4

Health Care

Introduction

4.1 A person experimenting with the use of a drug might have the occasional misadventure and wind up in hospital as a result, but a person who has become dependent or addicted to a drug will have numerous encounters with the health system over the course of his or her life. As many witnesses said:

> Addiction is a chronic relapsing disorder and needs to be recognised as such.[1]

4.2 The Committee has found and accepts that the causes of addiction are various, and there are many different models by which people attempt to understand the phenomenon. We do not propose in this interim report to delve deeply into the causes of addiction; suffice it to say that currently many rearchers are pondering this complex problem.[2] It is enough for us to recognise that the implication of seeing addiction as a 'chronic relapsing disorder' is to appreciate that we need to ensure that our health system is working effectively, in every sense, to maximise the probability that, as one witness put it, someone in a position to help will be in the right place at the right time in a person's life.[3]

---

1 Evidence, p. 30.

2 Evidence, p. 842.

3 Evidence, p. 116.

Costs and burdens

4.3 As the Alcohol and other Drugs Council of Australia pointed out in their submission to this Inquiry, approximately one in five deaths in Australia is drug-related.[4] In 1997, 22,724 people died from drug-related causes, and 256,991 hospitalisations were drug-related.[5]

4.4 Tobacco and alcohol are responsible for the vast majority of these drug-related deaths and hospitalisations. The Australian Institute of Health and Welfare estimates that the use of tobacco accounts for over 80% of drug-related deaths and around 60% of all drug-related hospitalisations, while the use of alcohol is responsible for around 16% of drug-related deaths and 37% of drug-related hospitalisations. Illicit drugs are responsible for 4% of these deaths and hospitalisations.[6]

4.5 In 1996, health economists Collins and Lapsley estimated the overall tangible and intangible costs of drug abuse in Australia in 1992 to be $18.8 billion; those associated with tobacco ($12.7 billion) comprised 67.3% of overall costs, while those associated with the abuse of alcohol ($4.4 billion) made up 23.8%; costs associated with illicit drugs ($1.7 billion) formed 8.9% of total costs.[7] Collins and Lapsley also estimated the health care costs (tangible and intangible) associated with the abuse of these three categories of drugs. Total 1992 health care costs associated with the abuse of alcohol were estimated to be around $1 billion dollars, those associated with the abuse of tobacco around $6.4 billion, and those related to the abuse of illicit drugs around $ 433 million.[8]

4.6 In 1999, the Australian Institute of Health and Welfare (AIHW) published the results of the Australian Burden of Disease and Injury Study, which enables the quantification of the 'disease burden' created by drugs for certain population groups. This study reveals that alcohol dependence and harmful use and road traffic accidents are the leading causes of disease burden for young Australians aged 15-24 years, while heroin dependence and harmful use is the fifth leading cause of disease burden for this age group, accounting for 6% of the total disease burden for this age group.[9]

---

4 Submissions Vol. 3, p. 551.

5 Submissions Vol. 8, p. 1699.

6 Submissions Vol. 8, p. 1699.

7 Collins, D.J., & Lapsley, H.M.,1996, *The social costs of drug abuse in Australia in 1988 and 1992*, AGPS, Canberra, p. vii.

8 Ibid., pp. 41, 43.

9 Mathers, C., Vos, T., Stevenson, C., 1999, *The burden of disease and injury in Australia – summary report.* AIHW, Canberra, pp. 19-20.

Responses

4.7 The following section describes in general terms what the Commonwealth government and nongovernment agencies are doing in the areas of prevention and treatment to try to minimise drug-related harms in Australian communities. Family-oriented initiatives, diversion, and school drug education programs will not be revisited here, as these were discussed in previous chapters. Issues relating to health care delivery will be discussed in a later section, which will be illustrated with evidence received from State and Territory governments.

Commonwealth

4.8 The Department of Health and Aged Care is the Commonwealth agency with responsibility for coordinating the National Drug Strategy and related programs. It plays a key role in the development of drug policies, supports the development of research and best practice agendas which inform these, funds the Australian National Council on Drugs as well as the Alcohol and other Drugs Council of Australia[10], and provides financial assistance to the States and Territories to support the implementation of the National Drug Strategy.[11] The Department also provides funds to support the operation of many generalist health services which are used by people with drug problems. In short, the Department undertakes and administers a wide range of activities with the potential to prevent and/or reduce drug-related harm.

Prevention and early intervention

Illicit drugs

Community Partnerships Initiative

4.9 Under the National Illicit Drugs Strategy, $8.8 million (over four years) has been allocated to the Community Partnerships Initiative, which is modelled on the World Health Organisation's *Global Initiative on Primary Prevention of Substance Abuse*. The aim of the Initiative is to encourage quality practice in community action to prevent illicit drug use and build on existing activity occurring across Australia.[12]

4.10 At the time of the writing of the Department's submission, 87 community-based projects had been funded under the Initiative to a total value of

10 Submission Vol. 9, p. 2011.

11 Submissions Vol. 9, p. 2009.

12 Submissions Vol. 9, p. 2012.

approximately $5.9 million[13]. Some of these were described in the submission from the Department of Health and Aged Care (DHAC) to give a feel for the sorts of projects funded under the Initiative. One example cited was the Manly Drug Education and Counselling Centre, which has received funding of $32,000 for one year for the 'Drugs Stop' project to use peer education as a strategy to educate young people (12 – 18 year olds) about the harms of both licit and illicit drug use.[14]

Needle and Syringe Programs

4.11 In April 1999, the Council of Australian Governments (COAG) approved a $221 million package of measures which included $30.6 million in funds (over four years) for the support of Needle and Syringe Programs (NSPs). Of the $30.6 million allocated for the support of NSPs, $27 million is being provided to States and Territories and the balance is for a range of related national activities which the Department is administering.[15]

4.12 The rationale for the expenditure is to increase the number of clients accessing education and treatment services, and increase the availability of sterile needles and syringes to reduce the transmission of HIV, hepatitis B and hepatitis C.[16] The Committee received evidence which argued that NSPs have been shown not only to be an effective way of preventing the spread of HIV, but also a good way to provide illicit drug users with an opportunity for health promotion and referral to other health and treatment services.[17]

4.13 While the Committee does not question the potential public health benefits of NSPs, some members do have concerns about the management of these programs and the adequacy of the oversight of needle distribution and retrieval. While in some jurisdictions needle exchange services are working well, with return rates in the order of 95%[18], in other areas control mechanisms are inadequate and a significant percentage of distributed needles and syringes are ending up on the streets, parks, properties and laneways of cities - and becoming a big headache for local councils.[19]

13 Submissions Vol. 9, p. 2013.
14 Submissions Vol. 9, p. 2049.
15 Submissions Vol. 9, p. 2024.
16 Submissions Vol. 9, p. 2025.
17 Submissions Vol. 9, p. 2025.
18 Evidence, p. 129.
19 Evidence, p. 596.

Legal drugs

National Tobacco Strategy

4.14 The National Tobacco Strategy was endorsed by the Ministerial Council on Drug Strategy (MCDS) in June 1999 and the 1998-99 budget provided $6.1 million over three years for tobacco harm minimisation measures[20]. The Strategy includes the following prevention measures:[21]

- changing tobacco excise arrangements to effect price rises on low weight cigarettes;
- reviewing current health warnings on tobacco products to see if these can be made more effective;
- phasing out all tobacco sponsorship at international sporting events by 2006;
- developing (together with the Australian tobacco industry) an agreed voluntary disclosure protocol about disclosing the ingredients found in cigarettes;
- developing, implementing and evaluating a national best practice model for the design of programs discouraging sales to minors;
- working with States and Territories in the development of a national response to passive smoking.

