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on Health, Aged Care and Sport
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Dear Committee Members,

APS response to the *Inquiry into the health impacts of alcohol and other drugs in Australia*

On behalf of the Australian Psychological Society (APS), we are pleased to respond to the *Inquiry into the health impacts of alcohol and other drugs in Australia* ('*The Inquiry*') which is has the potential to improve the health outcomes for a significant proportion of our society's most vulnerable. The APS is the leading professional association for psychologists in Australia and is dedicated to advancing the scientific discipline and ethical practice of psychology. Our work is informed by the United Nations' Sustainable Development Goals[1], which includes the promotion of health and wellbeing. Psychology is an essential component of holistic healthcare and is associated with better health outcomes and overall wellbeing[2].

Our response to the Terms of Reference (TOR) of *The Inquiry* is based on evidence-informed input from our members who work with individuals who misuse Alcohol and Other Drugs (AOD) in dedicated services and private practice as well as academics with relevant psychological research expertise. As an evidence-based profession, we have attempted to address TOR (d) and draw upon best practice (both Australian and international) as appropriate throughout our response.

However, we must point out that the scope of the inquiry, while admirable, is broad, complex, and sensitive. As they stand, the TOR would require significant time and investment to be addressed comprehensively. While we acknowledge that the due date for submissions was extended, we had already sought input from our members based on the very condensed timeline. In addition, as a peak body, we are not well placed to compare outcomes of individual AOD services across jurisdictions nor calculate returns on investments. We strongly urge the committee to consider commissioning funded, systematic, in-depth cross-jurisdictional research to adequately address TORs (a) and (b).

If any further information is required from the APS, I would be happy to be contacted through the national office on (03) 8662 3300 or by email at z.burgess@psychology.org.au.

Yours sincerely,

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APS response to the *Inquiry into the health impacts of alcohol and other drugs in Australia*

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;

For the reasons outlined in our attached letter, our response is not a systematic evaluation, and we are not in a position to provide comment on individual alcohol and other drug (AOD) services. Based on feedback from our members, however, we have highlighted the following comments and opportunities to improve services across Australia.

Firstly, we must acknowledge that any initiatives and recommendations to improve AOD and mental health services must have cultural safety and sensitivity as core values. Our First Nations peoples are particularly vulnerable to the negative health, social, economic, education and other impacts of AOD[3]. There must be recognition of the complexity of Aboriginal and Torres Strait Islander peoples' experience of using alcohol and other drugs in the form of dedicated or at least culturally adapted services. Some particular considerations include:

- The unique impact of colonisation means that there must be deep recognition of the intergenerational trauma experienced by First Nations peoples and the ongoing disenfranchisement that has been created in Australian society.
- The important role of culture, connection to country, connection to family and kinship as key parts of Aboriginal and Torres Strait Islander social and emotional wellbeing[4].
- Acknowledging that many of the social determinants of AOD use are not uniform across communities. Interaction with the criminal justice system,[5] racism and discrimination,[6] service inequalities, disconnection from country, education outcomes, health outcomes, and homelessness are some of the many factors that may contribute to AOD use and poor mental health. These inequalities must be addressed appropriately in order to see tangible progress.
- Recognising that access to mainstream services is not equitable. When dedicated services for First Nations peoples are not available, some initiatives need to be adapted to become more responsive to their specific needs.

The right of self-determination for First Nations Australians regarding AOD policy is critical[7]. In addition, trauma-informed care is essential for all First Nations peoples seeking help as many who may access AOD services have complex trauma histories which could be linked to the use of alcohol and other drugs[8]. It is also essential that AOD services are aware of closing the gap targets[9] and prioritise providing culturally safe, equitable, and accessible services for First Nations peoples which are co-produced and appropriately evaluated.

In addition, we have identified the following opportunities for improvement of AOD services across the board, based on input from APS members:

- **Limited psychological expertise and focus on mental health:** While psychologists are certainly employed in the AOD sector, our members describe that their numbers are often insufficient and that they are not routinely recognised or included in senior management structures. As such, psychologists are often managed by other health professionals who do not have advanced knowledge and skills in addressing mental health challenges, and in particular trauma. Many current AOD services segregate AOD treatment and mental health treatment, despite the inextricable link between the two.

- **Lack of focus on trauma-informed care generally:** While this varies considerably across jurisdictions, according to APS members, some AOD services are based on outdated treatment principles and do not prioritise trauma- informed care. In addition, there are limited training opportunities to adequately address this service gap.

- **Inequitable availability of services:** It appears that not all Australians are able to access AOD community-based support. For example, in the Northern Territory, many services are focussed on social welfare and justice issues.

  Individuals who seek AOD specific care are often limited to private facilities which necessitates private health insurance or having financial flexibility to pay (sometimes up to tens of thousands of dollars). Accessing private services also requires a referral from a psychiatrist which can further limit accessibility (due to wait times, session costs, and case load).

- **Confidentiality and dual relationships:** Particularly in rural and remote areas, limited services mean that there are high chances of knowing AOD staff personally or professionally. Similarly, AOD and mental health staff may be limited to accessing the same services as their patients. This can create a barrier in help seeking, with dual relationships complicating therapeutic dynamics, and ultimately impacting outcomes.

