WA PRIMARY HEALTH ALLIANCE SUBMISSION TO THE WESTERN AUSTRALIAN ALCOHOL AND DRUG INTERAGENCY STRATEGY 2017-2021

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Contact:
Chris Kane
General Manager, Strategy and Policy
WA Primary Health Alliance
2-5, 7 Tanunda Drive, Rivervale WA 6103

Chris.kane@wapha.org.au
www.wapha.org.au

Preamble
WA Primary Health Alliance (WAPHA) welcomes the development of the WA Alcohol and Drug Interagency Strategy 2017-2021 and is pleased to present its submission in response to the Consultation Draft.

WAPHA serves a population of approximately 2.57 million people, across the entire State of Western Australia through its three Primary Health Networks (PHNs) – North Metropolitan, South Metropolitan and Country WA. The WA PHNs are responsible for commissioning Commonwealth funded Alcohol and Drug treatment services across the State and WAPHA has focused its activity on the integration between alcohol and other drugs, mental health, co-occurring chronic conditions and primary care. WAPHA is particularly interested in intervening earlier in addressing problems associated with alcohol and drug use as well as provision of support to vulnerable and hard to reach populations who are not currently accessing services.

Collaborative approaches, as are commended throughout the Strategy, can build on the strengths of different service systems and provide a more responsive approach for people with harmful and/or problematic alcohol and other drug use.

WAPHA aims to increase the capacity within WA to provide AOD treatment, as well as facilitate easier access and better pathways to the "right" treatment to suit a person's needs. Commissioning will promote more joined up services, holistic responses, and will respond to the increased demand for services. The alcohol and other drug workforce should have the requisite skills, knowledge, values and attitudes to respond to people's needs and a capability and willingness to work across disciplines and sectors.

A robust and integrated primary care sector can provide the foundation for more effective and efficient mental health care for our community. In this context, it is worth highlighting that, as part of WAPHA's approach to mental health, WAPHA has become the first Australian National Chapter of the European Alliance Against Depression (EAAD). The EAAD is a global framework providing a community based approach targeting depression and the prevention of suicide. In WA, the EAAD framework will play a pivotal role in achieving effective integration. Integration is a purposeful piece of work that requires investment and constant contribution from committed stakeholders, including community. Community must be given meaningful opportunities to contribute which not only respond to needs but acknowledge their strengths and aspirations.

Overview:
The draft Strategy focuses on several priorities that are shared by WAPHA. It is hoped that this will provide for further alignment of State and Commonwealth funded activities. Focus on person centred models of care is central to the WA PHNs' commissioning strategy for alcohol and drug treatment services and we are pleased that this approach has been embedded in the Strategy. There does, however, need to be a more consistent use of the terminology in the Strategy to reflect an approach that tailors treatment to the multiple needs of the person – not just their drug and alcohol use. This approach supports people to be active and equal participants and partners in their treatment planning, taking into account their family, significant others, cultural circumstances and any other needs.

Development of the Strategy presents a unique opportunity to genuinely lay the foundation for an integrated / collaborative approach to addressing AOD related problems that spans across sectors and jurisdictions. At times, the Strategy appears to take a very Mental Health Commission centric position, thereby excluding the roles of other agencies and organisations and misses the unique opportunity to improve working together on agreed priorities.

The Strategy rightly prioritises capacity building and workforce development, including within the primary health care sector. WAPHA supports the specific reference to General Practitioners in respect to the expansion of training and engagement to increase screening, brief interventions and referrals. It is, however, important that capacity and capability building references a broader range of workers and community members. This leverages their ability to recognise and respond earlier to the alcohol and drug issues of individuals with whom they have longer term relationships and potentially a greater "whole person" understanding.

It is not clear which entities are bound by, and would apply, the Strategy. The Strategy does not clarify whether it is to be applied only across state government or across all relevant sectors. If the Strategy is limited to state government, it is doubtful that this is the most effective approach. In the context of a systems approach to services planning and provision, there are key roles assigned to local and federal government, non-government and business. Broader application of the Strategy, and clarification of roles, would facilitate cross jurisdiction / sector commitment to truly embody collaborative and comprehensive approaches. WAPHA further recommends the inclusion of a richer mix of KPIs that better represent the involvement of other partner agencies.

There may be value in articulating a more detailed description of the wide variety of responsibilities in prevention and support that exist across national, state, local, NGO and business agencies and organisations. This would enable clarity and accountability in prioritizing activity and optimising coordination and collaboration. In doing so, the Strategy would be of value in driving collaborative approaches in planning and funding of AOD services to truly address gaps in the system and enable sustainable change.

Multiple agencies exist within the AOD services sector. Some of these are working in silos, with duplication and limited cohesion in communication between the services, the client and the referring health practitioner. Integrated and holistic care relies on engaging practitioners from different sectors to provide coordinated care to meet people's diverse needs. It is recommended that a greater focus in the Strategy is on actions that will improve continuity of care and consider a broader range of stakeholders with collaborative roles in addressing problematic AOD use.

The Strategy references co-occurring mental health issues and this should be extended to include co-occurring physical health issues. The majority of people with problematic AOD use have comorbid mental illness, likely to exacerbate their vulnerability to poor physical health. With the potential for physical health screening to improve health outcomes for people with AOD issues, the Strategy should address the need for systematic identification and management of common health conditions and outline the framework for an interagency response.

