APPROVED Submission

Dr Michael Freelander
Chair
Parliamentary Inquiry into the Health
Impacts of alcohol and other drugs in Australia

Dear Dr Freelander, Committee members

Thank you for the opportunity of making a submission to the Parliamentary Inquiry. Below, we provide information on how and why WA Primary Health Alliance (WAPHA) commissioning activities are unambiguously focused on improved health equity, addressing the underlying biopsychosocial causes of and contributors to addiction through joined-up planning and services.

Introduction of WA Primary Health Alliance

Recognising the impact of Alcohol and other Drugs (AOD) on the health care system (see attachment 1), AOD commissioning is one of seven program funding streams managed through the Primary Health Network on behalf of the Department of Health and Aged Care (DoHAC).

WA Primary Health Alliance operates Western Australia's three Primary Health Networks (PHNs) in Perth North; Perth South; and Country WA. In planning and purchasing AOD services throughout Western Australia, we work closely with the WA Mental Health Commission and sector peaks in delivery of four overarching AOD priorities for 2023-2026:

1. Increase the skills and capacity of primary health care and specialist AOD workforce to respond effectively to current and emerging alcohol and other drug related harms.
2. Increase timely access to specialist AOD treatment and support for people in under-serviced groups and/or experiencing locational disadvantage.
3. Continuously improve the safety and quality of AOD treatment and support services.
4. Enhance efficiency and improve the experience and outcomes of people.

Our commissioned activities play an important part in Western Australia's response to the health impacts of AOD.

Health Equity is our North star

DoHAC identify a key function of the Primary Health Network is to Commission primary care and mental health services to address population health needs and gaps in service delivery and to improve access and equity. Alongside this, WAPHA commissioning focuses on ensuring services are available to those most in need – marginalised and vulnerable people and groups who frequently 'fall through the gaps' of both the Medicare system and the services available through mainstream services.

WAPHA's commissioning targets people from underserviced populations who are unable to equitably access MBS treatments due to overlapping factors indicating disadvantage, including:

- low income or inability to access services during business hours;
- job insecurity;
- material disadvantage;

- limited personal resources;
- social isolation;
- poor health literacy;
- other social, economic, cultural and personal reasons; and
- residing in rural and remote areas of Country WA or experiencing locational disadvantage.

Priority populations identified in WAPHA's AOD Strategy include:

- Aboriginal people
- People with mental health conditions
- Children, parents and families (including significant others)
- Young people
- Older people (defined as Aboriginal people over 50 years of age and non-Aboriginal people over 65 years of age)
- Culturally and linguistically diverse populations
- People identifying as lesbian, gay, bisexual, transgender, intersex, queer, asexual and other sexually or gender diverse

Within this context, we seek to reflect the needs of priority groups in AOD commissioning intent, encouraging our delivery partners to develop targeted services accordingly - to provide 'Wrap-around' services that addresses holistic biopsychosocial needs, not just a focus on AOD related problems including addiction, but the underlying environmental and behavioural *causes* of harm.

We do this through commissioning services targeted to priority populations (where possible), and/or by commissioning into locations of higher need as identified through PHN Needs Assessment.

Alongside this, an emerging priority for the Primary Health Network is to support workforce development strategies, to upskill both the specialist addictions sector and the broader field (health, mental health, justice, welfare, social, and educational services) in best practice management of AOD related problems.

We recognise that people with addictions typically have a range of life-long biopsychosocial complexities requiring joined-up responses. Attempts by services to treat co-occurring issues separately have not been associated with good outcomes. Rather, the 'correct' intervention must be individualised according to diagnosis (which may be ever changing), stage of treatment or stage of change, phase of recovery, need for continuity, and level of care required.

There is considerable research on best practice approaches to addressing co-occurring problems that identifies several core principles underpinning our approach to commissioning, such as:

- 'no wrong door' approach;
- holistic care;
- person-centred approach;
- routine screening using tools that are brief and easy to administer with assessment of all presenting conditions, and managing the most severe symptoms first;
- assertive care (service initiated through follow up contacts, not waiting for the client to recontact the service);
- a care coordinator to coordinate the provision of care, ensuring continuity of care from screening through to discharge/referral, and to manage effective communication between services and sectors;
- standardised training and orientation to all staff; and

- Codesign.

