4

Health care

Introduction

4.1 Addiction is now recognised as a chronic, relapsing disease. People who are dependent on drugs make demands on the health care system when they seek help to manage or kick their habit. When they become physically or psychologically ill as a result of their substance abuse, they also need medical care. The burden that they place on the health care system, as reflected in the numbers of drug-related deaths and hospitalisations, is considerable.

4.2 According to Collins and Lapsley, 19,429 Australian deaths in 1998-99 were attributable to tobacco smoking. As explained below in paragraphs 4.5 and 4.6, alcohol abuse both causes and averts deaths, so that overall in 1998-99, 2,744 net deaths were averted. Hospital beddays attributable to tobacco amounted to 965,433, while those attributable to alcohol were 138,974 net.[1] Smokers also spend longer in hospital than non-smokers.[2]

4.3 Collins and Lapsley did not provide data on deaths and hospital use due to illicit drug users. However, using a data set relating to 1998, the Australian Institute of Health and Welfare estimated that 1,023 deaths were attributable to illicit drugs, and in 1997-98 illicit drugs were responsible for 14,471 hospital episodes.[3]

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1 Collins DJ & Lapsley HM, *Counting the cost: Estimates of the social costs of drug abuse in Australia in 1998-9*, Monograph series no 49, Commonwealth Department of Health and Ageing, Canberra, 2002, pp 9, 11

2 English DR, Vu TVH & Knuiman MW, quoted by Collins DJ & Lapsley HM, p 30.

3 Australian Institute of Health and Welfare, *Statistics on drug use in Australia 2002*, Drug statistics series no 12, AIHW, Canberra, February 2003, pp 35, 36.

4.4 Substance abuse also influences the health and welfare of others in the community besides the abuser. For example, Donoghoe and Wodak reported that HIV spreads rapidly among injecting drug users and can be passed on through sexual contact to others.[4] According to the Australian National Council on AIDS, Hepatitis C and Related Diseases, an estimated 91 per cent of newly acquired hepatitis C cases in 2001 were related to injecting drug use.[5] Alcohol-related violence may cause harm and stress to an abuser's family, friends and colleagues, as may smoking tobacco. It is sometimes forgotten that drug use impacts on the unborn child as well as others. In fact, as Collins and Lapsley pointed out in relation to tobacco smoking, 'It has been demonstrated by Ricardo and Stevenson (2001) that, on current medical evidence, the overwhelming proportion of the morbidity attributable to involuntary smoking, as well as a high proportion of involuntary smoking mortality, is borne by the young'.[6]

4.5 Collins and Lapsley estimated that the health care costs of drug abuse in 1998-99 were $1,379.0 million. Of this sum 16.3 per cent was attributable to alcohol ($225.0 million) and 4.3 per cent to illicit drugs ($59.2 million). A much higher proportion (79.4 per cent or $1,094.9 million) is attributable to tobacco.

> … This is in spite of the fact that tobacco, because it produces a much higher level of premature mortality than the other drugs, produces substantial [health care] savings from these premature deaths …[7]

4.6 Although the proportion of people using alcohol greatly exceeds that of other drug users, it needs to be remembered, as Collins and Lapsley pointed out, that for some medical conditions alcohol consumption at moderate levels can have a protective effect, that is, it can reduce the risk of illness and death.[8] The National Health and Medical Research Council summarised the evidence for this effect when issuing the Australian Alcohol Guidelines in 2001.

> There is strong evidence that drinking alcohol reduces the risk of heart disease in people from middle age onwards. This protection

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4 Donoghoe MC & Wodak A, 'Health and social consequences of injecting drug use', in Stimson G, Des Jarlais, DC & Ball A, (eds) *Drug injecting and HIV infection*, World Health Organization, UCL Press, London, 1998, p 44.

5 Australian National Council on AIDS, Hepatitis C and Related Diseases, Hepatitis C Sub-committee, *Hepatitis C Virus Projections Working Group: Estimates and projections of the hepatitis C virus epidemic in Australia 2002*, National Centre in HIV Epidemiology and Clinical Research, August 2002, p 1, viewed 21/3/03, <http://www.ancahrd.org/pubs/pdfs/epidemic_02.pdf>.

6 Ricardo & Stevenson, quoted by Collins DJ & Lapsley HM, p 23.

7 Collins DJ & Lapsley HM, p 49.

8 Collins DJ & Lapsley HM, p 7.

> is achieved by drinking relatively small amounts of alcohol, with no additional benefit from drinking larger amounts. The benefit is largely attributable to alcohol *per se*, with other constituents of particular beverage types having little or no additional value. Protection is most closely associated with a consistent pattern of drinking small amounts of alcohol. More variable drinking patterns, especially involving large amounts of alcohol, may actually increase the risk of illness and death from heart disease.[9]

4.7 Collins and Lapsley estimated that, in 1998-99, alcohol caused 4,286 deaths but prevented over 7,029; alcohol-related disease consumed 394,417 hospital beddays but alcohol's protective effect avoided the need for 255,443 beddays. By contrast, few lives or beddays were saved by tobacco consumption.[10]

Role of government

4.8 As indicated in Chapter 2, the Commonwealth government provides national leadership in relation to the National Drug Strategy (NDS), as well as undertaking its own policies and programs. Action plans, agreed with state and territory governments, have been finalised for illicit drugs, alcohol and tobacco. These plans address both prevention and treatment and receive funding from Commonwealth, state and territory governments.

4.9 Commonwealth funding for prevention activities is directed to campaigns and services to provide information about drug use and to dissuade people from using drugs or, if they do, to use them in the least harmful way possible. For example, as detailed in Chapter 3, illicit drugs are targeted, by the National Illicit Drug Strategy (NIDS) through such initiatives as:

- the Community Partnerships Initiative to encourage community action to prevent illicit drug use;
- a national drug information service;
- the National Schools Drug Education Strategy and associated measures to manage drug-related incidents in schools; and

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9 National Health and Medical Research Council, *Australian alcohol guidelines: Health risks and benefits*, NHMRC, Canberra, October 2001, p 69, viewed 6/3/03, <http://www.health.gov.au/nhmrc/publications/pdf/ds9.pdf>.

10 Collins DJ & Lapsley HM, pp 9, 11.

- the National Illicit Drugs Campaign.[11]

4.10 The Commonwealth government does not directly provide treatment services but facilitates access to such services. In the case of treatment and rehabilitation of illicit drug users, for example, NIDS funds:

- the expansion and upgrading of non-government treatment services;
- the identification, evaluation, promotion and dissemination of best practice in the treatment of illicit drug dependence;
- the training of front line workers;
- the evaluation of alternative treatment modalities for illicit drug use and innovating with respect to prevention and treatment; and
- developing and introducing retractable needle and syringe technology.[12]

4.11 As part of the National Drug Diversion Initiative, by which illicit drug users are diverted from the criminal justice system into education and treatment, the Commonwealth government has funded assessment services and additional treatment places since 1999. This initiative has been supported by programs:

- to increase the number of pharmacies and other outlets distributing needles and syringes;
- to develop and disseminate cannabis cessation strategies; and
- to research the barriers and incentives to illicit drug users accessing and remaining in treatment.[13]

At the end of 2002 the Prime Minister announced continued funding for the National Drug Diversion Initiative for a further four years.[14]

4.12 The former Commonwealth Department of Health and Aged Care advised that treatment is also provided for people dependent on drugs by generalist health services, including general practitioners and hospital services. Commonwealth funding for these interventions is provided under Medicare, mainly in the form of:

- subsidies for prescribed medicines and private medical expenses;

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11 Commonwealth Department of Health and Aged Care, sub 145, p 87.

