COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH, AGED CARE AND DISABILITY

Inquiry into the health impacts of alcohol and other drugs in Australia

(Public)

TUESDAY, 14 APRIL 2026

PERTH

BY AUTHORITY OF THE HOUSE OF REPRESENTATIVES

[PROOF COPY]

STANDING COMMITTEE ON HEALTH, AGED CARE AND DISABILITY

Tuesday, 14 April 2026

Members in attendance: Mr Birrell, Ms France, Dr Freelander, Ms Jordan-Baird and Dr Ryan

Terms of Reference for the Inquiry:

The House of Representatives Standing Committee on Health, Aged Care and Sport will inquire into and report on the health impacts of alcohol and other drug use in Australia, with the aim to:

(a) Assess whether current services across the alcohol and other drugs sector is delivering equity for all Australians, value for money, and the best outcomes for individuals, their families, and society;

(b) Examine the effectiveness of current programs and initiatives across all jurisdictions to improve prevention and reduction of alcohol and other drug-related health, social and economic harms, including in relation to identified priority populations and ensuring equity of access for all Australians to relevant treatment and prevention services;

(c) Examine how sectors beyond health, including for example education, employment, justice, social services and housing can contribute to prevention, early intervention, recovery and reduction of alcohol and other drug-related harms in Australia; and

(d) Draw on domestic and international policy experiences and best practice, where appropriate.

WITNESSES

WITNESSES

ARPINO, Mr Alex, Executive Manager, Alcohol and Other Drug Consumer and Community Coalition

GUEST, Ms Alice, Lived Experience Representative and Member, Alcohol and Other Drug Consumer and Community Coalition

KANE, Mr Ben, Lived Experience Representative and Member, Alcohol and Other Drug Consumer and Community Coalition

Committee met at 09:02

CHAIR (Dr Freelander): I declare open this public hearing of the Standing Committee on Health, Aged Care and Disability's inquiry into the health impacts of alcohol and other drugs in Australia. I'd like to acknowledge the traditional custodians of the lands on which we meet. I pay my respects to their ancestors and elders, past, present and emerging. I extend this respect to all Aboriginal and Torres Strait Islander peoples and their cultural and spiritual connections to Australia's lands and waters. Today's evidence may include material that some people may find distressing. We encourage everyone present and those listening online to prioritise their own wellbeing and seek support if needed.

In accordance with the committee's resolution of 21 August 2025, this hearing will be broadcast on the parliament's website, and the proof and official transcripts of the proceedings will be published on the inquiry website. I remind members of the media of the need to fairly and accurately report the proceedings of the committee. I remind all stakeholders who are present before us of the need to ensure the safety and privacy of individuals during these proceedings. This includes avoiding the use of names or identifying details when referring to other parties, particularly children, and ensuring that any discussion is respectful, appropriate and consistent with our shared responsibility to maintain a safe environment.

I now call representatives of the Alcohol and Other Drug Consumer and Community Coalition to give evidence. Although the committee doesn't require you to give evidence under oath, I should advise you that this hearing is a legal proceeding of the parliament and therefore has the same standing as proceedings of the respective houses. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. The evidence given today will be recorded by Hansard and attracts parliamentary privilege. I would now like to invite one of you to make a brief opening statement before we proceed to discussion. That's all the official stuff we've gone through. Please don't feel intimidated. This is not meant to be an inquisition. We just want to hear what's happening on the ground, and we're very grateful for you appearing in front of us today.

Mr Arpino: Thank you for the opportunity to appear this morning. I'd like to begin by recognising the individual and collective expertise of people with a lived and living experience of alcohol and other drugs. We honour the emotional labour, the vulnerability and the strength of coming forward to share their stories and experience, often at their own cost, in the interest of building meaningful connection and understanding to help inform change. Our submission and opening statements are amplifying these voices.

The Alcohol and Other Drug Consumer and Community Coalition is the peak lived experience body for consumer systemic advocacy in Western Australia. We represent more than 990 members with lived and living experience of alcohol and other drug use, including families, carers and significant others; treatment; harm reduction; and the systems that surround them. At its core, our message is clear: alcohol and other drug use must be treated first and foremost as a health and social issue, not a moral or criminal failing. Stigma, discrimination, fragmented systems, and lacking and underresourced services continue to impact preventable harm to individuals, families and communities.

Our call to action begins with the need for a system-wide approach to addressing alcohol and other drug related stigma and discrimination. Stigma associated with alcohol and other drug use remains one of the most significant barriers to help seeking. It exists not only in the community but within healthcare, social services, child protection, housing, employment and justice systems. It undermines public trust, discourages accessing support and exacerbates poor health outcomes. Our last two annual membership surveys found that 85 per cent of participants have experienced stigma, discrimination or shame in relation to alcohol and other drug use.

Members reported that they experienced judgemental treatment at oral healthcare centres and dental clinics, dismissive or contemptuous attitudes from emergency departments and hospital staff, and being labelled as 'drug seeking' despite having legitimate medical needs. This has led to some members opting not to disclose drug use in health settings to avoid stigma, prolonging and compounding health issues. The World Health Organization has acknowledged that illicit drug dependence is the most stigmatised health condition globally, and alcohol

dependence is listed at No. 4. Public education, AOD literacy, policy reform and lived-experience informed workforce training must work together to address this preventable barrier and shift attitudes.

We call for the implementation and regulation of a national quality framework of alcohol and other drug treatment services applying to all AOD service providers, regardless of funding source. Consumers need to be assured that there are consistent standards of safety, quality, transparency and accountability. Unregulated services are a present risk to an already highly vulnerable cohort of our community. Safeguards are needed with robust, accountable consumer complaints processes and real penalties for breaching standards. Regarding current services across the AOD sector, our members report uneven access, poor system navigation and inconsistent value for money. Residential rehabilitation services are often unaffordable or inaccessible, especially for people not receiving Centrelink benefits or those at risk of losing housing while in treatment. Private services are prohibitively expensive and do not consistently deliver outcomes that justify their cost.

We call for enhanced family and supporter services. AODCCC members identifying as family, carers and significant others report they are often left unsupported in crisis. These supporters are the safety net of our community, long after services close their doors. Whether services bring them to the table or not, they continue to be present for their loved ones in need of understanding and support. We see this as an essential, holistic approach to addressing AOD harms. Importantly, our members emphasised that no single service model works for everyone. A diverse mix of harm reduction, pharmacotherapy, psychosocial support, peer led services and abstinence based options must be available within a nationally consistent framework.

We strongly support the expansion of harm reduction strategies, including needle and syringe programs, take-home naloxone, drug-checking services and supervised consumption environments. These programs save lives and reduce harm while also increasing engagement with health services in a non-judgemental and stigma-free setting.

We emphasise urgent action on alcohol related harms, which continue to cause the greatest health burden of all substances. This includes addressing online alcohol delivery, buy-now pay-later schemes, targeted digital advertising and the normalisation of binge drinking. We urge consideration of proven measures such as minimum unit pricing and advertising restrictions.

Lived and living experience must be meaningfully included at every level of policy design, service delivery, governance and evaluation. This includes authentic community representation with current grassroots AOD knowledge and cultural expertise, removing barriers to engagement in our highly diverse population. A well-supported and well-funded peer workforce is essential in providing service users with common ground and genuine hope in navigating treatment at times of crisis. It can be instrumental in addressing stigma and discrimination.

Finally, we draw attention to international best practice, including harm reduction led approaches in Portugal, Switzerland, Canada, Norway and Scotland which have demonstrably reduced deaths and improved outcomes.

In closing, AODCCC urges the committee to centre lived and living experience, reduce stigma, strengthen national standards and adopt a compassionate, evidence-based approach to alcohol and other drug policy in Australia. We thank the committee for this inquiry and welcome the opportunity to respond to any questions. Thank you.

CHAIR: Thanks very much for that. Deputy Chair.

Dr RYAN: Thank you, all, for appearing this morning. It's hugely helpful to have your input, and we're very grateful to you for that. I'm interested in the references you made to potentially preventive measures to protect people from alcohol related harm. You referred to taxation. Would you be able to expand on that a little bit more?

Mr Arpino: The evidence shows that minimum unit pricing is a safeguard for cheap alcohol being sold in very vulnerable communities. It's a very harmful risk to the community. There is evidence to show that tackling that at a taxation level has been very successful. We've got some examples of minimum unit pricing in Scotland, which they estimate reduced deaths caused by alcohol consumption by 13.4 per cent and hospital admissions by 4.1 per cent. Reductions were greatest for men and those living in the most deprived areas of Scotland. It's also estimated that it reduced alcohol sales by three per cent. There is a body of evidence here to show that these initiatives actually work, and AODCCC would certainly support and encourage exploring these options for the community.

Dr RYAN: I think it's an important thing for us to talk about as a committee. In your written submission you talked about the difficulties for people in accessing residential care and the cost barriers for some individuals, particularly those people who aren't receiving benefit payments. Could you expand on that a little bit.

Mr Arpino: What our members have shared with us is the challenge of maintaining a rental property or housing when there is a requirement for people to step out of that for a period of time and put their income into the residential rehabilitation phase. There can be some difficult decisions that have to be made as to whether to give up housing to access these types of services. For a lot of members of our community, pets are a very important part of their home life and their family. If they're living alone and they don't have options for pets to go into alternative supportive accommodation, wherever it is, that can be part of the difficult decision as to what to do to access these types of treatments. It can be very difficult to navigate that, particularly when you're in a housing situation with limited income. That's a challenge.

Dr RYAN: Sure. What would you suggest? People have got to rent. They don't want to lose their rental. What would you suggest people do to assist with that?

Mr Arpino: Well, I think that the community needs to work together to provide some leeway to cover some rental costs or to hold accommodation for people, acknowledging that a significant and crucial part of their treatment is having that housing available for them to come back to—to have a home to live in, to access employment et cetera. To lose that is a massive risk.

Dr RYAN: Agreed.

CHAIR: Sam.

Mr BIRRELL: You answered one of the questions that I had. I just wanted to go into a little bit more detail with some of the international experience. You mentioned Scotland and minimum unit pricing. Is there anything else specific that has struck you about the other countries that you cited? Are there specific things that may be working that we haven't yet looked at enough in Australia?

Mr Arpino: It's really about approaching alcohol and other drug harms from a human perspective and engaging in a person-first approach. I think what tends to happen in regard to alcohol and other drugs is that a lot of the campaigns in the media lean into fear based messaging. That can create a stigmatised outcome for the people that are dealing with alcohol and other drug challenges. So we really need to bring the human experience forward and understand the function that alcohol and other drug use has. If we start from that position, any activities that we engage in are going to be a lot more supportive in understanding the individual's needs.

As for harm reduction options around the world, decriminalisation is one of the significant approaches in Portugal. They've found that what's important in regard to that is that it's not just decriminalising drugs and letting people just get on with their lives; it's actually having health services backing that up, supporting people to enter into health services and support, in addition to the decriminalisation. They've seen significant reductions in drug related deaths, HIV and hepatitis C transmissions and problematic drug use. That's been shown to work well. They're able to lead individuals into health services rather than pushing them into the justice system, which is a very important thing.

Scotland have been instrumental in rolling out national naloxone programs, which has seen a significant reduction in opiate deaths and overdose. They've also been driving a lot of drug consumption facilities, which has also had an impact in reduced overdose and deaths. They've also rolled out a strategic framing of drug use as a public health emergency under a national mission with a long-term investment plan. That has seen some positive outcomes for the community.

Switzerland has an integrated four-pillar drug policy—prevention, treatment, harm reduction and law enforcement. Early adoption of needle exchange and supervised consumption rooms have seen a lot of positive impact in reduced deaths.

There is a lot of evidence and best-practice models that we can look at. But I think that, for Australia, it's important that we find something that fits our community and our specific needs. In order to do that, we need to draw on lived experience and actually engage the community to co-design all of these options. I think that's probably the main point that we would want to put across.

CHAIR: Thank you. Alice?

Ms JORDAN-BAIRD: Thank you so much for appearing before our committee today. It's wonderful to have you here. I just have two questions. Your submission calls for more accessible translated materials. I think you mentioned that the stigma of AOD use can be further compounded in diverse communities. Can you expand on where you think the service gaps are for AOD use in those communities, in terms of workforce and culturally appropriate care, as well as translated resources.

Mr Arpino: We see that, in a diverse community, it's important to actually engage those community members directly and speak, draw out and understand what their specific needs are in terms of access. Again, it comes back

to that lived experience informed approach. If we're engaging the community directly and speaking to those individuals and understanding what the barriers are, it's going to be a lot more accessible and fit for purpose. Regardless of the approach that we're taking, if there's lived experience voices around the table, we're going to be far more effective in supporting those communities. So, when we're talking about culturally and linguistically diverse communities, obviously there are language barriers, and there are cultural barriers that we may not understand. It's important to bring those individuals to the table to really understand those concerns. That would be our message on that.

Ms JORDAN-BAIRD: For sure. My second question picks up on what you're saying. The question is for Mr Kane and Ms Guest. Would you be comfortable sharing your stories on this issue and what changes you'd like to see in the system to better support people with lived experience?

Ms Guest: I've got a background of experience with drug and alcohol use for approximately the last 10 years or so and with accessing services in the community and with residential detoxes and rehabs. A major thing that I've noticed is that, when accessing services, like you said, there are limited services. They often have very strict exclusion criteria, which turns people away or means they can't access the service. Also, there are just not enough suitable services to fit what people need, so even the services that are available aren't effective.

Ms JORDAN-BAIRD: Is that in terms of flexibility—is that what you're talking about there?

Ms Guest: It is just in terms of the way the service is run, what that person needs, meeting them where they're at and not requiring them to have to be this or that to come to the service to receive support. There seems to be a big gap and a disconnect between the services themselves. They don't work collaboratively, in my experience anyway. There's a disconnect of some sort, and then you get passed around, and it just doesn't work.

Also, there's often a lack of support post rehab or detox that I've noticed. There is a lack of follow-up, so people are just left, and that is often where people then go back and are sometimes worse off. There seems to be a lack of support for transitioning from a detox or a rehab centre back into the community or back into their usual lives. They don't look at anything else apart from the drug use, but you can't really treat that without looking at where the person is returning to the environment that they're going back into. How can you treat that without looking at what that person is going back to, whether that's housing, their mental health, abuse or whatever it is? That is why it fails—because you're looking at one issue when you should be looking collectively to treat that issue, if that makes sense.

Within the healthcare service, I've personally experienced a lot of blatant discrimination and stigma. I've had my health dismissed due to drug use. I've had legitimate issues and things that have been disregarded just for that sole reason alone, which then makes me not want to go back to receive help the next time. That seems to be a very big issue. I don't understand why that is still an issue, if that makes sense, because everyone seems to have a shared opinion of what needs to change and why it doesn't work, but there doesn't seem to be a major shift—not that I've witnessed, anyway. The main things are stigma, the exclusion criteria and the model itself—the way services support that person and the disconnect between the services themselves. But I'd say the stigma is probably No. 1, and access is a close second, in my experience.

Ms JORDAN-BAIRD: Thank you for sharing. Your firsthand experiences are really powerful. Mr Kane, would you like to add anything?

Mr Kane: I grew up in the remote outback in the Pilbara. A lot of people up there don't get a mention. There are absolutely no services, so a lot of people that I grew up with, because they couldn't access services or they had to come to the city to access services, when they went back, eventually went back to using and committed suicide. It's a real thing, and I'd like to bring that up. It happens in the remote outback and all around Australia. I don't think it's just unique to WA. It's a problem that people have to come all the way to the city, and then, like Alex just said, they've got to keep their house up north, which is obviously very expensive.

I am an AOD peer worker on the ground with Homeless Healthcare. We provide services to the homeless and people that want to enter detox. One of the things we see a lot is stigmatisation, where people will present to an emergency department and they'll be refused treatment, maybe because of their previous drug or alcohol use. What will happen is that they just will not engage, because they fear being judged. I'd like to see a meaningful change where we get a voice at the table. For too long, we have been spoken to, spoken for, spoken about and researched, when we can do all those things ourselves. We're human beings. I really appreciate you hearing us today. Stigma is the biggest thing for people accessing services.

There also is a clear lack of funds for people and who gets prioritised into those services. I also see a lot of Indigenous people. They have a lot of issues accessing services as well, and unfortunately prison becomes probably the only place where a lot of people can access treatment, where they can get the continuity of service,

which is a sad thing. It's good that they get treatment, but it's sad that it has to take place there and not in the community, which is a lot less expensive to deliver. I'd just like to say thanks. Thank you so much for listening to us and hearing us today. It means a lot.

Ms JORDAN-BAIRD: Thank you so much for sharing. It's really powerful and will be really important for our committee's report, so thank you again.

Ms Guest: Another thing that's probably one of the main issues is how people will have a co-existing mental health issue along with drug and alcohol use. Everyone seems to acknowledge that, and the research backs that up, yet very limited services will deal with both of them. So they'll require you to be X amount sober, or whatever, before they will treat that issue, and vice versa. That has been a big issue with me when accessing any sort of support. I'll go to mental health—and they'll say, 'Stop the drug use,' then the other way is the same. I'm not sure of the exact percentage, but a very high number of people that use drugs and alcohol also have a co-existing mental health issue, and there don't seem to be any effective services that treat both of them. I struggle to understand why, but that's another big issue I want to highlight.

CHAIR: I don't want to be rude, but do you have a family?

Ms Guest: Yes.

CHAIR: Did you find it difficult to negotiate the system while you have children to think of?

Ms Guest: Sorry, what was that?

CHAIR: When you have children, sometimes people avoid getting support because they're worried about what will happen to their children.

Ms Guest: Sorry, I misinterpreted your question. I don't have children of my own.

CHAIR: Sorry.

Ms Guest: That's okay.

CHAIR: Ms France.

Ms FRANCE: Thank you all for coming along today. I was actually going to ask you, directly, that connection between mental health and getting access to support and how the two systems work together, so it was really great that you raised that. Could you give us some examples of not only the exclusion criteria but also the main barriers? I know you've described them, but could you give a bit more detail in terms of the mental health side of things and navigating those two systems separately?

Ms Guest: In terms of the exclusion criteria, do you mean, or both—and also accessing?

Ms FRANCE: Just some examples of the exclusion criteria—I have no idea about the exclusion criteria.

Ms Guest: Being homeless, not being homeless, not being suicidal or not attempting suicide in X amount of time, or being too complex—I've had that one a lot. What's another one? I think I have some written down. Sorry, I'm trying to find where I've written this down.

Ms FRANCE: That's okay; take your time.

Mr Kane: I can give you examples.

Ms Guest: Yes, you can.

Mr Kane: Where I work currently, they've just opened a new facility that we're working in partnership with—our two other agencies. We found that we were having extreme difficulty, like Alice said, placing people with mental health, homelessness and drugs—all those comorbidities. People were not accessing services, because they were deemed too difficult to deal with. The service would provide detox, but it wouldn't provide assistance for mental health, or it would provide detox, but it wouldn't provide assistance for homelessness.

Homeless Healthcare is the first service of its kind in Australia to provide that, and we've just opened a new facility where people with mental health, homelessness and AOD issues are prioritised to get care. So there are a wraparound services, there are GPs, there are nurses, there are peer workers—which I am—and there are caseworkers. It's the first of its kind in Australia, but unfortunately it's a 12-bed facility.

I work at one of the other facilities. We are constantly having people coming there and then we're having to put them back on the street because there is nowhere that will take them because of their complex needs. It's a revolving door that ends up costing the taxpayer probably five to 10 times more than it would if there was a service they could access. Having those complex needs—that's probably a big gap that we could work on.

I have a physical disability. I suffer from chronic pain. When I accessed treatment services, I was placed on the—registered drug addict. So I was taken off all my medication, which led me to relapse after about three years

of being clean. Thankfully, I got back. I had a good doctor and a good pain management specialist, and I got back. It's things like that which are deemed too complex. We find that, probably, the people that need the most help are the ones that we're putting back on the street the most, which is a real shame.

Ms FRANCE: It seems like a missed opportunity, because—

Mr Kane: Definitely.

Ms FRANCE: the opportunity for somebody to come and ask for help and then to be rejected is just—

Mr Kane: And then to be stigmatised, because that's what it is. It's stigma. They're not being accepted, because they're deemed too complex needs, which is crazy.

Ms Guest: Another thing that I was going to mention is that there seems to be a stain on your name, essentially, from any notes or previous interactions you've had with services. I've gone to services that I've been referred to, and, before even speaking to me, they deny my referral due to what notes have been documented about me from a previous time. It seems to follow you, and it doesn't seem to be possible to get rid of it—not completely anyway. For people I've never met, there's no reason they would have to deny me, but they seem to run with what they have read on whatever system, or whatever notes they have, about me. That's a big issue with going to a new service or trying to get different support from elsewhere.

Ms FRANCE: Thank you.

CHAIR: Mr Birrell.

Mr BIRRELL: That was the same question I was going to ask, Ali. What has struck possibly all of us is the exclusion criteria and the person not being dealt with in a holistic manner. There are alcohol, drugs and mental issues and probably other things too, which could have happened at different stages, or there could be different causal links between the two of them. But, to drill into that exclusion criteria a bit more, are you saying that there are people who are going to have a mental illness dealt with and the medical services are saying, 'I'm not going to deal with that until you can prove that you're sober,' or clean, or whatever it is?

Ms Guest: Yes.

Mr Arpino: That is going to be the challenge.

Mr Kane: Absolutely. I see it every day at work. People, and in particular people with disabilities, are being turned away. They'll say: 'We don't have the service. We can't provide a service.' So they're on the street. They want to get clean, they want to get help and they want to get a wraparound service, but they can't access it, because they're deemed too challenging and their needs are deemed too extreme.

Mr BIRRELL: I've heard this talked about in some community projects in my own electorate, which I've been talking about, that are hopefully going to be built. They talk about, in a crude sense, a one-stop shop or a no-wrong door. It would be a facility that when you walk in it won't be a referral, where you have to wait three weeks or go somewhere else. There'll be someone in there, perhaps in a collaborative way, to deal with the person. Is that part of the solution?

Mr Kane: That's awesome. That's exactly what you need. We're basically handcuffed by our funding as well. We have to deal with certain people, so people are triaged, and sometimes we're taking the easiest people we can, because you want service outcomes as well. But, if you don't have a facility to send someone with complex needs, the only option we have, unfortunately, is to put them back on the street. Once they're medically cleared, they're back on the street. It's a revolving door that's costing the taxpayer probably millions, which could be fixed with the solution that you've just suggested.

Mr Arpino: If I could add to that, I think one of the other core challenges is retaining that area of expertise under a shared banner, because alcohol and other drugs is a specific area of expertise—as is mental health, as is peer work. Ensuring that those streams are supported and strengthened under one banner can be an additional challenge. It's not a 'one size fits all' approach under one banner; it still requires that level of complexity and expertise within it.

CHAIR: I want to explore that a little bit if I can. We've had some models of care over many, many years that revolve around residential management, which I think one of you has already said. I think, Ben, you said that it's very expensive, and it is indeed.

Mr Kane: It's extremely expensive.

CHAIR: It's very expensive. Is there a more up-to-date approach that would look at outpatient management rather than residential management, which would use community resources, like drug and alcohol nurses, GPs and digital platforms?

Mr Arpino: As I mentioned in the opening statement, our members are calling for a diversity of options, because a one-size approach won't work for everyone. Outpatient is very important. Residential is very important. It's providing those options for the community. It's those intersecting issues that are the challenge as well around access to housing, security, employment et cetera.

CHAIR: All the social determinants of health.

Mr Arpino: The challenge with alcohol and drugs is that there are so many intersecting points that add to the issue. It's really around finding that person centred approach of understanding the individual that you're working with and then tailoring the supports for that individual. It takes time.

CHAIR: Is there a role for a drug and alcohol nurse navigator?

Mr Kane: Definitely. I work at a facility with wraparound services, the 12-bed facility that I just told you about that targets people with AOD and mental health. They get excellent care in there, and the services wrap around. But then, when we find them permanent housing and they move into the house, we're finding high relapse, and they're going back into homelessness. There's nothing back in the community. Once they leave our service, that's it. Our funding stops. The other day, we had a guy who'd been with us for 18 months. He'd been clean the entire time. We found him a really nice house. I think it was within four days that he rang us up and said, 'Can you come back and get me?' But we couldn't even go get him, so he's back on the street.

It's finding a service that connects with them in the community again. It's led by nurses. For instance, tomorrow, I'll go around the street with a nursing team and a social worker and engage with people on the street, provide medical healthcare, do a triage and then refer them to services, not just ours but others as well. We find that really effective, but it's once they leave the treatment as well. That's where we're having the biggest problems because there are no services once they leave the treatment. They're put back with a GP who may not have seen them for 18 months, because, once they're with us, they can only see the GP that we see, so it's a bit of a challenge.

CHAIR: So there's a disconnect.

Mr Kane: There's a big disconnect, yes. It's an awesome service, but, when they're put back into the community, they're basically just left to their own devices and there's no support there unfortunately.

CHAIR: Things like digital platforms have been brought up with us a bit. Is that a reasonable thing to look at?

Mr Kane: It depends on the cohort. It depends a lot on age. It's individual. Some people will engage a lot with that, but other people may not have the intellectual capacity or analytical capability or may be computer illiterate, particularly if they've been homeless for a long time, because they don't have access to the internet. They may have a phone, but it's usually one that's quite dated. Many of them are unaware of or can't use a lot of the social media platforms and things like that. It's finding a service that they can actually engage with once they leave our care.

Mr Arpino: Could I just add to that. One of the points that AODCCC is consistently advocating for is improved engagement with family carers and significant others to build those community connections, bring those individuals to the table to provide a safety net for the individuals when they get back into the community, and bring those people into support and wrap around those individuals. We acknowledge that that's not always available for some people. They don't have family. But, if we start to look at AOD as more of a community issue and create those community connections, I think that that will go a long way in supporting individuals.

CHAIR: Alice, when you've engaged with the rehabilitation services, what happened afterwards?

Ms Guest: After leaving the service?

CHAIR: Yes. Did you get follow-ups?

Ms Guest: In some services, yes. One service in particular was pretty good with that. I was still engaged in community care after that, and I would still see them regularly following leaving the service. I'm speaking mainly from one particular service. They were fairly good in that respect and would follow up regularly and provide supports after I left the rehab and detox service. But other places—not so much.

CHAIR: Do they help you re-engage with community, look at getting you into the workforce or education or anything like that?

Ms Guest: No.

CHAIR: Did you have any engagement with a GP?

Ms Guest: Yes, there was a GP. That would be linked in.

CHAIR: Did they provide support for you?

Ms Guest: Apart from medical needs, not really. That was as far as that support went with a GP.

CHAIR: We have heard from the College of GPs, who are keen to engage in the AOD space.

Mr Kane: Where I work, we have GPs, but the problem is, once you lose the funding, that's it—they're gone. I'm personally lucky, because, as I said, I have a disability and I've got a fantastic GP, but not all GPs are trained for that, and then they don't get paid for it. They might get a bulk-billing thing, but they're not going to spend hours and hours on it, because they're businesses.

CHAIR: One of the things they've asked for is a more prolonged—

Mr Kane: Yes, definitely, that's 100,000 per cent needed.

CHAIR: AOD consultation. Any further questions?

Dr RYAN: Can we circle back to the issue of Centrelink payments and how people's qualification for them—or non-qualification for them—affects their ability to access services. Can we talk about that a little bit more.

Mr Kane: I can give you a specific example. Right now, where I work, we have a nurse who's Kenyan, so she doesn't get Centrelink, so she's at our service. She's been in Australia for 10 years, and the only way she can get money is to quite literally walk around 12 hours a day and collect bottles to make money—things like that.

We also get people who are on Centrelink—the money they have will usually go to a lot of the services. The service where I work is actually free. It's the first of its kind in Australia. We don't take any of their Centrelink, whereas a lot of other services will take up to 95 per cent—for some people, 100 per cent. We encourage them to save the money while they're in the facility so that, if we can't find them accommodation, they've got enough money to find accommodation themselves. We're all about agency and building the people up so that, if they do leave or we can't find them a house, they've at least got enough money to secure short-term to medium-term accommodation.

Dr RYAN: Would it be fair to say that financial constraints limit many people from accessing services?

Mr Kane: Yes, 100 per cent. If you have access to private health care, you can pretty much go wherever you want and you can get whatever service you want, but, if you're stuck on Centrelink, it does really limit it. There are longer waitlists for things like that. If it's a private facility, the waitlists are pretty small, because you have the money and it's a pay-for-use service. I think that's something that really needs to be addressed, definitely.

Dr RYAN: Thank you.

CHAIR: How do people get access to your services?

Mr Arpino: We're a systemic advocacy organisation. An individual can become a member, and it's a free membership—they just go to aodccc.org and are able to become a member and be part of the conversation. We capture their voices and experiences. We have a number of reference groups, there are opportunities to contribute to submissions, we provide training et cetera—that's our organisation, as a systemic peak. We try and remove as many barriers as possible to have people come to the table and be part of this very important conversation.

Mr Kane: You taught us how to utilise our lived experience—and monetise it. There's been a massive expansion in peer-worker roles, which is really good because co-design is really important. Like I said before, for too long we've been spoken for, when we can speak for ourselves. We really appreciate having a seat at the table. I think it'll drive meaningful change if we're a part of it, because, while people might learn things at university—I've been to university myself—when you're on the ground, you see the reality of it. You might have a model, but it's not usually what we're using on the ground. We're just using whatever works.

CHAIR: And you work in the community.

Mr Kane: Yes.

CHAIR: Is there anything you'd like us to take home from your appearance today?

Mr Kane: Just be open to new approaches—that's the thing. What we're doing is, like I said, an Australian first. For me, the AODCCC was an absolute lifeline. It gave me the confidence to understand that I could go there and not be judged. No-one's ever judged me. I got paid to attend. I'd been on the disability pension for 15 years. I had the surgery and I was able to return to work. With the AODCCC, I met my boss at one of the reference group meetings, literally. Networking pays off.

CHAIR: Yes. Alice, is there anything you'd like us to take home?

