VICTORIAN ALCOHOL & DRUG ASSOCIATION

State Budget Submission

2022/23

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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Contents

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

Victoria's publicly funded alcohol and drug (AOD) system provides an essential service to all Victorians. Collectively, Victorian AOD services deliver close to 40,000 episodes each year. The existing system is creaking under the strain of growing numbers and complexity coupled with greater expectations. The sector has had to contend with the impacts of COVID-19, necessary changes wrought by social distancing, an increasing frequency of forensic clients working their way through the justice system, as well as changed community consumption patterns including the impact from increased alcohol consumption and burgeoning waiting lists across the system. In the background the sector has continued to focus its efforts to meet recommendations arising from the Family Violence Royal Commission and is now turning its attention to the rapid transformation agenda associated with Royal Commission into Mental Health.

As occurs yearly, the Victoria Alcohol and Drug Association (VAADA) prepares an annual state budget submission for the Victorian Government outlining a range of initiatives that can make a difference in reducing alcohol and other drug (AOD) related harms. Within a backdrop of both COVID-19 and the Royal Commission this state budget submission seeks to prioritize key recommendations which VAADA, in consultation with the Victorian AOD sector think will make a significant contribution to the functioning of our treatment system and to meet client needs.

For those with a good insight into the adaptability of the Victorian alcohol and drug system they will recognize that it is constantly evolving and adapting to address community need, however there is only so much that can be achieved with the resources available. People are missing out on support. This submission identifies a range of issues associated with current waiting lists and unmet demand, and historic funding and regional capacity inequity. It also identifies cost benefits to be derived from more adequate funding across key program areas.

While recent issues such as the VADC (Data System) persist, other areas are equally problematic such as access issues associated with the 'Opioid Replacement Therapy' (ORT) system, which currently is at the brink of collapse being held up by a small number of prescribing practitioners, many who are nearing retirement. In what has now become a regular yearly request VAADA makes a call for equity of access to AOD treatment for all Victorians, no matter their location. A clear demonstration of these issues is the palpable gap in service type, capacity and subsequently access existing between metropolitan, rural, and regional Victorians. It is most evident through AOD workforce shortages, lack of detoxification facilities, lack of outreach services, sparse local AOD services, limited access to ORT, or entrenched and unfair barriers to a range of diverse communities.

Given the close association of issues with the Royal Commission into Victoria's Mental Health System there is a clear focus on ramifications for the AOD sector, particularly for its workforce. Continued investment in building the alcohol and drug workforce is a key priority which will require not only further investment in staff numbers but in the associated system of education and training. This workforce issue is complex to address and should be the basis for comprehensive industry planning.

As highlighted in previous years, forensic clients continue to present a unique challenge to the AOD sector. With the impact of COVID-19 on Victoria's Court system currently exacerbating entrenched challenges for forensic clients, it is critical to address demand impacts on the AOD system. Continued reliance on correctional solutions to AOD contributes layers of complexity to the challenges which many Victorians face. Notwithstanding the need for a wholesale rethink of the way in which AOD

and mental health issues are dealt with in the correctional system, in the short and medium term, it is vital that suitable resources both in infrastructure and workforce are progressed to adequately meet client demand and service capacity issues.

While VAADA recognises the many demands that rest with Government we urge you to carefully consider the range of recommendations contained in this submission. What is provided in this document are a collection of pragmatic evidence-based solutions aligned to the current challenges impacting the Victorian AOD sector and its clients as well as sensible solutions to address future need. The recommendations are informed by contemporary research as well as expert knowledge from front-line workers, and those running AOD treatment agencies. Many recommendations have the potential to achieve immediate improvements, while others such as Mental Health reforms may require a longer-term commitment to acting in the best interest of some of our state's most vulnerable and stigmatised communities.

Sam Biondo

3. Summary of recommendations

Recommendation 1: $2M to support agencies to maintain flexible work arrangements and ensure that service users can maintain connected with online services.

