VICTORIAN ALCOHOL & DRUG ASSOCIATION

State Budget Submission

2021/22

VAADA Vision

A Victorian community in which the harms associated with drug use are reduced and general health and well being is promoted.

VAADA Objectives

To provide leadership, representation, advocacy and information to the alcohol and other drug and related sectors.

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1. About VAADA

VAADA is a non-government peak organisation representing Victoria's publicly-funded alcohol and other drug (**AOD**) services. VAADA aims to support and promote strategies that prevent and reduce the harms associated with AOD use across the Victorian community. VAADA's purpose is to ensure that the issues for people experiencing harms associated with substance use, and the organisation's who support them, are well-represented in policy, program development and public discussion.

VAADA seeks to achieve its aims by:

- Engaging in policy development;
- Advocating for systemic change;
- Representing issues identified by our members;
- Providing leadership on priority issues;
- Creating a space for collaboration within the AOD sector;
- Keeping our members and stakeholders informed about issues relevant to the sector; and
- Supporting evidence-based practice that maintains the dignity of those who use AOD (and related) services.

VAADA's membership comprises agencies working in the AOD field, as well as those individuals who are involved, or have a specific interest, in the prevention, treatment, rehabilitation or research aimed at minimising the harms caused by AOD.

2. Executive Officer's review

Each year the Victoria Alcohol and Drug Association (VAADA) prepares an annual state budget submission for the Victorian Government outlining a range of initiatives that we think can make a difference in reducing alcohol and other drug (AOD) related harms across the community. This year's submission could be considered supplementary to an earlier submission responding to the impacts of COVID-19 delivered in August 2020. It is also different in that it follows the delivery of Victoria's Royal Commission into Mental Health final report which may end up significantly influencing not just the Mental Health system but the AOD system as well.

Set within a backdrop of both COVID-19 and the Royal Commission it could be easily surmised that this is no ordinary year and that we are in a frame of extraordinary developments and that the work of the AOD system is anything but business as usual. Yet on the ground much remains the same, at least until such time as the wheels of policy and programmatic reform starts to edge closer to our model of service delivery.

Despite the constantly evolving AOD program space and however welcome the regular flow of investments are, within the 'big picture' our sector sits within a continuing backdrop of chronic underinvestment as well illustrated by **Figure 2** in this submission. Of course, we are cognisant of recent uplift funding and expansion yet the reality remains that the AOD sector still suffers from prolonged underinvestment with service gaps across different parts of the sector remaining. These gaps have led to imbalance and areas of dysfunction within the AOD system.

Effective planning in this sector is vital, yet despite the enormous efforts that have been made to implement a new data scheme (VADC), to date it has merely absorbed substantial amounts of time and money with little to no return. Both agencies and the broader sector as a whole are bereft of data that can help drive improvements and the tools to drive evidence based outcomes. Let's just for a moment consider the implications of recent Royal Commission's onto Family Violence, and Mental Health; add to this the impacts of 'Safescript' as well as COVID-19 driven demand or the possible impact on the AOD system of an accumulation of over 150,000 court cases, many which will result in referral for AOD treatment. Yet for each of the above issues there is no planning into the impact on our AOD system. There is no data or focussed assessment, yet a compounding of demand, layer upon layer which only goes to frustrate the community and the end consumer who struggle to understand why they can't get timely access to service. Within this wake, has been allowed to flourish in most part a flurry of unregulated private providers increasingly finding their way into media reports related to unconscionable conduct and 'rip offs'. While I would like to ask that it is time for the 'musical chairs' to stop, in reality much work needs to occur before we build a head of steam which heads us in that direction. Other than emerging narrative related to the Mental Health Royal Commission, so far consideration about addressing some of the sectors fundamentals remains muted.

Since VAADA's last state budget submission, the AOD sector has continued to adapt to and implement the swathe of reforms which have been introduced following 2016's Royal Commission into Family Violence. Significant effort has gone into submission writing to the Royal Commission into Victoria's Mental Health System with a clear focus on possible ramifications for the AOD sector, and particularly for its workforce.

Forensic clients continue to present a unique challenge to the AOD sector, with the impacts of COVID-19 on Victoria's Court system likely to exacerbate various entrenched challenges. Continued expansion of prison beds will only compound the situation further.

As in previous years VAADA makes a call on the need to provide equal access to AOD treatment for all Victorians, no matter their location. The gap which exists between metropolitan, rural, and regional Victorians continues to persist. It is most evident through AOD workforce shortages, difficulty retaining staff, and accessing professional development opportunities. For service users, it is seen in the unavailability of some forms of treatment (such as opioid replacement therapy), or barriers which make treatment virtually impossible (such a vast distances between service providers and a lack of public transport options). Given the high rates of illicit opioid use in country Victoria, coupled with the difficulty in accessing opioid replacement therapy, many are vulnerable to the risk of overdose due to their isolation. The solutions below are aimed at addressing this inequality.

VAADA urges the Government to carefully consider the range of recommendations contained in this submission. They are evidence-based solutions aligned to the current challenges facing the sector, and are informed by contemporary research as well as expert knowledge from front-line workers to those in senior management positions. While some of these recommendations are straightforward and have the potential to achieve immediate improvements, others require the Government to make a long-term commitment to acting in the best interest of some of our state's most vulnerable and stigmatised. There must be a sustained effort, matched by investment, to increase the capacity and ability of our AOD sector to meet the needs of all Victorians.

Sam Biondo

3. Summary of recommendations

REDUCING RECIDIVISM

Recommendation 1: Implement a comprehensive harm reduction strategy for people in prison including support for those approaching release. This strategy should incorporate enhanced guidance for correctional staff in delivering harm reduction training prior to release, including the provision of Naloxone (and training in how to administer it) and should allow for the provision of sterile injecting equipment in correctional settings.

Recommendation 2: Establish a co-located, coordinated suite of support services to assist with the integration of individuals with complex needs who have recently been released from prison. $5M funding should be invested to develop a specialist agency which specifically focusses on mental health, AOD, employment, training and mentoring support for this cohort. This organisation should also oversee an allocation in social and public housing.

Recommendation 3: All individuals charged with drug possession and use offences should be eligible for Court Diversion and for younger people cautions; to accommodate additional demand from the reform there should be a subsequent increase in the availability of community-based support and treatment services.

STREAMLINING *SAFESCRIPT* TO ENSURE THAT EVERYONE IS SUPPORTED

Recommendation 4: Invest $20M in the AOD sector to provide for the additional demand generated by SafeScript and other reforms aimed at reducing pharmaceutical related harm. This would provide for necessary workforce capacity-building, including greater capacity for Victoria's pharmacotherapy system, the expansion of addiction medicine and pain management capacity as well as the establishment of accessible specialist clinics across Victoria.

Recommendation 5: Undertake research and a review of the impacts of SafeScript, which includes an assessment of:

i) Patient outcomes following identification; and
ii) the limitations, benefits and impact of SafeScript, on targeted consumers, with particular reference to their healthcare needs, treatment and referral pathways.

RESPONDING TO SERVICE ISSUES IN RURAL AND REGIONAL VICTORIA AND POPULATION GROWTH

Recommendation 6: Invest $3M on a recurring basis to each interface region (Melton, Casey, Wyndham, Cardinia, Mitchell and Whittlesea) to enhance existing services and/or establish new services to address AOD-related harms in line with rapid population growth, disadvantage and local need.

Recommendation 7: Invest $10 million annually to enhance AOD service access and capacity in rural and regional Victoria, prioritising areas identified by local AOD catchment-based planning where there are challenges in service access, as well as high levels of morbidity and AOD related harms.

Recommendation 8: Apply a loading to all rural and regional AOD staff of 10% above the relevant award to enhance recruitment and better retain quality staff.

Recommendation 9: Apply a 20% increase in agency funding over three years in areas affected by disaster/crisis such as bushfires.

Recommendation 10: Convene a rural and regional AOD summit, as a matter of urgency, to engage with rural and regional communities in relation to measures that can be taken to address the range of AOD and system-related issues affecting them. An information gathering exercise should be undertaken to better inform stakeholders in the lead-up to the summit.

ADDRESSING AOD SERVICE AND SYSTEM ISSUES

Recommendation 11: Provide a recurring $17.26M boost to the AOD sector for additional 'Care and Recovery Coordination' treatment to account for the needs of approximately 30% of all AOD service users.

Recommendation 12: Provide increased access to transitional social housing for those whose circumstances require it on exiting formal AOD treatment.

Recommendation 13: Commence an immediate review into the value of a Drug Treatment Activity Unit (DTAU), based on a rigorous financial analysis which takes into account the realistic cost of service delivery.

AN ENDURING AND CAPABLE AOD WORKFORCE

Recommendation 14: Invest $1.5M to establish an entity to better coordinate training, streamline student placements and enhance the attraction of staff to Victoria's AOD sector. This entity would explore options for micro-credentialing and rapid accreditation of new AOD workers in relevant areas of high need. A central co-ordinating team of two staff would support existing RTOs, and the enhanced workforce training initiative.

Recommendation 15: Invest $2M to develop a broad 'industry plan' for the AOD sector which takes into account the specific needs of the AOD sector as well as the AOD-related workforce needs of related sectors, including mental health, homelessness, child and family support services, Aboriginal, hospitals and forensic health environments.

RESPONDING TO DUAL DIAGNOSIS; STRENGTHENING THE AOD RESPONSE FROM PRIMARY HEALTH

Recommendation 16: Recruit six specialist dual diagnosis clinicians into each AOD region to build the capability of the sector to respond to the needs of service users experiencing co-occurring AOD and mental health concerns.

Recommendation 17: Invest $2.5M on a recurrent basis to support and maintain service integration across the eight regions.

Recommendation 18: The Victorian Government should subsidise the ORT dispensing fee to increase program engagement and retention.

NECESSARY SUPPORT FOR UNDERSERVICED COHORTS

Recommendation 19: Provide state-wide youth dual diagnosis capacity though resourcing an additional 20 AOD youth dual diagnosis workers ($2M p/a).

Recommendation 20: Implement a three year pilot program which places an AOD support worker within a school (or cluster of schools) to work with at risk young people through counselling, referral and family support.

Recommendation 21: Develop a pilot outreach AOD treatment project to address the gap in AOD services for mature aged adults with age-related complexities throughout Victoria. The project should include outreach, project coordination, medical support (e.g. pain management) and initiatives that address social isolation, coupled with resourcing for research and evaluation.

Recommendation 22: Provide resourcing to establish a pilot program which places two bi-cultural liaison workers in four AOD catchments in Victoria. Bi-cultural liaison workers would be supported by two capacity building project support officers, to increase CALD community access to AOD services and build the capacity of catchment services to cater for the needs of these communities.

BUILDING THE CAPACITY OF VICTORIA'S RESIDENTIAL SYSTEM ON PAR WITH OTHER JURISDICTIONS

Recommendation 23: Develop a plan to increase the capacity of Victorian funded residential rehabilitation services to a level equivalent to other Australian jurisdictions. This will necessitate the development of approximately 200 additional beds lifting the rate to 1 bed per 10,000 head of population. It is estimated that the operational cost of running these facilities will amount to approximately $75,000 per annum per bed.

Recommendation 24: Increase residential withdrawal capacity, particularly in regional Victoria, with a portion of this increased capacity developed to support Aboriginal and Torres Strait Islanders.

4. Introduction

This submission makes recommendations for the consideration of the Victorian Government, which are aimed at enhancing current Victoria's response to alcohol and other drug (AOD)-related issues. Several of these recommendations are longstanding and have been canvassed in earlier submissions, and others are made in response to emerging issues.

2020 has been marked by a series of catastrophes, including bushfires, pandemic and the subsequent social and economic consequences necessitated in responding to the pandemic. COVID-19 continues to present an array of challenges cascading throughout the community, with the ramifications of these challenges to remain evident for many years.

While there is only limited data relating to the impacts of these disasters on AOD use and dependence, that which is available drawing on local and international sources highlights an emerging and enduring surge in AOD harms and treatment demand.

These harms present in various forms, including AOD-related dependence, illness (such as cancer[1]), injuries (including overdose), road trauma and violence (including family violence).

This submission is also made in the context of the Royal Commission into Mental Health, which provides an opportunity to identify and address a range of deficits across the health and welfare sectors in Victoria as well as the broader narrative of the mental health impacts of COVID-19.

The recommendations set out below are evidence-based, pragmatic and present a cost-effective and humane approach to minimising AOD-related harm and enhancing wellbeing across Victoria.

a) Impact of COVID-19 on AOD treatment

COVID-19 impacted the way people use AOD, their availability, harms, and accessing help. Due to the various restrictions, AOD agencies have had to change the way they deliver services, this has included transitioning to a telehealth model for many treatment types, as well as other innovations aimed at keeping people safe, such as the changes to pharmacotherapy. Other treatment types, such as residential services, effectively had to contract, reducing capacity, to facilitate a COVIDsafe environment. Outreach and group programs were also affected.