Ms Guest: I'm just trying to think if there's anything else. Similar to Ben, I'd just highlight the impact of lived experience. I think having it not as a token voice but really including it in decision-making at every level—for frameworks, policies and everything—will help a lot.

CHAIR: Thank you all for coming today. It's been very interesting and very informative, and we really appreciate you giving us your time today. If you've been asked to provide any additional information, could you please forward it to the secretariat within the next two weeks. You'll be sent a copy of the transcript of your evidence and will have an opportunity to request corrections to any transcription errors. Once again, thank you so much for appearing today.

Mr Kane: Thank you for having us. We really appreciate it. Enjoy your time in WA.

CHAIR: We will, if you put on some nice weather for us!

CLIFFORD, Dr Brendan, Vice-President, Drug and Alcohol Nurses Australasia [by audio link]

[09:53]

CHAIR: I now welcome representatives of Drug and Alcohol Nurses Australasia to give evidence today. Although the committee doesn't require you to give evidence under oath, I should advise you that this hearing is a legal proceeding of the parliament and therefore has the same standing as proceedings of the respective houses. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. The evidence given today will be recorded by Hansard and attracts parliamentary privilege. Do you have any comments to make on the capacity in which you appear?

Dr Clifford: I'm a registered nurse with a background in clinical care and academia.

CHAIR: Thank you. I now invite you to make a brief opening statement before we proceed to discussion.

Dr Clifford: DANA is the peak group for nurses working in AOD across Australia and New Zealand. Drug and alcohol nurses are a highly committed, skilled group of professionals working at the intersection of physical health, mental health and social need. We provide AOD harm-reduction, treatment and rehabilitation services in acute and community settings and work across systems to support professionals in other specialities, such as emergency medicine, perinatal health and infectious diseases.

AOD nurses provide care in settings as varied as injecting centres, pill-checking services, small community hospitals, inner-city emergency departments, maternity services and clinical research units. Through our national conferences and our regional forums, DANA hears directly from nurses across Australia about the realities of care on the front line, barriers to integrated care, workforce shortages and service gaps, particularly for First Nations people. We also see a lot of innovation to meet new challenges.

We undertook a study of the AOD nursing workforce in 2020 and repeated our survey component of that study in 2024. Our survey data show a workforce that is highly qualified and working autonomously, but also one that is ageing and under sustained pressure, particularly in regional and remote areas. Stigma is a major factor affecting not just our patients but also our workforce. AOD nursing is frequently undervalued as a speciality, and that impacts recruitment, retention and investment in training and career pathways. While AOD work is increasing in complexity, the nursing workforce needs more investment to keep pace. I know that nursing had the highest vacancy rates of all the professions surveyed in the New South Wales AOD workforce census in 2022.

DANA currently undertakes credentialing, clinical supervision and leadership development programs. In addition to supporting these efforts, we would also recommend building co-designed AOD content into undergraduate nursing education to build knowledge and enhance non-judgemental attitudes across the nursing workforce; the implementation of post-registration programs which provide structured, supported opportunities for graduate nurses and career pathways into specialist practice; supporting advanced practice nursing roles and nurse led models of care, including nurse practitioners and registered nurse prescribers, both in AOD specialist care and in other settings, such as primary care and mental health; the evaluation of models of integrated care so that AOD related needs continue to be recognised and afforded expert care in pressurised health systems; and a national approach to workforce planning that includes the unique challenges of AOD nursing as a speciality.

Nurses are well placed to provide non-judgemental and expert care to prevent and address AOD related harms. We support health-led, evidence-based and non-punitive approaches to alcohol and other drug policy and strongly believe this can only be meaningfully achieved in partnership with the people that it affects the most: people with lived and living experience.

Thank you for the opportunity to participate in this inquiry, and I welcome any questions that you might have.

CHAIR: Thank you. Ms France.

Ms FRANCE: Thank you so much, Brendan, for giving evidence to us here today. We really appreciate it. I'm interested in the voluntary credentialing. I'd like your views on whether there should be compulsory education within a tertiary setting and how that would help in terms of stigma—so not just providing more specialised services across the board but how that would support. And do you actually support compulsory courses within tertiary settings for health professionals?

Dr Clifford: Yes. I recognise how pressurised health professional curricula are at the moment. I would say that we need to have mandatory drug and alcohol education in those curricula, but it also needs to be supported out in the workplace. Once you go from university or your education provider into the workplace, that's where you will meet more stigmatising approaches. We need a systematic approach to it, not just a module in an undergraduate course.

I think you make a good point around stigma, because knowledge itself won't address stigma. There has been some good research done recently at Western Sydney University, where Dr Mark Goodhew has developed education that's co-delivered with people with lived experience. I think that's a very good way of imparting not just knowledge but also the attitude changes that are required. When people who are beginning to encounter harms from their substance use start entering the health system, it's generally not to a drug and alcohol service in the first instance; it will be to their primary care provider or to an emergency department, so we need to have a minimum skill set of AOD care for all health professionals so they are equipped to ask the questions and know what to do with the answers. I think health professionals are very good at helping people when they feel supported to provide that help. I think I've answered most of your question there.

Ms FRANCE: Thank you; that was helpful.

CHAIR: Alice.

Ms JORDAN-BAIRD: Thanks so much for appearing before our committee today. My question picks up on Ms France's question. There's no doubt that nurses play a really important part and an important role in the AOD space. You noted the issues with the ageing population and the sustained pressure on the workforce. How do we encourage more nurses to specialise in AOD? Is it through Ms France's suggestion, or is it through further incentives? How do you see that playing out?

Dr Clifford: I think exposure to AOD content, for an undergraduate and as a new graduate, is really useful in addressing some of the myths around AOD care that can be pervasive in the community. Then that feeds into our health workforce as well. That it's a meaningful area of health care with outcomes can be something that people don't believe when they first encounter it, so that initial entry into the health workforce needs that bit of support.

We also need to have a career pathway that has development opportunities along the way. Currently, I think there are only two graduate certificate courses for nurses to specialise in drug and alcohol care—and only one is nursing specific. We need more education opportunities that are specifically for nurses. We also need to have funded positions that attract nurses to stay in drug and alcohol sectors to achieve those. Things like nurse practitioners are really good ways of not just delivering care but enhancing the attractiveness of the speciality to people.

We undertake credentialing as a way of raising the profile of the speciality. That also supports nurses to feel expert in their practice. When you compare AOD nursing to specialities like theatres or emergency or critical care, that can undermine people's confidence that they're providing really expert care, because it's not as technology dependent. But the work of engaging with somebody who feels huge amounts of shame or stigma—having a good knowledge of the physiology of what's happening and also the social context in which that person is trying to meet their needs—is actually quite skilled. We need to remind not just nurses but the community that this is incredibly skilled work that we're doing—things like support for credentialing, educational opportunities and those positions that are really well recognised for the work that they're doing.

In addition to nurse practitioners, there are also nurse navigation roles that are often clinical nurse coordinator positions. They do really essential work in bridging system gaps—they'll work across systems. That is very interpersonal work, because you need to build relationships with people. It's very human work in that way. Recognising that as expert work, not just something that you can do within a graduate course, is also something that will, I think, attract people into speciality.

Ms JORDAN-BAIRD: Do the nurse navigator roles that you just mentioned support people in outpatient settings or within care?

Dr Clifford: There isn't a standard typology of those nurse led models. I'm using 'nurse navigators' as a term to look at the ways in which nurses work into other systems. You might have a nurse that works in a withdrawal management unit, for instance, whose work is AOD care, and their patients are there, but there are lots of other models of nurses that work across systems. In a hospital, you'll have consultation liaison services, where somebody might come in with an injection related infection, for instance, and they'll be seen by a drug and alcohol nurse during that admission. You will have nurses that go down to the emergency department and talk to patients there. In New South Wales, there are GP liaison nurses that will go from the hospital to work in GP practices. We also have nurses embedded within homeless-health teams, for instance, that provide drug and alcohol care there. There are lots of models that are being innovated in this space, because nurses are very good at seeing local problems and devising local solutions. They can be very fragile though, because it's dependent on short-term funding from PHN. They're also really dependent on the goodwill of those nurses to go above and beyond what the position description says, because to advocate for those patients in systems that are often highly stigmatising is a huge amount of emotional work.

The other thing that is really important—we talk about clinical supervision, and we have a small program that we are trying to run through our organisation—is supporting nurses to work with the high degrees of trauma, vicarious traumas, that can be experienced by this population. But also, how do you continue to advocate for patients in systems that don't recognise their problems as health problems? That's another thing around clinical supervision and why that's important for a nurse navigation role. It can be highly challenging work when you're dealing with services that would much rather not have to deal with your patient.

I recall a nurse practitioner I spoke to once who was working in a homeless health service. They met a client whose anxiety was increasing. It was being attributed to his mental health and substance use. But when she listened to his chest, she found that actually he wasn't breathing well; he had developed lung cancer. She was the person who identified that. She thought broader than mental health or substance use. She used the biopsychosocial model that nurses use and asked, 'What else could be going on here?' She referred him into treatment, which was good. Unfortunately, it was too advanced for long-term outcomes, but that person got to experience good Australian health care towards the end of their life because of that. And that shows what nurse navigation roles can achieve for this population.

Ms JORDAN-BAIRD: Most certainly. Thank you. I have no further questions.

CHAIR: Monique?

Dr RYAN: Thank you. I really appreciate your input this morning. I want to ask you about voluntary credentialing for alcohol and other drug nursing services? Is that a useful endeavour? Does it contribute to improved health outcomes and professional recognition for those nurses who engage with that? What are your feelings about voluntary credentialing?

Dr Clifford: I think so. Nursing research doesn't get a lot of funding to do this type of work, to appreciate what would be the best approach to do this. There are only a few groups who do credentialing in Australia, and it really depends on if it's rewarded or not. Nurses, as a group, are very busy at their jobs. The profession development opportunities might not be supported by organisations, and nurses often don't have the disposable income to invest in their own professional development. So unless there's a reward for something like credentialing, if there was greater take up and expectation of it, that might produce those shifts in nursing work for prestige and for the quality of the workforce that is provided for people with AOD issues. That might help. It probably would help. I don't have any strong evidence for that, and we would need to see larger upscale and rewards for it.

Dr RYAN: Thank you. So essentially, barriers to nurses undertaking that sort of credentialing would be cost. And I guess, from what you're saying, availability of the credentialing, the higher education training systems as well.

Dr Clifford: Yes. We provide credentialing across a number of criteria, because we try to make it—because of the nature of the workforce, there are lots of ways into AOD nursing. So we're quite flexible, but it does require postgraduate education to become credentialed. So, yes, the cost of undertaking that can be a barrier.

Dr RYAN: Okay. How is it physically done? Can it be done online, or do you have to physically attend training sessions?

Dr Clifford: How we credential is basically through a portfolio of work. You compile a portfolio of how you meet the criteria that we've set out to credential you as an AOD nurse. There are a number of quality-improvement projects, depending on how much postgraduate education you've had. It can be a graduate certificate, a master's degree or a PhD. It's quite flexible in how you get it, and the credentialing cost itself for people is pretty low entry. It's $100 or $150 or so. But the opportunities for nurses to develop their careers and to become credentialed are things that would be in the domain of health services or service providers to give. Often, nurses are working in places—if you're running at a staff shortage, for instance, getting the opportunity to go and do professional development is something that will stress managers out, so they might not be provided.

I think that the most important thing is how we incentivise and recognise the value of credentialing. If you're a credentialed nurse, is it a financial reward in your pay salary? We would say that you would be better placed to apply for and get more senior positions if you're a credentialed nurse. There would be a lot of scaling up required in terms of the system of credentialing if you were to bring in compulsory credentialing for nurses providing AOD care. You would also need to take consideration of the fact that there may be general nurses providing AOD care, there might be general nurses who are providing only AOD care and then there might be specialist nurses who provide specialist AOD care. A nurse on a withdrawal management ward in a hospital, for instance, might not need credentialing for that position, even though they're in an AOD speciality area, but the clinical nurse specialist in that unit might.

Dr RYAN: Thank you. I appreciate that.

CHAIR: Sam.

Mr BIRRELL: The last part of that answer clears a lot of things up for me. It's important that all nurses have some knowledge of alcohol-and-drug issues because they're probably going to be exposed to them sometimes, but then there'll be people who'll need to have specialisations to deal with them. You've explained that very well. Where would the biggest gaps in the nursing workforce be, in your opinion, if you were to say, 'Here's the extent of the alcohol-and-drug issue, but the biggest problem is that we don't have enough alcohol-and-drug specialist nurses,' or, 'We don't have general nurses with knowledge of alcohol-and-drug issues to be able to deal with them at the first level'?

Dr Clifford: Probably the most immediate gap would be that specialist AOD nursing capacity. We're a highly skilled group, but, as I said, it's relatively small, ageing and not growing in line with demand. While general nurses are increasingly encountering AOD issues, they often don't feel adequately supported or trained to respond. Having more specialist AOD nurses also helps that part of it. Growing and retaining the specialist workforce helps build capacity across the broader nursing workforce. That's how you begin to see reduced pressure in emergency departments and get those opportunities for early intervention that present themselves in those non-specialist AOD health settings.

Mr BIRRELL: Is that another issue? What you're saying is that we need more AOD specialist nurses, but let's assume that we've got those nurses and services. Is an issue the ability of people who aren't specialists but should have some sort of training? If they had that training, they might be able to make intervention earlier than they otherwise would.

Dr Clifford: Yes, I think that is a gap. It's a twofold priority. You need to have, say, that emergency department nurse recognise that this person has a substance-use issue, and then that nurse needs to be able to refer that person on to the appropriate specialist care if they need it. If somebody has started using methamphetamine but hasn't quite reached the phase of recognising that their use is beginning to escalate, that might be recognised, and then they can be referred to a nurse practitioner or into a senior nurse led model of care within the health service.

I would say, to sequence it, that that ED nurse is much more likely to undertake that kind of work if that work has been modelled to them by a specialist nurse. To get that momentum going of building a culture of non-judgemental AOD care throughout the healthcare system, I think having AOD nurse specialists as champions, working with people with lived experience and with peer workers, is a really strong model to support what, in an ideal world, would be some introductory AOD care in their undergraduate program and some post-registration structured programs as well.

Mr BIRRELL: Thank you.

CHAIR: I just want to explore a bit more about whether you think we have the capacity to have AOD nurses leading community based rehab services.

Dr Clifford: There's capacity within the nursing scope of practice to do that type of work, for sure. Nurses are highly educated to master and PhD levels and are highly experienced in terms of the type of care that they've delivered. They frequently manage services to very senior levels. So I think it's well within the nursing scope of practice to undertake that kind of work. Whether we've got the numbers would be the question.

CHAIR: And, if we don't, how do we get them?

Dr Clifford: It's hard to answer the question about numbers because workforce planning doesn't go down to the level of AOD nursing as a speciality. It'll go to broad categories like primary care and mental health, but it doesn't include drug and alcohol. And drug and alcohol could fit under either of those and faces unique challenges. So that's one thing.

When you look at the best indicator that we have—the little tick box in the nursing registration—it says that there are just over 2,000 AOD nurses in Australia, and that's growing in line with the nursing workforce. However, the census of the AOD workforce in New South Wales showed a vacancy rate of about 14 per cent for that workforce, so there's a workforce shortage. Where that workforce shortage is in terms of acute hospital or community rehabilitation, treatment or harm reduction, I don't have the granularity to say. In terms of how we grow it, I think it's those things that we've talked about already. There's raising the prestige; that stigma that affects our patients also affects the speciality, and that is through those things that I've mentioned already. There needs to be greater exposure to AOD content in undergraduate and new graduate positions, as well as credentialing to raise the profile of the expertise of drug and alcohol nurses. Also, there should be opportunities

for expert practice—so nurse practitioner roles, nurse prescriber roles and senior leader champion roles like nurse navigators, but at senior nurse levels.

CHAIR: Right. But you think it is possible to do it?

Dr Clifford: I think so, yes.

CHAIR: The reason I ask these questions is that people focus very much on residential rehabilitation, yet we've heard from a number of sources that, while that works while you're in residential accommodation, once you leave there's less and less effectiveness because of lack of follow-up.

Dr Clifford: There are nurses working in residential rehab settings. It is difficult to compete with public healthcare settings, with the awards and the contracts that are offered in the public health setting. To attract nurses into that sector, it would require, I think, more work on how to adequately remunerate those positions so that they're as attractive as those in public health systems. In terms of how you link care between those two systems—the residential rehab system and the broader healthcare system—I think nurses do a very good job of doing that because often they're in places. So, if you take a place based approach to health, I think that's a very sensible way of working in a population where you've got intersecting physical, mental and social needs. Those nurses can be really good at being with people for a long time and knowing how to create those linkages between services, because nurses are good at spotting gaps and coming up with a way of meeting with them.

That takes a lot of hard work, I think, in terms of not just knowing people but also working with systems where, like I said earlier, people might prefer to not have patients with AOD issues. Whether it's having a nurse who is based in a hospital but working into a GP practice or having a nurse based in a GP practice but working into a residential rehab, I think there are lots of ways of working with systems to bridge those gaps. And I think there'll always need to be place based work, as resources and needs always vary in places. So I think the thing that is needed is the supply of nurses into those systems to help bridge those gaps.

CHAIR: Great. Thank you for giving evidence today. If you've been asked to provide any additional information, could you please forward it to the secretariat within the next two weeks. You'll be sent a copy of the transcript of your evidence and will have an opportunity to request any corrections to transcription errors. Once again, thanks for appearing and giving us your valuable evidence today.

Proceedings suspended from 10:22 to 10:45

NIBLOCK, Mr Andy, Executive Manager, Business Development, Palmerston Association

STEPHENS, Mrs Rebecca, Executive Manager, Strategy, Engagement and Communication, Palmerston Association

WINTON, Mr Michael, General Manager, Operations, Palmerston Association

CHAIR: Thank you for appearing before the Standing Committee on Health, Aged Care and Disability. Although the committee doesn't require you to give evidence under oath, I should advise you that the hearing is a legal proceeding of the parliament and therefore has the same standing as proceedings of respective houses. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. The evidence given today will be recorded by Hansard and attracts parliamentary privilege. I will invite you to make a brief opening statement before we proceed to discussion.

Mr Niblock: Select Committee Chair Dr Freelander and committee members, thank you for the opportunity to speak today and to contribute to this important inquiry. It's my honour to represent Palmerston today and provide an opening statement to the committee. I've worked for Palmerston for around six years. Before I continue, I'd like to take the opportunity to acknowledge that I am speaking with you on Noongar boodja today and to acknowledge the traditional custodians of the land that we're meeting on, the Whadjuk-Noongar people. I'd like to pay my respects to elders, past, present and emerging, and also recognise the strength, resilience and capacity of Noongar people in this land.

As a not-for-profit organisation, Palmerston have more than 45 years experience in responding to the harmful and often devastating consequences of alcohol and other drugs, which here and after I will refer to as AOD. At Palmerston, we see over 7½ thousand clients each year, as well as families. We have over 220 employees, many of whom come with a lived experience which they bring with them to the workplace. We're really challenged to respond to and prevent the health impacts of alcohol related harm, and it's a real imperative for Palmerston.

Our work across WA spans across 15 community and residential locations, providing broad-ranging treatment, prevention and community development. Everything we do is guided by Palmerston's model of care, which really sets out the non-negotiable principles that underpin how we work with people, families and communities affected by AOD. Our central message is that the health impacts of AOD cannot be understood or effectively addressed in isolation. AOD use and harms are deeply interconnected with broader social issues, including trauma, and social and economic disadvantage. It's our view that a whole-of-government and whole-of-community approach is required if we are able to make further strides on the prevention front.

Whilst specialist AOD treatment is most appropriately targeted to people with chronic and dependent use, the majority of AOD related harm in the community is actually experienced by people who are not dependent, and alcohol remains the single largest contribution to this harm. Evidence tells us that brief low cost interventions and harm minimisation approaches are highly effective for this group, yet these responses are still not well-embedded across mainstream services, often contributing to inappropriate referrals, long waiting times and people being passed between systems without meaningful support. We submit that a renewed focus on supporting the development of professional and practice capability within the broader human services sector is effective prevention and will serve to reduce the need to always refer to the specialist AOD sector.

A defining feature of our client population is co-occurring need, and the majority of people who seek AOD treatment also experience mental health challenges, neurodiversity, histories of trauma, homelessness, justice, involvement and a range of other needs. These complexities are the rule not the exception, and the research is clear that people with these intersecting needs do seek help but too often receive none. We see this not as an individual failure but as a failure of systems that often remain fragmented, crisis driven and poorly aligned with the evidence.

At Palmerston, we consequently operate on a clear no-wrong-door principle where no person should be turned away because their needs are complex or they do not fit neat funding boundaries. Our model of care is purposefully person centred and trauma informed. We seek to support people to define what recovery looks like for them, and we work holistically, recognising that AOD use does not occur in isolation and that we must respond to the full complexity of people's lives. Trauma informed practice is really foundational to our model of care. It's not a program. It's a way of working at the very heart of everything we do.

We know that AOD treatment works. We see this every day. In our submission, which you've received, we've proudly presented the committee with some examples of the innovative work that we've done in areas such as community based detox, dental health and supporting children's programs. We are making a difference, but we know we cannot do this work alone. Investment upstream in prevention and community development presents the

greatest opportunity for health gain, and our central proposition is that it's only by working collaboratively to reduce disadvantage and build protective factors that AOD use can be effectively reduced and associated harms prevented. We submit that policy efforts that are targeted to AOD prevention and broad professional development presents a critical opportunity for holistic system-wide change, but only if supported by coordinated policy, flexible funding and genuine cross-sector collaboration.

As an NFP, we rely on long-term funding to provide the right conditions for stability and growth, and the reality is that many of our state and Commonwealth contracts are short-term. Some are 12 months, and the continuation is sometimes only decided weeks before the contract is due to end. As a result, NFPs like Palmerston often lose good staff, really capable staff, to government services where contracts are longer term and where they offer more security. As an NFP, we're often unable to compete with contract longevity to secure staff on a longer-term basis.

But with a bold strategic vision, Palmerston were committed to meeting the most vulnerable where they're at, and in recent years this has meant stepping outside of AOD treatment as we know it as we recognise that, as we've said before, you can't just treat one thing in isolation. We work and really are required to understand intersectionality—the belief that individuals are not shaped by one factor alone and that inequality cannot be solved by just focusing on a single issue, such as AOD in isolation. So we've really tailored our services in recent years to meet these intersecting aspects. But this work is not always funded appropriately or recognised in our commissioning arrangements. We've decided to step into a brave, bold space to offer more support and more innovative services on Noongar Boodjar. This has been enabled by a variety of funding sources, often non-traditional sources such as local government, community funding and others who, whilst not our traditional core funders, assist us to allow innovation to flourish within our services.

In closing, I would just like to provide a short overview of some of these examples of some new services. Firstly, as I mentioned earlier, we've had a really successful dental program for the last four years, which we've piloted in our AOD residential services. It's the first of its kind in Australia. This requires and helps residents in our programs to have access to free dental clinics, where we address issues such as fillings, extractions, dentures and root canals. By supporting physical health, they improve self-esteem and motivation. The programs really help residents to stay longer, often beyond 12 weeks in a program. Importantly, they restore their dignity and have built hope for the future.

Last year, at Palmerston, we started a new initiative with short-term funding from the City of Rockingham and WAPHA to provide AOD outreach services to street-present populations in Rockingham and Albany. This has resulted in us working in partnership with GP services and with homelessness specialists. We've seen an incredible range of people supported into positive health and wellbeing outcomes. In 2025, we were successful in gaining funding from the state to open a new women's refuge in the town of Katanning in the Great Southern, and this is working in partnership with Kadadjiny Aboriginal Corporation. This service really expands our integrated, trauma informed support for women and children experiencing family and domestic violence alongside co-occurring AOD and mental health challenges.

Thanks to two years of Commonwealth funding, another example is Kedala Mia, which is Noongar for 'day house'. This is a 10-week day program for young people aged 10 to 17 living in the Peel/Binjarab region. The program supports young people to address their substance use and offending behaviours and build confidence, practical skills and connections. To date, we have seen a range of powerful outcomes, such as young people moving into training and employment, returning as mentors and improving connection to their culture; and a reduction in AOD use. The latest cohort has seen 18 young people screened for 10 places. Many really presented with some highly complex needs.

Last but not least—it's a really exciting time for us—is a recent merger that we've been involved with. This happened in March 2026. Palmerston formally merged with Sussex Street Community Law Service to create an embedded health justice partnership within our service system. This merger reflects the reality that, for many people accessing AOD services, the challenges—as I've said earlier—rarely exist in isolation. They commonly include legal issues, such as housing instability; tenancy matters; financial distress, such as fines and debt; family law issues; protection orders; and unmet disability support needs. Where these services operate in silos, people are forced to juggle multiple disconnected systems, repeat their story and relive the trauma while delays and escalating stress increase the risk of relapse, mental health deterioration and justice contact.

This integrated model is designed to provide 'no wrong door' access with earlier intervention and coordinated support, including shared intake triage, handovers across AOD counselling and recovery supports alongside legal assistance, financial counselling, housing advocacy and disability support so that legal and practical barriers that

undermine recovery and health can be addressed as part of care. Thank you for the opportunity to share, and we welcome ongoing discussion with the committee.

CHAIR: Thank you. We might start with you, Alice.

Ms JORDAN-BAIRD: Thank you so much for appearing for our committee today. It's really wonderful to have you here. I'm really interested in AOD use and its impact on young people, so I was really excited to hear about your Kedala Mia dayhab model. Would you mind expanding a little bit on that? You mentioned the programs for children between 10 and 17. Could you talk us through the evidence around starting at that ten-year-old age. I'm sure the reason is very well informed, but I'd love to hear a bit more about that from you. And I'd love to also hear about the referral pathways, on how these children come into the program.

Mr Niblock: Thank you for the opportunity. I'll hand to Mike, who oversees that program.

Mr Winton: Thanks for the question. I've got something prepared, luckily enough. Kedala Mia is a small program in my portfolio that is achieving really big outcomes, as far as we're concerned. The funding model sits outside Palmerston's core funding structure and is currently only guaranteed for two years. After that we're at risk of the program not continuing. Despite this, Kedala Mia reflects Palmerston's commitment to innovation and to futureproofing what we think effective service delivery for young people in that cohort looks like.

The co-design process identified the hours between 4 pm and 8 pm as the highest risk time for those young people in terms of safety, vulnerability and risk. In response, the program engages young people, 10 people at a time, by picking them up from school, transporting them to the program, spending four hours with them and then transporting them home. Often the best engagement, really deep and trusting engagement, occurs while we're in transit.

Kedala Mia incorporates several key features that have proven to be very successful for Palmerston. One of them is inclusion versus exclusion. A lot of the young people, particularly those between 10 and 13 years old, don't suit any program, and they are constantly declined because of the risk. We invite the high-risk participants and nominations, and we adapt our program delivery to mitigate that risk. So the program itself is really flexible. We really look for reasons to include rather than exclude, a really important fact for us. The common denominator for a lot of these young people is rejection from programs and interventions. They're just not suitable for any programs at all.

The program actively engages families and significant others as well. It's our belief that we get the best outcomes when we include families or chosen families in young people's treatment. The program is grounded in the therapeutic community principle of community as method. So we really focus on a sense of belonging in the program. And there's mutual accountability, so everyone's responsible for everyone when they're in the program. We see that overflow in the schools when we have two or three participants in our program attending the same school. They look out for each other and often support each other in their brief intervention or relapse prevention with alcohol and drugs. So while they had never engaged with each other at school, they now know each other and look out for each other's AOD use, which we think is really powerful.

The evidence of the success is reflected not only in the data but in the lived experience of the young people themselves. Many report a new-found sense of hope—sometimes that hope is for the very first time—and some direction. Several graduates of this program have gone on to make some significant changes in their life, engaging in training and employment, getting a drivers licence—just practical things that they never had access to before. Importantly, for us, we have four of those young people returning to the program as mentors, really impacting the new young people that are coming through. It's a part of the TC kind of process about giving back—or reciprocity, if you like. Again, that's often for the first time.

Since implementation—we're a year into the pilot program—we have supported over 40 of the most vulnerable young people in Mandurah. It is being evaluated independently by the University of Western Australia across the whole life of the program. So it is being progressively evaluated. The early indicators for us are really encouraging, and we're looking forward to the outcome.

In terms of the age cohort, we split the program into two because there are different vulnerabilities and learning styles. We also have to manage the psychological safety. Our 10- to 13-year-olds are kept in one group. We have some common activities, which include cooking, preparing and serving a meal. They have their own key workers and would be doing age-appropriate activities. Our 14- to 17-year-olds would be doing more mature activities, such as learning to drive, some sports and some boot camp activities.

A lot of the presentation that we see, particularly in the 10- to 13-year-olds, is young people surviving trauma and neglect, a complete disconnect from culture for Aboriginal young people, particularly for those living in group homes, and food insecurity. It's really new for them to come into a facility where there is food available and

where they're all participating in cooking. We call it a sensory experience, where we start cooking the food, often before they arrive. So, when they walk in, they can smell food cooking. A lot of those young people have never experienced that before. I remember that from being a kid and coming in and my mum was cooking. Lots of them come back and comment on that—that it does evoke a sense of security. It's a small thing for us, but a really powerful experience for the young people.

There's some sexualised behaviour in the 10- to 13-year-olds, and some young people report surviving sexual assault. We collaborate with specialist services, particularly those services that are mandated reporters, and we work closely in partnership with those people. When these young people finish their 10-week program, they have access to ongoing case management as well, as do their parents. Often that will happen as a group. It's a small program with big outcomes.

Ms JORDAN-BAIRD: Where do you get the referrals for the program? Are they from schools? Are they from families?

Mr Winton: Anyone can make a referral. We call them nominations rather than referrals just to get out of that kind of practice. Young people can nominate themselves. We have a stakeholder group that we meet with once a month, and we invite nominations from those people. They would be schools, cultural centres, Banksia Hill Detention Centre, the Department of Justice and youth justice agencies. As the program is gaining momentum, that network of stakeholders is really growing.

