Submission to the Inquiry into the Health Impacts of Alcohol and Other Drugs in Australia.

The House of Representatives Standing Committee on Health, Aged Care and Sport.

December 30, 2024.

Acknowledgement of Country

The Mental Health Lived Experience Peak Queensland (MHLEPQ) respectfully acknowledges the Traditional Custodians of the Lands and Waters throughout Queensland. We thank the Elders—past, present, and emerging—for their wisdom and enduring strength.

We recognise that the legacy of colonisation has profoundly impacted First Nations peoples, contributing to unique and significant experiences of societal exclusion and health inequities that include disproportionate impacts of harmful AOD use. Colonisation has enforced systems of racism, stigma, and discrimination, leading to intergenerational social disadvantage and marginalisation. This further impacts the social and emotional wellbeing of First Nations communities.

We acknowledge the enduring resilience and resistance of First Nations peoples in the face of these adversities. We respect their rights and autonomy to lead their own healing journeys, guided by their beliefs and traditional practices and connectedness to Country, family, and spirit.

Who are the MHLEPQ?

The Mental Health Lived Experience Peak Queensland (MHLEPQ) was established in July 2021 to provide advice and advocacy informed by people with lived experience of the Queensland mental health system. Our work is underpinned by equity, access, cultural safety, recovery, and human rights and we are funded by the Mental Health, Alcohol and Other Drugs Branch, Qld Department of Health. MHLEPQ is a member of the National Mental Health Consumer Alliance, where other state and territory consumer peak bodies meet to coordinate on shared issues, including issues relating to Commonwealth policy and government-funded services.

Solidarity with Lived Experience

The MHLEPQ supports people with lived and living experience of mental ill-health and suicidality, some of whom have been harmed by breaches of their human rights within culturally unsafe systems that they sought for support.
We work in partnership with and are guided by the lived experiences and expertise of the MHLEPQ members, whose valuable recommendations have the power to create lasting change. MHLEPQ is committed to advocating for a human rights-based approach across the mental health and social systems, ensuring reform toward more representative, inclusive and responsive systems that meet the needs of the communities they serve.

Human rights statement

Mental health is integral to the human experience and is related to a person's ability to participate in society and live according to their own sociocultural and political values. The Mental Health Lived Experience Peak Queensland advocates that the right to mental health is a fundamental human right and a whole-of-society obligation to promote, protect, and uphold.

The right to health should include support with the social determinants of mental health such as adequate housing, a clean, healthy and sustainable environment, and health services that are affordable, effective, and culturally appropriate. By acknowledging mental health as a fundamental human right, we affirm our commitment to a just and equitable society where everyone can thrive. Human rights in mental health are both a constitutional and working principle of the peak and one of the main objectives of its advocacy work. The MHLEPQ work with members to prioritise the human right to mental health for all Queenslanders.

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Overview

The MHLEPQ is grateful for the opportunity to submit to the Parliamentary Inquiry into the health impacts of alcohol and other drugs in Australia (the Inquiry). Our organisation recognises the harm that people with problematic alcohol and other drugs (AODs) experience, while also noting that most people who use AODs do not experience harm or seek help relating to their use. The MHLEPQ advocates for the right to mental health (and more broadly, health), asserting that harm caused by alcohol and other drugs is a social and public health issue that must be addressed through human rights-based legislation, policy and practice.

The MHLEPQ notes the complex and interrelated relationships between mental health and suicidality and concurrent problematic AOD use, which are common. We consider it reductive to think about responding to the unmet needs of people with problematic AOD use without considering the broader contexts of the mental health and suicide prevention systems. Systemic reform requires an understanding of the complex relationships across these closely related sectors, as well as other social systems including criminal justice, child protection and policing.

We apply human rights-based and equity lenses to analyse systems from the viewpoint of people with lived experience. We amplify the knowledge and expertise of people with lived experience of mental ill-health, distress and suicidality in collaboration with other governmental, non-governmental and academic institutions to provide evidence-based recommendations for systemic change.

We advocate that systemic legislation and policy change should focus on shifting the current focus on criminal justice responses, bearing in mind the global evidence base shows us that most people use AOD infrequently and without problems and that the current system negatively impacts people who are already socially disadvantaged. The unintended consequences and ongoing harm of the current paradigm must change.

