Mental Health and Alcohol and Other drugs Strategy Discussion Paper Written Submission

10 December 2024

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Commissioner - Mental Health, Alcohol and Other Drugs
Mental Health Commission

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Dear Commissioner

Thank you for the opportunity to provide a written submission to the *Mental Health and Alcohol and Other Drug Strategy 2025 – 2030: Discussion Paper*.

WANADA appreciates the thought that has gone into the Discussion Paper, and the difficulties in developing a single strategy that is suitable for multiple systems – mental health, suicide, and alcohol and other drugs. The taxonomy for these systems is not always easy to match and service demand across the systems far outstretches the current service availability.

WANADA supports what the proposed Strategy aims to achieve (as presented in the Scope of the Strategy) and appreciates the intent. We welcome the focus on systems development and prioritisation across the continuum of care as well as the need for a person-centred approach that supports equitable access and addresses intersecting complexities within and beyond the remit of this Strategy. The recognition of the need for reform is very much welcomed, including in service modelling that should be informed by best evidence as well as community consultation. A Strategy that aims to be provider and funder neutral is invaluable when alcohol and other drug responses need to address cross-government agendas, and service diversity to meet diverse community needs has long been identified as a strength within the alcohol and other service sector and the rationale for predominant not-for-profit service provision.

The recognition of the unique differences between the mental health and alcohol and other drug systems and services is applauded, and clearly implies the need for strategies that enable an intersectional response.

WANADA's response is predominantly focused on the alcohol and other drug system and services, with the view that a sound system and quality services will respond to the multiple complexities that individuals, families and communities present with. As such, WANADA's response to the Discussion Paper does not correlate to the questions posed. We have responded where appropriate to what we see is strategically best for the community that is impacted by alcohol and other drugs.

I hope this response is of value and supportive of your process in developing a mental health, suicide, and alcohol and other drug strategy.

Yours sincerely

Jill Runde
CEO
WANADA

Contents

Acknowledgement of Country

WANADA acknowledge the traditional custodians of Country on which this submission was developed, the Whadjuk people of the Noongar Nation. We acknowledge their continuing and unbroken connection to land, sea and community. We pay our respect to their culture and Elders, past and present and acknowledge their ongoing contribution to WA society and the community.

About WANADA

The Western Australian Network of Alcohol and other Drug Agencies (WANADA) is the peak body for the specialist alcohol and other drug education, prevention, treatment and support sector in Western Australia. WANADA is an independent, membership-driven, not-for-profit association, currently representing approximately 65 member organisations (over 100 alcohol and other drug specific services across the state).

WANADA is driven by the passion and hard work of its member organisations, which include community alcohol and other drug counselling; therapeutic communities; residential rehabilitation; intoxication management; harm reduction; peer based; prevention; and community development services.

Recommendations

1. The proposed Strategy maintain a clear distinction between the alcohol and other drug and the mental health systems.
2. A meaningful and measurable strategy purpose be considered in place of a vision, incorporating structural requirements for success.
3. The proposed Strategy, as it applies to the alcohol and other drug system, emphasises the need for transformation that more appropriately focuses on community/population health and harm reduction to reduce the future acute/tertiary service demand.
4. The proposed Strategy aims are broadened to incorporate systems development intent and include targets that are measurable.
5. Initiate a systemic approach to reducing alcohol and other drug stigma and discrimination that considers the Western Australian context.
6. Equitable access, pathways and a balanced alcohol and other drug system is an enabler aimed at meeting the needs of all Western Australians.
7. The prevention and promotion (of health and well-being) pillar of the proposed Strategy be aligned with, and clearly defined by primordial and primary prevention as per, the *National Preventive Health Strategy 2021 – 2030*.
8. Community support, as it applies to the alcohol and other drug system, remains integrated with (community and community bed-based) treatment.
9. Strategic pillar 3, for the alcohol and other drug system, is dedicated to alcohol and other drug harm reduction.
10. A single dedicated focus area for alcohol and other drug community treatment to support systems awareness and development.
11. A dedicated focus area for alcohol and other drug community bed-based **treatment** to support clarity of purpose, systems awareness and development.
12. A dedicated Forensic Services pillar be created, with a specific focus area for alcohol and other drugs.
13. Capability building priorities be established through meaningful consultation with the alcohol and other drug sector and the affected community to inform planning and development.
14. A community alcohol and other drug summit in 2025/26 to contribute to community acceptability of evidenced and practical solutions for a planned approach to address the many gaps in the alcohol and other drug system to meet community needs.

Overview

Alignment with national strategies

WANADA would expect the proposed WA Mental Health and Alcohol and Other Drug Strategy to strongly align with the relevant national strategies – i.e. the *National Drug Strategy 2017-2026* (including the sub-strategies and relevant frameworks) and the *National Preventive Health Strategy 2021-2030*.

> [The National Drug Strategy] *identifies national priorities relating to alcohol, tobacco and other drugs, guides action by governments in partnership with service providers and the community and outlines a national commitment to harm minimisation through balanced adoption of effective demand, supply and harm reduction strategies. Its aim is to build safe, healthy and resilient Australian communities through preventing and minimising alcohol, tobacco and other drug-related health, social, cultural and economic harms among individuals, families and communities.*[1]

While the National Drug Strategy is currently under review, the pillars have remained consistent for many decades. The Discussion Paper includes consideration for demand and harm reduction variously throughout the proposed Strategy pillars. WANADA appreciates the pending development of the WA Alcohol and Other Drug Framework will provide an opportunity to broaden this scope to include supply reduction and possible increased emphasis on families and communities. The Mental Health Commission and the alcohol and other drug sector has a role in informing and is impacted by supply reduction initiatives including liquor licencing, restrictions, other supply regulations and law enforcement generally. WANADA believes this is inadequately considered.

The National Preventive Health Strategy addresses *the increasing burden of disease, reducing health inequity and increasing preparedness for emerging health threats*.[2] There are five 'types' of prevention identified, which for the alcohol and other drug system broadly correlate to the demand and harm reduction pillars of the National Drug Strategy.[3] These prevention types identify the relevance across the life-course of individuals, within family systems and the community.

Within the seven priority focus areas that contribute most to the health and social burden identified in the National Preventive Health Strategy, three are related to the proposed Strategy (reducing tobacco use, reducing alcohol and other drug harms, and promoting and protecting mental health). As such, the National Preventive Health Strategy should provide a foundation to the proposed Strategy.

WANADA would welcome clear demonstrated alignment with relevant national strategies, including the achievable national targets that Western Australia should strive to contribute toward. This is of additional importance given the aim of funder-neutrality.

Relevant key statistics

WANADA appreciates the Discussion Paper is intended to generate thought, and much of the information will not likely be included in the proposed Strategy. Unfortunately, the key statistics presented in the Discussion Paper do not reflect the growing sense of sector and community concern regarding alcohol and other drug use that WANADA is hearing. The inadequacies of these statistics do not provide confidence that the proposed Strategy will result in responses to address the levels of harm, or support needed reform.

It is important to note that Western Australia has some of the worst statistics compared with other Australian jurisdictions across a range of metrics. This is evidently putting pressure on communities,

[1] Commonwealth of Australia, Department of Health. (2017). National Drug Strategy 2017–2026. Pp.1
[2] Commonwealth of Australia, Department of Health. (2021). National Preventive Health Strategy 2021–2030. Pp.3
[3] Ibid. Pp.23

families, individuals, the sector and related systems. Examples of alarming statistics, while by no means comprehensive, include:

- WA has the highest rate of unintentional drug-induced deaths nationally by jurisdiction since 2011[4]
- WA recorded the highest increase and rate of unintentional deaths involving stimulants (3.8 per 100,000 population)[5]
- WA has the second highest unintentional deaths by opioid substances (2.7 per 100,000 population)[6]
- 20% of Western Australians consumed any illicit drug in 2022-23 (second highest nationally)[7]
- 33% of Western Australians aged over 14, consumed alcohol at levels that put their health at risk in 2022-23 (third highest nationally)[8]
- 4,599 hospitalisations in WA related to drugs (2021-22)[9]
- 20,917 hospitalisations in WA related to alcohol (2019)[10]
- 5,914 ambulance call outs in WA related to alcohol intoxication (2021)[11]
- 9,382 alcohol-related family assaults in WA occurred in (2021)[12]
- 36% of young people in Banksia Hill Detention Centre diagnosed with FASD (2015-16)[13]
- 26.6% of adults in regional areas and 24.3% in metropolitan WA exceeded the alcohol lifetime risk guidelines (2020)[14]
- Over 345,000 people in WA identified as being a victim of a drug-related incident (in the 12 months to 2019)[15]

Given the higher consumption of alcohol and other drugs per population in WA, the national statistics are also alarmingly relevant. They frequently reference the social costs of alcohol and other drug use, as well as inform priority populations that need to be considered in the proposed Strategy.

Western Australia needs to do better.

WANADA appreciates the relevance of the intersection between suicide and mental health. The suicide statistics presented in the Discussion Paper do not, however, adequately represent the intersectionality with alcohol and other drugs.