CHAIR: Do the police themselves make referrals?

Mr Winton: Yes, they do. The requirement eligibility for this program is that they've had interaction with police or justice, and had an AOD experience, either their own or a significant other's.

Ms JORDAN-BAIRD: I'm interested in the 17-year-old cohort, the higher age range in the program. How do you support them to transition out of the program, in terms of referring them to other support services when they've aged out of the program?

Mr Winton: Case management is a really powerful tool for that. We really walk alongside those young people, particularly the young males. We have a very powerful, young youth worker who connects with them really well, and will meet them on their own terms and in their own time. That works really well for us. We connect with age-appropriate things like martial arts and tenpin bowling—the activities that they like to do—and we do incidental counselling alongside that.

Ms JORDAN-BAIRD: That's great. You run a fantastic program.

CHAIR: Do you pick up kids with disabilities, those who have fetal alcohol syndrome, for example, or anything like that?

Mr Winton: We suspect that some do have that. We don't collect that information, but we're certainly open to that. I don't think that there's any exclusion, and we would certainly be looking for a very diverse group.

CHAIR: But what happens if you have a kid there who you think might fit into the fetal alcohol spectrum? Do you have any way of getting them assessed?

Mr Winton: We don't have a pathway to assessment, but, within our network in the wider Palmerston Association, we certainly have those agencies that we could employ. It hasn't occurred yet, but we're certainly open to that challenge.

CHAIR: Okay. Ali?

Ms FRANCE: Thank you all for coming along today. We really appreciate it. I love the sound of that program. It sounds amazing. We've heard a lot about the barriers to access, the exclusion criteria and things like that, so it's good to hear of one-door—no wrong door—access. What about for adults? Do you have a dayhab model for adults, and what are you seeing? We've also heard about the costs of having to leave housing and different things like that. Can you explain a bit about that?

Mr Niblock: Maybe I can start and then Mike, who manages those services, can contribute as well. Palmerston has two therapeutic communities which are residential programs. We offer over 60 bed spaces in those two places, and those programs have been going for many years. What we're seeing in there is definitely a trend towards more immediate treatments. People are asking for help quickly and wanting to move into these programs pretty quickly. That's when we have to really be flexible and look at the barriers that might slow down a referral into some of these programs.

In terms of dayhabs, it's something that Palmerston is really looking to pilot and innovate more in. We've got the youth example here, but we're really interested in looking at an adult dayhab. There's a cohort of people who may be working or have childcare responsibilities at home and can't commit to a residential program, but they

may want to come for five or six hours a day for three or four days a week. We think we can do some really valuable work alongside people there. Again, it's an innovation. We'd love the opportunity to identify funding to try that out in the coming years.

Ms FRANCE: Thank you.

CHAIR: Monique.

Dr RYAN: We've heard this morning and on other occasions in front of this committee about the difficulties in helping people access drug and alcohol services when they have other issues going on, whether that be mental health problems or other physical challenges. Are you able to tell us how you deal with those sorts of things? You mentioned that you have a model that is able to address all of those issues. How do you physically do that? How do you fund the services and engage other carers to provide people with the supports they need?

Mr Winton: We've intentionally refocused our workforce to include senior alcohol and drug and mental health clinicians so that we can actually sit right in that intersection and deal with both of those things. One of the biggest shifts that we have recently initiated is that we've opened a new hub in West Leederville, where we've integrated our Perth office, our clinical team, with our corporate team. So it's a one-stop shop, including psychology. We have got some external funding, and we've introduced psychologists into our team. We have rooms where visiting services come in. We only opened yesterday, so it's really new. Next time you're here, come and have a look. But the concept is that we can have specialist services onsite as a one-stop shop for everything that people need. We believe in warm referrals; they work really well. But if we've got people onsite within that window of opportunity, when people are help seeking, then I think that we can be much more effective. So that's a real physical action towards working in that intersection.

Dr RYAN: How do you fund that? We're hearing from many people that that's the biggest challenge. You said you've got some external funding. How have you managed that?

Mrs Stephens: We just didn't get some funding recently, which is disappointing because we constantly are putting in applications to value-add to the services that we know that we need. But maybe the example of the sites is a good one, though.

Mr Niblock: For the hub, that was an investment, essentially, from Palmerston. So we purchased the property, but we've thankfully had funding from Lotterywest to actually fit out the actual facility. As a capital project, it's worked seamlessly with external funders, but the operational side year in, year out is the challenge. It's the sustainability. As Mike has described, because we don't see AOD in isolation, we're trying to bring these allied health services to the client so that they don't have to constantly go to different services kilometres apart and retell their stories. So the challenge for us is: how do we innovate and identify sources of funding that can bring in additional roles to add to a client's overall journey, and how do we make that funding available year in, year out? Obviously we build therapeutic alliance with a client, and there's that connection. Then, if we have to backtrack from the service, it's a real challenge. That's constantly something that we as a team are totally having to work through, identifying those different areas for funding.

Dr RYAN: Is there a cost to the people who attend your services?

Mr Niblock: No, all our services are free. There's a small cost for people who go to our residential programs, which is for board and lodgings, which is standard across residential programs, but all our other services are free, including the dental program as well.

Dr RYAN: That's amazing. Just on the residential services, we heard this morning from people with lived experience about the challenges of accessing residential services. They were talking about services where there was a cost and where people who weren't receiving Centrelink payments were unable to access those services. That's one issue I'd be interested to hear your input on. The other side of the coin was that they were commenting on the difficulties, if you go into residential care, with walking away from your rental property, from your pet and from other commitments that you have and responsibilities that you have within the community. I'm wondering if you could give us your thoughts on those issues.

Mr Winton: They're great points. They're really good points, and they are barriers that we're aware of. We're in the middle of reforming what our therapeutic communities look like. We believe that there should be streams for different needs in our services, and we're certainly looking to establish that. Some of those streams may be that there may be intensive mental health support that's required on and off site while you're in a residential setting. Some people may require a shorter stay or a stabilisation period, rather than a 12-week episode of care. So we're really trying to tailor our program into what people need rather than just having one blanket, 12-week episode program. We also need to be culturally more appropriate and safer for our Aboriginal and CALD

communities, so we're certainly looking to include those things. I don't have all of the answers at this point, because it's mid-project, but it certainly is a priority for our therapeutic communities.

I think aftercare and continuing care are really important. We believe that the continuum of care should start at your first point of contact. That should be stage 1 of the program. It shouldn't be a separate piece of work. As you transition into a residential or intensive period of care and then transition out, we believe that that continuum should be really clear and available. We do have a fee-for-service offering for people. It's obviously not accessible for everybody, but it's certainly on our agenda to look at to make sure that we are accessible and equitable across the board.

Mrs Stephens: I live in Albany, so, from the Great Southern point of view, for someone to get to one of our residential locations in the metropolitan area—and there is a commitment from the state government to build one in the Great Southern, which we are actively supporting—there are a lot of those barriers around getting on a bus, getting to Perth and getting to the farm. We've changed quite a lot of our intake processes so that we can walk alongside that client and there isn't that barrier, as well as doing our community detox beds at the farm. That's funded through the proceeds of crime. So we've been able to use that money to flip some of the beds at the farm so that, if someone is homeless or street present and are suitable, they can come and do their detox at the farm.

For when they leave, we're partnering with housing providers. In the Great Southern, with Advance Housing, we've got an MOU for that transitional housing and helping that client along that journey of reintegrating back into community. We've got the 15 sites across the South West and Great Southern. Then, if a client comes up to a metropolitan location and they come back to the Great Southern, they're supported with our team in the Great Southern to then continue their journey with ongoing support. So they're not just left to their own devices when they come out of residential.

CHAIR: Can I interrupt and ask: do you provide rehabilitation that's non-residential, or is it all residential?

Mrs Stephens: Yes.

CHAIR: Is the non-residential program a significant part of your work?

Mr Niblock: Yes, it's probably the majority. Of the 15 locations, it's probably 11 or 12 that are community based. People can walk in. It's in their locality. However, the residentials are in specific locations across WA.

Mr Winton: We have integrated community sites with Next Step, who are the detox medical specialists. So we have integrated works with psychology, GPs, counsellors for Palmerston and Next Step detox at six sites.

Dr RYAN: Thank you.

CHAIR: Sam.

Mr BIRRELL: Firstly, Andy, your title of 'business development manager' indicates that, even though it's a not-for-profit, you've got to run it like a business. So you've got to understand having capacity and making sure that revenue is there to deal with capacity, as any business would. I'm hearing you express some difficulty and frustration with the way that government funding comes in. It must be very difficult to manage capacity while having such short-term and uncertain funding mechanisms. Can you tell us a bit about that and what would make it easier for you to operate a more sustainable business?

Mr Niblock: I'll try and keep it short; I'm aware of time. I think it's a challenge probably for the whole sector that we have to obviously—you've probably heard it numerous times recently. I think it's something that we've had to engage with, particularly looking at our core funding and also organic and inorganic growth. How does an organisation like Palmerston create stability but also be bold in terms of how we innovate? I think the challenge for us has often been understanding why some—the government, whether it's state or federal—can offer slightly longer contracts which bring that stability, allow us to innovate, allow our staff to feel a sense of certainty of a role.

There's a lot of advocacy that's happening through peak bodies to challenge our government partners around some of the CPI increases, some of the ERO-award-related challenges we've all had as providers. I think it's something we keep telling our story about and advocating to government and to the peak bodies for. But, in the meantime, Palmerston can't stand still. We want to keep innovating, keep growing, in a sustainable way. So that's why we innovate. We have to look at different ways of diversifying. Did you want to say anything?

Mrs Stephens: One thing that would be fabulous, whether the state or federal government wanted to do something along those lines, is a marketing proposal that happens in other sectors like NRM. You can put a proposal in, and it gets assessed. It could be a one-off pot of money, where the community sector can actually pitch for innovative ideas. Sometimes a lot of our contracts are set contracts, and then they're kicked down the road a bit more and they're not relooked at. When we tender for some of the contracts, they're three and five years

and then they add another two years. So it's actually not contemporary and it's not really what is needed at the time. So I think, if there were an innovative way of having a pot of funding that was market led and that the community sector could put into, then potentially these pilots could turn into actual outcomes rather than continuing to be short pilots. It would help the sector innovate, and you'd get incredible outcomes for community and for—it would be amazing.

Mr BIRRELL: As members of parliament, we've got two stakeholders in this. One stakeholder is the people that you're looking after; we want them to get the best treatment possible. The other stakeholder is the taxpayer; we want their money to be spent. So, if there are better ways to spend a similar amount of money over a longer period and get a better outcome, that's really what we're looking to try and flesh out to see whether that's possible.

Mrs Stephens: I think that's federally—well, take dental, for example. We would love—

CHAIR: I was waiting for you to ask about that!

Mrs Stephens: In our new building, we've been fortunate enough to build a dental—we've got a dental room. Uniting Smiles is our partner, and they're a not-for-profit as well. That's the only way we can really fund that. We would love to fund a dentist, but there's just nowhere to apply. We try, as you can imagine, to find funding all over. We've got a car from Bendigo Bank. We've got bits and pieces, but AOD isn't—the appetite isn't there from philanthropy like it is for mental health. So AOD sits in a really awkward and weird space for attracting external funding. Minderoo love early learning. So it's been really interesting. I've only been in the organisation for nine months. We are often and always looking for additional funding.

Mr BIRRELL: Would a market led proposal work—organisations such as yourself, maybe even a bunch of organisations coming together, saying to government, 'We think we can get the outcomes that you're looking for; here's the way we'd structure the financial agreement,' and that then being negotiated, rather than the government putting out guidelines and everyone being able to apply? That would be competitive, and everyone would be trying to hoover up what's there, and that might last for a year or so.

Mrs Stephens: I think you need to have set government opportunities and procurement, for all the right reasons. We often partner with people like Anglicare. But you could lose some of the small players. Palmerston are sitting in that middle, not-for-profit level. We do have financial backing, so we have been able to take some bold and proper—

CHAIR: And you have a track record.

Mrs Stephens: We have a track record, whereas I think you'd lose some of those smaller organisations. I go back to your market led proposal. If it was an invitation and there was a certain amount of money that you could pitch for to create greater outcomes, I think that would work, but the core funding still needs to stay with some of those, in the way it is happening but with that innovation space.

Mr BIRRELL: Thank you.

CHAIR: I could ask you a million questions about some of your very innovative programs, but I really want to concentrate on your dental program, because I'm someone who thinks that health care starts at dental care. As you've already mentioned, it has implications across self-esteem and ongoing commitment to improvement and whatever. I'm interested in how you fund it and in whether it is a complete service or whether there are limitations on what services can be provided and in how you get your dentists.

Mr Niblock: Some of the concept came from our CEO, Emma Jarvis, who has often recognised that people's challenges with their teeth were a missing piece of the jigsaw really, in terms of their recovery. So four years ago we identified a retired dentist who was prepared to provide pro bono dentistry into the pilot. That was through networks and that sense of us being a large organisation with relationships; we can kind of make that happen.

We also partnered with Saint Pat's community organisation in Fremantle. At that time, they had a dental suite themselves, and they're a homelessness organisation. We were able to start with a pilot that aimed at our residents in our treatment programs. We would bus them in to the facility in Fremantle and they'd get their free dental checks and their treatment in that dental suite. All that treatment was effectively paid for at that time by Palmerston. Our board were prepared to commit a small amount of money to pay for anything that wasn't covered by the public health system. Going forward, in our new hub that you've heard about, where we have a brand-new, amazing dental suite, we partnered with Uniting Smiles, a group of dentists who have chosen to volunteer their time.

CHAIR: So they're effectively doing it pro bono.

Mr Niblock: Yes. They are going to offer their time for weekly clinics that will work with the most vulnerable, including our clients. It's exciting, but, again, it's the sustainability. It does rely on finding dentists

who are prepared to give up their time, which is why, as Bec said, we'd ideally love to fund a full-time or nearly full-time dentist who would say, 'I'm happy to commit to that weekly.'

CHAIR: That's good. You did bring up Minderoo. Have they been approached for some funding in the AOD space?

Mr Niblock: Yes. We have a healthy relationship with Minderoo. Over the years, we have met with them and approached them for opportunities. But the reality is that, strategically, they may have different themes at this stage. With philanthropy, the challenge is understanding what philanthropists may expect government to fund and what they may be prepared to fund in terms of what they see as their priority. So we do keep an eye out to see if there's an opportunity coming up with people like Minderoo, but, obviously, the focus normally is on things that aren't necessarily AOD related. It could be about location. They tend to invest in areas where they have their own services and industry.

CHAIR: Yes. Do you get any federal government funding?

Mr Niblock: A small amount, yes. The majority is state funding, but we do have some federal.

CHAIR: You've also been able to get some local government funding.

Mr Niblock: That's right.

CHAIR: I'm interested in that because that has been an area of difficulty for some time.

Mr Niblock: Bec can talk about that.

Mrs Stephens: I sit on a local council, so I find it quite interesting that the City of Rockingham help fund the homeless outreach program to the tune of—it's not a huge amount—

Mr Winton: Five hundred, I think.

Mrs Stephens: but it's significant for a council. I think it was presented more around street presence and safety in the community. Maybe you can speak about the connection that that has brought together—the local and state governments, the police and the whole community—and the outcomes for the community. I think that's how the local government has been interested. Our other connections with local government are quite limited, and funding from them isn't very much at all. But they support what we do; that's probably the best way to put it.

Mr Niblock: Grow it anyway, yes.

Mr Winton: It's the first time a local council has actually funded an AOD agency, and it was in response to a growing homelessness or transient population in the City of Rockingham, with encampments growing and high AOD use. So we partnered with St Pat's for housing, homeless health care, and alcohol and drug services, and we hit the streets in an assertive outreach model four days a week. We've done incredibly well. We've got a fantastic continuum from engagement, detox, community detox, counselling into our residential services or into housing—so, incredible outcomes. There was always the potential for continued funding, but we've just been advised that that funding will not continue. It was just a pilot. For us the concern is about the therapeutic relationship we've got with those people. Some of them were already service resistant. What are we going to do with those people, as we roll out this contract?

CHAIR: Excellent. Thank you very much for coming today. It has been really valuable, and we've really learnt a lot from your very innovative programs. If you've been asked to provide any additional information, can you please forward it to the secretariat within two weeks. You will be sent a copy of the transcript of your evidence and will have an opportunity to request corrections to any transcription errors. Once again, thank you so much for coming along today.

POPOVICH, Mr Sean, Director, Alcohol and other Drugs Reform, Queensland Mental Health Commission [by video link]

[11:37]

CHAIR: Welcome. Although the committee doesn't require you to give evidence under oath, I should advise you that this hearing is a legal proceeding of the parliament and therefore has the same standing as proceedings of the respective houses. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. The evidence given today will be recorded by Hansard and attracts parliamentary privilege. I'd like to now invite you to make a brief opening statement before we proceed to discussion.

Mr Popovich: Thank you to the committee for the opportunity to appear today. Before I begin my opening statement, I'd like to acknowledge the traditional custodians of the lands on which we're meeting today and pay my respects to elders past and present.

The Queensland Mental Health Commission welcomes the committee's focus on the health impacts of alcohol and other drugs in Australia and the opportunity to contribute. As outlined in our submission, alcohol and other drugs related harm is shaped by a range of social, economic and structural factors including housing, trauma, justice system interaction and broader community conditions. While there are many effective services and programs across Australia, the system is not consistently experienced as integrated. Fragmentation across sectors, variability in access and gaps in coordination can limit the overall effectiveness of responses, particularly for those with the highest level of need. We also note that access to services remains uneven, including for people in regional and remote areas, First Nations communities and individuals with co-occurring mental health and substance use issues. These inequities impact system performance, and they impact outcomes for people in the community.

There's an opportunity to strengthen the system through a more coordinated and evidence informed approach, including improving integration across health and related sectors, strengthening early intervention and prevention, and ensuring that investment is aligned with approaches that are known to improve outcomes. The commission's focus is on system reform and strengthening how the system operates as a whole. The commission is established under the Queensland Mental Health Commission Act as an independent statutory authority, though we are a part of the Queensland government. We note that both national and international evidence continues to evolve in relation to approaches that reduce harm and improve engagement with care and support. I'll leave it there. Thank you for the opportunity once again, and I'm happy to respond to any questions in relation to our submission.

CHAIR: Thank you. Ali?

Ms FRANCE: Thank you for appearing before our committee. In my electorate of Dickson, lots of people talk about the lack of residential beds in the mental health space but also the AOD space. Correct me if I'm wrong; I'm not sure that there's any facility that deals with both. If there is, there are very few beds to deal with them both. Can you tell us a bit about the landscape in Queensland at the moment and what the biggest issues are for getting people the support that they need, particularly the residential programs?

Mr Popovich: I can certainly do my best. It might be helpful for the committee to understand the way in which the alcohol and other drugs system broadly operates in the first instance. There are a range of treatment types that people can access as part of alcohol and other drugs treatment. Those include psychosocial interventions, which might be delivered on an outreach basis, for example. I believe you just heard from Palmerston. I was fortunate to hear some of Palmerston's comments on delivering an assertive outreach model. That would be a psychosocial-intervention type of model. There are also options for treatment that relate to withdrawal management—detox and that kind of thing. There are also different options within that approach: inpatient hospital withdrawal management, outpatient withdrawal management or community based withdrawal management, which might be bed based or delivered by, for example, a GP in the community.

There are all these different levels and options based on complexity and severity. Some of that is medical complexity, and some of that is psychosocial complexity. Considering that, there are also different residential care options. When we talk about residential rehabilitation or rehabilitation in general, there's the residential, bed based component but then there's also the component that might be like a residential day program. Again—forgive the phrase—it's different strokes for different folks depending on the level of complexity and what the person's identified need is. Collaboration with a clinician who might help to assess that need will help to determine what type of response that person gets.

There are some system gaps in relation to the way that those treatment settings within the alcohol and other drug system are able to operate together as well. For example, if we think about things like access to withdrawal management, particularly with inpatient withdrawal management, there is a large system gap in the Queensland

landscape. What happens is some of those residential rehabilitation services require people to have safely withdrawn from their substance of concern before they can enter a bed-based rehabilitation service. What that means is that, when there's no withdrawal management available and if it's, say, a complex withdrawal like alcohol or benzodiazepines, then the person who needs support needs to wait until there's the withdrawal service available, and then there might be a logistical issue with arranging a transfer from the withdrawal service to the rehabilitation service, which could take weeks. Obviously that's not how substance dependence or those types of things work. The system doesn't readily link in that way—if that makes sense—from the perspective of the person accessing the service.

Then there's the availability issue that you are kind of alluding to. One of the issues not just in relation to withdrawal management but more broadly across the alcohol and other drugs treatment system in Queensland and across Australia is that there's good evidence to suggest that the investment into the system doesn't actually meet demand—not at all. There's been some work done both nationally and in Queensland to look at what that demand is and how we can at least build on investment in the space. But, again, colleagues over at Palmerston have already mentioned some of the challenges with that in terms of workforce sustainability and ongoing funding for services and how that can impact on workforce churn and that kind of thing.

So there are a range of issues with availability, but, to answer your question directly, there are certainly not enough services available across Australia for responding to alcohol and other drugs.

Ms FRANCE: Thank you.

CHAIR: Have you explored more innovative ways of rehabilitation using non-residential programs, as a government or government department?

Mr Popovich: I can't comment on behalf of the Queensland government, but I can say what the evidence suggests and what the commission has done as an independent statutory body. Our role is really in the implementation of whole-of-government plans. The overarching plan is *Shifting Minds*, and then there are the subplans: *Achieving balance*, which is the alcohol and other drugs plan; the Queensland Trauma Strategy; and also *Every life*, which is our suicide prevention plan. Under the alcohol and other drugs plan, *Achieving balance*, the primary focus is around upstream system reform in many respects—so your prevention, early intervention, harm reduction and that sort of thing. The funding under that plan is noted in our submission, but the *Achieving balance* plan had received, over the course of five years, $29.35 million of funding for those upstream initiatives. In terms of the investment that goes into treatment itself, that's really a question for Queensland Health more broadly.

But there are initiatives under *Achieving balance* that look at what types of models might help to facilitate some change across the system. For example, there's an initiative at the moment that the Queensland Mental Health Commission is funding in relation to what you'd call throughcare and how we can support people who are on a waitlist to access services and might need immediate support. There's good evidence to show that, if you can support early and hold people while they're waiting for access to treatment, then that will lead to better outcomes—and likewise when they leave treatment. So it's small initiatives like that, but we're not doing anything in the treatment model space, if that makes sense.

CHAIR: Sure. What about initiatives for prevention, like reducing availability of alcohol, for example? Did you make any comments in those areas?

Mr Popovich: There are a couple of things to consider in relation to availability of alcohol. One of the more recent things has been around the online sales and rapid delivery of alcohol. Different states across Australia have responded to this in different ways. The evidence suggests there are some concerns around rapid delivery of alcohol—for example, where people who may already be intoxicated are able to get alcohol delivered to their door—and the link to things like domestic and family violence and increasing community harm because of the increased availability. There are certainly things across Australia where we should continue to look at what the evidence suggests and how we might address those availability issues because of the harm that that is potentially leading to, especially in that social sense.

I'm also aware there have been some trials across Australia in relation to things like minimum unit pricing for alcohol, and there is some evidence, nationally and internationally, to suggest that unit pricing as a measure is effective on a public health level. Obviously, it would be highly dependent on context and the way that each state would implement such a thing, if it were to be implemented.

The flip side of that is that there is also some genuine concern around how minimum unit pricing could potentially impact marginalised communities. All of these things need to be deeply considered in terms of what both the intended and the unintended consequences might be. I'm not sure if that fully responded to your question.

CHAIR: That's good. They're the sorts of things we've been hearing about from other witnesses as well, so giving some reinforcement to that is important. We have also heard a lot about the social determinants of health and mental health, and housing has come up a lot. Has that been an issue that you have been looking at? How would you get more housing for people with mental health issues?

Mr Popovich: There are some really great local models here in Brisbane around responding to people with alcohol and other drugs concerns, mental health concerns and housing concerns. One of the providers that I'm familiar with is a service called Common Ground in Queensland. They do some work with a service called Micah Projects and another by the name of QuIHN. It's a partnership approach, and each of those services has a specialist area that they work in. Common Ground provide the tenancy arrangements, QuIHN provide the specialist alcohol and drug support and Micah provide more of a community based case management support.

My understanding is that it's a really effective model in addressing those issues, particularly in relation to the alcohol and other drugs space. Often what we see in a specialist housing or homelessness setting is that, where alcohol or other drug use is a concern, particularly illicit drug use, it can lead to the tenancy being put at risk. Sometimes that can also occur as a result of stigma—not just the illicit drug use itself but the response of the provider in not knowing what to do when a person is using illicit drugs: 'How do I manage this? Perhaps it is not our role.' There are complications where there are workforce capacity building needs across these systems. It gets quite challenging because, really, each of the related systems is trying to understand what the focus and scope of their role is. If I'm a housing specialist, how much do I need to know about drugs in order to appropriately support the people that I'm working with? There's always this tension within the system about: how do we facilitate the capacity building of the related workforces in this space and also reduce the stigma that is sometimes perpetuated within those workforces so that we can provide the best outcomes for the people we're working with?

CHAIR: We've heard a bit about that today, actually. We also heard that there needs to be better workforce education and support in the community around housing, alcohol and other drugs and mental illness. That's been very useful. Any questions, Monique?

Dr RYAN: Yes. We've heard from a number of people, who've spoken to us about the difficulties in accessing services if you have other sorts of issues—intersectional issues like physical health problems, active health problems and mental health problems. You've spoken in your submission about the challenges involved in caring for people who are actively withdrawing from medications or who are detoxing. How do you address those with your organisation? How do you provide wraparound care?

Mr Popovich: We don't provide service delivery support within the Queensland Mental Health Commission. We are not providing direct services or wraparound supports.

Dr RYAN: Sorry, I meant: how would you suggest that we ensure that those sorts of supports be provided?

Mr Popovich: That's a very big question. There are a couple of key issues within that. Our service system, in my understanding, provides quite a good level of support with the resources that it has. When I use the term 'integration', I use it to mean collaboration, coordination and a seamless sense of support from the perspective of the person who's receiving it. There are a range of challenges that relate to that. Some of those are funding challenges, which I touched on earlier. As I mentioned, with an earlier question around within the alcohol and other drug systems—from withdrawal management to residential rehabilitation being the example there—because the resourcing of the system is a challenge, you end up with these disparate services operating with gaps, particularly in Queensland which is a large geographical location. That is also the case with things like housing, mental health services and so on and so forth.

Providing that wraparound support is often a matter of addressing those broader system challenges, which are in relation to workforce capacity and workforce availability. In some places in Queensland we have fly-in fly-out arrangements with workforces. They're not always available and not always there when people need it. They're perennial problems in many respects. By and large, from a system perspective, which is the perspective that the Queensland Mental Health Commission has, many of these issues are about that broader question of how we rebalance our system investment so that we can better meet the needs of the community, based on what we understand the community needs through things like investment modelling, like the Queensland drug and alcohol service planning model or whatever it is.

CHAIR: Good. Sam?

Mr BIRRELL: When we talk about these issues, a lot of the discussion will be around how government services, which are important, are funded and how they're offered. But then there will be some people who'll talk about a personal responsibility narrative and harnessing that and giving people agency. It was interesting to hear you talk about issues around rapid availability of alcohol. Is there any other way that you see—there's treatment

and there's the government's role in it, but there's also helping people with their own agency when battling these issues. Have you got a comment on how that might work based on your observations?

Mr Popovich: I'm not sure I do. If you can indulge me, please, and explain the question—I'm not sure I fully understand the question.

Mr BIRRELL: How can society enable people to take personal responsibility in looking after themselves in relation to temptations of drugs and alcohol? One of those issues was the issues around rapid availability. Are there other issues that you see? I know that's an open-ended question, but I do want to just get your perspective based on the fact that we talk a lot about dealing with people who are suffering from addiction, and that's very important, but is there a way to stop people from finding themselves in these issues in a societal way?

Mr Popovich: Look, I think we've got really good measures that actually do help with those things. The National Drug Strategy talks about the three pillars under the National Drug Strategy, so it's really important that we consider those in the context of a question like this. No doubt, the committee is aware. Supply reduction is one measure under the National Drug Strategy and can encompass a whole range of things like enforcement but also things like reducing the ability of people to access rapid delivery of alcohol. There are also the demand reduction initiatives. Those are things like treatment or public health campaigns for example. We have a range of measures that we use in that respect. And then there's the harm reduction, which is also a really, really important component. We're enhancing the safety of people who continue to choose to use alcohol and other drugs, and all of those taken together are what makes a strategy in alcohol and other drugs effective.

To come to your point about if there are things that we can be doing, I think that actually there are really good examples. For example, some evidence around services like drug checking in the harm reduction pillar is well established in that respect. Where people are considering using drugs, that's often a last line of defence for access to a health worker who can have a conversation with that person and help to reduce the demand. It's often the first time a person has had a chat with a health worker about their substance use. So there are methods that we can use and can really facilitate demand and harm reduction in that respect, and they're very well evidence informed methods. There are other things that we can do in these spaces. Part of the challenge is often the priorities that we have socially and in terms of what we invest in and how we invest that money, but there's a good deal of evidence for a range of additional initiatives that we can implement that actually work.

Mr BIRRELL: So, just to paraphrase a little bit, the National Drug Strategy is sort of on the right track and there are some good evidence and some good initiatives happening. It's just looking further into that to see whether the things that are working should be expanded at all.

Mr Popovich: Yes, I think that's a fair statement. I also think that it's worth pointing out—it's in our submission as well—that the investment across those three pillars of supply reduction, demand reduction and harm reduction is really not well balanced at the moment. I believe there was a recent report—I think it's referenced in our submission—by a drug policy modelling program that, again, touched on what the investment looks like across those three pillars. From memory—please forgive me on these figures—around 20 per cent or 25 per cent of the investment goes to demand reduction initiatives, then you've got about two per cent that goes to harm reduction, and the rest goes to supply reduction.