4.15 In addition, the Department is collaborating with the Australian Cancer Society (ACS) in scoping a research agenda to inform future policy development for nicotine regulation.[22]

4.16 The Department's submission estimates that its social marketing activities under the National Tobacco Campaign, which was launched in June, 1997, have reduced adult smoking prevalence and saved an estimated $24 million in health expenditure.[23]

Alcohol Action

4.17 A National Alcohol Campaign was launched on 20 February 2000. The Campaign, to which the Commonwealth has committed $5.4 million, targets teenagers, young adults, and the parents of 12-17 year olds in an effort to minimise alcohol-related harms.[24]

---

20 Submissions Vol. 9, p. 2015.
21 Submissions Vol. 9, pp. 2015 – 2017.
22 Submissions Vol. 9, p. 2036.
23 Submissions Vol. 9, p. 2019.
24 Submissions Vol. 9, p. 2018.

4.18 In the 2000-2001 Budget, the Government announced an additional $4 million in funding over four years to implement the National Alcohol Action Plan 2000 – 2003 and support the development and implementation of the Commonwealth's own Alcohol Action Plan.[25]

4.19 At the time of the writing of this report, national endorsement of the draft National Alcohol Action Plan was imminent. One of the principal themes of the Plan is prevention and early intervention.

4.20 The Commonwealth's own Alcohol Action Plan will:

- complement State and Territory initiatives under the National Alcohol Action Plan;
- support collaborative projects with industry, community and other government agencies;
- augment the National Alcohol Campaign, launched in February 2000;
- provide for further development of the evidence base for alcohol policy;
- increase public awareness of responsible drinking behaviour; and
- promote evidence-based prevention and treatment of alcohol dependence.[26]

4.21 The Commonwealth's Department of Health and Aged Care is currently planning a major public education campaign to accompany the imminent release of revised National Health & Medical Research Council (NH&MRC) Drinking Guidelines.

Pharmaceutical misuse

4.22 The Health Insurance Commission administers the Commonwealth's Medicare and Pharmaceutical Benefits Schemes and, as such, receives a large amount of data about medical services rendered and medication prescribed.[27] For the past four years, the Commission has been running a 'doctor shopping' project which has aimed to achieve better health outcomes for people identified as being at risk of taking large quantities of pharmaceutical drugs.[28] So far the project has achieved cost savings of approximately $16 million, and reduced the number of 'doctor shoppers' by around 35%.[29]

---

25 Submissions Vol. 9, p. 2017.
26 Submissions Vol. 9, p. 2017.
27 Submissions Vol. 6, p. 1233.
28 Evidence, p. 960.
29 Evidence, p. 961.

4.23 The Pharmaceutical Health and Rational Use of Medicines Committee (PHARM), an expert committee which advises the Government on the quality use of medicines, formed a working party in 1999 to systematically examine the inappropriate prescribing and use of benzodiazepines. The Benzodiazepine Working Party is reviewing current practices and seeking to establish a national program for health services and health professionals to reduce benzodiazepine prescribing and promote positive alternatives, and encourage health services and health professionals to be involved in support and education programs.[30]

4.24 In public testimony before the Committee, the Commonwealth Department of Health and Aged Care acknowledged that intentional misuse of pharmaceuticals has not received as much attention as it should have under the National Drug Strategy[31]. The Commonwealth intends to do more work in this area under the current phase of the NDS, and the Committee will be more energetic in its collection of evidence on this subject when it continues this Inquiry in the next Parliament.

National Prevention Agenda

4.25 In February 2000 the Intergovernmental Committee on Drugs agreed to develop a national prevention agenda to sharpen the focus of the National Drug Strategy on preventing harmful drug use.[32] At this stage the Department of Health and Aged Care (DHAC) has commissioned the production of a monograph which will provide a comprehensive international review of the literature and examine the application of this to drug policy and strategy. The monograph is expected to be completed in May 2002.

Treatment

4.26 While the Department of Health and Aged Care does not directly provide treatment services, it facilitates access to such services in a number of ways. The Illicit Drug Diversion Initiative discussed in Chapter 3 is an example of such a mechanism; under this Initiative, the Commonwealth is providing States and Territories with $105 million over four years to ensure that diverted offenders have access to suitable treatment services. Other mechanisms through which the Commonwealth dedicates funds for treatment include the Pharmaceutical Benefits Scheme and Medicare.

30 Submissions Vol. 9, pp. 2062-63.

31 Evidence, p. 78.

32 Submissions Vol. 9, p. 2012.

Pharmaceutical Benefits Scheme

4.27 The Commonwealth Government funds the cost of methadone syrup under Section 100 of the Pharmaceutical Benefits Scheme and payments are made directly to suppliers on a monthly basis. In 1999-00 the Commonwealth spent $3.9 million on the provision of methadone syrup. As of 30 June 2000, there were 30,237 people on methadone programs in Australia.

4.28 Methadone treatment is recognised nationally and internationally as an effective way of treating opioid dependence and reducing the individual and social harms associated with the use of illicit opiates. A recent review of the national and international medical and scientific literature conducted by the National Drug and Alcohol Research Centre (NDARC) found that methadone maintenance treatment is more effective than a range of alternative approaches to treatment for opioid dependence.[33] It is, as one witness said to the Committee, the 'gold standard' for best practice for heroin dependence.[34] Many other witnesses sang its praises, including the Health Minister of the Australian Capital Territory, who described it as 'our major and most successful form of treatment for many years'. [35]

4.29 The Committee does not question the fact that methadone enables people to stabilise their lifestyle. Methadone is, however, a highly addictive substance[36] from which it is difficult to withdraw; [37] its prophylactic value is better at higher doses, [38] but this makes it harder to come off the drug. It is possible that we have not focused enough on the transition from dependence on methadone to a non-dependent state and that, as one witness suggested, alternative pharmacotherapies might help to manage this transition better.[39]

4.30 A range of other pharmaceutical products used in the management of dependence are available at subsidised rates under the PBS - acamprosate and naltrexone, for example, when these are used within a comprehensive treatment program for alcohol dependence.[40] Naltrexone for use as a detoxification agent in the treatment of heroin dependence does not currently attract a subsidy under the PBS. As of 1 August, 2001, buprenorphine will be subsidised through the PBS, as research has

33 Submissions Vol. 9, p. 2030.
34 Evidence, p. 857.
35 Evidence, p. 91.
36 Evidence, p. 140.
37 Evidence, p. 827.
38 Evidence, p. 564.
39 Evidence, p. 858.
40 Submissions Vol. 9, p. 2030.

demonstrated it is an effective opioid substitution treatment. The Committee considers that naltrexone should be subjected to comparable research and trialing to determine whether it, too, should be subsidised through the PBS as a treatment agent for opioid addiction.