12 Commonwealth Department of Health and Aged Care, sub 145, pp 87-88; Commonwealth Department of Health and Ageing, sub 238, p 27.

13 Commonwealth Department of Health and Aged Care, sub 145, p 88.

14 Hon John Howard MP, Prime Minister, *Illicit Drug Diversion Initiative*, media release, 31/12/02, p 1.

- substantial grants to state and territory governments to contribute to the costs of providing access to public hospitals, at no cost to patients, and other health services; and
- specific purpose grants to State / Territory governments and other bodies.[15]

4.13 In addition, some medicines used to treat dependence are available under the Pharmaceutical Benefits Scheme. They are either subsidised, like acamprosate and naltrexone for alcohol addiction or, as for methadone, the cost is fully met by the scheme.[16]

4.14 Alcohol and tobacco dependencies are also targeted by the Commonwealth government with support for training of workers and promotion of best practice in relation to training, management, control, treatment and legislation.[17]

4.15 Research into issues raised by substance abuse is carried out at three national research centres that have been established to work on:

- the prevention of substance abuse: the National Drug Research Institute;
- treatment and rehabilitation: the National Drug and Alcohol Research Centre; and
- the education of professionals and non-professionals working with drug and alcohol addiction: the National Centre for Education and Training in Addiction (NCETA).[18]

Research is also carried out elsewhere, including with funds provided to the National Health and Medical Research Council and the Alcohol Education and Rehabilitation Foundation.[19]

4.16 The role of state and territory governments is to deliver services within the framework of the national strategy in such a way as best suits local health needs. The former Commonwealth Department of Health and Aged Care listed the following as activities undertaken by state and territory governments:

- provision of health care to drug addicts through the public sector health services and / or fund community-based organisations to provide drug prevention and treatment programs;

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15 Commonwealth Department of Health and Aged Care, sub 145, p 117.

16 Commonwealth Department of Health and Aged Care, sub 145, pp 115.

17 Commonwealth Department of Health and Aged Care, sub 145, pp 119-120.

18 Commonwealth Department of Health and Aged Care, sub 145, p 82.

19 Commonwealth Department of Health and Aged Care, sub 145, p 122-123; Commonwealth Department of Health and Ageing, sub 238, pp 23-24.

- regulation and administration of the delivery of methadone services and needle and syringe programs; and
- the development of effective and comprehensive professional education and training, research and evaluation strategies, in close cooperation with other jurisdictions so as to achieve consistency.[20]

Non-government organisations

4.17 The former committee noted that NGOs contribute substantially to the welfare of substance users and abusers, both through the provision of services and as lobby groups advocating change to government policies. Many of these organisations receive funding from state and territory governments or the Commonwealth government, or both.[21]

4.18 Non-government service providers run a range of mostly non-medical, residential and non-residential treatment services that are widely used by those who have already undergone detoxification in a hospital. The programs run by NGOs offer outreach services, counselling, and community education and referral, and vary in the approaches they take with respect to the treatment modalities they employ. As the former committee remarked, 'it is clear that governments rely very much on the dedication of this sector'.[22]

4.19 Among the larger lobby groups for drug-related issues is the Alcohol and other Drugs Council of Australia (ADCA), the peak body for the alcohol and other drugs sector in Australia. It develops, in consultation with its broad membership base and through a number of expert reference groups, comprehensive policy positions which it then advocates to governments, businesses and communities.[23] Another organisation through which the voice of NGOs is conveyed to government is the Australian National Council on Drugs (ANCD). The council is the peak advisory body to government on drug policy and programs.[24] Input to the drug debate is also provided by public health associations such as the Australian Medical Association (AMA) and the Public Health Association of Australia.

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20 Commonwealth Department of Health and Aged Care, sub 145, p 90.

21 House of Representatives Standing Committee on Family and Community Affairs, *Where to next? - A discussion paper: Inquiry into substance abuse in Australian communities*, FCA, Canberra, September 2001, p 42.

22 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 42.

23 Alcohol and other Drugs Council of Australia, sub 61, p 3.

24 Australian National Council on Drugs, sub 47, p 1.

Issues in providing health care

4.20 In its discussion paper, the former committee identified a number of key issues that require attention in relation to providing care for drug dependents. Many of the same points were also raised during the inquiry with the current committee.

Service delivery

Access to treatment

4.21 On the basis of a national stocktake of treatment facilities which it undertook, the former committee concluded that:

> Governments appear to be working hard to ensure that suitable treatment services are available to assist drug dependent people wanting to address their drug dependence problems. Despite this, the Committee heard from many sources that treatment services simply are not as available as they need to be to facilitate rehabilitation from drug abuse …
>
> …
>
> Detoxification from alcohol and other drugs is a pre-requisite for gaining entry into most treatment facilities, but there are few detoxification beds available, and hospitals appear to be pulling back from providing this relatively costly service. A lengthy waiting period may be involved before access is obtained, and then after a medically-supported withdrawal there might be another wait before access to a suitable, nearby rehabilitation facility is secured. These waiting periods are risky, and many opportunities for recovery are wasted as drug users drift back into their old, familiar, drug-using environments.[25]

4.22 The current committee was told that these problems still exist. Dr Wodak claimed that the mismatch between the demand for detoxification and the supply of places continues across the country.[26] Furthermore, according to Professor Webster:

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25 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, pp 51-2.

26 Wodak A, transcript, 16/8/02, p 1251.

> … if you went to most public hospitals, you would find virtually no drug and alcohol unit or not much of a drug and alcohol unit—if there is one, it might be a shed round the back …[27]

4.23 Participants at the committee's roundtable commented on the rehabilitation services available. Professor Webster pointed out that long-term, residential places give addicts the opportunity to 'learn to become a different person …'[28] Such places, according to Professor Mattick, are proven to give quite good outcomes.[29]

4.24 Professor Mattick pointed out that residential treatment does not appeal to everyone and is difficult for those undergoing treatment to incorporate with work and other responsibilities.[30] Mr Trimingham claimed that:

> … there is a need in Australia for day treatment: multidimensional services that take people wherever they are on the spectrum of need—and that includes families. This type of service would have assessment, pharmacotherapies, detox, rehab, counselling, dual diagnosis, impact on housing, child care, employment preparation, leisure, life skills—the lot, including clean needles. Moving people back to their own family on a daily basis, rather than taking up expensive residential beds, would be very cost effective. This system is widely used overseas, particularly in the United Kingdom …[31]

4.25 ADCA advised, however, that there was evidence of some improvement in the availability of treatment. The 2001 census of clients of treatment service agencies indicated an increased treated prevalence of alcohol and other drug problems among people over 15 years of age. The prevalence had increased from between 2.5 and 3.6 per 1,000 people in 1995 to between 3.4 and 4.6 per 1,000 in 2001. During the last 10 years the proportion of those in treatment who received that treatment in residential facilities has fallen as the proportion of outpatient interventions has grown.[32]

Conclusion

4.26 The committee:

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27 Webster I, transcript, 15/8/02, p 1113.

