies and the allocation of AOD funding is:

> …made in the context of scant data on Tasmanian drug use and service usage. The collection of data and information is a fundamental component that scaffolds any service system. Such evidence works to enhance the responsiveness of service provision. Data provides a rich asset about the services that are being provided by organisations and to whom and whether successful outcomes are being achieved for individuals and the broader community. Information on region specific drug trends also adds value in service design processes and underwrites responsible decisions around the distribution of public funds.[17]

3.10 The ATDC expressed concern that calls for enhanced treatment and policing have been made based on anecdotal reports, and:

> …to date, there has been a lack of any rigorous research conducted in these regional areas of Tasmania to support these claims. The ATDC wishes to highlight that the lack of data necessarily impedes responsible allocation of public funds into law enforcement, and health initiatives.[18]

3.11 The NIT recommended the expansion and improvement of data sources available for illicit drug trends. Specifically, it recommended:

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13 PJCLE, *Inquiry into crystal methamphetamine (ice): First Report*, September 2017, pp 25–26.

14 PJCLE, *Inquiry into crystal methamphetamine (ice): First Report*, September 2017, pp 25–26.

15 National Drug and Alcohol Research Centre (NDARC), *Submission 85*, p. 1.

16 NDARC, *Submission 85*, p. 1.

17 Alcohol, Tobacco and other Drugs Council Tasmania (ATDC), *Submission 97*, p. 5.

18 ATDC, *Submission 97*, pp 5–6.

- the establishment of the wastewater program;
- the expansion of sites for the Drug Use Monitoring in Australia (DUMA) program;
- a national system to gather and share ambulance data; and
- commissioning the Australian Institute of Health and Welfare (AIHW) to conduct the household survey on a more regular basis and to strengthen its methodology, including the use of online distribution methods.[19]

3.12 The NIAS included an announcement that there would be an increase in the quality and quantity of drug data use in Australia via the aforementioned recommendations, as well as enhancing national treatment data.[20]

Improved services in regional and remote communities

3.13 Attracting qualified AOD treatment staff, securing AOD funding, and access to treatment services are additional challenges for regional and remote communities when seeking to assist drug users.[21]

3.14 Professor Steve Allsop from the National Drug Research Institute (NDRI) discussed the difficulties attracting suitably qualified AOD staff to regional and remote communities. One challenge, according to Professor Allsop, is the lack of popularity and attractiveness of the profession.[22] Another challenge for professionals is working in very remote locations with limited clinical support and supervision,[23] which is compounded by the uncertainty of funding in the AOD sector:

> If we asked the Sir Charles Gairdner emergency department to apply for funding every year, they would be unsure of whether or not they were going to be able to employ staff in three months' time. So I recognise that there is a need for government to ensure value for money and that a quality service is delivered, but we also need to recognise that if we want to retain quality staff in very difficult circumstances—not uniquely but particularly in the remote and rural areas—we need to come up with a process that delivers quality, value for money and flexibility for government but also ensures security. Otherwise you simply cannot retain staff generally in this field and particularly in rural and remote areas, because of all the additional challenges that exist there.[24]

3.15 Professor Allsop recommended that funding be set aside to deliver AOD services more effectively in regional and remote regions across Australia, in particular

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19 NIT, *Final Report*, p. xiv.

20 COAG, *National Ice Action Strategy (NIA*S), p. 25.

21 PJCLE, *Inquiry into crystal methamphetamine (ice): First Report*, September 2017, pp 25–26.

22 Professor Steve Allsop, Project Leader, National Drug Research Institute (NDRI), Curtin University, *Committee Hansard*, 3 May 2017, p. 39.

23 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 39.

