Chapter 5

Funding of alcohol and other drug services

5.1 This chapter reviews additional funding for the alcohol and other drug (AOD) treatment sector announced as part of the National Ice Action Strategy (NIAS). It also considers evidence regarding:

- the rollout and preparatory work required of the Public Health Networks (PHNs) to distribute NIAS funding;
- the formula used to determine the allocation of funding to PHNs and concerns that sufficient funding has not been allocated to regions with more problematic crystal methamphetamine use;
- the timing of the funding rollout and the short timeframe provided for AOD service providers to apply for NIAS funding;
- delays with the distribution of NIAS funding; and
- transparency of the funding arrangements.

5.2 The chapter concludes with a brief consideration of AOD funding more broadly, and concerns expressed by submitters and witnesses that funding to the AOD sector remains insufficient, particularly across the three pillars of the National Drug Strategy (NDS) (demand, supply and harm reduction). Finally, the chapter considers the use of the Confiscated Assets Account (CAA) under the *Proceeds of Crime Act 2002* (PoC Act) for drug treatment and diversionary measures.

National Ice Action Strategy funding

5.3 A core component of the NIAS was the announcement of $241.5 million in additional funding to PHNs for procuring AOD treatment services. In advance of funding being allocated, the PHNs undertook a planning and consultation process to increase their understanding of local AOD services and community needs.[1] The DoH required each PHN to complete a regional needs assessments and drug and alcohol treatment activity work plan, which identified the AOD treatment activities to be funded under the new model.[2]

5.4 In a PHN circular from February 2016, the DoH explained that there would be a phased implementation of the NIAS funding model. During this time, pre-existing

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1 Department of Health (DoH), *Drug and Alcohol Treatment Services PHN Circular 1–4 February 2016*, 4 February 2016, http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Circular1_AOD (accessed 21 July 2017).

2 DoH, *Drug and Alcohol Treatment Services PHN Circular 1–4 February 2016*, 4 February 2016.

Commonwealth funded AOD services had their contracts extended for a further 12 months to the end of 2016–17.[3]

5.5 An important consideration for the DoH was how to distribute the $241.5 million funding to the PHNs. The circular stated that the DoH was looking at implementing a distribution model consistent with the existing funding methodology for PHNs.[4] The DoH would also target vulnerable population groups in most need of AOD treatment services.[5]

5.6 The DoH explained to the committee that the formula for allocating funds to each PHN was informed by the 2011 Census data,[6] and allocated:

> …on the basis of population rurality—the degree to which there were rural and regional populations in a particular PHN as well as an assessment of socioeconomic disadvantage and proportion of Indigenous population—so the $241 million was allocated on that basis.[7]

5.7 Of the $241.5 million funding to the PHNs, $78.6 million of NIAS funding was allocated to Indigenous-specific services. The allocation of this funding was informed by the DoH's engagement with local Aboriginal and Torres Strait Islander communities, through the PHNs,[8] and by using population figures derived from the 2013 Estimated Resident Population.[9] The DoH also ensured that culturally appropriate mainstream treatment services would be accessible to Indigenous Australians.[10] Routine performance reporting would require PHNs to provide evidence of culturally appropriate services for Indigenous Australians under the Drug and Alcohol Treatment Program.[11]

5.8 In allocating the remaining funding to PHNs, the government also considered other high-risk populations such as services for lesbian, gay, bisexual, transgender and intersex people.[12]

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3 DoH, *Drug and Alcohol Treatment Services PHN Circular 1–4 February 2016*, 4 February 2016.

4 DoH, *Drug and Alcohol Treatment Services PHN Circular 1–4 February 2016*, 4 February 2016.

5 DoH, *Drug and Alcohol Treatment Services PHN Circular 1–4 February 2016*, 4 February 2016.

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

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

8 Dr Southern, DoH, *Committee Hansard*, 24 March 2017, p. 21.

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

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

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

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

5.9 The DoH provided PHNs with the autonomy to commission AOD services in their area.[13] However, the PHNs were restricted in the types of services which could be funded. These were limited to:

- early intervention services (including brief interventions);
- counselling services;
- withdrawal management services with pathways to post-acute withdrawal support;
- residential services and other intensive non-residential programs;
- post-treatment support and relapse prevention programs;
- case management, care planning and coordination services; and
- projects that support the workforce through 'activities which promote joint up assessment and referral pathways, quality improvement, evidence-based treatment, and service integration'.[14]

5.10 As of 5 May 2017, the 31 PHNs had collectively executed contracts for 208 drug and alcohol projects across Australia.[15] Twenty-nine PHNs had commenced supplying services in their areas, with a total of 165 projects being delivered.[16]

5.11 The period for the $241.5 million funding to the PHNs commenced in 2016–17 and will end in 2019–20.[17] A total of $177.1 million was committed for AOD treatment programs for 2016–17, 2017–18 and 2018–19.[18] The remaining $64.4 million was allocated to the PHNs for 2019–20.[19] The breakdown of funding by state and territory is listed in Table 3.

13 DoH, answer to question on notice, no. 1, 24 March 2017, p. 3 (received 10 May 2017).

14 DoH, answer to question on notice, no. 1, 24 March 2017, p. 3 (received 10 May 2017).

15 DoH, answer to question on notice, no. 1, 24 March 2017, p. 2 (received 10 May 2017).

16 DoH, answer to question on notice, no. 1, 24 March 2017, p. 2 (received 10 May 2017).

17 DoH, answer to question on notice, no. 4, 24 March 2017 (received 10 May 2017).

18 DoH, answer to question on notice, no. 4, 24 March 2017 (received 10 May 2017).

19 DoH, answer to question on notice, no. 4, 24 March 2017 (received 10 May 2017).

Table 3: PHN funding allocations by state/territory 2016–19[20]

State/territory	Mainstream Service Delivery	Indigenous Service Delivery	Total
New South Wales (10 PHNs)	$35,439,694.28	$16,758,997.61	$55,300,301.16
Victoria (6 PHNs)	$22,871,683.75	$3,869,862.99	$29,081,056.06
Queensland (7 PHNs)	$24,847,121.31	$15,545,038.65	$42,516,113.37
South Australia (2 PHNs)	$7,940,018,23	$2,993,277.20	$11,654,954.79
Western Australia (3 PHNs)	$11,716,966.42	$7,443,165.46	$20,219,586.79
Tasmania (1 PHN)	$3,515,997.71	$1,937,899.96	$5,693,440.29
Northern Territory (1 PHN)	$3,768,196.04	$5,847,592.68	$9,752,082.48
Australian Capital Territory (1 PHN)	$2,207,053.12	$503,233.85	$2,857,465.05
Contracted total	$112,304,730.87	$54,899,068.41	$117,075,000.00