28 Webster I, transcript, 15/8/02, p 1127.

29 Mattick R, transcript, 15/8/02, p 1106.

30 Mattick R, transcript, 15/8/02, pp 1105-1106.

31 Trimingham, T, transcript, 15/8/02, pp 1146-1147.

32 Torres et al (1995) and Shand and Mattick (2001) quoted by the Alcohol and other Drugs Council of Australia, informal communication, 11/4/03.

- was concerned to learn of the continuing shortage of services that provide detoxification and / or rehabilitation;
- views that it is vital that places are available to assist those who need and want them. It is also important that treatment is provided in a variety of settings so that it is as readily available as possible to patients and can accommodate involvement of families in the treatment process;
- believes attention must also be given to ensuring an appropriate balance of residential and non-residential care; and
- recognises that Australia cannot expect to reduce the harm caused by addictions if the requisite health services are not there.

Recommendation 19

4.27 **The committee recommends that the Commonwealth, State and Territory governments must work together to substantially increase the number of places and access to detoxification, including rapid detoxification, and rehabilitation services that are critical to the successful transition from abuse to non-use.**

Recommendation 20

4.28 **The committee recommends that the Commonwealth, State and Territory governments, in order to achieve a substantial reduction in substance abuse, consult with non-government organisations to ensure that alcohol and other drug services offer a range of approaches to treatment and rehabilitation.**

Governments should consult with non-government organisations to ensure they are mindful of the need for an appropriate mix of residential and non-residential services, making provision for family involvement if desired.

4.29 In its discussion of factors that affect the accessibility of services to drug-dependent people, the former committee also highlighted three other issues:

- the particular disadvantage suffered by certain groups of Australians:

> … Access to drug treatment services … appears to be worse for people suffering from mental health as well as drug problems,

Indigenous Australians, young people, and people living in rural and remote parts of Australia[33];

- the difficulty of providing services in the face of community opposition to siting them where addicts can most easily travel to them: the former committee commented on the 'NIMBY' (Not In My Back Yard) factor[34]; and
- the cost of treatment for some drug users.

4.30 An example of this last point is provided by former heroin users who are on methadone maintenance programs. The former committee noted that, while some of these former users obtain their methadone free of charge through public programs, those who access it from pharmacies are required to pay. The former committee concluded that 'Other forms of treatment such as naltrexone programs [for heroin and methadone addicts] and rehabilitation clinics can cost thousands of dollars, an insurmountable obstacle for prospective clients without well-heeled connections'.[35]

4.31 The committee discusses this last matter further in Chapter 7 and the needs of disadvantaged groups later in this chapter. The difficulty posed by community attitudes to drug-dependent people is dealt with in Chapter 3.

Funding

4.32 The former committee pointed out in its discussion paper that, despite increased expenditure in recent years, adequacy of funding for drug-related health services remained an issue throughout Australia. The current committee was also told of underfunded services, for example, by Dr Wodak.[36] This is true not only of public institutions but of the non-government sector too. Professor Roche stated that 'Charitable organisations and the non-government sector, which Australia relies on tremendously for the provision of services and support in these areas, are traditionally underfunded'.[37]

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33 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 51. Prisoners are another relatively disadvantaged group as far as access to treatment is concerned, as discussed in Chapter 7.

34 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, pp 60-61.

35 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 52.

36 Wodak A, transcript, 16/8/02, pp 1246, 1254.

37 Roche A, transcript, 15/8/02, p 1116.

4.33 Funding inadequacies are reflected in lengthy waits and waiting lists for treatment, and pressure on resources can also affect the quality of service delivery. As the former committee reported, 'agencies feel they cannot afford, for example, to hire extra staff, diversify program offerings, evaluate services, or send staff off for training to upgrade their skills'.[38] Furthermore, as Professor Roche pointed out, under-resourced services employ the staff they can afford and often these are not the most well-qualified.[39]

4.34 Another area where the impact of inadequate funding on quality of treatment was very apparent to both the former and current committees was the way in which methadone treatment for heroin addiction is often managed. Both committees gained the impression that, once stabilised on methadone, some patients 'may not be getting the sort of help they need' in terms of counselling and education.[40] They appear to have been 'parked' in a situation without other options when, in fact, they would like or benefit from assistance to leave both heroin and methadone completely behind them. This issue is discussed further in Chapter 7.

Conclusion

4.35 The committee:

- believes that additional funds must be made available for alcohol and other drug treatment services. This may be achieved through the reallocation of existing resources;
- is convinced that only with adequate funding can enough facilities with the most qualified staff be secured to meet the treatment needs of drug-dependent people; and
- believes that increased funding is needed for ongoing medical, psychological and community support.

4.36 Later in this chapter, the committee identifies four groups of Australians whose particular needs are not always well-met by existing services: young people, Indigenous Australians, those living in remote and regional areas, and people who abuse substances and suffer mental ill-health. In the committee's view, support services for these groups require special attention, particularly those who are substance abusers and mentally ill.

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38 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 53.

39 Roche A, transcript, 15/8/02, p 1116.

40 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, pp 53-54.

Recommendation 21

4.37 **The committee recommends that the Commonwealth government, in consultation with State and Territory governments:**

- **provide additional funding for alcohol and other drug treatment so that the shortfall in services is eliminated and adequate numbers of appropriately qualified staff are employed to work in these services, with the ultimate objective being to obtain a drug free status for the client; and**
- **pay particular attention to the needs of people who abuse substances and suffer mental ill-health, including those in prison.**

Recommendation 22

4.38 **The committee recommends that the Commonwealth, State and Territory governments give priority to funding the ongoing medical, psychological and community support systems required for those users who have undertaken detoxification in order to provide the optimal chance of successful transition to an alcohol or a drug free state.**

4.39 The quality of treatment that non-government service providers are able to provide is impacted on by the insecurity of their funding over the long term. At intervals they must apply for further funding which is a very time-consuming process. The former committee reported:

> … Many NGOs complained of onerous grant application processes and the frustration of getting up good programs only to have these de-funded several years later. The National Aboriginal Community Controlled Health Organisation … argued that these processes appear to reward the quality of grant applications, rather than the relative merit of proposals. Some witnesses acknowledged that the competitive nature of submission-driven funding processes was divisive and meant that the NGO sector was not working as cohesively as it might.[41]

41 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 54.

Some of these same points were made to the current committee, for example by DrugBeat of South Australia.[42]

4.40 The Commonwealth government has introduced greater continuity into the funding of these NGOs and of the more than $65 million allocated to the NGO Treatment Grants Program in 2002-03, more than $46 million will be allocated to currently funded organisations, the balance being set aside for new treatment services that will fill gaps in service provision.[43]

4.41 The committee welcomes this initiative to provide greater security to NGOs which are demonstrating effective programs targeted at eventual cessation of substance abuse, rather than mere maintenance programs such as methadone parking.

Workforce recruitment and development

4.42 According to Professor Roche, there is a shortage of skilled workers in the alcohol and drug field. Many of the approximately 8,000 staff who work in about 550 specialist treatment services round Australia have minimum qualifications. In this respect:

> We know Australia lags very much behind North America – Canada and the United States. You are not required to have any kind of formal qualifications to work in this area; there is no formal accreditation system as there is for, say, counsellors in the addictions area in the United States … We have invested relatively little in providing training at the undergraduate and postgraduate level. Although Australia has made great strides forward in the last decade, we still lag substantially behind in the provision of professional training and upskilling in this area …[44]

4.43 The committee was told about steps that should be taken to improve the workforce.

- Professor Roche and Outcare suggested a better accreditation system.[45]
- Turning Point Alcohol and Drug Centre recommended 'proper career structures'.[46]

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42 DrugBeat of South Australia, sub 271, p 11.