While the telehealth offerings received a mixed reception from service users, it is evident that the contraction of residential programs (by at least 20 precent) has caused a blow out in wait times, setting residential rehabilitation capacity back prior to the uplift in capacity in 2018.

VAADA prepared a submission which reflected key findings from a nation-wide COVID-19 sector survey, including responses from 93 senior Victorian managers and CEOs. Additional to the above, the findings include:

[1] Research indicates that alcohol is directly linked to an increased risk for six different types of cancer (Garaycoechea et al 2018)

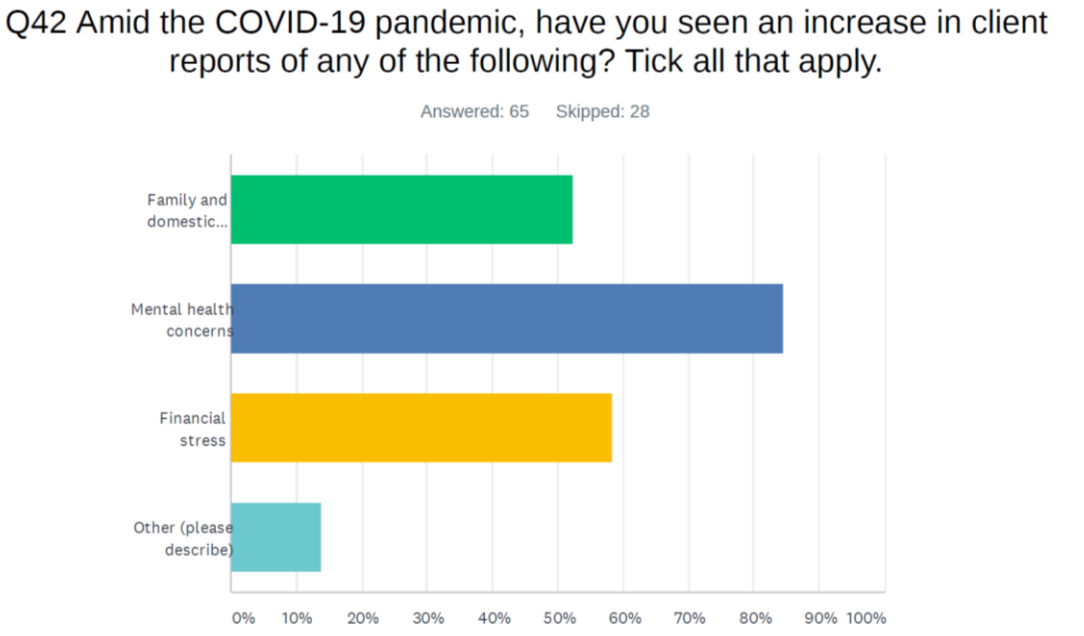
1. **The impact was great:** All respondents indicated that COVID-19 affected their service, with 62.50 percent of responders noting 'a great deal' of impact
2. **Most agencies transitioned to a telehealth model:** 93.18 percent adopted telehealth (phone or online) which accounted for over 80 percent of the service delivery provided by seven in 10 agencies;
3. **Many agencies had to reduce client numbers:** 45.25 percent of agencies had to reduce their client numbers to accommodate risk mitigation measures;
4. **COVID-19 necessitated new ways of doing business:** two in three agencies (67.47 percent) had to implement various changes (beyond telehealth)**;**
5. **COVID-19 has ushered in additional expenses:** additional expenses reported by agencies include PPE, sanitation, technology and reduced income due to service access;
6. **Demand has increased:** while elements of the sector contracted, 42.5 percent of agencies reported an increase in demand; 18.75 percent reported a decrease;
7. **COVID-19 has reduced residential service capacity:** 88.89 percent note a reduction in number of beds available;
8. **The number of client appointments largely remains unchanged:** three quarters of responders noted that the number of available appointments was either unchanged or increased;
9. **There are varied experiences in client engagement:** 56 percent of responders noted greater attendance; one in three noted shorter service user engagement and one in four noted longer service user retention;
10. **Service gaps are evident:** 26 responders noted barriers to accessing residential services (detox and rehabilitation); 19 responders noted difficulties in supporting service users with complex issues and 10 noted a limitations in progressing harm reduction services such as NSP and naloxone training;
11. **Agencies saw a rise in complexity including:**
    a. 52.21 percent increase in family violence;
    b. 84.62 percent in mental health concerns;
    c. 58.46 percent increase in financial stress;
12. **COVID-19 largely did not change staff numbers:** 81.33 percent of responders noted no change to staff numbers;
13. **Agencies had to redeploy or access support to retain staff:** 48 percent of responders had redeployed frontline staff and 22.67 percent accessed *Jobkeeper*; one in three made no staffing changes;
14. **COVID-19 impacted on staff wellbeing;** 76.06 percent of responders noted a moderately adverse impact on staff; 11.27 percent noted a positive impact;
15. **COVID-19 necessitated additional training:**
    a. 97 percent identified the need for additional training / capability in the provision of telehealth;
    b. 27 percent identified the need for additional training / capability in sanitation and infection prevention (this figure would have been higher at the beginning of the pandemic); and
    c. 30 percent identified the need for additional training in responding to complexity in presentations;
16. **Enforcing social distancing has been challenging for PWUD:** four responders are aware of service users receiving infringements relating to social distancing[2].

[2] Fox Koob, S & Butt, C 2020. Hundreds of Thousands Call Police to Dob in Coronavirus Breaches. *The Age*. 3 October. https://www.theage.com.au/national/victoria/hundreds-of-thousands-call-police-to-dob-in-coronavirus-breaches-20201002-p561ij.html

AOD service users are presenting with more challenges during COVID-19

VAADA's COVID-19 sector survey supports the regular feedback received from AOD treatment agencies regarding an increase in the challenges evident with service users engaging in AOD treatment. Figure 1 reflects COVID-19 sector survey feedback and highlights a significant increase in mental health, family violence and financial stress amongst those presenting.

Figure 1: co-occurring harms in service user presentations



ANSWER CHOICES	RESPONSES	
Family and domestic violence	52.31%	34
Mental health concerns	84.62%	55
Financial stress	58.46%	38
Other (please describe)	13.85%	9
Total Respondents: 65		

Agencies have also reported changes in the composition of presentations, including more acutely harmful AOD patterns of use, the emergence of an increasing number of people who are new to the sector and an increasing rate of relapse from those in recovery.

There are varying indications on changing drug trends, depending on the region, with some services reporting that specific regions have experienced an increase in GHB and cocaine. There was a general decline in methamphetamine and heroin during the height of the second wave, with reports

that purity has declined as has availability with the cost increasing during that period[3]; more recently, there are early indicators of a gradual resurgence in purity and availability. Agencies reported a strong increase in alcohol related presentations which is not surprising on the back of a 26.7% increase in turnover from alcohol sales[4], with a growing trend among the feedback of an increased frequency of people at acute risk of alcohol related harm. One agency reported:

> *"My staff have been seeing more people presenting who are drinking more since COVID, with some consuming up to three bottles of vodka daily."*

Agencies have also reported increased presentations involving cannabis. The fluid substance use trends combined with the exacerbated COVID-19 related anxieties have resulted in both new cohorts and greater complexities among those presenting to AOD agencies.

Impact of COVID-19 on services

Counselling wait times have extended to up to eight weeks in some areas

Residential services have contracted by approximately 20% extending wait times.

Outreach services have been restricted by physical distancing measures

Wait times

VAADA's COVID-19 Sector Survey indicated that COVID-19 impacted all AOD agencies and treatment types. Face to face counselling shifted to a telehealth or online model as did group work. While well received in many cases, at the start of 2021, a number of agencies are reporting wait times up to 10 weeks for standard counselling, which agencies reported as being far higher than pre COVID-19. The provision of outreach was greatly limited due to social distancing and residential services contracted and wait times ballooned. The same survey revealed that 88.89% of agencies providing residential services experienced a reduction in bed availability. Further feedback from agencies indicated a 20% reduction in bed availability across the sector.

Telehealth

Delivering AOD treatment via a telehealth model for counselling services was well received by some, although a number of issues were identified, such as limited online and telephone access for service users, reluctance from some service users to engage (such as some vulnerable young people), difficulty in detecting clinical cues and issues relating to anonymity for all parties. While telehealth offerings will be part of the service mix going forward, caution should be applied with any attempt to supplant face to face modalities with remote telehealth options.

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[3] NDARC 2020. Methamphetamine and Heroin availability down since March, prices up: survey. 5 November. https://newsroom.unsw.edu.au/news/health/methamphetamine-and-heroin-availability-down-march-prices-survey

[4] Fare 2021. Australia records highest month in history for alcohol reataler turnover in December. 12 February. https://fare.org.au/australia-records-highest-month-in-history-for-alcohol-retailer-turnover-in-december/

Agencies report that clinicians are under greater duress, as they face greater complexity among those presenting and grapple with diminished means of support through working remotely. There is an increase in the frequency of clinicians reporting personal duress and due to the nature of remote working, with the provision of support being more time consuming creating a greater burden for the agency.

Missing and emerging cohorts

COVID-19 has placed limitations for some cohorts to engage treatment while drawing other cohorts into the treatment sector. The deleterious impact on residential services has already been noted, as it has for those engaging in outreach and some group programs. Uncertainty remains regarding the level of support available to regular service users during the lockdown who were seeking to engage these treatment modalities. The Victorian Government budget announcement allocating $25.62M[5] to support those waiting will go some way in supporting many of these people going forward, but the adverse impact of the limited contingency afforded during lockdown remains to be seen.

Agencies reported that there has been an increase in the number of people relapsing during the lockdown and many also noted that there is an increase in the frequency of new service users, unknown to the sector. The broader longitudinal AOD impact of the community is unclear although there is evidence of increased AOD use following natural disasters such as Black Saturday and the Queensland Floods.

- Following the Black Saturday fires, 23.2 percent those residing in severe fire affected areas engaged in heavy drinking compared to 17.6 percent in low affected areas;[6]
- Alcohol use was 1.4 times higher in fire affected areas following Black Saturday amounting to an estimated lifetime cost of $190 million;[7]
- Similarly, following the Queensland floods, people in flood affected areas were
    - 5.2 times more likely to increase alcohol consumption;
    - 4.5 times more likely to increase tobacco usage; and
    - 5.1 times more likely to increase medication consumption[8] amounting to a lifetime cost of $20 million[9]

These findings speak to an increase in substance dependence in the long term, with data reflecting the harms three to four years after the crisis.

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[5] Victorian Government 2020. Building our recovery workforce to support our state. 10 November. https://www.premier.vic.gov.au/building-our-recovery-workforce-support-our-state

[6] Bryant et al. 2018. Longitudinal study of changing psychological outcomes following the Victorian Black Saturday bushfires. ANZJP. 52(6). Pp 542-551.

[7] Deloitte Access Economics 2016. The Economic Cost of the Social Impact of Natural Disasters. http://australianbusinessroundtable.com.au/assets/documents/Report%20-%20Social%20costs/Report%20-%20The%20economic%20cost%20of%20the%20social%20impact%20of%20natural%20disasters.pdf

[8] Turner et al 2013. Impact of the 2011 Queensland Floods on the use of Tobacco, Alcohol and Medication. 37 (4).

[9] Deloitte Access Economics 2016. The Economic Cost of the Social Impact of Natural Disasters. http://australianbusinessroundtable.com.au/assets/documents/Report%20-%20Social%20costs/Report%20-%20The%20economic%20cost%20of%20the%20social%20impact%20of%20natural%20disasters.pdf

b) Pressure bearing on the sector

While various components of the AOD sector have received increased funding, this uplift has not been consistently applied. As a result, increasing expectations for enhanced cross-sector capability are not matched by commensurate funding. Recent funding increases have focused on specific programs or initiatives like the Drug Court, SafeScript and residential services; at time of writing, as well as the $25.6M announcement of 100 new AOD workers.

While important, these initiatives do not necessarily support the broader population of service users. This amounts to a lost opportunity to enact an effective early intervention. As a result of the inadequate resourcing of the sector, voluntary clients in particular are incurring increased waiting times for treatment. Such issues and waiting times are further compounded when considering trends such as the burgeoning prison population and their complex AOD needs on release.