- Suicide is a leading cause of death for people aged 20-39 years, with 49 intentional suicides through illicit drug use in WA in 2022 (noting this number may be higher).[16]
- alcohol consumption has shown to be associated with 65% increased risk of suicidality[17]

[4] Penington Institute. (2024). Australia's Annual Overdose Report 2024. Pp.33
[5] Ibid. Pp.135
[6] Ibid. Pp.218
[7] Australian Institute of Health and Welfare. (2024). National Drug Strategy Household Survey 2022–2023: State and Territory summaries of alcohol, tobacco, e-cigarette and other drug use
[8] Ibid
[9] Chrzanowska A, Man N, Sutherland R, Degenhardt L and Peacock A (2021) *Trends in drug-related hospitalisations in Australia, 1999-2020*, National Drug and Alcohol Research Centre, UNSW.
[10] Mental Health Commission. (2021). *Alcohol Harm Statistics*. Alcohol. Think Again
[11] St John WA (2022*) Surge in alcohol-related ambulance cases prompts warning for revellers.*
[12] Cancer Council Western Australia, WA Network of Alcohol and other Drug Agencies, Alcohol and Drug Foundation and Telethon Kids Institute (2022) *WA's Hidden Crisis: Harm from Alcohol.*
[13] Bower C, Watkins RE, Mutch RC, et al. (2018) *Fetal alcohol spectrum disorder and youth justice: a prevalence study among young people sentenced to detention in Western Australia*, doi: 10.1136/bmjopen-2017-019605.
[14] Epidemiology Directorate, WA Department of Health (2021) *Health and Wellbeing of Adults in Western Australia 2020, Overview and Trends.* Pp.55
[15] Australian Institute of Health and Welfare (2019) *National Drug Strategy Household Survey* (Table S.50).
Note: Incidents refer to verbal and/or physical abuse or being put in fear by someone they suspect is under the influence of illicit drugs.
[16] Penington Institute. (2024). Australia's Annual Overdose Report 2024. Pp.26
[17] Amiri, S., & Behnezhad. S. (2020). Alcohol use and risk of suicide: a systematic review and Meta-analysis - PubMed

- 48% of the estimated burden of suicide and self-inflicted injuries is due to four modifiable risk factors, including alcohol, child abuse and neglect, intimate partner violence, and illicit drug use.[18]

Representing the unique differences of the mental health and alcohol and other drug systems while also addressing intersectionality

WANADA understands the pillars as represented in the Discussion Paper relate more closely to the taxonomy of the mental health system. For a combined systems Strategy there is benefit in applying a consistent taxonomy. This was recognised as important in the *WA Mental Health, Alcohol and Other Drug Services Plan 2015-2025*. Consideration, however, of the different systems requirements needs to allow for flexibility, an appreciation of the current strengths, challenges and reform priorities within the different systems.

WANADA believes the blended mental health and alcohol and other drug focus areas, as presented within the Discussion Paper pillars, reduces the clarity of both systems. WANADA proposes separating and defining alcohol and other drug system requirements within each of the pillars to enable increased understanding of the system as a whole, enabling a better sense of the system gaps, system balancing and reform requirements.

Intersectionality between mental health and alcohol and other drugs – supporting appropriate responsiveness in both systems – is an enabler (referred to in the Discussion Paper as 'system integration'). Research suggests system integration is best achieved through service collaboration. WANADA and WAAMH have proposed a process to support cross-sector capability building for improved and appropriate responsiveness in addressing the intersecting issues. This cannot be at the expense of strong independent systems.

Recommendation 1:

The proposed Strategy maintain a clear distinction between the alcohol and other drug and the mental health systems.

WANADA hopes that its response to the Discussion Paper provides example solutions that support this recommendation.

[18] Cancer Council Western Australia, WA Network of Alcohol and other Drug Agencies, Alcohol and Drug Foundation and Telethon Kids Institute. (2022). WA's Hidden Crisis: Harm from alcohol

Vision, Aim and Principles

We appreciate the proposed joint Strategy needs to consider shared elements, such as vision, aim and principles.

Proposed Vision - *All Western Australians experience optimal wellbeing and quality of life.*
WANADA believes the nuances of the two systems that the proposed Strategy represents are necessarily lost in a shared and overly generalised vision. What would be the measures for progress against this vision, achieved through the implementation of the proposed Strategy?

The current National Drug Strategy presents a 'purpose' rather than a 'vision', which identifies the evidence informed elements that are required to achieve success – i.e. partnerships between governments, service providers and community and commitment to the framework and balanced system. WANADA is not suggesting such partnerships or commitment have necessarily been demonstrated, however they introduce the opportunity for consistency across systems and stakeholders, for evaluation and continual improvement irrespective of Government changes or personnel changes in decision makers.

Recommendation 2:
A meaningful and measurable strategy purpose be considered in place of a vision, incorporating structural requirements for success.

Proposed Aim – *Drive mental health and alcohol and ither drugs system transformation so that …*
As stated above, WANADA appreciates the proposed Strategy aims identified in the Discussion Paper 'Scope of the Strategy'. The aim, as presented in the Discussion Paper 'Section 4', is reductive, reflects a singular system for transformation (rather than transformation requirements for the unique systems). Three of the dot point intents for transformation within the aim in section 4 of the Discussion Paper are individual focused, as distinct from system focused, while the fourth dot point is more related to governance. The aim excludes prevention, life-course and community-led considerations, all of which present opportunities for significant evidence-informed 'transformation' of a system.

Recommendation 3:
The proposed Strategy, as it applies to the alcohol and other drug system, emphasises the need for transformation that more appropriately focuses on community/population health and harm reduction to reduce the future acute/tertiary service demand.

WANADA believes the intent of system transformation (i.e. '… transformation so that:') speaks more to enablers for improvement. Feedback on enablers is presented below.

The National Drug Strategy aim emphasises the alcohol and other drug-related harms as they intersect with multiple systems (health, social, cultural and economic). It also speaks to these harms as they impact on individuals, families (not just individual family members/carers), and communities. Such an aim is transformative in recognising the need for a population health approach.[19]

The aims in the National Preventive Health Strategy identify relevant targets, for example against the aim of 'investment in prevention is increased' the target is 5% of total health expenditure.[20] The Discussion Paper indicates that this has already been achieved for the alcohol and other drug system in Western Australia, with 14% on prevention. As the whole alcohol and other drug system falls under preventative health and the allocation of what is identified for alcohol and other drugs in the 'prevention and promotion' pillar, this

[19] Commonwealth of Australia, Department of Health. (2017). National Drug Strategy 2017–2026. Pp.1
[20] Commonwealth of Australia, Department of Health. (2017). National Preventive Health Strategy 2021–2030. Pp.9

figure needs to be more transparent and related only to primordial and primary prevention. The alcohol and other drug sector has provided WANADA with a clear message - that prevention and well-being promotion at the community level needs to be much better resourced to stem the flow of acute presentations. Community engagement/development approach to prevention is evidence-informed, targeted and relevant to the community context (community informed and led), and cost efficient compared to media campaigns.

Recommendation 4:
The proposed Strategy aims are broadened to incorporate systems development intent and include targets that are measurable.

System transformation needs to be clearly understood before it can be translated into practice. WANADA believes alcohol and other drug system transformation needs to be informed by local knowledge and responsive to risks and harm experienced in the community. This will require effective engagement with the alcohol and other drug sector (including service users) and the community impacted by alcohol and other drug use.

Proposed Principles – *as per page 21 of the Discussion Paper*
There are four clear principles within the Nation Drug Strategy:

- Partnerships
- Coordination and collaboration
- National direction and jurisdictional implementation
- Evidence-informed responses.

From WANADA's perspective these are sound strategy principles that can translate to the State proposed Strategy for the alcohol and other drug system.

These principles are intended to guide the governance of the strategy. Implementation would require a focus on the enablers, including collaboration across relevant funding bodies for resourcing to ensure there are enough services to meet community demand, etc.

Many of the guiding principles in Discussion Paper are practice rather than strategy oriented. WANADA sees it as a given that services within the alcohol and other drug system are, for example: responsive, accountable and deliver quality, responsive to family and significant others as well as supportive of family systems well-being, person-centred and needs driven in relation to the complexities that individuals, families and communities present with, and are trauma informed. These 'principles'/practices are included in quality requirements, and are enhanced, for example, by being required to engage with communities and be responsive to their needs. If services need to be accountable to these 'principles' they would be better placed in service agreements rather than the proposed dual systems Strategy.

WANADA has concerns with a number of the suggested principles from the Discussion Paper.

- Any 'community-led' principle requires considerable unpacking in relation to what this means in practice. WANADA would welcome community engagement to enable partnership. WANADA sees community leadership and partnership as being very different to being 'place based' - which speaks more to ensuring adequate resources enable equitable access to services across the service system.
- A 'human rights centred' principle is foundational, however is challenged by existing stigmatising and discriminating government legislation and policies, including for example, criminalisation of some drugs while others can be promoted for profit motives, and juveniles with cognitive impairment being overrepresented in a criminal justice system.