43 Hon Trish Worth MP, Parliamentary Secretary to the Minister for Health and Ageing, *Allocation of funding under the Non-Government Organisation Treatment Grants Program*, media release, 1/12/02, p 1.

44 Roche A, transcript, 15/8/02, p 1117.

45 Outcare, sub 139, p 4; Roche A, transcript, 15/8/02, p 1117.

46 Turning Point Alcohol and Drug Centre, transcript, 23/11/00, p 502.

- The Catholic Women's League, NCETA and Professor Roche pointed out the need for more and better training that has been shown to be effective.[47]
- Professor Roche called for the provision of training on a nationally coordinated basis. At present each jurisdiction develops its own university and TAFE courses. To improve the training provided we need a better idea of what treatment services exist and what skills they require.[48]

4.44 Professor Roche also suggested that we require a means of transferring new knowledge to existing workers in the field. With the explosion of knowledge:

> … there is a major difficulty in how you translate that knowledge base into practice; how you get it into the hands and the minds of the clinicians and the other required workers in the area ... That translation of research into practice is a major dilemma for us.[49]

In addition, as Professor Roche pointed out, the drug scene is changing very rapidly and services need to change quickly to meet new demands. The increase in polydrug use and the uptake of drug use by ever younger people are two of the areas where new skills and ways of addressing problems are needed.[50]

4.45 Professor Roche pointed out that much is now known about the most effective mix of methods of transferring new knowledge to the workers who need it. Training and education are useful here, but should not stand alone. They should be supplemented by information tools such as internet-based clearing houses and journals that organise, synthesis and critique new information. Supportive workplace structures and policies are also important in encouraging the adoption of new approaches and practices.[51]

4.46 At present, according to Professor Roche, 'we have very little information about our [alcohol and other drugs] services … we know very little about who provides the services that are out there …' Professor Roche reported that NCETA is collecting information on the workforce of specialist alcohol and drug services, the skills requirements of these services and the

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47 Catholic Women's League, sub 75, p 26; National Centre for Education and Training, sub 208, pp 6-7; Roche A, transcript, 15/8/02, p 1117.

48 Roche A, transcript, 15/8/02, p 1117.

49 Roche A, transcript, 15/8/02, p 1117.

50 Roche A, transcript, 15/8/02, pp 1116-1118.

51 National Centre for Education and Training, sub 208, pp 5, 12, 20.

training needed to provide the requisite skills. Such information is needed to underpin systematic planning for workforce development.[52]

4.47 Professor Webster claimed that work in the alcohol and drugs arena is 'of poor status, poorly regarded and not … an area that professional people really want to work in'.[53] According to Professor Roche, the stigma attached to drug users extends to those who treat them.[54] These perceptions of work in the alcohol and drug field are one of the factors that contribute to the shortage of skilled workers in the field.

Conclusion

4.48 The committee agrees that:

- more attention needs to be given to developing the skills of Australia's alcohol and other drug workers through a variety of approaches that have been shown to be effective;
- there is a need to match the skills training provided to the requirements of the jobs in which workers are employed; and
- senior professionals have a responsibility to pass on their expertise with service training and acquaint themselves with the current standards and training of alcohol and other drug services which report to them.

Recommendation 23

4.49 **The committee recommends that the Commonwealth, State and Territory governments work with the alcohol and drugs sector, to improve the training available to workers in that sector by:**

- **supporting the development of a nationally agreed curriculum and accreditation system;**
- **providing adequate training opportunities to supply sufficient qualified staff, including ongoing access to new information and the implications of this new information for practice;**
- **sponsoring work on best practice in educating and training alcohol and drug workers; and**
- **encouraging senior professionals to inform themselves of the**

52 Roche A, transcript, 15/8/02, p 1117; Roche A, informal communication, 22/1/03.

53 Webster I, transcript, 15/8/02, p 1113.

54 Roche A, transcript, 15/8/02, p 1116.

needs of other drug and alcohol service providers and fully participate in that education and training.

Integration and coordination

Integration and coordination in the health care system

4.50 Links between different parts of the health care system are often needed to treat the complex problems that alcohol and drug addiction present. NCETA claimed that these complex problems need comprehensive, multi-sectoral responses.[55] Yet the previous committee reported hearing 'much about the "siloed" structure of government services and … lack of coordination …'[56]

4.51 The current committee learnt that there is often a failure to link the different phases of treatment that are needed to help addicts to manage their substance abuse and recover from it. Professor Mattick commented that 'Detox tends to be a bit stand alone … A better linkage would certainly be a very sensible thing, and that does not happen particularly well at the moment'.[57] After detoxification, drug-dependent patients must be supported by ongoing medical help as well as an enormous amount of psychological help, and this is often missing. Dr Currie from Westmead Hospital, Dr O'Neil in Perth and Mr Colquhoun of R&D Counselling and Therapy Group told the committee informally about the superior outcomes obtained in treating opioid dependent people using extensive counselling and family support.

4.52 In addition, as recovering addicts develop or re-establish the skills for living a more mainstream lifestyle, they often need assistance with training, employment and housing. To provide this requires linkages between health agencies and other government services and these too are often missing.

4.53 The lack of integration and coordination is also reflected in the multiplicity of services. As the Aboriginal Alcohol and Drug Council (SA) pointed out, some of these services duplicate one another and waste resources that could be better used.[58] Some governments, such as those in New South Wales and Western Australia, have attempted to better integrate the delivery of services by establishing offices with

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55 National Centre for Education and Training in Addiction, sub 208, p 11.

56 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 56.

57 Mattick R, transcript, 15/8/02, p 1106.

58 Aboriginal Alcohol and Drug Council (SA), transcript, 21/11/00, p 319.

responsibilities for coordination.[59] Another problem where service silos disadvantage patients is in the treatment of those with coexisting substance abuse and mental ill health.

Conclusion

4.54 The committee is concerned about reports of duplicated and uncoordinated services. It believes that better coordination and integration of services is critical in delivering improved health and other outcomes for drug-dependent people and in stretching scarce resources further. The committee is encouraged to hear of steps being taken to improve coordination and urges all parties that provide services to extend these efforts.

4.55 The committee acknowledges that support services including rehabilitation and detoxification are provided to those afflicted by illicit drugs by all levels of government and many NGOs. As a result of this good intention, considerable duplication has occurred, meaning valuable resources are diverted into administration and away from service delivery. The committee believes that more focussed allocation of resources to specialist services would result in more tangible outcomes.

4.56 In the committee's view, it is also critically important to improve the links between services provided by different parts of the health care sector and to provide adequate support to recovering addicts, both psychological and practical. On hearing and viewing evidence of the benefits of linked programs that are inclusive of family support, treatment options and post-treatment support services, the committee advocates urgent action to ensure linked services are available that can empower users to make a successful transition to non-user status. The committee has already recommended increased funding for adequate support in Recommendation 22 above. If a patient cannot move smoothly through the process of treatment, with ongoing help including with housing, training and employment if this is needed, his chances of recovery are considerably lessened.

Recommendation 24

4.57 **The committee recommends that the Commonwealth, State and Territory governments, working with the non-government sector, give priority to coordinating and integrating the many professionals and**

59 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 57.

agencies that serve substance-dependence people.