5.12 The Senate Standing Committee on Community Affairs (Community Affairs Committee) discussed the allocation of NIAS funding during Senate Estimates on 30 May 2017. The DoH provided information on the weightings applied to the formula to determine the allocation of funds to each PHN:

> In terms of the weightings that were applied, I can tell you that non-Aboriginal or Torres Strait Islanders had a weighting of one. For Aboriginal and Torres Strait Islanders there was a weighting of three. For the different socioeconomic quintiles: for the most disadvantaged there was a weighting of two, for the second quintile there was a weighting of 1.5 and the remaining quintiles had a weighting of one. It also took into account the [Australian Standard Geographical Classification] remoteness areas. Major

20 DoH, answer to question on notice, no. 4, 24 March 2017, Attachment A (received 10 May 2017).

cities received a weighting of one,[21] then there was a stepped scale to very remote areas, which had a weighting of 2.5.[22]

5.13 The DoH subsequently provided additional information: each PHN was allocated $500 000 per annum (a base level funding of 3.2 per cent per PHN), totalling $6.4 million.[23] The remaining $97.3 million in mainstream funding to 2019–20 was allocated using 2011 Census population data and weighted according to socioeconomic disadvantage, remoteness and indigeneity.[24] A further $5.4 million has been reserved to respond to any emerging priorities in future years.[25] A breakdown of the percentage of funds allocated to each PHN is detailed in Table 4.

Table 4: Percentage of NIAS funding allocated to PHNs[26]

State/territory	PHN Name	Indigenous Funding	Base funding	Weighted funding[27]
NSW	Central and Eastern Sydney	2.1%	3.2%	4.9%
	Northern Sydney	0.4%	3.2%	2.5%
	Western Sydney	2.1%	3.2%	3.4%
	Nepean Blue Mountains	1.7%	3.2%	1.3%
	South Western Sydney	2.4%	3.2%	4.0%
	South Eastern NSW	2.9%	3.2%	2.7%
	Western NSW	4.9%	3.2%	2.2%
	Hunter New England and Central Coast	8.6%	3.2%	5.8%
	North Coast	3.8%	3.2%	2.8%
	Murrumbidgee	1.7%	3.2%	1.4%

21 There were five levels of weighting: 1 (major city), 1.2, 1.5, 2 and 2.5 (very remote location). See Mr David Laffan, Assistant Secretary, Drug Strategy Branch, Population Health and Sport Division, DoH, *Committee Hansard*, 30 May 2017, p. 87.

22 Mr Laffan, DoH, *Committee Hansard*, 30 May 2017, pp 86–87.

23 DoH, answers to questions on notice, no. SQ17-000589, (received 16 August 2017).

24 DoH, answers to questions on notice, no. SQ17-000589, (received 16 August 2017).

25 DoH, answers to questions on notice, no. SQ17-000589, (received 16 August 2017).

26 DoH, answers to questions on notice, no. SQ17-000589, (received 16 August 2017).

27 Weighted funding is determined by Indigenous population, socioeconomic disadvantage and rural and remoteness.

Victoria	North Western Melbourne	1.5%	3.2%	5.6%
	Eastern Melbourne	0.9%	3.2%	4.4%
	South Eastern Melbourne	1.1%	3.2%	4.8%
	Gippsland	0.7%	3.2%	1.3%
	Murray	2.0%	3.2%	3.0%
	Western Victoria	1.1%	3.2%	2.7%
Queensland	Brisbane North	2.7%	3.2%	3.2%
	Brisbane South	3.6%	3.2%	3.8%
	Gold Coast	1.2%	3.2%	1.9%
	Darling Downs and West Moreton	3.5%	3.2%	2.7%
	Western Queensland	2.0%	3.2%	0.9%
	Central Queensland and Sunshine Coast	4.2%	3.2%	5.1%
	Northern Queensland	11.1%	3.2%	5.1%
South Australia	Adelaide	2.7%	3.2%	4.5%
	Country SA	2.8%	3.2%	3.0%
Western Australia	Perth North	2.5%	3.2%	3.4%
	Perth South	3.0%	3.2%	3.4%
	Country WA	8.1%	3.2%	4.1%
Tasmania	Tasmania	3.5%	3.2%	3.0%
Northern Territory	Northern Territory	10.3%	3.2%	3.2%
Australian Capital Territory	Australian Capital Territory	0.9%	3.2%	1.1%
Total		**$76.8 million**	**$62 million**	**$97.3 million**

5.14 An additional $56.7 million of NIAS funding was reserved for non-treatment services (excluding the $241.5 million allocated to the PHNs). This has been allocated to:

- communities to deliver locally-based and tailored crystal methamphetamine preventative and educational activities ($24.9 million). Of this total, $19.2 million has gone to the establishment of 220 Local Drug Action Teams, $1.1 million for the expansion of the Positive Choices online portal and $4.6 million for the expansion of the Good Sports program;
- $13 million for the introduction of new Medicare Benefits Schedule items for addiction medicine specialists;
- $10.7 million for clinical research into new treatment options, the training of AOD professionals and the evaluation of clinical care for those people using methamphetamine. This includes $8.8 million for a new Centre for Excellence for the Clinical Management of Emerging Drugs of Concern, and the remaining amount to be allocated to the expansion of an early intervention tool and development of evidence-based guidelines; and
- $8.1 million to improve the Commonwealth's data sources on emerging trends in illicit drug use patterns, treatment options and early intervention of emerging drug threats.[28]

Allocation of funding to areas with high methamphetamine use

5.15 The committee heard concerns that NIAS funding had failed to target areas with the most severe illicit drug problems. This matter was discussed at length during the committee's hearing in Western Australia (WA).

5.16 The Palmerston Association argued that there was a disconnect between the usage rate of crystal methamphetamine in WA and the funding accolated to it:

> …[WA] not receiving a fair share of the national funds. We work on the basis of about 11 per cent of the share, given our population. We believe—and I am sure that the Department of Health could confirm this, because I may be wrong—that we are getting about nine per cent. That two per cent difference is a significant amount of money.[29]

5.17 The Palmerston Association asserted that WA should be getting more funding because:

- usage figures in WA are double the national average;
- the geographic size of the state; and
- the distribution of the state's population.[30]

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28 DoH, answer to question on notice, 30 May 2017, No SQ17-000699 (received 21 July 2017).

29 The Hon. Sheila McHale, Chief Executive Officer (CEO), Palmerston Association, *Committee Hansard*, 3 May 2017, p. 14.

