



Alcohol and other drug treatment policy in Australia

We need more resources that are better spent

Alcohol and other drug (AOD) treatment policy is at a significant point of transition in Australia. The media is replete with examples of people unable to access appropriate AOD treatment — whether it be for detoxification, residential rehabilitation, pharmacotherapy or counselling. Anecdotal reports are backed by evidence of high unmet need and demand for treatment. Fewer than half of those seeking AOD treatment in Australia are currently able to access appropriate treatment.¹ This is an appalling situation, but not much different than in most developed countries,² and all the more concerning because we know treatment works and it reduces the substantial social costs of harmful AOD consumption.³

Good AOD public policy involves a balance between reducing the supply of drugs (through regulation and law enforcement), reducing the demand for drugs (through prevention and treatment) and reducing the harmful consequences of use (through harm reduction interventions). Australian governments currently spend most on law enforcement.⁴ Yet research shows that law enforcement responses, notably those related to incarceration, are far less cost-effective than treatment.⁵ Governments need to shift investment away from law enforcement and into treatment, including the resourcing of effective referral and treatment pathways for people who come into contact with the criminal justice systems.

Despite a clear need, finding more funding for AOD treatment and effectively allocating it may be harder than anticipated. There is a complicated array of funding arrangements for AOD treatment in Australia.⁶ State and territory governments fund most specialist AOD treatment. The federal government funds primary health care and pharmaceuticals (via Medicare and the Pharmaceutical Benefits Scheme) and also contributes a significant share of specialist AOD treatment funding.⁷ However, there is little planning and coordination between levels of government in Australia.¹ The National Drug Strategy 2010–2015⁸ is silent on the division of responsibilities between state and federal governments for AOD policy and practice, which compounds the problem federalism presents for coordinating effective AOD treatment services. It is therefore difficult to hold any one level of government to account. A doubling of current resources would be required to address unmet treatment need, and this will inevitably lead to arguments about who is responsible for this funding and where new funds should be allocated.

Policymakers at both state and federal levels currently operate in a vacuum; there is no Australia-specific research evidence they can bring to bear on decision-making for how to organise and fund AOD treatment. Jurisdictions have developed autonomous and

independent treatment service systems. For example, the predominant purchasing mechanism in New South Wales involves block grants, but it is a variant of activity-based funding in Victoria.¹ In Western Australia, 88% of AOD treatment episodes are provided by non-government organisations, whereas in NSW this figure is 26%.⁹ While increased resourcing is the primary priority, concurrent comparative analysis of the impact and cost-effectiveness of AOD treatment funding systems, including purchasing models and provider types, would inform refinements to AOD treatment services in Australia.

Despite the absence of such research, Australian governments must increase their investment in AOD treatment. In this context, it was pleasing to see the federal government apportioning the lion's share of funds allocated in response to the work of the National Ice Taskforce to new AOD treatment resources.¹⁰ This significant investment (\$241.5 million and an additional \$13 million for new Medicare Benefits Schedule items for addiction medicine specialists) has the potential to reduce some of the unmet demand for AOD treatment. The way in which those resources are distributed will be critical to their success. In particular, we need to understand how funds will be distributed between primary health care and specialist AOD treatment. The greatest need is in specialist treatment services, although there is a risk that new funds will be targeted at primary health care. This would be a wasted opportunity.

For the first time in Australia, we know the extent of unmet AOD treatment need and demand. We also have a good understanding of the complicated funding flows in this area. While more resources for AOD treatment are needed, responses should also include appropriate resourcing of broader social support services. Although local data on the prospective drivers of sustained drug use are scarce, overseas evidence¹¹ and reflections from Australian service providers suggest that social stability factors — such as employment, positive family relationships and stable housing — are crucial determinants of drug use patterns. Alongside AOD treatment, effective responses must appropriately resource integrated services that support people to achieve their AOD treatment goals.

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