Medicare

4.31 Treatment for many drug problems occurs through generalist health services, incuding general practitioners and public hospitals. Commonwealth funding for these interventions is provided under Medicare, mainly in the form of:

- subsidies for prescribed medicines and private medical expenses;
- 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.[41]

NGO Treatment Grant Program

4.32 Under the National Illicit Drugs Strategy (NIDS), approximately $57 million in funds (over four years) have been allocated to 133 drug treatment programs across Australia.[42] The Program has a particular emphasis on filling geographic and target group gaps in the coverage of existing treatment services. Funding has also been allocated for expanding and upgrading existing non-government treatment services to strengthen the capacity of NGOs to deliver improved services and increase the number of treatment places available. Of the 133 projects funded under the NIDS NGO Treatment Grants Program, 45 specifically target young people.[43]

Specific Populations

4.33 The Commonwealth Department of Health and Aged Care's Office for Aboriginal and Torres Strait Islander Health (OATSIH) administers the Aboriginal and Torres Strait Islander Substance Misuse Program which provided, in 1999-2000, $18.4 million towards the operation of 69 community-controlled health and substance misuse services nationally. Twenty-six of these services provide residential rehabilitation and treatment for acute and chronic alcohol problems.

41 Submissions Vol. 9, p. 2032.

42 Submissions Vol. 9, p. 2030.

43 Submissions Vol. 9, p. 2048.

4.34 Substance misuse services are located across urban, rural and remote locations and deliver education and prevention programs, early intervention strategies, as well as treatment and rehabilitation within non-custodial settings. Some community-controlled health services funded by OATSIH also provide substance misuse services as part of their overall service, even those these are not specifically funded by the Substance Misuse Program. [44]

Research

4.35 Under the National Drug Strategy, Australia has been committed to the role of research in policy development. The Commonwealth has established three national 'centres of excellence' to support policy development in this area and, in addition to the ongoing research products of these Centres, the Government occasionally dedicates additional funds to other research agencies to undertake particular pieces of commissioned research.

Centres of Excellence

4.36 In 1986, the Commonwealth established the National Drug and Alcohol Research Centre (NDARC) and the National Drug Research Institute (NDRI). These were funded as Centres of Excellence to undertake research on, respectively, the prevention of drug abuse (the NDRI), and the treatment and rehabilitation of alcohol and drug dependent persons (NDARC).[45] In 1999 another centre, the National Centre for Education and Training on Addiction (NCETA), received funding under the National Drug Strategy to research issues relating to the education of professionals and non-professionals working in the field of drug and alcohol addiction.[46] The total amount of Commonwealth funding received by these Centres in 2000-2001 was $4,052,177.

4.37 Under the NIDS, $1.3 million in funds have been dedicated to the National Evaluation of Pharmacotherapies for Opioid Dependence (NEPOD) project, which NDARC is coordinating. The three-year project, which began in July, 1998, recently released its report recommending, among other things, that diversity of treatment options for heroin dependence should be promoted on the basis that patients will require different forms of treatment at different stages of their drug-use career. [47]

---

44 Submissions Vol. 9, p. 2040.

45 Submissions Vol. 4, p. 847.

46 Submission Vol. 9, p. 1997.

47 National Drug and Alcohol Research Centre 2001, *National Evaluation of Pharmacotherapies for Opioid Dependence (NEPOD): Report of Results and Recommendations*, UNSW, p. 10.

4.38 NIDS has also dedicated $1.1 million in funds for the development of cannbis cessation strategies for adults and adolescents, and research into factors which act as barriers or incentives for treatment. It is anticipated that, after an intervention strategy is developed and clinically trialled in several jurisdictions, a resource package and training module for health care workers will be developed and distributed through a national training program.[48]

The National Health and Medical Research Council

4.39 The NH&MRC has received approximately $4 million under the National Illicit Drug Strategy to undertake an expanded program of interdisciplinary research to achieve innovation in the prevention and treatment of illicit drug use.[49] In June 1998 an Expert Committee was established to manage the development of a research agenda, and in January 2000 funding for sixteen projects was approved.[50]

4.40 In the future, the Committee would like to explore the possibility of expanding the NH&MRC's research role in substance abuse. Furthermore, it notes there is as yet no national clearinghouse for drug-related information, [51] and it would like to investigate the possibility of having the NH&MRC assume responsibility for the establishment of this.

Promoting Best Practice

4.41 Many individuals will consult their own doctor, community nurse, pharmacists or other community workers about the harms arising from the use tobacco, alcohol, pharmaceuticals and illicit drugs. Others will come into contact with police, ambulance officers, and youth and correctional staff. In short, there are few working in the health, welfare, law enforcement or justice sectors who will not meet people with alcohol and other drug-related problems. The Commonwealth Department of Health and Aged Care's submission argues therefore that providing appropriate education and training for these workers, and producing and disseminating best practice guidelines, is essential to the effectiveness of any harm-reduction strategy.[52]

4.42 Accordingly, under the National Illicit Drug Strategy, $3.0 million dollars has been allocated for the 'Training of Frontline Workers Initiative' to

48 Submissions Vol. 9, p. 2038.
49 Submissions Vol. 9, p. 2037.
50 Submissions Vol. 9, p. 2038.
51 The establishment of one of these was recommended in the 1997 evaluation of the NDS by Professors Single and Rohl.
52 Submissions Vol. 9, p. 2033.

fund projects aiming to better equip front-line workers (including general practitioners, hospital staff and police officers) coming into contact with drug users or at risk groups.[53]

Nongovernment Organisations

4.43 The Committee received evidence from many NGOs operating in this arena. These can be distinguished according to whether they are principally: (1) service providers, or (2) agencies which can be said to be operating, mainly, as lobby groups or advocates for change to government policies.

4.44 The following section describes in general terms the nature of the work of nongovernment agencies in this area, and refers to some of the issues raised by peak NGOs - for example relating to access to treatment. Issues will be elaborated in a later 'Issues' section.

Service provision

4.45 Most nongovernment service providers receive some funding either from State/Territory governments or the Commonwealth, or both, and it is clear that governments rely very much on the dedication of this sector. In many ways NGOs have become, as one witness put it, the 'little fingers of government'[54]. In Victoria, for example, all treatment services are provided by nongovernment agencies.[55]

4.46 Nongovernment organisations provide a range of residential and non-residential treatment services, including 'outreach' services designed to support users on the streets, counselling programs, and community education and referral services. Outreach services, such as those provided by Victoria's Youth Substance Abuse Service (YSAS), enable health workers to go to where help is needed rather than wait for would-be clients to knock on the doors of treatment services. YSAS reported to the Committee that in one year it responded to over 8000 young people '…with brief intervention, harm minimisation strategies and immediate support to their problematic drug issues'.[56]

4.47 Some NGOs, such as Odyssey House in Victoria[57] and the Ted Noffs Foundation in New South Wales,[58] offer both non-residential and

53 Submissions Vol. 9, p. 2002.
54 Evidence, p. 768.
55 Evidence, p. 430.
56 Submissions Vol. 6, p. 1276.
57 Submissions Vol. 10, p. 2384.
58 Evidence, p. 668.

residential treatment services. One advantage of offering both is that this can facilitate the assessment and transition of an at risk substance abuser from a community setting into a more protected residential treatment environment.

Residential treatment

4.48 In the main, residential treatment services provided by NGOs are non-medical, though DrugBeat in South Australia is an example of a place where detoxification can take place in the same setting as rehabilitation[59]. In most cases, though, a person needing treatment for drug dependence would need to have been 'detoxified' of drugs prior to being admitted into such a program. Detoxification facilities are usually provided by hospitals, but people can opt for a medically supervised 'home detox', if they are fortunate enough to have a home, supportive friend or family member to help them through the process.