30 Ms McHale, Palmerston Association, *Committee Hansard*, 3 May 2017, p. 15.

5.18 Further, the Palmerston Association argued that future funding should be allocated on a needs basis and be informed by the best evidence, experts and policy work:

> Here in WA, the former state government developed its mental health, drug and alcohol plan. That is a very sound document that ought to inform funding and policy. That has identified where the need is and a plan to get there. As minister, if I knew that my public funds were being determined by some of the best research and the best thinkers, then I think that I would be quite happy. What I would not be happy with is a lot of money going into duplication of bureaucracies.[31]

5.19 This concern was shared by the Western Australian Network of Alcohol & other Drug Agencies (WANADA), which argued for additional weightings to be applied to areas with known drug use, based on evidence from the wastewater analysis.[32] The WANADA also called for more consideration of the geographic size of the state and the impact of distance on services to regional, rural and remote populations:

> Some of the services in Western Australia cover enormous geographic areas to provide those services. We know that people in regional, rural and remote areas are impacted by methamphetamine use. It is not just within metropolitan Perth. When you are driving hours and hours and hours within a single region to deliver services, then we need some additional weighting to ensure that there is some degree of equitable access to services for people in regional, rural and remote Australia, of which WA has its fair share.[33]

5.20 The WANADA argued that existing research conducted by the WA government should be relied upon to better inform the allocation of AOD funding to PHNs:

> I think we need a focus on meeting demand based on sound population planning, and research that has been undertaken and that has been refined for Western Australia by the state government—it was done by the previous state government and which is going to be supported by the current state government—is based on sound research and evidence. We have the demand; we know what the demand is; we need to meet this demand.[34]

5.21 The National Drug Research Institute (NDRI) held views similar to the WANADA and the Palmerston Association. Professor Rebecca McKetin of the NDRI stated that the level of problematic use should at least be considered, and stated:

> I used to work a lot in Sydney and I have moved from Canberra over to Western Australia in the last 12 months. The problem here is much greater than it is in a lot of those places and, as I said before, it is not uniform

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31 Ms McHale, Palmerston Association, *Committee Hansard*, 3 May 2017, p. 15.

32 Ms Jill Rundle, CEO, Western Australian Network of Alcohol & Other Drug Agencies (WANADA), *Committee Hansard*, 3 May 2017, p. 30.

33 Ms Rundle, WANADA, *Committee Hansard*, 3 May 2017, p. 30.

34 Ms Rundle, WANADA, *Committee Hansard*, 3 May 2017, p. 30.

> across the country. It is affecting some communities very strongly and others not much at all. So in that equation there needs to be some index of the level of problematic methamphetamine use or drug use.[35]

5.22 Professor Steve Allsop, also of the NDRI, added that more consideration needs to be given to rural and remote communities, and argued for the setting aside of additional funds in order:

> …to deliver more effectively to rural and remote regions across Australia, particularly in the Northern Territory, Queensland, Western Australia and the northern parts of South Australia, where there are incredible challenges.[36]

NIAS funding for 2019–20

5.23 The DoH advised the Community Affairs Committee during Senate Estimates that the remaining funding for 2019–20 has been allocated to treatment services, but had 'not been committed to specific PHNs at this time'.[37] The Community Affairs Committee requested details about how the remaining funds would be allocated, and whether the same formula would be applied. The Community Affairs Committee also questioned whether it was appropriate to allocate the remaining NIAS funds based on Census data from 2011, noting up-to-date data is available through the wastewater analysis and the 2016 Census. In response, the DoH stated that it had consulted with experts, who:

> …thought [the formula] was a reasonable basis for allocating quite a large amount of money across 31 PHNs. I would think that the services themselves might then use some of that more granular data around the patterns of drug use in their communities, the drugs of concern and the subregions within a PHN—and that would be the level of data. I don't think we have put any money into an area where there is not some need for enhanced services. So I don't think there is a gross misallocation.[38]

5.24 The DoH subsequently advised the Community Affairs Committee that it was not considering changing the funding model to allocate the final year of funding to the PHNs for 2019–20.[39] Table 5 sets out the total remaining amount yet to be committed to the PHNs, along with the total amount of funding across the entire four year period.

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35 Associate Professor Rebecca McKetin, Senior Research Fellow, National Drug Research Institute (NDRI), Curtin University, *Committee Hansard*, 3 May 2017, p. 40.

36 Professor Steve Allsop, Project Leader, NDRI, Curtin University, *Committee Hansard*, 3 May 2017, p. 40.

37 Mr David Laffan, Assistant Secretary, DoH, *Committee Hansard*, 30 May 2017, p. 88.

38 Dr Lisa Studdert, First Assistant Secretary, Population Health and Sport Division, DoH, *Committee Hansard*, 30 May 2017, p. 87.

39 DoH, answer to question on notice, No. SQ17-00589, 30 May 2017 (received 21 July 2017).

Table 5: 2019–20 NIAS funding and total funding (four year total) by state and territory[40]

State/territory	2019–20 funding	Total funding (four year total)
New South Wales	$18,433,433.73	$73,733,734.92
Victoria	$9,693,685.35	$38,774,741.40
Queensland	$14,172,037.79	$56,688,151.16
South Australia	$3,884,984.93	$15,539,939.72
Western Australia	$6,739,862.26	$26,959,449.04
Tasmania	$1,897,813.43	$7,591,253.72
Northern Territory	$3,250,694.16	$13,002,776.64
Australian Capital Territory	$952,488.35	$3,809,953.40

Committee comment

5.25 The committee commends the Commonwealth government's substantial contribution of $241.5 million to AOD services as part of the NIAS.

5.26 The committee notes concerns that the funding for 2019–20 is informed by Census data from 2011. The most recent Census data for 2016 was released on 27 June 2017, and for this reason, the committee suggests that the DoH considers using 2016 Census data to inform the allocation of the remaining NIAS funds, rather than the 2011 data.

5.27 In addition to the use of 2016 Census, the committee is of the view that the remaining NIAS funding could also be informed by data from the wastewater analysis. The use of wastewater analysis data should assist in allocating resources to areas with known higher methamphetamine use.

Recommendation 11

5.28 The committee recommends that the Department of Health considers using 2016 Census and National Wastewater Drug Monitoring Program data to determine the allocation of National Ice Action Strategy funding for 2019–20.

Tender process

5.29 Submitters and witnesses to the inquiry raised concerns with respect to the timing of and short timeframe for the tender process.