24 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, pp 39–40.

for the Northern Territory (NT), Queensland, WA and northern parts of SA. He added that it is not just about setting up another rehabilitation clinic in a rural town, but:

> …looking at how we deliver services remotely, whether that be through online interventions or whether that be using telemedicine approaches. For example, there is a service in Western Australia, Women's Health Care House, who have delivered services to remote areas using local expertise but also using expertise within the metropolitan area to supplement that, using technology. I think we have to look at better and more innovative ways of delivering services. Yes, those rural and remote areas do need more services, but they also need a wider range of options. We have to explore how we do that, not state by state but collectively for those of us who have similar challenges.[25]

Committee comment

3.16 Regional and remote communities in Australia face unique and complex challenges regarding drug use and access to AOD treatment services. The primary issue is to understand the nature of illicit drug use in regional and remote communities. Without a thorough understanding of illicit drug use, the development of appropriate responses is hindered. For this reason, the committee supports calls for the collection of improved drug use data in regional and remote communities, in particular, through the AIHW's household survey to ensure it adequately targets and reaches regional and remote communities. Access to this data will help community leaders, health experts and police develop informed, evidence-based responses to drug use issues in these communities.

3.17 The committee supports the NDRI's comments that more needs to be done to retain qualified professionals in the AOD treatment sector, especially for those professionals based in regional and remote communities. The allocation of funding to regional and remote communities, through initiatives such as the NIAS, will help retain professionals. Commonwealth, state and territory governments should also ensure secure, longer term funding to AOD treatment service providers, especially those in regional and remote communities.

3.18 Finally, insufficient access to AOD treatment services is a part of a broader issue related to the complexity of providing adequate health services to regional and remote communities in Australia. The NIT and NIAS recognised this issue, and the formula for allocating NIAS funding included preferential weightings for regional and remote Australia.[26] The committee supports this and the innovative delivery of AOD treatment services through technology, such as online interventions and telemedicine.

Treatment services for Aboriginal and Torres Strait Islander peoples

3.19 The committee's first report discussed Aboriginal and Torres Strait Islander peoples as an at-risk community for problematic crystal methamphetamine use.[27] The

25 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 40.

26 See chapter 5, pp 4–6.

27 PJCLE, *Inquiry into crystal methamphetamine (ice): First Report*, September 2017, pp 27–29.

committee considered in that report the rates of crystal methamphetamine use in Indigenous communities, in particular for young Indigenous people.[28]

3.20 The following section considers AOD treatment for Indigenous Australians, and concerns regarding accessibility, culturally appropriate services and the need for further investment and training in the sector.

3.21 According to the Australian Health Council of Western Australia (AHCWA), Indigenous communities face a number of barriers to addressing AOD issues, including:

- the lack of opportunities for children to access appropriate AOD treatment programs;
- unemployment;
- few holistic service providers; and
- under-resourcing of the sector.[29]

3.22 The AHCWA also reported that available AOD services often lack consistency, adequate communication and collaborative partnerships.[30] The AHCWA added that there are resources being directed to them, but there are no 'effective outcomes because no-one is getting community agreement to work with an individual'.[31] A risk, according to AHCWA, is that Aboriginal people can become overwhelmed by service providers, and the recipients of those services can form barriers to effective treatment.[32] The AHCWA spoke of the importance of cultural context and effective communication in these settings, and that currently Aboriginal people:

> …are not co-designers of their programs. We are not co-commissioners of some of their programs.
>
> Our communication is around body language not dialogue with English. We have language barriers and we also have a number of socioeconomic impacts that are contributing factors as to our social and emotional wellbeing, and appearances and abilities to get change in our behaviours as well. What people do not understand are the complexities around our culture. It is particularly hard for younger generations to make that change. People do not understand the cultural obligations that they have to their families, particularly if they are entering the workforce. We live a very dynamic, complex life. However, we know the dynamics that we are

28 PJCLE, *Inquiry into crystal methamphetamine (ice): First Report*, September 2017, pp 27–29.

29 Ms Michelle Nelson-Cox, Chairperson, Aboriginal Health Council of Western Australia (AHCWA), *Committee Hansard*, 3 May 2017, p. 46.