One perverse result of the AOD system's lack of capacity is the creation of fertile ground for unregulated 'for profit' treatment facilities. Some of these private operators exploit desperate and vulnerable Victorians by promising fast and significant results, while providing high-cost programs often with little evidentiary grounding. Beyond rich anecdote, evidence of the extent of 'dodgy' private AOD treatment in Australia is limited, but the costs to the individuals are likely to be significant.

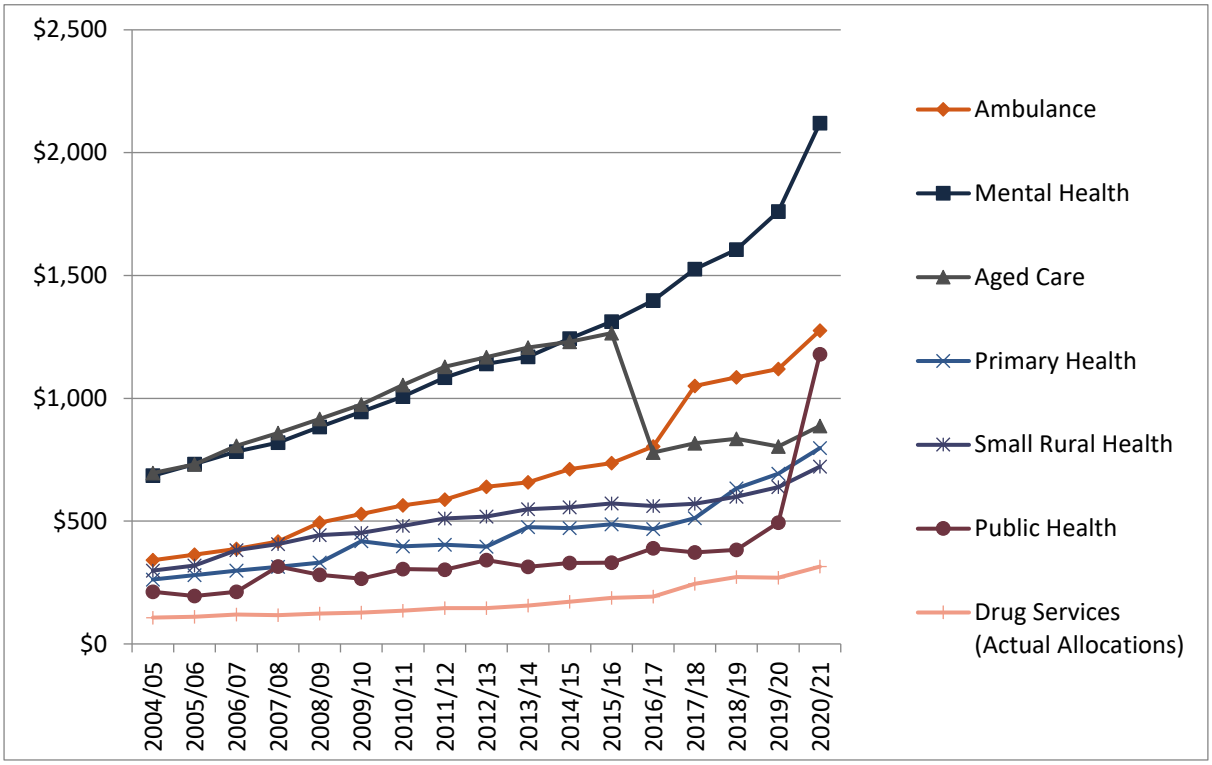
Experts from the National Drug and Alcohol Research Centre have estimated the current shortfall in terms of AOD harms versus investment in services in Australia. Ritter et al estimate current national investment in AOD treatment at around $1.26 billion per year.[10] Compared to the costs of AOD harms — estimated at $55.2B per annum[11] — the disparity between investment, sector capacity and harm is stark. Victoria's investment in addressing AOD harms needs to reflect its proportion of Australia's AOD harms.

Despite recent and welcome funding announcements from the Government, **Figure 2** (below) shows that the AOD sector lags well behind other health sectors in terms of funding. This is despite a wealth of evidence showing a strong return on investment in AOD.

[10] A Ritter, L Berends, J Chalmers, P Hull, K Lancaster and M Gomez, 'New Horizons: The review of alcohol and other drug treatment services in Australia' in *Drug Policy Modelling Program, National Drug and Alcohol Research Centre*, University of New South Wales, Sydney, 2014, p 14.

[11] D Collins and Lapsley, H, *The Costs of Tobacco, Alcohol and Illicit Drug Abuse to Australian Society in 2004/05*, Commonwealth Government, Department of Health and Ageing, Canberra 2008, xii.

Figure 2: Output funding (health) 2004/05 – 2019/20 (in $millions)[12]



c) What is needed?

A properly-funded AOD system supports families and is cost-effective.

Despite the challenges currently facing the Victorian AOD sector, it delivers treatment which provides positive outcomes for clients as well as returns on government investment.

Over a 12-month period, treatment provides a cost benefit ratio of $8 saved for every $1 spent.[13] This is additional to significant benefits for social cohesion and community well-being.

A cost/benefit analysis of AOD investment in Australia shows that:

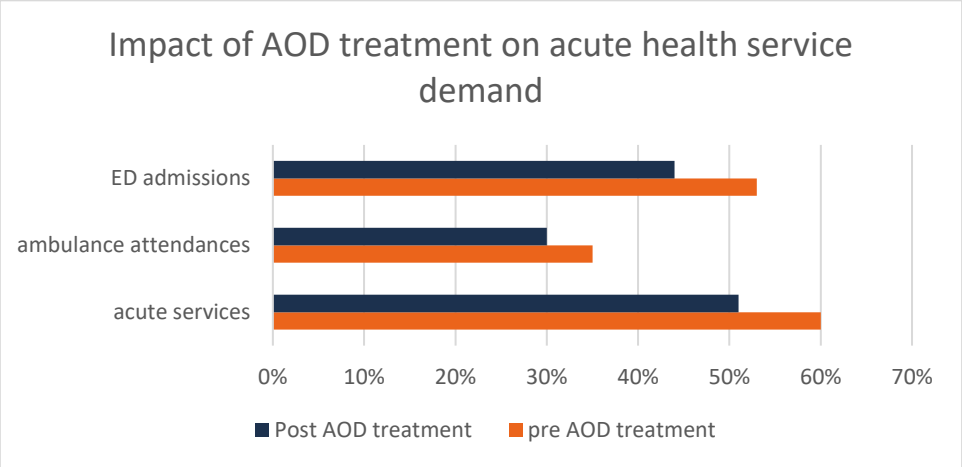
- individuals who had engaged in AOD treatment were found to access acute health services (ambulance attendances[14] and hospital emergency department admissions[15]) at a lower rate in the year post- treatment, compared to the year prior to treatment; [16]

[12] Data for Figure 2 has been obtained from Victorian Government Budget Papers.
[13] J Coyne, V White, and C Alvarez, C, *Methamphetamine: focusing Australia's National Ice Strategy on the problem, not the symptoms*, Australian Strategic Policy Institute, Barton, 2015, p 21.
[14] Ambulance attendances decreased from 35 to 29%
[15] Hospital emergency admissions decreased from 53 to 44%
[16] V Manning et al, 'Substance use outcomes following treatment: findings from the Australian Patient Pathways Study', *Australia and New Zealand Journal of Psychiatry,* vol 51, no 2, 2017, p. 11.

- AOD residential rehabilitation is more cost effective than prisons. The diversion of Aboriginal people to rehabilitation programs saves $111,458 per person, with additional health-related savings valued at $92,759;[17] and
- Over two years, the Victorian Drug Court found that it accrued $1.2M in savings through reducing the prison population (in addition to reducing recidivism and improving health and welfare).[18]

In addition to improving outcomes for clients, investment in the AOD treatment sectors shows clear reductions in downstream institutional costs. Further, the preventative effects of AOD treatment combined with diversion initiatives reduces the incidence of recidivism, thereby reducing both downstream and upstream enforcement and institutional costs. Targeted investment in the AOD sector will increase returns for the Victorian taxpayer.

Figure 3: Impact of AOD treatment on acute health service demand (Manning et al. 2017)



[17] National Indigenous Drug and Alcohol Committee, 'An economic analysis for Aboriginal and Torres Strait Islander offenders prison vs residential treatment', Australian National Council on Drugs research paper no 24, accessed 13 January 2020, https://www2.deloitte.com/au/en/pages/economics/articles/cost-prison-vs-residential-treatment-offenders.html, xi.

[18] KPMG, *Evaluation of the Drug Court of Victoria: Final Report*, Magistrates Court of Victoria, Melbourne, 2014, https://www.mcv.vic.gov.au/sites/default/files/2018-10/Evaluation%20of%20the%20Drug%20Court%20of%20Victoria.pdf accessed 13 January 2020, p. 6.

d) Adapting to community need and COVID-19

Appropriate levels of funding based on an assessment of need and implemented in accordance with a comprehensive AOD industry plan should be progressed. They which need to be informed by COVID-19 related increases in demand.

A 2019 study carried out by researchers at the National Drug and Alcohol Research Centre into unmet demand for AOD services in Australia (**NDARC Study**) reveals the urgent need to increase AOD service capacity nationwide. The NDARC Study showed that between 26.8% and 56.4% of those in need of treatment accessed it. This translates to a demand gap of 43.6 to 73.2%, or 180,000 to 553,000 people nationally.[19]

Since COVID-19, agencies have reported an increase frequency of service users new to the sector putting further strain across most treatment types. This is coupled with an increase in relapse among those in recovery, overlayed by many 'mum and dads' seeking assistance for increased alcohol consumption during the restrictions.

To meet Victoria's share of national unmet demand, the government needs to support a raft of reforms to the sector. It would not just require the necessary expansion of the core AOD system including access to residential rehabilitation and withdrawal AOD services, but many other significant investments and system wide modifications. This includes ensuring that the system is geared to cater for various at risk cohorts, including those in need but not engaged with the system, emerging new populations such as those identified through SafeScript and ensuring that the workforce has the capability to support an increasingly complex cohort of service users. This expansion would be informed by a systematic assessment of current need and be implemented in accordance with a comprehensive industry plan.

Assessing treatment demand: the Drug and Alcohol Services Planning (DASP) Model

In order to expand the AOD system to meet the needs of Victorians in a cost-effective way, the Government must first develop an accurate estimate of those needs. To this end, VAADA recommends that the Victorian Government utilise the Drug and Alcohol Services Planning Model (**DASP Model**). The DASP Model was commissioned by the inter-governmental Ministerial Council on Drug Strategy and developed by the NSW Ministry of Health between 2011 and 2013, this national planning tool estimates future need and demand for AOD treatment services in Australia.[20]

The DASP Model was developed with two primary aims:

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[19] A Ritter, J Chalmers and M Gomez, 'Measuring Unmet Demand for Alcohol and Other Drug Treatment: The Application of an Australia Population-Based Planning Model', *Journal of Studies on Alcohol and Drugs, Supplement*, s18, 2019, p. 42.

[20] Network of Alcohol and Other Drugs Agency, *Submission to the New South Wales Health Ministry of Health for the provision of additional residential rehabilitation and withdrawal management beds in New South Wales*, Attachment 1, March 2019, https://www.nada.org.au/wp-content/uploads/2019/03/NADA-Submission_-NSW-AOD-Beds_120319.pdf accessed 14 January 2019, p. 21.

1. estimating future population need for AOD treatment; and
2. providing a basis to achieve consistency of health planning across Australian states and territories.[21]

The DASP Model provides estimates on the following outputs:

- numbers of people suitable for, seeking and likely to benefit from treatment in any one year;
- service types required to meet demand (i.e. the number of beds and number of outpatient treatment places across service types);
- workforce requirements to meet demand (number of medical, nursing, allied health and AOD workers); and
- The resources required to deliver care in line with the packages specified in the model.[22]

The DASP Model has been used by several Australian jurisdictions[23] to assess investment need and is a potentially valuable planning tool for Victoria. The identification of the gap between the *need for treatment* and the *availability of treatment* allows for investment that effectively targets areas of greatest need.

The need for a comprehensive AOD industry plan

To guide this necessary shift, VAADA suggests the establishment of a well-researched and appropriately funded Industry Plan for the AOD sector.

The focus of the Industry Plan should be to enhance the efficacy and efficiency of meeting service user demand as well as maximising access. The primary issues that the Industry Plan would need to address are:

- geographic need;
- community need;
- workforce capacity including recruitment, retention, training and capability; and
- the impact of sector reforms and initiatives.

The Industry Plan should be based on population health planning projections such as the DASP Model which has been used by several other Australian jurisdictions.[24].

An Industry Plan would allow for strategic remediation of funding gaps and service blockages within the existing AOD service system structure, as well as the telegraphing of investment to areas of growing need and urgency.