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40 DoH, answer to question on notice, No. SQ17-000597, 30 May 2017 (received 21 July 2017)

5.30 Holyoake Tasmania was critical of the NIAS tender process. It expressed concern about the short timeframe to apply for funding: from the announcement in December 2015 to the closure for applications on the 12 January 2016.[41] Holyoake Tasmania opined that this decision resulted in a:

> …rushed procurement process [that] did not enable an adequate time for competing organisations to thoroughly research and prepare tenders which will deliver the best possible outcomes for clients using ice or their families.[42]

5.31 The same concern was expressed by the Network of Alcohol and other Drug Agencies (NADA) about the tender process in New South Wales (NSW). NADA advised the committee that its members were only provided with:

> …three to four weeks over the Christmas and New Year period…to apply for grants in their on-line tender process. This severely weakens many NGO services position to compete in external tender processes as agencies staff are on holidays, partner agencies are also not as available for collaboration in the tender application and the Christmas period is generally a crisis time for clients and people seeking to access services placing extra demand on the personnel of drug treatment NGOs.[43]

5.32 NADA acknowledged community expectations that delivery of treatment services would occur promptly, but argued that:

> ….this timing problem should have been addressed between both the Australian Government and the PHNs so that timeframes for the roll out of competitive tendering could have been more realistic and less burdensome on services. A communication strategy developed in partnership with the Australian Government, PHNs and the Network of AOD Peaks could have gone to supporting realistic and appropriate timeframes, as well as community expectations on the commissioning of new services. This approach should be taken in the future.[44]

5.33 The committee queried the DoH on the timing of the tender process and the role it had in determining the timeframe. The committee asked the DoH about the tender process occurring over the Christmas period and whether it had impacted on service providers' ability to form partnerships. In response, the DoH advised that the tender process varied from PHN to PHN and that the:

> …commissioning periods varied quite considerably depending on how far forward each of the PHNs was in its planning process. Each PHN basically did its needs assessment for its region then determined how it was going to do its commissioning process. Apart from providing the broad guidelines

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41 Ms Sarah Charlton, CEO, Holyoake Tasmania, *Committee Hansard*, 24 March 2017, p. 17.

42 Ms Charlton, Holyoake Tasmania, answer to questions on notice, 24 March 2017 (received 20 April 2017), p. 1.

43 Network of Alcohol and other Drug Agencies (NADA), *Submission 96*, p. 8.

44 NADA, *Submission 96*, p. 8.

> around the sort of services that could be funded under the program the department has not been involved in the commissioning process.[45]

5.34 The committee asked whether the DoH advised PHNs that the Christmas or Easter periods were not appropriate times for the PHNs to initiate tender processes. The DoH reassured the committee that it is in:

> …constant communication with the PHNs providing feedback on how things are going. The commissioning process is now in its second year with PHNs. Certainly we have opportunities to feed back to PHNs what works and what does not work. I guess that is something we have learned in the department over many years, that Christmas is a difficult period for commissioning.[46]

Committee comment

5.35 The committee sympathises with submitters and witnesses about the timing of the tender process and the short timeframe available to tender for NIAS funds. Individual PHNs have responsibility for their tender processes, however, the committee believes the DoH should ensure adequate time frames are in place and occur outside of holiday periods. Failure to do so may undermine service providers' ability to develop well-informed, collaborative tenders; the committee therefore supports NADA's proposal that future tender processes should have realistic timeframes and occur at appropriate times of year.

Recommendation 12

5.36 The committee recommends that the Department of Health ensures that Public Health Network's conduct future tender processes with realistic timeframes and at appropriate times of year.

Distribution of funding to AOD service providers

5.37 The delay with the rollout of NIAS funding through the PHNs was the subject of concern during the course of the inquiry, with both the Australian Medical Association (AMA) and the Palmerston Association criticising the delay. The AMA submitted that the NIAS was agreed by COAG on 11 December 2015 and that:

> A year later some of the most vital aspects, including expanded access to treatment and support for crystal methamphetamine users, has not progressed. While many PHNs will commence with their plans to expand treatment and support services on 1 January 2017, other PHNs have not finalised their plans and so will not be in a position to implement them. This is despite the commitment being made over a year ago.[47]

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

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

47 Australian Medical Association (AMA), *Submission 86*, p. 4.

5.38 A similar critique was outlined by the Palmerston Association: 'we are only now beginning to see some of the funding come through. The task force reported November 2015 or thereabouts. We are now 18 months later'.[48]

5.39 The Western Australian Primary Health Alliance (WAPHA) addressed the Palmerston Association's criticism regarding the delays distributing the NIAS funds, explaining that it was:

> …required to undertake a sequence of processes to ensure that commissioned services are purposed for the people and the place for which they will be provided. There are specific governance processes, mandated by the Commonwealth, to ensure that new treatment services can be provided that will not cause harm. The haste that is recommended by the Palmerston Association would subvert this process…A cautious and planned approach is necessary that upholds the integrity of the Commonwealth's mandated requirements.[49]

5.40 In some cases NIAS funding to AOD services was delayed for an extended period. For example, the Australian Capital Territory did not receive its additional funding (above the 3.2 per cent base level funding) until August 2017, almost two years after the Commonwealth government's announcement.[50] Similarly, Tasmania received its funding in April 2017, more than a year after the government announced the NIAS funding.[51]

Committee comment

5.41 The committee acknowledges that many in the AOD treatment sector would like NIAS funding distributed as quickly as possible; however, the committee agrees with WAPHA's view that a more measured and less hasty implementation is preferable.

5.42 It seems to the committee that better communication about the distribution of funding would have ameliorated some of the concerns. The committee suggests the Commonwealth government and PHNs proactively communicate to stakeholders about the distribution so as to manage the expectations of service providers and assist both service providers and communities to plan around the rollout of the funds.

Transparency

5.43 Both the Palmerston Association and WANADA expressed concerns about the transparency and governance of PHN funding. The Palmerston Association

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

49 Ms Learne Durrington, The Western Australian Primary Health Alliance (WAPHA), correction of evidence, 3 May 2017, p. 2 (received 29 May 2017).

50 Daniel Burdon, '$2.8 million for ACT drug treatment flows two years after ice strategy announced', *The Age,* 31 August 2017, http://www.theage.com.au/act-news/28-million-for-act-drug-treatment-flows-two-years-after-ice-strategy-announced-20170831-gy7tzp.html (accessed 15 November 2017).