30 Ms Nelson-Cox, AHCWA, *Committee Hansard*, 3 May 2017, p. 46.

31 Ms Nelson-Cox, AHCWA, *Committee Hansard*, 3 May 2017, p. 46.

32 Ms Nelson-Cox, AHCWA, *Committee Hansard*, 3 May 2017, p. 46.

> dealing with in terms of service providers and the quality of care that we deliver to our people.[33]

3.23 The importance of co-designed AOD treatment programs was also raised by the WA Primary Health Alliance (WAPHA). In WAPHA's view, AOD treatment programs for Indigenous communities must be co-designed with the community to provide:

> …a sense of ownership of the service, be committed to what it is seeking to achieve and provide local leadership with their community members so that the service is not running at odds with the community but is well integrated. If we are to prevent the trajectory of young people then community ownership becomes key.[34]

3.24 The WAPHA has established differentiated Aboriginal-specific services, separate from mainstream services. These specific services are tailored to the needs of Aboriginal people, which are integrated and linked with both urban and rural-remote communities.[35] Indigenous people in WA are also able to access mainstream services.[36]

3.25 The AHCWA called for funding to be directed to the underlying factors that contribute to AOD dependency in Indigenous communities, and the development of community-led, holistic strategies that target AOD use.[37] Further, it was proposed that these services must be culturally appropriate and enhance the capacity of the Aboriginal Community Controlled Health Organisations (ACCHOs).[38] AHCWA endorsed:

> …increasing support for community-based and community-led services which will reduce the long-term cost and greatly benefit individuals, families, and communities impacted by methamphetamine use, thus delivering better, healthier communities.[39]

3.26 Despite existing investment in AOD treatments for Indigenous communities, the AHCWA was of the view that:

> …the primary focus of government responses relate to investment in law and other mechanisms, the cost of which is significant, and which do little to address the causal factors of alcohol and drug use. From our experience and perspective, this approach is consistent across both state and Commonwealth government investment in our services with regard to A&D

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33 Ms Nelson-Cox, AHCWA, *Committee Hansard*, 3 May 2017, p. 46.

34 Ms Learne Durrington, Chief Executive Officer (CEO), WA Primary Health Alliance (WAPHA), *Committee Hansard*, 3 May 2017, p. 18.

35 Ms Durrington, WAPHA, *Committee Hansard*, 3 May 2017, p. 18.

36 Ms Durrington, WAPHA, *Committee Hansard*, 3 May 2017, p. 18.

37 Ms Nelson-Cox, AHCWA, *Committee Hansard*, 3 May 2017, p. 42.

38 Ms Nelson-Cox, AHCWA, *Committee Hansard*, 3 May 2017, p. 42.

39 Ms Nelson-Cox, AHCWA, *Committee Hansard*, 3 May 2017, p. 42.

> services and programs. AHCWA, whilst supporting the need for law and order intervention, particularly for those involved in trafficking and large-scale drug supplies, propose a marked shift in the approach to methamphetamine use in the community.[40]

3.27 The benefits of prioritising health focused investments, rather than law enforcement measures was discussed in chapter 2. As noted, research by the Australian National Council on Drugs showed that for Indigenous Australians, there is a saving of $111 458 per offender if a person is dealt with in a residential rehabilitation facility compared to imprisonment.[41] A further saving of $92 759 is made when accounting for improved health-related quality of life and lower mortality rates.[42]

3.28 The AHCWA pointed out that since 2015, it has not seen a 'marked shift towards investment for community interventions'.[43] Whilst Commonwealth and state strategies aimed at early intervention, prevention, treatment and support services are encouraging, AHCWA expressed frustration because it is 'yet to really see that trust and faith provided by commissioning bodies to our sector'.[44]

3.29 When asked what the biggest challenge is for delivering culturally relevant services to Aboriginal communities, the AHCWA responded that one of the barriers had been its ability to provide:

> …sustained investment resources for us to deliver on-ground programs that are going to provide full complementary social determinant programs, and to have them tailor made to fit the individual. We already know the history of the family dynamics. Our particular sector has delivered more than six intergenerations of care to a particular family group, which no other service provider is able to perform. We meet the outcomes, and, importantly, the number of service activities that we deliver goes above and beyond what we get resourced to do; it exceeds the quality performance around ensuring that we make a positive change within our individuals. We are constantly confronted with some of our barriers, but one of our biggest barriers is not having culturally appropriate resources in some of the regions at a localised level, as opposed to some of our Aboriginal community members coming down to access these major facilities in some of the regional towns or in urban towns in particular.[45]

3.30 The AHCWA described the Narrogin region of WA, a township 192 kilometres southeast of Perth. AHCWA advised that a number of recorded drug

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40 Ms Nelson-Cox, AHCWA, *Committee Hansard*, 3 May 2017, p. 42.

41 Victorian Alcohol and Drug Association (VAADA), *Submission 95*, p. 7

42 VAADA, *Submission 95*, p. 7.

43 Mr Shaun Wyn-Jones, Senior Policy Officer, AHCWA, *Committee Hansard*, 3 May 2017, p. 46.

44 Mr Wyn-Jones, AHCWA, *Committee Hansard*, 3 May 2017, p. 46.

45 Ms Nelson-Cox, AHCWA, *Committee Hansard*, 3 May 2017, p. 47.

users in that region were travelling to Broome to access the only Aboriginal community controlled rehabilitation centre in WA.[46] The AHCWA added that this highlights the difficulty for Aboriginal people accessing appropriate, quality care:

> …of the differences within the cultural delivery of those models of programs and…that family is returning back into the same environment. It will enable them to have a sustainable revitalised change in life. Having that treatment away from country does not have the same impact on them returning back to their country.[47]

3.31 The NDRI identified two issues faced by the Indigenous AOD treatment sector. The first is paucity of data on the use of amphetamines in Indigenous communities. Although research into amphetamine use is conducted, it is understood that the results are under-estimated and are not representative. The second issue is that many Indigenous service providers 'are skilled in treating alcohol related problems, fewer have the skills to address the issues arising from illicit drug use'.[48]

3.32 Both the NIT and the NIAS considered the unique challenges faced by Indigenous communities in Australia and ways to address AOD use. The NIAS specified actions that included:

- increased investment in Indigenous-specific AOD services;
- investment in remote Indigenous sporting clubs, as part of the Good Sports Programme;[49] and
- research into methamphetamine use in Indigenous communities.[50]

3.33 $78.6 million of NIAS funding was allocated to Indigenous-specific services, which was informed by the DoH's engagement with local Aboriginal and Torres Strait Islander communities, through the PHNs,[51] and by using population figures derived from the 2013 Estimated Residential Population.[52] Culturally appropriate mainstream treatment services are also available to Indigenous Australians. Performance reporting requires PHNs to provide evidence to the DoH that culturally appropriate services for Indigenous Australians are provided under the Drug and Alcohol Treatment Program.[53]

3.34 Since the release of the NIAS, the Commonwealth government has made a number of investments in Indigenous-related AOD treatment services. Some of the most recent initiatives include:

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46 Ms Nelson-Cox, AHCWA, *Committee Hansard*, 3 May 2017, p. 47.