- A 'recovery oriented' principle is similarly challenged by legal/criminal implications that may curb individual preferences and self-determination. The reference to abstinence in this context is misplaced. It is not in and of itself a final goal in alcohol and other drug recovery. The National Drug Strategy emphasises 'quality of life' as a recovery indicator:

  > *Evidence indicates that maintenance of recovery is strongly associated with quality of life. Quality of life factors include issues such as family life, connection to community, employment and recreational opportunities. Therefore, investing in strategies to enhance social engagement, and where indicated, re-integration with community, is central to successful interventions that can reduce alcohol and drug demand and related problems, including dependence.*[21]

[21] Commonwealth of Australia, Department of Health. (2017). National Drug Strategy 2017–2026. Pp.9

Priority population groups

> *Whole of population strategies can be very effective at reducing total harm and social impact of alcohol and drug use. However, there are specific priority population groups who have higher risk of experiencing disproportionate harms (direct and indirect) associated with alcohol, tobacco and other drugs. Policy responses designed to prevent and minimise the harms of alcohol, tobacco and other drugs should have particular reference to these priority populations, to ensure that new efforts will benefit those most at risk of harm, marginalisation and disadvantage.*[22]
>
> *Approaches and policy responses aimed at reducing alcohol, tobacco and other drug harms in priority populations should be informed by evidence as it develops and should be reviewed regularly. It is also important that any responses do not inadvertently or unintentionally further marginalise or stigmatise people who are at higher risk of experiencing alcohol, tobacco and other drug related harm.*[23]

Based on available evidence relevant to alcohol and other drug risk factors, WANADA is supportive of the need to prioritise population groups such as:

- Aboriginal peoples
- ethnoculturally and linguistically diverse
- LGBTQIA+SB.

WANADA is also supportive of a Strategy that enable relevant life-course responses, from prenatal to retirement/older age.

Many of the alcohol and other drug services that WANADA has consulted with over the last 12 months have reported experiencing increasing complexity and associated experiences of crisis in service user presentations. Noting that the level of complexity has always been an integral part of the treatment and support that they provide, what was consistently shared, is that relevant services from other sectors (e.g. mental health, health, homelessness, family and domestic violence, etc.) are not working with people who use or have an alcohol and other drug concern. Consequently, many cross-sector services are diverting people to alcohol and other drug services prior to meeting individuals' primary needs.

These complexities highlight the need to prioritise different population groups, including:

People with co-occurring alcohol and other drug and mental health concerns.

> *Up to 90% of people receiving alcohol and other drug treatment have at least one co-occurring mental health condition, and up to 71% of people in mental health treatment experience alcohol and other drug use issues. People with these co-occurring conditions often face complex challenges, including more severe health and social issues and complicated treatment needs.* [24]

There is a need to build the capability of services in both sectors to be responsive to these co-occurring concerns, ensuring the intersecting impacts can be addressed. This has been highlighted as a need for many decades. The solution is not a 'one-stop-shop' integrated service, but a recognition of the need for responsiveness from both specialist sectors. WANADA and WAAMH developed and trialled a capability building tool to enable better outcomes for people presenting with this co-occurrence. WANADA continues to hear from our member services that mental health services are 'referring people with alcohol and other drug use concerns before they address their mental health issues'. The prioritisation of this population group endorses strategies to ameliorate this situation to achieve the vision of the strategy, and indeed, the

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[22] Commonwealth of Australia, Department of Health. (2017). National Drug Strategy 2017–2026. Pp.26
[23] Ibid
[24] Lee, N., & Allsop, S. (2020). Exploring the place of alcohol and other drug services in a successful mental health system

primary purpose of amalgamation of alcohol and other drug governance into the Mental Health Commission in 2015.

Individuals with neurodiversity and impaired cognitive function

Western Australian alcohol and other drug services are reporting an increase in people presenting with neurodivergence as well as impaired cognitive function.

Alcohol and other drug services are not specialists in addressing these additional concerns. There are, however, alcohol and other drug services that are building their capabilities in this respect, and an `opportunity to build the capability of the alcohol and other drug service sector as a whole to be responsive to, and have strategies to enhance engagement, to achieve better outcomes. Highlighting individuals with neurodiversity and impaired cognitive function as a priority population group will ensure there is a commitment to workforce development, service modelling and planning, and established referral pathways where needed. The need to consider the intersectionality of alcohol and other drug and neurodiversity is -+reflected in research.

> *It is acknowledged that neurodivergence impacts the way in which people engage in substance use. People with ADHD and/or ASD, for example, may be more likely to engage in problematic substance use and to use substances to manage symptoms of their neurodivergence.*[25]

Those involved in the criminal justice system

> *Around 70% of offenders reported consuming drugs in the 12-months prior to entering the custodial system.*[26]
>
> *In 2022-2023, there were 5,786 (or 16% of total) offences where the principle offence types were illicit drug related.*[27]

It is broadly recognised that a significant proportion of offenders in WA prisons have alcohol and other drug concerns. People engaged in the criminal justice system experience significant stigma and discrimination and face significant barriers to maintaining their health, and social and emotional wellbeing while incarcerated and post-release.

The likelihood of illicit drug consumers contracting a blood-borne virus is high while incarcerated, there is a significant overdose risk in the days after release, and employment and housing options are limited, placing them at risk of homelessness. Coordinated cross-government systems planning needs to be responsive to the needs of people who are involved in the criminal justice system ensuring the range of initiatives across the alcohol and other drug system are available and understood. Appropriate alcohol and other drug responses will maximise the benefits of any recovery efforts and contribute to reducing the cycle of incarceration.

Access to alcohol and other drug treatment and support is inconsistent across the Western Australian justice and prison system. Justice is also a commissioning body for alcohol and other drug services and refers to services. There are concerns that some referrals breach the requirements of the *National Quality Framework for Drug and Alcohol Treatment Services*. This demonstrates the prioritised need for a funder neutral, whole of Government strategy that ensures consistency and accountability to the National and State strategies, policies and frameworks, collectively addressing stigma and discrimination and ensuring human rights.

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[25] New Zealand Drug Foundation. (2024). Report: Neurodivergence and substance use
[26] Office of the General Auditor. (2017). Minimising drugs and alcohol in Prisons. Executive summary.
[27] Australian Bureau of Statistics. (2024). Recorded Crime - Offenders, 2022-23 financial year

WANADA member services are reporting increased referrals from the justice system. They report many of these referrals are not suitable – contributing to a number of 'non-attendance'. Cross-sector capability building needs to focus on appropriate screening, assessment and referral practices of cross-government bodies, ensuring the under-resourced community alcohol and other drug sector is efficient in meeting community demand.

Whole families at risk including those at risk of child protection system engagement

Through consultation, WANADA heard that whole families are at risk of alcohol and other drug related harms. System-wide leadership and strategic coordination is needed to enable a life course and a family systems approach to address multi-generational exposure to alcohol and other drug related harms. This approach is based on reducing risk factors and alcohol and other drug related harms from prenatal through to retirement/older age and requires whole-of-government responsiveness.

People and communities from regional rural and remote locations

68 non-government organisation services provide treatment and support in major WA cities, 8 in the inner region, 17 in the outer region, 15 in remote areas, and 14 in very remote areas.[28] People and communities from regional, rural and remote locations need equitable access to alcohol and other drug services across the service system`.

People and communities in the Kimberley, Pilbara and Goldfields are the most disadvantaged, and therefore at increased risk of alcohol and other drug harms.[29] In terms of illicit drugs, regional, rural and remote Western Australia has one of the highest rates of unintentional overdose in the nation (8.2 per 100,000 population), a rate that has been steadily increasing since 2002.[30] The broader implications of alcohol and other drug related harms are more visible and acute due to the size of communities, insufficient cross-sector service providers, and services not having capacity to meet demand - compounded by significant specialist workforce related challenges including access to housing.

The cheaper cost of illicit drugs compared to alcohol (in light of law enforcement implications, not levels of harm) is frequently shared with WANADA and has been reported in the media. This is seen as an inadvertent consequence of alcohol restrictions and controls, compounding cost of living, increasing homelessness, and other complex inter-generational and societal issues. Alcohol and other drug use impacts vulnerable members of the community, including children, and undoubtedly contributing to high rates of suicidal distress. The proposed Strategy needs to ensure these consequences are adequately considered in policy developments and are not used as a rationale for reducing alcohol and other drug service provision. The proposed Strategy needs to ensure against the possibility of harms relating to changing drug trends.

People experiencing poverty or significant disadvantage

In Western Australia, 10% of locations account for 56% of the most disadvantaged.[31] Across the domains of social distress, health, environmental, economic, community safety, education and lifetime disadvantage, two-thirds of disadvantage was experienced outside of Perth.[32] People who experience poverty and significant disadvantage face several barriers to accessing alcohol and other drug services (not enough services, transport or even digital access). This population group faces considerable risks associated with multi-generational exposure to alcohol and other drug related harms, higher rates of intersecting alcohol

[28] Australian Institute of Health and Wellfare. (2024). *Alcohol and other drug treatment services in Australia annual report, Western Australia*
[29] Tanton, R., Dare, L., Miranti, R., Vidyattama, Y., Yule, A. & McCabe, M. (2021). Dropping Off the Edge 2021: Persistent and multilayered disadvantage in Australia
[30] Penington Institute. (2024). Australia's Annual Overdose Report 2024
[31] Tanton, R., Dare, L., Miranti, R., Vidyattama, Y., Yule, A. & McCabe, M. (2021). Dropping Off the Edge 2021: Persistent and multilayered disadvantage in Australia
[32] Ibid

and other drug use and family and domestic violence, overcrowded living conditions, and increased engagement in the child protection and criminal justice systems.

There is a need for cross-government leadership and strategic coordination to develop sustainable strategies to address alcohol and other drug harms to ensure health and wellbeing of people who experience poverty and social disadvantage are prioritised.