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[21] Ibid.
[22] Ibid.
[23] Including Western Australia, Tasmania and the ACT
[24] Including Western Australia, Tasmania and the ACT. The model identifies the gap between the need for AOD treatment and the availability of treatment and allows for investment that effectively targets areas of greatest need.

Currently, access pathways between service areas – for example, from hospital or prison to community-based services, or from detox to a residential-based service are complex and difficult to navigate. An industry plan, which facilitates cross-sectoral collaboration, will require strong commitment from government in terms of time and funding. It can only achieve its objectives if appropriate human and financial investment in Victoria's core AOD service system occurs.

The establishment of an integrated and co-ordinated system, which can work across sectors and with greater capacity to address community demands arising from a large number of areas (including corrections, youth, family violence, CALD and Indigenous), is a significant yet beneficial endeavour. The issue for government is not whether it considers this an affordable option in the short-term, but rather, what the resulting long-term cost will be if it does not invest in a system, which is equipped to prevent harm and associated expenditure.

In the meantime, the sector has identified areas requiring urgent investment. These specific funding requests fall under three key themes:

1. Responding to increased demand;
2. Enhancing the AOD sector; and
3. Increasing access to AOD treatment.

The submission will address each theme, and associated recommendations, in this order.

5. Current AOD sector investment requirements

a) Responding to increased demand

i. Responding to increased demand: forensic clients

The AOD sector continues to experience a year on year increase in demand from forensic clients. The sector is not adequately resourced to cater for increasing demand going forward with systemic impediments to the optimal provision of forensic services. Forensic clients are likely to present with complex needs: they commonly experience more severe AOD issues as well as other co-morbidities such as poor housing stability, poor mental health and are often disengaged from supports and services. Forensic AOD treatment is vital in reducing recidivism. An increase in targeted funding to address the needs of forensic clients is necessary to meet demand, lower recidivism (and subsequent justice-related expenditure), and reduce the rate of overdose deaths amongst people who have formerly been in prison.

VAADA's 2019 Sector Priority Survey identified a significant increase in demand from forensic clients. It also found that a significant proportion of respondents considered forensic counselling to be the most inadequately funded services in the AOD sector. This increase is borne out in current statistics

which show that approximately 37% of Victorian AOD clients are forensic clients[25], with VAADA sector surveys indicating that some regions maintain a caseload consisting of 80% forensic demand.

Despite a dip in the rate of imprisonment in Victoria due to COVID-19, the broader demand across the correctional system to increasing forensic AOD treatment will continue on an upward trajectory. The expanding correctional system, exemplified by the need for a new prison during each term of government, reflects a trending state-wide increase in forensic demand.

The rise in presentations by forensic clients has had an enormous impact on the AOD sector by displacing voluntary clients. The DTAU funding model requires adjustment to cater for a high rate of forensic demand which is presenting with increasing complexities. The DTAU should be adequate to allow for 'realistic' remuneration, training and support to retain high quality staff. The limitations in funding through the current model have reduced capacity and reportedly led to a worrying trend of Courts referring forensic clients to the unregulated for profit sector.

Some related facts:

The rate of substance use disorder amongst people in prison is considerable. It is estimated that 55-76% of people in custody in Australia experience a substance use disorder - 11 times the rate for the general population.[26]AOD harms persist within the prison environment, with an increase in sharing injecting equipment[27] among the 46% of the cohort in prison who have previously used intravenous drugs in the community opting to injecting drugs at some time during a period of imprisonment.[28] These people are at great risk of contracting blood borne viruses such as hepatitis C.

Further to this, there is a consensus of evidence re-entering the community carries huge risks to health and wellbeing. In August 2019, VAADA received correspondence from the Coroners Court of Victoria advising that 41% of a sample of 220 people who died from heroin-related overdoses in 2017 had had previous contact with the justice system.

Continuity of care is critical in supporting a person's recovery and therefore in reducing recidivism. Literature suggests that continuity of care for people leaving prison in Australia is inadequate.[29] [30] In consultations held by VAADA with the Victorian AOD sector, inadequate discharge planning prior to release was identified as a major

[25] VAHI data 2018/19

[26] J Young, K Snow, L Southalan, R Borschmann and S Kinner, *The Role of Incarceration in Addressing Inequalities for People with Mental Illness in Australia*, Submission to the Productivity Commission's Issues Paper on the Social and Economic Benefits of Improving Mental Health, 5 April 2019, https://www.pc.gov.au/__data/assets/pdf_file/0017/240902/sub339-mental-health.pdf, accessed on 7 November 2019.

[27] Cunningham et al 2018. Longitudinal injecting risk behaviours among people with a history of injecting drug use in an Australian prison setting: The HITS-p study. *Journal of Drug Policy.* Vol 54. pp. 18 – 25.

[28] Featherstone et al 2013. Rates of injecting in prison in a sample of Australian injecting drug users. Journal of Substance Use. Vol 18, no 1. Pp 65 – 73.

[29] P Abbott, P Magin, S Lujic, W Hu, 'Supporting continuity of care between prison and the community for women in prison: a medical record review', *Australian Health Review,* Vol. 41, No. 3, 2017, pp. 268-76.

[30] J Johnson, Y Schonbrun, M Peabody, et al, 'Provider Experiences with Prison Care and Aftercare for Women with Co-occurring Mental Health and Substance Use Disorders: Treatment, Resource, and Systems Integration Challenges', *J Behav Health Serv Res*, Vol. 42, No. 4, 2015, pp. 417-36.

disrupter of continuity of care. A lack of adequate support for people recently released from prison transitioning back into community increases the likelihood of recidivism and healthcare costs, as well as placing a significant economic burden on our community.[31]

Addressing these issues requires a significant shift in current strategies related to incarceration and community reintegration of people released from prison. Better AOD treatment support and improved linkages with other service systems including mental health and housing is essential if we are to address this crisis.

Recommendation 1: Implement a comprehensive harm reduction strategy for people in prison including support for those approaching release. This strategy should incorporate enhanced guidance for correctional staff in delivering harm reduction training prior to release, including the provision of Naloxone (and training in how to administer it) and should allow for the provision of sterile injecting equipment in correctional settings.

Essential elements of an enhanced forensic AOD response would include:

- A re-examination of the value of the Forensic Drug Treatment Activity Unit;
- Increased staffing, including increased numbers of in-house forensic specialists on retainer, outreach AOD workers, and peer workers;
- Mandatory comprehensive discharge planning and preparation for continuity of care for people exiting prison;
- Enhanced, integrated and co-ordinated support on exit focused on integrating AOD treatment, employment, education and training, provision of appropriate housing, community-based mental health supports;
- Government subsidisation of the ORT dispensing fee ; and
- Training in the use and distribution of Naloxone to all people exiting prison.

Recommendation 2: Establish a co-located, coordinated suite of support services to assist with the integration of individuals with complex needs who have recently been released from prison. $5M funding should be invested to develop a specialist agency which specifically focusses on mental health, AOD, employment, training and mentoring support for this cohort. This organisation should also oversee an allocation in social and public housing.

[31] Victorian Alcohol and Drug Association, *Submission to the Royal Commission into the Mental Health System in Victoria*, 2019.

Increase access to diversion

Illicit drug offences are the second most common category of criminal offence among Victorians in prison. As of 30 June 2020, 14.6% of people in Victoria prisons (a total of 1,051 out of 7,151[32]) were serving a custodial sentence relating to a drug offence.[33] The rate of offences recorded for drug use and possession has almost trebled from 11,775 (2011) to 32,087 (2020)[34]. This surge in offences recorded has occurred as the percentage of these people receiving diversion has declined from 66% (2010/11) to 62% (2014/15).[35]

In 2019, Dr Caitlin Hughes of the National Drug & Alcohol Research Centre led a study of the barriers and facilitators to the expansion of diversion in the Australian context (Hughes Study). Hughes found that diversion programs provide a significant return on investment, reduce recidivism (one study saw a recidivism rate of 31.5% for diversion participants compared to an average of 41.3% to 31.5%) as well as improving housing and employment outcomes when compared with standard correctional responses.[36]

To capitalise on these benefits, there is a need for a default response where people charged with drug possession and use offences are required to be placed on diversion.

Research into the efficacy of forensic AOD programs has found that rates of recidivism were reduced by 30%, and the severity of offending was similarly lowered.[37] [38] The individual and community benefits which flow from the use of diversion are considerable.

Despite the efficacy of diversion programs, long wait lists (often two to three months) and access difficulties are a major barrier to engagement, particularly in rural areas. One expert respondent to the Hughes Study noted that in Australia:

> *From 2007 to 2018 there has been a 37% increase in reported illicit drug use but no accompanying rise in treatment. The problem is particularly acute in rural areas where service access is a big issue… some people have to sit on a bus for 2 hours to get to treatment.*[39]

And

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[32] Corrections 2021, *Prisoners and offenders*, accessed 5 April 2021, https://www.corrections.vic.gov.au/prisons/prisoner-and-offender-statistics

[33] Australian Bureau of Statistics, *Prisoners in Australia, 2020,* 3 December 2020 2019, https://www.abs.gov.au/statistics/people/crime-and-justice/prisoners-australia/latest-release#key-statistics, accessed 5 April 2020.

[34] Crime Statistics Agency, 'Recorded Offences' 14 January 2021, https://www.crimestatistics.vic.gov.au/crime-statistics/latest-victorian-crime-data/recorded-offences-1

[35] Hughes et al. 'Criminal justice responses relating to personal use and possession of illicit drugs: the reach of Australian drug diversion programs and barriers and facilitators to expansion'. *Monograph 27.* UNSW 2019.

[36] ibid

[37] S Larney and K Martire, 'Factors affecting criminal recidivism among participants in the Magistrates Early Referral Into Treatment (MERIT) program in New South Wales, Australia', *Drug and Alcohol Review*, vol. 29 no. 6, 2010, pp. 648-688.

[38] O Mitchell et al, 'Does incarceration-based treatment drug treatment reduce recidivism? A meta-analytic synthesis of the research', *Journal of Experimental Criminology*, vol. 3, no. 4, 2007, 353-375.

[39] C Hughes et al, 'Criminal justice responses relating to personal use and possession of illicit drugs: the reach of Australian drug diversion programs and barriers and facilitators to expansion', *Drug Policy Modelling Program Monograph Series 27*, 2019, p. 51.

> *Availability of treatment is a major barrier, especially at the high level with problematic drug use… the availability of treatment and programmes had made it difficult. …. We heard there was a lack of services, especially if you are outside the metro area. In regional areas there are very few avenues for that type of diversion… that higher end problematic drug use diversion.*[40]

A particular aspect of Victoria's diversion system requiring scrutiny is the fact that it relies on police discretion in determining access. The use of discretion has led to inconsistencies in the use of diversion: the Hughes Study notes that while diversion is used more frequently in some areas, other 'local police area commands actively resist diversion,' leading to what has been call 'postcode discrimination'. The Victorian Parliamentary Inquiry into Drug Law Reform expressed its concern about this issue in its 2018 report, summarising, 'you can get a wide range in approaches across different stations and different areas within the state and same system'.[41] To address this issue, it would be beneficial to consider a best practice model of diversion which meets the needs of offenders.

This will ensure that diversion is applied in a consistent manner, ensuring that Victorian offenders who would benefit from diversion are able to access it.

Recommendation 3: All individuals charged with drug possession and use offences should be eligible for Court Diversion and for younger people cautions; to accommodate additional demand there should be a subsequent increase in the availability of community-based support and treatment services.

ii. Responding to increased demand: SafeScript

*Victoria's Real Time Prescription Monitoring (**RTPM**) system, 'SafeScript' provides an opportunity to address pharmaceutical related harm occurring within a largely hidden cohort. The benefits of SafeScript remain to be seen as the Department of Health is not seeking to evaluate patient outcomes. As pharmaceutical related harm remains a pressing issue in the community, the absence of a coordinated response from the AOD, pain medicine and mental health sectors to address these harms reflects a missed opportunity to capitalise on a good program.*

Victoria's RTPM system, SafeScript, has been mandatory since 1 April 2020, and the impact of this program have been significant. Of the 618,000 Victorians in the trial region, 4,500 (0.73%) were identified as being at-risk of harm associated with their use of pharmaceutical medication.[42] Following an FOI by the ABC, it was revealed that between 1/1/20 to 30/6/20, 69,201 Victorians were identified through the system.[43] At time of writing, we understand that the Department has no assurances as to what supports if any were provided to these people.