47 Ms Nelson-Cox, AHCWA, *Committee Hansard*, 3 May 2017, p. 47.

48 NDRI, *Submission 113*, p. 5.

49 COAG, *NIAS*, p. 24.

50 COAG, *NIAS*, p. 25.

51 Dr Wendy Southern, Deputy Secretary, DoH, *Committee Hansard*, 24 March 2017, p. 21.

52 DoH, answer to question on notice, no. 5, 24 March 2017 (received 10 May 2017).

53 DoH, answer to question on notice, no. 1, 24 March 2017, p. 1 (received 10 May 2017).

- on 4 September 2017, $1 million of Commonwealth funding was invested in a Kimberley post-residential rehabilitation program, to support individuals transitioning out of residential rehabilitation and back into their communities;[54]
- from 2016–17, an investment of $9.1 million targeting crystal methamphetamine dependency, mental health, suicide prevention and chronic disease will be made available through the North Coast Primary Health Network;[55] and
- on 15 December 2017, it was announced that a further 14 NT Aboriginal health services staff would undertake specialised leadership and management training (at a total cost of $715 535) and that this new funding would be shared amongst four NT Indigenous health services.[56]

Committee comment

3.35 Indigenous communities in Australia face heightened risk of people developing problematic amphetamine use. To address AOD use in these communities, it is vital that AOD treatment services are culturally and linguistically appropriate and are provided in partnership with communities.

3.36 The committee supports the work of Commonwealth, state and territory governments in developing and investing in culturally appropriate AOD treatment services for Indigenous communities. The NIAS, in particular, dedicated funds and implemented measures that ensure PHNs allocate funding and services to Indigenous Australians.

3.37 Although there is recognition, support of and investment in culturally appropriate and co-designed AOD treatment services, the AHCWA's evidence indicates that demand for culturally appropriate and locally available treatment services remains. For this reason, the committee recommends Australian governments continue to develop culturally and linguistically appropriate AOD treatment services, in partnership with Indigenous communities and Indigenous health experts.

Recommendation 7

3.38 The committee recommends that Australian governments continue to advance collaboration with Indigenous communities and Indigenous health experts to provide culturally and linguistically appropriate alcohol and other drug treatment services.

54 The Hon. Ken Wyatt AM, Minister for Indigenous Health, 'Kimberley post-residential rehabilitation program supports sustained recovery', *Media release*, 4 September 2017.

55 The Hon. Ken Wyatt, AM, Minister for Indigenous Health, 'Ice dependence, chronic disease among targets of North Coast Health Blitz', *Media release*, 6 November 2017.

56 The Hon. Ken Wyatt AM, Minister for Indigenous Health, 'More Indigenous Health Leaders for Remote Australia', *Media release*, 15 December 2017.

Treatment and support services for people with children

3.39 A number of submitters and witnesses discussed treatment and support services for people with children, especially women.

3.40 Professor Allsop and Mr Craig Cumming identified people with young children, particularly women, as a vulnerable group. Mr Cumming explained that parents, primarily women with children, often have privacy concerns when accessing AOD treatment services, and fear losing custody of their children if they access these services.[57]

3.41 Professor Allsop spoke of parents' fears for their children; that is, if they access treatment services, do they risk losing their children, or what happens if a drug user attends a residential or day treatment service?[58] He added that some services have specifically designed programs to provide care facilities for children 'to enhance access to treatment for young families'.[59] One example of this type of treatment service in WA is Cyrenian, which according to Professor Allsop 'has a facility specifically for women with young children. I think it is a very good example of how the sector can and does respond to these challenges'.[60]

3.42 More broadly, the committee heard that there is a lack of support for families that are dealing with a family member using crystal methamphetamine. For example, the Palmerston Association noted that there was 'very little for families' and that '[w]e need to look at the culture and the attitudes that exist to enable families to seek support'.[61] Problems of stigma and discrimination have meant that families 'mostly suffer in silence'.[62] Often families do not raise their issue with a professional service:

> …because they think their son or daughter might be whisked off by the police and put into prison. They do not want that; they just want to get their son or daughter back. That is how families see it: they have lost their child to this drug. So we need to create an environment where people can actually come and seek support.
>
> No, there is not enough focus on families. Families suffer in silence. They either suffer in silence or they suffer in violence when their son, daughter, family member, husband or partner is having a psychotic episode. We need to provide more information, better ways of communicating and understanding and the skills to actually say: 'No. I love you dearly, but can't

57 Mr Craig Cumming, Research Associate, Centre for Health Services Research (CHSR), School of Population Health, University of Western Australia, *Committee Hansard*, 3 May 2017, p. 39.