4.49 The sorts of programs and treatment modalities on offer in residential facilities vary – and this is a good thing because, as many witnesses told the Committee, there is no one treatment type which will suit all individuals.[60] Programs vary in terms of length and formality of structure, but also in terms of the relative emphases given to factors thought to have contributed to the development of the drug dependence problem. Interventions may differ, therefore, in terms of the relative amount of attention given to supposed underlying physical, psychological, spiritual, and social issues. As one witness in Canberra told the Committee:

> Your perception of the nature of addiction will determine for you the nature of the intervention that you want to provide.[61]

4.50 The Committee visited a number of residential facilities and therapeutic communities including, for example, the one run by Odyssey House in Victoria, where 80 residents live in a drug-free therapeutic community.[62] The Committee visited similar places in South Australia, the Australian Capital Territory, Western Australia, the Northern Territory, New South Wales, and Queensland, and received submissions from many more than could be visited.

4.51 Typically, establishments like these offer individual counselling and group therapy in a drug-free environment, which gives residents a chance to confront personal issues and begin a journey of self-discovery. At Logan House on the Gold Coast, for example, residents undertake a 12-week self-

59 Evidence, p. 405.

60 Submissions Vol. 8, p. 1776.

61 Evidence, p. 854.

62 Submissions Vol. 10, p. 2384.

improvement and change program based on a particular psychological model of behaviour. Other residential programs, such as those employed at Karralika in Canberra, Odyssey House in Victoria and Banyan House in Darwin, are structured around the 'level' principle. The way these places work was explained in a general way by one witness, who said:

> It is based on the levels principle, which mimics the way larger society operates. Under this system residents come into the program on a low level, with few responsibilities and likewise few privileges. As the residents show that they are motivated to changing their lifestyles and are participating fully and sincerely in the program, they advance to higher levels where they take on greater responsibilities and gain greater privileges.[63]

4.52 Depending on the understandings informing them, programs are more or less insistent on the importance of abstinence as a basis for long-term recovery; these differ too in the extent to which they appeal to spiritual values or encourage participation in self-help groups, such as Alcoholics Anonymous or Narcotics Anonymous, to assist with the maintenance of recovery after rehabilitation. The Salvation Army's Bridge Program is based on the 'disease' model of addiction and has adapted for its purposes the 12-step program of Alcoholics Anonymous, which is founded on a recognition of the basic importance of total (and permanent) abstinence as well as surrender to a personal conception of a 'higher power'. Many rehabilitation programs are based on variants of this model.

4.53 It would be wrong to suppose that abstinence-based programs are inimical to the principles of harm minimisation or opposed to the recognition of addiction as a chronic relapsing disorder. The Salvation Army's submission notes that, while it does promote an abstinence lifestyle in its treatment services, it recognises that some people are not yet ready for that choice and so it is always ready to offer options across what it describes as a continuum of care.[64]

Advocacy

4.54 For ease of discussion, advocacy agencies are distinguished according to whether they work specifically in the area of alcohol and other drugs (AOD), or whether they do more general public health advocacy work.

AOD specialist agencies

4.55 There are many such agencies but only two will be discussed in this section: the Alcohol and other Drugs Council of Australia (ADCA), and

63 Evidence, p. 686.

64 Submissions Vol. 2, p. 266.

the Australian National Council on Drugs (ANCD). Their importance and effectiveness is reflected in the fact that key representatives of each will be at the helm of a new Alcohol Education and Rehabilitation Foundation, which will soon be responsible for managing $115 million in Commonwealth funds for the prevention and treatment of harms related to the abuse of alcohol and other licit substances.

The Alcohol and other Drugs Council (ADCA)

4.56 ADCA is 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.[65]

4.57 ADCA has developed a strategic drugs policy document, *Drugs Policy 2000,* which identifies ten key areas for action in reducing drug-related harm. The policy document presents detailed recommendations for action under each of these and raises a number of important questions about the conduct of the current National Drug Strategy (NDS) , including:

- the balance of funding between prevention, treatment and supply reduction initiatives;[66]
- whether in its operation the NDS reflects a true partnership with the nongovernment sector;[67] and
- whether, in the absence of targets for harm reduction and annual reporting by governments on expenditure and outcomes of drug-related policies and service delivery, the NDS can be effectively evaluated.[68]

The Australian National Council on Drugs (ANCD)

4.58 The ANCD was established in 1998 in part as a response to the 1997 evaluation of the National Drug Strategy, which argued that nongovernment organisations were not sufficiently involved in the development and management of the National Drug Strategy, and that the NDS was weakened by its failure to more fully engage the sector.[69] The Council is tasked with facilitating an 'enhanced partnership' between

65 Submissions Vol. 3, p. 548.
66 Submissions Vol. 3, p. 581.
67 Submissions Vol. 3, p. 580.
68 Submissions Vol. 3, p. 581.
69 Single, E., & Rohl, T. 1997, *The National Drug Strategy: mapping the future*, AGPS, Canberra, pp. 68-69.

governments and the nongovernment sector[70] and providing independent expert advice to government on drug policy and programs.[71]

4.59 The Council's submission to the Inquiry:

- expressed its support for the availability of not only a wide range of treatment options, but also sufficient places within these treatment facilities, in appropriate geographical locations;[72]
- expressed its concern about the number of reports it is hearing about people being unable to gain access to treatment services[73];
- argued there is a shortage in skilled, trained, professional workers in the alcohol and other drug sector;[74] and
- said there is a need to raise levels of public awareness about drug and related public health issues, and an associated need to encourage balance in media portrayals of drug-related issues.[75]

Public health NGOs

4.60 The Committee received submissions from a number of public health associations in the business of advocating for changes in public health policy-making. These were notable for their concentration on minimising the costs associated with the use and abuse of legal substances, ie, alcohol and tobacco, and their emphasis on evidence-based approaches to dealing with the challenges posed by the abuse of illicit drugs.

4.61 The Australian Medical Association (AMA) observed that the Government commits less money per death to tobacco-related public health measures than it does to other major public health programs, despite the fact that tobacco consumption is the major cause of drug-related death in Australia. [76] The Public Health Association noted that expenditure on public education about tobacco has been declining for many years.[77] Both agencies provided detailed recommendations for strategies to intensify tobacco control efforts.[78]

4.62 The AMA expressed concern about the phenomenon of 'binge drinking', which it said is associated with suppression of the central nervous system,

70 Submissions Vol. 9, p. 1991.
71 Submissions Vol. 2, p. 297.
72 Submissions Vol. 2, p. 302.
73 Submissions Vol. 2, p. 302.
74 Submissions Vol. 2, p. 303.
75 Submissions Vol. 2, p. 305.
76 Submissions Vol. 7, p. 1469.
77 Submissions Vol. 10, p. 2440.
78 Submissions Vol. 10, p. 2436, and Submissions Vol. 7, p. 1469.

stomach inflammation, toxic damage to the bowel, suicide and falls, motor vehicle and pedestrian accidents.[79] The PHAA submission referred to binge drinking too, and argued that:

> Vastly greater costs to society are incurred from the lower ends of the continuum of alcohol use (eg binge drinkers) than from the few people (problem drinkers) at the severe end of the continuum, and this is supported by epidemiological evidence.[80]

4.63 The AMA and PHAA submissions provided detailed recommendations for ways of alleviating the burden of disease and social disruption associated with excessive alcohol consumption, including the introduction of a 'volumetric' approach to the taxation of alcoholic beverages which would mean that tax on alcoholic beverages would directly reflect the total volume of alcohol in the product.[81]

4.64 Both the AMA and the PHAA expressed their support for the conduct of properly evaluated trials and research to facilitate the expansion of viable treatment options for opiate dependence.[82] The PHAA further argued that it believed current national policy was too focused on supply reduction and appeared, to an increasing number of people, to be arbitrary and punitive.[83] The PHAA's submission also argued that treatment programs for users of illicit drugs should not be rationed – that people seeking treatment should have immediate access to expert help.[84]

Issues

4.65 A number of key issues emerged from the evidence. These are discussed under the following headings: service delivery, management, and community attitudes.