Attention should also be given to the reverse proposition – recognising that a large proportion of people with untreated mental health issues (due to lack of services or awareness of appropriate services) turn to prescribed or illicit drugs and alcohol as a coping strategy.

Principles:
WAPHA supports the principles of the Strategy and recommends including an additional principle of enabling integration and addressing fragmentation. The efficacy of an interagency framework depends, in large part, on all parties driving solutions to address common barriers to integration such as data sharing, eligibility criteria and service boundaries. The co-ordinating role of Primary Health Networks suggests it is important to work across agencies and sectors so that alcohol and drug problems are detected and addressed within their local community.

Strategic Areas:
The comprehensive data and evidence (quantitative and qualitative) that can be legitimately obtained from various stakeholders has not been recognised within the Strategy for the value it would provide in planning a comprehensive cross sector response. The value of this collective resource should be overtly stated in the Strategy.
In the information, support and referral section of Strategic Area #3, reference is limited to the AOD sector. This should be broadened to include other areas of primary and social care to better facilitate system navigation and appropriate pathways of referral, care and support. Similarly, in supporting primary care practitioners to reduce health system fragmentation, attention should be given in the Strategy to improving the pathways, information flow and shared care arrangements between primary and secondary care providers.

Key Strategic Area #4 includes a key initiative to provide a 24 hour telephone clinical advisory service. Such a service would increase the capacity within primary care to recognise and respond to AOD related issues and to increase practitioners' knowledge and access to the range of services available. This will be of particular value to addressing capacity and capability issues within primary care in rural and remote areas.

In the context of rural and remote WA, specifically the transitional nature of their populations, there may be value in considering approaches that support a communication network that crosses regional or State boundaries.

The Strategy appropriately recognises the importance of undertaking research into FASD within a juvenile justice context. WAPHA recommends further consideration of a broader application of screening within primary and secondary care. The Australian FASD referral and screening guidelines highlight that consideration of prenatal alcohol exposure should be part of 'mainstream' clinical practice for all health professionals taking a pregnancy history. FASD should be considered as a possible diagnosis in any individual with unexplained neurodevelopmental problems.

Terminology and Definitions:
The Strategy repeatedly references *holistic* responses. There is inconsistency in the use of this terminology. WAPHA recommends applying consistent meaning to acknowledge that effective responses to harmful alcohol and drug use attend to multiple needs of the individual, not just his or her drug use. To be effective, approaches must address the individual's drug use and any associated medical, psychological, family, social, vocational, and legal problems.

Similarly, consistent definition should apply in the use of terminology such as *person centred*. A person centred approach tailors treatment to the multiple needs of the individual – not just their substance abuse. This approach supports people to be active and equal participants and partners in their treatment planning, taking into account their family, significant others, cultural circumstances and any other needs.

Similarly, the term *problematic* has been used in the Strategy's introduction and *dependence* in its aim. This fails to recognise that, in all likelihood, a person's alcohol and drug issues will occur at various points in between.

The term *entrenched* is used in the Strategy and it may be useful to consider an alternative term that does not have the same negative / value laden connotations.

Drugs of Concern:
Opioids are listed as a drug of concern. It is unclear whether these are illicit or licit and therefore requires clarification. A greater focus in this section on the harms from licit drugs, such as medicines would be useful.

Key Initiatives:
The Key Initiatives that are aligned to the Key Strategic Areas require consistency to ensure they are clear and fit for purpose. In some instances, the key initiatives are delivery methods (e.g. brief interventions) and in other instances they are settings or target groups.

Priority Populations:
The Strategy does not provide practical, evidence based best practice approaches for the priority population groups. This section needs to be more comprehensive to ensure that practical strategies for meeting the needs of these groups are identified.

CALD communities are not specifically mentioned as a high risk priority population. This is an increasing population group in WA and their health and mental health needs are not met. Evidence shows that people from CALD backgrounds who have substance use issues are underrepresented in AOD treatment, and when in treatment, are less likely to be networked with professional support services. Concrete strategies are needed to enable an interagency approach to better support people from CALD backgrounds.

In the context of the priority populations within prison and community corrections, it is important to focus on strengthening the communication from the prison medical services to the community GPs or community AOD clinics following release of people from the prison system.

Older adults remain an underserviced group and WAPHA supports a greater focus on strategies to reduce the harmful use of prescription medications and effects of alcohol and illicit drug use within this priority population group.

Cognisant of the identification of priority populations groups within the Strategy, access to a diversity of localised, person-centred approaches should be a principle applied throughout the strategy.

Data, Outcomes and Research:
Data, outcomes and impact need to be further addressed within the Strategy as a priority area. The Strategy applies an evidence based approach throughout and this could be better articulated as a key strategic area. The stated data and research initiatives require expansion of scope and clearer commitment within the Strategy.

The key outcomes and performance indicators within the Strategy are useful to a degree and may be further refined to support data driven continuous improvement, effectiveness, efficiency and accountability across agencies. Closer links are required between the measures and achievements that can be directly related to the Strategy. Appropriate data and outcome measures will further inform policy.

Overall, The KPIs seem restricted and don't necessarily reflect the key outcomes. Further exploration is recommended to assess other options that could be included in the KPIs to truly reflect an interagency approach. Much of the content in the Strategy reflects Mental Health Commission activity rather than that of partner organisations. WAPHA recommends reflection of KPIs of other partners in order to give the full picture.

A specific strategy acknowledging the value of sharing jurisdictional information (State, Federal and Local Government data for example) is recommended to better inform future planning of AOD prevention, support and treatment services.