Strategic Pillar 1: System-wide enablers

As mentioned above there are a range of enablers needed to support transformation for the alcohol and other drug system to meet the aim of the proposed Strategy as presented in the Discussion Paper. WANADA has attempted to thematically group these below, forming the priority enablers specifically for the alcohol and other drug system. The enablers presented in the Discussion Paper are also mostly encapsulated. Many of these are not stand-alone enablers, hence WANADA's attempt at thematically grouping them for more effect. There are four categories of system enables considered pivotal to alcohol and other drug system transformation:

- A systemic approach to reducing alcohol and other drug stigma and discrimination
- Equitable access, pathways, and balance of services across the alcohol and other drug system
- Workforce development and planning
- Alcohol and other drug governance leadership

A systemic approach to reducing alcohol and other drug stigma and discrimination

WANADA acknowledges stigma and discrimination, as it relates to alcohol and other drugs, is identified in the Discussion Paper – within the proposed human rights centred principle and as an identified key challenge, opportunity (and proposed initiative) for prevention, community support, community treatment and hospital-based services. As an identified key challenge and opportunity across the different service areas WANADA believes it is more appropriately elevated as an enabler.

> *Stigma is the "cement" that holds our unfair system together. Over 30 years of drug use, the pervasive impact of stigma on my life has remained largely the same* (paraphrasing from lived/living experience representative presenting at 2024 NSW Drug Summit).

It is well documented over many years that individuals, families and significant others impacted by alcohol and other drug use experience considerable levels of stigma.[33] [34] The World Health Organisation states that illicit drug dependence is the most stigmatised health condition in the world and dependence on alcohol is ranked as the fourth most stigmatised condition.[35]

Alcohol and other drug stigma and discrimination is widely acknowledged as impacting on, and the biggest barrier to, individuals' health and general quality of life. The reasons behind alcohol and other drug use are complex. Problems relating to alcohol and other drug use can stem from individual and environmental factors across the life-course, including family functioning, childhood trauma or neglect, poor living conditions, and social marginalisation. The impacts of stigma and discrimination relating to alcohol and other drug use are wide ranging, including but not limited to: [36] [37] [38] [39] [40]

- Low self-esteem and self-worth
- Feelings of isolation

[33] Adlaf EM, Hamilton HA, Wu F, Noh, S. Adolescent stigma towards drug addiction: Effects of age and drug use behaviour. Addictive Behaviors. 2009; 34(4): 360–4.
[34] Corrigan PW, Kuwabara SA, O'Shaughnessy J. The public stigma of mental illness and drug addiction: Findings from a stratified random sample. Journal of Social Work. 2009; 9(2):139–47.
[35] Kelly JF, Westerhoff, CM. Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. International Journal of Drug Policy. 2010; 21(3): 202–207.
[36] Link BG, Phelan JC. Conceptualizing stigma. Annual Review of Sociology. 2001; 27: 363–85.
[37] Australian Injecting and Illicit Drug Users League (AIVL). Why wouldn't I discriminate against all of them? A report on Stigma and Discrimination towards the Injecting Drug User Community. Canberra: AIVL; 2011.
[38] Hopwood M. Stigma and health. Paper presented at NCHSR Consortium workshop. Sydney; 19 May 2007.
[39] Alcohol and Drug Foundation. (2024). Alcohol and other drug stigma: Why it matters and what you can do about it
[40] Australian Alcohol and other Drug Council. (n.d.). AADC Position Statement: AOD related stigma and discrimination, and the role of the AOD sector.

- Development of self-hate
- Feelings of helplessness and disempowerment
- Exclusion from community life
- Physical and psychological distress
- Compromised quality of life
- Chronic stress and depressive symptoms, which has further implications for physical and mental health and wellbeing
- Unemployment and loss of income
- Difficulty obtaining employment
- Difficulty obtaining housing
- Problems accessing education
- Problems accessing insurance
- Problems accessing community services and emergency relief
- Problems accessing health and mental health services
- Limited social opportunity
- Avoidance, forgoing or delaying access to alcohol and other drug treatment
- Reluctance to access health services, negatively impacting health and well-being, and seeking help for preventable health conditions
- Perpetuation of alcohol and other drug related stigma and discrimination and community fears due to criminalisation of illicit drugs.

The difficulty in attracting the required number of professions, such as addiction medicine specialists and general practitioners willing to engage people with problems associated with their alcohol and other drug use, is a further impact of stigma, discrimination and prejudice. Alcohol and other drug services and their workforce frequently experience the impact of stigma and discrimination.

Alcohol and other drug policies are stigmatising. Given the evidenced positive impact on a sustainable health system and the reduction of health and social burdens, there is little doubt that resourcing to meet individual, family and community needs is itself impacted by stigma and discrimination.

The National Drug Strategy identifies '*improving community understanding and knowledge, reducing stigma and promoting help seeking*' is an evidenced, good practice strategy.[41]

Given stigma, discrimination and prejudice are experienced across the range of health and social services, government bodies, and the broad community, there is a need for a systemic approach to reduce alcohol and other drug stigma and discrimination. The proposed Strategy, as it applies to the alcohol and other drug system, will fall short in realising its potential without due consideration of stigma and discrimination.

Recommendation 5:

Initiate a systemic approach to reducing alcohol and other drug stigma and discrimination that considers the Western Australian context.

Equitable access, pathways and balance of services across the alcohol and other drug system

Equitable access to care, as it relates to alcohol and other drugs, is included in the Discussion Paper within the introductory purpose and aim of the proposed Strategy. Otherwise, increased access, improving access, and general accessibility are mentioned throughout as preferred practice.

WANADA sees a balanced alcohol and other drug system as foundational to equitable access, without which equitable access will perpetually be unachievable as acute service demand increases. Similarly, the

[41] Commonwealth of Australia, Department of Health. (2017). National Drug Strategy 2017–2026. Pp.10

identification of place-based approaches as a guiding principle speaks to equitable access. Unfortunately place based approaches are minimally detailed for further consideration within the proposed Strategy.

Given the expectations developed in the introduction, and its relevance implied in opportunity to "rebalance" the alcohol and other drug system, with the principle of place-based approaches, equitable access, pathways and balance of services across the alcohol and other drug system needs to be at least an aspiration, and an enabler for reform.

WANADA acknowledges equitable access does not equate to "cookie-cutter" service models throughout the state, or the same number of services simply based on population numbers. Service models need to consider place-based requirements. For example, cultural models of services, based on the principles of social and emotional wellbeing, need to be supported to meet the needs of Aboriginal peoples, just as services models appropriate to children and young people, and family systems initiatives need specific considerations. Levels of risk factors and harms need to be considered in planning for equity, based on local/regional consultation with communities and service providers with the contextual knowledge. This type of planning will enable an informed approach to the system's development that maximises relevance, effectiveness and efficiency. Through cross-government coordination equitable access, pathways and a balanced system will support the identification of required resource investment from all relevant funding bodies over the term of the proposed Strategy.

Recommendation 6:

Equitable access, pathways and a balanced alcohol and other drug system is an enabler aimed at meeting the needs of all Western Australians.

Workforce development and planning

WANADA agrees workforce is a significant enabler. Various terms related to workforce are used: capacity, capability, development, planning.

> *The primary aim of workforce development is to facilitate and sustain the AOD workforce by targeting organisational and structural factors as well as individual factors.* [42]

The National Centre for Education and Training in Addiction proposes:

- **individual factors** for workforce development include knowledge, skills and attitudes (simplistically – education and training). This would include cultural competence and responsiveness to diversity.
- **organisational factors** for workforce development include organisational structures, systems and culture (e.g. recruitment and retention, worker support and wellbeing, lived and living experience engagement, practice supervision and supports for the application of evidence informed practice, leadership and quality processes, infrastructure and technologies, etc)
- **structural factors** for workforce development include government policies and strategies (e.g. a systems approach to reducing stigma and discrimination which then impacts; resourcing to support recruitment and retainment of workers and adequate staff numbers to meet community demand, legislation, reporting and evaluation, partnerships for referral and shared care, and cross-sector capability building)

Workforce planning is also an important component of structural workforce development, however, needs to be informed by system planning (i.e. understanding the sector service expansion/priority requirements

[42] https://nceta.flinders.edu.au/about-aod/aod-workforce-development

and the planned future role and requirements of all other human service sectors where alcohol and other drugs intersect for effectiveness, consistency and efficiency.

Workforce development and planning, with the above scope and considerations, encompasses many of the Discussion Paper's system-wide enablers. The multiple suggested enablers in the Discussion Paper inadequately speaks to their shared reliance and relevance to each other.

Sector services have informed WANADA that there is inadequate availability and access to training and education for their staff, there are recruitment barriers particularly in regional rural and remote locations, inadequate resources to maintain worker levels and work security, inadequate capacity resources to meet demand or to enable capability building across relevant intersecting sectors.

WANADA's Aboriginal leadership report spoke to the need for enhancing cultural 'competence' and supports for engagement with appropriate Elders.

When appropriate systems planning is undertaken with the inevitable requirement of service expansion, the training institutions (universities and vocational education and training) need to be appropriately ensuring the future workforce has relevant alcohol and other drug knowledge, skills, attitudes, and work readiness. WANADA successfully undertook a workforce planning initiative, funded by the Mental Health Commission, informed by desk top analysis indicating that most relevant university courses had none, or inadequate alcohol and other drug content. While the 12-month initiative was able to focus on a single university (Curtin), the sustainability of what was achieved and the learning from the initiative inform similar initiatives at other relevant tertiary/higher education institutions is needed (i.e. ongoing funding is essential).

