11 March 2025

The Productivity Commission
mentalhealthreview@pc.gov.au

Dear Commissioners King and Button

Thank you for the opportunity to provide feedback on the Productivity Commission's *Mental Health and Suicide Prevention Agreement Review*. The Queensland Network of Alcohol and other Drugs Agencies (QNADA) submission is attached.

QNADA represents a dynamic and broad-reaching specialist network within the non-government alcohol and other drug (NGO AOD) sector across Queensland. We have more than 55 member organisations, representing the majority of specialist NGO AOD providers. This submission is made following consultation with QNADA members.

QNADA is pleased to provide further information or discuss any aspect of this submission. Please don't hesitate to contact me.

Yours sincerely

Rebecca Lang

CEO

Submission to the Mental Health and Suicide Prevention Agreement Review

March 2025

This submission has been prepared by the Queensland Network of Alcohol and Other Drug Agencies (QNADA). Its content is informed by consultation with QNADA member organisations providing alcohol and other drug treatment and harm reduction services across Queensland, as well as a review of relevant research and reports.

As noted in the National Mental Health and Suicide Prevention Agreement (the Agreement) problematic alcohol and other drug (AOD) use and mental illness or suicidal distress can co-occur frequently, and AOD use frequently interacts with other socio-economic and environmental determinants of suicide and mental ill health. People who use of alcohol or other drugs at harmful levels are also recognised as a priority population group within the Agreement.

In this submission, we highlight a range of issues related to the AOD sector and identify opportunities to enhance outcomes which will support delivery of the goals of the Agreement. QNADA has identified the following areas of improvement to Australia's current approach:

- Chronic underfunding of the AOD sector
- The need to resolve issues within the current funding, contracting and commissioning environment
- Issues associated with the PHN network
- The need for national level governance arrangements for the AOD system

Chronic underfunding of the AOD sector

Although only a relatively small proportion of people who use alcohol and other drugs experience problematic use, there is insufficient supply of specialist alcohol and other drugs treatment and harm reduction services to meet demand. It is an established and demonstrable fact that the sector has been underfunded by both Commonwealth and State/Territory governments for many years. This continues to affect not only those organisations receiving funding directly from the Department of Health and Aged Care, but also those receiving Commonwealth funding through PHNs and NIAA.

Research suggests that the Australian AOD sector is only able to treat between 30% and 48% of the population who would seek and benefit from AOD treatment – leaving a potential unmet demand of 207,966 and 469,767 people[1]. This gap represents a significant cost to society—not just in economic terms (where the burden of untreated substance use disorders is substantial[2]), but also in terms of the physical and psychological effects (pain and suffering) that could be alleviated with the provision of treatment.

Over the past five years this gap has begun to be addressed by the Queensland Government through additional funding allocations, including three new State funded residential rehabilitation services under development. The updated Queensland Drug and Alcohol Services Planning Model (QDASPM) also provides a solid foundation to grow treatment and harm reduction services. However, growth plans for the specialist alcohol and other drug treatment sector are moderated by the need to continue to develop a specialist workforce, and new service models to improve access for vulnerable

[1] Ritter, Alison, and Keelin O'Reilly. "Unmet treatment need: The size of the gap for alcohol and other drugs in Australia." *Drug and Alcohol Review* (2025).
[2] Collins D. J., Lapsley H. M. The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05. 2008 Retrieved

populations. This includes an under-supply of withdrawal management (particularly inpatient), family units and non-residential specialist services for young people.

We recognise the critical role of Aboriginal and Torres Strait Islander community-controlled services in the Australian AOD sector. QNADA advocates for increased recognition, in funding and commissioning processes for services which derive and are controlled by the communities. Aboriginal and Torres Strait Islander community controlled health services, including Aboriginal and Torres Strait Islander Community Controlled Primary Health services, as well as those that are AOD specific (e.g. community controlled residential rehabilitation), are often best placed to treat and support people from their community because they have a deep understanding of how colonisation, racism, and disconnection from language, land and sea Country, and culture affects Aboriginal and Torres Strait Islander health. This understanding is embedded in models of care, with social and emotional wellbeing central to health outcomes. Adequately and appropriately funding community-controlled services supports self-determination, health equity and aligns with the goals of the National Agreement on Closing the Gap.