One of the things that we need to consider is how we can rebalance that investment to ensure that it's actually achieving what we mean it to achieve and getting the outcomes that it needs to. I'll refer back, again, to our Palmerston colleagues' answer to a question—I think it may have been asked by you—around the interest in looking at how we can do the best we can with the bucket of money that we currently have. I believe that the rebalancing of investment is our answer to that question. It's understanding where our money is most effective, based on the evidence, and putting our money into where it's most effective, based on the evidence.

Mr BIRRELL: Thank you.

CHAIR: Alice.

Ms JORDAN-BAIRD: I have one quick question. Thanks so much for appearing before our committee today. My question is on data collection. Do you think the way we collect data on AOD harm in CALD communities, for people in custody and for young people is adequate? If not, how do you think we can improve this?

Mr Popovich: Starting with CALD communities, we know that it's not adequate. We don't have adequate data in that space. It's very much the same with other priority communities as well. I'm sorry; I don't have answers to that question. I think that we need to work with those communities to understand, in the first instance, how we can have better conversations around alcohol and other drugs. My understanding is that part of the problem for those communities is that, because illicit drug use in particular is very stigmatised, those communities are less likely to disclose their use, less likely to disclose any problems that they might be experiencing and less likely to

seek help. So, even with the best data systems and the best assessments and all that sort of stuff, we still have a gap in our ability to reduce the stigma of talking about those things as well.

Beyond that, I think consistency in data collection is another point that probably needs to be made. Some of our national datasets are, understandably, slow to change, because there's an effect where we want the previous data to still match the existing data. Also, our national datasets don't always capture the full picture of things. I'm thinking here about the Alcohol and Other Drug Treatment Services National Minimum Data Set, where there are data items in that dataset that perhaps could be improved to help with that as well. Sorry, I know that's not a very clear answer to the question.

Ms JORDAN-BAIRD: No, it's all good. Thank you.

CHAIR: Thank you very much for your evidence today and for your attendance. If you've been asked to provide any additional information, could you please forward it to the secretariat within the next two weeks. You'll be sent a copy of the transcript of your evidence and will have an opportunity to request corrections to any transcription errors. Once again, thanks very much for giving us your valuable time today.

Mr Popovich: Thank you to the committee.

BRUNKER, Ms Ameina, Director, Community Led Harm Reduction Unit, NT Health

[12:09]

CHAIR: Welcome. Although the committee doesn't require you to give evidence under oath, I should advise you that this hearing is a legal proceeding of the parliament and has the same standing as proceedings of the respective houses. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. The evidence given today will be recorded by Hansard and attracts parliamentary privilege. I now invite you to make a brief opening statement before we proceed to discussion.

Ms Brunker: Thank you for allowing time today for me to speak at the hearing. In the Northern Territory, we have a key focus on tackling problem drinking. The key elements of that, as the counterpart before us spoke about, are under the three pillars of supply, demand and harm reduction. To reduce supply and reduce unsafe access to alcohol, we aim to maintain strong and enforceable restrictions on alcohol sales and delivery timeframes through the use of risk based licensing—which our counterparts in the Department of Trade, Business and Asian Relations do—and the use of the Banned Drinker Register and banned drinker orders to prevent takeaway alcohol purchases where people are subject to such orders.

In terms of reducing demand through prevention, early intervention and treatment we have a number of programs that are funded under the Northern Territory Remote Aboriginal Investment through the alcohol harm reduction schedule. They have a focus on creating those clear pathways for people who are dealing with alcohol within quite complex scenarios, who are from remote communities and who have found themselves in towns; on being able to support their access to alcohol treatment services; on following up with access to support, when people return to communities; and then on giving further support through social and emotional wellbeing based programs in communities.

In terms of reducing harm, there are also a number of programs we are tackling, in particular, the community alcohol planning that's undertaken through the department of health and the delivery of the community led solutions. Communities identify strategies and initiatives that they see are pivotal in reducing alcohol related harm. We know the Northern Territory is one of the highest per capita for alcohol consumption and has the highest rates of hospitalisations and deaths from alcohol misuse, and alcohol related harm remains a key issue for us. Given the significance and complexities of it, there are a number of initiatives and programs that we are currently undertaking and there are also a number in development.

CHAIR: Thank you. Monique, do you have any questions?

Dr RYAN: Do you have any specific policy suggestions regarding how we can decrease alcohol harm in the NT? I'm a paediatrician, so I'm very interested in fetal alcohol syndrome and related disorders and what we can do to decrease their incidence and prevalence.

Ms Brunker: One thing we do hear during our work that we're undertaking with communities across the Northern Territory is the need for education. Education needs to be not only place based and culturally tailored to the groups that it's working with but also strength based. It needs to really utilise culture as a protective factor in addressing alcohol related harm, in particular, around obligations for parents—and not just focused on the woman. What we're currently hearing is there also needs to be inclusiveness of the wider family unit, and support and structure needs to be maintained to address alcohol consumption in the family unit, which also impacts those women that are pregnant.

Our effort to support this, recognising communities are best placed with the answers, is in extending funding for Aboriginal community controlled health services, who work closely with their communities in addressing FASD, using strategies that meet their community needs. We see a little bit of difference in focus across the regions that the services are delivered to. Some have been strongly focusing on a social and emotional wellbeing approach to working with the women and families, and others are running quite significant public health campaigns in their communities.

Dr RYAN: One of the challenges is making sure these sorts are education programs are culturally sensitive. How do we do that for different Indigenous communities, for example? Would it be necessary to have a different program for every community?

Ms Brunker: I think an outline of program guidelines is what we're hearing is required, but then the adaption, delivery and design of that particular program need to be nuanced to the region and the community, recognising the efforts and the barriers and challenges that exist in the community. So the answer is yes and no. Yes, we can have a bit of an outline of a program that can be applicable across the Territory, as long as it's been developed in ways that recognise the common themes that we're hearing across communities across the Territory. But the design of any delivery does need to be nuanced to those particular communities, particularly around cultural

elements. With regard to education, and delivering it from more of a cultural perspective, that absolutely needs to be tailored and reflective of the practices that exist within that community.

Dr RYAN: Do we have the workforce to deliver those sorts of supports and services?

Ms Brunker: As other jurisdictions around Australia are finding, workforce is one of our biggest challenges. It is an enabler as well, though. In the Territory we recognise that we actually have an untapped workforce that exists out there in remote communities. We're taking an approach of looking at how we can better create jobs that are more relevant and more appropriate, recognising the skills of local people, creating better pathways into these jobs and recognising better ways of training people. That's taking into consideration place based training and microcredentialing, where learning is conducted in microsessions.

So, yes, workforce is a huge challenge, but we recognise that there are untapped workforces out there in remote communities that can contribute to this. We also recognise that local people in their communities are the experts in their livelihoods and can help shape and form the delivery and design of programs. We note, though, that, if we do need to engage with more of that specialist end of particular professions, we also need to have a focus on what that looks like and the challenges that exist in that space. Generalised professions and positions can definitely look at how we can better enable and access local people to do those jobs.

CHAIR: Ali.

Ms FRANCE: Thank you for appearing before us today. We really appreciate it. I was interested in your submission, which I think was submitted a little while ago. You talked about high rates of pharmaceutical drug misuse in the NT. For context, is it much higher than in other states? What is the national perspective? Do you have any figures? What is being done in that space to address the issue? Do you think enough is being done?

Ms Brunker: Unfortunately I don't have any stats in front of me that I can share with you all today, but I'm happy to take that on notice and provide any relevant information from outside that can answer that question. I'll take that one on notice.

Ms FRANCE: Thank you. Do you know of any specific initiatives or measures to target pharmaceutical drug misuse in the NT?

Ms Brunker: One way is our focus on supporting clinical decisions and conversations to reduce medication related harm. That is a focus at the primary healthcare level and for the frontline workers who are working with the communities. I also note that opioid use is less common than what we see in the larger jurisdictions but that opioid pharmacology data shows ongoing treatment and demand. There are programming clinical guidelines currently under review to address that as well.

Ms FRANCE: Thank you.

CHAIR: Alice.

Ms JORDAN-BAIRD: Thanks so much for appearing before our committee today. My question is around one of your recommendations to ensure that treatment of AOD use considers co-occurring mental health conditions, eliminates entry barriers and allows concurrent treatment. We've heard from a number of people this morning and over the course of this inquiry about exactly this issue and a bit about exclusion criteria as well. Could you expand on how you see this working in practice and what recommendations you'd make to the committee around this specific issue?

Ms Brunker: One approach that we have here in the Territory is working towards a 'no wrong door' policy and ensuring that, when people front up to whatever service that they're using, they're going to be supported in a timely way to address their issue or link them in with the relevant supports or services that they require. That's one way to ensure that, at the front of it all, and particularly during the client's journey, they're not going to be turned away at all.

Another way is taking an approach, particularly for Aboriginal populations up here in the Territory, that utilises the holistic view of social and emotional wellbeing. It is an approach that looks at out-services, design and delivery that take that whole social and emotional wellbeing approach where we're not treating just one co-occurring mental health issue or one body part in particular in the wider health scheme but we're actually treating the person as a whole and looking innovatively at how we can do that at our level, in terms of not just commissioning services to provide one or two sorts of interventions but also looking at how they can work within the wider system.

Looking at opportunities for better collaboration across other different funding bodies is another area of focus that we're particularly tackling. We know that siloed policies and programs also create fragmentation on the ground. We're also aware, as are others who have spoken before us, of restrictions and limitations on those

services. Eligibility requirements further exacerbate fragmentation on the ground. We're really coming from a base where we're operating from an inclusive approach wherever we possibly can.

Ms JORDAN-BAIRD: Thank you.

CHAIR: Sam.

Mr BIRRELL: This follows on from Dr Ryan's question a little bit—the targeted approach to dealing with these issues in remote communities as opposed to Darwin or Alice Springs. Given that they've all got their own challenges and secrecies, in terms of those communities, do we need different approaches and different rules for regional communities and cities?

Ms Brunker: We have a high mobility of people from remote communities staying for short periods of time, or even longer periods, in our rural towns. The short answer is, yes, we do take an approach that recognises that different settings require different approaches. But, generally, we're looking at it as a pathway. No matter how someone accesses a support service—whether they're accessing it in town or at a remote community—we want to build a system where they can follow through that pathway, whatever that looks like for them. If it is moving into a residential rehabilitation centre that's based in town for a stint of treatment, then that's what it can look like. Or if it does look like returning to community after an episode of living rough in town, then they're going to be well supported.

So the short answer is yes, we do take different approaches, but the main aim is to create more of a smooth pathway that people can come in and out of on their journey to reducing harm or living with that in safe ways, wherever they are—whatever setting they're accessing it from.

Mr BIRRELL: We also heard some evidence today that it's all very well to treat a person, and the treatment can be very good, but, if the person then goes back to an environment where there's instability with residence, there's violence and there's easy access to alcohol, it can undo a lot of the good work that's been done. You spoke about services in different communities. Have you got a view on access to alcohol?

Ms Brunker: One of the key initiatives that we are running up in the Northern Territory are community led solutions, where communities are supported to identify and design and deliver what they see as their strategies, initiatives, programs, activities or even community based rules to reduce alcohol related harm. That's one way that we're investing in the communities to really empower them to make these tough decisions around alcohol and reduce harm at a place based level.

Through this work that we do across the Territory, we do recognise that a lot of our communities are quite conservative in their views around introducing supplies of alcohol and are quite concerned already around the rates of the violence that is occurring in their communities that's associated with what we call sly grogging. That is illegal alcohol, on the black market, being brought into communities. I hope that answers your question, but please do reiterate that, because I've slightly lost the question myself.

Mr BIRRELL: No, that's a really interesting answer. You talked about the conservative approach to alcohol in communities. When you say communities are making the decision themselves about how they want to deal with this, which is good, does that depend on the community leadership and how strong that community leadership is to go down a certain path? Then I suppose it's up to the government—in this case, the Northern Territory government—to adequately police that and make sure that the will of the community is not being overridden by people breaking the law and bringing black-market alcohol into the place.

Ms Brunker: Yes, it definitely does require community leadership in that respect. We do recognise that, as every community is different, every leadership group within a particular community is also different. We work with communities to take a responsive approach to meet them where they're at. So, if community leadership is still emerging because they've experienced quite a number of deaths of elders and leaders, we work closely with them to build up their capability to take on these more contentious issues and those tough conversations that are occurring at a community level around reducing supply, reducing harm and reducing demand related to alcohol.

But we do see that there has always been quite a strong history of community leadership in tackling alcohol problems across the Territory, and a lot of our communities have been the first ones to advocate strongly around the association of alcohol with harm that's created in communities.

So, yes, there definitely is divergence between community leadership, but we take a responsive approach to support communities and their leadership groups that they determine—to help support them in their efforts to reduce harm.

Mr BIRRELL: Thank you very much.

CHAIR: I've got a couple of questions around alcohol supply. When I was recently in Alice Springs, I was shocked by the level of public drunkenness and the level of distress in some of the women, talking about what alcohol was doing to their communities. Are we restricting supply enough? Is there more that we should be doing?

Ms Brunker: I won't be best placed to answer that question, given it is particular to Alice Springs. Our overall position, though, is that we need a multipronged approach to address the alcohol related harm that we experience here in the Territory. It's not just one solution, one agency or one bucket of money that's going to resolve this issue that we're experiencing. What we do see, though, is that when all key parties are involved—whether it's the police at the front line or health playing a role through a community development approach to supporting communities or community leadership taking initiatives to call it out for what it is and address issues through a community response—that can actually work quite well at the small-scale community size. That's when the police have a strong relationship with the community, when the community is well supported and when we can fund the initiatives that they think are going to reduce harm.

At a wider, larger scale, and with the complexities that we see down in Alice Springs, I feel there isn't one answer that's going to solve or resolve this. I think, though, there is a lot of effort to reduce harm in Alice Springs, with the particular action planning that's been undertaken. To date that has been looking at reducing the supply components that are associated with that. But we also know that, whilst we do need to reduce supply, we also need to enhance the social and emotional wellbeing and community safety initiatives and programs to help reduce demand for alcohol.

CHAIR: Should we be training more Indigenous health workers in alcohol and other drug management?

Ms Brunker: We definitely recognise that. We have a program up here called the support in healing program, which was formerly called the Remote Alcohol and Other Drugs Workforce Program. It looks at training and supporting, through practical workforce supports, a local Aboriginal workforce to tackle alcohol problems in the communities by delivering education and by delivering initiatives, programs and activities such as diversionary community based events that promote alcohol-free activities and programs. So, yes, we do recognise and support that, and we are currently delivering that.

CHAIR: Are there any other questions? No? Thank you very much for giving evidence to us today. It's been very valuable. If you've been asked to provide any further information—I don't think you have—could you please forward it to the secretariat within the next two weeks. You'll be sent a copy of the transcript of your evidence, and will have an opportunity to request corrections to any transcription errors.

Ms Brunker: Thank you all for allowing me to speak today.

Proceedings suspended from 12:32 to 13:17

WRAY, Mr David, Senior Policy Analyst, Western Australia Primary Health Alliance

CHAIR: Good afternoon, Mr Wray. Although the committee doesn't require you to give evidence under oath, I should advise you that this hearing is a legal proceeding of the parliament and therefore has the same standing as proceedings of the respective houses. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. The evidence given today will be recorded by Hansard and attracts parliamentary privilege. To assist with the transcription of the public hearing, it would be appreciated if you could please state your name before responding to each question. I now invite you to make a brief opening statement before we proceed with discussion.

Mr Wray: Thank you, Dr Freelander and committee members, for the opportunity to present today and to contribute to the important inquiry. It's my honour to represent the WA Primary Health Alliance, which is the operator of Western Australia's three primary health networks. I'm representing our CEO, Bernadette Kenny, who sends her apologies.

Today, I'm summarising WAPHA's submission to the inquiry via a five-minute overview. Alcohol and other drugs continue to have a significant impact on individuals, families, communities and the broader health system. WAPHA operates Western Australia's three primary health networks—which are Perth North, Perth South and Country WA—and commissions AOD services on behalf of the Commonwealth Department of Health, Disability and Ageing. Our AOD commissioning budget is approximately $13 million this year, which is around only 10 per cent of the state's investment through the WA Mental Health Commission.

Primary healthcare responses are central to addressing AOD related harms, particularly for people who experience disadvantage and poor access to mainstream services. The key purpose of our submission was to outline how WAPHA's commissioning approach contributes to reducing AOD related harm, particularly by targeting health equity by strengthening the state's AOD treatment system and by purposefully addressing the social and structural drivers of addiction in Western Australia through our commissioning services.

Health equity is the north star that guides our commissioning activity. We've seen that many people affected by AOD harms fall through the gaps in the health system due to complex, overlapping social and economic disadvantage, including low income, job insecurity, social isolation, low health literacy and geographical disadvantage, particularly in rural and remote areas of Western Australia. WAPHA focuses on commissioning services that reach those underserviced populations to complement Medicare funded primary health care.

Our AOD strategy outlines four overarching AOD commissioning priorities for 2023-26: building workforce capacity, improving access, improving safety and quality, and, finally, enhancing system efficiency and client experiences. Our focus going forward is firmly on supporting primary health deliverables in each of these priority areas. We do this through two key approaches that we highlighted in our submission. Firstly, we acknowledge that effective responses to AOD harm require more than treatment alone. In particular, our submission highlights the importance of addressing biopsychosocial contributors to addiction, which include housing insecurity, mental health comorbidity, trauma and social exclusion. Secondly, we stress the importance of joined-up planning, a priority reflected in a number of bilateral documents and reviews. Our submission described how WAPHA have led the way through formalised commissioning partnerships with the WA Mental Health Commission to ensure collaborative and coordinated statewide approaches to the planning of services here in WA. Thank you.

CHAIR: Thanks. I might start with a couple of questions. I don't think there's any disagreement that primary health care is central to managing AOD harm, but how do we do it? How can we encourage primary health networks, GPs, nurses and community health organisations to engage with AOD management?

Mr Wray: I guess, first of all, they already are. AOD is a very prevalent issue facing GPs and other primary health practitioners already. There are, in fact, requirements on GPs around things like conducting screening of patients as part of their accreditation processes. WAPHA really is there to try to support those processes and make it easier wherever possible.

CHAIR: We have met with the College of GPs and the AMA, and they all say that they don't have enough time.

Mr Wray: Yes.

CHAIR: How can we encourage it?

Mr Wray: A big focus is multidisciplinary teams, and the AOD sector provides that. I think the workforce actually is already multidisciplinary, but the key is around how we can form more effective partnerships with GPs. There are some good successes in that regard through funding streams, but we want to do more. I think probably the solutions to that are individual as well; there's no one-size-fits-all. Co-location is probably kind of a

gold standard. We'd love to see more of that, though the practicalities in GP surgeries very often prohibit that, but also virtual based consultations and really developing shared pathways with the primary health sector so that people can flow through and receive the services that they need to receive at the appropriate time.

CHAIR: The College of GPs says we should be increasing funding for more prolonged consultation. Do you think that is a worthwhile support?

Mr Wray: I can't really comment on the Medicare reforms for AOD; I'm not quite across that. There have certainly been a lot of Medicare reforms to enable longer consultations, which I would imagine extend to AOD as well, but it's also about making more effective use of the items that are already there. Certainly one of the things that we'd like to see providers doing is supporting GPs to make use of those items.

Just as a little aside, my understanding is that in GP land, for every one long consultation, you require around 13 short consultations, otherwise the service very quickly tips into becoming a specialist practice. It can be quickly occupied with a cohort of patients, rather than being a family practice. So that's part of the challenge—supporting more GPs to take on a smaller number of clients, rather than only a few GPs taking on large numbers, if that makes sense.

CHAIR: Yes. Another thing that has come up is better training for nurse practitioners and the community nursing cohort in alcohol and other drug use management, and there has been a bit of a discussion around stigma. Has that come across in your research as a workforce issue?

Mr Wray: In terms of nurse practitioners and what they can contribute to this, we've got a service here called DAWN—Drug and Alcohol Withdrawal Network—which supports GPs and their patients to do withdrawal in the home. That's proven to be very, very effective. I do think that there are huge gaps in withdrawal services and large waits for access. Some of the anecdotal evidence is that people only get into the central drug unit if they have very strong comorbidities—if they're pregnant and they have health conditions that are running alongside their withdrawal, for example. The majority of people don't need to be getting that type of inpatient withdrawal service.

CHAIR: So it's called d-a-w-n?

Mr Wray: That's DAWN, yes—the Drug and Alcohol Withdrawal Network—which is a home based service. My point there was just that there are large gaps in withdrawal services and primary health has a big role to play.

CHAIR: Is that in your submission at all?

Mr Wray: I don't think so, no. I think we were focusing on equity.

CHAIR: Is there any information you could send us about that?

Mr Wray: Yes.

CHAIR: Only because there's been a lot of focus on residential management, which clearly is expensive and of limited access to people that don't necessarily live in central business districts or big cities. We are keen to look at more innovative models.

Mr Wray: I can send through some general information on it. I think that program is funded by the Mental Health Commission.

CHAIR: Anything you could send us about that would be appreciated. Multiple issues have come up in this inquiry. Clearly, we're looking at all different aspects, but one of them is the availability of alcohol and other drugs and the easy and low-cost availability of alcohol. Does the PHN have any views on those issues?

Mr Wray: Our remit in prevention is largely around secondary prevention, rather than primary. I know that the WA Mental Health Commission provided information around their efforts in availability and their actions in that regard.

CHAIR: Good. Any questions, Monique?

Dr RYAN: Yes. Thank you for coming to talk to the committee today. In your group's submission to this inquiry in the last parliament, you were talking about the nexus that you'd established with mental health services for WA. We've been hearing a little bit about the difficulty in providing appropriate drug and alcohol support services to people who have active or untreated mental health issues. Are you able to give us any information about how it's working in WA—what has been effective and what has perhaps been more challenging?

Mr Wray: Gosh! It's an expectation within WAPHA funded services that there's collaboration around comorbidity, but I don't think it's an area where there needs to be a greater focus. It's certainly a joint priority with the WA Mental Health Commission as well. They're really leading that work. We try to fill some of the gaps, with a focus on primary health and what GPs and other primary health practitioners can do better in that space. But, as we said in the submission, it's the norm, not the exception, that people have complexities going on in their life,

including mental health comorbidities, alongside a whole range of other biopsychosocial things. Our commissioning intent is broad services. It's treating people rather than diagnoses.

Dr RYAN: There are three areas that you represent—two in Perth and then country Western Australia. To what extent is the provision of services by the primary health networks in rural WA different from that in metropolitan Perth?

Mr Wray: How are they different?

Dr RYAN: Yes.

Mr Wray: Well, I guess the first thing to mention is the sparsity of services—populations are scattered, whereas services are very often centralised. Again, the WA Mental Health Commission purchased the services of drug service teams located in regional centres. I'm sure they do their best, and we try to supplement that with our funding to enable them to do outreach beyond the regional centres, but WA is a huge space. Providing equitable services across the region is a real challenge, and in we wade with our little bits of funding. We look at how we can supplement that to make it more effective, so that people are not disadvantaged by geographical isolation, but we have a small amount of money.

Dr RYAN: Yes, sure. I appreciate that. Thank you.

CHAIR: Sam?

Mr BIRRELL: When you're looking at analysing policy, I assume you might be analysing trends as well, in terms of societal use of drugs and alcohol—presentations of different age groups and different parts of society—and what the system has to deal with. Are there any trends that you can share with us in what you're seeing?

Mr Wray: COVID had a big impact. Some of the research might be getting a little bit outdated now, but we were seeing alcohol use disorder, amongst middle-aged people in particular, and the challenges that are happening in the healthcare system for that particular cohort. I think that's an important area to be focusing on.

Mr BIRRELL: Do we know if that was a phenomenon that ended with, or shortly after, COVID—not ended but reduced—or do we see it as a triggering thing that has caused an increasing or plateauing problem?

Mr Wray: I think it's the latter. I'm not sure if that trend is continuing now, but certainly over the last few years we've seen a rapid increase in consumption by that particular cohort.

Mr BIRRELL: When you're looking at analysing policy, I assume you might be analysing trends as well in terms of societal use of drugs and alcohol, different age groups, different parts of society and presentations—what the system has to deal with. Are there any trends of what you're seeing that you can share with us?

Mr Wray: COVID had a big impact. Some of the research might be getting a bit outdated now. There was research around alcohol use disorder amongst middle aged people in particular and the challenges that are happening in the healthcare system for that particular cohort. I think that's an important area to be focusing on.

Mr BIRRELL: Do we know if that was a phenomenon that decreased with COVID or shortly after COVID, or do we see it as a triggering thing that's caused an increasing or plateauing problem?

Mr Wray: I think it's the latter. I'm not sure if that trend is continuing now, but, over the last few years, you certainly saw a rapid increase in consumption by that particular cohort.

Mr BIRRELL: Do you have any insight into why that was? Was it because people found themselves at home early in the afternoon with not much else to do, or was it the anxiety of the situation?

Mr Wray: I'm not 100 per cent sure. I think COVID probably exacerbated something, but this is around societal norms and expectations. You see it in other cohorts as well. Different groups will be drinking at harmful levels—young, middle aged and senior. The middle aged cohort was something that really stood out for me.

Mr BIRRELL: I've asked other witnesses in other hearings this. Do you anecdotally feel that there are trends of younger people moving away from alcohol and more towards other drugs? Are you seeing that as well, traditionally?

Mr Wray: I don't know what the latest NDS household surveys are reflecting around other drugs, but we've certainly seen a downward trend in alcohol use, which has got to be great news.

Mr BIRRELL: Thank you.

CHAIR: Alice, did you have any questions?

Ms JORDAN-BAIRD: Apologies. I was a little bit late. My question is around improving the current care arrangements and patient outcomes with co-occurring mental illness and AOD use? It's something that my local

PHN raises with me quite a lot. We've got quite a high population of people in this category. What do you think we can do to improve this care?

Mr Wray: We talked a little bit about that in your absence and noted that this is the norm rather than the exception. I actually think that the AOD sector have been very good at treating people rather than diagnoses, probably more so than the mental health sector. That's something to see more of going forward, and that's what we try to do in our commissioning: recognise that people present with a whole plethora of problems. Alcohol and other drugs is one of those issues. To really be effective, you need to treat the whole, not the part. AOD is really valuable, though, because it's a trigger point. It's often the reason that individuals and communities will start to address some of the most tricky issues that are facing them and us. It's a great foot in the door to actually address those things. People will present to AOD services with a range of problems, including problematic drug use. What we try to do in our commissioning is ensure that the whole person is being treated, not just the AOD part.

CHAIR: You represent all three PHNs in WA, which is a bit unusual. You probably get a pretty good overview. Is there pressure on you from the GPs to improve access to AOD services, or is it something that flies under the radar a bit? Do people just accept it as part of life?

Mr Wray: I've certainly heard it anecdotally, and we've had some focus groups with GPs that have absolutely highlighted gaps in services. Like I say, we've only got a relatively small purchasing budget compared to the state. We want to lever off the services and the commissioning that's been done by the state to fill the gaps and target the most needy areas, and GPs are critical to that. It's partnerships with the other services and commissioning activities that we're doing and about how we can do that holistically.

CHAIR: Good. Thanks for your evidence today. It's been very valuable. If you've been asked to provide any additional information—I think it was just that one thing around the dawn service; as we approach the Anzac Day, I don't mean that sort of dawn service—could you forward it to the secretariat within the next two weeks. That'd be great. You'll be sent a copy of the transcript of your evidence and will have an opportunity to request any corrections to transcription errors. Once again, thanks for appearing.

DESSAUER, Mr Paul, Chief Executive Officer, Peer Based Harm Reduction WA; and Board Director, Western Australian Network of Alcohol and other Drug Agencies

LALOR, Dr Erin, Chair, Alcohol Change Australia [by video link]

McINTOSH, Mrs Rochelle, Second in Command and Sector Development Manager, Western Australian Network of Alcohol and other Drug Agencies

PIERCE, Ms Hannah, Executive Officer, Alcohol Change Australia [by video link]

RUNDLE, Ms Jill, Chief Executive Officer, Western Australian Network of Alcohol and other Drug Agencies

[13:40]

CHAIR: Welcome. Although the committee doesn't require you to give evidence under oath, I should advise you that this hearing is a legal proceeding of the parliament and therefore has the same standing as proceedings in the respective houses. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. The evidence given today will be recorded by Hansard and attracts parliamentary privilege.

I now invite a representative to make a brief opening statement before we proceed to discussion. I'm thinking that WANADA would like to make a brief opening statement, and then we might follow with Alcohol Change Australia. If we could keep the opening statement brief to allow time for questions, that'd be great.

Ms Rundle: We thank the committee for inviting us to appear today. I acknowledge the traditional owners of the land on which we meet, the Whadjuk people of the Noongar nation, and pay respects to elders past and present.

The Western Australian Network of Alcohol and other Drug Agencies, WANADA, is the peak body for the specialist alcohol and other drug services in Western Australia. WANADA is an independent, membership-driven, not-for-profit association. Our membership predominantly comprises community-based not-for-profit organisations, and we have close to 100 member services located across the state in metropolitan, regional, rural and remote locations.

At least 90 per cent of the specialist alcohol and other drug sector in Western Australia is not for profit. Our broad membership represents the system of services needed to respond to alcohol and other drugs. For example, we have community development and prevention services, harm reduction services and treatment services including withdrawal, counselling, residential and aftercare services. All of these services empower changed behaviour for improved wellbeing.

WANADA's two submissions to this inquiry emphasise the need for an effective governance structure which oversees and monitors the implementation of the National Drug Strategy and the range of related strategies aimed at minimising the harm associated with alcohol and other drugs. This includes harms associated with stigma and discrimination at a systemic level.