Attention should be given to:

- **improved links between different parts of the health care sector and between the health care sector and social service agencies such as those dealing with housing, training and education; and**
- **the funding for medical, psychological and community support services as recommended in Recommendation 22.**

Integration and coordination in disciplines and research

4.58 NCETA commented that:

> Not only are our administrative and functional responses to AOD [Alcohol and Other Drugs] issues constrained by 'silo-like' structures, so too are the knowledge and scientific bases which underpin these responses also contained within silos – albeit, discipline silos. Hence, it is not only integration of services that is often sought but also a better integration of knowledge domains … a shared knowledge and skill base is more pertinent here than perhaps in many other areas. A comprehensive understanding of these phenomena requires high level integration and synthesis.[60]

4.59 A similar point was made to the committee by Professor Patton in relation to the development of policy and programs that target drug use by young people.

> We need to be doing our research differently, for a start. We have tended to start with developing policies within silos, with doing our research within silos … if we can begin to do our research and our development of program work differently, with common objectives and common goals, then we can move to some common policies around this. And, moving to common policies across departments, we will then be moving to a situation where we are able to develop the infrastructure we need for doing prevention well.[61]

Conclusion

4.60 In view of the points raised in the last two paragraphs, it is clear to the committee that the better integration of services recommended above

60 National Centre for Education and Training in Addiction, sub 208, p 11.

61 Patton G, transcript, 15/8/02, pp 1097-1098.

must also be supported by similar efforts in the training and research that underpin the health services. The committee therefore recommends accordingly.

Recommendation 25

4.61 **The committee recommends that the Commonwealth, State and Territory governments, working with assistance from the non-government sector, in the training and research that underpin the health services, also ensure the integration of:**

- **knowledge from different disciplines to better train drug and alcohol workers so they can deliver the best possible services; and**
- **research efforts which will advise the development of new, more integrated policies and programs.**

Needs of special groups

4.62 As indicated earlier in this chapter, there are a number of Australians who have particular needs that are not always well-met by existing services. Drug addicts who are also mentally ill need treatment for both disorders and many services are not adequately equipped to do this. The conventional approach to dealing with drug addicts also fails to meet the needs of young people, many Indigenous people, and some groups of non-English-speaking Australians. In remote and regional Australia, with its small population, it is impossible to provide the full panoply of services that is required to deal with the range of drug-related problems that arise, and other means of delivering these services must be found. The challenge is to provide equitable access to services for all these groups.

Coexisting substance abuse and mental illness (comorbidity)

4.63 ADCA reported that an estimated 20 per cent of people with mental disorders also engage in harmful drug use, and three-quarters of all clients to alcohol and other drug services are mentally ill. Yet there are, according to ADCA, too few adequately trained workers to cope with complex multi problem cases.[62] As Gomes et al pointed out, services set up originally to treat one or the other condition have tended to pay inadequate attention to

62 Alcohol and other Drugs Council of Australia, sub 221, pp 7-8.

the coexisting condition.[63] As discussed in Chapter 8, prisons are another area where there are shortfalls in the provision of services for people suffering from both conditions. While there is growing recognition of the extent to which substance abuse and mental disorder occur together, there is still scope for improvement in the services provided to those suffering from comorbidity.

4.64 The National Comorbidity Project, funded by the Commonwealth Department of Health and Ageing, is developing a comprehensive evidence base to better inform those working in the field. It comprises the following resources:

- a monograph that reviews national and international evidence about comorbidity, including treatment and service provision ;
- a updated monograph on diagnostic screening; and
- scoping studies of:
  - ⇒ comorbidity in general practice and primary health care (which recommended research to establish what interventions work and 'are practically possible in the swamp of clinical reality …'[64]); and
  - ⇒ specialist treatment services for comorbid patients which describe the different characteristics of treatment services and help to identify best practice.[65]

4.65 While welcoming the National Comorbidity Project, ADCA called for 'a more concerted, strategic and adequately funded approach …' to comorbidity.[66]

4.66 In the 2003-04 federal budget the government provided $4.4 million over two years for the National Comorbidity Initiative.[67]

Conclusion

4.67 The committee:

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63 Gomes A, Robinos S & Pennebaker DF, 'Co-occurring mental illness and substance abuse: Poor service preparedness a significant issue', *Conference Papers Collection*, CD-ROM, 2nd Australasian Conference on Drugs Strategy, Perth, 7-9 May 2002, powerpoint presentation, slide 16.

64 McCabe D & Holmwood C, *Comorbidity in general practice: The provision of care for people with coexisting mental health problems and substance use by general practitioners*, Primary Mental Health Care Australian Resource Centre, Department of General Practice, Flinders University, Adelaide, revised July 2002, p 8, viewed 9/1/03, <http://som.flinders.edu.au/FUSA/PARC/comorbidityreportrevised2002.pdf>.

65 Commonwealth Department of Health and Ageing, sub 238, p 34.

66 Alcohol and other Drugs Council of Australia, sub 221, p 8.

67 *Budget measures 2003-04*, p 175.

- is pleased that the Commonwealth government is addressing the pressing issue of comorbidity, and agrees that it should be more vigorously pursued;
- is concerned at the lack of research available on the linkage between mental health, drug abuse and suicide; and
- expresses concern at the lack of support for parents and families coping with mental health, drug abuse and suicide.

Recommendation 26

4.68 **The committee recommends that the Commonwealth government, in consultation with State and Territory governments and all non-government stakeholders:**

- **evaluate the outcomes to date of the National Comorbidity Project;**
- **investigate the linkages between mental health, drug abuse and suicide; and**
- **identify from these outcomes and other sources what further steps must be taken to improve the treatment of and provision of services to people suffering from co-occurring mental ill health and substance abuse and their families and ensure their implementation.**

Indigenous Australians

4.69 Between 1997 and 2000, the former committee carried out an inquiry into indigenous health and recommended in relation to substance abuse that:

> The [then] Commonwealth Department of Health and Aged Care ensure that Commonwealth, state and territory substance misuse programs incorporate:
>
> - early and opportunistic intervention programs by health professionals;
> - diversionary and sobering-up shelters, including night patrols;
> - detoxification programs; and

- rehabilitation programs, including residential and family rehabilitation, and follow up after care programs.[68]

4.70 The Commonwealth government was able to accept this recommendation in principle only as it could not ensure the content of state and territory programs. However, it demonstrated in its response to the report, that it was addressing each element listed above.[69] Funding is provided annually to the Commonwealth Office of Aboriginal and Torres Strait Islander Health for the National Aboriginal and Torres Strait Islander Substance Misuse Program; in 2001-02, it amounted to $18.8 million.[70] An additional initiative, announced in May 2002, targeted $1 million at controlling tobacco use by Indigenous people.[71]

4.71 In addition, since 1999 the National Drug Strategy Reference Group for Aboriginal and Torres Strait Islanders has advised the Commonwealth government on Indigenous issues, and in 2001 the National Indigenous Substance Misuse Council was formed as the peak body for Indigenous Community Controlled Substance Misuse Services. The National Aboriginal Community Controlled Health Organisation, which is the peak body for community controlled primary health care services, also has a substantial interest in substance misuse. These three national bodies create a greater focus on Indigenous substance abuse than in the past. For example, according to the Commonwealth Department of Health and Ageing, the Reference Group has contributed to the development of an Indigenous drug strategy to complement the NDS.[72]

4.72 The Commonwealth Department of Health and Ageing is concerned that the health of Aboriginal and Torres Strait Islander people is significantly worse than that of the rest of the Australian population. The department also drew attention to the harmful effects of high tobacco use and excessive alcohol consumption among Indigenous drinkers.[73] An ANCD report on Cape York pointed out that, while Indigenous use of illicit drugs generally has been low, it appears now to be increasing.[74] Volatile

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68 House of Representatives Standing Committee on Family and Community Affairs, *Health is life: Report on the inquiry into Indigenous health*, FCA, Canberra, May 2000, p 92.