Service delivery

4.66 As has been previously mentioned, under the National Drug Strategy, State and Territory governments are responsible for provision of law enforcement, education, and health (including treatment) services. In the following sections, four service delivery issues are discussed.

79 Submissions Vol. 7, p. 1469.
80 Submissions Vol. 10, p. 2443.
81 Submissions Vol. 10, p. 2444, and Submissions Vol. 7, p. 1471.
82 Submissions Vol. 10, p. 2448 and Submissions Vol. 7, p. 1464.
83 Submissions Vol. 10, p. 2448.
84 Submissions Vol. 10, p. 2448.

Access to treatment

National stocktake

4.67 The Government of the Australian Capital Territory (ACT) operates a 12-bed detoxification facility at Canberra Hospital and funds a local nongovernment agency to manage another 10-bed detoxification service. The Government also funds the Alcohol and Drug Foundation of the ACT, which manages a suite of residential programs for people with drug and alcohol problems. The primary service is Karralika, a 50-bed therapeutic community, but the agency also manages four half-way houses; one of these is for women and children, one for families, and two for men.[85] The Government also provides financial support to the Salvation Army, which runs a residential rehabilitation program for men, and the Ted Noffs Foundation, which has recently opened a residential rehabilitation service for youth. In total, the Government funds the provision of 100 residential rehabilitation beds. The ACT runs a needle and syringe program (boasting excellent return rates)[86] and a methadone program (with three streams)[87].

4.68 The New South Wales Government told the Committee it is committed to the view that, when it comes to treatment and rehabilitation, governments need to try to provide a range of options for people. [88] In June 2000, the NSW Government released its promised Drug Treatment Services Plan 2000 – 2005, which is dedicating $120 million over four years towards the enhancement of the range, quality, and availability of drug treatment services in NSW. [89] The Plan, which proposes to augment the number of residential detoxification beds by 42,[90] identifies there is a significant need for more detoxification services for women, Aboriginal and Torres Strait Islanders, adolescents and young people in the State.[91]

4.69 The Northern Territory Government operates a 10-bed detoxification facility in Darwin and supports the operation of a four-bed detoxification facility in Alice Springs. In addition to this, the Territory Government funds a large number of nongovernment organisations to deliver rehabilitation services for people suffering from substance misuse. Altogether, nongovernment organisations manage 167 rehabilitation

85 Submissions Vol. 9, p. 2243.

86 Submissions Vol. 9, p. 2268.

87 Submissions Vol. 9, p. 2271.

88 Evidence, p. 553.

89 NSW Health Department 2000, *The NSW Drug Treatment Services Plan 2000 – 2005,* NSW Health Department, Sydney, p. v.

90 Ibid., p. 19.

91 Ibid., p. 21.

beds.[92] The Territory Government does not currently operate a methadone maintenance program[93], but it runs a needle and syringe program which distributed 440,686 syringes in the 1999-2000 financial year.[94]

4.70 The Queensland Government told the Committee that, while it does not offer long-term residential treatment services, over the past two years it has funded a considerable number of detoxification beds in non-government facilities; at the present time it is funding a withdrawal service for young people at the Mater Hospital. [95] Nongovernment agencies estimated that there are around 50 detoxification beds available throughout the State[96], and between 350-450 rehabilitation beds.[97] The Government's strategic plan advises that the Government has received $4million in NIDS funding for the enhancement and diversification of needle availability and support services, and provided an additional $1.3 million in 1998-99 to expand the State's methadone program.[98]

4.71 The South Australian Government's Drug and Alcohol Services Council fully funds a therapeutic community, the Woolshed, and provides financial assistance to approximately twenty other treatment and rehabilitation services including, for example, the Archway Sobering Up Service. [99] Overall, the State funds the provision of a total of 24 detoxification beds and 171 places in residential rehabilitation establishments. The State has a heroin overdose strategy which Government witnesses claim has been very successful[100], and operates needle and syringe programs with 'as little intervention as possible' to encourage people to use them. [101] The Government told the Committee it has received funds to expand its community-based Clean Needle and Syringe Program, [102] and that it has a 'wait and see' position with regard to supervised injecting facilities.[103]

4.72 The Tasmanian Government operates a ten-bed detoxification facility at 56 Collins Street in Hobart[104] and provides community outpatient support

92 This number is expected to be reduced by 22 sometime in the near future.
93 Evidence, p. 703.
94 Evidence, p. 681.
95 Evidence, p. 736.
96 Submissions Vol. 12, p. 3292.
97 Submissions Vol. 12, p. 3293, and Evidence, p. 772.
98 Queensland Government, 1999, *Beyond a Quick Fix: Queensland Drug Strategic Framework 1999/2000 to 2003/2004*, pp. 96-97.
99 Submissions Vol. 10, p. 2411.
100 Evidence, p. 229.
101 Evidence, p. 236.
102 Submissions Vol. 10, p. 2396.
103 Evidence, p. 237.
104 Evidence, p. 1045.

through alcohol and drug services in the north and south of the State[105]. The State does not run any long-term rehabilitation services because it considers these not to be cost-effective.[106] Two nongovernment organisations operate medium and long-term rehabilitation programs in the State, and one of these receives NIDS funds through the Tasmanian Government. A Needle and Syringe Availability Program (NSAP) has been operating in Tasmania since the introduction of the HIV/AIDS Preventive Measures Act (1993). Needles and syringes are distributed through some 90 outlets in the State.

4.73 The Victorian Government is working to expand treatment services and options; expenditure in this area has more than trebled over the past five or six years.[107] With financial assistance from the Commonwealth, the Victorian Government funds 120 beds for residential drug withdrawal, 176 residential rehabilitation places, and 380 beds for alcohol and drug supported accommodation;[108] all services are community-based. By 2003, the Government expects there will be 800 beds available for rehabilitation, withdrawal, and supported accommodation; this would represent a four-fold increase in bed numbers since the mid-1990s. The State has a Needle and Syringe Program and is planning to further increase the resources dedicated to these services – and to put particular emphasis on retrieval strategies. [109] It has also developed a heroin overdose prevention package which will employ peer education strategies designed to reinforce health education messages to users.[110]

4.74 The Western Australian Government told the Committee its treatment services have been subsantially expanded by a number of measures, including the establishment of 12 Community Drug Service Teams which provide treatment, support to mainstream agencies, and support to the community to prevent drug abuse. [111] The Government funds provision of 29 detoxification beds, 17 through its Specialist Drug and Alcohol Services at Next Step, and 12 through the Salvation Army's Bridge Program. It also funds five major nongovernment agencies which provide, altogether, a total of 117 residential rehabilitation beds. Methadone treatment services

105 Evidence, p. 998.

106 Evidence, p. 997.

107 Evidence, p. 443.

108 Alcohol and drug supported accommodation treatment services provide short-term, safe, secure and affordable supported accommodation to alcohol and drug clients who have undergone a drug withdrawal program or who require assistance in controlling their alcohol and drug use.