51 Sarah Fitzpatrick Gray and AAP, 'Federal funds to combat ice in Tassie', *Hobart Mercury*, 13 April 2017.

explained that it was unsure whether funding it had received through WA's PHNs (WAPHA) was NIAS funding or other AOD funding.[52] More broadly, the National Drug and Research Centre (NDARC) argued that AOD funding and commissioning of services in a federal system leaves service providers vulnerable.[53]

5.44 WANADA expressed a similar concern regarding the lack of transparency, particularly in instances of money received from a non-government commissioning body. The committee heard that when services receive funding from government, service providers are able to:

> …access information about what services are being funded and how much money they have received; you can even access what is in their contract. But when it comes through effectively a non-government commissioning body—…as a peak body I do not know where this money is actually going. In terms of the peak body being able to provide support for all of the services that are getting alcohol and other drug funding, I do not know how to support the capacity of those services, I do not know who they are. So there is no transparency about where it is going, what it is for, what the process is—all those sorts of things—at this stage. It is certainly something that I have requested, but I am yet to receive that information.[54]
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> …
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> In Western Australia…the Ice Taskforce money has been blended with mental health funding that the primary health care networks get as well. That is unique to WA. Again, I guess there are concerns there in terms of the transparency of this going to services that are delivering early intervention, brief intervention, where they should be providing it as a matter of course versus AOD specialist treatment services. But I do not know where the money has gone. I have no idea who has received the funding. At this stage, there is no transparency broadly, certainly with the not-for-profit sector.[55]

5.45 WAPHA responded to the criticisms about transparency and governance around commissioning of AOD activities, including the acquittal of the NIAS funding. It cited the PHN Grant Programme Guidelines[56] under the Drug and Alcohol Treatment Activity Work Plan as providing clear guidance on activities commissioned

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

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

54 Ms Rundle, WANADA, *Committee Hansard*, 3 May 2017, p. 29.

55 Ms Rundle, WANADA, *Committee Hansard*, 3 May 2017, p. 29.

56 Available at: DoH, *PHN Programme Guidelines,* 21 April 2017, http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines (accessed 18 January 2018). Other resources available to inform PHNs on the commissioning processes are: *PHN Commissioning Resources*, 27 February 2017, http://www.health.gov.au/internet/main/publishing.nsf/Content/PHNCommissioningResources (accessed 18 January 2018); *PHN Needs Assessment Guide,* 24 December 2015, http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Needs_Assessment_Guide (accessed 18 January 2018).

by PHNs under the NIAS.[57] Further, WAPHA explained that 'WA PHNs are required to provide regular and detailed activity reports to the Commonwealth Department of Health on a six and 12 monthly basis'.[58]

5.46 A DoH circular of 4 February 2016 outlined the AOD funding arrangements for the NIAS.[59] It noted that the additional $245.1 million to the PHNs was not exclusively for crystal methamphetamine-specific services, but instead 'is intended to increase the capacity of the drug and alcohol treatment sector broadly, to adequately and effectively deliver treatment services':[60]

> New drug and alcohol treatment services refers to new investment in additional drug and alcohol treatment services commissioned through PHNs. PHNs role in commissioning treatment services at the local level will complement their new role in coordinating Commonwealth-funded mental health programmes at the local level, as well as build linkages with primary care.
>
> The new role of PHNs will also not impact on existing Indigenous-specific treatment services already contracted by the Department of Prime Minister & Cabinet through the *Indigenous Advancement Strategy*, but will build on this existing investment.[61]

5.47 Dr Jenny Chalmers, Professor Alison Ritter, Dr Lynda Berends and Dr Kari Lancaster considered the issue of transparency, accountability and AOD funding in an article in *Drug and Alcohol Review*.[62] Chalmers et al. demonstrated the complexities of the funding flows for AOD services and the tendency for there 'to be several layers of governance or intermediaries between the funding sources and the final use of funds or services funded'.[63]

5.48 They noted that Australia's increasingly decentralised health system, with multiple layers and partners, raises a concern about the efficiency and effectiveness of AOD funding.[64] The analysis by Chalmers et al. shows that source funders can be

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57 Ms Durrington, WAPHA, correction of evidence, 3 May 2017, p. 2 (received 29 May 2017).

58 Ms Durrington, WAPHA, correction of evidence, 3 May 2017, p. 2 (received 29 May 2017).

59 DoH, *Drug and Alcohol Treatment Services PHN Circular 1 – 4 February 2016,* 4 February 2016.

60 DoH, *Drug and Alcohol Treatment Services PHN Circular 1 – 4 February 2016,* 4 February 2016.

61 DoH, *Drug and Alcohol Treatment Services PHN Circular 1 – 4 February 2016,* 4 February 2016.

62 Dr Jenny Charmers, Professor Alison Ritter, Dr Lynda Berends and Dr Kari Lancaster (Charmers et al.), 'Following the money: Mapping the sources and funding flows of alcohol and other drug treatment in Australia', *Drug and Alcohol Review,* 35, May 2016

63 Charmers et al., 'Following the money: Mapping the sources and funding flows of alcohol and other drug treatment in Australia', *Drug and Alcohol Review,* 35, May 2016, p. 256.

64 Charmers et al., 'Following the money: Mapping the sources and funding flows of alcohol and other drug treatment in Australia', *Drug and Alcohol Review,* 35, May 2016, p. 262.

'many times removed from service delivery, their decision making around the amount of funding disconnected from decisions about what is funded'.[65] The authors concluded that these 'decisions are crucial in determining performance, efficiency and affordability of AOD treatment' and cause challenges for AOD service providers that are forced to navigate 'multiple and sometimes competing funding and accountability frameworks'.[66]

5.49 The NDARC came to a similar conclusion, stating that a key challenge for the AOD sector is the:

> …fragmented approach to service planning and purchasing and the challenges associated with federalism where the two levels of government (federal versus state/territory) do not dovetail together. The states/territories fund the majority of alcohol and other drug treatment, including methamphetamine and are seen as the central planning unit for their jurisdiction.[67]

5.50 NDARC stated that, as a consequence of this contracting system, AOD treatment services providers are left very vulnerable (for example, as a result of inconsistent funding), an issue which requires sustained attention by policy makers and those implementing funding programs.[68]

Committee comment

5.51 It is apparent to the committee that there are valid concerns about transparency of NIAS funding, primarily due to existing transparency issues with AOD funding more generally.

5.52 As demonstrated by Chalmers et al., the funding of AOD services is complex. The committee is concerned that NIAS funding will be indistinguishable from existing funding, thus undermining the Commonwealth government's ability to assess the effectiveness of NIAS-funded AOD treatment services.

5.53 The committee, in its first report, recommended that progress reports and the mid-point review provided to the Ministerial Drug and Alcohol Forum and Council of Australian Governments on the implementation of the National Drug Strategy (NDS) 2017–2026 and the NIAS are made publicly available. As part of this recommendation, the committee included reporting of initiatives implemented through the PHNs.

5.54 Concerns expressed by WANADA, the Palmerston Association, the NDARC and research conducted by Charmers et al. all relate to a broader concern about

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65 Charmers et al., 'Following the money: Mapping the sources and funding flows of alcohol and other drug treatment in Australia', *Drug and Alcohol Review,* 35, May 2016, p. 262.

66 Charmers et al., 'Following the money: Mapping the sources and funding flows of alcohol and other drug treatment in Australia', *Drug and Alcohol Review,* 35, May 2016, p. 262.

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

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

transparency of AOD funding in a federated system. The committee acknowledges this issue, and agrees that transparency and accountability should be improved.