Recommendation 2: Permanently resource the $25M 100 AOD workers initiative to account for future demand with additional capacity built in annually over the next four years.

Recommendation 3: Resource an additional 4 EFT of forensic capacity in each AOD catchment to account for increased Forensic client demand. This would amount to $450,000 per catchment in the first year then $400,000 each year after plus CPI.

Recommendation 4: Additional resourcing is provided to enable a continuum of care for people exiting prison to enhance health outcomes and reduce overdose risk. This should include an enhanced ORT offering as well as wrap around support aligned with individual needs.

Recommendation 5: All individuals charged with drug possession and use offences should be eligible for Diversion; to accommodate additional demand there should be a subsequent increase in the availability of community-based support and treatment services to support diversion participants in need of treatment.

Recommendation 6: Invest $5M in the AOD sector to provide for the additional demand generated by SafeScript and other reforms aimed at pharmaceutical harm-reduction measures. This would provide for necessary workforce capacity-building, including greater capacity for Victoria's pharmacotherapy system, the expansion various specialisations to support people experiencing harms from pharmaceuticals across Victoria.

Recommendation 7: Undertake research and a review of the impacts of SafeScript, which includes an assessment of:

- *i) Patient outcomes following identification;*
- *ii) the limitations, benefits and impact of SafeScript, on targeted consumers, with particular reference to their healthcare needs, treatment and referral pathways; and*
- *iii) The breadth and range of service system enhancements required to meet demand arising from pharmaceutical related harm*

Recommendation 8: Invest $750,000 recurrently to support training across the sector and primary health to respond, refer and support people presenting with issues relating to benzodiazepines. This includes:

1. *$350,000 for providing training state wide ($300,000 each year after);*
2. *$400,000 recurrently0 for providing specialist support for benzodiazepine dependency through counselling and other support services*

Recommendation 9: Invest a sum of $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 10: Infrastructure funding to establish and expand services within growth corridors should be availed to ensure that treatment facilities are suitable for clinical purposes.

Recommendation 11: Invest an interim sum of $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 12: Avail a range of incentives such as salary supplementation, re-location allowances, housing support, scholarships and graduate training incentives to build the attraction and capacity of the rural workforce.

Recommendation 13: resource AOD agencies in disaster affected areas with a 20% increase to existing funding levels to support increased demand over three years.

Recommendation 14: Provide a recurring $18M 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 15: Prioritise AOD service users for a portion of social housing from Victoria's Big Build with CRC facilitating the necessary support services.

Recommendation 16: 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 and evidence-based cost of service delivery.

Recommendation 17: Invest $1.5M to extend the activity of VAADA's Elevate program to better coordinate training, streamline student placements and enhance the attraction of staff to Victoria's AOD sector. This entity would progress options for micro-credentialing, course development and opportunities to upskill new and existing AOD workers. A central co-ordinating team of at least two additional staff would support the Elevate program.

Recommendation 18: Invest $2M to develop a broad 'industry plan' for the AOD sector which undertakes an assessment of the core elements of the Victorian AOD system, current and future demand as well as forecasting future workforce and infrastructure need.

Recommendation 19: Improve industrial and wellbeing conditions of the AOD workforce in alignment to similar changes in the mental health workforce to improve workforce attraction and retention.

Recommendation 20: Recruit three 'specialist' dual diagnosis and trauma clinicians into each AOD region to build the capability of the sector to respond to the needs of service users experiencing acute co-occurring AOD and mental health and other concerns.

Recommendation 21: that $2.5M be provided on a recurrent basis to support and maintain service integration across the eight mental health and wellbeing regions.

Recommendation 22: The AOD peak body is funded for two years to deliver a sector transition role to support the sector, monitor the process and respond to issues arising from the integration of the AOD and mental health services.

Recommendation 23: establish a funding model that makes the nurse practitioner model a viable support, especially in those areas where there is an acute shortage of prescribing practitioners.