The need to resolve issues within the current funding, contracting and commissioning environment which hamstring the ability of AOD services to operate effectively

The AOD sector is currently facing some significant and immediate challenges to its capacity to continue to deliver services to Australians who need them, noting that between 180,000 and 553,000 Australians need yet can't access AOD services[3]. Funding continues to be the central issue to our member services.

The funding environment for Australia's AOD treatment sector is characterised by complexity, insecurity and system capacity that is not commensurate with need/demand for services. AOD treatment and other services are funded through a complex mix of Commonwealth, State and Territory funding. At the Commonwealth level, in addition to PHN commissioning, AOD services are also funded directly through the Department of Health and Aged Care and through the National Indigenous Australians Agency (NIAA). Sector funding issues have been exacerbated by the lack of indexation on Commonwealth contracts with AOD services for the better part of a decade.

This continues to affect not only those organisations receiving funding directly from the Department of Health and Aged Care, but also those receiving Commonwealth funding through Primary Health Networks (PHNs) and the National Indigenous Australians Agency (NIAA). This has had the obvious effect of reducing service capacity over time, often because services are unable to sustain existing staff levels whilst meeting Award wage rates. As is often the case in the community sector, this impacts on our disproportionately female, over 45 and part time workforce. In addition, lack of consistency in contract length across Commonwealth funding sources and regular delays in execution of contracts through some PHNs is causing an ongoing challenge.

For the AOD sector that delivers the best outcomes for Australian's, stability in the market is desperately needed. Less than one fifth of NGO AOD providers across Australia have some portion of their funding as recurrent, making services extremely vulnerable. Surety of continued operations, through secure funding contracts, and confidence in continued service operations are fundamental for

[3] Ritter, A., Chalmers, J., & Gomez, M. (2019). Measuring Unmet Demand for Alcohol and Other Drug Treatment: The Application of an Australian Population-Based Planning Model. Journal of studies on alcohol and drugs. Supplement, Sup 18(18), 42–50. https://doi.org/10.15288/jsads.2019.s18.4

health care organisations. Despite relying on community-based NGOs to provide 71% of all treatment episodes nationwide[4], the funding and purchasing arrangements for these services serve to increase organisational instability and vulnerability.

These issues are exacerbated by cyclical short-term funding arrangements, particularly from the Commonwealth government, which impacts the capacity of services to effectively plan, develop and retain their workforce. Stop-start funding arrangements and last-minute contract renewals impact the ability of services to develop and maintain a skilled and available workforce and ultimately creates a range of quality, safety, and treatment access issues for people seeking advice and assistance. This can lead to detrimental outcomes as when people are unable to access the necessary support, it can also reduce the likelihood of future help-seeking. It also increases pressures in other parts of the system (e.g. mental health services, emergency departments) contributing to:

- coordination and collaboration issues, meaning people can fall through the gaps;
- limitations in information and knowledge sharing which impacts the capacity of services to provide holistic and coordinated care;
- a varying appetite for risk between systems which may result in punitive responses when people disclose their use; and
- unhelpful and outdated system responses and philosophies that can perpetuate stigma and discrimination.

This has been a long-standing issue in the sector. In 2010 the Productivity Commission argued that:

> "Substantial reform of the ways in which governments' engage with and contract NFPs is urgently needed" and that "The efficiency and effectiveness of delivery of services by NFPs on behalf of governments is adversely affected by inadequate contracting processes. These include overly prescriptive requirements, increased micromanagement, requirements to return surplus funds, and inappropriately short-term contracts" [5]

In an already stretched and under-resourced system, with known workforce pressures, we should be looking to increase stability and predictability in order to facilitate access to treatment for those who need it, through the continuation of block-funding as the preferred model of funding for the alcohol and other drugs system.