69 *Government response to the House of Representatives Inquiry into Indigenous Health – 'Health is Life'*, pp 29-30, March 2001, tabled 22/5/01.

70 Commonwealth Department of Health and Ageing, sub 292, p 5.

71 Senator the Hon Kay Patterson, *New package to tackle tobacco use in indigenous communities*, media release, 31/5/02, p 1.

72 Commonwealth Department of Health and Ageing, sub 238, p 11.

73 Commonwealth Department of Health and Aged Care, sub 238, p 10.

74 Australian National Council on Drugs, *ANCD Report: Cape York Indigenous issues*, 2002, p 4, viewed 23/12/02, <http://www.ancd.org.au/publications/pdf/cape_york_report.pdf>; Illicit Drugs Taskforce, *Illicit Drugs Taskforce Report 2002*, Northern Territory Department of Health and Community Services, pp 28, 52, viewed 23/12/02,

substance misuse by Indigenous young people in remote communities is also causing great concern.

4.73 Edwards et al reported that some Indigenous drug addicts have successfully used mainstream treatment and rehabilitation services, preferring them to their own community's services because of the shame they would feel when using the latter.

> … They think that everyone will know their business, or will think they or their whole family are bad people …
>
> [However] Other community members say that mainstream de-tox and rehab programs have not been much help to them, because the service is not very 'Aboriginal friendly'. They say the way mainstream services work does not fit in with Aboriginal lifestyle and culture. They say mainstream workers do not really understand how it is for Aboriginal people, even though some try.[75]

4.74 Professor Webster made a similar point when he commented to the committee, that Indigenous people have their own way of thinking about alcohol and drug problems which means that, even where they have access to mainstream services, they tend not to use them. In these cases, Indigenous people are best helped to address their problems in a culturally appropriate way by working through their own organisations.[76]

4.75 It is clear from the number of alcohol and drug projects that Indigenous people have initiated that this is something that they want to do. Gray et al pointed out that Indigenous people can be helped in this by being empowered 'to define the "problem" or "problems" and to determine appropriate solutions'.[77] This issue was also the subject of recommendations by others. Several organisations, both Indigenous and non-Indigenous, called for the creation of new and the maintenance of existing culturally specific programs for Indigenous citizens.[78]

<http://www.nt.gov.au/health/healthdev/aodp/illicit_drugs/Illicit_Drugs_Report_B.pdf>; Wilson S, Aboriginal Drug and Alcohol Council (SA), media release, 22/6/02, p 1.

75 Edwards G, Frances D & Lehmann TC, *Community report: Injecting drug use project*, Victorian Aboriginal Health Service Co-operative Ltd, Fitzroy Victoria, 1998, p 31.

76 Webster I, transcript, 15/8/02, p 1132.

77 Gray D, Sputore B, Stearne A, Bourbon D & Strempel P, *Indigenous drug and alcohol projects 1999-2000*, ANCD research paper 4, Australian National Council on Drugs, Canberra, 2002, p 44.

78 DRUG-ARM, sub 199, p 15; NACCHO, sub 122, p 2.

4.76 The committee:

- recognises that Indigenous-controlled organisations are better placed than mainstream services in some localities to maximise the reach of alcohol and drug programs; and
- believes that support for these organisations must be continued and expanded where needed.

Recommendation 27

4.77 **The committee recommends that Commonwealth, State and Territory governments continue to support and expand substance misuse programs that assist Indigenous planning processes to best achieve their objectives in delivering acceptable forms of treatment.**

4.78 As part of its undertaking to map all the drug and alcohol services available across Australia, the ANCD commissioned a national stocktake of the Indigenous alcohol and drug projects in operation in 1999-2000. It identified 277 such projects, 81.6 per cent of which were conducted by 177 Indigenous community-controlled organisations. The projects were both residential and non-residential and delivered:

- prevention through health promotion, community development and sporting and recreational activities;
- acute intervention by night patrols and the use of sobering up shelters; and
- other services such as support, referral, and program, staff and resource development.

4.79 In 1999-2000 $35.4 million was spent on these projects. Of this funding, all but $129,000 was provided by the Commonwealth, state, territory or local governments.[79]

4.80 The stocktake's authors, Gray and his colleagues, came to some important conclusions and indicated areas where future action might be focused. First, they pointed out that there is at present 'no comprehensive database

79 Gray D, Sputore B, Stearne A, Bourbon D & Strempel P, pp vii, 36-37. In 2001-02 the Commonwealth government contributed through the Office for Aboriginal and Torres Strait Islander Health's Aboriginal and Torres Strait Islander Substance Misuse Program to the operation of 65 community-controlled health organisations, of which 45 were devoted solely to substance abuse (Commonwealth Department of Health and Ageing, sub 238, p 36).

that would facilitate the identification and comparison of needs at regional levels' and help governments allocate resources to where they are most needed.[80]

4.81 Secondly, they drew attention to the considerable variation between regions and between states and territories in per capita expenditure. Per capita expenditure was highest in South Australia, followed by Victoria, Western Australia and the Northern Territory.[81] The stocktake's authors warned, however, that:

> … This information alone is not a sufficient basis upon which to recommend that additional funding, if it were to become available, be directed to [those regions with lower per capita expenditure]. It does, however, warrant further investigation into whether people in those regions are adequately serviced.[82]

4.82 Thirdly, Gray et al, while cautioning against the danger of dispersing funds too widely, suggested that an analysis of the data indicated where infusions of new funding were most needed. Some of the areas that require new funding were training for Indigenous workers and measures to address the increasing use of illicit drugs particularly in urban areas.[83] Submissions to the inquiry from DRUG-ARM and Wu Chopperen Medical Service also underlined the need for training for those working with Indigenous people.[84]

4.83 In the committee's view, the stocktake has usefully drawn attention to areas where work is required. It is important to know what alcohol and other drug services are needed by Indigenous people across Australia and whether adequate funding is available to provide those services.

Recommendation 28

4.84 **The committee recommends that the Commonwealth government, State and Territory governments and Indigenous organisations work together to:**

- **collect information on Indigenous needs for alcohol and other**

80 Gray D, Sputore B, Stearne A, Bourbon D & Strempel P, p 43.

81 Gray D, Sputore B, Stearne A, Bourbon D & Strempel P, p viii.

82 Gray D, Sputore B, Stearne A, Bourbon D & Strempel P, p 43.

83 Gray D, Sputore B, Stearne A, Bourbon D & Strempel P, p 44. A useful adjunct to training will be the information on best practice in Indigenous alcohol and drug programs that is to be assembled in the next phase of the Australian National Council on Drugs stocktake (p 1).

84 DRUG-ARM, sub 199, p 15; Wu Chopperen Medical Service, Cairns, sub 189, p 4.

drug services and how well those needs are currently being met;

- **direct existing resources to regions of greatest need and provide additional funding where required; and**
- **identify and, in the light of emerging trends, respond to new needs by ensuring access to appropriate programs.**

4.85 The committee also believes that the particular deficits identified by the stocktake should be addressed immediately. Accordingly the committee considers that attention be paid to Indigenous training needs and measures to combat the previously identified problem with increasing illicit drug use.