Recommendation 24: increase the stability of the Victorian ORT system through resourcing community health centres to maintain capacity to prescribe in each region.

Recommendation 25: The Victorian Government should subsidise the ORT dispensing fee to increase program engagement and retention;

Recommendation 26: undertake a review of the ORT system to ascertain viable and sustainable future model.

Recommendation 27: Resource over the next four years an additional 10 AOD youth complex care workers (approximately $2M p/a).

Recommendation 28: pilot and evaluate over a three year period a metropolitan and regionally based AOD support worker to work with at risk young people within a school (or cluster of schools) to support with counselling, referral and family support.

Recommendation 29: increase regional youth outreach capacity to meet demand and support people awaiting residential support.

Recommendation 30: 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 31: 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.

Recommendation 32: Expand LGBTIQ community controlled AOD counselling and care and recovery coordination capacity across metropolitan Melbourne and regional Victoria to ensure equitable access to specialist support for LGBTIQ communities at an approximate cost of $750,000 P/A.

Recommendation 33: In partnership with an existing residential rehabilitation provider, develop a specialist LGBTIQ community controlled residential rehabilitation facility, consulting with LGBTIQ communities and agencies to ascertain the most suitable organisational structure.

Recommendation 34: 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 35: Increase residential withdrawal capacity, particularly in regional Victoria, with some of this increased capacity developed to separately support both young people as well as Aboriginal and Torres Strait Islanders.

4. Introduction

This submission provides a range of considered proposals to support the many Victorians in need to alcohol and other drug (AOD) treatment as well as those experiencing AOD related harm. The impact of COVID-19 on the community has been profound, with the myriad harms to persevere for years to come. There is a recognised shift in the way people engage with treatment, the risk profile associated with substances and increasing evidence of expanding wait times along with more people transitioning to patterns of consumption resulting in dependence.

This submission details a range of recommendations to ensure equitable support for all Victorians experiencing AOD issues. It details what's needed in response to the pandemic as well as the enduring areas of neglect which are leaving so many Victorian's bereft of support.

This submission also reflects a pragmatic response to the reform environment, providing a measured pathway for enacting effective responses to the Royal Commission into Victoria's Mental Health System. The document has been prepared in the context of the Royal Commission, 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 has continued to impact 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, which 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 provision. 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.

Since the pandemic commenced, agencies have reported an increased frequency of service users new to the sector putting further strain across most treatment types. COVID-19 has ushered in changes in the type of person presenting for help; we are now seeing more women, greater levels of relapse as well as new service users who have been sought help during or soon after restrictions are lifted. The highest number of women on record experienced alcohol related fatal overdose in 2020.[1]

Many of these service users find accessing treatment difficult, in some cases due to limited technology to support online interventions. As a result agencies are often having to support clients financially to engage in online treatment. Furthermore, COVID-19 has impacted work practices, with

[1] Coroners Prevention Unit.2021. Request for information on alcohol contributions to fatal overdose.

agencies required to provide additional IT support for workers to work remotely. This amounts to an ongoing recurrent cost.

Recommendation 1: $2M to support agencies to maintain flexible work arrangements and ensure that service users can maintain connected with online services.

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

VAADA's 2021 sector priorities survey builds on feedback from treatment providers from 2020 and aligns with the regular feedback received from AOD treatment agencies regarding an increase in the challenges evident with service users engaging in AOD treatment. Table 1 reflects Victorian AOD agency survey feedback and highlights a significant increase in mental health, changes in drug use patterns, COVID-19 stressors and family violence amongst those presenting.