With a baseload of stable service delivery, attention could then be turned to increasing the supply of harm reduction and treatment initiatives. For example, work has been undertaken to improve planning and contracting arrangements for specialist alcohol and other drugs services in Queensland in recent years. The Qld Drug and Alcohol Services Planning Model (QDASPM) has been developed and is based on epidemiological data, contextualised by expert input. It provides an estimate for the number of full-time equivalent positions required across alcohol and other drugs professions and treatment types per 100,000 people, calculated by unpacking the components of each type of treatment provided.

We are supportive of the QDASPM being used to plan for specialist treatment services in the future and the continuation of the collaborative approach taken to update this model for use in Queensland. In addition, Queensland Government's move to longer term (5 year) contracts has contributed to

[4] Australian Institute of Health and Welfare. (2024) Alcohol and Other Drug Treatment Services National Minimum Data Set. Retrieved from: https://www.aihw.gov.au/about-our-data/our-data-collections/alcohol-other-drug-treatment-services

[5] Productivity Commission 2010, Contribution of the Not-for-Profit Sector, Research Report, Canberra. Retrieved from https://www.pc.gov.au/inquiries/completed/not-for-profit/report/not-for-profit-report.pdf

increased stability for services. However, delays at a national level in Commonwealth funding flowing to PHNs and then decision making by individual PHNs has had a negative impact on service provision. For example, last financial year several QNADA members' reported they had to stand-down staff due to late contract renewals and with the delays in announcements related to Commonwealth funding beyond 30 June 2023. Other members retained staff and carried the balance sheet risk for months on the promise of contracts arriving 'soon', which turned out to be October 2023.

Commissioning of services based around competition, shorter contract lengths, output and outcomes-based funding models, and detailed standards and measures of accountability is not conducive to establishing and maintaining long-term approaches to holistic treatment planning, particularly for clients with complex needs while simultaneously hamstringing the ability of services to operate effectively and recruit and retain qualified and experienced employee[6]. Although having multiple funding sources can spread financial risk, applying to multiple funding schemes and the requirements for reporting on the use of the funding is a significant burden that draws resources away from service delivery.

The establishment of a national governance framework for the AOD sector would enable greater coordination of Commonwealth funding to AOD sector organisations across the Department of Health and NIAA portfolios, including greater oversight and monitoring of funding currently administered by the PHNs, and integrated planning in the allocation of funding by Commonwealth, State and Territory governments in line with the National Drug Strategy. This would also promote greater consistency in the application of indexation, contract length and commissioning practices for AOD sector organisations seeking to negotiate the current maze of parameters and requirements for funding from different sources, as well as enable coordinated priority setting to improve the efficiency and targeting of funding in line with agreed strategic priorities.

It is clear that part of the solution to improving the visibility of the AOD sector in national policy development is providing recurrent funding to the national peak body for the AOD sector, the Australian Alcohol and other Drugs Council (AADC) to provide coordination and representation that improves visibility of good practice with policy makers and program administrators in the Commonwealth public service.

Issues associated with the PHN network

The commissioning of services through the PHN network has also been a source of issues for Queensland's AOD sector. While $400 million in AOD funding has been distributed successfully through PHNs, the model has also generated significant issues. In the AOD sector, PHNs have added to funding insecurity and workforce sustainability[7]. Keeping in mind the timeliness issues around PHN funding, the performance management and monitoring frameworks for PHN commissioning of AOD services is focussed on outputs rather than outcomes at the detriment of on-the-ground service delivery.

Further, inexperience with alcohol and other drug services and treatment approaches has resulted in one Queensland PHN trialling funding by outcomes despite clear evidence that this is an ineffective

[6] Van De Ven, K., Ritter, A., Vuong, T., Livingston, M., Berends, L., Chalmers, J., & Dobbins, T. (2022). A comparison of structural features and vulnerability between government and nongovernment alcohol and other drug (AOD) treatment providers. *Journal of Substance Abuse Treatment*, *132*, 108467.