Rebalancing the three pillars of the National Drug Strategy

5.55 The NIAS funding is part of broader AOD funding committed by the Commonwealth government. Since 1 July 2016, the Commonwealth government has invested almost $685 million to reducing the impact of drug and alcohol abuse on individuals, families and communities.[69] Of this total, $544 million has been provided for treatment services, with approximately $75 million per annum, under the *Drug and Alcohol Program*, allocated to support existing AOD treatment services.[70] The PHNs will administer $42.6 million per annum of the $75 million.[71]

5.56 Although the Commonwealth government has made substantial investments in AOD services, the committee heard consistently from AOD service providers, researchers and peak body representatives that the sector is under-resourced. Charmers et al. noted that the AOD treatment sector 'is generally underfunded' but acknowledged that it was 'difficult to gain an appreciation of the total level of funding given the complexities of the [funding] arrangements'.[72]

5.57 The committee's first report expressed the view that, although law enforcement strategies play a vital role in combating the manufacture, importation and distribution of illicit drugs, there are limits to the success of law enforcement strategies in mitigating the effect of illicit drugs on individuals and community. A broad range of evidence from the NIT's final report, the Commonwealth government, law enforcement,[73] health professionals and AOD service providers supported the maxim that 'we cannot arrest our way out' of the illicit drug problem.[74]

5.58 Despite the recognised limitations of law enforcement approaches, law enforcement receives the largest proportion of government expenditure dedicated to addressing illicit drugs. For this reason, there are calls for the Commonwealth, state and territory governments to rebalance the distribution of funding across the three pillars of Australia's drug strategy.[75]

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69 DoH, answer to question on notice, SQ17-000497, Budget Estimates 2017–18.

70 DoH, answer to question on notice, SQ17-000497, Budget Estimates 2017–18.

71 DoH, answer to question on notice, SQ17-000497, Budget Estimates 2017–18.

72 Charmers et al., 'Following the money: Mapping the sources and funding flows of alcohol and other drug treatment in Australia', *Drug and Alcohol Review,* 35, May 2016, p. 261.

73 See for example, Deputy Commissioner Naguib (Nick) Kaldas, Deputy Commissioner, Field Operations, New South Wales Police Force, *Committee Hansard*, 29 July 2017, p. 4.

74 The Hon. Malcolm Turnbull MP, Prime Minister, 'Joint Doorstop Interview with Minister Keenan and Minister Nash', Sydney, 6 December 2015, https://www.malcolmturnbull.com.au/media/joint-doorstop-interview-with-minister-keenan-and-minister-nash-sydney (accessed 11 January 2018).

75 The three pillars of the National Drug Strategy are supply, demand and harm reduction measures. See Parliamentary Joint Committee on Law Enforcement, *Inquiry into crystal methamphetamine (ice): First report*, September 2017, pp 55-57.

5.59 In 2009–10, Professor Alison Ritter, Dr Ross McLeod and Dr Marian Shanahan estimated that the Commonwealth, state and territory governments spent approximately $1.7 billion on illicit drug programs. The analysis[76] estimated that 64.1 per cent of this total (over $1 billion) was dedicated to law enforcement policies,[77] whereas:

- 9.7 per cent (approximately $156.8 million) was spent on prevention activities;
- 22.5 per cent (approximately $361.8 million) was spent on treatment services;
- 2.2 per cent ($36.1 million) was spent on harm reduction measures; and
- 1.4 per cent ($23.1 million) on other activities.[78]

5.60 The disparity between the funding traditionally allocated to law enforcement and that provided for treatment and harm reduction has led organisations such as the Network of Peaks to be critical of additional investment in law enforcement strategies that 'preferences supply reduction over demand and harm reduction'.[79]

5.61 The Ted Noffs Foundation highlighted the need for a balanced, co-ordinated approach to tackling the illicit drug problem:

> Law enforcement, including street-level policing, will not, by itself, counter the prevalence of illicit drug use. A coordinated, balanced strategy, involving prevention and treatment harms, as well as a resourced health sector, will always have the most positive effect. The Australian Crime Commission report into the methamphetamine market has highlighted that to deal with ice we need an overarching national strategy that includes the health sector, industry, educators and the not-for-profit sector. By acknowledging that law enforcement measures alone will not adequately address the problem, the Crime Commission has signalled to the Australian government that a significant and considered investment is required in early

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76 Evidence presented by submitters shows original estimates from the Alison Ritter, Ross McLeod and Marian Shanahan et al. (Ritter et al.) report. On 20 August 2013 an addendum was issued due to amendments being made to the Australian Federal Police's allocation of resources towards illicit drug strategies. These changes resulted two scaled down estimates for law enforcement, one was 70 per cent the original estimate, the other was 50 per cent. This report has opted to use the 50 per cent estimate. See Ritter et al. *Government Drug Policy Expenditure in Australia – 2009/10,* Drug Policy Modelling Program Monograph 24, NDARC, June 2013, https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/24%20Government%20drug%20policy%20expenditure%20in%20Australia%20-%202009_10.pdf (accessed 17 November 2017).

77 Ritter et al. *Government Drug Policy Expenditure in Australia – 2009/10,* Drug Policy Modelling Program Monograph 24, NDARC, June 2013.

78 Ritter et al. *Government Drug Policy Expenditure in Australia – 2009/10*, Drug Policy Modelling Program Monograph 24, NDARC, June 2013.

79 Australian Network of State and Territory Alcohol and other Drug Peak Bodies (Network of Peaks), *Submission 108*, p. 8.

> intervention and treatment services. Currently, relative to law enforcement resourcing, funding for drug treatment services is woefully inadequate.[80]

5.62 Professor Nadine Ezard from St Vincent's Hospital also advocated for a rebalancing of funding across the three pillars:

> …with the three pillars of demand reduction, supply reduction and harm reduction we would really like to see adequate resourcing of the health system within those three pillars—within the demand reduction and harm reduction area. We need to be really making sure that when the proportional direction of resources is decided we get adequate resources into those two areas.[81]

5.63 The WANADA considered that law enforcement strategies need to operate in concert with harm reduction and treatment programs. It argued that a law enforcement approach would not deliver the health outcomes that are evidently needed; WANADA submitted that government policy should place an increased emphasis on demand and harm reduction initiatives[82] because:

> …for every treatment dollar spent, $7 is saved, and for every dollar spent in harm reduction, $27 is saved, so we have these broad areas. We would like to be able to—and I think it is important—demonstrate the value of what we are doing. Across the three pillars, the demand for services is inadequately met. It would be great to be able to say, 'With enough services, we will be able to contribute effectively to social cost savings.'[83]

5.64 WANADA highlighted that each year across Australia, between 200 000 and 500 000 people are unable to access the AOD treatment they seek.[84]

5.65 Professor Allsop from the NDRI argued that just because an illicit drug offence is a criminal offence, it does not mean the best response is a law enforcement response. Instead, policymakers need to address demand reduction because:

> If lots of people associated with methamphetamine end up in our criminal justice system, it still might mean that we need to get more people into treatment. It might mean that we need to have much more effective prevention strategies, so that we begin to reduce demand. It might mean that, instead of putting people into the criminal justice system, we divert them into treatment systems.[85]

5.66 Professor Allsop acknowledged and commended both federal and state governments that have:

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80 Mr Mark Ferry, Chief Operating Officer, Ted Noffs Foundation, *Committee Hansard*, 29 July 2015, p. 51.