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[40] Hughes et al, *Criminal Justice Responses*, pp. 51-52.
[41] Victorian Parliamentary Inquiry into Law Reform, cited in Hughes, p. 50.
[42] Western Victoria Primary Health Network, 'SafeScript Real-Time Prescription Monitoring', *Western Victoria Primary Health Network* [website], 2019, https://westvicphn.com.au/health-professionals/health-topics/alcohol-and-other-drugs/safescript-prescription-monitoring/ accessed 15 January 2020.
[43] Department of Heath 2021. Safescript. FOI February

Additional considerations include:

- This figure is approximately 50% greater than the number of Victorians who were engaged AOD treatment in 2019/20;
- The ACIC 2021 Waste Water Analysis, which was undertaken after SafeScript became mandatory, has revealed regional Victoria has a high rate of pharmaceutical opioid use compared to the rest of Australia;[44]
- Pharmaceuticals have consistently contributed to eight in 10 fatal overdoses[45]; and
- Victoria has an enduring illicit and pharmaceutical opioid market with elasticity in the illicit market potentially limiting the impact of SafeScript to reduce opioid related harm.

Those individuals impacted by SafeScript have likely experienced reductions in the quantity and type of medication available to them.

However, beyond the above data, little is known about the subsequent impacts on those monitored under SafeScript. There is a pressing need to examine the journey beyond the general practice or pharmacy to ascertain whether additional support is required, the type of support utilised and any longer-term outcomes.

It is anticipated that the flow-on effects of SafeScript may include:

- increased demand, with impacted cohorts likely to require additional support. This is compounded by the reported increase in demand following the second wave; and
- an increased number of people using alternate (and more risky) means of procuring various substances, including engaging with illicit street-based markets, legal highs or the Dark Web. This concern is exacerbated through pandemic related changes to the illicit drug market.

The positive impacts of Safescript will be at risk if this reform is not supported by a robust and capable AOD sector, as well a range of related service sectors. As these impacts were not accounted for in the design of SafeScript, an evaluation should be undertaken.

Recommendation 4: Invest $20M in the AOD sector to provide for the additional demand generated by SafeScript and other reforms aimed at reducing pharmaceutical related harm. This would provide for necessary workforce capacity-building, including greater capacity for Victoria's pharmacotherapy system, the expansion of addiction medicine and pain management capacity as well as the establishment of accessible specialist clinics across Victoria.

Recommendation 5: Undertake research and a review of the impacts of SafeScript, which includes an assessment of:

i) Patient outcomes following identification; and
ii) the limitations, benefits and impact of SafeScript, on targeted consumers, with particular reference to their healthcare needs, treatment and referral pathways.

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[44] Australian Criminal Intelligence Commission 2021, *National Waste Water Drug Monitoring Program – report* 12, Australian Criminal Intelligence Commission, https://www.acic.gov.au/sites/default/files/2021-02/National%20Wastewater%20Drug%20Monitoring%20Program%20Report%2012.PDF accessed 20 March 2021

[45] Coroners Prevention Unit 2020. Overdose deaths, 2010 – 2019 Victoria. Coroners Court of Victoria.

iii. Responding to increased demand: growth corridors

Population growth in many interface regions of Melbourne is outstripping the supply of various health and welfare services, including AOD treatment, necessitating additional capacity to provide services for a rapidly growing population. Growth corridors have been heavily impacted by COVID-19 and have a large uptake of various government supports such as Jobkeeper[46].

Prior to COVID-19, Victoria's population was expanding at a higher rate than any other state or territory within Australia.[47] Victoria's growth rate is 1.8% compared to the national average of 1.4%[48] and has a higher population density than any other state at 23.54 people per square kilometre.[49] Prior to COVID-19, it was estimated that from 2016 – 2036, Victoria's growth corridors will experience up to a 20-fold increase in population growth, far surpassing the state and national average of population growth (Environment, Land, Water and Planning 2019).[50] These regions will face increased harms if investment in services, including AOD, does not meet this level of growth.

It is evident that Melbourne's growth corridors have been heavily impacted by COVID-19, with the most salient being employment. Communities in the South East, North West and Northern parts of Melbourne, including Cranbourne, Tarneit, Craigieburn and Dandenong have relied heavily on Jobkeeper[51].

According to the 2015 *Dropping off the Edge* report (**DOTE Report**) commissioned by Jesuit Social Services and Catholic Social Services Australia, many of Victoria's growth corridor regions experience high levels of disadvantage.[52] Although the DOTE Report does not provide details on AOD-related harms or issues, we know that communities experiencing high rates of poverty, homelessness, mental illness and criminal justice involvement are more likely to experience AOD-related harms.[53]

Rapid population growth combined with inadequate health infrastructure, will perpetuate disadvantage and create pockets of extreme disadvantage. This may lead to Melbourne becoming a two-tiered city, with a widening gulf between a rapidly expanding, under-resourced outer ring and more advantaged and well-serviced middle and inner regions further exacerbated by COVID-19.

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[46] Australian Government Treasury. 2020. Jobkeeper Postcode Data. Viewed 20 November 2020, https://treasury.gov.au/coronavirus/jobkeeper/data

[47] Australian Bureau of Statistics 2020, https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release

[48] Australian Bureau of Statistics, *3101.0 – Australian Demographic Statistics, Mar 2018*, Australian Bureau of Statistics, 2018, http://www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0 accessed 10 October 2018.

[49] Population Australia, *Population of Victoria* 2019, http://www.population.net.au/population-of-victoria/ accessed 30 October 2019.

[50] Environment, Land, Water and Planning, *One page profiles*, Victorian Government, 2016, http://www.delwp.vic.gov.au/planning/forward-policy-and-research/victoria-in-future-population-and-household-projections/one-page-profiles viewed 20 September 2016.

[51] Australian Government – The Treasury 2020. Economic Response to the Coronavirus. https://treasury.gov.au/coronavirus/jobkeeper/data

[52] T Vinson and M Rawsthorne, *Dropping off the Edge 2015: Persistent Communal Disadvantage in Australia*, Jesuit Social Services/Catholic Social Services Australia, 2015, https://dote.org.au/findings/full-report/ accessed 15 January 2020.

[53] D Lubman et al, *A study of patient pathways in alcohol and other drug treatment,* Turning Point, Fitzroy, 2014.

AOD treatment providers operating in these areas identify a range of issues that influence service access, including:

- limited capacity for outreach, which is a priority in areas with limited transport infrastructure;
- limited community development capacity;
- limited capacity to provide after-hours service provision, crucial in areas isolated from public transport infrastructure;
- limited availability of suitable facilities for treatment providers;
- limited capacity for specialist services to engage with high-risk CALD communities;
- very high proportions of forensic AOD service users (in some places, 80% of all service users), which indicates that forensic clients are displacing voluntary clients in AOD treatment, given the limited capacity of the AOD treatment system;
- limited pharmacotherapy dispensers and prescribers, including accessibility issues; and
- A lack of capacity to provide flexible service models to accommodate the challenges associated with growth corridors.

Recommendation 6: Invest $3M on a recurring basis to each interface region (Melton, Casey, Wyndham, Cardinia, Mitchell and Whittlesea) to enhance existing services and/or establish new services to address AOD-related harms in line with rapid population growth, disadvantage and local need.

iv. Responding to increased demand: Rural and regional areas

In rural and regional Victoria, demand for AOD services outstrips capacity, and there are significant challenges in recruiting and retaining quality staff. Inducements to work in rural and regional areas, together with a broad ranging increase in capacity, are necessary to address these challenges.

Rural and regional Australia experience greater disadvantage and poorer socio economic circumstances compared to metropolitan areas.[54] The Australian Institute of Health and Welfare (**AIHW**) notes:

- in 2015, remote and very remote areas experienced a burden of disease rate 1.4 times greater than the metropolitan rate;
- between 2015 and 2017, a direct correlation was established between life expectancy and remoteness;
- those residing in rural areas are more likely to consume alcohol at riskier levels than their metropolitan counterparts;
- access to primary health services decreases as remoteness increases; and
- the number of health professionals decreases as remoteness increases.[55]

[54] Vinson and Rawsthorne, *Dropping off the Edge 2015*.
[55] Australian Institute of Health and Welfare 2019.

Infrastructure Victoria

Furthermore, Infrastructure Victoria, in recommending additional residential rehabilitation facilities in neglected parts of regional Victoria[56], notes:

- in rural and regional Victoria, the rate of unintentional fatal overdose is higher than metropolitan areas; and
- From 2015/16 to 2018/19, alcohol related ambulance attendances have increased by 42% compared to 28% in Melbourne with illicit substance attendances increasing by 37% (rural and regional) compared to 25% (Melbourne).

Infrastructure Victoria recommends the development of additional residential facilities in neglected areas; while VAADA supports this recommendation, there is a need to ensure that the number of beds provided are optimal for cost and efficiency, and furthermore, as detailed below under 'increasing residential capacity' there is also need for additional residential withdrawal capacity in these regions. To meet efficiency quotas, facilities could be developed which cater for both residential rehabilitation and withdrawal needs.

Rural and regional AOD harm

Hospitalisations related to illicit substance use in regional Victoria increased by approximately 50% in the four years leading to 2018/19 (see Figure 4 below).

Figure 4: Rural & regional alcohol related hospitalisations - Victoria

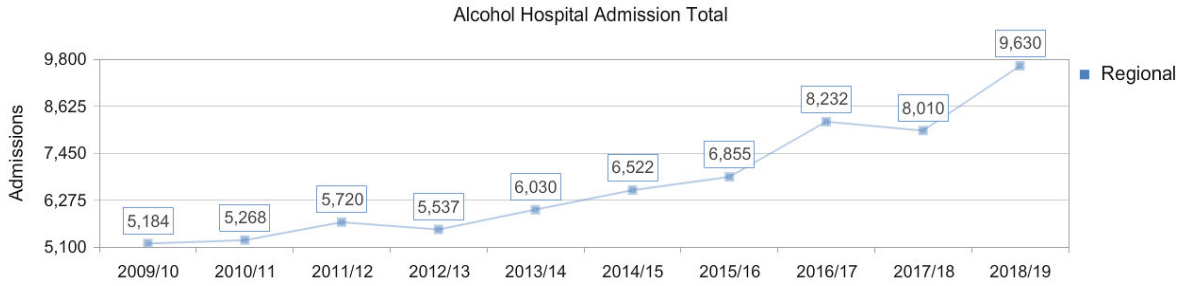
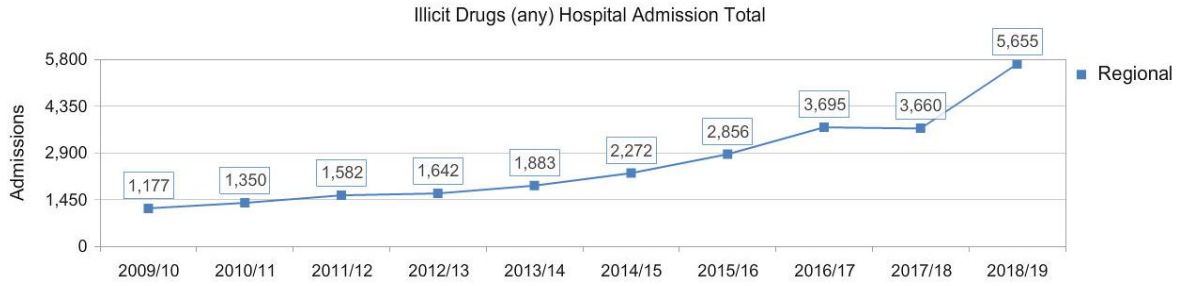


Figure 5 reveals that rural and regional illicit substance hospitalisations have increase by more than 50% in the year leading to 2018/19.

[56] https://www.infrastructurevictoria.com.au/wp-content/uploads/2020/12/Infrastructure-Priorities-for-the-Regions-December-2020.pdf

Figure 5: Rural and regional illicit substance related hospitalisations - Victoria



(Turning Point 2020)

The disproportionate rates of AOD-related harm in regional Victoria relate to acute systemic and resourcing limitations: rural and regional AOD services experience limited distribution of services, transportation challenges and workforce issues.

The VAADA 2019 Sector Priorities Survey revealed that, due to funding, many AOD employment opportunities in rural Victoria are part-time and short-term. Skilled workers are often reluctant to move to rural areas for the promise of an isolated part time job in a position that may only be funded for a limited duration. Most rural and regional providers noted that demand for services outstrips capacity. They noted stigma, anonymity, AOD service navigation and access as common challenges.