Alcohol and other drug governance leadership

The alcohol and other drug governance principles presented by WANADA on behalf of the sector included the need for:

- dedicated domain for the alcohol and other drug system with accountable, transparent, and impactful leadership
- coordination of the broad range of alcohol and other drug treatment and care within the wider system
- alcohol and other drug expertise, and capability to translate evidence into policy and systems and services planning
- capacity to engage/partner with the sector and consumers to achieve best system and service outcomes for the community

WANADA is concerned that the blending of focus areas in service pillars within the Discussion Paper do not support an enhanced dedicated domain for the alcohol and other drug system, the alcohol and other drug system coordination/pathways, or the building of expertise across the Mental Health Commission areas of responsibility. WANADA believes there is an opportunity for the agreed principles for alcohol and other drug governance to be better presented in the proposed Strategy as an enabler for effectiveness and efficiency in the term of the proposed Strategy.

While consultation for the proposed Strategy has been undertaken, and the alcohol and other drug framework is pending, to be effective the proposed Strategy must incorporate the potential framework requirements. WANADA's Aboriginal Leadership report has also called for a dedicated Aboriginal alcohol and other drug strategy and plan. Any progress for this will require significant consultation with Aboriginal communities and the sector to ensure the principles of social and emotional wellbeing are adequately considered.

The governance structure that is needed for the National Drug Strategy has been abolished for a number of years, however the review of the National Drug Strategy will undoubtedly incorporate the governance requirements – including all of government responsibilities for implementation. The proposed Strategy, as it applies to the alcohol and other drug system, will need to complement the national agreed agenda.

Strategic Pillar 2: Prevention and promotion (of health and well-being)

The World Health Organisation defines prevention as "approaches and activities aimed at reducing the likelihood that a disease or disorder will affect an individual, interrupting or slowing the progress of the disorder or reducing disability".[43] The National Preventive Health Strategy explains prevention as taking measures to keep people healthy as well as to avoid the onset of illness, disease or injury.[44] The National Preventive Health Strategy adds that the goal of prevention is to maintain and improve the health and wellbeing of the entire population.[45]

The *National Preventive Health Strategy 2021 – 2030* covers a range of health issues, including: tobacco, alcohol and other drugs, and mental health. As such it is relevant to the proposed Strategy in that it covers the two systems.

The National Preventive Health Strategy presents five different types of prevention, each appropriately recognising the many factors that influence health and wellbeing, including *social, environmental, cultural, structural, economic, commercial and digital environments experienced throughout life, as well as various individual attributes like genetic make-up.* To promote health and wellbeing requires consideration of all relevant factors to reduce the health inequalities, inequities that exist for priority populations, and the different life-course stages (from prenatal through to retirement/older age). [46]

Given the multiple types of prevention, the significance of 'prevention and promotion' as it applies in this pillar must be clear. WANADA suggests this pillar relates to primordial and primary prevention as defined in the National Preventive Health Strategy. As WANADA understands:

- **primordial prevention** includes the wider determinants of health with the goal of reducing environmental, structural and social factors that impact health and wellbeing. Primordial prevention, as it applies to the alcohol and other drug system, needs to be focussed on encouraging healthy behaviours, physical activity, access to clean food, water, air and housing.[47]
- **primary prevention** is focussed reducing the risks associated with alcohol and other drug use before they arise and delaying the uptake of alcohol and other drugs in the first instance. In the case of the alcohol and other drug system, this may be achieved through community awareness and education, reducing the prevalence of foetal alcohol spectrum disorder, and community-led prevention initiatives. [48]

WANADA believes there needs to be clear distinction in this pillar from the other areas of the National Preventive Health prevention types, i.e. secondary, tertiary and quaternary prevention.[49] Categorising and reporting on investment should also be aligned to prevention types, ensuring transparency and accuracy of investment which will then enable planning to achieve reform.

Recommendation 7:

The prevention and promotion (of health and well-being) pillar of the proposed Strategy be aligned with, and clearly defined by primordial and primary prevention as per, the *National Preventive Health Strategy 2021 – 2030.*

The key challenges and opportunities for prevention and promotion (of health and well-being) as it applies to the alcohol and other drug system are presented below.

[43] World Health Organization, 2004. *Global forum on chronic disease prevention and control (4th, Ottawa, Canada).* Geneva: WHO.
[44] Ibid.
[45] Commonwealth Department of Health. (2021). National Preventive Health Strategy 2021–2030
[46] Ibid
[47] Ibid. pp.23
[48] Ibid. pp.23
[49] Ibid

There is a need for appropriate levels of investment in prevention relative to alcohol and other drug risk factors and harm. Investment in alcohol and other drug prevention and promotion should be informed by data on indicators of risk factors influencing health and well-being and current harm at the local level. There is evidence to support community engagement as the most effective and cost-efficient prevention approach. A single prevention worker to support community engagement at a regional level is grossly inadequate. Community engagement ensures a life course approach. Long-term sustainable funding should underpin prevention mechanisms.

Effective prevention and promotion are impacted by industry pressures. Alcohol preventive initiatives are hampered by alcohol industry interests. There is a need to privilege the voice of the community and well-established evidence over the voice of profit motivated industry. That it took decades of research evidence, lobbying and advocacy to ensure appropriate labelling on alcohol and tobacco products is a testament to this challenge.

The examples offered in the Discussion Paper are not consistent with the National Preventive Health Strategy primordial and primary prevention and are for the most part harm reduction or secondary prevention initiatives which focus "on the early detection and best practice management of a disease or disorder to reduce deterioration and long-term effects".[50] These should be represented in a following pillar focusing on reducing harms related to alcohol and other drugs use. WANADA suggests the following are not relevant in this pillar.

- An alcohol and other drug stigma reduction Toolkit in emergency departments is a specific harm reduction initiative focused on practice that needs to be integrated with tertiary prevention.
- A systemic approach to addressing alcohol and other drug stigma and discrimination is an 'enabler' rather than a prevention initiative.
- Monitoring and investigating high-risk liquor licence applications is a community-based harm reduction initiative – i.e. secondary prevention.
- Regulatory amendments related to the WA Medicines and Poisons Regulation (related to nitrous oxide) have been legislated. Monitoring the application of the amendments is a harm reduction initiative (secondary prevention as opposed to primordial or primary prevention).

To assist in describing and differentiating the alcohol and other drug system as it applied to this pillar, the **focus area for alcohol and other drug prevention and promotion (of health and well-being)** should be a systems and community response rather than a person-centred approach. Initiatives need to include:

- **Cross-Government and community approaches** to address the significant determinants of health. Systems responsiveness to intersecting concerns is needed. As stated in the National Preventive Health Strategy, creating a more resilient prevention system includes "a governance mechanism within government, and across relevant portfolios, that have an influence on the health and wellbeing of Australians".[51] Long-term sustainable funding at a cross-government level is essential.
- **Foetal Alcohol Spectrum Disorder prevention** needs to be achieved through community engagement, with support from some population wide campaigns to demonstrate the whole of community relevance. There are some great examples of community led solutions to reducing foetal alcohol spectrum disorder that are not funded by the Mental Health Commission. Supporting community groups with appropriate information and resources, however, would support the shared objective.
- **School drug education** needs to be reinvigorated with the view to expand the initiate across all schools for an evidence-informed consistent approach. WANADA believes

[50] Commonwealth Department of Health. (2021). National Preventive Health Strategy 2021–2030 pp. 23
[51] Ibid pp.36

increased collaboration with community-based specialist alcohol and other drug services contribute to awareness raising of available services where they might be needed by students and the broader school community.

- **Community education and awareness raising** needs to be informed by local level data and ongoing community consultation and engagement. This engagement could contribute to, as examples: the systemic approach to reducing stigma and discrimination; awareness of the intersection with related risk factors, the identification of community-led solutions to enhance connectedness/'community medicine' approaches; the identification of community-led solutions that contribute to supporting the principles of place-based and Aboriginal self-determination, awareness of the community role in supporting treatment access and community re-integration following treatment, etc.
- **Media campaigns** need to complement community engagement.
- **Coordination and collaboration with other prevention initiatives,** where there is relevant intersection resulting from present risk factors, would be ideal - such as health and wellbeing, mental health, suicide, family and domestic violence, etc.

The **focus area for suicide prevention** in this pillar needs to adequately reference the intersection with alcohol and other drugs. It is well known that alcohol and other drug use reduces inhibitions and affects clarity of decision making, therefore, increases the risk of suicidal behaviour if a person is experiencing suicidal distress. The Western Australian alcohol and other drug service sector is engaged to deliver suicide prevention and coordination throughout the State. Appropriate levels of funding are needed to have the desired impact of preventing suicide in terms of primordial and primary prevention. Currently, in some regions, one suicide prevention coordinator/worker is employed across an entire region – to undertake suicide prevention, early intervention, support, after-care and postvention, with a focus on Aboriginal peoples and regional rural and remote factors. The tokenism of this as a response is grossly inadequate and impacting community as well as alcohol and other drug services, staff wellbeing and retention.