109 Evidence, p. 441.

110 Evidence, p. 440.

111 Submissions Vol. 8, p. 1763.

have been expanded through community-based programs, [112] and the State provides naltrexone free of charge to about 450 people through its primary service, Next Step.[113] The Government provides a needle and syringe service which is innovatively linked to the State's heroin overdose strategy: the cost of ambulance call-outs to overdoses is nil, because these are funded by a levy on needles and syringes.[114]

Adequacy of access

4.75 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. The Australian Association of Social Workers, for example, told the Committee that:

> We find all the time that there simply are not the services, the range of services and the diversity of services that there ought to be to cater for them. We have got massive waiting lists all the time to get into residential rehabilitation…[115] .

4.76 In Tasmania, a doctor working at the Hobart Clinic told the Committee that:

> If you are looking at a return for an intervention in the whole alcohol and drug field, methadone stands out. For each dollar you spend on methadone, you save the community between $4 and $20, depending on which study you look at…Yet in Tasmania, there is a huge waiting list for methadone.[116]

4.77 Timely access to treatment is as critical for drug addiction as it is for any other potentially fatal health condition. Access to drug treatment services is a widespread problem, but it 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.[117] The Committee heard, for example, that there are no indigenous illicit drug rehabilitation centres in South Australia, Western Australia, or the Northern Territory.[118]

112 Submissions Vol. 8, p. 1764.
113 Evidence, p. 114.
114 Evidence, 121.
115 Evidence, p. 910.
116 Evidence, p. 1066.
117 Submissions Vol. 13, p. 3709.
118 Evidence, p. 311.

4.78 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[119] from providing this relatively costly service. [120] 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.

4.79 Cost is another aspect of 'access'. While methadone is supplied free-of-charge by the Commonwealth, and most jurisdictions have public programs which supply this for free, most methadone users obtain this from pharmacies and pay from between $25 - $50/week, a not inconsiderable amount for someone on a low, fixed income.[121] A witness from the Salvation Army told the Committee:

> …our family support services would see people who are getting emergency relief of food parcels and fares because they need their money to pay for methadone.[122]

4.80 Other forms of treatment such as naltrexone programs and rehabilitation clinics can cost thousands of dollars, an insurmountable obstacle for prospective clients without well-heeled connections.[123]

Funding

4.81 The Government of the Australian Capital Territory (ACT) spent nearly $8.5 million providing alcohol and other drug services in 2000-01, and expects to spend around $9.5 million in 2001-2002. The New South Wales Government's Plan of Action, developed in response to the Drug Summit in July of 1999, will involve over $500 million in expenditure over the four-year period from 1999-2000/2002-2003.[124] The Northern Territory Government spent a total of $13.6 million in 1999-2000 on the provision of alcohol and drug services. In Queensland, the Health Department spent $37 million on dedicated alcohol and drug services in the 2000- 2001 financial year. In South Australia, fourteen new initiatives are receiving a total of $31 million over four years; the Commonwealth is contributing

---

119 Evidence, p. 500.

120 Evidence, p. 999.

121 Evidence, pp. 181, 508, 657.

122 Evidence, p. 459.

123 Evidence, pp. 836, 405, 772, 1017.

124 Evidence, p. 551.

$13 million for four of these, while the SA Government is contributing $18 million for ten.[125]

4.82 The Tasmanian Government estimates that in 1999-2000 it spent approximately $6 million on its Alcohol and Drug Service budget and grants to nongovernment organisations. In addition to this, the Government spent $2.6 million on drug-related costs at the Royal Hobart Hospital.[126] The Victorian Government has a comprehensive and integrated drug policy framework based on harm minimisation principles, and a dedicated drug budget of some $67 million.[127] In Western Australia, direct expenditure by the Government for drug-related programs across all government services is estimated to have increased by 78.6% from $28.1 million in the 1996-1997 year to $50.2 million in 2000-2001.[128]

4.83 Despite evidence that in recent years some governments have increased expenditure in this area, adequacy of funding remains an issue. One submission cites survey results revealing that demand for services has risen three times faster than funding increases[129]. The Alcohol and other Drugs Council of Australia (ADCA) points out that, while the Federal Government collects about $7 billion each year in alcohol and tobacco taxes, it returns only about 1.6 %[130] (of this amount) each year to prevention and rehabilitation programs. [131]

4.84 Funding inadequacies are reflected in lengthy waiting lists for treatment, described above, but pressure on resources can also affect the quality of service delivery when agencies feel they cannot afford, for example, to hire extra staff, diversify program offerings, evaluate services[132], or send staff off for training to upgrade their skills.[133] As one witness said:

> …drug treatment really works but it's inadequately funded. We cannot get capacity, quality or the range of treatments up with the funding that we have got at the moment.[134]

4.85 Methadone programs should, for example, be comprehensive and involve ongoing counselling and health education as well as dose monitoring.

---

125 Submissions Vol. 10, p. 2396.

126 Submissions Vol. 9, pp. 2115-2116.

127 Evidence, p. 429.

128 Submissions Vol. 8, p. 1766.

129 Submissions Vol. 13, p. 3708.

130 This percentage includes an amount of $115 million obtained from invalidated beer excise revenue collected by the Commonwealth Government on draught beer sales.

131 Submissions Vol. 13, p. 3707.

132 Evidence, p. 134.

133 Evidence, p. 11.

134 Evidence, p. 628.

However, resource shortfalls mean that many of these services are operating principally as methadone distribution centres.[135] People on methadone may not be getting the sort of help they need, as this witness pointed out:

> We are not against methadone, but we certainly think it does not have the counselling, support and guidance at a level that it should have. It is often a matter of stabilising people and putting people on to the program and letting them sit there. [136]

4.86 Insecurity of funding and time-consuming submission-driven funding processes are other important funding-related issues for nongovernment service providers. Many NGOs complained of onerous grant application processes[137] and the frustration of getting up good programs only to have these de-funded several years later.[138] The National Aboriginal Community Controlled Health Organisation, NACCHO, argued that these processes appear to reward the quality of grant applications, rather than the relative merit of proposals.[139] 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.[140]

Workforce development

4.87 According to many witnesses, training for workers in the alcohol and other drug arena is under-funded[141] and there is a shortage of skilled staff in the alcohol and other drug sector. The Australian National Council on Drugs (ANCD) wrote in their submission:

> …the Council is aware of an existing shortage in skilled, trained, professional workers in the alcohol and other drug sector. The current shortage is set to worsen if more efforts are not made to entice professionals such as psychologists, doctors, counsellors, and others to the field.[142]

4.88 In Victoria, for example, the Committee took evidence from the Clinical Director of the Victorian Institute of Forensic Mental Health, who was

135 Evidence, p. 613.
136 Evidence, p .772.
137 Evidence, p. 1031.
138 Evidence, p. 303.
139 Submissions Vol. 7, p. 1491.
140 Evidence, p. 1060.
141 Evidence, p. 11.
142 Submissions Vol. 2, p. 303.

described by one of his colleagues as the only expert in the field of forensic mental health in Australia. The Director told the Committee that:

> We actually allowed knowledge and training in this field to deteriorate in Australia to the point where we do not have any experts of international standing who can combine the knowledge of the treatment of the mentally ill and the treatment of severe and serious substance abuse.[143]

4.89 In an effort to address the issue of workforce development, State and Territory governments around the country are:

- supporting the delivery of tertiary-level training and education of drug service providers, as well as other health and welfare workers;[144]
- investing in the training of youth workers to give them competence to deal with drug issues;[145]
- running training workshops for community-based drug and alcohol workers and developing culturally-sensitive training programs;[146] and
- supporting collaborations between tertiary training providers and government service providers to develop volunteer training programs.[147]

4.90 But the solution to this problem will require more than simply throwing more money into training, as the Director of Victoria's Turning Point Alcohol and Drug Center pointed out to the Committee:

> We have engaged in this country in endless one-off, itsy-bitsy programs, saying 'Throw a bit of training at it; that will be a good thing to do'. We just cannot keep doing that. If there are not proper career structures for workers, we will never have a good drug and alcohol work force. So it is absolutely essential that we work hard across some of the key professions to see what is necessary to have a critical mass of well qualified, trained and committed people, and to keep them in the sector.[148]

4.91 A submission from the National Center for Education and Training in the Addictions (NCETA) pointed out that, while there has been a substantial increase in the provision of alcohol and other drug (AOD) training over

---

143 Evidence, p. 473.

144 Queensland Government 1999, *Beyond a Qiuick Fix: Queensland Drug Strategic Framework 1999/2000 to 2003/2004*, p. 97.