Further, adding to the challenge of AOD treatment access in rural and regional areas will be the flow-on effects from the 2019/20 bushfires across Victoria coupled with the impact of COVID-19. Bushfires of this magnitude, which are likely to become an increasingly common feature of the Australian environmental landscape, are known to increase the incidence and severity of mental illness and problematic substance use in affected communities.[57] Following the 2010 Black Saturday bushfires in Victoria, rates of heavy drinking increased the highest in those communities hit hardest by fire. Despite the Government initiating various programs in the wake of Black Saturday, the response was not adequate.[58] A study of the response suggested that areas suffering high distress must be prioritised to ensure that appropriately-trained professionals are available to provide the support required.[59] Following the last year's fire devastation across East Gippsland and the High Country, investment into support services must be increased to assist with the non-physical detriment which has been caused that will continue to manifest once the immediate fire risk has abated.

VAADA recommends the Government consider additional resources for bushfire affected areas to increase capacity to deal with the increase in mental health and AOD-related harms. A vital element is ensuring that support is available when required alleviating the risk of a more acute response at a later date.

[57] Psychological outcomes following the Victorian Black Saturday bushfires p. 643.
[58] Ibid
[59] ibid.

These harms, along with other risk-factors faced by regional Victorians, can be effectively mitigated through:

- increased and equitable access to AOD treatment in rural and regional areas; and
- increased opportunities for cross sector collaboration, crucial in areas with limited service availability.

Recommendation 7: Invest $10 million annually to enhance AOD service access and capacity in rural and regional Victoria, prioritising areas identified by local AOD catchment-based planning where there are challenges in service access, as well as high levels of morbidity and AOD related harms.

Recommendation 8: Apply a loading to all rural and regional AOD staff of 10% above the relevant award to enhance recruitment and better retain quality staff.

Recommendation 9: Apply a 20% increase in agency funding over three years in areas affected by disaster/crisis such as bushfires.

Recommendation 10: Convene a rural and regional AOD summit, as a matter of urgency, to engage with rural and regional communities in relation to measures that can be taken to address the range of AOD and system-related issues affecting them. An information gathering exercise should be undertaken to better inform stakeholders in the lead-up to the summit.

iv. Responding to increased demand: Care and Recovery Coordination

*Care and Recovery Coordination (**CRC**) provides support to deliver integrated support for people experiencing acute and complex AOD-related harms. CRC is a valuable yet under-resourced activity, which requires additional capacity to meet community demand.*

CRC is an essential intervention for complex clients and those experiencing multiple difficulties, in addition to AOD-related issues. For instance, survivors of family violence, who may be juggling AOD, housing and legal issues, would greatly benefit from this service type. CRC is a highly effective support service through which to engage in long-term AOD treatment, but its potential benefits are not being fully realised.

The utility of a CRC approach to treatment was recognised by the 2016 Royal Commission into Family Violence, which recommended that a range of services, including but not limited to AOD services, are needed by people experiencing family violence.[60] An appropriately-funded and enhanced Care and Recovery model of treatment will lead to improved outcomes for those affected by family violence, as well as for range of other cohorts including youth, CALD, Aboriginal and forensic clients.

[60] M Neave, P Faulkner, T Nicholson, *Royal Commission into Family Violence*, Victorian Government Printer, Melbourne, 2016.

Unfortunately, CRC at the time of recommissioning was grossly under-resourced and has been for some time. The 2015 Aspex Report highlighted a deficit in the resourcing of care and recovery coordination.[61] Almost 50% of respondents to VAADA's 2019 Sector Priorities Survey considered that funding for CRC was insufficient.

While the Government predicted in 2013 that up to one third of AOD service users would benefit from CRC, current estimations suggest there is only capacity for 3804 individuals to access CRC support annually.[62] Given the estimated 13,000 Victorians in need of CRC every year, this leaves a gap of 9,196 people who would benefit from CRC but are unable to access it. In order to meet demand for CRC, an additional 9,196 CRC interventions must be funded at an overall cost of $17.26M.

There is also a pressing need to evaluate the current value of the CRC DTAU rate. The 2020/21 price for a DTAU is $853.21, and the weighting on CRC currently sits at 2.22 DTAUs. It is apparent that this current rate is insufficient to cover the actual costs associated with providing CRC treatment, and therefore a review should be undertaken, with a view to increasing the current rate from 2.22 DTAUs.

To facilitate longer-term planning, the Government should undertake a comprehensive assessment of demand for this treatment type, using the DASP Model as earlier recommended. This would likely allow for additional capacity to maintain a continuum of care beyond the course of treatment, and provide a safety net to support people who may struggle to maintain positive treatment outcomes, based on relevant data.

Increased funding is also needed to enhance the resources necessary to provide CRC treatment: specifically, supported housing. Supported housing is a key element of CRC treatment, as it provides complex clients the stability they require in the period immediately following formal treatment, when risk of relapse is it its highest. During this time, many return to their former using environments and social groups, and supported housing can assist by providing an alternative environment which complements the recovery process.[63] Victoria's Big Build, which has allocated $5.3B in response to housing affordability, should prioritise a portion of housing for AOD service users. International research has indicated that supported housing has been associated with a range of positive treatment outcomes, including reductions in substance use, fewer arrests, and an increased likelihood of obtaining permanent housing and employment.[64]

Despite the value of supported housing, it is not adequately resourced: specifically, the staffing levels required are not sufficiently funded, leaving CRC clients without a vital part to the recovery

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[61] Aspex Consulting, *Independent Review of New Arrangements for the delivery of Mental Health Community Support Services and Drug Treatment Services: Final Report, Department of Health and Human Services*, September 2015.

[62] Department of Health and Human Services, *Service specification for the delivery of selected alcohol and drug treatment services in Victoria*, Advertised call for submissions No. 2487, 2013.

[63] D Lubman, V Manning and A Cheetham, Informing Alcohol and Other Drug Service Planning in Victoria: Final Report, Turning Point, Melbourne, 2 May 2017, p. 17.

[64] Fisk, Sells et al. 2007, Polcin 2009, Polcin, Korcha et al. 2010, Majer, Jason et al. 2011, cited in Lubman, Manning and Cheetham, Information Alcohol and Other Drug Service Planning, p. 18.

process. Clients accessing CRC treatment have complex needs, and supported accommodation during the transition period from residential rehabilitation to the community is crucial for maintaining people engaged with long-term AOD treatment. Accordingly, VAADA recommends that the Government consider funding targeted at increasing staffing levels within supported housing for those undertaking CRC.

Recommendation 11: Provide a recurring $17.26M boost to the AOD sector for additional 'Care and Recovery Coordination' treatment to account for the needs of approximately 30% of all AOD service users.

Recommendation 12: Provide increased access to transitional social housing for those whose circumstances require it on exiting formal AOD treatment.

b) Enhancing the AOD sector

i. Enhancing the AOD Sector: Drug Treatment Activity Units

The current value of the DTAU is widely considered to be inadequate: many within the AOD sector believe the DTAU should be increased by 30% to account for the range of unfunded activities necessary in providing treatment. VAADA recommends a comprehensive review into the value of a DTAU.

The 2015 Government-commissioned ASPEX report (**ASPEX Report**) which examined the state of the AOD service sector, identified the inadequacies of the current Drug Treatment Activity funding model. The ASPEX Report recommended that the then Department of Health and Human Services undertake a costing study to analyse the appropriateness of the current DTAU rate, given its inflexible nature and low costing, which means that the funding for some activities is too low to meet the actual costs of supporting vulnerable Victorians experiencing AOD dependency.[65]

Since the publication of the ASPEX Report, the broad sector experience confirms that the DTAU is considered inadequate and unrealistic in its expectation of covering all treatment activities: VAADA's 2019 Sector Priorities Survey revealed approximately 95% of survey respondents considered the current DTAU rate inadequate to cover expenses associated with providing funded treatment.

In theory, the formula determining the value of the DTAU should account for costs associated with workforce training and development. However, in practice, this does not occur. The workforce needs of the AOD sector expand each year, to cater for the growing demand in forensic, family violence, child protection, homelessness, CALD, LGBTIQ, older people, pharmaceuticals and dual-diagnosis. The progression of the relevant recommendations from the Royal Commission into Mental Health will likely add a greater burden of complexity for AOD agencies.

[65] Aspex Consulting, *Independent Review of New Arrangements*, p. 54.

Further, the current DTAU is based on the erroneous notion that AOD presentations are unencumbered with other issues. Consistent feedback from the sector reveals that counsellors are burdened with unfunded work which can take hours of additional time; this includes liaising and supporting service users with the NDIS, referring to other AOD agencies, mental health as well as family violence supports among others. The current value attributed does not account for this extra work, which is more closely aligned to care and recovery coordination. The changes in service delivery necessitated through COVID-19 have exacerbated these issues as services users present with increasingly complex issues.

VAADA reiterates the recommendation included in the ASPEX Report, that the suitability of the DTAU should be assessed against the real needs and activities of the sector.

Recommendation 13: Commence an immediate review into the value of a Drug Treatment Activity Unit (DTAU), based on a rigorous financial analysis which takes into account the realistic cost of service delivery.

ii. Enhancing the AOD sector: Workforce development – creating a sustainable AOD workforce

The AOD workforce is expected to increase its expertise and demonstrate strong competence and capability across a range of areas. AOD clinicians are expected to respond to a range of issues relating to AOD, such as family violence, forensics, mental health, and child protection. Despite these expectations, agencies face ongoing limitations in workforce development activity.

- There is an expectation of a broader skill set among AOD clinicians; and
- There is a need to provide greater work experience to students so they are more work ready.

As in previous years, the 2019 VAADA Sector Priority Survey revealed ongoing concerns regarding recruitment, retention and remuneration of staff in the AOD sector. More than half of respondents identified recruitment as an issue for their agency. This was more pronounced among organisations located in rural and remote communities.

While unemployment has soared during COVID-19, there is still a dearth of within the broader workforce of people with requisite skill set to support those experiencing AOD dependency.

The impact of state-wide AOD sector reforms in 2014 required clinicians to demonstrate capability across a range of areas and populations, including family violence, child protection, youth, Aboriginal and Torres Strait Islander and CALD communities. Compounding this burden is a marked increased demand from forensic clients.

There is an urgent need to establish mechanisms to efficiently upskill the Victorian AOD workforce on an ongoing basis.

VAADA recommends the development of a fast track system to address challenges associated with securing, training and allocating staff to a suitable service. This should focus on training and

experiential learning, coupled with 'micro-credentialing': the delivery of training units relating to family violence, children and youth, dual diagnosis, and other key areas of expertise.

Training 'intake' should occur at predetermined times during the year, to ensure new staff members receive training promptly and provides existing staff the opportunity to re-train.

Furthermore, there is a need for state-wide coordination and facilitation of workforce development opportunities such as sector network meetings, consultation forums, education, student placements and training opportunities as well as strengthening intra-sectoral communication and relationships. An entity (run by a team of two staff members) should be established to coordinate these training, student placement and capacity-building opportunities on behalf of the AOD sector. This entity will play a vital role in developing pathways to increase sector involvement in student placements to enable greater competency among the emerging workforce. It will also maintain and support a network of funded AOD registered training organisations (**RTOs**) with the express purpose of increasing workforce capability and would seek to generate greater interest in working in the AOD sector.

Recommendation 14: Invest $1.5M to establish an entity to better coordinate training, streamline student placements and enhance the attraction of staff to Victoria's AOD sector. This entity would explore options for micro-credentialing and rapid accreditation of new AOD workers in relevant areas of high need. A central co-ordinating team of two staff would support existing RTOs, and the enhanced workforce training initiative.

Recommendation 15: Invest $2M to develop a broad 'industry plan' for the AOD sector which takes into account the specific needs of the AOD sector as well as the AOD-related workforce needs of related sectors, including mental health, homelessness, child and family support services, Aboriginal, hospitals and forensic health environments.

iii. Supporting people experiencing co-occurring AOD and mental health concerns

While VAADA commends the final report from the Royal Commission into Mental Health and looks forward to working with the government in progressing the recommendation, there are significant AOD workforce and sector capacity implications which need to be considered in tandem with the progression of the necessary reforms.

The Royal Commission into Mental Health provided favourable feedback on the model of care provided by AOD services and asserted the need that the AOD sector continue to operate and support the many Victorians experiencing AOD dependency.

While the Royal Commission into Mental Health included two AOD specific recommendations (recommendations 35 and 36) there are a number of additional recommendations which broadly relate to supporting people experiencing co-occurring AOD and mental health issues through a model of integrated support provided at a service level. This, and other recommendations will have

significant implications on AOD sector capacity and potentially put considerable strain on an already overburdened workforce.

Integration: In particular, we note that each of the eight regions will be expected to be supported by a demonstration project which will pilot optimal means of service integration to support people who are experiencing co-occurring AOD and mental health issues. This is premised on the notion that many of these people to date have not been able to receive adequate support. Service integration is a resource intensive process, which will require additional staff as well as an uplift in capability and infrastructure. Currently, there are significant challenges in recruiting suitable staff, especially in rural and regional areas of Victoria. These issues will be exacerbated by increased demand triggered by greater levels of service access due to service integration.