[7] Department of Health and Aged Care. (2024) Effectiveness of the Department of Health and Aged Care's Performance Management of Primary Health Networks. Retrieved from: https://www.anao.gov.au/sites/default/files/2024-03/AuditorGeneral_Report_2023-24_19b.pdf

approach and counterproductive to increasing system stability and service quality. Thankfully we were able to bring this to their attention prior to the arrangements being established and the approach was ultimately discontinued.

We are not always able to dissuade PHN's from ineffective approaches. Actions taken in 2024 by the Wide Bay, Central Queensland and Sunshine Coast PHN (also known as the Country to Coast PHN) demonstrate the instability and insecurity that can occur under the PHN model. In May 2024, the Country to Coast PHN acted unilaterally and retendered their entire mainstream AOD investment, without engaging peak bodies, Qld Health or other key stakeholders – despite their commitment to joint regional planning. The tender required all referrals to be made through Head to Health, despite the mandated screening tool for H2H not including any measures around substance use.

Additionally, the tender did not require compliance with the National Quality Framework for AOD services, nor that the AODTS-NMDS be collected. They undertook this action despite no meaningful engagement with current service users, service providers, public AOD providers or the State MHAOD branch in their current process. After being made aware of this situation, QNADA had several conversations with senior management at the PHN, as well as meeting with the CEO. However, despite the CEO acknowledging the points raised were legitimate and concerning, the process continued without pause.

They undertook this action at the same time the Qld Government is rolling out $1.645 billion of new investment in mental health and alcohol and other drug services. It strains credulity that they were unaware of the State Government plans and were able to effectively undertake any type of needs analysis without reference to them. Yet their process somehow met the Department's performance requirements for PHNs.

The Australian National Audit Office audited the PHN model and found:

> "Health has not demonstrated that the PHN delivery model is achieving its objectives. Health had no evaluation plans for the PHN delivery model after 2018. Health has not conducted a comprehensive delivery model evaluation. A 2018 early implementation evaluation was inconclusive about the achievement of objectives at that early stage in the delivery model's implementation. A lack of baseline and relevant performance data impedes understanding of whether the delivery model has met its objectives."[8]

[8] Department of Health and Aged Care. (2024) Effectiveness of the Department of Health and Aged Care's Performance Management of Primary Health Networks. Retrieved from: https://www.anao.gov.au/sites/default/files/2024-03/Auditor-General_Report_2023-24_19b.pdf

National level governance structures are required to address the lack of coordination in priorities and funding within the Australian AOD sector

While Queensland is outperforming other states when it comes to AOD harm reduction, treatment, and prevention, we need federal government to provide leadership so all jurisdictions can move forward alongside Queensland, instead of one state pushing ahead and other states lagging behind.

The lack of a national AOD governance structure has hamstrung coordination of the development, implementation, and funding of National Strategy priorities. It would be of significant benefit to the sector and the community if the Minister for Health established a national level governance framework for the AOD sector which brings together Australian, State and Territory governments, representatives of key AOD sector stakeholders and those with relevant personal experience.

Under the previous Government, the governance structure for the AOD sector was disbanded, following the removal of the Council of Australian Governments (COAG) structure. In years gone by, national governance structures such as the Ministerial Council on Drug Strategy, the Intergovernmental Committee on Drugs and the National Indigenous Drug and Alcohol Committee (NIDAC) were integral to the development and implementation of National Drug Strategies. They ensured a better coordinated approach to system development and funding for the AOD sector at both Commonwealth and State/Territory levels. National governance structures remain in place for other sub-sectors within the Health portfolio (such as in the Blood Borne Viruses and Sexually Transmissible Infections sub-sector) and reinstating such a structure for the AOD sector is seen as critical for the ongoing development and advancement of coordinated priorities for the AOD service sector across Australia.