- **Limited opportunities for people with the most profound distress:** APS members report that patients with very acute distress such as suicidal ideation are often excluded from mainstream AOD services and, as a result, are left with few options, even after multiple emergency presentations. Once 'stabilised', patients are often discharged from acute, high intensity settings (such as emergency rooms) without any follow-up care in community-based services.

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;

It appears from input shared by APS members that while there are certainly pockets of excellence, with examples of units and centres and individual practitioners achieving positive outcomes with patients, there appears to be significant room for improvement across the sector. As a peak professional body, we are not appropriately placed to comment on individual services or jurisdictions but have presented consolidated feedback based on our members' input. We have identified the following considerations:

- **Some private facilities are unregulated:** As discussed in response to TOR a, the lack of community based AOD services mean that patients often seek private rehabilitation options. In WA, for example, there was an inquiry undertaken into Esther House, a private facility offering AOD rehabilitation. In our response, we drew attention to the necessity of regulating private AOD facilities to ensure the safety of patients[10]. The WA Government's response includes in-principle support to ensuring a regulatory process for AOD treatment services is established, giving "full effect to the National Quality Framework for Drug and Alcohol Treatment Services"[11(p. 2)]. Facilities that remain unregulated potentially leave vulnerable patients being exposed to non-evidence based treatment approaches and open to exploitation. For example, some faith-based practices promote the idea that AOD misuse is based on an individual's moral failings. This premise limits a trauma-informed and social-determinants approach. Such treatments would not be accepted in other areas of healthcare.

- **Treatments offered are not evidence-based:** It is clear that across the sector, there is a distinct lack of best-practice approaches, e.g., cognitive behavioural therapy (CBT) being offered in AOD services for patients with a substance use disorder. According to the *Australian Guidelines for the Treatment of Alcohol Problems*, CBT is listed as "an effective treatment for alcohol dependence and should be used as a first-line psychosocial intervention for all dependent patients[12(p. 146)]." As experts in human behaviour and supporting mental health and wellbeing, psychologists are best placed to offer this gold-standard treatment. This gives further credence to the necessity of employing sufficient psychologists in AOD services. In addition, our members report that some AOD treatment services often administer brief interventions that are not appropriate for individuals with moderate or severe substance use disorders.

- **Lack of advanced psychological knowledge to address cognitive impairments:** A significant proportion of patients with alcohol or substance use disorders can experience cognitive impairment, however, such impairments often remain unrecognised or unmanaged[13,14]. Cognitive impairments can affect treatment success[15] so it is essential that differential diagnosis occurs to minimise the risk of sustaining long term harms including substance-acquired brain injury. It is essential, therefore, that patients have access to psychologists with advanced expertise in assessment and management of cognitive impairments[13,16], for example clinical neuropsychologists, within the public system.

  APS members report that in one of Australia's largest states, there are only two public community-based clinical neuropsychology services and only one that is a dedicated statewide addiction clinical neuropsychology service. This service receives referrals for some of the most complex, 'at risk' patients across the state, and is staffed at just 2.0 full-time equivalent. Essentially, this means that timely access to clinical neuropsychologists is very limited for some of Australia's most vulnerable people who cannot afford private services.

  Clinical neuropsychologists within the AOD sector can support management and therapeutic engagement, optimising patient outcomes[17,18]. Access to clinical neuropsychology is also essential for additional funding (for example from the NDIS) to support management in the community and optime patients' participation in society.

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

As we have already discussed, problematic AOD use rarely (if ever) occurs in a vacuum i.e. there are multiple factors and social determinants which contribute to AOD misuse and abuse[19,20]. Policy initiatives must recognise the complex interplay between substance use, poor mental health, domestic and family violence *inter alia*[19,21]. Given this, we have identified a number of opportunities for improvement:

1. **Integrated services and whole of Government approaches:**
   The APS strongly advocates for an integrated, preventative approach to reducing the harms associated with problematic use of AOD. Our members report positive experiences with working with agencies outside of health (such as Justice Departments) and we strongly advocate for increasing links between agencies and reducing siloed approaches. For example, individuals returning to community settings from prison may need additional support to increase their chances of successful adjustment due to a history of trauma. This may include assistance with housing, education, employment, and community-based mental health care. AOD problems in rural and remote areas need to be address proactively with Police, Justice Departments, and AOD services working together. Critically, services need to be accessible to First Nations peoples (as discussed above), and members from other vulnerable groups (e.g. LGBTIQA+ communities[22]).

2. **Stigma reduction within the sector to improve the provision of equitable care:**
   Stigma remains a significant issue in the AOD sector and is a major barrier in accessing equitable care. This can result in significant delays in individuals accessing treatment services for AOD concerns. For instance, it can take between 18-20 years (median 14 years dependence, 23 years of abuse) for an individual with alcohol dependence to seek treatment[23]. By this time, high levels of other psychosocial and medical issues can arise[24]. AOD related concerns are a factor in a significant proportion of emergency presentations, yet individuals are often precluded from mainstream mental health services because of their substance use. Unfortunately, stigma regarding AOD misuse and abuse remains high among many health care workers, and staff not specifically working in this area often lack expertise around how to provide appropriate treatment and support.