Emergency Departments: The Royal Commission rightly notes that entry into the mental health system has traditionally been crisis driven and has therefore recommended that each of the eight regions hosts an emergency department with specialist mental health and AOD support. This will provide short stay capacity as well as support following discharge. The Commission highlights the significant cross over of AOD issues among those presenting to emergency departments with mental health concerns. Other than the additional workforce demands in progressing the acute elements of this recommendation, many of the people following discharge will require intensive support. This will necessitate an able and ready dual diagnosis capable workforce.

Primary and Secondary Consultations: In support of service level integration, the Commission has recommended a program of additional primary and secondary consultations. This will necessitate greater demand on the AOD workforce as it provides simultaneous support to mental health services and their clients in matters relating to co-occurring AOD and mental health presentations.

As a starting point in ensuring there is adequate capacity to progress the intention and aim of the Royal Commission, VAADA recommends AOD agencies in each new region host six 'specialist' dual diagnosis treatment clinicians.

These cross sector capable workers would support those discharged from emergency departments assist mental health services in supporting people presenting with co-occurring AOD and mental health concerns.

Recommendation 16: Recruit six specialist dual diagnosis clinicians into each AOD region to build the capability of the sector to respond to the needs of service users experiencing co-occurring AOD and mental health concerns.

Cost per region:

Year 1:	**6 x dual diagnosis clinician**	**$900,000 per region**
Year 2 +	**6 x dual diagnosis clinician**	**$800,000 per region**

Recommendation 17: Invest $2.5M on a recurrent basis to support and maintain service integration across the eight regions.

c) Improving access to AOD treatment

i. Improving access: Opioid replacement therapy

COVID-19 has resulted in a number of significant changes to how opioid replacement therapy (ORT) operates in Victoria. To accommodate the restrictions, greater flexibility was applied across a number of elements of the program and a number of people have transitioned onto long acting buprenorphine. While these are positive changes, access to this life saving program continues to be hampered by the daily dispensing fee, which needs to be subsidised.

The Australian Institute of Health and Welfare (**AIHW**) reveal that 14,085 Victorians accessed opioid replacement therapy (**ORT**) in 2019.[66] This amounts to 21 service users per 10,000 head of population, a near doubling of the rate in 1998 (12 per 10,000).

While this figure has remained steady in recent years, sector leaders have indicated that there has been an increase during the pandemic. A number of factors have been contributing to this, including the reduction in purity and increase in price of heroin[67] as international markets are restricted due to COVID-19. Furthermore, *Safescript* which aims to improve prescribing practices and reduce the non-medical use of pharmaceuticals, including opioids, should increase demand for ORT[68].

Some agencies have indicated to VAADA that there are people who are engaging ORT because of a shortage of heroin during the second wave of the pandemic. More recently, we understand that the availability and purity of heroin has increased and we remain uncertain whether people have remained on ORT.

ORT is considered the international gold standard for treatment of opioid dependence. ORT generates greater social stability and improves physical and mental health, reduces drug use, increases capacity for workforce engagement and reduces drug-related offending.[69]

Despite the unambiguous benefits associated with this long-standing treatment, clients encounter multiple barriers to access. This ranges from discrimination in healthcare settings, difficulty finding prescribing doctors or dispensing pharmacies and prohibitive costs associated with daily dispensing fees.

Conservatively two thirds of people engaged on ORT are on welfare benefits. As such, ORT dispensing fees may be more than 10% of a client's weekly income.[70] Payment of dispensing fees can

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[66] Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2019*, https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics-2019/data

[67] NDARC 2020. Decline in the reported availability of methamphetamine and heroin during the COVID-19 restrictions. Drug Trends. https://ndarc.med.unsw.edu.au/news/decline-reported-availability-methamphetamine-and-heroin-during-covid-19-restrictions

[68] At time of publication, there is no data available on outcomes related to Safescript.

[69] Pennington Institute, *Chronic Unfairness*, Pennington Institute, Carlton, 2015; J Kelsall, T King, A Kirwin, and S Lord, *Opioid pharmacotherapy fees: A long-standing barrier to treatment entry and retention,* CREIDU, 2015.

[70] J Kelsall et al, *Opioid pharmacotherapy fees.*

also cause conflict between pharmacist and ORT clients. This can lead to the accumulation of debt and may lead to the discontinuation of treatment.[71]

The impact of the fee may have been temporarily attenuated through the application of the COVID-19 Supplement to Jobseeker payments. Now, with the supplement concluded, the fee will be felt more keenly.

VAADA holds grave concerns that with COVID-19 abating and international drug markets reopening flooding Australia with far more pure heroin. With many users experiencing reduced tolerance, the impact by way of fatal overdose could be devastating.

Subsidising the dispensing fee would create an incentive to remain on ORT, thereby reducing the risk of people shifting back to heroin.

In mid-2019, several prominent Australian addiction experts called for the dispensing fee to be fully subsidised, citing that for every $1 spent on ORT, $7 is gained in avoided costs.[72]

With more than 14,000 people accessing ORT in Victoria, the annual cost of covering dispensing fees would be approximately $30M per annum.

Recommendation 18: The Victorian Government should subsidise the ORT dispensing fee to increase program engagement and retention;

ii. Improving access: supporting Victoria's young people

The youth alcohol and other drug treatment sector has been largely neglected since its' inception and is overburdened. The impact of COVID-19 and the associated restrictions have weighed heavily on the health of young people. Accessible youth AOD treatment coupled with greater capacity within the education system to support young people at risk will reduce future demand and harms.

Youth AOD treatment agencies have observed a significant uptick in demand since COVID-19 as well as, similar to the adult sector, an increasing array of challenges evident with the young people presenting. Due to the restrictions, a number of service types including outreach, were not readily available with many of the young people seeking these services disengaging.

The youth AOD treatment sector has also noticed an alarming increase in the number of concerned parents seeking help for the adolescent children. These pressing concerns are reinforced through an overlay of increasing COVID-19 related mental health concerns among young people[73]. With

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[71] Pennington Institute, *Chronic Unfairness*.

[72] D Hendrie, 'Renewed calls to fully subsidise methadone treatment', Royal Australian College of General Practitioners, 10 April 2019, https://www1.racgp.org.au/newsgp/clinical/renewed-calls-to-fully-subsidise-methadone-treatme accessed 15 January 2020.

[73] Edwards, B et al 2020. Initial Impacts of COVID-19 on Mental Health in Australia. ANU. https://openresearch-repository.anu.edu.au/bitstream/1885/213198/1/Mental_health_before_and_during_the_COVID_crisis.pdf; Westraupp E et al 2020. Child, parent, and family mental health and functioning in Australia during COVID-19: Comparison to pre-pandemic data. https://psyarxiv.com/ydrm9/; Headspace 2020. Coping with COVID: the mental health impact on young people accessing headspace services.

evidence linking the enduring AOD and mental health impacts to crisis or disasters[74], enhanced support for AOD and mental health concerns for young people experiencing COVID-19 related stressors will be a solid investment for the future. Youth AOD treatment provides a conservative return on investment of 4.66 for each dollar spent.[75]

The Royal Commission into Mental Health will establish a number of new Area Mental Health Services which will include 13 Infant, Child and Youth Services. Align with the prioritisation of service integration there is a need to immediately invest in additional AOD youth dual diagnosis clinical capacity.

Recommendation 19: Provide state-wide youth dual diagnosis capacity though resourcing an additional 20 AOD youth dual diagnosis workers ($2M p/a).

Most young people spent a significant period of 2020 engaging in home learning and therefore may not have been able to utilise the various supports that are available within an educational setting. With a dramatic increase in parents expressing concerns regarding their children, specific AOD capacity within an educational setting in targeted schools would affect a robust early intervention which would reduce future demand for both youth and adult AOD treatment support going forward.

Not dissimilar to the Governments initiative to ensure that every Victorian school has access to psychological supports, AOD clinicians/practitioners would be able to provide the necessary support identify at risk youth and provide support and referrals.

A program was trialled in the Barwon region in 2010 (the First Response Program) which employed a worker who would provide and early response for young people (aged 12 – 25 years) at risk of AOD issues. While not school based, the proposed school based program would be similar with referral to primary health or AOD treatment as well as internally via school linkages as well as family.

This program would seek to engage with young people at a period prior to adverse interactions with the justice system while they are still engaged in the education system. It should be trialled in one region and supported through an established AOD treatment program with expertise in youth AOD work.

The First Response Program provided improvements in wellbeing and a reduction in suicide ideation and distress[76].

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https://headspace.org.au/assets/Uploads/COVID-Client-Impact-Report-FINAL-11-8-20.pdf; Tsirksakis A 2020. Pandemic's mental health impact on young people a 'national crisis'. RACGP. https://www1.racgp.org.au/newsgp/clinical/pandemic-s-mental-health-impact-on-young-people-a

[74] See page 6, VAADA 2020. COVID-19 Pre Budget Submission. https://www.vaada.org.au/wp-content/uploads/2020/08/SUB_covid-pre-budget-2020-21_21072020.pdf

[75] Frontier economics (2011) Specialist drug and alcohol services for young people – a cost benefit analysis. Department of Education UK

[76] Miller P and Droste N 2010. First Response Intervention Program. 6 Month Progress Evaluation. Deakin University.

Recommendation 20: Implement a three year pilot program which places an AOD support worker within a school (or cluster of schools) to work with at risk young people through counselling, referral and family support.

iii. Improving access: Looking after our mature aged people

Mature aged people experiencing AOD dependency experience significant yet preventable AOD-related harms and are currently underserviced. It is probable that COVID-19 and the associated restrictions have increased both isolation and the risk of increased substance use among mature aged people. A specialist AOD service catering for mature aged people needs to be piloted.

The proportion of Australians aged over 65 years is steadily increasing. Matured aged people experience greater health problems than younger cohorts, consume more medication, and are more likely to experience significant life transitions such as retirement or losing a life partner. As an individual ages, their physiological tolerance of AOD diminishes, resulting in a greater risk of substance related harm.[77] AOD-related harms appear to be becoming more prevalent, particularly in light of Victoria's aging population:

- Anxiety relating to COVID-19 is more likely to be acute among mature aged people due to their reported vulnerability to the illness. These anxieties will likely remain for many beyond the expiration of the pandemic. Moreover, the impact of physical distancing on isolation and loneliness has been more keenly felt among mature aged people, with the risk of an increase substance use and commensurate reduction in help seeking during the pandemic;
- More than 15% of Victoria's population is aged over 65. This population will treble by 2058,[78] and population growth in the older demographic in Victoria is forecast to increase more rapidly than any other age group;[79]
- The fatal overdose annual rate for people over 65 years of age has increased by 140% from 2009 (22 fatalities) to 2017 (52 fatalities) with 275 fatal overdoses from that age group during that period;[80] and

[77] M Taylor and H Grossberg, 'The growing problem of illicit substance use in the elderly: a review', *Prim Care Companion CNS Disord.* Vol. 14, no. 4, 2012.
[78] Department of Health and Human Services, *Ageing,* Victorian Government, 2019, https://dhhs.vic.gov.au/ageing accessed 21 January 2019.
[79] Department of Planning and Community Development, *Victoria in Future: 2008*, Melbourne, 2009.
[80] Coroners Court of Victoria, *Average Annual Overdose Death Rate, Victoria 2009 – 2017*, Coroners Prevention Unit, Southbank, 2018.

- Despite the facts that drug-induced deaths among mature aged people have been increasing since 1999,[81] they are less likely to access traditional services due to stigma and mobility limitations.[82]

Costs associated with ageing including healthcare and welfare provisions are increasing. Productivity is anticipated to decrease as a larger portion of the population retire or work less. It is incumbent upon government to anticipate the impact of this on Victoria's health system, including the AOD sector.

Currently, there is only one AOD treatment program in Victoria specifically servicing mature aged people. VAADA recommends the development of a pilot outreach program which engages the services of two outreach teams, to provide specialised AOD treatment to older adults throughout Victoria. Demand for and efficacy of this program should be evaluated with a view to future service planning.

Recommendation 21: Develop a pilot outreach AOD treatment project to address the gap in AOD services for mature aged adults with age-related complexities throughout Victoria. The project should include outreach, project coordination, medical support (e.g. pain management) and initiatives that address social isolation, coupled with resourcing for research and evaluation.