Strategic Pillar 3: Community Support

Community support in the alcohol and other drug system is integrated with, and not able to be separated from, (community and community bed-based) treatment. Acknowledgement for this is indicated in the description for focus area 10 of the Discussion Paper. Psychosocial support, including systems navigation and care coordination, is undertaken as a part of the holistic response to meet the diverse needs of individuals and groups – to enable best outcomes for treatment.

It is WANADA's view that emphasising the difference between the service pillars of support and treatment, for the alcohol and other drug service system, would jeopardise the existing integration and contribute to the imbalance experienced in the mental health service system.

Recommendation 8:

Community support, as it applies to the alcohol and other drug system, remains integrated with (community and community bed-based) treatment.

Recommendation 9:

Strategic pillar 3, for the alcohol and other drug system, is dedicated to alcohol and other drug harm reduction.

Proposed Strategic Pillar 3: Alcohol and Other Drug Harm Reduction

As one of the three pillars of the National Drug Strategy, harm reduction requires its own pillar in the proposed Strategy. Alignment and clarity of scope for a harm reduction pillar needs to be informed by existing relevant national strategies.

- **National Drug Strategy** - *Harm reduction strategies identify specific risks that arise from drug use. These are risks that can affect the individual who is using drugs, but also others such as family members, friends and the broader community. Harm reduction strategies encourage safer behaviours, reduce preventable risk factors and can contribute to a reduction in health and social inequalities among specific population groups.*[52]
- **National Preventive Health Strategy** - *Secondary prevention focuses on the early detection and best practice management of a disease or disorder to reduce deterioration and long-term effects. This includes identifying people at risk of ill-health through screening programs, general health examinations, as well as the identification of complications and co-morbidities.*[53]

Harm reduction services are accessed by the broad spectrum of the community and social demographics, through a combination of service delivery modes (including discrete and postal services). People accessing harm reduction services are not exclusively people with alcohol and other drug dependence or demonstrating problematic behaviours. Harm reduction responses need to address harms associated with any drug, including alcohol, tobacco, prescription medications, performance and image enhancing, and illicit substances. Anyone who is using alcohol and other drugs deserves the right to access harm reduction services.

Systemic stigma and discrimination limits access to needed harm reduction services. Harm reduction services actively support service users who experience stigma and discrimination from the range of needed cross-sector services, particularly allied, primary, tertiary and mental health, and housing/homelessness, etc. Prejudice, stigma and discrimination impact harm reduction services and workers, as well as policy and planning that enable these services to operate and be supported. Stigma and discrimination has a greater

[52] Commonwealth Department of Health and Aged Care. (2017). National Drug Strategy 2017–2026. pp.13
[53] Commonwealth Department of Health. (2021). National Preventive Health Strategy 2021–2030. Pp.23

impact on people needing harm reduction services in regional, rural and remote locations due to potential identification and possible legal and social consequences. Stigma and discrimination are frequently perpetuated via alarmist media reporting, which demonises alcohol and other drug use and people accessing harm reduction services. Systemic approaches to the reduction of stigma and discrimination needs to be elevated as an enabler.

The need for increased investment in harm reduction has long been recognised. The Western Australian Mental Health, Alcohol and other Drug Services Plan 2015-2025 indicates a significant need for expansion of harm reduction services. These services need to be located across the state to support equitable access. Harm reduction is a pillar of the National Drug Strategy, however, nationally it only receives around 2% of total funding. This needs to be addressed at both the state and national levels.

Peer harm reduction workers play a vital role in these services. With additional investment there is an opportunity to engage more peer workers across the State to provide harm reduction information, education, services and supports.

There is a significant, and growing body of evidence-based research that supports peer-based models of harm reduction. Rather than building additional evidence (as stated in the Discussion Paper), the Mental Health Commission needs to work in collaboration with existing harm reduction service providers and the Communicable Disease Control Directorate (WA DoH) to capitalise on the professional knowledge-base and existing evidence to inform harm reduction policy, strategy and community support.

Alcohol harm reduction initiatives are hampered by alcohol industry interests. There is a need to build community awareness of evidence and privilege the voice of the community and researched evidence over the voice of profit motivated industry.

Criminalisation of illicit drug use increases rather than reduces harm. There is an opportunity to ensure there are strategies that are complementary to harm reduction within existing legislation, with discussion on potential law reform that is health focused where appropriate.

There are a lot of initiatives that best fit within the harm reduction pillar of the proposed Strategy that need planning and coordination to support the effectiveness and efficiency of the alcohol and other drug system, including some that need consideration for Western Australia.

To assist in describing and differentiating the alcohol and other drug system as it applied to this pillar, the **focus area for alcohol and other drug harm reduction** should include/consider initiatives such as:

- **Needle and syringe (provision and exchange) programs**. Dedicated harm reduction services for people who inject drugs are mostly metrocentric, leaving few options for people who live in regional, rural and remote areas to access equipment and credible harm reduction education, anonymously and without potential discrimination from identification.
- **Sobering up centres and safe places for intoxicated people.** These services provide a short-term bed-based service for people who are intoxicated. Generally, sobering up services do not operate 24 hours per day, 7 days per week. Workers, many of whom may identify as peers with lived/living experience, undertake brief interventions and provide information and education as well as referral when requested. These services treat intoxicated people with dignity and respect, which they may not receive from any other cross-sector service.
- **Promotion of alcohol guidelines and the raft of harm reduction alcohol consumption strategies.** Alcohol is the drug that causes most harm to the Australian community. Every local community need to be aware of these harm reduction initiatives, together with the research evidence. Such initiatives need to be promoted.
- **Promotion of harm reduction strategies for a range of drugs** is also needed. The consumption of drugs is not just related to dependence. Availability of drugs is universal within metropolitan Perth

and the most remote of the State's communities. Simple harm reduction messages specific to different drugs need to be understood, promoted and targeted.

- **Alcohol restrictions** should be population based, supported by informed community consultation (not informed by profit motivated industry or top-down decisions), and ideally community-led in response to levels of harm experienced. The unintended impact of individuals and communities, and impost on systems needs to be considered – e.g. police and alcohol and other drug treatment services.
- **Minimum unit price of alcohol** is a whole of state response aimed at reducing harms. The proposed approach is for a floor price that applies only to the cheapest alcohol products, which we know account for only a small proportion of products available for sale in Western Australia, however, are often the cause of most harm within our communities. A floor price would have minimal, if any, effect on moderate drinkers, and has been shown internationally and interjurisdictionally, to contribute to reducing alcohol related harm. This evidence-informed harm reduction approach has faced significant resistance from the alcohol industry.
- **Place-based community awareness and education related to reducing harms from all drugs.** The impact of alcohol and other drugs is experienced differently from community to community. People are aware of the alcohol and other drug issues that are occurring in their communities. There is a need to harness this information to develop place-based and community-led solutions.
- **Take Home Naloxone** provides a critical health service to supply free naloxone throughout WA. Engaging the pharmacy industry to support the affordability and availability of naloxone is critical to reducing the impacts of overdose and death. Around 40% of Western Australian pharmacies do not stock naloxone.[54] General Practitioners need to ensure they are also providing adequate information about naloxone to their patients accessing opioid medications – particularly the elderly. When expanding access to naloxone in regional, rural and remote settings, there is a requirement to facilitate discrete access as privacy issues can be amplified.
- **Drug checking** services exist in other jurisdictions and have been central to monitoring, identifying and responding to new and emerging drugs of concern, such as nitazenes and other novel psychoactive substances. Drug checking services, like harm reduction services, facilitate access to peers, counselling and brief intervention, harm reduction information and advice, nurse consultations, bloodborne virus and sexual health testing and treatment, and mental health advice, free of cost. These services can be fixed site facilities, as well as supportive of festival drug testing.
- **A pre-emptive plan to prevent drug related overdose/deaths** needs to include a rapid assessment and response in any location across the state. Similar responses have reduced deaths internationally.
- **Early warning systems** are a critical component to reducing illicit drug related harms. There is a need to ensure illicit drug users have access to prompt alerts related to dangerous, new and emerging, and high potency illicit drugs in the market, including for example stimulants that contain opioids. Early warning systems require close collaboration and coordination to monitor emerging drugs via Emerging Drugs Network of Australia; communications between various stakeholders; early detention of dangerous substances in the market; and a timely response to reduce the threat posed by emerging drugs in in the community.[55] The sector needs to be a part of this warning system.
- **Real-time prescription monitoring and script checking** contribute to possible doctor-shopping and reduced over-prescription of drugs by prescribers.
- **Decriminalisation of personal use of illicit substances,** while controversial, is an evidence-informed strategy to minimise harms associated with illicit drug use. Decriminalisation of small quantities of drugs for personal use has been legislated in the Australian Capital Territory for more than a year, with law enforcement, community alcohol and other drug service providers, and

[54] Monash University. (2024). New data shows naloxone availability is improving but there is no time to lose for action on overdose prevention
[55] United Nations Office of Drugs and Crime. (n.d.). Early Warning Systems

criminal justice system stakeholders indicating there has been no discernible increase in drug use as a result. Central to decriminalisation is ensuring alcohol and other drug services have the capability and capacity to provide education and information together with adequate treatment and support where appropriate. Decriminalisation should be a coordinated method of harm reduction that steers people who use small amounts of drugs away from criminal justice interaction and provide evidence informed education, information and promotion of available service.