The absence of national governance structures has resulted in a critical lack of monitoring of key sub-strategies and frameworks that guide the work of the AOD sector. We note the planned mid-term review of the National Drug Strategy 2017-2026 has been abandoned. We also note that the previous National Aboriginal and Torres Strait Islander Peoples Drug Strategy lapsed in 2019 and stress the importance of Frist Nations peoples' voices being heard on this policy area, particularly in light of the outcome of the Voice referendum and the connections between drug policy and colonisation.

We are highly concerned about the demonstrable lack of lack of monitoring and implementation funding for National Quality Framework for AOD Treatment Services (NQF). While the majority of the funded AOD service sector provides evidence-based, safe, high-quality care, stigma around substance use and the root causes of substance use problems means anyone can establish a residential service and make untested claims about their approach. In Queensland, this often connects with evangelical church activity with devastating effects.

While there are high levels of compliance with the national quality framework among funded providers in the public and non-government sectors, the status of providers not receiving government funding is more difficult to establish, as there is no mechanism requiring them to be licenced to provide treatment, outside those required by professional bodies regulated by (as monitored by the Australian Health Practitioner Regulation Agency, or APHRA). Since the NQF's release, QNADA has been advocating for the Queensland Government to proactively regulate private providers of residential services to ensure there is effective oversight of service quality and safety. This is particularly critical in Queensland, as the current lack of access to publicly funded services has left a gap in the market which has contributed to a rise in the number of unregulated private organisations claiming to provide

specialist alcohol and other drug residential treatment, some connected to evangelical churches and others with costs up to $1,000 per day.

We consider that the re-establishment of a national governance framework for the AOD sector would also enable greater coordination and oversight of the allocation of Commonwealth funding to AOD sector organisations across the Department of Health and Aged Care and NIAA portfolios, as well as monitoring of funding currently administered by the PHNs, in line with the National Drug Strategies.

This would promote greater consistency in the application of indexation, contract length and commissioning practices for AOD sector organisations seeking to negotiate the current maze of parameters and requirements for Commonwealth funding from different sources. While there are a number of reputable and accredited private organisations offering high quality residential treatment options, there is an ongoing issue with some who are unable to demonstrate either quality treatment nor how their high cost reflects the services provided, (such as by individual access to clinical psychology services, or access to onsite medical support). These organisations are in effect, if not intention, exploiting people who are desperate to access alcohol and other drugs treatment but have been unable to do so due to the under resourcing of the publicly funded system (both public health and non-government services), or because they don't know a publicly funded system exists.

The West Australian parliamentary inquiry in the Esther Foundation found that "no legislative or regulatory measures available … to enforce the NQF requirements" and that "Failure to fully implement the NQF allows private AOD treatment providers to continue self-regulating"[9]. The AOD sector needs support, funding, and leadership to regulate non-government funded services in order to prevent adverse outcomes, such as the Esther Foundation disaster.

QNADA has had to decline a number of privately funded evangelical sober houses on the basis that they are dangerous and ineffective. In a system that lacks capacity (driven by chronic under funding) – such services are likely to continue to be the only option for some people seeking help. The role of federal government should be to set up and support state government capacity to regulate both funded and non-government funded services to prevent the proliferation of dangerous and ineffective service models. Exploratory work has commenced in Queensland to create a licensing regime for services, which we believe would benefit from national coordination.

Such an initiative may be able to be achieved primarily within the existing resources of the respective Departments, and potentially through a relatively modest allocation in the federal Budget and would enhance transparency and funding accountability, which in turn would no doubt better inform the development of AOD sector Budget priorities moving forward.

[9] The Education and Health Standing Committee of the Legislative Assembly of Western Australia (2022) *Report of the Inquiry into the Esther Foundation and unregulated private health facilities.* Retrieved from: https://www.parliament.wa.gov.au/Parliament/commit.nsf/(Report+Lookup+by+Com+ID)/2ABA1113F29846094825890A00268F40/$file/221128%20-%20EF%20inquiry%20report.pdf