Our third recommendation is related to regulation and provides a practical example of the role of a governance body to oversee and monitor nationally agreed developments—in this case, the National Quality Framework for Drug and Alcohol Treatment Services, which was released in 2018. The national quality framework identified shared responsibility between state and territory governments and the Commonwealth under the governance arrangement of the Ministerial Drug and Alcohol Forum, which was disbanded in May 2020. The national quality framework identified the need for regulation of alcohol and other drug treatment services, specifically focused on those not receiving government funding. To date, regulation has not been achieved, as far as I'm aware, in any jurisdiction, including Western Australia. I do, however, acknowledge that there have been some developments in WA towards licensing and regulation, driven to a large extent by a state inquiry into the significant harmful and dehumanising practices at a service that was not funded by government.

The last two of WANADA's recommendations, split over both submissions, are focused on systemic practice solutions—that is, the need to support capability building across all human service sectors and support for community led approaches or solutions that build on the evidence base, for a balanced system of services that meet community needs.

If there is interest in exploring these issues, we have two people presenting with me at this hearing that are well placed to contribute to the discussion. Paul Dessauer is well placed to speak directly to the work of harm reduction services. Peer Based Harm Reduction WA is a consumer-led peer-based service and the state's largest

provider of health and harm reduction services for people who inject drugs. Harm reduction in general contributes significantly to reducing the impact on the health system.

Rochelle is well placed to speak to effectively building cross-sector alcohol and other drug capability, and brings experience of enabling community led solutions. Concerns related to alcohol and other drugs do not happen in isolation. Just as alcohol and other drugs services need to be responsive to the many intersecting issues, all human services sectors need to be responsive to alcohol and other drugs, whether this is through providing evidence and information, early intervention or referring to appropriate specialist services, whether they're harm reduction or treatment services. WANADA's experience in supporting community led solutions has contributed to raising awareness of the network of cross-sector services available and the need for these services to work collaboratively, with the shared objective of improving wellbeing, including for people impacted by alcohol and other drugs.

In summary, WANADA strongly believes the specialist alcohol and other drugs service sector in Western Australia contributes to reducing the impact on ambulance services, emergency departments, hospitals and the broader health system, as well as reducing the burden across human services generally. There are not enough alcohol and other drugs services to meet community demand. There is a need for a systemic approach to addressing harms associated with alcohol and other drug use, one that relies on cross-sector services responding, within their capability, to alcohol and other drugs. While more resources are clearly needed for the specialist sector, there is also a need for efficient collaboration that best meets individual, family and community needs. Thank you.

CHAIR: Thank you. I now invite Alcohol Change Australia to speak.

Ms Pierce: We thank the committee for the opportunity to appear today and to provide an opening statement. I'd like to acknowledge the traditional owners of the land from which we are joining you today, the Wurundjeri people of the Kulin nation, and pay my respects to elders past and present.

Alcohol Change Australia is an alliance of health and community organisations working together to prevent and reduce harm from alcohol among Australian individuals, families and communities. The committee will have already heard extensive evidence on the harm caused by alcohol products. They contribute to thousands of deaths each year, placing enormous strain on our hospitals, ambulance services, law enforcement and justice system. You will also have heard about the significant pressure on AOD treatment services, with demand far exceeding available programs across the country. But behind these statements are real people. There are countless Australian families whose lives are disrupted, homes are affected and wellbeing is undermined by alcohol products. The scale of harm cannot be disputed.

Today we will focus on what works to reduce and prevent harm from alcohol. The World Health Organization identifies three best buys: effective taxation, comprehensive restrictions on advertising, and limits on availability. These measures address the drivers of alcohol use, reducing demand for treatment services and improving outcomes across the system. Importantly, these measures aren't new. They're reflected in our National Alcohol Strategy. The issue is not a lack of evidence but a lack of implementation.

First, on taxation, over 15 years ago, Ken Henry called our alcohol tax system incoherent. Unfortunately, this assessment still holds true today. Public health advocates and the alcohol industry rarely agree, but you will hear from all quarters that the current system is broken. It taxes alcohol products inconsistently, making it inefficient, inequitable and a driver of harm. Tax reform is feasible. The United Kingdom recently simplified its alcohol duty to address similar issues of complexity, market distortion and administrative burden. Learning from this, Australia's Treasury should undertake evidence based analysis and modelling to develop a simplified, equitable and transparent alcohol taxation system that better aligns fiscal and health objectives.

The second of the WHO best buys is alcohol marketing. Australia continues to rely on a system of self-regulation that does not protect children and young people from exposure to alcohol marketing. The Australian government can no longer legitimise a system that is failing the community. It should withdraw from current arrangements and develop enforceable legislation to regulate harmful products marketing.

The last of the WHO best buys is alcohol availability. While primarily a state and territory responsibility, it remains central to reducing harm, particularly in addressing alcohol's role in gender based violence. National leadership on this issue is essential.

Finally, these regulatory measures must be complemented by sustained investment in prevention. This includes public education campaigns, clear product labelling and community based programs that build capacity and reduce risk at the local level. In closing, the path forward is clear. What is needed is an increased focus on

prevention using coordinated, decisive action to implement measures that will improve the health and wellbeing of all Australians. Thank you.

CHAIR: Thank you. We'll go to questions. Ms France?

Ms FRANCE: Thank you all for giving evidence to our inquiry today. We appreciate you taking the time. I have two questions. First, for both WANADA and Alcohol Change Australia, what trends have you seen over the past 10 years in the complexity and the patient presentations that you think should be addressed in a new national strategy or a new national approach? The second question is specifically for WANADA. Could you give some examples of non-regulated services and the evidence of their impact? So the first question is for both of you. Over the ten years since the current strategy was developed, what has changed? What are the big things that need to be addressed in a new strategy? What has changed in terms of complexity or patient trends or presentations? What are the big things that have changed?

Ms Rundle: Whether it's a change or not, we don't have enough services to meet demand. We don't have enough harm reduction services to meet harm reduction demand. There was national population modelling for treatment services. We also, in Western Australia, did population modelling for harm reduction services and justice services et cetera. We clearly do not have enough harm reduction. We do not have enough services at whatever level, whether they're support, whether they're counselling, whether they're residential, whether they're withdrawal et cetera.

There have been some developments in WA to build the withdrawal supports, whether that's low or medium withdrawal. I know David spoke about home based withdrawal, but there's been an increase in low to medium medically supervised withdrawal. We've also seen some increases in some residential services, but there is nowhere near enough services to meet demand.

The trends are perpetually changing in regard to different substances and different issues. In Western Australia we have one of the highest rates—the second-highest rate compared to Northern Territory—in regard to alcohol consumption per population. We have the highest, if not the second-highest, consumption of methamphetamine per population. The complexity of people presenting to alcohol and other drug services more often than not is as a result of inadequate response from cross-sector. So alcohol and other drug services are seeing people with more complexity on the basis that they're not being picked up by other services. So that early intervention that can be happening at other services is not happening, and that is contributing to the acuity of conditions that present to alcohol and other drug services.

Mr Dessauer: Can I make a brief comment here?

Ms Rundle: Please.

Mr Dessauer: There are social and economic determinants of health, and those apply to people's mental health and to their alcohol and other drug use as well. The demand for alcohol and other drugs within the community is not necessarily something government has levers to control. Some of the trends I've seen most prominently in my work in the last decade are increasing housing insecurity and increasing cost-of-living pressures, and we tend to see more problematic patterns of substance use in response to those pressures.

There's a temptation to think, 'If we increase alcohol taxes, we'll see reduced alcohol consumption.' But there is a price point where increasing the price doesn't reduce use any more. It just creates incentive for a black market, and that's what we've seen happen with tobacco in Australia. So I think the alcohol taxation system most definitely needs to be reformed, and it should really be based on units of alcohol.

But you need to have this broader perspective, more nuanced perspective, of what the possible unintended consequences are of focusing on one element of the picture and not looking at the rest. The people who framed our National Drug Strategy had a really good understanding of this, and that's why they divided it into three pillars. The idea is the three pillars are complementary. But, if we overinvest in one or underinvest in another, we run the risk of accidentally creating problems.

Ms FRANCE: Alcohol Change Australia, did you have a response?

Dr Lalor: I support the comments made by Jill and Paul. In addition to patient complexity, which they've addressed, there's also changing complexity in the world in which people are living, which is impacting on their alcohol and drug patterns of use and the harms that they may experience from them. You've spoken about this with other people who've talked to you. Some of them are COVID, natural disasters and a world that is becoming slightly more incoherent each day. Those are impacting on people's resilience and their ability to cope. And often substance use is a result of that.

We're also seeing changes in the way industry, particularly the alcohol industry, is marketing to individuals with what emerged during COVID. There's a real growth in online sale and delivery into the home. We know that the majority of presentations, for example, to an emergency department occur from alcohol that is drunk within the home purchased as packaged liquor.

We also know that there's novel synthetic substances which are emerging. Stigma plays a huge part in the ability for people to be able to self-manage their substance use without significant harm. We're seeing an increase in alcohol related harms with an increase in deaths and hospitalisations. To Paul's point, the allocation of investment to prevention and harm reduction as opposed to law enforcement and treatment is unweighted, with a heavy, heavy focus on law enforcement.

I think it's important not just to think about the complexity of the caseload and the people who are needing treatment but to think about what we can do with the environment in which they operate to reduce the harms and pull the load off the treatment system as well.

Ms Rundle: In relation to your question about examples of unregulated services, the inquiry that I mentioned in Western Australia was the Esther Foundation inquiry, which found a number of human rights abuses at that service. This service was not funded by government in terms of the delivery of the service.

Mr Dessauer: The national quality framework applies to any agencies receiving state or federal funding, but there are agencies that operate outside of that framework. There's no regulatory oversight at all.

CHAIR: Alice.

Ms JORDAN-BAIRD: I'm the member for Gorton. I represent the community in Melbourne's western suburbs. We're one of the youngest electorates in the country, so I'm really interested in AOD use and its impact on young people. I know Alcohol Change Australia do great work with a lot of our local sporting clubs, among many others. My question is around celebrity endorsements. There's no doubt that young people spend a lot of time on social media, and seeing a certain celebrity with a certain seltzer or whatever it is, is very impactful. Could you provide your perspective on celebrity partnerships with alcohol companies for the committee? It's a question to both of you.

Ms Pierce: I'm happy to start. We know that the alcohol industry uses influencers and celebrities to promote their products because it works. It's a tactic that works. There's evidence that children as young as six can recognise alcohol companies, gambling companies et cetera on their favourite sports stars. That is a strategy that the industry use to really market their products to young audiences. As I said, it works from a marketing perspective, but it's also reflected in some of the trends that we're seeing among young people's drinking. The latest NDSHS data shows that we have been seeing some falls in alcohol use among young people that, in some groups is actually reversing. We saw increasing alcohol use among young women in particular, 18- to 24-year-olds, and the marketing from alcohol companies is a big part of that. We have a system of advertising regulation in Australia that is self-regulated. The alcohol and advertising industries fund the system. They manage it. They write their own code. Conveniently, a lot of the time, celebrity endorsement is not included because they explicitly state that they don't include sports sponsorship as a form of alcohol marketing. It's a grey area that the industry is really using to their advantage.

Ms JORDAN-BAIRD: Do you have any comments you'd like to add?

Mrs McIntosh: I'd love to. We've just recently worked in partnership with the Aboriginal Regional Governance Group in one of our regional areas to revisit and redesign an approach to young people, and alcohol and other drug use in the region, which is remote and very remote. The findings from that, including the data and the research, are that, for this particular cohort—young and predominantly Aboriginal communities—cannabis is the primary drug of concern. That is from very, very early ages, as young as eight and 10, consistently reported across the community, and that's, again, consistent with other research into regional and remote areas. Alcohol absolutely is an issue, but it becomes more of an issue in the older years—those older years being from 15 to 18 and then 18 to 25 and so on. So I think it's really important for some cohorts that we talk about the other drugs that are primary drugs of concern, and the impacts of that type of drug use—any type of drug use—from very young ages can be permanent for those children, obviously, their families and their communities.

Ms JORDAN-BAIRD: Thank you.

CHAIR: Monique, any questions?

Dr RYAN: I've got a question for Hannah, if I could. You mentioned that you think of our alcohol tax system as being incoherent; I think that's the word that you used. Are you able to give us a bit more information about why you used that word in particular and what you might propose regarding the taxation of alcohol in Australia?

CHAIR: I think she said Ken Henry said it was incoherent.

Ms Pierce: Yes, I did; I borrowed that phrase from Ken Henry. That was, back in 2009 or 2010, his description of the alcohol tax system following his review of the tax system as a whole.

The current alcohol tax system is really working for nobody. The primary beneficiaries at the moment are the major liquor retailers and the multinational alcohol producers. The small independents, the government and the community are the ones losing and the ones bearing the cost. We essentially have a two-tax system when it comes to alcohol. Beer and spirits are taxed largely based on their alcohol content—so, the stronger the product, the more tax that is paid. Wine is subject to the wine equalisation tax. That's a values based tax, which means, the cheaper the wine product, the less tax that is paid. So that's how Aldi can sell $3.50 bottles of wine and Dan Murphy's can sell four litres of cask wine for $25, or as little as 30c a standard drink. The tax system is favouring wine over other alcohol products, and then, within wine as a category, the tax system is actually favouring the major liquor retailers who have become vertically integrated businesses—they own the wineries, they harvest the grapes, they make the wine and they produce it, distribute it, market it and then sell it in their retail stores.

The review of the wine industry last year by Wine Australia highlighted the issues around these vertically integrated businesses and how they can manipulate the tax that they pay on their products. They can artificially lower the wholesale price, and, because a loss from the winery is a gain for the retailer, the parent company doesn't lose out at all, because they're all owned by the same people. Small independents are not able to do that. They cannot manipulate the tax system in the same way. So the small independent wineries are losing. Small craft brewers and craft distillers are losing because they're paying significantly higher tax on their products, despite beer actually having a lower alcohol content than wine.

We know that there have been at least 10 reviews, inquiries, consultations that have examined the tax system and said that alcohol should be taxed volumetrically; wine products should be taxed based on their volume, as beer and spirits are. What we really need now is for Treasury to have a good look at the tax system and conduct the appropriate modelling and analysis that we need to determine what a reformed system with wine taxed volumetrically would look like.

Dr RYAN: Has that sort of volumetric tax been instituted in any other jurisdictions that you know of?

Ms Pierce: Yes. The UK provides a really good case study for Australia, firstly because the UK is quite a comparable nation in terms of it being a high-income, developed country. Pre their tax reform, their alcohol tax system was similar to ours, in that products were taxed differently; it was inconsistent and had distorted markets. They've completed tax reform over the last six years. So, through COVID, through global inflation and through cost-of-living concerns, the UK Treasury conducted a review of the tax system, identified that all alcohol products should be taxed volumetrically and implemented a reformed system. I will note that most of the reforms came in over a couple of years, with transitional measures in place to support businesses that would have been most affected by the changed system. But they have done that.

The government has also funded the University of Sheffield to conduct an evaluation of the reform. They've got quite a comprehensive five-year work program that is looking at the impacts of the reformed tax system. It's early days, but today they've found that there's been modest consumption impact—modest reductions in alcohol use. There have been limited impacts on levels of inequity, so it's not causing greater inequity. Quite importantly, they've seen that the industry is reformulating its products to bring it to a lower tax rate, which, from a public health perspective, is a good thing. If people are choosing to drink alcohol, choosing low-alcohol products is a good option.

Dr RYAN: The last time we met, we heard from ABAC about the alcohol advertising broadcasting code, and they had no concerns at all about that code or how it functions. They seemed quite satisfied with it in general. What are your thoughts about it and the extent to which it's effective?

Ms Pierce: I'm not surprised that they're quite satisfied. Given that it's funded by the alcohol and advertising industries, they would probably be quite happy with the performance. The issues with ABAC and self-regulation go back a long time. I would say ABAC is the perfect example of the fox guarding the henhouse. They've written a code that's really narrow. It's doesn't cover the whole industry, so it's voluntary. It has no penalties. If an ad is found in breach of the code, they're told to remove it and, if they don't, there are no enforceable penalties in place. And so what we see time and time again is community members making complaints about alcohol advertising that concerns them. It might be an ad that their kid has seen while watching a YouTube video or an alcohol ad during the broadcast of Carols in the Domain when the Wiggles were showing, and they just get dismissed because they're not in breach of the code and there's nothing that can be done about it. So it's very evident that self-regulation is failing in this instance, and the Australian government representative on the ABAC

Management Committee adds credibility to a system that really is not credible. As a first step, the Australian government representative should step off the management committee, and, as a second step, we need a legislated form of advertising controls implemented.

Dr RYAN: I request that, if you have any supportive materials regarding that statement, you table them to the committee if you are able? Is that reasonable, Chair?

CHAIR: Yes.

Ms Pierce: Yes.

Dr RYAN: Thank you. I really appreciate it.

CHAIR: In particular, if you're recommending that the Australian government representative be removed from that group, I think that would be important information.

Dr RYAN: Thank you.

CHAIR: Sam.

Mr BIRRELL: In your submission, this sentence struck me:

Empowering Australians with the knowledge that alcohol causes harm is an important part of a comprehensive approach to reducing harms …

Would you acknowledge that, whilst there is harm caused by alcohol and we're hearing about that, most people use alcohol in a responsible way and there are very limited, if any, harms and that some would say there is societal good from alcohol when used in moderation?

Ms Pierce: Firstly, I would say that alcohol is a harmful substance. We know that it's carcinogenic. It's up there with asbestos and tobacco. According to the World Health Organization, it's a leading cause of injury, hospitalisations and death, and those harms are increasing. So I think we can't discount the harms from alcohol. We know from the National Drug Strategy Household Survey that about six million Australians are drinking alcohol at levels that put their health at risk. Those are either moderate- or high-risk groups. So there is a large proportion of Australians who are not drinking alcohol in a way that doesn't jeopardise their health. It's only about a third of Australians drinking at that level.

When we look at the people who are drinking alcohol at harmful levels and we ask them whether they want to do anything about that, about a third of them say no. That could be taken as a misunderstanding of the potential harms. It could be taken as a reluctance to do anything about their alcohol. All of those are completely understandable, and we understand that from behaviour change science that's been around for a very long time, but it does signal that there may be misperceptions amongst the Australian community about the harms from alcohol, which is why things like labelling on alcohol about cancer risks is being explored in other jurisdictions, like Ireland and some parts of Europe. It also indicates that we need to make it easier for people to be able to seek help. The majority of people who are wanting to change behaviour want to do it themselves. About 80 per cent of people want to do it themselves. That's irrespective of whether they're at moderate or high risk. We know that, if they are high-risk users of alcohol, they are more likely to want the sorts of services that WANADA has been talking about: professional services that are delivered by treatment providers.

I think it's important to note that alcohol is not a harmless substance. Even when you drink at very low levels, you are increasing your risk of cancer. But the NHMRC guidelines are clear around the levels at which the harm increases, and we know that that's more than 10 standard drinks a week and more than four in any one sitting.

Mr BIRRELL: The evidence I've heard you give is very critical towards the alcohol industry, and I put to you that the alcohol industry is probably an important part of Australian society, with the wineries, breweries and that sort of thing. It employs a lot of people and creates a lot of enjoyment for people who use alcohol at a moderate level. I put that to you for comment.

You're also concerned about alcohol companies marketing to younger people, but most of the analysts or people, when we've asked about trends around alcohol, have told us that the trend for young people is away from alcohol and onto other, possibly illegal, substances. Would you agree with that? That's a question in two parts.

Dr Lalor: I can take the second part of the question, about the trends, and Hannah will respond to the industry part of the question. As Hannah said, we have over many years seen alcohol use by people under the age of 18 declining. That trend is reversing, particularly in girls. For the first time in a long time, we're seeing girls under the age of 18 more likely to use alcohol than boys, and more of them are using alcohol than were in 2019. In 2019, I think, 28 per cent of girls under the age of 18 had used alcohol. That number is now 35 per cent. So the trend is not reversing. In the 18-to-24-year-old age group, we're seeing young women using alcohol at risky levels almost on par with young men. Young men were always the highest risk users of alcohol. That is not necessarily

going to continue for much longer. With young girls 18 to 24, about 40 per cent of them are using alcohol compared to 45 per cent of young men. So it's not a trend that is continuously going down. Yes, it was in the past, but that is reversing now. A lot of it has to do with the way alcohol is promoted, priced and marketed, and that is about the alcohol industry.

Ms Pierce: The objective of the alcohol industry is to sell as much alcohol to as many people as possible. They're for-profit businesses that sell a product, so that is their objective. There's really no denying that. And that objective does conflict with public health objectives to reduce harm from alcohol. Say we look at tax reform. We're talking about wanting to reform the tax system. When we're looking at sectors of the alcohol industry, we see that they're currently disadvantaged by the tax system. Independent winemakers and independent brewers are disadvantaged. The major liquor retailers are benefiting from the wine equalisation tax anomalies that exist, while the independents are facing higher costs and market barriers. Independent brewers pay significantly higher tax than wine producers. So, when we're looking at tax reform, we're looking at achieving public health objectives, but we're also looking at addressing the inconsistencies and anomalies that exist within the system and are disadvantaging sectors of the alcohol industry. The other important element to look at is the cost of alcohol harm to Australia. Estimates are around $70 billion—what alcohol use is costing the Australian community both in direct and indirect costs. When we consider what the industry delivers in terms of economic benefit, we have to take into account the negative externalities they are causing our community and our economy.

Mr BIRRELL: Is there a comment from the WANADA people on some of the points I've raised about alcohol use trends or alcohol's role in society and use in moderation?

Mr Dessauer: Sure. I believe you will be speaking with my colleague Paul Griffiths from the National Drug Research Institute. He can probably speak more to large-scale trends. That's the job of the National Drug Research Institute. We are seeing an increasing trend, as Hannah mentioned. I'm turning 60 next year. When I was a young man, everything was saturated with tobacco advertising. All sporting teams had the branding. Most of my contemporaries and I started smoking in our teens. Paul Hogan was the spokesperson for 'Anyhow, have a Winfield'. It was a primary school catchphrase. So Australia has addressed this sort of thing in the past. The tobacco industry was a very, very powerful industry. The alcohol industry is not a discrete thing. Hannah has pointed to some of the inconsistencies in taxation—how it's actually favouring monopolies rather than supporting the local industry. So there's a more nuanced conversation here. It's not about, 'Is the industry bad?' It's about, 'How do you regulate the industry?'

Ms Rundle: I'll also add that alcohol continues to be the principal drug of concern of people accessing alcohol and other drug services. That's been a constant. It continues as a constant. It is the drug that causes most harm. It's widely recognised.

Mr Dessauer: Our modelling in Australia shows that there's only about 50 per cent of places for treatment as there are people in Australia seeking treatment for alcohol or other drug related issues. So the treatment sector is most definitely underfunded.

Mr BIRRELL: Thank you.

CHAIR: I've got a couple of questions. There is this perennial argument around alcohol availability and taxation. We're interested in things we can do and things we can't. I know that other jurisdictions have been quoted, but they don't necessarily have a wine industry like Australia does. There are no bottles of Cambridge claret on the shelves—that I see. We do have to work within the reality of the situation. I'm interested in what we can do and what we can't. A prominent thing that's come up is alcohol availability and how we look at recent trends. COVID and what's happened since COVID, with the availability of alcohol 24 hours a day ordered online or by the phone, has been mentioned. Do you have any views on that and on whether we should be looking at reducing alcohol availability that way?

Ms Rundle: Across Western Australia, we have various restrictions that are different for different communities and different for different regions. As Erin raised before, we need to raise community awareness of the harms of alcohol, and other drugs for that matter, so that the community can be empowered to make the appropriate choices. Restrictions or different sorts of regulations or different processes will just result, as Paul indicated before, in sly grogging or in behaviour that criminalises access to alcohol. So I think we've got to be careful of just having a top-down approach. Feeding in much more of a community led solution with raised awareness means we can tackle these problems. The top-down approach just contributes to more and more complexity in how we might end up dealing with this problem.

CHAIR: Does that include the taxation approach as well?

Ms Rundle: We're very supportive of minimum unit price, appropriate taxation, and regulations of promotion et cetera, and that needs to come with community awareness raising. Community based services that have their footprint on the ground to see what the issues and concerns are in those communities experiencing these issues and concerns need to be empowered to have a voice to control what is going on in their communities.

CHAIR: We've had education programs for a long time around alcohol harm, and maybe that has reduced consumption a bit, but we're still seeing high-risk behaviour.

Ms Rundle: Yes.

CHAIR: We need to look at ways to reduce that. Taxation is one way. Availability is another way. And improving access to rehab is another. But there is evidence that reducing access can have an effect.

Ms Rundle: I'm not denying that, absolutely not. All I'm saying is that it needs to come together. And, yes, there are media campaigns, but I'm talking about grassroots community awareness that is actually needed. In terms of working with Aboriginal community controlled health organisations—and Rochelle can speak to some of this—at times there is no awareness of the harms of alcohol and that there is an appropriate response. We would like to see a response that is consistent with the specialist sector across all community services, whether that's the Aboriginal health services, domestic family violence or homeless services. There is no consistent approach to raising awareness of alcohol and other drugs.

CHAIR: So a national campaign?

Ms Rundle: A capability-building approach that includes raising awareness and a response—absolutely.

Mr Dessauer: I'll refer back to something I said earlier about social and economic determinants of health. You need a whole-of-government approach to these issues. If I meet someone who's homeless and they're drinking alcohol heavily, I don't expect them to stop drinking alcohol while they're homeless. I'm going to try and focus on getting them into stable and suitable accommodation, and then their alcohol use is going to be easier to deal with. As long as we're seeing these pressures in the community and seeing life getting harder for people, with increasing housing instability and so on, we're probably going to see increasing levels of problematic substance use. It's a coping strategy. Unless we take that broader view and look at whether there's a community that's having issues rather than trying to police the issues away, we should be trying to look at what we can do in that community to build its health.

CHAIR: Social determinants of health have been mentioned by virtually every group that has spoken to us. There's a lot of agreement; there's also a more connected response and a more one-stop-shop approach to stop restricting access to programs because of minor criteria changes.

I'll just go back to alcohol change. We have to be realistic about what we can and can't recommend. What are the three most important ways we could change the system, if we look at availability, taxation and advertising?

Dr Lalor: Jill has touched a little on the way in which alcohol regulation and prevention programs and awareness programs come together. It's worth remembering that the regulatory system sits around people within a community. I'm CEO of the Alcohol and Drug Foundation. We run a program on behalf of the Australian government called the Local Drug Action Team Program, where communities identify local needs and deliver local programs to prevent alcohol related harm. Ninety-six per cent of the communities are demonstrating that they are doing that very effectively. But if they're doing work with young people in a community, where it's very cheap to get alcohol and very easy to get alcohol and alcohol is heavily promoted, it makes their efforts all that much harder. We do need to think about investment in prevention programs and awareness campaigns, because I don't know that we've had a national alcohol awareness campaign in this country for very many years apart from the wonderful FASD work that's happening at the moment. We haven't really invested, as we have with tobacco, in getting Australians to understand harms of alcohol and how to get support to reduce their alcohol use.

Then the issue of accessibility is often a state responsibility. Delivery of alcohol into the home is regulated through the liquor acts. There was a commitment from first ministers to look at the way that they may be able to address alcohol availability to reduce family and domestic violence. We haven't seen a lot of activity associated with that commitment. The levers that the federal government has are much more around taxation, which is difficult. I think it's fair to say it's a difficult conversation to have, but we are seeing more countries recognise the benefits not just for community but for sector in taxation reform—but also in the way in which alcohol is marketed to individuals, particularly using online advertising.

Ms Pierce: I'll just pick up in terms of recommendations around taxation. We really need Treasury to undertake some evidence based modelling and analysis to help inform a tax system that supports public health objectives as well as business objectives. Treasury is well placed to do that, as the central government agency.

CHAIR: I think that's a very good point.

Mrs McIntosh: Can I just layer into that as well. There's a lot of mention of campaigns, and, Erin, I'm assuming you're talking at the national level when you mention campaigns—

Dr Lalor: Yes, I am.

Mrs McIntosh: but you've also dovetailed down to the local drug action teams. Campaigns, to be effective in terms of community education and community led change, are relevant at that local level. A campaign could include or be inclusive of coordinated action led by community, and what is led by community in Kununurra is going to be very different to what is led by community in your electorate.

CHAIR: Sure.

Mrs McIntosh: A campaign should be inclusive of coordinated activity. Whether it's a national action or whether it's a regional or a local action, that activity should be coordinated and be consistent and aligned with the pillars we talked about and the dual approach, or the balanced approach, with prevention and those other levers that we can pull on.

CHAIR: Exactly. Local government has been left out of the argument a bit, but then they have significant power in terms of local planning laws, around availability et cetera.

Mrs McIntosh: And are great enablers for coordinating action and bringing community along the journey in terms of the change journey and raising awareness. That education isn't about education in a school system, necessarily, or a media campaign. It's about collaborating with community and having conversations and supporting different alternatives to drinking environments.

CHAIR: Good. Thank you all for your evidence today. It's been really valuable, and I think we've taken on board most of what you've said. I don't think you've been asked to provide anything, but, if you have, could you forward it to the secretariat in the next two weeks. You'll be sent a copy of the transcript of your evidence and will have an opportunity to request corrections to any transcription errors. Once again, thanks very much.

ELLIOTT, Professor Elizabeth, Distinguished Professor, Speciality of Child and Adolescent Health, Faculty of Medicine and Health, University of Sydney; and Director, FASD Research Australia, National Health and Medical Research Centre of Research Excellence in Fetal Alcohol Spectrum Disorder [by video link]

MEDLOW, Associate Professor Sharon, Associate Professor, Speciality of Child and Adolescent Health, Faculty of Medicine and Health, University of Sydney; and Manager, FASD Research Australia, National Health and Medical Research Centre of Research Excellence in Fetal Alcohol Spectrum Disorder [by video link]

ROBARDS, Dr Fiona, Senior Research Fellow, Speciality of Child and Adolescent Health, Faculty of Medicine and Health, University of Sydney [by video link]

UINK, Dr Bep, Director, Australian Indigenous HealthInfoNet [by video link]

[14:35]

CHAIR: Welcome. Do you have any comments to make on the capacity in which you appear?