58 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 39.

59 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 39.

60 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 39.

61 The Hon. Sheila McHale, CEO, Palmerston Association, *Committee Hansard*, 3 May 2017, p. 14.

62 Ms McHale, Palmerston Association, *Committee Hansard*, 3 May 2017, p. 14.

> give you any more money. I can't take out another mortgage on this house.' That is the reality for many families.[63]

3.43 Professor Allsop spoke of the need to enhance the 'access of support for families and others affected by an individual's drug use', and although there has been a 'significant increase in the investment in treatment services…we also need to recognise the needs of other people who are affected by a person's use.[64]

3.44 The committee asked the Department of Health (DoH) about the NIAS's consideration of family-friendly and youth-friendly treatment services. In response, the DoH advised that it is the responsibility of each PHN to undertake a needs assessment for its region and as part of that process:

> …look at existing services in their geographic area, both Commonwealth and state funded, work with peak bodies and others within their PHN to determine where the gaps were, and then commission accordingly. It is a question of whether youth services or family-friendly services came up as a gap in the planning. I am not sure if it did. That would be the part of the process where those issues need to be raised.[65]

3.45 The NIAS includes actions such as the Positive Choices online AOD information portal, and a national phone line for AOD information, counselling and other support services.[66] Other phone support services for families and their children are listed on the Alcohol and Drug Foundation's website, which includes a number of organisations that specialise in youth and family support (such as the Parent and Family Drug Support Line, Ted Noffs Foundation helpline, Headspace, Kids Help Line, Family Drug Support and Family Drug Help).[67]

Committee comment

3.46 It is vital that families are adequately and appropriately supported in circumstances where a parent or child is dealing with a methamphetamine dependency issue. Failure to do so has adverse outcomes for the drug user and their family.

3.47 The committee is particularly concerned about reports that parents, in particular women with young children, are opting not to undergo treatment out of fear of losing their children. The committee is, however, encouraged that specialised AOD treatment services are available to people with young children and that this issue appears to be getting more explicit consideration in some states and territories. The committee supports these types of AOD treatment facilities and recommends Australian governments ensure such services are provided in all jurisdictions.

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63 Ms McHale, Palmerston Association, *Committee Hansard*, 3 May 2017, p. 14.

64 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 31.

65 Dr Southern, DoH, *Committee Hansard*, 24 March 2017, p. 26.

66 COAG, *National Ice Action Strategy*, 2015, p. 24.

67 Alcohol and Drug Foundation, *Help and support services*, https://adf.org.au/help-support/support-services-directory/ (accessed 21 February 2018).

Recommendation 8

3.48 The committee recommends Australian governments ensure specialised alcohol and other drug treatment services are available to people with young children in all jurisdictions.

At-risk workplaces

3.49 During the course of the inquiry the committee heard that there are some workplaces more at risk of employees using crystal methamphetamine. For this reason, some submitters and witnesses advocated for drug testing to occur in these at-risk workplaces.

3.50 Holyoake Tasmania referred to the use of crystal methamphetamine in the hospitality industry. Anecdotally, Holyoake Tasmania has found that there is a high rate of use in Hobart's hospitality industry due to long working hours:

> …we are finding quite a few people who are working in pubs and clubs, that type of thing, who are having long or late shifts, are using ice and it is becoming problematic. They were using speed but they cannot get speed now so they are using ice.[68]

3.51 Fly-in fly-out workers were also identified as a group with a slightly greater risk of being exposed to, and using crystal methamphetamine.[69]

3.52 The Penington Institute described some of the drivers behind crystal methamphetamine use in some industries, such as the perception that it increases productivity and alleviates boredom, and the culture of some workplaces:

> People think that they can do more work, work longer, work harder, especially if they are piece workers. Fruit pickers et cetera think that they can pick more fruit if they are on ice. They make a flawed assumption around the mathematics, which is that they will use ice in order to generate more income. What ends up happening is that they develop an addiction, lose whatever income, lose their tolerance et cetera. It is a false equation, but, nonetheless, some people use it to increase their productivity. Some people use it to address boredom in their work role, and some people use it because it is part of the culture of their workplace—for example in the hospitality industry, where people are working night shifts until 3 am or whatever and their customers are quite possibly using the same substances, there is a culture that develops. So it is absolutely not just about the trades or the building industry—even though that is a very high profile issue—or the trucking industry.[70]

3.53 The Penington Institute cautioned against the assumption that only "blue-collar" workers are using crystal methamphetamine:

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68 Ms Sarah Charlton, CEO, Holyaoke Tasmania, *Committee Hansard*, 24 March 2017, p. 18.

69 Mr David Taylor, Policy Officer, Victorian Alcohol and Drug Association (VAADA), *Committee Hansard*, 27 July 2015, p. 36.

70 Mr Ryan, Penington Institute, *Committee Hansard*, 27 July 2015, p. 12.

> It is people on the land, on the farming lands, as much as it is people in factories et cetera. I should say that it is also an issue on Collins Street as well. I have heard lots of stories from people that work in the corporate sector around ice use in the business community. It is absolutely not just blue-collar workers.[71]

3.54 In 2015, the Australian Industry Group (Ai Group) called for workplace AOD testing as a means to address the safety issues caused by illicit drug use in workplaces. It recommended that crystal methamphetamine use can be tackled by:

> …firstly, recognising that drug and alcohol testing at the workplace is a key action that employers can take to protect the safety of employees and the community; secondly, conducting work health and safety campaigns aimed at educating the community about the risks created by ice use, particularly in operating machinery and vehicles; thirdly, encouraging law enforcement agencies to provide liaison services and dedicated hotlines for not only employees but employers impacted by ice, including, of course, regional and remote locations; and, fourthly, developing education resources to assist employers to deal with the impacts of ice in their workplaces.[72]

3.55 The Ai Group's 2016 submission repeated calls for drug testing in workplaces. It claimed that the NIT and the NIAS are inadequate responses to drug use in the workplace, stating that neither adequately deals with the impact of crystal methamphetamine or other drugs on workplaces, and the 'strict statutory obligations employers have to provide healthy and safe workplaces'.[73] The Ai Group recommended the following amendments to the *Fair Work Act 2009* (Cth):

- section 194 'so that enterprise agreements cannot contain terms that restrict drug and alcohol testing at the workplaces';
- subdivision D of Division 3, Part 2–3 'to prevent modern awards including terms dealing with drug and alcohol testing' to prevent limitations or restrictions on AOD testing; and
- other amendments that ensure 'procedural errors by an employer would not result in reinstatement or compensation for a former employee if there is a valid substantive reason for dismissal' to 'prevent a dismissal of an employee for a serious breach of work health and safety requirements from being overturned due to procedural deficiencies'.[74]

3.56 Professor Nadine Ezard, St Vincent's Hospital, raised concerns about workplace testing because it 'encourages subversion of the system if there is going to

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71 Mr Ryan, Penington Institute, *Committee Hansard*, 27 July 2015, p. 12.

72 Mr Stephen Smith, Head, National Workplace Relations Policy, Australian Industry Group (Ai Group), *Committee Hansard*, 29 July 2015, p. 63.