For the significant majority, the risk of harm to both themselves and others is increased primarily as a result of the social, policy and legislative responses to their use rather than the substance itself. One of the most serious harms is contact with police and the criminal justice system more broadly, which can have a range of immediate and longer-term consequences including disruption to a person's employment, housing and relationships[1]

For people who do experience problems with AOD, the appropriate multi-sector response to both the social determinants and underlying drivers of harmful AOD behaviours is crucial for people's support and recovery. These responses must consider the continuum of prevention to intervention, as well as the needs of the person from their community setting through to tertiary and long-term programmes. We understand from evidence and the expertise of AOD sector organisations that there is a shortage of specialist AOD treatment and harm reduction services for those people[2].

Criminal justice responses are a factor in strengthening societal and structural stigma and discrimination, reduced help-seeking, increased use of fatal and non-fatal overdose and limiting community and employment participation. The MHLEPQ supports and is informed by the submissions made by other community and governmental organisations that advocate for reframing the AOD policy discourse away from policing and supply reduction toward health and harm reduction narratives, including but not limited to #012 Suicide Prevention Australia; #075 QNADA; #109 QuIHN Ltd & QuIVAA Inc and #145 National Aboriginal Community Controlled Health Organisation (NACCHO).

Effective and evidence-based approaches to reducing AOD harms requires a health led response, not justice led*. Scaling up of harm reduction, prevention, and drug treatment programs will see significant social, health, and economic benefits, while reducing drug related harms and increasing equity of access*[3]*.*

This submission offers seven (7) main discussion points and twelve (12) recommendations based on consideration of the terms of reference.

[1] Submission #075 Queensland Network of Alcohol and Other Drug Agencies (QNADA), p.4.

[2] Submission #109: QuIHN Ltd and QuIVAA Inc

[3] Submission #109: QuIHN Ltd and QuIVAA Inc, recommendation 19.

Terms of Reference

The MHLEPQ has taken a systemic approach to considering the terms of reference. Due to the complex and broad nature of the issue of the health impacts of alcohol and other drugs on Australians, all insights and twelve (12) recommendations touch on all four terms of reference set by the Committee.

TERMS OF REFERENCE
1. 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
2. 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
3. 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
4. Draw on domestic and international policy experiences and best practice, where appropriate.

Discussion

Lived and living experience leadership and expertise

National, state and territory governments are obligated to co-design all reform processes with people with lived experience of problematic AOD use, mental ill health and / or suicide, from strategic design through to implementation and evaluation. Collaboration must include partnership principles of genuine power-sharing, including the capacity for lived experience decision-making, recommended in multiple inquiry reports relevant to the AOD, mental health and suicide prevention systems.

The *Inquiry into the opportunities to improve mental health outcomes for Queenslanders* recommended including people with lived experience in service delivery reform, and this is no less relevant for the AOD sector. For example, Queensland AOD organisations recommended the following immediate priority in their evidence-based action plan to address the growing threat of a synthetic opioid crisis:

A proactive, peer-led plan that integrates lived-living experience into harm reduction strategies can significantly mitigate the risks posed by potent synthetic opioids such as fentanyl and nitazenes. A plan to integrate the efficacy of community-led interventions and peer involvement will comprise astute and responsive policy[4].

Recommendation 1

Consider recommendations from the *National Mental Health and Suicide Prevention Agreement*[5], the *Productivity Commission Mental Health Inquiry Report* (2020)[6], and the *Parliamentary Committee Inquiry into Mental Health Outcomes for Queenslanders*[7] concerning co-design of system reform with people with lived and living experience. Adapt the recommendations for the AOD system and integrate them into the next National Drug Strategy.

Structural culture change

A whole-system paradigm shift is required within legislative and regulatory frameworks away from the current punitive criminal justice response, to a "health in all policies" approach[8]. Responses to people with problematic AOD use must address structural determinants including the impacts of colonisation, trauma, childhood adversity, socioeconomic factors, housing and food insecurity, and poverty. A holistic, person-centred and trauma-informed approach to understanding the drivers will require across-sector cohesion and navigation through the existing silos that people experience.

Recommendation 2

That the Committee accepts recommendation 11 of NACCHOs submission (#145): "Government adopts a 'health in all policies'

[4] QuIVAA Inc, QuIHN Ltd, QNADA & The Loop Australia (2024). *Overdose Prevention Queensland.* https://quivaa.org.au/app/uploads/2024/11/Overdose-Prevention-Queensland.pdf

[5] National Mental Health and Suicide Prevention Agreement

[6] Productivity Commission 2020 Mental Health Inquiry Report

[7] Inquiry into the opportunities to improve mental health outcomes for Queenslanders. Report No.1. 57th Parliament, June 2022

[8] Submission #145. National Aboriginal Community Controlled Health Organisation (NACCHO).

approach, recognising that health outcomes are influenced by a wide range of social, commercial, political, environmental and cultural determinants" (p. 4).