- **Sexual health and blood borne virus testing and treatment** has significant intersectionality with alcohol and other drug use. WANADA has been supporting the capability of alcohol and other drug services across the State to contribute to the global goal of eliminating hepatitis C virus by 2030. The relevance of this initiative is that approximately 90% of people with hepatitis C contracted it through injecting drugs. The capability building includes staff/individual peer training on hepatitis C, organisational development to support uniform screening and assessment (data and practice supervision support etc), and systems pathways that support refer for appropriate treatment response when needed.
- **Opioid Substitution Therapy (OST).** Around 3000 Western Australians access various forms of OST – methadone, buprenorphine and buprenorphine/naloxone. For several reasons, it is commonly understood that the Community Program for Opioid Pharmacotherapy is highly stigmatising for participants. There is a lack of prescribers, and many pharmacies are reluctant to dispense the medication – this is particularly impactful in regional, rural and remote locations where people must travel long distances to access their medication. Western Australian guidelines need to contribute to a systemic approach to reducing stigma and discrimination, which will in turn contribute to building a sustainable pool of prescribers and accessible dispensers.

Strategic Pillar 4: Community Treatment

The proposed Strategy, as it relates to alcohol and other drug (community and community bed-based) treatment needs to align with, and be informed by, relevant national strategies. Treatment in the alcohol and other drug system falls within the demand reduction pillar of the *National Drug Strategy*, and tertiary prevention in the *National Preventive Health Strategy*. The *National Framework for Alcohol, Tobacco and Othe Drug Treatment (2019 – 2029)* defines treatment as:

> *Structured health interventions delivered to individuals (by themselves, with their families, and/or in groups) to reduce the harms from alcohol, tobacco, prescribed medications or other drugs and improve health, social and emotional wellbeing.*[56]

The Framework recognises treatment experiences vary depending on individual circumstance, and that alcohol and other drug treatment is only a part of what a person might need.

> *For some people with alcohol and other drug problems, treatment will be required over the course of their life (consistent with dependence being a chronic condition, like asthma or diabetes). In many cases ongoing support to achieve long-term change is crucial in helping people achieve a more enduring set of life changes. For other people, support and treatment early on will be sufficient to prevent alcohol and other drug problems into the future; and for others they may access treatment intermittently as required. Some people will independently receive support through mutual aid services, such as Alcoholics Anonymous. And for others, the problems associated with substances will subside over time without the need for any formal intervention.*[57]
>
> *People who seek or receive alcohol or other drug treatment may have social, psychological or other health care needs that they consider more, or as pressing, as their alcohol or other drug problems. This may include social issues (e.g., housing, family and domestic violence, employment, welfare, child protection, legal problems), and other medical and health needs (e.g., co-occurring mental health conditions, liver disease, chronic obstructive pulmonary disease, blood borne viruses). Integration of care, addressing an individual's needs, is the foundation for successful alcohol and other drug treatment. Alcohol and other drug treatment services need to collaborate and coordinate with other systems of care because attending to the overall health, wellbeing, cultural, and social needs of the person enables alcohol or other drug treatment to be most effective. Improving the health, social and emotional wellbeing of people who are seeking or receiving alcohol or other drug treatment not only relies on activities undertaken within the alcohol and other drug treatment service system, but on actions across a wide range of social, economic, political, cultural and environmental determinants of health.*[58]

Alcohol and other drug community and community bed-based treatment speaks to the setting that the service is provided in, and the intensity of the treatment able to be provided.

The community treatment pillar in the proposed Strategy, for the alcohol and other drug system, provides the basis for specialist individualised care and treatment for individuals, families and significant others. A person-centred community treatment response to alcohol and other drugs includes:

- Screening and assessment
- Treatment planning
- Psychosocial counselling and group therapy

[56] Commonwealth of Australia, Department of Health and Aged Care. (2019). National Framework for Alcohol, Tobacco and Other Drug Treatment 2019–29. Pp. 4
[57] Ibid. pp. 2
[58] Ibid. pp. 3

- Appropriately responding within staff and organisation capabilities to intersecting concerns – including mental health, domestic and family violence, general health, etc
- System navigation, case management, care/shared coordination as appropriate
- Peer support where relevant and available
- Systems pathway supports as needed, including low and high medical withdrawal
- Exit planning and referral
- Etc

It is well known that there are **not enough community alcohol and other drug treatment services** to meet community demand or support equitable access across the State.

Blended focus areas (related to mental health and alcohol and other drugs) within this pillar do not support the recognition of the differences between the systems, or the capacity to identify gaps and expansion needs of the specialist systems. A significant difference between the systems is the percentage of government vs not-for-profit providers. Treatment services in the alcohol and other drug system make up approximately 90% of the services. The strength of a majority not-for-profit sector is in its flexibility to respond to individuals, families and community needs.

Recommendation 10:

A single dedicated focus area for alcohol and other drug community treatment to support systems awareness and development.

The delivery of alcohol and other drug community treatment is reliant on **appropriately qualified workforce**, continued professional development, capability building to maximise responsiveness to intersecting concerns, and cross-systems partnerships. Capability building needs to support responsiveness strategies to address significant intersectionalities – including neurodiversity and cognitive impairment. Capability building needs appropriate resourcing.

Recruitment and retention of staff in many of the regions is impacted by inadequate housing. Cross-government support is needed to ensure essential workers, including alcohol and other drug professionals, have accessible and affordable housing.

Lived/living experience is strongly represented in the alcohol and other drugs system, with around 67% of workers across the spectrum of roles indicting a relevant personal experience of alcohol and other drugs. The alcohol and other drug sector have a strong peer-based workforce (in designated and non-designated roles) who draw on their lived/living experience, as well as their professional qualifications as appropriate to their role. Lived/living experience and a peer workforce has been embedded in the alcohol and other drug system since its inception in Western Australia. Career pathways for people with lived/living experience in the alcohol and other drug sector is supported as an integral workforce planning strategy.

Service models need to be considered to support diverse population needs. This is not to discount the need for dedicated population services, such as age specific services for young people, Aboriginal services, or services for women who may not feel safe accessing mix-gender facilities.

As per the *National Quality Framework for Drug and Alcohol Treatment Services (2018)* all treatment services need to be **certified against a recognised quality standard and appropriately regulated**.

> *The [treatment provider] organisation employs appropriately qualified and skilled staff to ensure treatment services are delivered in accordance with legislative and regulatory requirements, and*

appropriate to the client cohort, including establishing policies and upholding professional codes of practice.[59]

All government have a responsibility to ensure the quality and effectiveness of AOD treatment services. This includes ensuring equity and fair delivery of treatment services and treatment outcomes.[60]

Drug and alcohol treatment regulation and funding is primarily the responsibility of state and territory governments. The Commonwealth also performs an important role by providing sector leadership, leading national policy, and contributing to sector funding.[61]

Low medical withdrawal is an essential pathway for many people needing community alcohol and other drug treatment. There needs to be adequate and equitable access to these services across the State. Hospital/high medical withdrawal for people with additional complex health conditions need to be assured, and accessible.

Western Australia has a range of **evidence-informed guidelines** for various community (and community bed-based) treatment provision.

To assist in describing and differentiating the alcohol and other drug system as it applied to this pillar, the **community treatment focus area for alcohol and other drugs needs to** include:

- Not-for-profit led **Integrated Services**, with the primary integration being with Next Step Services to support alcohol and other drug related medical/health responses.
- **Regional Community Alcohol and other Drug Services** (CADS) ensuring each health region has accessible treatment and support options. Each of the regional CADS provide services across a specific health region. The largest of these regions in size is the Goldfields which is more than three times the size of Victoria, and the most populated region is the South West. The regional CADS have fixed site offices and provide outreach to multiple communities of varying population sizes and remoteness. These services play a vital role in building community trust and awareness, demonstrating the capacity to flexibly respond to the context and need.
- **Diversion services** are undertaken by the Integrated Services and regional CADS.
- **Population specific community treatment services** have been established to meet the needs of Aboriginal peoples, young people and women. There need to be more population specific community alcohol and other drug treatment options resourced across the State to support appropriate equitable access.
- **Various other** community treatment services are available. These services provide service options to meet diverse needs. It is not enough to have only one service option in a whole health region.
- There is one **day-rehabilitation** service in metropolitan Perth, provided by an Aboriginal Community Controlled Organisation. Other 'drop-in' facilities are also operating, although not necessarily providing alcohol and other drug primary services. This service models, as alternative options, need to be explored across the State to contribute to reducing demand pressures and to meet the needs of particular population groups such as young people. The service model provides opportunities for connectedness as well as addressing some of the social determinants of health.
- Most community treatment services provide **counselling and support for family members and significant others**, irrespective of whether the dug using family member is accessing treatment and support. Where there are appropriately trained and qualified staff, family counselling may also be available.

[59] Commonwealth of Australia, Department of Health. (2018). national-quality-framework-for-drug-and-alcohol-treatment-services_0.pdf
[60] Ibid. pp. 6.
[61] Ibid. pp. 6.