145 Evidence, p. 428.

146 Submissions Vol. 2, pp. 286-287.

147 Evidence, p. 113.

148 Evidence, p. 502.

the past ten years at the tertiary provider level, there has been little definitive documentation of this development. NCETA further noted that at the present time in Australia, there is no overarching mechanism to monitor and guide advances in AOD education and training. NCETA is currently working to establish such a mechanism. [149]

Integration and coordination

4.92 The Committee heard much about the 'siloed' structure of government services, and how lack of coordination is resulting in the duplication of services[150] and/or the neglect of the needs of certain people[151]. One witness explained the problem in the following way:

> The alcohol and drug field is especially affected by the siloed structures of our systems and services, as this field is characterised by its multidisciplinary nature. Alcohol and drug problems are complex, and require comprehensive, multi-sectoral responses. Hence, 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.[152]

4.93 People suffering with both a mental disorder and a drug dependence ('comorbid', or with a 'dual diagnosis') were often cited as an example of where lack of coordination in the health system is resulting in a real failure to assist.[153] The Mental Health Council of Australia pointed to research suggesting that 46 percent of females and 25 percent of males with substance use disorders also experience a mental illness.[154] Conversely, between 30 and 80 percent of those people who are in our mental health services now in Australia have an underlying or associated drug and alcohol problem.[155] However there are very few services equipped for dealing with individuals with 'dual diagnosis', and so they tend to fall between the 'silos' of service structures. As one witness explained:

> When people turn up to the hospital they will not accept them in the mental health ward because they have a drug problem, and

149 Submissions Vol. 12, p. 3403.
150 Evidence, p. 319.
151 Evidence, p. 916.
152 Submissions Vol. 12, p. 3403.
153 Evidence, pp. 471, 822, 875, 953.
154 Evidence, p. 952.
155 Evidence, p. 3.

> they will not accept them into detox because they have a mental health problem.[156]

4.94 The Committee notes that the Commonwealth Department of Health and Aged Care is currently running a National Comorbidity Project[157] which is working on the development of integrated services (at all levels of the health system) for dealing with the challenge of comorbidity. The Committee looks forward to the results of this Project, and to continuing its investigation of this subject as part of this Inquiry in the next Parliament.

4.95 Some governments have attempted to facilitate coordination of the delivery of alcohol and drug services by establishing offices with responsibilities for coordination. In New South Wales, for example, the Government has established an Office of Drug Policy which, among other things, is charged with coordinating drug policy across government and facilitating the integration of programs.[158] Similarly, Western Australia has a Drug Abuse Strategy Office (WADASO) and a designated Minister who is responsible for drug abuse strategy.[159] While the establishment of coordination mechanisms like these has undoubted advantages, WADASO's Director told the Committee that coordination remains a challenge :

> So, trying to coordinate that effort across government and across the community requires a lot of hard work. Structures take you half the way – and I think our structures are good – but I repeat: there is no magic in them.[160]

Management

Planning and evaluation

4.96 Current national drug strategic planning processes are broadly consultative and provide for national leadership while allowing flexibility for States and Territories to ensure that plans developed to address drug problems are responsive to the needs and priorities of particular jurisdictions.[161] 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

156 Evidence, p. 875.
157 Submissions Vol. 9, p. 2050.
158 Evidence, p. 552.
159 Submissions Vol. 8, p. 1765.
160 Evidence, p. 107.
161 Submissions Vol. 9, p. 1992, and Evidence, p. 230.

efforts. With regard to the recently-developed National Tobacco Strategy (NTS), for example, the federal Department of Health and Aged Care said:

> In terms of performance information, the NTS currently identifies long and short-term indicators, including reference to existing baselines and sources of data. It recognises the need to strengthen existing, or develop new, baselines against the prevalence indicators and process indicators against which the strategies will be assessed.[162]

4.97 During the Inquiry, a number of key nongovernment agencies called for governments to be more specific in their goal-setting – in short, to set some hard targets. The Alcohol and Drug Foundation of Queensland, for example, strongly recommended that all government strategies and programs state benchmarks and quantitative goals. It said that very few programs and services forecast what is hoped to be achieved.[163] The CEO of the Alcohol and other Drugs Council of Australia (ADCA) suggested a reason for this could be:

> The setting of targets is too often avoided by organisations as they are afraid they will be held accountable if they are not achieved.[164]

4.98 Related to this call for greater specificity about desired outcomes is the recommendation that strategic approaches be more focused on the needs of particular population groups.[165] 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.

4.99 Greater specificity about program outcomes is a pre-requisite for the generation of useful program evaluation information. The most recent evaluation of the National Drug Strategy recommended there be a significant increase in the proportion of treatment and prevention programs which are subjected to systematic outcome evaluation.[166] A number of witnesses passed on this message to the Committee.[167] One said:

> I would like to push that we really need good research and evaluation frameworks because we cannot be dynamic and progressive in this issue unless we constantly self-assess it and

---

162 Submissions Vol. 9, p. 1993.

163 Submissions Vol. 12, p. 3313.

164 Evidence, p. 4.

165 Submissions Vol. 8, p. 1817, and Evidence, p. 951.

166 Single, E., & Rohl, T. 1997, *The National Drug Strategy: mapping the future,* AGPS, Canberra, p. 86.

167 See for example Evidence, p. 434.

> self-evaluate what is going on. I would say that that is a real priority, both locally, nationally and globally…[168].

Accountability

4.100 The Committee was disappointed to find a lack of easily-accessible, coherent, basic information which could have supported deliberations on this Inquiry. It sought, for example, a comprehensive list of treatment service providers from the Commonwealth, only to discover that such a thing did not exist. In the end, the Committee obtained information directly from jurisdictions, and the ANCD told the Committee it has commissioned some work to:[169]

> …try to get a map of what drug and alcohol services exist, where they are located, whom they service and how many beds are available. It is difficult to make decisions when you do not have a complete map of what exists here and now.

4.101 Similarly, a submission from the National Centre for Education and Training in the Addictions (NCETA) pointed to the lack of a consolidated national database to support workforce development planning.[170]

4.102 The Committee is equally concerned about the fact that, at the present time, it is not possible to get a firm handle on national expenditure in the AOD arena. While such an undertaking would always have been a substantial challenge, it has been made even more difficult since the Commonwealth has been providing NDS financial assistance to States and Territories through a broadbanded funding mechanism (the Public Health Outcome Funding Agreements, or PHOFAs) which does not require the reporting of expenditure for particular programs.[171] The National Public Health Expenditure Project was established to facilitate the development of agreed national reporting procedures to enable cost-benefit analyses of different kinds of public health activities[172]; the Committee understands that work is currently underway and results are expected to be published later this year and early next year.