Recommendation 29

4.86 **The committee recommends that the Commonwealth, State and Territory governments institute programs to:**

- **combat increasing illicit drug use by Indigenous people; and**
- **provide improved training to Indigenous drug and alcohol workers.**

4.87 As with all Australians, it is important to look at the wider context within which substance abuse occurs and to address problem elements in the wider environment as well as the problems due specifically to substance abuse. Only in that way will prevention, treatment and rehabilitation be given the best chance of succeeding. The South Australian Drug Summit, for example, recommended that that state's government should pursue community development, housing and the employment of Aboriginal people in leadership positions in government organisations relevant to matters of substance abuse.[85] A previous and unrelated study of alcohol-related problems in Cape York recommended an integrated and coordinated approach: in such an approach demand reduction programs targeted at individuals, families and communities should be supported by wider structural support from government, for example, through

85 South Australian government, sub 279, attachment, *Communique*, South Australian Drugs Summit 2002, Adelaide, 24-28 June 2002, p 8.

legislation that limits alcohol supply.[86] Gray et al pointed out that 'Alcohol and other drug-specific interventions must go hand-in-hand with broader strategies to address Indigenous inequality …'[87] This issue has been addressed in the committee's Recommendation 24 above.

Australian Youth

4.88 ADCA claimed that 'The misuse of drugs is the sixth largest killer of young people, …'[88] However, according to both ADCA and Brisbane's Youth Substance Abuse Service, few services exist that are specifically designed to meet their needs.[89] Furthermore, as Professor Roche pointed out, many services exclude people under 18 years of age.[90] Professor Patton stated that:

> … the way in which we configure our health services for young people does not and has not worked … we need to be smarter in the way in which we make our services more accessible. Part of that is about the training of health professionals in responding appropriately to this age group. Part of it is also about looking at the way in which our services are structured and at how the younger group get to treatment, because they are not utilising the services as they currently are.[91]

4.89 This is a particularly important issue because, according to Professor Roche, people are starting to abuse drugs at younger and younger ages. Having had less opportunity to develop life skills than those who become drug dependent at older ages, young people need not only treatment for their drug habit but also substantial help in other aspects of their lives.[92] This last point has already been addressed in Recommendation 24; the

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86 *Advanced Copy: Cape York Justice Study Report: summary of brief in volume 2*, November 2001, p 18, viewed 15/1/03, <http://www.premiers.qld.gov.au/about/community/pdf/capeyork/summary.pdf>.

87 Gray D, Sputore B, Stearne A, Bourbon D & Strempel P, p 12.

88 Alcohol and other Drugs Council of Australia, sub 221, p 8. NB Australian Institute of Health and Welfare, Australia's health 2002: The eighth biennial health reports of the AIHW, AIHW, Canberra, May 2002, p 187 stated: In year 2000 drugs were responsible for 108 deaths of young people (83 males and 25 females). These accounted for 6 per cent of all deaths of young people aged 12-24 years. The rate of death related to drug dependence for young males in year 2000 was over three times that for young females.

89 Alcohol and other Drugs Council of Australia, sub 221, p 8; Youth Substance Abuse Service, sub 102, p 7.

90 Roche A, transcript, 15/8/02, p 1118.

91 Patton G, transcript, 15/8/02, p 1098. The same point was made by Ms Annie Madden about young Asian drug users' use of mainstream services (Madden A, transcript, 15/8/02, p 1134).

92 Roche A, transcript, 15/8/02, pp 1117-1118.

committee deals with the other points raised in this section as follows. The issue of compelling young people into treatment is covered in Chapter 8.

Recommendation 30

4.90 **The committee recommends that the Commonwealth government work with State and Territory governments and non-government organisations to:**

- **identify the best structures and practices to engage and retain young drug users in treatment;**
- **ensure that trained skilled health professionals are available to deal with young people who are substance-dependent; and**
- **ensure adequate support services are available to families and that families are getting the skills required as well as to cope with young people who are substance-dependent.**

Remote and regional Australia

4.91 Data from the NDS Household Survey showed that more people in regional areas reported smoking in 2001 than in urban areas (25.0 per cent and 22.5 per cent respectively). The reported use of alcohol, however, was similar in regional and urban areas (82.6 per cent and 82.5 per cent respectively), although there were more drinkers at risk or high risk in country areas (11.3 per cent compared with 9.3 per cent).[93] In addition, according to Gray and Chrikritzhs, alcohol use is substantially higher in the Northern Territory than in Australia as a whole.[94] The NDS Household Survey showed cannabis use in regional Australia approximated that in the city, but the use of other illicit drugs was less.[95] However, Graycar reported that illicit drug use is increasing in regional Australia.[96] In view of this situation, the shortfall of detoxification and rehabilitation places in regional Australia is particularly worrying.

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93 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, Drug statistics series no 11, AIHW, Canberra, December 2002, p 110.

94 Gray D & Chikritzhs T, 'Regional variation in alcohol consumption in the Northern Territory', *Australian and New Zealand Journal of Public Health*, vol 24, February 2000, p 35.

95 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, p 110.

96 Graycar A, quoted in the introduction to Williams P, 'Illicit drug use in regional Australia, 1988-1998', *Trends and issues in criminal justice*, Australian Institute of Criminology, no 192, February 2001, p 1, viewed 18/3/03, <http://www.aic.gov.au/publications/tandi/ti192.pdf>.

4.92 In 2000 the ANCD hosted consultations on addressing alcohol and drug use in rural and regional centres around Australia. The ANCD national report on rural and regional alcohol and other drugs consultation forum, reported the following conclusions and recommendations.

- It is important to recognise that rural and regional areas require their own strategies. It is not feasible to simply apply urban-based strategies to the rural and regional setting.
- With innovation, creativity and cooperation, good services can be delivered in rural and regional areas even though economic constraints preclude the provision of a full suite of services. Innovative approaches must be supported.
- With greater local government involvement, local issues are more effectively addressed and local drug action teams are more effective.
- Lack of transportation and housing are two specific factors which diminish the chances of successful treatment.
- The cost of providing services in rural and regional settings is more expensive than in urban areas, and funding bodies should recognise this. [97]

4.93 This latter dot point was also made by Gray et al in relation to Indigenous services: 'The more remote a location, the higher the cost of providing services'.[98]

4.94 The ANCD is pursuing improved funding for rural and regional services as a matter of high priority.[99] In the 2003-04 federal budget the government provided $4 million over four years to improve access to treatment and referral for illicit drug users in regional Australia.[100]

Conclusion

4.95 The committee believes that the shortfall in detoxification and rehabilitation places in rural and regional areas should be addressed as a matter of high priority. Furthermore, the matters outlined above should be pursued further with a view to identifying and disseminating information about best practice, and then making adequate funding available for its implementation.

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97 Australian National Council on Drugs, *Rural and regional alcohol and other drugs consultation forums,* pp 10-12.

98 Gray D, Sputore B, Stearne A, Bourbon D & Strempel P, p 43.

99 Australian National Council on Drugs, informal communication, 23/4/03.

100 *Budget measures 2003-04,* p 176.