Why a focus on health equity? (Terms of reference B and C)

Bronfenbrenner's bioecological model of development[1] [2] [3] sees people and their behaviours as products of the combined effects of different systems (e.g., families, neighbourhoods, communities, organisations, nations), presenting a mix of both risk and protective factors which variously expose or inoculate individuals to poor health outcomes.

Sir Michael Marmot and Richard Wilkinson (2003) led the world in defining and applying the principles of social determinants of health. With regard addictions specifically, they note:

> *"Alcohol dependence, illicit drug use and cigarette smoking are all closely associated with markers of social and economic disadvantage. The causal pathway probably runs both ways. People turn to alcohol to numb the pain of harsh economic and social conditions, and alcohol dependence leads to downward social mobility. Social deprivation – whether measured by poor housing, low income, lone parenthood, unemployment or homelessness – is associated with high rates of drug use and very low rates of quitting."*[4]

That is, health inequity comes in many forms and its effects vary across communities and individuals. The implications of this, according to Marmot and Wilkinson, is that an effective drug treatment response must be supported by **a broad framework of social and economic policy**. This includes the need to address the patterns of social deprivation in which the problems are rooted, with action across a range of domains and including addressing socioeconomic inequity as the starting point.

The cumulative effects of **Adverse Childhood Experiences** (ACEs) is strongly associated with socio-economic status and compounds the risk of people experiencing AOD related harm. For example, Bellis et al[5] looked at subgroups who had experienced clusters of four or more ACEs and found they were much more likely to have lives characterised by things like unintended teen pregnancy, smoking, violence, binge drinking, poor diet and illicit drug use. A 2017 study[6] found that for each extra ACE, there was at least a 34% increase in the chances of a person developing a clinically significant substance use disorder as an adult. Further, the effects of ACEs on drug use problems seems to hold across both sexes.[7]

Walsh et al.[8] note that in Australia, children growing up in poverty are three times as likely to experience abuse, neglect or to be exposed to domestic violence than those not in poverty. They also refer to a West Australian study that found children growing up in poor neighbourhoods were 14 times more likely to experience abuse and neglect than their counterparts in other areas. So while it is important to recognise that exposure to ACEs can happen regardless of family wealth or suburb, the accumulating effect of ACEs alongside other risk factors, combined with the absence of protective factors often experienced in disadvantaged communities is highly predictive of problematic drug use, along with a range of other social outcomes.

Best Practice responses (Terms of Reference D)

We submit that new models of joint planning and commissioning are required to address the precursors and underlying factors influencing AOD related problems. Treating addiction/ AOD related harm in isolation is only addressing symptoms. The holistic needs of clients can only be addressed through interagency and inter-sectorial collaboration, and this commences with joint commissioning.

The WA Mental Health Commission (WA Commission) and WA Primary Health Alliance (WAPHA) have partnered to ensure collaborative and coordinated approaches to the planning of mental health, suicide prevention, and alcohol and other drugs (AOD) services in Western

Australia, as a commitment under the Western Australian Bilateral Schedule[9] to the *National Mental Health and Suicide Prevention Agreement* (National Agreement).

The Fifth National Mental Health and Suicide Prevention Plan 2017[10] identified the importance of joint regional planning to address fragmentation, gaps and duplications of services and treatment pathways. Joint regional planning has the potential to address systemic issues faced by people with lived experience and reinforces the need to focus on person-centred care.

The need to improve planning and coordinated commissioning has further been reinforced through the National Health Reform Agreement (2020) (NHRA)[11] and associated Long Term Reforms Roadmap (2021)[12] as well as the Productivity Commission in its *Mental Health Inquiry* Report (2020).[13]

The *Joint Regional Planning in Western Australia* complements initiatives and partnership arrangements to be developed under the WA Health Bilateral Agreement between the Western Australian and Commonwealth Governments and provides a framework for WAPHA and the WA Mental Health Commission to identify shared goals and provides a guide for future joint service planning and commissioning opportunities.