81 Professor Nadine Ezard, Clinical Director, Alcohol and Drug Service, St Vincent's Hospital, St Vincent's Health Australia, *Committee Hansard*, 29 July 2015, p. 74.

82 WANADA, *Submission 107*, p. 7.

83 WANADA, *Submission 107*, p. 7.

84 WANADA, *Submission 107*, p. 7.

85 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 37.

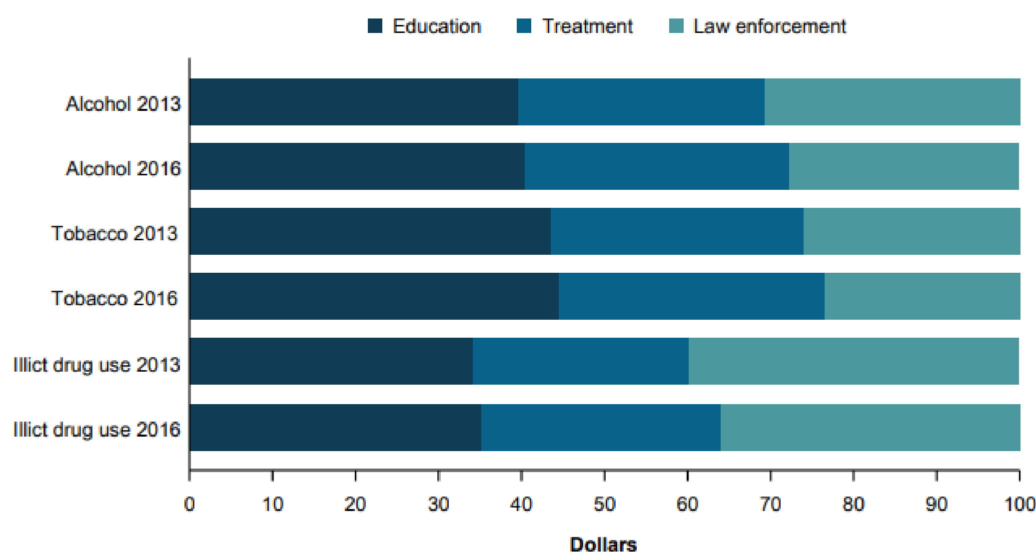
> …allocated increasing funds and resources to [treatment services]. The federal government and various state governments, including Western Australia, should be applauded for that. But the problem is that there is still an enormous unmet need, and it is in the access to that service.[86]

5.67 The AIHW's *National Drug Strategy Household Survey 2016* (household survey) revealed growing public support for the prioritisation of health and education policies over law enforcement. Participants were asked to distribute a hypothetical $100 across these three policy responses for alcohol, tobacco and illicit drugs, and found that irrespective of the type of drug:[87]

> …people thought that a greater proportion of funds should be allocated to education or treatment in 2016—making up about 64% to 77% of total dollars. Conversely, there was a significant decrease in the allotted dollars for law enforcement for all 3 drug types.[88]

5.68 Figure 5 shows the household survey's results of participants preferred distribution of the hypothetical $100.

Figure 5: Preferred distribution of a hypothetical $100 to reduce the use of selected drugs, people aged 14 or older, 2013–2016[89]



86 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 38.

87 Australian Institute of Health and Welfare (AIHW), *National Drug Strategy Household Survey 2016: Detailed findings,* 2017, p. 131, https://www.aihw.gov.au/getmedia/15db8c15-7062-4cde-bfa4-3c2079f30af3/21028a.pdf.aspx?inline=true (accessed 28 February 2018).

88 AIHW, *National Drug Strategy Household Survey 2016: Detailed findings,* 2017, p. 131.

89 AIHW, *National Drug Strategy Household Survey 2016: Detailed findings,* 2017, p. 132.

Committee comment

5.69 The Commonwealth government's investment of $241.5 million in AOD treatment services via the NIAS, together with a broader investment of $685 million, marks a significant step forward in the redistribution of resources across the three pillars of Australia's drug strategy. However, this additional funding may not necessarily result in the demand for treatment and harm reduction services being met.

5.70 While the NIAS funding goes some way to addressing the imbalances between the pillars of Australia's drug strategy, the committee acknowledges the need to ensure that policies and funding are not disproportionately weighted towards law enforcement.

5.71 Evidence in this report demonstrates the benefits of prioritising demand and harm reduction policies over law enforcement policies when it comes to assisting people to reduce or cease their illicit drug use. Again, the committee supports law enforcement's role in the NDS, but considers that police resources should be primarily aimed at those who profit from the importation, manufacture and distribution of illicit drugs (namely serious and organised crime groups and outlaw motorcycle gangs), rather than people that use or are found in possession of small quantities of illicit drugs.

5.72 Allocating funding in a way that prioritises law enforcement strategies above demand and harm reduction policies runs the risk of undermining the success of Australia's NDS. Therefore, the committee is of the view that the Commonwealth, state and territory governments must continue to re-balance funding across all three pillars of the NDS. The AIHW's household survey indicates a high level of public support for such an approach.

Recommendation 13

5.73 The committee recommends that the Commonwealth, state and territory governments re-balance alcohol and other drug funding across the three pillars of the National Drug Strategy (supply, demand and harm reduction strategies).

5.74 In addition to Commonwealth, state and territory governments re-balancing alcohol and other drug funding across the three pillars of the NDS, the committee recommends that the Commonwealth government refers to the Productivity Commission an inquiry into the costs and benefits of the National Drug Strategy as it is currently implemented.

Recommendation 14

5.75 The committee recommends that the Commonwealth government refers to the Productivity Commission an inquiry into the costs and benefits of the National Drug Strategy as it is currently implemented.

Confiscated Assets Account

5.76 A common concern expressed to the committee during the course of the inquiry was insufficient funding available for AOD treatment services.[90] To alleviate this financial pressure, and to provide an additional revenue stream for AOD treatment services, this section considers the use of the CAA to fund treatment services. The section below outlines the provision under the PoC Act to fund measures relating to treatment of drug addiction and diversionary measures, followed by listing the initiatives that have received PoC funding.