Recommendation 31

4.96 **The committee recommends that the Commonwealth, State and Territory governments, in consultation with non-government organisations:**

- **ensure the needs for regional detoxification, treatment and rehabilitation facilities are met;**
- **assemble information on best practice options for providing alcohol and other drug services in remote and rural areas, and disseminate that information widely; and**
- **provide additional funding where needed to implement best practice.**

Management - Planning and evaluation

4.97 One of the issues raised earlier in this chapter is the lack of integration and coordination between different programs addressing substance abuse. This topic also is the subject of Recommendation 24. An additional concern in the planning of services is appropriately targeting them to those groups in the community that need them most. On this point the former committee commented, 'Where resources are not infinite, it is obviously critical to ensure these are dedicated in the most cost-effective ways and directed to areas of greatest need'.[101]

4.98 Evaluation is a useful tool in assessing the success of programs and indicating where fine tuning is required. The 1997 evaluation of the NDS recommended a significant increase in systematic evaluation of prevention and treatment programs and this is now happening.[102]

4.99 Among the elements that could drive planning processes and contribute to evaluations of service delivery are targets and performance indicators for alcohol and drug-related services. Yet, as the former committee noted, there is a dearth of them. The former committee explained that:

> Current national drug strategic planning processes are broadly consultative and provide for national leadership while allowing

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101 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 58.

102 The most recent submission to the inquiry from the Commonwealth Department of Health and Ageing (sub 238) refers to numerous evaluations of ongoing prevention programs and to the National Evaluation of Pharmacotherapies for Opioid Dependence.

> flexibility for States and Territories to ensure that plans developed to address drug problems are responsive to the needs and priorities of particular jurisdictions. National strategies and action plans do not provide, therefore, the specificity about outputs and performance indicators which is necessary to evaluate the effectiveness of national harm minimisation efforts …[103]

4.100 A number of key non-government agencies recommended to the former committee that governments should 'be more specific in their goal-setting – in short, set some hard targets'.[104] This call was repeated to the current committee by Professor Webster:

> … there should be targets put in place. In health care agreements you could put in expectations of performance and achievements that you would mark. For example, you could include the access of people with drug and alcohol problems to an appropriate level of services or you could ensure that a public hospital provided appropriate detoxification facilities. You could examine the extent to which … the proper standards of professional practice are incorporated into the work force …[105]

4.101 The committee is pleased that evaluations of drug-related programs are more routinely carried out now than they used to be. It believes, however, that evaluation and planning processes would be sharpened if more use was made of specific targets for each program. Performance against targets could also contribute to accountability arrangements for drug-related health programs.

Recommendation 32

4.102 **The committee recommends that the Commonwealth, State and Territory governments, in consultation with the non-government sector:**

- **establish targets for all drug-related health programs against which their outcomes can be judged;**
- **use this information to evaluate existing programs and plan new ones; and**

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103 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, pp 57-58.

104 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 58.

105 Webster I, transcript, 15/8/02, p 1129.

- **report annually to their parliaments on their performance against targets for each program.**

Information on service provision

4.103 The former committee commented on its disappointment that there was no available source of 'easily-accessible, coherent, basic information which could have supported deliberations on this Inquiry'. It reported that it had 'sought, for example, a comprehensive list of treatment service providers from the Commonwealth, only to discover that such a thing did not exist'. It commented too on its concern that there was also no consolidated national database to support workforce planning and that it was not possible 'to get a firm handle on national expenditure in the AOD arena'.[106] The committee has covered the issue of the list of treatment service providers project commissioned by the ANCD in Chapter 3.107 and has recommended accordingly.

Expenditure reporting

4.104 Commonwealth expenditure on substance abuse that is directly allocated for use, as in the case of Non-Government Organisation Treatment Grants, is more readily monitored than Commonwealth funding provided to state and territory governments. Commonwealth funds for the NDS are supplied to the states and territories under broadbanded bilateral Public Health Outcome Funding Agreements (PHOFA), along with the funds for eight other public health categories.[107] The PHOFAs are outcomes-based agreements, focusing on the achievement of agreed outcomes, and do not tie the states and territories to specific activities or matching of funding. The states and territories report on their performance against indicators on an annual basis.[108]

4.105 According to the most recent annual report on expenditure under the PHOFAs, the Commonwealth government spent $21.9 million to prevent hazardous and harmful drug use in 1999-2000, principally on:

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106 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 59.

107 Australian Institute of Health and Welfare, *National public health expenditure report 1999-00*, Health and expenditure series no 16, AIHW, Canberra, 2002, p xiii; Commonwealth Department of Health and Ageing, sub 238, p 31.

108 Commonwealth Department of Health and Ageing, 'Public Health Outcome Funding Agreements', pp 3-4, viewed 16/1/02, <http://www.health.gov.au/publhlth/about/phofa/phofa.htm>.

- preventing alcohol abuse ($5.2 million), mostly spent on the National Alcohol Strategy;
- addressing tobacco smoking ($3.4 million), almost totally focused on the National Tobacco Campaign; and
- preventing illicit drug use ($13.2), with the main items of expenditure being the Community Partnerships Initiative ($1.7 million), grants to non-government treatment organisations ($5 million) and the National Illicit Drugs Campaign ($3.2 million).[109]

4.106 The 1999-2000 annual report also indicated that state and territory expenditure of Commonwealth funds on prevention in 1999-2000 varied considerably from jurisdiction to jurisdiction. It is, however, difficult to make direct comparisons between jurisdictions as their financial reporting systems differ somewhat, as do their methods of recording comparable activities. The extent of the services provided in each jurisdiction is also affected by such factors as its population demographics and how far each, given its size, can pursue economies of scale. Notwithstanding the difficulty of making comparisons, some broad conclusions can be drawn: on the basis of a per person index, Victoria and New South Wales can be seen to have spent well below the average while Queensland spent more than the average.[110]

4.107 The PHOFA reporting system has been established only recently but will, with further refinement, allow the cost effectiveness and / or cost efficiency of public health interventions to be analysed.[111] In addition, the PHOFA report covers only part of the funds expended on drug-related harm. Information about funding for treatment and research would have to be sought from other, scattered sources. ADCA and Odyssey House claimed that it would be useful to have a consolidated report on all expenditure which would provide details of the amount of money spent on all alcohol and other drug programs and on the outcomes generated by this expenditure.[112] However, the committee was told by the Commonwealth

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109 Australian Institute of Health and Welfare, *National public health expenditure report 1999-00*, pp 19-20.

110 Australian Institute of Health and Welfare, *National public health expenditure report 1999-00*, pp 102-104. The index is (per person expenditure for the PHOFA category, prevention of hazardous and harmful drug use, in a particular state or territory) ÷ (per person expenditure for the PHOFA category, prevention of hazardous and harmful drug use, in all states and territories) x 100 (p 102).

111 Australian Institute of Health and Welfare, *National public health expenditure report 1999-00*, 2002, p 106.

112 Alcohol and other Drugs Council of Australia, sub 221, p 5; Odyssey House Victoria, sub 155, p 2.

Department of Health and Ageing that it would be time consuming and resource intensive to prepare such a report.[113]

Conclusion

4.108 The committee agrees that:

- despite the cost, the committee would like to see a comprehensive report on the nation's expenditure on health care for drug-related problems for accountability purposes;
- it has particular concerns about the accountability arrangements for research funding in the area of substance abuse. This issue is discussed in Chapter 11; and
- it accepts, however, that the resources needed to collect this information would be considerable and would be better directed to efforts to improve prevention and rehabilitation.

113 For example, in relation to research funds, Commonwealth Department of Health and Ageing, sub 293, p 1.