While neither the *National Mental Health and Suicide Prevention Agreement*[14] nor the *Western Australian Bilateral Schedule*[15] reference alcohol and other drug use, the *Joint Regional Planning in Western Australia* document references AOD throughout, to acknowledge the interrelationship between mental health issues, suicidal distress, and alcohol and other drug use. This also aligns with the commitments under the *National Mental Health and Suicide Prevention Agreement*, the *National Framework for Alcohol, Tobacco, and Other Drug Treatment (2019–2024)*, and the WA State Government commitment to implementing mental health and alcohol and other drug system-wide reform as a recommendation of the *Independent Review of WA Health System Governance*.[16]

The complexity and interdependencies between different parts of the AOD and broader health and other social services are recognised and acknowledged in Commitment 8 of Schedule A to the National Agreement. To support this perspective, joint planning approaches broadly align with the *Equally Well National Consensus Statement*,[17] the *Quintuple Aim for Healthcare Improvement*,[18] and the WA Mental Health Commission's *Commissioning Cycle Dimensions*[19] that outline objectives and provide guidance for improving the physical health, mental health, and wellbeing, of people living with AOD use issues.

Critically, outcomes are focused on equity of access to quality health care for all populations, improving health outcomes, ensuring best value for funding and resources, improving the experiences of people accessing services and supports, and improving the experiences of those providing the services.

Thank you for your consideration.

C. Kane.

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Impact of AOD on health care

- The evidence is clear that a significant and growing number of patients have complex biopsychosocial issues including alcohol and other drug use which confound their planned treatment. The evidence is also clear that these people frequently seek support to deal with their issues, but typically do not receive it.
- The costs of this to the health care system are profound. For example, hospital patients experiencing withdrawal are often retained in extended episodes of care simply because of such complexity impacting discharge.
- The impact that the presence of a drug use disorder may have on the course of treatment for mental illness alone has been described as 'dramatic'.[20]
- The NOUS Review of Community Drug and Alcohol Services (2021)[21] highlights increasing complexity of presentations and issues to community AOD services. This is not unique to the AOD sector - GPs too are frequently having to manage clients with complexities including family and domestic violence, homelessness, lack of finances, and comorbid physical and mental health issues.
- It is well known that a high number of hospital presentations are alcohol related. Overall, alcohol use is a major health risk, and in 2010 caused 2.7% of the total burden of disease in Australia.[22] More recently, the *Australian Burden of Disease Study 2024*[23] found that alcohol use was the sixth highest risk factor contributing to the burden of disease in Australia and was responsible for 4.1% of the total burden of disease and injury.
    - Health conditions that can be caused by alcohol include various cancers, liver disease, injuries from falls, physical assaults, road traffic crashes and mental health disorders.[24]
    - Over the ten year period between 2010 and 2019, alcohol use was documented in 44% of admissions for domestic and family violence.[25]
    - Other health conditions highly associated with alcohol include: Child abuse and neglect (35-39%); drowning (up to 30%); motor vehicle accidents (45%); self-inflicted injuries (25%); and various cancers (up to 70%).[26]
- One in five (19.8%) of all trauma admissions to a local Perth hospital had documented alcohol and/or drug use in the 12 hours preceding their trauma event.[27] Alcohol was involved in 32% of emergency department presentations due to injuries in WA, and 11.8% of non-fatal injury hospitalisations.[28]
- AIHW analysis of the National Hospital Morbidity Database[29] showed that alcohol accounted for over 1 in 2 (53%) drug-related hospitalisations in 2019–20 and has remained the most common drug recorded in drug-related hospitalisations across the 5 years to 2019–20.
- The total number of AOD-related hospital separations increased by 23% between 2012–13 and 2016–17. There was a notable increase regarding methamphetamine drug-related principal diagnosis, rising from 1.6% of all drug-related principal diagnoses in 2012–13 to 6.3% of all drug-related principal diagnoses in 2016–17.[30]

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