Indicative pilot outreach program (including two teams statewide) components and costs include:[83]

Item	EFT	Cost
Establishment costs – vehicle		$35,000 per team
Establishment costs- office/IT		$11,700 per team
Staffing – outreach team	3 inclusive of 0.5 team leader per team	$424,000 per team PA
Project coordination	1 coordinator, training & development	$160,000 PA
Research and evaluation	1 research and evaluation officer	$132,000 PA
TOTAL COST		**$1,233,400.00**

[81] Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2017–18*.
[82] Nicholas R, Roche A, Lee N, Bright S, & Walsh K, *Preventing and reducing alcohol- and other drug-related harm among older people: A practical guide for health and welfare professionals*. National Centre for Education and Training on Addiction (NCETA), Flinders University: Adelaide, 2015.
[83] This pilot program outline has been adapted from VAADA's 2014/15 State Budget Submission

iv. Improving access: Enhancing pathways for CALD communities to access AOD treatment

CALD communities are less likely to engage AOD treatment services for a range of reasons, thus contributing to avoidable AOD related harm among some CALD populations. Bi-cultural liaison workers should be engaged to work with high-risk cohorts to effect better linkages and pathways between CALD communities and AOD services

People from CALD communities are currently under-represented in the AOD treatment system. Data shows that only 14% of closed treatment episodes for Australians in 2017-18 applied to clients born overseas, yet in the general population, 29% of people living in Australia were born overseas.[84]

In 2016, VAADA conducted an analysis of the extent of AOD harms among CALD populations in Victoria,[85] which identified a number of challenges including:

- Inadequate data detailing the prevalence of AOD use within CALD communities;
- Low treatment admission rates for individuals from CALD backgrounds (which does not reflect lower need but rather an under-utilisation of services);
- The additional challenges associated with adjusting to a new culture, including feelings of dislocation and isolation, community shame and a lack of familiarity with Australian health systems and services;
- For some, increased vulnerability to problematic AOD use due to experiences of torture, trauma, grief and loss. This can be exacerbated by factors associated with migration like unemployment, language barriers and a lack of culturally appropriate services; and
- Significant forensic demand among some CALD cohorts, highlighting lost opportunities for preventative engagement and early intervention via the voluntary system.

Working with CALD clients in the AOD sector requires a targeted and multi-faceted approach. Currently, this occurs infrequently.

VAADA reiterates the recommendation included in its 2016 CALD AOD Project Report, which endorsed the establishment of a pilot program placing two bi-cultural liaison workers into AOD treatments services across four AOD catchment areas funded for three years. Bi-cultural liaison workers would be responsible for:

- Engaging CALD communities and agencies with the emphasis on relationship building and cross-sector collaboration;
- Raising awareness of available supports while facilitating access to AOD treatment for individuals and families from CALD communities;
- Liaising with CALD community members and/or representatives about their specific health literacy needs, experiences navigating the AOD sector, and ways to improve the system; and

[84] Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2017–18*.
[85] Victorian Alcohol and Drug Association, *CALD AOD Project: Final Report*, VAADA, Collingwood, 29 March 2019, https://www.vaada.org.au/resources/cald-aod-project-final-report/ accessed 15 January 2020.

- Promoting culturally appropriate models of service delivery while strengthening ties between CALD communities, ethno-specific agencies and AOD treatment services.[86]

Bi-cultural liaison workers should be located in catchments which have been identified as having the greatest need, would have competency in the language/s most commonly spoken in the relevant catchment area, and would work in partnership with language-specific agencies, with the potential to be co-located. Ideally, projects should be co-sponsored with other relevant agencies. Bi-cultural liaison workers would be supported by two capacity building project support officers who would operate across the four catchments, to increase CALD community access to AOD services and build the capacity of catchment services to cater for the needs of these communities.

Key learnings would be documented and recommendations forwarded to DHHS, with a view to scoping out further opportunities to replicate the program in other catchments.

VAADA also recommends that resources be directed into a capacity-building stream, staffed by two project officers located at VAADA, whose role would be to:

- Support, capacity build and report on the activities undertaken within each catchment;
- Develop resources and other initiatives which support AOD and allied agencies in the delivery of culturally responsive services to CALD individuals and family;
- Work with stakeholders in each catchment to identify barriers and gaps in service delivery as well as measures to address them; and
- Oversee the program's evaluation and disseminate findings to key stakeholders.

<u>Recommendation 22</u>: Provide resourcing to establish a pilot program which places two bi-cultural liaison workers in four AOD catchments in Victoria. Bi-cultural liaison workers would be supported by two capacity building project support officers, to increase CALD community access to AOD services and build the capacity of catchment services to cater for the needs of these communities.

Indicative program components and costs include:

AOD CALD Engagement Pilot Program				
Category	**Item**	**Quantity**	**Cost**	**Total cost**
Establishment costs	Vehicle	4 (1 per catchment)	$35,000	$140,000
	Office and IT	4 (1 per catchment)	$10,000	$40,000
Staffing (costs p/a)	Bi-cultural liaison workers	2 r catchment (4 catchments)	$100,000	$800,000
	Project officers	2	$125,000	$250,000
	Office expenses	1	$30,000	$30,000
				TOTAL: $1,260,000

[86] Victorian Alcohol and Drug Association, *CALD AOD Project: Final Report*.

v. Improving access: Increasing residential rehabilitation capacity– a case for parity

The demand for residential rehabilitation services across Victoria continues to increase. Previous budget announcements from the Government have made positive headway in addressing the lack of residential rehabilitation capacity, including rural and regional Victoria. However, the contraction in in residential capacity due to COVID-19 has blown out wait times. Despite recent uplifts, Victoria has the second lowest capacity per capita in Australia. Furthermore, there has not been a commensurate increase in residential withdrawal services, with a number of regions bereft of this support.

Consistent evidence supports the effectiveness of residential treatment (including therapeutic communities and integrated mental health treatment) across various outcomes,[87] including the cost effectiveness of residential rehabilitation. For instance residential rehabilitation is cost effective in addressing methamphetamine-related presentations.[88] The then Australian National Council on Drugs noted that, for Aboriginal populations, residential rehabilitation achieves $111,458 saving per person when compared with the cost of prison, with additional savings of $92,759 in reduced mortality and improved health.[89] Other studies note a conservative net economic benefit of approximately $1M per person.[90]

Despite the clear economic and social benefits of this treatment modality, the number of beds available in Victoria remains limited. While the increase in funding for residential rehabilitation is welcome, families relay to VAADA that significant barriers to this treatment type remain. Furthermore, due to COVID-19, the benefits associated with the uplift have been lost as agencies reported a 20% reduction in capacity.

We estimate that, based on approximately 450 beds soon to be operating, Victoria's residential bed capacity is forecast to increase from 0.45 to 0.7 beds per 10,000 population (the latter 2020 estimate represented in purple in Figure 6 below).[91] Despite this welcome increase, this remains inadequate to address demand, especially with the COVID-19 triggered blow out. As Figure 6 shows, Victoria has the second lowest ratio of residential rehabilitation beds per head of population nationally.

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[87] De Andrade et al, 'The effectiveness of residential treatment services for individuals with substance use disorders: A systematic review' *Drug and Alcohol Dependence* vol. 201, 2019, pp. 227-235.

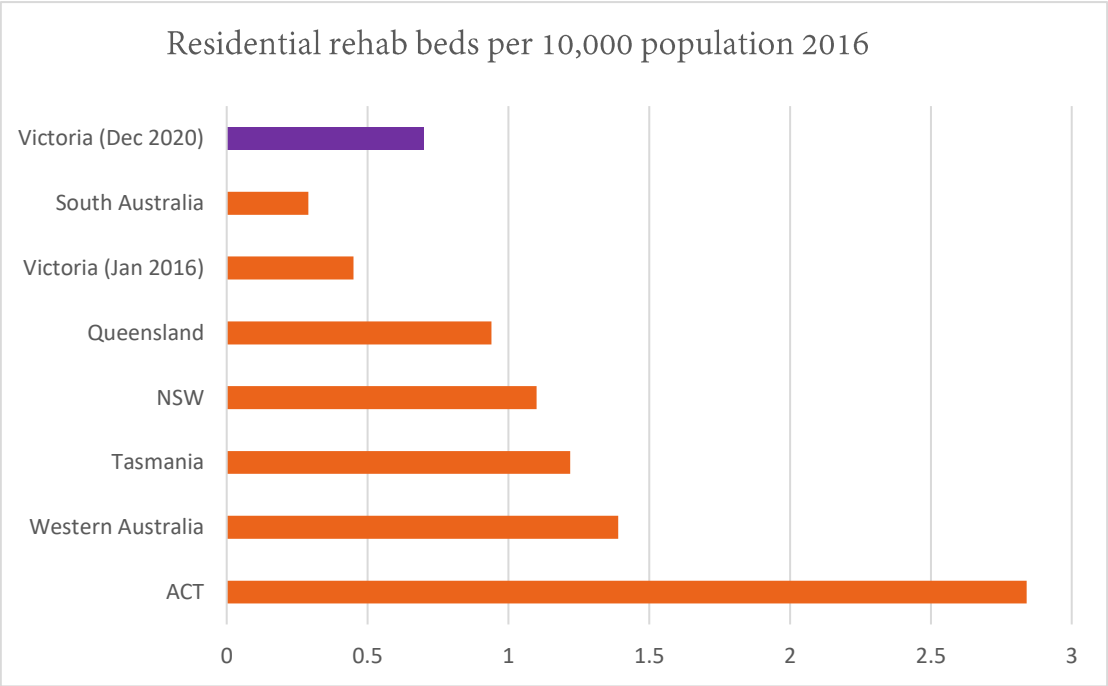
[88] D Lubman et al, *A study of patient pathways in alcohol and other drug treatment,* Turning Point, Fitzroy, 2014; S Ciketic, R Hayatbakhsh, R Mcketin, CM Doran, and JM and Najman, 'Cost-effectiveness of counselling as a treatment option for methamphetamine dependence', *Journal of Substance Use*, Vol 20, no 4, 2015, pp. 239 – 246.

[89] National Indigenous Drug and Alcohol Committee, 'An economic analysis for Aboriginal and Torres Strait Islander offenders prison vs residential treatment', Australian National Council on Drugs research paper no 24, 2012, https://www2.deloitte.com/au/en/pages/economics/articles/cost-prison-vs-residential-treatment-offenders.html accessed 13 January 2020.

[90] Rae, J, *Economic impact of residential treatment for alcohol and other drug addiction in therapeutic community (TC),* Odyssey House, Victoria, 2013.

[91] This figure reflects the 2016 estimation of beds listed in Figure 5 in combination with additional capacity outlined in various Victoria Government statements, leading to an estimation of approximately 478 residential rehabilitation beds either committed or operating (Premier of Victoria 2019). Based on a population of 6,566,200 (ABS 2019) this amounts to 0.73 beds per 10,000 head of population.

Figure 6: Residential rehabilitation beds per 10,000 head of population by state/territory



Unmet demand for residential rehabilitation is often diverted to an unregulated private sector, to the Victorian justice system or the acute health system. To address this capacity deficit, there is a need for further expansion in capacity of residential rehabilitation. This significant commitment will necessitate accounting for gaps in service availability and demand by region, increases in workforce capacity, and opportunities for partnership.

VAADA recommends that the Government implement a minimum benchmark for residential rehabilitation sector capacity at ratio of 1: 10,000 population, which is still below the national average. In real terms, this would mean funding an additional 200 beds.

This would provide for an additional 800 Victorians annually and would lift Victoria to be the third lowest quantity of residential rehabilitation beds per capita in Australia.

Currently, the cost per bed varies depending on whether treatment is forensic or voluntary. An average derived from the current providers suggests the cost per bed (three to four episodes delivered each year) amounts to approximately $75,000 per annum.

Residential withdrawal, which did not receive an uplift commensurate with residential rehabilitation, has also contracted during COVID-19. The treatment pathway for many is to engage with residential withdrawal then transition into a longer term residential rehabilitation program. There is an acute need for additional residential withdrawal services, particularly in rural and regional Victoria, to allow for a smoother and more coherent treatment pathway. This should include both community and hospital based withdrawal capacity. Furthermore, there is a need to have Aboriginal and Torres Strait Islander withdrawal capacity increased, particularly in a number of areas in regional Victoria. We would encourage engagement with Aboriginal Community Controlled Health Organisations to inform on demand, service design and location.

Recommendation 23: Develop a plan to increase the capacity of Victorian funded residential rehabilitation services to a level equivalent to other Australian jurisdictions. This will necessitate the development of approximately 200 additional beds lifting the rate to 1 bed per 10,000 head of population. It is estimated that the operational cost of running these facilities will amount to approximately $75,000 per annum per bed.

Recommendation 24: Increase residential withdrawal capacity, particularly in regional Victoria, with a portion of this increased capacity developed to support Aboriginal and Torres Strait Islanders.

6. References

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