- Most alcohol and other drug services have been/continue to be engaged in capability building to support appropriate **responsiveness to meet the needs of people with co-occurring/intersecting alcohol and other drug and mental health concerns**.
- A significant proportion of people accessing alcohol and other drug concerns have experienced or used domestic and family violence. Capability building to appropriately respond to this intersection has been a sector priority for some time – with a cross-sector call for whole of sectors (**alcohol and other drug and domestic violence) capability building** to ensure allied responses are consistent and barriers and enablers for improvement identified, supported and appropriately resourced.
- **Telephone support and referral** is provided by the Mental Health Commission Alcohol and other Drug Support Line (ADSL), with support also offered to family members and parents. There are opportunities to support improved collaboration of these services, and for the model of service to be shared with the not-for-profit providers across the State to enhance service access and relevance at a regional level.
- The **Drug and Alcohol Clinical Advisory Service** (DACAS) provides clinical advice to health professionals. As above, collaboration between DACAS and not-for-profit services could be improved to support local referral from health professionals where needed.
- **Immediate Drug Assistance Coordination** (IDAC) provides more immediate responses for some people in the metropolitan region, with the capacity to hold people until crisis has abated or alternative treatment options are available.
- **Screening, assessment and supporting residential readiness** is a vital service offered by community alcohol and other drug treatment services. They contribute to the balance of service system – contributing to maximising the efficiency of residential/bed-based treatment. **Post residential continued treatment and support** is also a significant system role of community treatment services. System coordination is needed to support service option access and sustainability of outcomes. As described in the National Treatment Framework, treatment for some people can be a long-term proposition.

There are not enough community alcohol and other drug treatment services to meet demand. To ensure efficiency there is a need for improved systems knowledge sharing, and collaboration. This requires systems leadership, that in turn requires governance knowledge and expertise that cuts through commissioning competitiveness.

The sector has told WANADA that there are multiple factors, other than inadequate resourcing, that add to demand pressures in the alcohol and other drug system. These include a lack of cross-sector responsiveness to alcohol and other drug use and inappropriate referral. Cross-government and cross-sector planning, coordination, capability building/change management is urgently needed.

Strategic Pillar 5: Community Bed-Based

Community bed-based services in the alcohol and other drug system include residential rehabilitation and therapeutic communities that deliver intensive treatment options. Support to address the range of related factors is essential – as described above in the definition of treatment. The intensity able to be offered in a residential setting support significant behavioural change where this is not achievable through non-residential options.

They are not crisis accommodation services or residential services for people with alcohol and other drug concerns that exploit people, for example, for labour hire profits.

The definition of community bed-based treatment is as above – in community treatment. Community bed-based treatment is a service model specifically for individuals needing more intensive treatment and support, where the setting is residential.

Many of the opportunities and challenges for services in this pillar are shared irrespective of the service setting, i.e. there are not enough services to meet demand, the workforce needs to be appropriately trained and qualified, lived/living experience of staff (in dedicated or professional roles) is high, evidence-based guidelines inform practice, and service models need to consider population group needs.

Alcohol and other drug community bed-based treatment provides an opportunity to address significant complex/intersecting concerns. Equitable access across the State needs to be a priority.

People on welfare benefits have the opportunity to waver their job-seeking obligations while in residential, requiring services to form effective partnerships with Job Active providers. Residential participation may contribute to reducing outstanding fines, with treatment participation recognised as a Work Development Order.

People in need of these services may be particularly vulnerable – especially if they feel there are no other options to support behaviour change and improved health and well-being. Western Australia has more than its share of unaccountable and unregulated services offering bed-based services that exploit the gaps in the current system as well as the participants, and as described in the Esther Foundation Inquiry abused participants human rights. **Quality and regulation for such services that are not accountable through government funding is essential**.

WANADA welcomes the dedicated focus area for alcohol and other drug community bed-based services. These services need to be clearly identified as treatment to avoid potential exploitative residential based accommodation.

Recommendation 11:

A dedicated focus area for alcohol and other drug community bed-based **treatment** to support clarity of purpose, systems awareness and development.

To assist in describing and differentiating the alcohol and other drug system as it applied to this pillar, the **community bed-based treatment focus area for alcohol and other drugs needs to** include:

- **Residential rehabilitation programs and therapeutic communities.** Western Australia currently offers residential services for mixed gender populations, women (with children), Aboriginal peoples, and young people. Different service models need to be supported to meet the different population group needs. Exclusion criteria for existing services need to be assessed to determine any population group that is currently unable to access these services if they are needed, or where a dedicated service model would best meet their needs.

WANADA and the Western Australian alcohol and other drug sector have long been calling for (at least 20 years) a community bed-based treatment service for Aboriginal people in the south of the state. Meeting this service need is long overdue.

- **Low medial withdrawal services** are currently provided by not-for-profit, private, and government services. Supported access to a withdrawal service, where needed, is timed to ensure a seamless pathway into a residential rehabilitation service. Access to low and high medically supervised withdrawal services are essential to ensure maximum capacity of community bed-based services.
- **Transitional Housing and Support Program (THaSP)** services support people exiting residential care, providing safe housing that enables the maintenance of outcomes. These services are particularly relevant for people who do not have stable accommodation to return to, following engagement in community bed-based treatment. THaSP services provide a "stable affordable home, along with access to support to help [people] with managing home, finances, health and work or training commitments."[62]

[62] Cyrenian House (n.d.). Transitional Housing & Support Program

Strategic Pillar 6: Hospital-Based Services

WANADA broadly supports focus area 14 of the Discussion Paper for *integrating and building alcohol and other drug services in hospitals*. While not currently happening as described, the opportunities and challenges need to be delivered as a priority. This should be a part of their core business.

In the five-year term of the proposed Strategy, we would expect every Western Australian hospital (including those in regional areas) has the mandate and capability to provide high/complex medically supported withdrawal, and referral pathways to community alcohol and other drug services following appropriate screening and assessment. Measures of success would include: no individuals needing high/complex medically supported withdrawal are turned away, and no individual with alcohol and other drug related use feels stigmatised and discriminated against through their hospital engagement.

Reducing systemic stigma and discrimination, ensuring equitable access to hospital-based services across the State, and coordinating systems pathways (with referrals from and to community and community bed-based treatment services where appropriate) are key enablers.

Strategic Pillar 7: Specialised Services

The Discussion Paper incorporates blended mental health and alcohol and other drug forensic services in the **focus area 15**. Given the significant differences across the two systems, as they relate to the criminal justice system, WANADA proposes these are separated.

The Mental Health, Alcohol and other Drug Services Plan 2015-2025 presented forensic services as a distinct 'pillar'. Forensic services, as it applies in the alcohol and other drug system, requires a focus on prevention and health and well-being promotion, harm reduction, as community treatment (in the case of community corrections, diversion, and post-prison release), prison in-reach programs, and prison therapeutic communities. As such there is a need to ensure the alcohol and other drug system is replicated and accessible to people engaged across the criminal justice system from courts, community corrections, remand, prison.

Recommendation 12:

A dedicated Forensic Services pillar be created, with a specific focus area for alcohol and other drugs.

Many of the alcohol and other drug forensic services are funded by the Department of Justice. Clarity of the system gaps, challenges and opportunities, and enablers need to inform planning and development.

Focus area 16 is a further blended mental health and/or alcohol and other drug approach. Many of the issues incorporated into this focus area are intersecting concerns for people with problems associated with alcohol and other drug use. For example, eating, sleeping, personality disorders and mental health concerns, neurodiversity and cognitive impairment, chronic health conditions, etc are common intersecting concerns that people present with when accessing alcohol and other drug services. In responding to individual needs alcohol and other drug services ideally build capability (through individual and organisational development), establish their clear limitations when addressing issues outside of their capability and establishing referral and shared care pathways as needed. The same applies for different population groups, including Aboriginal peoples, gender diversity, ethnocultural and linguistically diverse, and people with disability (including people with FASD).

Capability building also applies across social concerns, such as domestic and family violence. Capability building should not just apply to one system – rather apply to the intersecting systems so that there is consistent responsiveness irrespective of the service that is accessed.

Capability building prioritisation is dependent on resourcing.

Recommendation 13:

Capability building priorities be established through meaningful consultation with the alcohol and other drug sector and the affected community to inform planning and development.

Strategic Pillar 8: Country Western Australia

The proposed Mental Health, Alcohol and Other Drug Strategy needs to present the alcohol and other drug system and mental health system separately, including as it applies to the pillar of Country WA. There is a need to quantify all alcohol and other drug services across the pillars in the different regions of Western Australia, funded by all relevant commissioning bodies. This will enable the identification of service gaps and prioritisation.

There is a need to ensure equitable service delivery across the State based on population, risk factors and harm related data. This is not intended to reduce services in regions where there are more services per population, but to raise the availability of appropriate services to enhance equitable access across all regions.

Meaningful consultation with the alcohol and other drug sector and the communities impacted by alcohol and other drug use in the development of the pending alcohol and other drug framework will undoubtedly identify priorities for each region and for each pillar. This will hopefully enable clarity where the Discussion Paper language includes 'consideration' or 'opportunity to explore' options that are not clear – as well as prioritisation to meet service gaps.

Regional alcohol and other drug services have reported common concerns, including the impact of:

- systemic stigma and discrimination
- inequitable access to the range of services across the pillars
- lack of clear alcohol and other drug system pathways
- inadequate and inconsistent access to data to inform service models, planning and responsiveness to different population groups and disadvantage
- lack of leadership and cross-government coordination, including a response to the housing crisis as it impacts on community well-being, service users and the system workforce, exacerbating existing challenges related to workforce planning and development, recruitment and retention.

Recommendation 14:

A community alcohol and other drug summit in 2025/26 to contribute to community acceptability of evidenced and practical solutions for a planned approach to address the many gaps in the alcohol and other drug system to meet community needs.