3. **Increase public awareness to reduce Australia's drinking culture:**
   Since colonisation, alcohol has been an important part of Australian culture and periods of prolonged drinking have often been synonymous with celebrations, watching sport, and payment for work[25,26]. Alcohol advertising during sport and within other settings, for example, has been shown to influence children and adolescents' drinking expectancies, norms and intentions[26,27].

Recent evidence has shown that over 2,800 alcohol advertisements were shown on television during a two-month period, half of those during children's viewing times[28,29]. Advertising on social media also means young people are exposed to more than 20 alcohol related advertisements per hour[30]. In addition, careful marketing warning of alcohol's harmful effects may counterintuitively make it more appealing to young people[31].
Given the power of this industry, there must be concerted public awareness efforts to change long-entrenched attitudes and beliefs about alcohol.

4. **Adopt preventative and early intervention approaches in families and schools:**
Taking a lifespan approach to prevention and early interventions that address AOD use in young people is essential. Recent evidence highlights the importance of parents setting explicit rules and expectations and monitoring AOD use in their children [32].

Psychologists are able to work across the full spectrum of prevention, early identification, treatment, and recovery in diverse organisations and settings. Given that it is estimated that the psychology workforce in Australia is meeting just 35 per cent of projected national demand[33], anything that can help to increase the numbers of qualified psychologists is a critical priority for reducing AOD related harm in Australia.

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

Consistent with our response to TOR c, we have identified the following international evidence-based initiatives which may serve as useful examples to inform responses to AOD misuse and abuse in Australia. The APS advocates for greater efforts to be placed on prevention to ultimately reduce the impact of problematic AOD use[34]. When considering international practices, however, we recommend that any initiatives be adapted for Australian contexts by including a wide variety of voices including lived experience[35] and First Nations peoples in their development, implementation and evaluation. We have identified the following examples:

- **A trauma-informed, low stigma approach to AOD (Scotland):** Scotland has a whole of Government approach to trauma informed care[36]. Through the National Health Service Education for Scotland (NES), the Scottish health workforce is able to access standardised training and support. In addition, there are public awareness campaigns to destigmatise problematic drug and alcohol use by promoting "understanding, hope and kindness"[37]. The Scottish police service has a violence reduction unit which treats crime as a preventable public health issue. Trauma-informed practices focus on adverse childhood events and the police work with other agencies to proactively engage people at risk of AOD issues[38].

- **LifeSkills Training (United States):** LifeSkills Training (LST) is a comprehensive prevention program tailored for middle and high school students that focuses on three core areas: self-management skills, social skills, and drug resistance strategies. Through engaging activities, role-playing, and discussions, students learn how to handle peer pressure, manage stress, and make informed decisions regarding substance use. The program's effectiveness is well-documented with numerous studies showing that it significantly reduces the rates of alcohol, tobacco, and illicit drug use among participants[39,40] and that these results can be sustained over time[41].

- **'Good behaviour games' (United States):** There are multiple examples of elementary school-based 'good behaviour games' which are designed to promote positive behaviour by employing team-based behaviour competitions. Research suggests that this approach is linked to lower rates of drug and alcohol use disorders, reduced smoking and fewer negative social and health outcomes[42,43].

- **World Health Organization (WHO) Global Alcohol Strategy and Global alcohol action plan (2022-2030)[44]:** The WHO's Global Alcohol Strategy advocates for evidence-based policies to mitigate alcohol-related harm globally, focusing on evidence-based practices such as increased pricing and reduced availability[45].

- **Ban on alcohol advertising in sport (France):** Alcohol advertising during sport was banned in France in 1991 and has been associated with a decrease in alcohol consumption[26].

- **Learning from other inquiries (New Zealand):** In 2018, the New Zealand Government undertook an inquiry into Mental Health and Addiction[46]. Many of the lessons learned and recommendations from the inquiry could be applicable to the Australian context.

- **Alcohol and drug prevention in the Nordic Countries (Norway):** In late 2022, there was a conference hosted by the Norwegian Ministry of Health and Care Services which brought together experts and the industry to discuss practical, evidence-based AOD prevention initiatives. Evidence-based substance use prevention is cost effective, with conservatively, "one dollar invested [in prevention] today will yield 10 dollars in the future."[47(p. 14)]

In summary

The APS response to this Inquiry highlights the need for culturally sensitive and trauma-informed care, particularly for First Nations peoples, while emphasising the importance of addressing social determinants of AOD use. We identify areas of improvement for the sector including overcoming inequitable access, insufficient use of psychological expertise, and a lack of integrated care for co-occurring mental health and AOD issues. We advocate for a preventative, whole-of-government approach involving sectors such as education, justice, and housing to reduce AOD-related harms and stigma. Our response also calls for evidence-based interventions, regulation of private facilities, and the adoption of international best practices tailored to the Australian context.

The APS would like to acknowledge and sincerely thank the members who so kindly contributed their time and evidence-informed knowledge, experience and research to this submission.

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