Equity and human rights

We commend the use of an equity lens to include seven (7) priority populations within the current National Drug Strategy, including people with co-morbid mental health conditions. We note that there are gaps in the representation of people most disproportionately impacted by harmful AOD use, for example, survivors of childhood sexual abuse (and other developmental trauma), people experiencing homelessness or living remotely or rurally, and people who have high intersectionality across the described populations. Equity is underpinned by the totality of universal human rights, a principle that should be applied to all reform activities.

Recommendation 3

That in the absence of a National Human Rights Strategy, international human rights instruments are applied to the National Drug Strategy that considers the inalienable rights of people who are harmed by alcohol and other drugs. Human rights conventions include but may not be limited to the Universal Declaration of Human Rights, UNCRPD[9], UNDRIP[10], and UNCRC[11].

The MHLEPQ advocates for approaching First Nations health equity based on the unique cultural rights of Aboriginal and Torres Strait Islander people in Australia. The connections between drug policy, colonisation and ongoing intergenerational trauma for First Nations people have caused marked inequity and require a unique First Nations-led approach.

Recommendation 4

That the Committee represent NACCHOs eleven (11) recommendations to government, particularly those pertaining to equitable access and choice of culturally safe models of care[12]:

[9] United Nations Convention on the Rights of Persons with Disabilities

[10] United Nations Declaration on the Rights of Indigenous Peoples

[11] United Nations Convention on the Rights of the Child

[12] Submission #145. National Aboriginal Community Controlled Health Organisation (NACCHO), p.4.

- Rec 1: any interventions to address the impacts of AOD align with the National Agreement [*Closing the Gap*] and its four Priority Reform Areas.
- Rec 3: greater accountability of mainstream service providers to deliver culturally safe services to Aboriginal and Torres Strait Islander people and communities.
- Rec 5: a holistic, health-based approach to address the impacts of AOD to reduce harms in Aboriginal and Torres Strait Islander communities.
- Rec 9: developing a new National Alcohol and Other Drug Workforce Development Strategy.

The MHLEPQ notes the importance of prevention and early intervention of harmful impacts of AOD use that are person-led, accessible and provide a choice of models and services that suit their needs. Through an equity lens, priority populations should have access to approaches that work for them and their families within their communities of choice. This will require the intentional development of workforces in rural and remote areas tailored for certain identities, sexual orientations, ethnicities and intersectionalities.

Recommendation 5

> That government recognises the interconnectedness of the AOD, mental health and suicide prevention sectors. Strategic reform should focus on streamlining the national, state and territory sectors to work cohesively across the three interdependent systems to provide access and choice to people who experience harmful effects of AOD use.

Stigma and discrimination

The experiences of societal and structural stigma and discrimination against people who use alcohol and other drugs continue to impact them in many areas of their lives negatively. MHLEPQ members describe the enduring harm of stigmatisation and negative judgements by AOD service staff when they have voluntarily sought support:

You know, it's the devastation of stereotypes and stigmas and the trauma that I still feel today of the judgement. I mean, like, I'm a strong person, I've recovered for the want of better words, but it's still there. It's not, once you've experienced it, it's not something that you lose.

~MHLEPQ member~

The predominating police and criminal justice system responses create cumulative harmful impacts due to stigma and discrimination, particularly where illicit drug use is involved – a factor that would be lessened by a health and social model of response. All government responses that take human rights-based and health approaches contribute to decreasing societal and structural discrimination by normalising those principles. Recent commendable examples include the establishment of the national take home naloxone programme, and the addition of medications used for opioid dependence treatment on the PBS[13].

Recommendation 6

> The MHLEPQ advocates for a National AOD Workforce Strategy that includes the pillars of anti-discrimination and anti-stigma that are included and reproduced across all relevant national, state and territory AOD strategies and implementation plans.

National governance

It is widely recognised that a stronger national response to harmful AOD use is required. The MHLEPQ supports QNADAs recommendation to reinstate the national governance structure for the AOD sector to support the development, coordination and funding of AOD priorities. In addition, there are several existing mechanisms that the MHLEPQ advocate the government leverage in future policy directions, including but not limited to the *National Agreement on Closing the Gap* and the *National Agreement on Mental Health and Suicide Prevention*.

This Government's first Closing the Gap Implementation Plan commits to achieving Closing the Gap targets through implementation of the Priority Reforms. This represents a shift away from focussing on the Targets, towards the structural changes that the Priority Reforms require, and which are more likely to achieve meaningful outcomes for our people in the long term. The four Priority Reforms offer a roadmap to meaningfully impact structural drivers of chronic disease for Aboriginal and Torres Strait Islander people[14].