73 Ai Group, *Submission 112*, p. 2.

74 Ai Group, *Submission 112*, p. 2.

be a punitive response to the work-based testing'.[75] Rather than a punitive response, Professor Ezard suggested that the most effective model is:

> …where the health system is separate from employment such that people are directed to the health system but the results from the health system are not sent back to the employer. That is a very useful way of detecting people's use and responding early.[76]

3.57 Professor Ezard added that there should be trained health professionals permitted to engage with high-risk workplaces, such as mining and commercial driving, to provide health-focused interventions.[77]

3.58 The NIT considered ways to address illicit drug use in at-risk industries. It found that there is a lack of evidence 'regarding the effectiveness of workplace prevention activities' due to 'challenges associated with conducting controlled outcome and effectiveness evaluations in the workplace'.[78] The NIT argued that despite this lack of evidence, preventative activities should not be overlooked and workplaces are an effective setting for preventative and intervention strategies.[79] The NIT was in favour of a pilot program partnership between the Commonwealth, state and territory governments and industry groups designed for high-risk industries.[80] According to the NIT, this program should:

- be developed in consultation with AOD experts;
- be rolled out across high-risk industries and for an appropriate length of time to monitor its outcomes; and
- incorporate a robust evaluation of the methodology used to inform future workplace AOD prevention strategies.[81]

3.59 The use of drug testing in workplaces was briefly considered by the NIT, which recognised that this:

> …is a sensitive and complex issue, which should be underpinned by a clearly defined and agreed rationale, developed in consultation with the workforce. Identifying lower-cost drug testing options would enhance the usefulness of drug testing as a tool in a range of contexts, particularly for roadside drug testing.[82]

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75 Professor Nadine Ezard, Clinical Director, Alcohol and Drug Service, St Vincent's Hospital, St Vincent's Health Australia, *Committee Hansard*, 14 October 2015, p. 15.

76 Professor Ezard, St Vincent's Health Australia, *Committee Hansard*, 14 October 2015, p. 15.

77 Professor Ezard, St Vincent's Health Australia, *Committee Hansard*, 14 October 2015, p. 15.

78 NIT, *Final Report*, p. 119.

79 NIT, *Final Report*, p. 119.

80 NIT, *Final Report*, p. 119.

81 NIT, *Final Report*, p. 119.

82 NIT, *Final Report*, p. 154.

3.60 In response to the NIT's recommendations, the NIAS noted that preventative AOD programs in workplaces are already run by employers and state and territory governments.[83] It also acknowledged that government needs to expand efforts 'in high-risk workplaces so they are better able to prevent ice use and respond to ice when it emerges as an issue'.[84] An action under the NIAS is to '[d]evelop strategies to increase prevention and education about ice in high-risk industries such as mining, construction and transport'[85]; however, the NIAS did not address the role of drug testing in workplaces.

Committee comment

3.61 A range of industries, both "blue-collar" and "white-collar", are susceptible to problematic AOD use. Crystal methamphetamine use has been specifically identified in hospitality, transport, agriculture, construction and mining, as well as corporate environments, for reasons such as perceived increases in productivity and alertness.

3.62 A gap in the nation's response to AOD use in these industries is the development of evidence-based workplace preventative activities. The NIT recognised this need and recommended the development of a pilot program that develops a workplace preventative strategy to be implemented across high-risk industries. The NIT emphasised that this program must be thoroughly evaluated to inform future workplace prevention activities.

3.63 In response to this recommendation, the NIAS called for the development of strategies aimed at education about and prevention of crystal methamphetamine use in high-risk industries.

3.64 The committee is supportive of the measures outlined by the NIT and in the NIAS, and is of the view that governments and industry should implement strategies to address AOD use in at-risk workplaces.

3.65 The committee can see the appeal of drug testing in the workplace; however, such an approach must be given careful consideration in consultation with employees so that consequences both intended and unintended are identified and resolved, taking into account the rights and responsibilities of employers and employees alike. The committee has a preference for the development and implementation of preventative strategies in at-risk workplaces so that employees with AOD use issues are directed to treatment and support services in the first instance.

83 COAG, *NIAS*, p. 23.

84 COAG, *NIAS*, p. 23.

85 COAG, *NIAS*, p. 24.