



Productivity Commission Inquiry into Mental Health

Submission on the draft report – January 2020

This submission has been prepared by the Queensland Network of Alcohol and Other Drug Agencies (QNADA). QNADA welcomes the opportunity to provide a submission on the draft report to the Productivity Commission (the Commission) Inquiry into mental health. The content of this submission is informed by consultation with QNADA member organisations providing treatment services in Queensland.

In our view, the draft report frames substance use primarily through the lens of the mental health service system, which limits the discussion to those diagnosed with a substance use disorder and lacks proper consideration of broader issues such as non problematic substance use in the community or issues experienced by those accessing specialist alcohol and other drug treatment services. While we acknowledge that jurisdictional differences in the funding and operations make this a challenging exercise for the Commission, we believe more can be done to develop the understanding of the issues relevant to the specialist AOD system in the draft report given the inclusion of substance use disorder in its scope. The recently released *National Framework for Alcohol, Tobacco and Other Drug Treatment 2019-2029*¹ and *National Quality Framework for Drug and Alcohol Treatment Services*² are likely to provide important context, alongside state based frameworks such as the *Queensland Alcohol and other Drug Treatment Service Delivery Framework*³ and the *Queensland Alcohol and other Drug Treatment and Harm Reduction Outcomes Framework*.⁴

Defining substance use disorder, dependence, and problematic substance use

While the scope of the inquiry with regard to substance use is limited to those people diagnosed with a substance use disorder, the term ‘substance abuse’ is used interchangeably throughout the draft report (including figures and tables) with other language to variously describe substance use, problematic substance use and dependent use. ‘Substance abuse’ is a dated and stigmatising term and its use should be discontinued immediately. There is a vast array of language that better describes the experience of people who use drugs, including:^{5 6 7}

- Substance use
- Person who uses drugs (when not problematic)
- Person with problematic use
- Experiencing dependence
- Substance use disorder (if diagnosed)

¹ <https://www.health.gov.au/resources/publications/national-framework-for-alcohol-tobacco-and-other-drug-treatment-2019-29>

² <https://www.health.gov.au/resources/publications/national-quality-framework-for-drug-and-alcohol-treatment-services>

³ https://qnada.org.au/wp-content/uploads/2017/11/QldAODTreatmentFramework_March2015FINAL.pdf

⁴ https://qnada.org.au/wp-content/uploads/2019/03/Fin_20190308_Queensland-Alcohol-and-other-Drug-Treatment-and-Harm-Reduction-Outcomes-Framework_Web.pdf

⁵ https://www.nada.org.au/wp-content/uploads/2018/03/language_matters_-_online_-_final.pdf

⁶ https://www.globalcommissionondrugs.org/wp-content/uploads/2018/01/GCDP-Report-2017_Perceptions-ENGLISH.pdf

⁷ https://qnada.org.au/wp-content/uploads/2019/04/Fin_20190411_Fact-Sheet-Alcohol-and-Other-Drugs-Treatment-1.pdf

Outside the treatment system, amongst people who have used any illicit substance in the previous 12 months, only 15.9% reported being diagnosed with or treated for a mental illness⁸. When discussing substance use throughout the report, we strongly recommend clearly distinguishing between substance use (non-problematic), problematic substance use (experiencing harm), dependence (physical and/or psychological adaptation), and substance use disorder (diagnosed). It is important to note that illicit drug use prevalence data often doesn't provide information on frequency or dose, meaning it is difficult to determine if prevalence of the illicit drug use in mental health cohorts is in fact problematic.

We note that substance use disorder is considered in scope for this review in the context of comorbidity. We also note the difficulty in delineating between mental illness and substance use disorder in prevalence data and the impact of this on understanding real and perceived treatment access.

Proposed regional commissioning authorities

QNADA cautions against proceeding with the Productivity Commissions preferred option to implement Regional Commissioning Authorities (RCAs) and instead urge the Commission to consider ways to build upon the existing infrastructure of PHNs. PHNs have been involved in, and currently collaborate on, a range of local and statewide planning activities across government and non-government systems. Since the PHNs were established in 2015, the AOD sector in Queensland has worked hard to establish strong and productive relationships with the Qld PHNs.