Prof. Elliott: I am also the lead of the New South Wales FASD assessment clinic and a professor of paediatrics at the University of Sydney.

Dr Robards: I am also a senior lecturer at the University of Sydney.

CHAIR: Although the committee doesn't require you to give evidence under oath, I should advise you that this hearing in Perth of the Standing Committee on Health, Aged Care and Disability is a legal proceeding of the parliament and therefore has the same standing as proceedings of the respective houses. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. The evidence given today will be recorded by Hansard and attracts parliamentary privilege. I now invite you to make a brief opening statement before we proceed to discussion.

Prof. Elliott: Thanks very much for the invitation to speak today. We acknowledge and pay respects to the traditional Aboriginal owners of the lands on which we live and work. Our centre for research excellence brings together national and international research expertise to improve the identification, management and prevention of fetal alcohol spectrum disorder, or FASD, and translate research into better clinical outcomes.

A critical focus of the CRE is prevention of the harms from alcohol use in pregnancy, which occur in about 50 per cent of all pregnancies and have consequences and costs for children, families and the broader community. Prenatal exposure to alcohol can result in FASD, a lifelong brain-based disability affecting learning, impulse control, language, memory and attention, associated with birth defects and growth failure. We recently estimated that 3.6 per cent of the general Australian population could have FASD. That is one child in every classroom. This is a higher prevalence than cerebral palsy and autism combined. Although potentially preventable, FASD remains underrecognised and underdiagnosed. Services are inadequately resourced and access to services is inequitable; thus, waitlists are long and many children do not receive the early intervention they need to thrive. We need increased investment in health professional training and capacity and in publicly funded FASD-informed services in all jurisdictions.

Community-level prevention programs reduce harm from prenatal alcohol exposure and remain critical. We require continued investment in public education campaigns—the ones you've just heard about, such as the Every Moment Matters campaign and the Strong Born campaign. We need enforcement of mandatory labels warning of alcohol harms in pregnancy. We need support for community led alcohol controls, including by Indigenous communities. We need reinforcement of the NHMRC alcohol guidelines that recommend that there is no safe level of alcohol use in pregnancy and that women who are pregnant or planning a pregnancy should not drink alcohol. We must continue to fund the FASD Hub Australia, the National Organisation for FASD and Learning with FASD, which provide education and training to a wide range of professionals and to the community.

Preventing alcohol related harms in pregnancy also requires a strong universal health system response. We recommend routine prenatal screening for alcohol use in all pregnancies in all antenatal services. We need pathways for timely, non-judgemental treatment and referral for women who are drinking in pregnancy. This must be matched by improved access to alcohol and other drug treatment services, particularly in rural and remote areas, and they must have capacity to treat alcohol dependency in pregnancy. Long-term harm reduction also depends on legislating the levers that we know decrease alcohol harm. These include taxation, pricing and limits on advertising and promotion. This requires political will and a commitment to preventing the alcohol industry from influencing public health policy.

National assets such as the Australian Paediatric Surveillance Unit, the FASD Australian Registry and the new personal electronic patient records are essential for monitoring national trends in the prevalence of prenatal alcohol exposure and FASD and the impacts of prevention strategies, and these require ongoing support. The impact of prenatal alcohol exposure extends beyond health, though, and we recommend early routine screening to identify disability, including FASD, in schools and at the first point of contact with child protection and juvenile justice systems. We emphasise the need for long-term, whole-of-system investment, including support for Aboriginal community controlled organisations and for culturally informed responses to FASD, such as the youth Koori clinic.

Finally, the National FASD Strategic Action Plan is due for renewal in 2028, and its implementation is being monitored by the National FASD Advisory Group convened by the Department of Health, Disability and Ageing. Funding will be required to revise this plan to enable it to address identified gaps in progress against the desired outcomes.

CHAIR: Sam, would you like to start?

Mr BIRRELL: I have had some experience with this in my electorate with people who are suffering from FASD and creating awareness about it, so there is that sense of awareness out there—the Red Shoes Rock campaign. I'd like to ask you about the major cause of women drinking during pregnancy. When I think about it, there are probably three reasons. One is a lack of knowledge of the harm. Another one could be an acknowledgement of the harm but an addiction, or people are drinking alcohol and not realising that they're pregnant. So, in that time before you realise that you are pregnant, you still drink alcohol, and then, when you find you're pregnant, you stop, but maybe there's been some damage done. Can you comment on those? Am I missing something there, or are those the three scenarios?

Prof. Elliott: Yes, you're absolutely right. First of all, people drink because they don't know they're pregnant. Most women will stop once they're pregnant, unless they are alcohol dependent. Then they can't just stop, so we can't pretend that giving them advice or even information about harms will help them stop drinking. We've really got to provide specialist support. My contention is that really that support should be provided much earlier, before they even become pregnant. So we need awareness campaigns in schools, and we need GPs and primary health professionals and others to identify women who have a problem with alcohol before they become pregnant. So either they can use contraception or they can be helped to stop using alcohol.

Then the other reason is that, yes, women don't know about the potential harms. We've done a national survey and reckon that's still about 30 per cent, although the Every Moment Matters campaign has been well evaluated and suggests that it's had tremendous reach and that awareness has increased. And then there are the groups who are just disadvantaged by historic trauma and current disadvantage and are living in overcrowded housing or are homeless or living in domestic violence situations and have little access to health services. Those include people in very remote communities.

Mr BIRRELL: Is there any sense of what percentage are drinking until they find out they're pregnant, what percentage are addicted and what percentage just lack the knowledge to know that there are harms? I ask because that leads to the policy response. If a lot of it were lack of knowledge, then the awareness campaign might be there, but from what you're saying there might be a better focused awareness campaign that says, 'If there's a chance that you might become pregnant, you need to do this.'

Prof. Elliott: There are two distinct groups. There's the general population. They need to know that if they're drinking heavily—and many young girls are binge drinking—they need to use contraception. If they want to get pregnant, they need to stop drinking. Then there are the second group, who need to be aware of the harms, because they will stop drinking once they're pregnant. But the problem is that about 50 per cent of pregnancies are still unplanned, and about 60 per cent of women tell us that they drink alcohol during pregnancy.

Then there's really the very small group who I do think require a very targeted response. That requires identifying them well before they become pregnant. That's the women who are alcohol dependent. And there are many of them. Many of them tell us that they even alert health professionals but that health professionals fail to respond. I think we do have an added responsibility for that small but very significant proportion who cannot stop drinking just because they're warned of the harms.

Mr BIRRELL: Thank you very much.

CHAIR: Monique.

Dr RYAN: Thanks, Elizabeth—good to see you. I was just looking at the Senate inquiry into FASD from 2021. It's remarkable, actually—we've come a long way, even since then. The on-the-label warnings on alcohol products—do you have any information on how effective they've been and any thoughts about whether they

should be expanded to include warnings about other alcohol related risks? We've just been having a conversation about the cancer risk associated with alcohol, for example, and the fact that, I suspect, most Australians aren't aware of it. What are your thoughts about the on-the-label warnings that we have in place right now?

Prof. Elliott: Well, I'm very pleased that we've got them in place, because we first went to talk to Nicola Roxon about mandatory labelling back in 2010, and I think it was 2023 when they became mandated. It is clear from overseas evidence that the labels raise awareness in the general community about the harms of alcohol. We battled a lot about the type of label. It had to be large print, black and white, with the red that attracted the attention and incited a warning in people.

I'm not aware of any evaluation of the effectiveness of those labels in Australia, but I am aware that the labelling is being well complied with. Certainly, anecdotally, there's increased community awareness. There is a slight problem with them—and I think there's been some evaluation done by Simone Pettigrew—in that the warning labels don't seem to apply to online sales. I think that's a little loophole that's being attended to. All I can say is that the rationale for the labelling came from international evidence. I think it would be very good to evaluate the effectiveness of them, and that may be underway. I know Simone has been doing some work in that regard.

Overseas, as you know, there are much broader warning labels, which advise about all the other harms of alcohol. Again, I don't know whether those have been well evaluated. I guess it could be like cigarettes in that we rotate those labels. From our point of view, rotating out the pregnancy warning label and rotating in the liver disease label or the brain injury label might detract from the prevention of fetal alcohol spectrum disorder—and, I might say, the many other harms that occur from alcohol use in pregnancy before you even get to the level of fetal alcohol spectrum disorder. It's hard to know. I think we should perhaps be looking—we could undertake to do that—at the evidence of the effectiveness of the labelling: whether that's being evaluated in Australia and what the impact of multiple labels overseas has been on the pregnancy warning.

Dr RYAN: That's really interesting. Just to clarify, the online advertising of gambling doesn't, or didn't—

Prof. Elliott: Of alcohol.

Dr RYAN: Of alcohol, sorry—one-track mind!

CHAIR: Don't get me into more trouble!

Prof. Elliott: There is a paper that showed up that loophole, and I will send that to you. My understanding was that, when you went onto those online sites and ordered the alcohol, the labelling wasn't evident, whereas it is evident on all alcohol products and all packaging that you would buy in a shop.

Dr RYAN: Thank you, that's really interesting.

CHAIR: Alice.

Ms JORDAN-BAIRD: Thanks so much for appearing before our committee today. We've heard quite a bit about FASD over the course of this inquiry. It's really interesting. I didn't quite realise—I think you mentioned, Professor Elliott, that 3.6 per cent of the general population may have FASD, which is pretty significant.

My question is more around school resourcing and how we can create more awareness in the younger years. Do you think there's a role for us to work closer with the Department of Education to embed FASD awareness in the curriculum? Do you think it's something that every student should learn about when they get to a certain age?

Prof. Elliott: Absolutely. I can tell you that we have been working very closely with the education department and with early childhood workers. We've developed some resources for the early childhood group and they have been very well received. We have currently got funding for a website called Learning with FASD, and we have developed resources for both primary and secondary school teachers, with input from educators and from people with lived experience.

We have currently got a grant application in—I think it's with either the NHMRC or the MRFF—to try and do a large cluster randomised controlled trial to introduce a module into high school education. That module would include the harms of alcohol use and the harms of alcohol use in pregnancy and contraception because they all go very well together. That work is proposed as a collaboration with the Matilda Centre, which has extensive experience in education, particularly regarding mental health and drugs and alcohol in schools. We would propose to run this trial in 60 schools for over 4,000 children. It would be, really, a world first if we got funded for that.

Yes, I agree that we really do need to get in early and perhaps we need to be getting in even earlier than high school. We need to provide teachers with the supports, which I think we're doing, and early childhood educators. We now need to inform school students themselves.

CHAIR: Ali.

Ms FRANCE: Obviously, prevention is the best way to treat FASD—before it happens. I'm wondering about the assessments and how we diagnose FASD and what you would recommend. Where do you see that being most effective? Is it at a newborn screening, at early childhood education or is it a school referral? Is there a problem in general with it? In newborn screening, it involves parents admitting that they've had a problem and owning up to it. Do you have any insights into when screening would occur?

Prof. Elliott: Screening or prevention?

Ms FRANCE: Screening.

Prof. Elliott: If I go to your first point about prevention, I totally agree. We see children in our clinic every week who have substantial challenges and we see families where there are four or five affected children with these complex needs. We've already discussed preventing alcohol use in pregnancy to some extent and it's crucial. With regard to early identification, which can then prevent some of the complications and the adolescent and adult problems, yes, the earlier the better. Again, we recommend screening. We've just done a big trial in Hunter New England where we've screened people as early as possible in their pregnancy, and we embedded the questions about alcohol in the electronic maternity records. When doctors or nurses asked the question, they were then prompted with advice as to what they should do. They should reassure the woman, but tell them about the harms or they should provide a brief intervention, which has proven to be effective in helping women to stop drinking, or, if they were alcohol dependent, they should refer them to the appropriate service, which would come up on their screens. That's one approach.

The second approach is screening. What we are doing at the moment is working with SUPPS, which is the substance use in pregnancy program in New South Wales. They are referring to us any child who they identified was exposed to alcohol prenatally. We've established, within our New South Wales assessment service, a baby clinic. So we see these babies and we establish rapport with the parents and then we follow those babies till school age. So, whether or not they ever end up with a diagnosis of fetal alcohol spectrum disorder, we do identify if they have problems early, and we can provide them with early intervention.

Otherwise, the age that we tend to see children in our clinic at is between eight and nine, when they're in primary school, they've got major behavioural problems and they've got problems with attention and learning. Often it's really quite difficult to manage their behaviours, even at that age. But, again, the earlier they're identified and the earlier that supports are put in place, the better they will do. And, the better supported the parents are, the better they will do.

The majority of our children in Australia with fetal alcohol spectrum disorder live in out-of-home care. Probably about 80 per cent of them live in out-of-home care. So, again, when any child goes into care, child protection should be asking about prenatal alcohol and other drug exposures, should be looking at the maternity records and, really, should be providing the foster parents with as much support from early on as they can possibly give them. We know that children with good support will do better. We know that the brain is very malleable in early infancy and early childhood and that early interventions have much better effectiveness than interventions provided later.

Ms FRANCE: Thank you.

CHAIR: Thank you for all the work that you and your team have been doing over many, many years.

Prof. Elliott: Forty years.

CHAIR: It's ongoing and valuable work, so we do appreciate it. We know that there are cohorts at high risk. Should we be doing more in terms of supporting and educating those communities? It's already been brought up that—

Prof. Elliott: Well—yes. When we developed the original guidelines for the assessment and diagnosis of fetal alcohol spectrum disorder, we did look at developing a screening tool. The conclusion, after the literature review and expert consultation, was that screening the general population was not going to be viable. However, there would be potential for screening at-risk populations, and I think the particular ones are—any child going into foster care must be screened. If you are adopting or fostering a child with a severe congenital heart lesion, you need to know that they may develop symptoms, they may require treatment, they may require surgery et cetera. So we do need to screen any child going into foster care or adoptive care.

We need to screen any child who comes in contact with the juvenile justice system. FASD has been in the news, as you know, associated with adult time for adult crime, associated with the move to decrease the age of incarceration, associated with the civil unrest in central Australia, associated with the Banksia Hill detention—FASD has been implicated in all of those things. Many of those children have had recurrent contact with the justice system and have never been assessed in any way, let alone for fetal alcohol spectrum disorder. Their

cognitive impairment is often quite significant. Even intellectual disability has never been recognised. Any child in contact with the justice system should be assessed and treated appropriately.

Any child who is identified as having neurodevelopmental problems at school—as you know, we now have a national, universal screening for neurodevelopmental problems. This is one of the issues that should be thought of. Obviously, it's only one of hundreds of causes of neurodevelopmental delay and disability, but it should be considered.

CHAIR: We should have national recommendations around those areas, shouldn't we?

Prof. Elliott: We should. They're the three big populations: out-of-home care, juvenile justice and—what was the third one?—foster care. Of course, we know that there are pockets of high alcohol use, not in all communities but in some Indigenous communities, particularly in the very remote communities which have been highly impacted by historic and current trauma. And obviously there are kids who are siblings of a child with FASD or who are born to a mother who's known to be alcohol dependent. But it's extraordinary to us in our clinic how often, as I said, we might see four or five children from the same mother, in different foster care placements, who have severe problems which could have been prevented.

CHAIR: So some recommendations around a national at-risk screening program would be—

Prof. Elliott: Targeted screening of high-risk groups.

CHAIR: Okay. How about for the communities themselves where these kids are coming from? What can we do for them?

Prof. Elliott: The Aboriginal communities have in fact really led the way. I was listening to the people giving evidence previous to us, and, as you know, communities such as the Fitzroy Crossing community, in the Kimberley, in Western Australia, have led community-led alcohol restrictions, which have been evaluated formally and found to be highly effective in decreasing the amount of alcohol that's sold and in informing campaigns which have led to reductions in alcohol use in pregnancy. So, yes, I think community control is a very important aspect of all of this, and any program of prevention needs to be co-designed with the local community. If it's an Aboriginal community, they're highly heterogeneous. NACCHO has done an extremely good job, as part of the Every Moment Matters campaign, in developing resources for people living in Aboriginal communities and people working in Aboriginal communities. There has been a lot of groundwork done, and perhaps they just need support to enable them to continue those education and support campaigns.

CHAIR: Would any of your colleagues like to make any comments? Is there any information they think we should have?

Prof. Medlow: I'm just wondering if anyone's interested in our research program as part of the centre of research excellence. I'm happy to take any questions about that.

CHAIR: Sure. Are you looking Australia-wide with your research program? Do you want to tell us about it?

Prof. Medlow: I'd love to. It's organised in three streams, and the first one's looking at national data, so it's very much national surveillance and bringing that all together. We're also looking at birth cohorts and comparing these with birth cohorts from overseas, so we're creating a really comprehensive picture of FASD here and comparing with data overseas. As part of that, we're looking also at the true burden of disease, so we're looking at comorbidities in mental and physical health. One of the really interesting projects—it's an Australian first—will be looking at the health economics associated with FASD, and that will be looking at it in two ways. The first will be what the cost is of making a diagnosis—so the program cost to the assessment service. The second way of looking at it is: what is the cost to the individual and society? We're looking at that really broadly—the adverse impacts in, say, education, justice, emergency departments and so forth, as well as the MBS, PBS, NDIS. It's all of those costs. That's going to be, we think, really useful. At the moment we tend to draw on overseas data when we talk about costs. We know that they're high, but it'll be a really interesting piece of work.

Then, just briefly, in our other two streams of research we're looking at diagnosis and management. We're trying to think about how to have an accurate and effective diagnosis as early as possible, as has already been discussed. We know that it's quite expensive to come to our clinic, for the government, and there are long waitlists, so we're thinking about what sorts of novel technologies we can be using that will make access a bit easier and a bit more cost effective. Then, of course, we're looking at management and treatment for when someone does have a FASD diagnosis.

We've spoken a lot about prevention today, and that's our third stream of research. We're coming at that at all angles. We had a question about education, and Liz has already spoken about that quite a lot—but education resources, both for educators themselves and for young people before they become parents. We're looking at

helping clinicians to ask and advise about alcohol. And we've got a program of policy research, led by Dr Robards, and that allows us to translate all of the evidence, no matter what topic we're studying, into policy-ready briefs and things ready for submission. We hope that will be helpful nationally.

CHAIR: Over what period of time is this research project running?

Prof. Medlow: We have five years of funding. We just began at the beginning of this year, so we'll be ending at the end of 2030. Of course, well before that time, we'll be thinking about the sustainability of the research centre and how we can continue our projects. A lot of them require a lot of long-term input. For example, some of the birth cohorts we're following—of course, we follow them as the children get older, and we learn more and more about that. Then we've got the original projects we proposed, but we're thinking of new ones all the time. We're hoping to have a long future, but five years is guaranteed.

CHAIR: Where's the funding from at the moment?

Prof. Elliott: This is an NHMRC Centre for Research Excellence grant, which is the large sum of $3 million for five years. There are 20 investigators, and we've got multiple projects. We will, of course, be applying for refunding at the end of that period, but there are a very small number of those grants given. One of your questions was about data collection and research. In the future, there would be either larger supports for these national collaborative centres of research excellence, a longer duration for the grants or both.

CHAIR: Any questions?

Dr RYAN: What would be the optimal way of giving you permanent, long-term support for the sort of data collection that you've instituted but would no doubt like to continue in the long term? The issue with NHMRC or any other medical research grant, obviously, is the time limited nature of the funding and, sometimes, limits to the scope of what you can undertake. Do you have any thoughts?

Prof. Elliott: Money is scarce, but we know that there is some money that's spent that has been put aside for research. I think that we need to perhaps look at comparative schemes. I understand that other schemes—I think the ARC, but I'd have to check that—provide a much larger amount of money for centres of research excellence, which are national endeavours designed to bring networks of researchers and clinician-researchers together and also to provide capacity building for the next generation of researchers. I think looking at the way in which that funding is provided and whether it's commensurate with the number of projects and the number of researchers and whether five years is long enough to really make an impact would be worth reviewing. Sharon, did you want to comment?

Prof. Medlow: Yes. It would be wonderful if it were possible to not have to be in a competitive round all of the time, because a lot of time has to be spent creating those proposals. I can understand that, but, if there were some means of thinking that a research program—maybe it's competitively funded to begin with, but it's working really well and has been very effective. I wonder if there could be some sort of a mechanism for that to then evolve into sustained funding. I think it would have proved its value at that point, so that's a model I'd like to see.

Prof. Elliott: For example, NHMRC used to have a scheme called the enabling grant scheme to enable infrastructure—for example, to enable national surveillance or a specific mechanism. The projects had to be funded on top of that, but it provided security in the long term for an endeavour in an ongoing way. For example, we hope that FASD Hub Australia—which is the website for health professionals, policymakers and researchers—would be something that might get infrastructure funding. Similarly, the national data collection and the training for health professionals in how to use the diagnostic guidelines—those sorts of things are really key.

Dr RYAN: Thanks.

CHAIR: Thank you to all of you for your attendance today. If you've been asked to provide any additional information, would you please forward it to the secretariat within the next two weeks. You'll be sent a copy of the transcript of your evidence and will have an opportunity to request any corrections to transcription errors. Once again, thanks for giving us your time from all different places. It's been very, very valuable.

Dr Uink: Excuse me, Chair, did you want to hear from the Alcohol and Other Drugs Knowledge Centre, because there is an intersection with FASD?

CHAIR: I'm sorry. We didn't realise you were online. Would you like to introduce yourself?

Dr Uink: I'm the director of the Australian Indigenous HealthInfoNet at Edith Cowan University, which runs the Alcohol and Other Drugs Knowledge Centre, which is federally funded. The Alcohol and Other Drugs Knowledge Centre is Australia's only dedicated national online hub for Aboriginal and Torres Strait Islander information about alcohol and drug use, and research and policy. We do have a section dedicated to FASD, but we are in internal discussions around removing that section and renaming it around AOD use in pregnancy,

because we are concerned about the focus on single-indicator research and the single-indicator focus on complications in pregnancy around AOD, particularly with the absence of discussion around the impact of smoking and pregnancy.

CHAIR: You listened to Professor Elliott and her colleagues?

Dr Uink: Yes. As an Aboriginal woman myself, it's quite upsetting to hear that evidence. At the HealthInfoNet and AOD Knowledge Centre, we have a very strict evidence based approach to placing information on our database, which includes peer reviewed studies—not to say that all those peer reviewed studies are ones that we would recommend that practitioners listen to, because of the low levels of evidence contained within them. We encourage people and consumers to read that evidence, based on logic and best practice science. And we have grave concerns around some of the evidence that sits around FASD.

CHAIR: We might open up for questions. Monique?

Dr RYAN: Yes. I'm sorry, the interface is a bit complicated. We didn't realise that you were there. I do apologise for that. Could you explain what the nature of your concerns around the information are? Are you talking about the stuff that's on the hub that Professor Elliott was referring to or activities around FASD in general?

Dr Uink: On the hub, I note that, under the Aboriginal and Torres Strait Islander resources section, there are about 46 listed, whereas on our current FASD portal there are over 275 publications, 29 policy documents, 37 programs, 95 resources and 14 organisations. I'm not sure why the FASD hub hasn't captured those. The concerns centre on single-indicator research in pregnancy and this focus on single-indicator research of what affects neurodevelopmental conditions. As you would be very aware, it's very impossible to disentangle what happens in childhood development once baby comes out of the womb.

In the Fitzroy Valley study that's often cited, the exposure to early life trauma was removed from modelling due to low power in the sample size, and I don't believe that's been modelled or included again in models. The original focus of that project was alcohol exposure and exposure to early life trauma, although only alcohol was focused on. We also have other teratogens—smoking, cannabis use and methamphetamine use—that I haven't heard discussed, which also need to be screened for. I also gave a keynote presentation towards the end of last year to the International Family Nursing Association, pointing out international research with black mothers in America. For example, you could take a social factor such as racism. A mother's experience of racial discrimination in health care is associated with the same level of executive function deficit that is reported in the FASD papers, which raises the question of why we don't have a racism in utero exposure disorder. It sounds absurd, but, to me, that's the absurdity level when we talk about single-indicator research in pregnancy.

Dr RYAN: I think you raise a fascinating and incredibly important point, which is the intersection or compounding influence of things that can negatively impact children's early development. Do you have suggestions for us on how we could better understand how we can study these things and follow them longitudinally?

Dr Uink: Yes, absolutely. Birth cohort studies which are discussed are an excellent way. They're very limited in Australia for Aboriginal people in particular. Very few studies at the moment recruit Aboriginal people into birth cohort studies. We can follow those to look at a comprehensive set of factors that sit around pregnancy and then into childhood where you have enough power, enough representation, in your sample to be able to model the multiple influences. It's called an interaction effect. There are lots of ways that you can model that quite easily to understand the proportion of variance in individual differences in disease and healthy outcomes that are attributable to certain factors. Most often, they're not. What we see in international samples is that it is an interaction effect between multiple factors, so you could have maternal alcohol use and domestic violence exposure interacting to create what we see as an outcome in the child. There are also child health outcomes such as hearing, which was also very impaired in the Fitzroy Valley study. Again, there are limitations in the diagnosis and assessment of Aboriginal children with non-Aboriginal tools.

Dr RYAN: Such important issues—so important that we look at them in detail and well—come back to the last question that we were discussing with Professor Elliott and the team from the University of Sydney as to how best to do that. We're talking about things which need to be done in detail over a long period of time with people with the scientific knowledge and also the cultural sensitivity required. How best would you propose that we do that?

Dr Uink: There are examples. There's Professor Sandra Eades from the University of Melbourne, who runs the Next Generation study, which is the longitudinal birth cohort study of Aboriginal children. There's expertise in Australia around recruitment of Aboriginal families into birth cohort studies that could be funded. They just need

to have a whole holistic health focus in terms of looking at factors other than alcohol—alcohol is included as well—that bubbies are exposed to in their developmental journey, as well as correct assessment of their developmental abilities. There are opportunities for longitudinal research. We would strongly urge that comes from a holistic healthcare model to look at all the factors that impact child development.

There's also the Tackling Indigenous Smoking team who, although a service focused team, have research capacity to also look at the impacts of smoking and pregnancy and are doing quite a bit of work around preventing smoking and pregnancy. We have quite a substantive list listed on the Alcohol and Other Drugs Knowledge Centre research indicating some of the deficits and the health problems that come with smoking and pregnancy. A birth cohort study that truly looks at the multiple indicators of child development and maternal outcomes would be the way to do it.

Dr RYAN: Thank you.

CHAIR: Sorry that we didn't hear from you as part of that original group. Let me get it clear. You feel that Professor Elliott's work focused too much on just one factor. Is that your concern? That some kids who may have other neurodevelopmental risks may well have other causes rather than alcohol—is that what you're saying?

Dr Uink: Yes. The downstream consequence of that is—anecdotally from community, from my own community, from communities who speak with the Alcohol and Other Drugs Knowledge Centre work—

CHAIR: Where is your community, pardon?

Dr Uink: The Noongar community. I'm a Noongar woman.

CHAIR: Right.

Dr Uink: The downstream consequence is that if we have campaigns to have children assessed for fetal alcohol spectrum disorder then we miss opportunities to look at other factors in children's lives that could be contributing to the difficulties that they are presenting with.

We also have what we might call a re-inscription of a colonial narrative of Aboriginal mothers as unfit parents. And although a lot of work has been done to reduce the bias in FASD diagnosis, when you're essentially saying that the deficit is within the child and the family you're taking away from solutions around why there is such a level of alcoholism, for example, disadvantage, family violence and violence in the community to start with. So the intervention looks very different.

CHAIR: So it stigmatises from the beginning.

Dr Uink: It stigmatises from the beginning and it directs attention towards a very narrow level of intervention, rather than all the factors we know affect community health.

CHAIR: And have you made a submission to the inquiry?

Dr Uink: No, I haven't made a submission. I have here my submission on behalf of the Alcohol and Other Drugs Knowledge Centre. Our submission, based on FASD, is to communicate that we are moving away from that labelling on the website, and we'll be transitioning to labelling it around AOD use in pregnancy, again to look at those multiple indicators.

CHAIR: Okay. Your submission is here with the committee? Have we received it?

Dr Uink: I can send it through. I wasn't asked for a written submission. We have other broader recommendations on the dissemination of research for alcohol and drug use and policies for Aboriginal and Torres Strait Islander people, which is in that submission as well.

CHAIR: You will send that through?

Dr Uink: Yes.

CHAIR: If you could send that through to us as soon as possible, that would be good.

Dr Uink: Yes; no problems.

CHAIR: Hopefully we'll see that in the next few days.

Dr Uink: No problems.

CHAIR: Are there any suggestions for what you think we should do as a committee in our recommendations about FASD?

Dr Uink: I would question why there is an Aboriginal and Torres Strait Islander section on the FASD hub that isn't at least as comprehensive as the one provided on the Alcohol and Other Drugs Knowledge Centre, noting that we aren't specifically funded to collect that information, but we do it. We get captured in it.

The other broad recommendation is that, regardless of the condition we're talking about when it comes to alcohol and drugs conditions in Aboriginal and Torres Strait Islander populations, our stakeholders, who are our practitioners on the ground, tell us that they don't have the time to implement the evidence into the practice. They don't have professional development and work development opportunities. Our recommendation would be building in that professional network of practice where they can learn from each other. That is something that practitioners call for. That is something that was recommended in the DAP funding review, the final evaluation report, to mimic something like the National Best Practice Unit Tackling Indigenous Smoking team have, which we also are a part of on HealthInfoNet. Our recommendation would be a national best practice unit between alcohol and drug workers, policymakers and researchers for Aboriginal and Torres Strait Islander people.

CHAIR: Great. Thank you very much. Are there any other questions?

Ms JORDAN-BAIRD: I don't have any more questions, but I just want to thank you, Professor Uink, for your insights. They are really important. It's something for us to think about, what other uses that pregnant woman might be going through, like nicotine addiction and other things like that. It's a really important point you've made, so thanks for appearing today.

Dr Uink: Thank you.

CHAIR: Thanks very much.