4.103 The Committee supports the call made by the Alcohol and other Drugs Council of Australia (ADCA) for all governments, including the Federal Government, to report annually to their Parliaments on the amount of

---

168 Evidence, p. 700.

169 Evidence, p. 850.

170 Submissions Vol. 12, p. 3408.

171 Submissions Vol. 9, p. 2009.

172 Submissions Vol. 9, p. 2010.

money spent on all alcohol and other drug programs, and on the outcomes generated by this expenditure.[173]

Balance of effort

4.104 Health experts have long argued that there is an imbalance in the amount of effort and resources going into prevention and treatment areas. While there is obvious merit and economies to be gained by investing in prevention, treatment services have usually received the lion's share of resources. This has been true in the AOD area as well, but, as previous sections of this report have indicated, there is a recent burgeoning of interest and expenditure in the prevention of drug problems, and the Committee applauds this development. While the Committee sees the merit of placing a greater emphasis on prevention, it would not like to see this achieved at the expense of a diminution of resource allocation for treatment.

4.105 Of greater interest to the Committee in this Inquiry has been the balance of effort with regard to licit and illicit drug abuse; it seemed to Members that the preponderance of interest and activity was directed at illicit drugs. Numerous agencies [174] expressed their dismay at how a preoccupation with illicit drugs has resulted in relative inattention to the social and economic costs associated with the abuse of alcohol and tobacco, which accounts for the vast majority of social harms. This disproportionate focus on illicit drugs is reflected in relatively modest Commonwealth outlays for alcohol and tobacco programs, though the Committee is pleased to see that this imbalance has been somewhat redressed by the recent announcement that $115 million of Commonwealth monies are to be dedicated (through the newly-established Alcohol Education and Rehabilitation Foundation) for licit drug harm minimisation activities.

4.106 The Committee acknowledges there has been a disproportionate emphasis in the Inquiry thus far to the social effects of illegal drug abuse. This reflects, we think, greater levels of community concern about the abuse of illegal drugs.

Community attitudes

4.107 The NSW Government acknowledged to the Committee that it was having trouble locating treatment services in some areas of need because of the 'NIMBY' (Not in My Back Yard) factor. A Government witness explained to the Committee that:

173 Submissions Vol. 13, p. 3707.

174 See, for example, Evidence, pp. 453, 983, 132, 589.

> There is a problem in expansion of treatment services and as a member for this area you will be well aware of that in that there is a very strong NIMBY factor that goes with treatment services, that people are concerned about having such facilities located in their areas. We have to try and find ways to deal with that particular characteristic but it has caused some delay for us in terms of expansion of services. I have additional funds for additional services for this area and we are having great trouble in expanding services in relation to that.[175]

4.108 Other State and Territory governments experience similar problems in their jurisdictions.[176] The Committee thinks it is a sad irony that, while many in the community are demanding more resources to help deal with this important social problem, others are denying the scope of the drug problem or else insisting on its being dealt with somewhere else. A member of Family Drug Support (FDS) in Sydney said:

> We need to have an acceptance. It angers me so much to hear the mayor Fairfield sitting here this morning spending $2 million on surveillance cameras and paying lip service to treatment, yet they will not have a treatment centre in Fairfield or Cabramatta. The state government is willing to provide them with one. Now it is just bullshit when he sits here and he says, 'It's their fault'. I commend the community of Kings Cross, who have lived with this problem for 30 years and have said, 'We have got the problem. We are not in denial; we are willing to accept it.'[177]

4.109 Lack of acceptance and understanding about drug abuse is widespread in the community and sometimes it is encountered where it is least expected. The Committee heard stories from people on methadone complaining about the attitude of some chemists, for example. A mother in Western Australia said:

> Amanda would go into the chemist and there would be three people there, and so she would wait. Then more people would come in, and he would make her wait until there was no one in there, and then he would make a big thing of giving it to her. Or if she said, 'Look, I am really in a hurry', or whatever, he would say, 'You are only getting methadone; you can wait'. It was that sort of attitude.[178]

175 Evidence, p. 578.
176 Evidence, p. 118.
177 Evidence, p. 616.
178 Evidence, p. 199.

4.110 The CEO of the Youth Substance Abuse Service in Victoria said that some chemists probably did need to improve the way in which they regard individuals coming in to fill methadone prescriptions. He pointed out that one of the possible consequences of a negative experience at the chemist is dropping out of treatment[179] - a move which can have fatal results.

4.111 The Australian National Council on Drugs argued in their submission to the Inquiry that more needs to be done to educate the community about drugs. The media, they suggested, could play a more positive role:

> Council is urging the sector to engage with the community in an attempt to raise the level of understanding and awareness of both the broad drug issue and the specific nature of the services provided in their area. Media portrayals of drug-related issues is not always balanced, and often focuses on negatives, and it is important to attempt to achieve a balance in the information getting out into the public arena.[180]

4.112 Certainly, there were many witnesses who referred to the negative role played by the media in creating unnecessary levels of fear and division in the community.[181] The Committee had experiences of its own which illustrated the negative potential of the media in this area.[182]

4.113 The Committee is persuaded that governments and people employed in the alcohol and other drug (AOD) sector need to work harder at engaging the media to do what it can to promote reasoned debate in the community. Some governments [183] already appear to be engaging successfully with the media in this way.

4.114 The Committee convened a private meeting at Parliament House on 8 August 2001 to discuss the role of the media in the area of substance abuse – in particular, whether the development of voluntary media guidelines for the reporting of drug issues might help to improve the quality of general reportage. The Committee was encouraged by the response of the media and NGO representatives who attended the meeting, and would like to continue to explore this particular issue as part of this Inquiry in the next Parliament.

179 Evidence, p. 527.

180 Submissions Vol. 2, p. 305.

181 See for example Evidence, pp. 582, 864, 847, 887, 240, 241, 437, 495.

182 Evidence, p. 437.

183 Evidence, p. 111.

Summary

4.115 The Committee is aware of the magnitude and complexity of the challenges facing governments tasked with the job of figuring out how to devise and fund service delivery systems that are innovative but responsible, humane but effective and efficient, flexible but accountable. The sorts of system challenges posed by substance abuse are not unknown in the health arena, where one often hears of the need for better coordination and cooperation, not to say better funding and accountability.

4.116 Try as we might to argue it is more appropriate and helpful to regard substance abuse as a chronic, relapsing disorder, in many sectors of the community there persists the view that people with drug dependence problems are bad, rather than sick. One of the reasons why it is difficult to combat this widely-held impression is that the phenomenon of addiction to illegal drugs is linked – in reality and in peoples' minds - with crime. Life is tough for alcoholics, but at least they don't have the additional misfortune of being addicted to a substance which is illegal. They, too, can find themselves on the wrong side of the law, but the negativity directed at them is nothing compared to that which is reserved for those who are dependent on other (illegal) substances.

4.117 We have to work harder to combat the corrosive effects of prejudice and ignorance. We believe these are limiting the ability of governments and communities to devise health systems with the capacity to provide, as we said at the beginning of this chapter, the services and staff which we need to have in a position to help, at the right time and place in the life of a person with a drug dependence problem.