We support the continued development of shared or integrated planning and commissioning processes via collaboration between PHNs, the State Government Department of Health, the Commonwealth Department of Health, which includes strong representation of non government providers through their peak bodies. We believe another wide scale system reform process would be highly disruptive and undermine the gains made in Queensland's AOD system, with no assurance that RCAs will support better outcomes for people who need treatment and support. What the system currently requires is stability, not another change.

Over the last 5 years we've had significant sector growth, with increased funding stability, increased investment and growth in Queensland's AOD treatment workforce. We are keen to work to consolidate and build upon these gains and are concerned that another change (to RCAs) could be destabilising and place excessive burden on the AOD system, for example through recommissioning of services, leading to workforce attrition and loss of specialised experience and skills.

We agree there is scope to improve geographic equity, however the structure and boundaries of commissioning authorities are unlikely to solve issues like workforce shortages, particularly in areas such as Western Queensland, nor provide additional value in metropolitan areas. We note workforce shortage issues impact commissioning bodies and treatment services equally, in that planning, commissioning and performance management skills are similarly concentrated in metropolitan workforces.

⁸ Australian Institute of Health and Welfare (2017). National Drug Strategy Household Survey 2016: detailed findings.

Proposed integrated funding and governance

Comorbidity responses do not require systems integration to be effective.⁹ The draft report presents the argument that ‘separate governance and funding arrangements present barriers to service integration’, however this is based on an assumption that systems integration will produce service responses that meet the diverse needs of clients. The draft report states:

‘A more integrated funding and governance model, which spans health and non-health sectors, would facilitate developing holistic and person-centred care models for addressing comorbidities’ (p. 329).

While the draft report considers access issues for people experiencing comorbid substance use issues in the Mental Health system to be related siloed funding, it does not provide any analysis of the varying levels collaboration and coordination occurring across a range of specialist AOD service settings (eg withdrawal management, residential treatment, psychosocial interventions, harm reduction) or the extent or capacity of AOD services to currently address mental and physical health comorbidities.

For instance, the report does not consider:

- The current level of AOD system coordination and planning with other systems (eg housing, corrections, mental health)
- The extent of AOD service collaboration co-location, and coordination both within and outside the sector
- Issues around practice based coordination and treatment planning
- The impact of previous attempts to integrate governance and funding for AOD and mental health systems
- Tensions arising from differing treatment system philosophies and processes.¹⁰

For example, while there is a high proportion of people experiencing physical illness, as well as mental illness, integrated governance and funding is not considered an appropriate solution to that issue. Likewise, from an AOD system perspective, combining funding and governance arrangements is unlikely to improve comorbidity responses and has the potential to be detrimental to an already stretched and under resourced sector.¹¹ In this context, the limitations and constraints that exist in one system can lead to investment being used in unintended ways, such as funds from one system being used to prop up/maintain the status quo of another.

Where there have been attempts to integrate funding and governance for AOD and mental health systems in the past, it has resulted in a devaluing of AOD treatment services and the incorrect assumption that AOD treatment could be provided in mental health settings. The gains in comorbidity treatment in the AOD sector have been achieved through investment in sector capacity building (via the State and Territory AOD Peak Bodies) in the non government treatment sector. A similar

⁹ 360edge, “More effective alternatives to integrating alcohol and other drug and mental health services” (Victoria: 360edge). <https://www.360edge.com.au/360media/#1995-2> Accessed 22 January 2020

¹⁰ Claire D Clark et al., "Providers' Perspectives on Program Collaboration and Service Integration for Persons Who Use Drugs," *Journal of Behavioral Health Services & Research* 44, no. 1 (2016).

¹¹ Alison Ritter et al., "New Horizons: The Review of Alcohol and Other Drug Treatment Services in Australia," (New South Wales: National Drug and Alcohol Research Centre, 2014).

investment in the public mental health system would likely yield better outcomes for people accessing that system.

We note with interest the draft report's exceptions in favour of hypothecation. We support maintaining hypothecation of funding for mental health programs for Aboriginal and Torres Strait Islander people due to concerns around a lack of cultural understanding on the part of commissioning bodies. We also argue that hypothecation in AOD settings is necessary to protect the system from destabilisation.