Proceedings suspended from 15:27 to 15:38

CURTIS, Dr Michael, Research Fellow, National Drug Research Institute, Curtin University [by video link]

DIETZE, Professor Paul, National Drug Research Institute, Curtin University [by video link]

GRIFFITHS, Professor Paul, Director, National Drug Research Institute, Curtin University

GRIGG, Dr Jodie, Research Fellow, National Drug Research Institute, Curtin University

LENTON, Professor Simon, National Drug Research Institute, Curtin University

McBRIDE, Professor Nyanda, Prevention and Early Intervention Team, National Drug Research Institute, Curtin University [by video link]

McNAMARA, Dr Kelly, Senior Lecturer, Obstetrics and Gynaecology, University of Newcastle [by video link]

QUINTRELL, Ms Ebony, Private capacity

TAYLOR, Dr Nicholas, Research Fellow, National Drug Research Institute, Curtin University [by video link]

CHAIR: Welcome. Although the committee doesn't require you to give evidence under oath, I should advise you that this hearing is a legal proceeding of the parliament and therefore has the same standing as proceedings of the respective houses. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. The evidence given today will be recorded by Hansard and attracts parliamentary privilege. I invite you to make a brief opening statement.

Prof. Lenton: It's wonderful to have the opportunity to speak with you today. We put in a large 44-page submission, back in November 2024, with many hundreds of references attached to it. I don't think you all read it on the plane on the way over—that's fine—but let me just say that each of the people we have online will speak to a different part of that submission. Rather than taking up a lot of time summarising a large document, let me just tell you that we have addressed the following topics: the cost of alcohol and other drugs in Australia; the response to alcohol related harm; school alcohol and drug education programs; the father's contribution to alcohol exposed pregnancy, harm reduction, drug overdose and toxicity; and prisons and people who inject drugs. Across those topics, and to any other questions that you have, we'll respond as appropriate. That's about it from us in terms of an opening statement.

CHAIR: Great. Thank you very much. Ms Quintrell, would you or Dr McNamara like to make an opening statement.

Ms Quintrell: Yes, I have an opening statement on behalf of both of us. Thank you for the opportunity to appear before the committee. I'm an epidemiologist presenting today in an individual capacity as a research fellow at the University of Western Australia. I've recently completed my PhD examining alcohol use disorder and alcohol withdrawal in pregnancy and the use and safety of pharmacological treatments. Joining me online is Dr Kelly McNamara. Dr McNamara is an obstetrician and gynaecologist at the University of Newcastle, based on the Central Coast of New South Wales. She provides clinical and research expertise in substance use in pregnancy, and her PhD examined links between substance use disorder, unplanned pregnancy and birth outcomes, informing contraception pathways within alcohol and other drug services. Dr McNamara recently contributed to an international review of clinical guidelines for the management of alcohol use disorder in pregnancy.

There is no known safe level of alcohol use in pregnancy. Therefore, abstinence is recommended due to the risk of harm, including fetal alcohol spectrum disorder. However, not all women are able to stop drinking without assistance. There are significant gaps in clinical guidance for women who enter pregnancy with an alcohol use disorder, which is a medical disorder characterised by repeated or continuous use of alcohol, with many people experiencing dependency. Guidance is lacking on how to best identify alcohol use disorder, manage it safely and provide pregnancy-specific care. These shortcomings are evident in national and international guidelines and reflect a broader lack of research in this area.

Alcohol use during pregnancy in Australia is common, with cohort studies suggesting up to 60 per cent of women consume alcohol at some point in pregnancy. Although many women reduce or cease consumption once pregnancy is identified, harm may have already occurred. A small proportion continue to drink at harmful levels. Despite broad use of validated screening tools, alcohol use remains underrecognised in maternity settings, with as few as five per cent of women disclosing use to their provider. Complicating this, alcohol use and alcohol use

disorder are poorly distinguished, and many women with drinking patterns suggestive of a use disorder are not referred to substance use pregnancy services.

The reasons for underrecognition may reflect multiple intersecting factors. Women may be reluctant to disclose use due to stigma, fear of child protection involvement, perceptions of low risk of harm or lack of effective interventions to support abstinence. In addition, alcohol use may not be asked about in ways that enable open and honest disclosure. Clinicians may lack time or training to properly implement screening, and available screening tools may not capture all aspects of drinking. As a result, alcohol use disorder in pregnancy is often missed or identified late, limiting opportunities for timely treatment, coordinated pregnancy care and appropriate follow-up for alcohol exposed infants. Often the first disclosure of alcohol use in pregnancy occurs many years later, when the child is engaged in paediatric care for behavioural difficulties.

Current pregnancy guidelines lack specific guidance for caring for pregnant women with an alcohol use disorder, including effective interventions to support cessation and appropriate obstetric management. As a result, care is inconsistent and clinicians must navigate complex decisions without adequate support. Medications such as naltrexone and acamprosate are effective for alcohol use disorder in the general population but are underused and rarely considered in pregnancy. Although safety data in pregnancy are limited, available evidence does not indicate harm.

In the absence of clear guidelines on pharmacological and psychosocial treatments, women with an alcohol use disorder in pregnancy have very few treatment options despite alcohol's severe teratogenic effects. We recommend three key actions: first, to invest in research to improve detection and management of alcohol use disorder in pregnancy and to develop evidence based approaches to pregnancy care; second, to support research into the safety and effectiveness of interventions for alcohol use disorder in pregnancy, including psychosocial and pharmacological treatments; and third, to invest in the development of a multidisciplinary expert consensus living guideline for the detection and management of substance use disorders, including alcohol use disorder, in pregnancy.

Fetal alcohol spectrum disorder is preventable yet has lifelong consequences for affected children and families. When evidence and guidance are lacking, the burden of complex and challenging decisions is placed on women and clinicians, often resulting in delayed and fragmented care. We hope to see meaningful progress in this area. Thank you for the opportunity to speak.

CHAIR: Thank you. Dr Ryan.

Dr RYAN: Thank you all for appearing in front of the committee today. I might start with the National Drug Research Institute, but I'll allow you to determine which one of you is best placed to answer this question. We've heard from a number of people who've talked to us today about the need to address the complexities of the tax system around alcohol in Australia. A couple of people have suggested that the wine equalisation tax is contributing to some of the issues we see, with very low priced wine and the potential for abuse of that by people who have an issue with alcohol. Would you agree with other people who've appeared in front of the committee today that we should look at an overall simplification and modification of the alcohol taxation system in Australia to perhaps better align the fiscal objectives of the taxation and the potential health impacts?

Prof. Lenton: I'll use the Australian vernacular and handball that to Dr Nic Taylor in our Melbourne office, who wrote our submission on that matter.

Dr Taylor: In short, yes. In long, Australia's wine tax isn't based on the strength of the alcohol whereas our taxes on beer and spirits are. As a result, we've seen a real growth in cheap wine being made available, and, over time, it's become our most consumed alcohol product. So, yes, we really need major revisions to the taxation system, specifically the removal of the wine equalisation tax in some form, and for that to be restructured so that wine is taxed based on its alcohol content or, if that isn't an option for some reason, for there to be some sort of minimum price for alcohol that is related to the amount of alcohol contained in each product.

Dr RYAN: Thank you. We discussed the issue of purchasing alcohol online for home delivery with an earlier witness, and you've touched on it in your submission as well. I know that you've expressed some concerns that the people who access alcohol out of hours online tend to be those people who are at higher risk of harm from it. Could you speak to your concerns around that, particularly with respect to whether or not there are appropriate warnings when people go to buy alcohol online as to the potential complications associated with alcohol use. That would include warnings for women of childbearing age who might be pregnant.

Dr Taylor: Alcohol is very easily and readily available online, and we do not have a real system for monitoring the sale of alcohol online. I think that speaks to a broader issue that we have. Beyond taxation—a national monitor of just beer and spirits—we have very limited knowledge of how much alcohol is sold, what

price point it's sold at, where it's sold, when it's sold. So, yes, in terms of online shops, as well as other retailers and home delivery, we really need to make point-of-sale alcohol monitoring a part of our policy to be able to actually have any understanding of it all—of how these different markets work and how they can influence harm.

In terms of the second part about warnings, there are very few warnings or checks online. Some of the bigger players or retailers may point to some of the safety checks that they've put in place, but there are very, very many different alcohol retailers online that take lots of different forms, with varying levels of checks, including websites that themselves may not be alcohol retailers but that facilitate the sale of other people's alcohol. This may be something like Dan Murphy's Marketplace, Dick Smith or Kogan. Again, there is very little monitoring in this space, there's very little warning around the nature of these products, and it's definitely something that's a blind spot for policy currently.

Dr RYAN: So is this an issue with the legislation and the regulation around the selling of alcohol, or is it a problem with enforcement? We heard from ABAC that they had no concerns around advertising or regulation of alcohol sales in Australia.

Dr Taylor: Realistically, it's both, and policy on this differs state by state. We know that there are issues with sales, with different states not necessarily following the same rules or regulations that another state might. We know that there are issues—I'll give the marketplace example again. We've heard accounts of people who don't actually have a licence to sell alcohol being able to sell alcohol through these marketplaces. In the online space, it's very hard for enforcement to have any knowledge that that's even happening until after it's happened, and it's very difficult for enforcement to actually regulate a lot of this behaviour when they don't have the policy to back them up, particularly when there are such discrepancies between policies from state to state.

Then you have the taxation issue. Taxation is handled, obviously, by the ATO—that's a national department. Coordination—nationally and across different states—differs by state, and then there's the extra complexity that comes from different states having different regulations and different investment in enforcement.

Prof. Lenton: Could I add a comment, please. My understanding is that ABAC is actually an industry constituted body of players within the alcohol industry and advertising associated with that. It doesn't surprise me that such a body says there's nothing to worry about in terms of the promotion of alcohol. I think there are vested-interest questions that need to be asked, and my sense is that we need to have these matters, which are incredibly important from a public health perspective, regulated by governments, not left in the hands of industry bodies for self-regulation.

Dr RYAN: Thank you, I appreciate that.

CHAIR: Alice.

Ms JORDAN-BAIRD: Thank you all for appearing before our committee today. I've got two questions. The first is in relation to trends of alcohol use among young people. We've heard from a previous witness that the 18 to 24 age cohort is seeing an increase in alcohol use in younger women and that's trending up. I was wondering if that is what your research is saying as well. You look quite concerned there, so maybe you disagree with what we've just heard, but my question is why you think that might be happening. Why are we seeing an increase in alcohol use in that young cohort of women?

Prof. Lenton: There may be other people on the panel that would like to comment, but I'd again hand over to Nic. Nic, did you want to comment on the issue of gender difference in young people's drinking?

Dr Taylor: Yes. It's an interesting question in that we know that alcohol use across the population is declining in most age groups. But was this a proportional increase, or is this an overall increase in drinking that's been reported to the committee?

Ms JORDAN-BAIRD: I'm not sure. An overall increase was my understanding.

CHAIR: That was the suggestion, yes.

Dr Taylor: I will say this is a bit of a complex space. Women's drinking is lower than men's drinking. We do see movement in this space. We do see—some people have described it as—gender convergence, but my understanding is that men's drinking is dropping faster, and I believe that overall in the population there is a decline in women's drinking. However, it's not at the same rate as men's drinking.

Ms JORDAN-BAIRD: Interesting. What were you going to say?

Prof. Griffiths: Generally, the trends are, in younger age cohorts, downwards, but I would suggest that, given that the data can be expressed in different ways depending on how you look at it, we could reply in a written follow-up to that question if you wanted us to produce something more definitive, because it is quite a

complicated issue. Nonetheless, I think not just in Australia but internationally—in most countries—we're seeing a decline in youth drinking trends at the moment.

Ms JORDAN-BAIRD: Thank you.

Prof. Griffiths: And more pronounced in male populations.

Prof. McBride: I'm happy to provide a bit of information. I spent a very short, brief [inaudible].

Prof. Lenton: Nyanda, your audio is breaking up.

Prof. McBride: This is content based on a summary that I provided for the 2026 roundtable, and it's based on a qualitative study with high-risk youth in regional areas. Qualitatively, what we find is that they are tending to buy alcohol which is [inaudible], which tastes like [inaudible]. We are seeing a shift in women's alcohol use.

Prof. Lenton: Sorry, Nyanda, it's really breaking up again. You might have to provide some written evidence.

CHAIR: Yes, if you could make a submission for us, that would be good.

Prof. Griffiths: We will respond to this question specifically.

Prof. McBride: Okay, I'll take this on notification then.

CHAIR: That'd be great.

Ms JORDAN-BAIRD: That'd be great. I have one follow-up question. It's around pill testing. I'm a big supporter of pill testing, and I know we've got some really successful examples around the country of it working really well at festivals. I see that your submission specifically calls that out as well. I was wondering if you could expand on that and if you think there might be an opportunity to expand the programs we currently have and even look at settings other than festivals.

Dr Grigg: I can talk to that a bit. The question was around what else we can be doing to expand. Obviously, we've got the three active services at the moment—New South Wales, ACT and Vic. Unfortunately, Queensland's is no longer operating due to the change in government. I think it's widely agreed upon that we need both fixed sites and mobile sites, and most of the existing services are doing both. I think that needs to continue.

There's also the acknowledgement that, even in those jurisdictions that do have drug checking, it's not reaching everyone that needs to access it. And those windows that people are able to access it with are very small; sometimes it's just one afternoon due to a lack of funding. They're operating under really challenging political circumstances. So I think that needs to be broadened to access more people. That might mean postal services or looking at other ways internationally that people have submitted their drugs. We've got research at NDRI on that very topic at the moment, so we can probably provide some further information on notice. But, yes, I think it needs to be expanded across all jurisdictions, because obviously there's a huge gap in Western Australia, particularly with some of the high risk stuff we're seeing. I think there's a huge range of things we need to be doing to expand those services.

Prof. Lenton: I go to your earlier question about evidence around effectiveness and so on. I think there are two quick points that I'd want to make. The first thing is that there's good international evidence and growing evidence in Australia that, when people attend drug-checking services when drug checking services are established at music festivals and other events, the number of people that are required to be transported to hospital for treatment for serious drug related complications goes down. That's now been well established. The second thing that's important is that, for many people that attend drug-checking services, this is the first time ever that these young people have ever discussed their drug use with a trained professional and a lot of what goes on at a drug-checking service isn't just about the chemical testings of the drugs. It's also, for many people, the first conversation they've had about what they were intending to use, why they were using it, what they actually used, what they expected would happen, what some of the potential complications and risks are and how those risks might be mitigated, including by not using drugs. When we talk about drug checking, there's often a focus on the chemical checking, but actually there's a much bigger intervention that happens, which is a unique opportunity for many young people to discuss this important health issue.

Prof. Griffiths: Prior to this, I was responsible for the EU's early warning system on new psychiatric substances. I think one of the upstream things that drug checking provides in very dynamic and complex drug markets, where we're seeing a lot of new substances appearing and we're seeing a lot of mixtures appearing is that they can form a very important information point for actually keeping track of what's happening in the drug market, which is increasingly very dynamic and very complex, often with quite nasty new challenges appearing in it. So I think that, as well as the intervention opportunities and the public health role as an epidemiological early warning system role, in terms of keeping policy informed of market dynamics, they can play a useful role.

Dr Grigg: In terms of thinking about expansion, I know one of the problems that has occurred is around liability and insurance. I know that there have been actions within Victoria in order to make it more feasible. From a national perspective, if it was more broadly recognised within a national framework, I think that might assist with insurance and those challenges in terms of implementation.

CHAIR: Ali.

Ms FRANCE: Thank you all for appearing today. We're really grateful. I could ask so many questions on all of the stuff that you've provided, but I'm most interested in access and, particularly after COVID, the increase in people being able to get alcohol at all hours and also drinking more at home. Do you have evidence that having a cut-off point actually makes a difference? Is there any international evidence? Could it also create a black market effect because everything's so immediate and online and people have become so used to that? Do you have evidence around what works around 24/7 access?

Prof. Lenton: Before Nic takes off, can I clarify? When you're talking about a cut-off, are you talking about a closing hour in terms of late-night trading, late-night delivery services and those kinds of issues?

Ms FRANCE: Some of your recommendations say that delivery should be limited to 10 pm. Does that then create a black market after 10 pm? What's the evidence overseas? Has anyone done this?

Dr Taylor: In terms of home delivery, it is more of an emerging space, but there is a lot of literature in terms of both on-licence and off-licence venues that show that the reduction in hour of service is significantly associated with substantial reductions in harm as well as consumption. I am doing a bit of illicit alcohol or black market research. Trading hours is not internationally one of the conditions that we've seen particularly give rise to a black market. I wouldn't think there would be a black market in that relatively small window of time when legal alcohol is available for most of the day, quickly delivered, as you've said. But it is worth noting that, in our research on illicit alcohol so far, there is already an illicit alcohol market in Australia, and there are illegal products that are already available through home-delivery apps with the current conditions that we have. I don't think we should be really concerned about giving rise to an illicit alcohol market more than regulating the market so that the current illicit market can be reduced.

Ms FRANCE: Thank you.

CHAIR: Sam?

Mr BIRRELL: Coming back to the question on the home delivery of alcohol and—I suppose it might be for you, Nic—regulation or enforcement, if I order a pizza or whatever, I think those companies now say, 'We can deliver you alcohol as well.' So I'll order 12 cans of beer or whatever it is—

Dr RYAN: Twelve?

Mr BIRRELL: I don't order that. I don't drink beer with pizza. I just wanted to get that on the record, Dr Ryan. But let's just say that I did order 12 cans of beer. Does the person who's delivering me the pizza, the delivery person, have to have a responsible service of alcohol qualification or certificate to see whether I shouldn't be served any more alcohol, as I would if I were ordering it in a restaurant or a pub? That's the first thing. Do they check for ID to see that I'm over 18? Are those things legislative or enforcement?

Prof. Lenton: Do you want to start with that, Nic? I've got a couple of comments as well.

Dr Taylor: Yes. I will say it is state dependent, to some degree. At least, that's my understanding. I believe that the person delivering the alcohol is meant to make that check. I have been involved with some research projects where we have had people make these orders who may appear to be under the age of 25, so they should be getting checked. I believe that in 25 per cent of cases we didn't get ID checked, so there is a definite gap there.

Sorry, was there more to that question? I was mainly caught up on—

Mr BIRRELL: The question was mainly: is it a legislative issue where it needs to be legislated that that person is required to do that? Or—I take your point that it's probably state dependent—is it something where the legislation exists, but it's just not enforced because this is probably an evolving method of delivering alcohol to people?

Dr Taylor: It's very difficult to imagine how that could reasonably be enforced at all without the liquor regulator also being at the door when you get your home delivery. I would suggest that it really does need to be a policy issue in that the ID check needs to be made, potentially, online in some way or at a point where that can be verified and can be monitored by the regulator because we can't regulate every delivery to every person's door. We can't guarantee that the person who's making that delivery is going to make that check every time. I will note as well that I believe at some of these companies there's an incentive for the delivery person to make the delivery; I believe that, in some cases, if you fail to make a delivery, there is some sort of financial penalty to that. It really

shouldn't be these people who are almost in the most vulnerable position in the chain that we're relying on to make that check every time.

Prof. Lenton: I have a couple of quick comments. I think the question is an incredibly important one because, really, what it's showing is that in this dynamic environment, where things are changing very rapidly, there are things happening now that we couldn't even have imagined two years ago—where you've got low-status rideshare drivers on motorbikes delivering alcohol to people, putting it on their front doorstep and taking a photo to show it's there, but there's no check done in terms of people's age and so on.

I think this is a new area. It's one where there are obvious probably regulatory as well as legislative things that need to be tied down, and we're only now starting to understand what some of those gaps are. I don't think we have answers to them, but I think there are serious questions which we do need to find answers to because we know that these kinds of matters, in terms of the responsible service of alcohol, are one of the important measures of alcohol related harm, particularly when we're talking about young people's access to alcohol. In the olden days, we used to knock it off from our parents' liquor cabinet. Now you can get it delivered straight from the liquor store to your front door. I think that's a problematic issue that we need to sort out.

Mr BIRRELL: Further to that, I'll tell you what I think is happening, anecdotally, and COVID probably exacerbated this. I would say that the percentage of people who drink alcohol at home compared with people who do it at a venue has massively increased from 10 years ago to now. And this maybe goes to taxation, bureaucracy, red tape or whatever it is, but there's a huge difference between the cost of drinking alcohol in a venue compared with drinking the same amount at home. These are my rough calculations, based on alcohol purchases that I make. A pint of beer, which would be 560 millilitres, in a pub would be about $12 to $14. A carton of beer, which I calculate to be 9,000 millilitres of alcohol, would be about $60. So it's a huge expense in a pub. That means that more people are drinking alcohol without getting it from someone who's got a certificate in the responsible service of alcohol and not in a venue where they can be observed and monitored. Is that a concern?

Prof. Lenton: I think it is a concern. I'd also note that there are lots of products that we consume at home that are a lot cheaper than if we consumed them elsewhere, like steak at home versus steak in a restaurant. So I think that's something that's across the board, for all products. But alcohol is no ordinary commodity, as we know, and we need to be identifying where these problems are and resolving them. I don't have the data in my head about rates of consumption at home versus at a venue. We know about preloading; it's more of an issue for young people—drinking before you go out. Nic, did you want to comment on that issue of at-home drinking versus on-licence drinking?

Dr Taylor: Yes. Much of the research in Australia shows that the predominant place of drinking is at home, and that's prior to COVID. Yes, it became more and more at home during COVID and subsequently, but it has been the most predominant drinking place in Australia for a while. I do want to add, though, that taxation can't be the cause of this disparity between on-licence and off-licence. The taxation of the alcohol products in the off-licence is the same as the taxation of the alcohol products in the on-licence. There are other costs associated with running an on-licence venue and there are other reasons and factors that go into the decisions behind those price points that are likely driving the more substantial increase that we've seen in these venues. Just to reiterate that point, the off-licence is affected by the same taxation regime, so a divergence can't be solely due to the tax system.

Prof. Dietze: Could I just jump in and add to that? I think what Nic was sort of pointing towards was that one of the issues is that the price per standard drink in a licensed venue is just so much more than it is in a bottle shop. So what people have been arguing for is a minimum unit price to try and adjust for that; that would effectively make bottle shop alcohol purchases more expensive. The taxation system can't necessarily adjust in the way that Nic was outlining, but something like a minimum unit price would actually mean that costs could be equalised more.

Mr BIRRELL: I'm coming from a regional electorate where we've had a lot of issues of social isolation that cause a problem, and alcohol use at home probably has exacerbated that. Where people used to come together and go to pubs, even though there were issues around alcohol and driving and those sorts of things, there was a social benefit to that. So I would like us to think about the social good that comes from responsible alcohol use and whether there's a way of people doing that together rather than sitting at home. That's more of a comment. I'm interested if you've got a view on whether we should be looking at that.

Prof. Griffiths: I would say more that your question, to reflect on the earlier part of it, is: how do we look at ensuring the same regulatory standards for home delivery and home consumption as we do for public consumption? I think that's where the issues are, where the policy gains are and where the policy levers probably are. Probably it's not that we need less attention on public drinking; we need more regulatory attention on what's

happening in terms of market developments and in terms of home drinking. That would be my personal opinion. It's something that I think we would also like to see more research on, to be honest.

Mr BIRRELL: Thank you for that discussion. I appreciate it.

CHAIR: I've got a few questions, if we've got time. First of all, to Dr McNamara and Ms Quintrell, we've had some conflicting evidence today; I don't know if you saw the previous discussion—

Ms Quintrell: I didn't catch all of it, no.

CHAIR: with Professor Elliott and her group and Dr Uink from the Alcohol and Other Drugs Knowledge Centre about fetal alcohol syndrome disorder. It raised concerns about the stigmatising effect on Indigenous communities of the concentration on fetal alcohol as a cause for neurodevelopmental problems in kids, where there may well be multiple other risk factors—in particular, frightening mothers about admitting alcohol use during pregnancy. Can you reflect on that for the populations that you've studied?

Ms Quintrell: I might handball this to Dr McNamara; she has clinical experience which might be helpful in answering that question.

Dr McNamara: I will speak to that but from the maternal side rather than the paediatric side, as I work on that side of the patient spectrum. There is stigmatisation of everyone's alcohol use, and this does have impacts on the Indigenous population. There is a prevailing misunderstanding in the maternity community, and perhaps more broadly, that fetal alcohol spectrum disorder is a disease, or a disorder, that is most common in Indigenous populations. Whilst there are populations with increased prevalence, the bulk of women that use alcohol during pregnancy in Australia are non-Indigenous women, and that's not clear in the rhetoric.

There's the typical story of an older, highly educated woman that continues to use alcohol during pregnancy and that doesn't get screened for alcohol use during pregnancy because her providers perhaps don't recognise that she might be somebody that is using alcohol during pregnancy. She doesn't come under the watch of child protection services because she doesn't meet preconceived ideas of what somebody who might be consuming alcohol in pregnancy might look like. You can take that with the flip side of an Indigenous woman that might be overexamined in this regard by clinical services and child protection services and that has a very real sense of fear around the reporting of alcohol. I do think it's a concern—the focus on harm for the Indigenous population.

I caught the tail end of the last discussion, probably the last three or four minutes. The evidence being presented, I would have largely agreed with—that I heard, regarding this issue. Does that answer your question?

CHAIR: Sort of. You're suggesting we need to take a broader view. The whole community is involved in this. That we need to be—

Dr McNamara: Yes. There are women throughout the spectrum of society consuming alcohol. There are really three ways in which women consume alcohol in pregnancy. There's the woman that doesn't recognise the risk of harm that she is putting the child under by consuming alcohol in pregnancy, and that's quite amenable to public health campaigns. And there are some of those ongoing at the moment. There's the woman that perhaps didn't realise she was pregnant and consumed alcohol up until the point when she recognised she was pregnant, and then she typically stops or tries to reduce use, but that harm may have already been done in that timeframe. And then there's a group of women with alcohol use disorder, which is what our submission was mainly focused on. These are women who can't just stop in pregnancy. It's not a homogenous situation across society, but there are women from all walks of life consuming alcohol in pregnancy.

CHAIR: That's important. I've got some other questions, and perhaps, Professor Griffiths, you could start. Are we seeing any trends in Australia—I think you've already mentioned the synthetic opioids and nitazene et cetera that are becoming available here—that we should be worried about and should be doing more to look for?

Prof. Griffiths: I'll make a brief opening comment on that and then I'll hand to Jodie. I'm quite new to Australia, but what we're seeing is a very dynamic globalised drug market. We're seeing an increasing emphasis on synthetic drugs that can be produced near to consumer markets, and we're seeing much more complexity in terms of the products that are arising and the mixtures that are sold. There is a blurring of boundaries between illicit drugs, medicines, study aids and health food supplements, so things are getting very complicated. They're changing very quickly. We see the internet, digitalisation, enabling that market, and I think our policies and surveillance systems are struggling to keep up. I'm quite new to Australia, so I'll hand over to one of my colleagues who is more informed about the dynamics of the situation here.

CHAIR: Sure.

Dr Grigg: I'll just make a brief comment from the perspective that I work in, which is mainly around monitoring trends in ecstasy and related drug use in party settings. From my perspective, it is a concern. The

higher potency novel synthetic opioids, like nitazenes, wouldn't have really been on our radar for young people using stimulants like ecstasy, ketamine and cocaine, but now those opioids are infiltrating those markets, and they've been detected increasingly in those types of drugs. That's quite an unprecedented concern for young people who have no experience with using opioids and wouldn't really know how to identify an opioid overdose or know how to respond. It's a completely new risk, from my perspective, and we should be doing more to monitor the market to detect that.

CHAIR: Should we be doing more with public health campaigns about public availability of naltrexone and so on?

Dr Grigg: Yes. I do believe the harm reduction campaigns from the Western Australian government have started to acknowledge the risk of nitazenes and availability of naloxone. I don't know how broadly that's being done, but I do think that's worthwhile.

Prof. Dietze: These things are really important. We've identified those new substances, but we've also shown, just recently, the massive shifts that we've seen in relation to heroin and methamphetamine. We shouldn't forget those key substances as major drivers of drug related harm in this country. We've shown that the purity adjusted price of heroin has declined by more than 50 per cent since 2014. To use an analogy that might make sense in relation to alcohol, if you went up to a bar and you asked for a pot of beer and someone gave you a pot of whisky for that same price and you consumed that whisky in the way that you would consume the beer, you're going to feel a bigger effect, aren't you?

That has driven a whole range of harms in relation to heroin. We've seen an increase in ambulance attendances connected to heroin and an increase in opioid related deaths that are connected to heroin. At the same time, we've also seen a similar shift in the methamphetamine market. That took place in about 2014. Right across the country, we now have high-purity methamphetamine at record low prices. We have seen a lot of the indicators of harm tail off, but they're still at record highs. They're higher than they ever were in 2009 and so on.

We've got to remember that, while we need to focus on these new and emerging substances, we also need to have this focus on some of the traditional ones in Australia that have been unaffected by COVID, wars and all of those sorts of things. And our policy response is still lacking. We don't have needle and syringe programs in prison. We don't have comprehensive opioid agonist therapies. We haven't looked at things like slow-release oral morphine and the things that we mentioned in our submission. There's so much more that we need to be doing in that space as well.

CHAIR: Thank you. Professor Lenton?

Prof. Lenton: Paul Griffiths is absolutely right. We're living in an international, very dynamic drug market where all these things are changing very quickly. We've got various monitoring systems monitoring these things in Australia. So far, we haven't seen a huge flood of these new, very potent opioids in particular hitting our shores. But they have appeared, and they've appeared in strange things like cannabis vapes and a range of other things where you wouldn't expect them. You would have heard evidence from people around the country about that stuff. We really need to be mindful of the threat posed by what's happening internationally and be doing everything we can to be monitoring all different sorts of places where these drugs might emerge.

One of them, which we already mentioned once this afternoon, is the opportunity for festival related drug checking to tell us a lot about what's happening in the community now—not what happened with someone who died two years ago but what's actually happening today and yesterday. That's an incredibly important tool in terms of monitoring for these new substances emerging. From a public health point of view and from a surveillance point of view, expanding drug checking just from that perspective would be incredibly helpful in terms of preventing Australian carnage from these substances.