5.77 The PoC Act establishes a mechanism for confiscated assets to be re-invested in the community. Under section 298 of the PoC Act there is a provision for the Minister of Justice to 'approve a program for the expenditure of money standing to the credit of the [CAA]' for the following purposes:

- crime prevention measures;
- law enforcement measures;
- measures relating to treatment of drug addiction; and
- diversionary measures relating to illegal use of drugs.[91]

5.78 Despite the Act permitting the distribution of CAA funds for drug treatment and diversionary measures, it appears that a larger percentage of funds are directed to crime prevention and law enforcement measures. On 22 March 2017, the Australian National Audit Office (ANAO) released a report on PoC, which included consideration of how funds from the CAA are used. According to the ANAO, CAA funding has been provided to 'Commonwealth and state government entities, non-government organisations, community groups and local councils'.[92] Stand-alone project, grant programs, or the expansion or continuation of existing activities have received funding through the PoC's CAA.[93]

5.79 Between 2010–11 and 2015–16, the Minister for Justice approved $161 million in funding under section 298 of the PoC Act. The ANAO's analysis of this funding shows that law enforcement entities are the primary beneficiaries. The allocation of CAA funds, between 2010–11 and 2015–16 consisted of:

- $86.7 million directed to Commonwealth criminal intelligence and law enforcement entities ($51.3 million to the Australian Federal Police (AFP) and $28.9 million to the Australian Crime Commission (ACC)). The ANAO

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90 See paragraphs 5.16–5.19, 5.29 and 5.69.

91 *Proceeds of Crime Act 2002*, s. 298.

92 Australian National Audit Office (ANAO), *Proceeds of Crime,* 22 March 2017, https://www.anao.gov.au/work/performance-audit/proceeds-of-crime (accessed 22 December 2017).

93 ANAO, *Proceeds of Crime*, 22 March 2017.

noted that '[o]f the funding going to the AFP and the [ACC], $30.0 million wholly or partly supports these entities' proceeds of crime operations';[94]

- $21.6 million to NSW, Victoria and Queensland to support various Commonwealth–State taskforces dedicated to waterfront crime; and
- $52.7 million allocated to non-government or community organisations, as well as local councils. The bulk of this money ($37.4 million) was dedicated to funding the Safer Streets program. Table 6 shows a breakdown of this funding.[95]

94 ANAO, *Proceeds of Crime*, 22 March 2017.

95 ANAO, *Proceeds of Crime*, 22 March 2017.

***Table 6: Funding to non-government and community organisations and local councils, 2010–11 to 2015–16*[96]**

Recipient	Project(s)	Total funding ($ million)
Various local councils and non-government and community organisations (including Neighbourhood Watch Australasia and Youth off the Streets	Enhancing security and safety of community through improved environmental design; closed circuit TV monitoring; security infrastructure; lighting and early intervention and crime prevention activities (Safer Streets programme)	37.4
Youth Off the streets	Early intervention outreach activities (National Crime Prevention Fund)	5.0
Various local councils and non-government and community organisations	Graffiti Prevention	3.0
Police-citizens youth clubs/Blue Light organisations	Early intervention outreach activities	1.9
Anti-slavery Project; Australian Catholic Religious Against Trafficking Human; Project Respect and Scarlet Alliance	Various anti-people trafficking activities	1.6
Neighbourhood Watch Australasia	Establish national office and undertake various activities with police and communities	1.5
Various non-government and community organisations	Improve security and domestic violence crisis accommodation facilities	1.0
Crime Stoppers	Dob-in-a-dealer	1.0
Firearm Safety Foundation Victoria	Improve firearm safety	0.3

5.80 The Attorney-General's Department released a *Proceeds of Crime Act 2002 Funded Projects* report on 2 March 2015.[97] This report detailed the names, amount

96 ANAO, *Proceeds of Crime*, 22 March 2017.

97 Attorney-General's Department (AGD), *Proceeds of Crime Act 2002 Funded Projects*, March 2015, https://www.ag.gov.au/CrimeAndCorruption/CrimePrevention/Documents/POCA%20Funded%20Projects.pdf (accessed 11 January 2018).

provided and project description of projects funded under the PoC Act. Under community programs (completed projects), the report listed a number of projects related to drug treatment programs, such as:

- drug treatment programs in correctional facilities;
- Indigenous drug treatment programs;
- youth focused AOD programs;
- culturally and linguistically diverse AOD programs; and
- residential AOD treatment services.[98]

5.81 No AOD treatment program was listed as an active project in this report. Active projects included:

- Safer Street Programme (Round One);
- Graffiti Prevention Reduction and/or Removal Funding 2012;
- Police and Youth funding 2011;
- National Crime Prevention Fund 2013;
- Neighbourhood Watch Australasia; and
- People trafficking/Labour exploitation projects.[99]

Committee comment

5.82 The need for greater funding for AOD treatment services was a key theme communicated to the committee during the course of its inquiry. As discussed earlier in this chapter and in chapter 2, despite substantial investments by the federal, state and territory governments, high demand and long waiting lists for accessing AOD treatment services remain.

5.83 The drug policy expenditure analysis conducted by the NDARC shows that AOD expenditure is heavily weighted towards law enforcement measures (64.1 per cent in total), whilst preventative (9.7 per cent), treatment (22.5 per cent) and harm reduction measures (2.2 per cent) are allocated far less.

5.84 It appears that the allocation of funds from the CAA reflects a similar prioritisation of law enforcement measures over treatment initiatives. This prioritisation has occurred despite section 298 of the PoC Act permitting CAA funds to be allocated to drug treatment and diversionary measures.

5.85 The committee understands the complex environment in which law enforcement agencies operate, and that law enforcement activities require significant resources. The committee does not question the effectiveness of law enforcement activities funded under the CAA. However, the committee suggests that serious

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98 AGD, *Proceeds of Crime Act 2002 Funded Projects*, March 2015, pp 17–51.

99 AGD, *Proceeds of Crime Act 2002 Funded Projects*, March 2015, p. 2.

consideration is given to the benefits that could be achieved by allocating CAA funding to drug prevention and treatment services.

5.86 For this reason, the committee recommends that the Commonwealth government, under section 298 of the PoC Act, ensures CAA funds are allocated to crime prevention, law enforcement, drug treatment and diversionary measures more equitably. The committee also calls for state and territory governments to examine their PoC legislation so that funding is equitably allocated to law enforcement and AOD treatment measures.

Recommendation 15

5.87 The committee recommends that the Commonwealth government, under section 298 of the *Proceeds of Crime Act 2002*, ensures Confiscated Assets Account funds are equitably allocated to crime prevention, law enforcement, drug treatment and diversionary measures.