Relevant issues include:

- a lack of understanding about what constitutes specialist AOD treatment from many planners, commissioners, other service systems, and the general community (sometimes related to stigma and discrimination)
- funding of the AOD system falls well short of treatment demand (as noted in the draft report)
- the size of the specialist AOD workforce (including planners and commissioners of AOD services) is comparatively smaller than other systems
- a risk of diluting the already scarce specialist AOD workforce, which will create more service gaps rather than fill them
- short-term or stop-start contracting arrangements, which stifle collaboration and coordination between systems of care and encourages a sense of competition for funding
- people who use drugs are heavily stigmatised and experience access issues in other systems of care.^{12 13}

¹² Queensland Mental Health Commission, "Changing attitudes, changing lives: Options to reduce stigma and discrimination for people experiencing problematic alcohol and other drug use," (Brisbane: Queensland Mental Health Commission, 2018).

¹³ International Network of People Who Use Drugs (INPUD), "Drug user peace initiative: Stigmatising people who use drugs," (London: INPUD, 2014)

Workforce skill and risk appetite

A number of initiatives have been established to build the capacity of the AOD workforce to respond to mental health comorbidity. For example, under the Improved Services Initiative funding announced in 2006, capacity building grants were provided to NGO AOD services and peak bodies to support partnerships and workforce development with mental health and community sectors.¹⁴ Since this time, the non government part of the AOD system has improved its capacity to respond to comorbid mental illness, however our member feedback indicates substance use still tends to be an exclusionary criteria for clients wishing to access mental health services.

We note page 327 of the draft report indicates both mental health and AOD practitioners experience knowledge and confidence issues when dealing with comorbidity issues. The suggestion by the Matilda Centre that training the AOD workforce to use the national comorbidity guidelines is startling to us in that it perpetuates the perception that the mental health workforce does not need to improve its capacity to respond to comorbid substance use.

Similarly, the draft report does not consider the impact of differences in the organisational and workforce risk appetite, workforce capacity building needs, policies and system philosophies between AOD and mental health. These factors frame access and exclusion criteria and underpin many of the identified access issues experienced by people in the systems. Understanding that AOD treatment process are not the same as mental health treatment process will assist us to better define our role and scope of practice to work in a more coordinated fashion. For example, while the scope of the inquiry includes substance use disorders, the AOD treatment system sees many people who have not been diagnosed (irrespective of whether they would meet the criteria for diagnosis) or who experience mental health issues that are not routinely seen in public mental health systems, such as PTSD, personality disorders and anxiety.

Improved system level coordination and planning, rather than system integration per se, is likely to support shared goals, activities and measures of success. Likewise, a focus on supporting services to formalise collaboration efforts (eg through structured case conferencing, co-location) to meet community need may lead to the experience of integrated services for clients, 'without the need for structural or cultural change.'¹⁵

People interacting with the justice system

We note the Productivity Commission's draft report indicates the scope excludes 'broader policies relating to substance use disorders' and is silent on the impact of current drug policy on people who experience problems with substance use. In contrast, the draft report (rightly) details the significant issues experienced by people who experience mental illness and interact with the criminal justice system.

There is an opportunity for the Commission to provide analysis on the impact of current drug policy on individual and community mental health and wellbeing. We note the Queensland Productivity Commission's draft report into imprisonment and recidivism provides a useful analysis of these issues in the Queensland system including:

¹⁴ Amanda Tovell et al., "Outcomes from the National Improved Services Initiative Forum: A Tale of Two Systems," (2010). <http://www.atoda.org.au/wp-content/uploads/National-ISI-Forum-Report-2010.pdf>

¹⁵ 360edge.

- Increasing imprisonment rates despite falling rates of crime
- Illicit drug possession (as most serious offence) being a major contributor increasing imprisonment
- The high cost of imprisonment for personal use and possession of illicit drugs (social and economic).

We believe recalibrating the system towards health-based responses for people who use illicit drugs, and moderating the law enforcement approach for drug trafficking and supply, will contribute to improved mental health and wellbeing for people who experience these issues.