CHAIR: I'm glad you brought up cannabis, because I've got some questions about that as well. But, Professor Griffiths, you wanted to make a comment?

Prof. Griffiths: I'll just finish and try and bring together my colleagues' comments. We live in a much more complicated drug market, where all substances seem to be cheaper, more widely available and increasingly available at high potency. You've got new substances coming in, and you've also still got established substances—we can't take our eye off that important ball, and Professor Dietze is completely correct about that. I think, again, we have to see this global connection. The increased production of heroin and methamphetamine in some Asian countries at the moment is probably partly responsible for why we're seeing increases in purity and potency and decreasing costs here.

I do think, at the same time, though, we need effective early warning systems to keep on track with changes in the market. We have to see the market holistically. We have very good data sources in Australia, but there's still, I

think, a need to join them up better. And it's important in this area—you need, I think, coordination at the federal level, because, really, you've got to bring these different datasets together and you've got to create a real-time space for information exchange.

CHAIR: Yes. We're running out of time—one last question I have relates to evidence we've heard in this committee of enormous increases in the imports of medicinal cannabis. I wonder whether you feel this is contributing to the problems we have with alcohol and other drugs as well, as a sort of add-on for people. Do have any concerns about that?

Prof. Lenton: Can I just clarify—when you're talking about the importation of medical cannabis, are you thinking of illicit importation or are you thinking of importation through the system?

CHAIR: Through the system.

Prof. Lenton: I think, with the way the medical cannabis scheme has unfolded in Australia, there've been some benefits, but there've also been some costs. You will know that very early on, from 2016, when the scheme was first set up in Victoria—and then other states caught on and then we had Australian federal legislation—it was very tightly regulated and there were only a few conditions for which it could be used. Then what we saw was advocating from industry, saying there was too much red tape and that people weren't able to get their medicine and so on, so we saw growth happening outside of the regulatory system through special-access arrangements. What has happened is that, since 2019—the number of prescriptions for cannabis per year is now 10 times higher than it was back in 2018, so there's been a huge expansion.

And what's happened is that we've seen vertical integration, where companies set up cultivation, manufacturing of products, medical assessment, prescription and online delivery. That's a very concerning development, because the ability for proper scrutiny of this has been undermined. We saw the TGA last year institute an inquiry into this.

So we've gone from a very tightly controlled system which had its problems to, now, a system that is very unregulated. There are many people who are on medical cannabis, many of whom will have legitimate reason for that—but there are questions about the way the system has been set up. For me, the concern is about the commercialisation of the medical cannabis system in Australia.

CHAIR: And the vertical integration.

Prof. Lenton: And vertical integration—that's absolutely right. We think it's very timely that the TGA is looking into it and that the Commonwealth is looking into it as well. From my point of view, I think that's important.

CHAIR: We have run out of time, but I know there are many more questions we could have asked you. Thank you for your time, both here and online. It's been very valuable. If you've been asked to provide any further information, could you please deliver it to the secretariat within the next two weeks. You'll be sent a copy of the transcript of your evidence, and we'll have an opportunity to request any corrections to transcription errors. If you don't have any questions of us, I just thank you very much for all the effort you've put in.

LUKJANOWSKI, Ms Sandy, Chief Executive, Injury Matters

[16:38]

CHAIR: Hello. Although the committee doesn't require you to give evidence under oath, I should advise you that this hearing is a legal proceeding of the parliament and therefore has the same standing as proceedings of the respective houses. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. The evidence given today will be recorded by Hansard and attracts parliamentary privilege. To assist with the transcription of the public hearing, it would be appreciated if you could please state your name before responding to each question. If you'd like to make a brief opening statement, that would be great.

Ms Lukjanowski: I'll keep it really brief because I know that you've been having people going over time and it's shuffling back. I'm conscious of your evening. Very quickly, I wanted to introduce Injury Matters as a not-for-profit organisation that innovates and delivers injury prevention recovery solutions that empower people, organisations and policy makers. We're based in Western Australia, and we support informed, safer choices. We work in areas from road safety and trauma recovery to falls and substance related harm. We also provide vital, frontline education support programs. We equally support critical research that enables agencies and policymakers to make informed decisions that help to mitigate the personal and broader economic impacts of injury within the community.

I think it might be easier if I skip to what questions you've got, and then we can utilise the time in the best possible way for you.

CHAIR: Ms France, would you like to start?

Ms FRANCE: Yes. Thank you so much for appearing today. We really appreciate it. Do you want to give us a little bit of an overview of your older adults pilot and what you found? Some insights into that would be great.

Ms Lukjanowski: We, not too long ago now—I think it was towards the end of last year—finished a pilot program that was funded through Healthway, which piloted the use of the ASSIST-Lite tool. That's a world renowned tool that's been put in place to support allied health workers working generally with older adults but mainly in regional areas. That's where we focused the pilot because we recognise that there is a disparity between what's available within regional areas and what's available in the metro area. Within that, we provided a lot of education and assistance to close to 100 allied health support workers within one region to help upskill them so that they could ascertain and understand where risk factors were. And they could potentially look to cut off usage before it started to become problematic and divert patients to appropriate services and supports to enable a healthier community and better outcomes. We know that there are strong links between alcohol and injury.

The main thing that we took away from the pilot was that our allied health support workers were not adequately trained. They weren't confident in knowing where they could refer somebody to, when they should intervene, when it is problematic or when it's valuable for them to say something and also that they have the tools to be able to start some of those conversations. This really helped them to have a very clear checklist and to be able to help them to ascertain: 'Okay. This looks problematic, and this is a pathway within which I can support this person.'

Ms FRANCE: Would you say—I think Dr Mike raised it earlier—that you see a role for an alcohol and other drugs nurse navigator and some sort of education of allied health professionals and GPs and that sort of thing?

Ms Lukjanowski: Yes. Educating the workforce is critical because they're our frontline that are there at the coalface that can potentially work in that prevention area. At the moment a lot of the funds and the investment need to go to crisis and end-care types of goals as opposed to trying to cut it off before it happens. I know that in the previous group there was talk about whether or not public health campaigns might be beneficial. I think that there is definitely a role for things like public health campaigns that heavily look at the behaviour change, how we can help people to understand what problematic alcohol intake looks like and what the possible impacts are, but we would need to dovetail that with what the current issues with alcohol advertising are because we're not going to be able to match the volume that is probably there across the market with a public service campaign. It would be really important to have a look at how we scrutinise what's actually making it through whether it's on free-to-air TV or on digital marketing.

Ms FRANCE: Thank you. That was useful.

CHAIR: Alice?

Ms JORDAN-BAIRD: Thank you for appearing before our committee today. You mentioned before you did some work in the road safety space. I was wondering if you could expand on what that was. Was it in terms of drink driving or awareness—I'd love to hear from you about that.

Ms Lukjanowski: In Western Australia we run the Road Trauma Support program for anybody that has been impacted by a road crash in Western Australia irrespective of the fault or blame. We see everybody from a police officer, a non-professional first responder, the person that caused the crash right through to maybe somebody that's lost a loved one in a crash and that whole breadth there in between. But what we also do know is that alcohol in Western Australia impacted 9.5 per cent of fatal road crashes in 2023. That's one of the most recent stats that we have around what that looks like and trying to quantify that a little bit. That's 15 people who have died as a result of that.

Ms JORDAN-BAIRD: Thank you. No further questions.

CHAIR: Monique?

Dr RYAN: Thanks for appearing in front of the committee today. Many of the themes in the submission that you gave us a couple of years ago now are very consistent with things that we've heard from other people who've appeared in front of the committee today. I wanted to ask you about one of them. You've talked about the need to reduce exposure to alcohol marketing, particularly for children and young adults, and expressed some concerns in that submission that the Alcohol Beverage Advertising Code Scheme feels largely unregulated and expressed that a voluntary industry run code is an ineffective way of protecting children and young people from alcohol. Are you able to give us a bit more detail about those concerns and perhaps some illustrative examples of the sorts of things that have prompted that comment?

Ms Lukjanowski: Yes, I'm sure that we could pull some examples for you to demonstrate what that actually looks like in practice. Ultimately, it is the industry almost policing the industry, so that therefore means that the slope starts to get a little bit more slippery and we start to see more and more that actually don't even meet what the criteria are that they've set for themselves. However, there is no real teeth to it. There are no real consequences based on what people are putting out there. It's also quite difficult because it's hard to see what reaches a young person or a child versus what is reaching what would be the target market being adults that are of legal drinking age. So it's not that we necessarily want to be the fun police and say, 'No, you can't advertise these things; you can't have them there'; it's really important that they're not appealing to children. We're seeing advertising with people looking like they're having a great time, often on the water, and we're seeing more and more drownings involving alcohol now. There are lots of different risk factors that they're almost modelling, probably quite inadvertently, and I think it's really important that we start to look at that as well because we are normalising some of these different things. It would be important for us to create a more accurate picture.

Dr RYAN: Are the concerns that you have around alcohol advertising with the traditional media platforms like TV and radio or online, or all of the above?

Ms Lukjanowski: It would be a bit of all of the above. We're seeing what used to be on free-to-air sort of morphing through to your digital platforms, so it's on your streaming platforms and all of those different types of ways that people are now consuming media. It has sort of moved through that way. We also see a lot of young people who choose not to engage with the news or direct public health messaging that doesn't come via an app, whether that be TikTok or Instagram, or whatever their app of choice may be. So it's really important that the way that we get messaging out is not exclusionary and that it's going to reach all of the different demographics across our community. Older adults between 60 and 69 years of age are one of the largest growing sectors of drinking, increasing over the last couple of years. You could draw a whole heap of different conclusions on that, whether that is to do with being a little bit more sedentary or whether that's to do with changes since COVID or whether it's a mix of a whole lot of different things. However, with an ageing population, it would be really important for us to be making sure that we're reaching each of those different segments, from your free-to-air to your streaming platforms.

Mr BIRRELL: One of the points made in your submission was that Injury Matters noted there has been a lack of public reporting regarding the effectiveness of the National Alcohol Strategy. Does that mean you think that the National Alcohol Strategy has been really effective and hasn't been reporting?

Ms Lukjanowski: It's more so that we don't know. It would be really valuable for us to see that to date—well, when we wrote this; it might be very different now. When we wrote this, there hadn't been anything published to date. It was really about that transparency of data and information to see how it's tracking for organisations like Injury Matters that work at the community level. We want to see what's working really well because that helps us

to know how best to reach people and also where to refer people and to support positive behaviour change in the community.

Mr BIRRELL: You make another point around limited evidence on the effectiveness of education programs. What encourages young people toward a healthier approach to alcohol consumption or toward not consuming alcohol other than the binge-style culture that existed when I was a young person, which was a while ago? It seems to be very different now. It seems to be a healthier culture. Your point is that there's not enough education around whether there is a better culture now and what's caused it or whether we need to keep going down a certain path?

Ms Lukjanowski: It's a bit of all of that. Again, it comes down to the availability of data, which you'll notice we talked about in our submission, because that's what really tells us the story. That is what helps us to understand the levers that we're able to pull and why we're seeing—I would definitely agree with your point that it appears that our younger generations are taking a slightly different approach, which is positive to see when you look at it from an alcohol focused lens.

I think some of the things that would be really important to have a look at, when we look at the different levers that really work for young people, are potentially going to be things like minimum unit pricing. As soon as things start to impact how much it costs—when you're drinking in a problematic way—it becomes a choice. It becomes something that you look at and re-evaluate, whereas, if you are a bit older, more established and more financially stable, it probably has a little bit less of an impact. That's where some of those other behaviour change campaigns come in.

That's not to say that I don't think that a behaviour change campaign would be really effective with younger people, but it would be really important to get evidence and understand what those particular drivers that are really going to reach young people are. There are some different countries that have done that, across the globe, so it would be really valuable to look at those sorts of things as examples. This is not to say that it will always work in an Australian context, but it gives us something to at least aim towards or further understand.

CHAIR: Thanks, once again, for coming today. We've heard a lot, in our inquiry, about the stigma associated with drug and alcohol abuse. I just wonder if you have done any work with health providers in this space to see how we can make it easier or more appropriate for them to see these issues as health problems rather than socialisation difficulties or things like that. Have you done any work in that area?

Ms Lukjanowski: I think the pilot that we did via Healthway was a good indication of that. In just working with the allied health support workers who had daily access to the community, it was really important to see that there were stigmas—there were thought patterns that were well established within that group. However, this gave us an opportunity to really talk about what problematic use looks like and what some of the profiles look like. They don't always look how you might think. We also talked about the fact that it is your role as a health provider to support somebody towards a prevention approach and you are doing really important health based work by doing that, whereas I think that some people probably came into their first bit of training thinking: 'Oh, this is one of those conversations I hate. I avoid it. I prefer not to butt in; it's not my place.' So it's really about equipping those different providers with more tools. In terms of the education, it needs to happen at the community level and the workforce level. It's vital that it comes from all sides.

CHAIR: Have you done any work with GPs, as well, on this issue?

Ms Lukjanowski: Only a little bit. We've done a bit, mainly with GPs, around older adults and falls prevention, which is one of the big things that we've really worked on with them. They've also raised the fact that the alcohol guidelines don't exactly work as well for somebody that's 75 as they do for somebody that's 25. I think, as soon as you start adding comorbidities in there, and as people get a little bit older, it's important for us to have a look at whether that should look a little bit different. GPs have raised that as an area that they find a little bit difficult, because they don't have something to hang their hat on to say, 'This is what the guideline says.'

CHAIR: Yes. What about time for consultation? Have they raised any of those issues?

Ms Lukjanowski: I think it's pretty much an across-the-board thing. We often hear from practitioners that they're pretty time poor, so it's difficult for them to get access to information and to swot up on it to be able to share it with their community, as well. It's a common issue that we've definitely heard echoed.

CHAIR: Great. I don't have any further questions. Are there any further questions? No. Thank you very much for giving evidence today and for your submission. It's very valuable. I don't think you've been asked to give us any further information, but, if you have, please forward it to the secretariat within the next two weeks.

HOLMAN, Ms Sarah, Policy and Advocacy Lead, Financial Counsellors' Association of Western Australia

HOPKINSON, Ms Melanie, Chief Executive Officer, Financial Counsellors' Association of Western Australia

[17:00]

CHAIR: Welcome. Although the committee doesn't require you to give evidence under oath, I should advise you that this hearing is a legal proceeding of the parliament and therefore has the same standing as proceedings of the respective houses. Giving false or misleading evidence is a serious matter and may be recognised as a contempt of parliament. The evidence given today will be recorded by Hansard and attracts parliamentary privilege. I now invite you to make a brief opening statement before we proceed to discussion.

Ms Hopkinson: Thanks for the opportunity to appear today. We are the state body for the financial counselling profession. You may be aware that financial counsellors provide free, independent and confidential support to individuals and families experiencing financial hardship and work across housing, justice, family violence, gambling harm and community services.

Financial hardship, including debt, housing instability, fines, income disruption and economic abuse, has strong and enduring impacts on people's health, wellbeing and life outcomes. We believe that the financial counselling profession has a very important role within alcohol and other drug responses because financial security is a key determinant of wellbeing in today's economic environment. Financial stress is both a driver and a consequence of alcohol and other drug harm. Rising cost-of-living pressures, insecure housing, unmanageable debt, fines, economic abuse and income instability are well established social determinants that increase vulnerability to harmful alcohol and other drug use and reduce a person's capacity to engage with treatment and recovery supports. This has been reflected in submissions to the inquiry and in broader social outcomes research.

You would have heard from the Western Australian Network of Alcohol & other Drug Agencies today. They noted in their submission:

Alcohol and other drug-related harms are intrinsically linked to broader determinants of health, including socio-economic disadvantage …

Other submitters, including the Australian Multicultural Action Network and the Western Region Drug & Alcohol and Drug Centre—WRAD Health—have highlighted that financial hardship, housing stress and family pressure are common features of the lived experience of people affected by alcohol and other drug harms.

The pattern that we see is reinforced by national frontline evidence. The National Debt Helpline consistently reports high levels of alcohol and other drug related complexity among their callers who are experiencing financial hardship. The national data shows that financial stress, housing instability, fines and income disruption commonly co-occur with alcohol and other drug issues, demonstrating that these are not isolated or localised experiences. It's also important to note that AOD involvement is frequently underrecorded in financial counselling data. Many services are unable to isolate AOD issues because they are captured within broader health or wellbeing categories rather than recorded as a standalone presenting issue. As a result, low recorded figures reflect limitations in data structures, not in lived experience. Frontline services report that AOD issues are embedded across mental health, employment, family violence, housing and legal systems even where they're not identified as the presenting issue. This means that the quantitative data alone can really underestimate the prevalence and impact of AOD related harm.

Accessibility is central to effective engagement. Evidence to this committee has highlighted that people experiencing alcohol and other drug harm do not follow through on external referrals due to shame, chaos in their lives, limited transport or limited capacity to navigate fragmented systems. Co-located onsite financial counselling within alcohol and other drug services removes these barriers by providing immediate, trusted support as part of the care team. Wraparound service models allow financial and clinical issues to be addressed concurrently, strengthening engagement and reducing drop-off from care. Evidence from integrated models supports this approach. Odyssey House Victoria specialist onsite financial counselling within residential rehabilitation demonstrates improved retention and smoother transitions when financial stresses are addressed alongside clinical treatments.

The economic case for embedded financial counselling is equally strong. A cost-benefit analysis undertaken in 2014 by the University of Adelaide found that every dollar invested in financial counselling has approximately a $5 return, even using understated assumptions. More recently, Financial Counselling Victoria commissioned a return-on-investment analysis that was published in 2025. It estimated a social return on investment of between $3.70 and $5.30 per dollar invested in the general population, confirming that financial counselling remains a cost-effective early intervention in the current policy settings. The same analysis identified returns of up to $8 per

dollar invested for people experiencing high and complex disadvantage, reflecting the greater costs avoided through early intervention. It's important to note that these estimates do not capture longer term benefits and non-economic outcomes, such as financial improved financial capability, mental health or housing stability, indicating that the true value of financial counselling is likely understated.

So our position is that the financial counselling profession should be embedded within alcohol and other drug frameworks as a core psychosocial support, not an optional add-on or bolt-on service—not referral based but delivered onsite as part of multidisciplinary care. This would mean embedding the profession within services and warm onsite engagement rather than reliance on referrals. This also, importantly, requires cross-portfolio commissioning of the profession across alcohol and other drug, housing, justice and mental health services in relation to the social services department, which currently funds financial counselling services. Without addressing the financial drivers of harm, policy will continue to treat symptoms rather than causes. We thank the committee for the leadership on this issue and welcome continued collaboration to strengthen prevention, recovery and long-term outcomes for individuals and families.

CHAIR: Thank you. Sam, would you like to start?

Mr BIRRELL: Financial counselling is very important and very valuable. Would we need as much—I'll put it this way—emergency or crisis financial counselling if we had better financial literacy lessons in schools?

Ms Hopkinson: Great question. I think the short answer to that is: absolutely.

Mr BIRRELL: Absolutely we wouldn't, you mean?

Ms Hopkinson: Yes, we wouldn't. I think both Sarah and I are very big proponents for that early intervention engagement work. I think it's about how it is embedded within the curriculum in the way we embed other really important things into the curriculum. Often it's seen, again, as an add-on or a bolt-on. It's often given to health. So it's about how it's done, but I totally agree that improving financial literacy certainly helps those longer term outcomes for people. I think I would say it wouldn't remove the need for financial counselling and for the awareness of financial counsellors to be raised, but yes.

Mr BIRRELL: No, definitely not. I wasn't implying that at all. It will always be very necessary, and maybe we need to front-end it into education campaigns. You must see—well, I'll ask you. Do you see people in terrible situations who need your assistance with financial counselling and who might have managed to avoid some of the problems that you're trying to deal with if in the later years of school, at the time when we ask people to become adults—which is 18 years old—they had just gained knowledge about credit cards, interest rates, savings budgets and all of those things—you know, the things that you do need to have money for?

Ms Hopkinson: I think they'd make different choices. I acknowledge it's not just about the financial literacy education. We also know it's about having the tools to implement that. Whilst the education is really important, how do we make sure they're embedding that and using those actual tools to set themselves up well, especially in today's world of buy now, pay later and all the options that young people have. Before, it was a lot more difficult to get credit. And, of course, the other big thing we see is gambling and its harms particularly on young men in terms of the decisions they're making. So there's a lot involved. I totally agree though; education is key. I think it's how we then scaffold that into the rest of people's lives.

Ms Holman: To add to that, going back to your original question—if they had that literacy from school age onwards, would we still see people with these big issues—yes, we would, because each person's financial hardship comes from different means. You could have the best role models. Home is usually where our money values come from. You could have had the best set up from home or school, but you still may hit financial hardship through other means—excess medical bills, separation from a partner or mental health concerns. There are many reasons why someone may be impacted by financial hardship. I don't believe that it would fully address the situation. While it would help people to learn better ways of managing money and their options, it still will not replace when people are impacted and have those life events pop up that do need that additional advocacy help.

As you'll be well aware, many people do very well at self-advocating in any areas of their life. Especially if you're impacted by mental health, sometimes that's one of the first things that can fall off; you're not very equipped to self-advocate. And that's where financial counselling is gold.

CHAIR: Thank you very much for appearing in front of the committee and giving us your expertise. Do you have any particular suggestions for us regarding younger people and their access to financial counsellors? I suspect that young adults don't perhaps access financial counselling in the same way that people of my generation, who think about it and go there, do.

Ms Hopkinson: I think a big problem is awareness. Most people have never heard of financial counselling, or, if they have, they don't necessarily think it's for them. I heard someone also talk earlier about the shame and

stigma with alcohol and other drugs. You see exactly the same with people's finances. People don't want to accept they're struggling. For us—if we could go back to the submission—it would be the same. We don't see the financial counselling profession embedded into programs. It sits separately. So I'll constantly see media releases about new programs and new funding, and then, when I look into it, there is no financial counselling. It's always expected that that will be referred out. And what we know is that, if there's a financial counsellor in the mix as part of the care of that individual, it lowers the myths; that financial counsellor is not going to tell me that I have to stop my cigarettes or I have to stop my vaping. They're going to work with me, together. We just lose a lot of people in that referral, and that would stand particularly for young people. So we do see it.

Vinnies do have a young people's program where, because they've got financial counsellors, the young people do get soft-referred in, and they see some good outcomes. But, again, the financial counselling is not part of the program. It just so happens that Vinnies also has financial counselling on board. For us, it's about integrating the financial counselling into the program design. In terms of AOD, for us, there's a strong area certainly in rehabilitation, where they've almost got a captured audience in terms of what they can do. There's the one-on-one work and also the group work. There's ensuring that, when someone is transitioning into rehab, they've made sure they've got everything squared away, so they're not coming out straight into a whole heap of debt and creditors chasing them. When they're in there, can do lots of group work. They can do individual literacy work. Then, transitioning out, they know that service is out there for them and they can revert back to that advocacy that Sarah was talking about. Relapse is a very challenging thing, and if you've got financial issues and financial hardship, that relapse is going to be a lost closer to home. We know that.

Dr RYAN: I've met with a group in my electorate, which is inner-Melbourne, which has a fantastic community legal service with financial counselling embedded in the wraparound services that it affords to people, particularly those escaping domestic violence. This would be a similar sort of model where any service that interfaces with vulnerable people, such as the ones we're talking about, would be offered financial counselling support. I think it's a great idea.

Ms Holman: I think they can do it reasonably well.

Ms FRANCE: Can you give us some examples of how you identify people and how you then refer, as a demonstration of the issues in terms of getting people help? What's a typical situation that you would see, and what happens when an alcohol and other drug service refers to you? Do you have that continuity?

Ms Hopkinson: We're not actually in service delivery, as the peak body, but I can speak to membership. There are many doors to financial counselling, and while it's a consistent profession, it can look and feel very differently if you're in community as opposed to in the metro area. One of the doors is through the National Debt Helpline, but many people will approach through different avenues—perhaps through emergency relief, perhaps through community legal services. It's usually those community service areas where the majority of financial counsellors are found, and that's why we're advocating to see financial counselling become more mainstream.

In terms of what a typical client would look like, it's anybody and everybody. In terms of how AOD is identified, as we've highlighted in some of the other work, it is not shown, and is often put as a co-occurring health condition. It's not necessarily identified. I also listened to the previous evidence; a lot of frontline financial counsellors won't necessarily want to go into AOD use unless they feel equipped to be able to refer, and where to. Many do, but not all of them.

Ms Holman: I did a few years of financial counselling before I moved into the policy space. Clients are not presenting with their AOD issues; they're presenting with financial issues. Any co-occurring mental health issues are not always disclosed to a financial counsellor. It's really about gaining the rapport with the client. They may open up, or if you're looking through things trying to troubleshoot, it will pop up. You might find there are a lot of $20 trips to IGA, and then you identify that they're smoking cigarettes or buying lots of alcohol. It is through that relationship-building that you get with a financial counsellor that it may be disclosed to you by them.

In terms of AOD referrals, it's not a warm referral. Hypothetically, if I had a client with me that potentially needed a wraparound service or an AOD service, those pathways aren't always smooth, and they are usually a cold referral, because we are not in the services. This would be very different in services like Ruah or Odyssey, who have embedded financial counselling and AOD programs. That, there, is the issue. Again, the referrals from the AOD services to financial counselling are the same, just role-reversed. They're cold referrals; we're not getting calls from the caseworker warm-referring their client with them. It is, 'Call this number.' That's my experience of it, but I daresay that's echoed throughout Australia.

Ms JORDAN-BAIRD: Thank you for appearing before our committee today. It's great to have you here. Your submission references the fact that financial stress can be both a driver and a consequence of AOD harm,

and I was wondering if you could elaborate a bit on that, and give any other perspectives you want to provide the committee with.

Ms Hopkinson: I didn't bring the Venn diagram, I'm sorry. We can send it through—in fairness. I think, as Sarah was alluding to there, it's very much a two-way street, and the fragmented systems are not allowing the co-occurring issues to be case managed appropriately. If you are using a lot of alcohol or other drugs, often that impacts on your ability to make decisions and, perhaps, on your employment. If you have real issues with substance use, it's definitely going to impact on your discretionary income. Even if you can afford it, there are still going to be impacts on family and children—on what money is not going through to the family unit. Very often, certainly if it's problematic using, you're going to get to a point where it's impacting significantly on your financial health, and often vice versa with financial distress. People will use maladaptive coping mechanisms to help them cope with that. Unfortunately, if they're using those coping strategies, chances are they're going more into denial and shame and not reaching out for help.

What we often see at the moment is that financial counselling is very much picking people up when they've fallen off the cliff. We are really passionate about trying to move the profession a little bit more upstream. It's still absolutely vital where it is—don't get me wrong—but we need to see more financial counsellors where people are at, with AOD and mental health. I heard the conversation before about the GPs. We'd love to see GPs social prescribing to financial counselling, but we can't push that social prescribing, because at the moment there are not enough financial counsellors out there. We don't want to set people up to fail, with huge waitlists.

The other point at the moment, with financial counsellors doing fabulous jobs—and I really don't want to take away from this in our organisations—is that many people will not take an appointment at Anglicare, Vinnies or the Salvos; they'll feel: 'That that's not for me. That's for someone who needs it more than me.' We really need to go on that journey, where financial counselling is a lot more mainstream and a lot more understood, so that the awareness is there.

We're seeing a wider and wider demographic. The National Debt Helpline is reporting a lot more two-income families and mortgagees ringing up the National Debt Helpline. The whole demographic of people needing that support is getting wider and wider, but the profession is not expanding in the same way. The reason is that it's very much seen as programmatic. It sits within the Department of Social Services, and within the Department of Communities at the state level, and it doesn't go outside of that. We really need to see cross-portfolio commissioning, with financial drivers sitting across many different areas of government.

Ms JORDAN-BAIRD: So the way we break that cycle is earlier intervention, but we need to build the workforce to be able to support that.

Ms Hopkinson: Yes.

CHAIR: If I can carry on with that discussion, you're saying the workforce needs to be embedded in a one-stop shop, where people are being seen in a more holistic way, and financial counselling should be part of that.

Ms Holman: Yes.

CHAIR: This is my opinion—you can tell me if I'm wrong—but I think people are more stressed now than I've ever seen, and financial stress is a big part of that. Is that what you're hearing from your workforce?

Ms Holman: Yes, and there's a very large lack of emergency relief funding at the moment, especially with the crisis in the Middle East; that has just amplified everything for everybody. But it's definitely not getting better; it's been getting worse since COVID.

CHAIR: Do you have any data about that that you can show us?

Ms Holman: We can take that on notice and reach out to our networks. We have limited data available to us at the moment, but Mel might like to add to that comment.

Ms Hopkinson: That is one of the issues around the fragmentation—us being able to get the data to actually show there is a return on investment. That's why Financial Counselling Victoria did that return-on-investment research—to try and highlight the value so we can try and boost financial counselling. Once we've got it in place, we can certainly show the outcomes. A lot of our providers do work under different funding streams, whether it be state or national, trying to get that overall data. I heard the lady mention it earlier, as well, with injury prevention. It is quite challenging, and of course government want to see that data to be able to put the investment in. So we do get stuck in—

CHAIR: We're not disagreeing with anything you're saying, but if we're going to do some recommendations it's always nice to have some data to back it up.

Ms Holman: We can take that on notice and pull together what we've got. I know there are some analyses in the submissions that we made to our own state budget and to the federal budget.

Ms Hopkinson: Yes, definitely.

CHAIR: That would be great, if you don't mind. As there are no further questions, thank you for coming. It's been very valuable. Even though it's the end of the day, you managed to capture all our attention. That by itself is a feat!

Ms Holman: We appreciate it.

CHAIR: You have been asked to give us some information on notice. If you could do that within the next two weeks, that would be great. Once again, thanks for your very valuable time today. Thank you, Hansard. Thank you, committee. Thank you, secretariat.

Committee adjourned at 17:24