Recommendation 7

> That national governance prioritises recommitment to implementing the recommended structural changes described in the *Closing the Gap* Priority Reforms and the shared government commitments on

[13] Pharmaceutical Benefits Scheme.

[14] Submission #145. National Aboriginal Community Controlled Health Organisation (NACCHO), p.5.

AOD outlined in the *National Agreement on Mental Health and Suicide Prevention*.

National Drug Strategy

Aligning the National Drug Strategy with other human rights-based frameworks signals to governments the required direction to deliver person-centred, culturally safe and recovery-oriented services that improve outcomes for communities.

Recommendation 8

That the Committee supports the recent recommendation by the Parliamentary Joint Committee on Law Enforcement for the Australian and state and territory government review and evaluation of the National Drug Strategy (2017-2026). Evidence of under-resourcing of demand and harm reduction funding should be rectified, but not at the expense of supply reduction efforts[15].

Recommendation 9

That the review of the National Drug Strategy (2017-2026) strengthens the human rights, public health and harm reduction approaches and frameworks. An equity lens should be applied to understand the needs of socially disadvantaged, marginalised and minority groups that are disproportionately impacted by the social determinants of problematic AOD use (who are absent from the current strategy).

Funding models

Funding policy settings are crucial for the sustainability of a more streamlined, efficient and cost-effective AOD system. Funding mechanisms across sectors (AOD, mental health and suicide prevention) and settings (community, primary and tertiary) are inefficient. Funding approaches don't consider social determinants and sectors outside AOD enough, for example, supported housing and education. In 2020, the Productivity Commission recommended improvements to funding and commissioning such as strengthening the primary health network-local hospital network

[15] Submission #075 Queensland Network of Alcohol and Other Drug Agencies (QNADA)

nexus, transition to regional commissioning authorities, and the *National Mental Health and Suicide Prevention Agreement*[16]:

Cooperation and coordination between the Australian Government's Primary Health Networks and State and Territory Governments' Local Hospital Networks is very patchy, which undermines accountability for delivering improved consumer outcomes.

Recommendation 10

> That the Government reviews national, state and territory funding and commissioning mechanisms as recommended by the Productivity Commission in 2020. That health funding reform includes but is not limited to strengthening the Primary Health Network-Local Hospital Network nexus.

The MHLEPQ agrees with QUiHN Ltd and QuIVAA Inc that addressing the shortages and complexity of AOD service system funding must be a major priority of this inquiry. Sector experts describe issues relating to insecure, short (1-2 year) contracts that create distress within the service delivery system impacting workforce retention[17]. Another major issue is the problematic and disproportionate spending on policing and supply reduction across the three pillars of the national AOD policy. This is an enduring issue that must change toward a balanced spend on harm and demand reduction[18].

Recommendation 11

> That the government addresses chronic underfunding of demand and harm reduction services by balancing the spend across the three pillars of the National Drug strategy, without decreasing the resourcing of supply reduction (as recommended by the Parliamentary Joint Committee on Law Enforcement).

Achieving First Nations health equity must be supported by government prioritisation of funding across the four Priority Reforms, most notably by building the community-controlled sector (Priority Reform 2).

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[16] Productivity Commission 2020, *Mental Health,* Report no. 95, Ch 23 Funding and Commissioning, p.1133. Canberra.

[17] Submission #109: QuIHN Ltd and QuIVAA Inc.

[18] Submission #075 Queensland Network of Alcohol and Other Drug Agencies (QNADA).

Recommendation 12

The government supports NACCHOs recommendations[19] for investment mechanisms that provide sustained capacity building and ongoing consistent funding into the community-controlled organisations, including but not limited to:

- Rec 2: government increase funding to grow and sustain the ACCHO/ACCO AOD services sector in line with Priority Reform 2.
- Rec 4: ACCHOs are funded to deliver holistic health promotion, prevention and engagement programs that address AOD use.
- Rec 8: ACCHOs and ACCRTOs are funded to work in partnership to develop shared, culturally safe AOD training resources for the sector.
- Rec 10: the Australian Government redirects funding to support AOD treatment services for
- Aboriginal and Torres Strait Islander people to the ACCHO/ACCO sector.

Contact

MHLEPQ welcomes further discussion about this submission or any other matters relating to the relationship between mental health and childhood contact with the criminal justice system. Please contact:

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[19] Submission #145. National Aboriginal Community Controlled Health Organisation (NACCHO), p.4.