Table 1: Agency Observations: Factors impacting on changes in AOD demand 2021[2]:

	INCREASED	DECREASED	STAYED THE SAME	TOTAL
Family violence	74.36% 29	2.56% 1	23.08% 9	39
Safescript	29.63% 8	0.00% 0	70.37% 19	27
Mental Health	94.87% 37	2.56% 1	2.56% 1	39
Pharmacotherapy	46.43% 13	3.57% 1	50.00% 14	28
Changed drug use patterns	72.97% 27	0.00% 0	27.03% 10	37
Justice and Corrections issues	55.17% 16	10.34% 3	34.48% 10	29
COVID-19 and the associated restrictions	89.47% 34	2.63% 1	7.89% 3	38

Agencies have also reported changes in the composition of presentations, including a continuation of 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 have been changes in drug use patterns, both in type and severity.

[2] VAADA 2021. Sector Priorities Survey 2021. Victorian Alcohol and Drug Association.

In particular, 70% of AOD treatment agencies have reported an increase in the prevalence in alcohol related presentations since the pandemic commenced, with the same number reporting an increase in the severity of alcohol related presentations.

This is not surprising with a 26.7% increase in turnover from alcohol sales[3]. 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 and GHB, as well as some disturbing trends involving novel psychoactive substances such as novel benzodiazepines, which experienced a surge in fatal overdose in 2020[4]. 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.

Wait list blowouts

Over the past year, VAADA's waitlist snapshot survey has revealed a 51% increase in the number of people waiting for treatment in Victoria from 2385 people (July 2020) to 3599 people (September 2021) waiting for treatment each day.

Access varies greatly across the state, with surveyed wait times for counselling ranging from 0 to 60 days. Other treatment types have similar ranges, with assessments ranging from 0 to 45 days and non residential withdrawal ranging from 0 to 21 days. COVID-19 has drawn the lack of equity in access into sharp relief.

Residential services remain burdened by the limitations engendered through COVID-19 restrictions with Victoria retaining the second lowest capacity in residential rehabilitation across all jurisdictions in Australia.

Missing and emerging cohorts

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 impact on AOD use and dependence amongst 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;[5]

[3] Fare 2021. Australia records highest month in history for alcohol related turnover in December. 12 February. https://fare.org.au/australia-records-highest-month-in-history-for-alcohol-retailer-turnover-in-december/
[4] Coroners Court of Victoria. 2020. Victorian Overdose deaths, 2011-2020. https://www.coronerscourt.vic.gov.au/sites/default/files/2021-07/CCOV%20-%20Overdose%20deaths%20in%20Victoria%202011-2020%20-%2029Jul2021.pdf
[5] Bryant et al. 2018. Longitudinal study of changing psychological outcomes following the Victorian Black Saturday bushfires. ANZJP. 52(6). Pp 542-551.

- Alcohol use was 1.4 times higher in fire affected areas following Black Saturday amounting to an estimated lifetime cost of $190 million;[6]
- 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[7].

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. Given that the duration of substance dependence in the absence of treatment can span well over 20 years, VAADA is concerned that COVID-19 has generated a new cohort of people who may not have otherwise experienced substance dependence. AOD treatment can greatly reduce the duration of dependency, on average almost halving it.[8]

This surge in demand, already evident over the past 12 months with the increase in daily waitlist figures (from 2385 in September 2020 to 3599 in July 2021)[9] is unlikely to abate as the pandemic progresses. The growing prevalence of AOD dependency throughout the community and concerning forecasts regarding future demand persisting long after the pandemic, necessitates greater capacity within the sector. The Victorian's Government's $25.6M 100 workers initiative, which potentially expires in September 2022, should be continued and expanded to account for the growing demand.

Recommendation 2: Permanently resource the $25M 100 AOD workers initiative to account for future demand with additional capacity built in annually over the next four years.

b) Community need for AOD treatment

While various components of the AOD sector have received increased funding, the recent 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 and most recently the $25.6M announcement of 100 new AOD workers. While the most recent announcement was very welcome, it was not evenly dispersed across the state and not necessarily in line with demand pressures. Inequity in access remains a significant issue for the Victorian community. This will require continued workforce investment into the near future.

While important, these initiatives do not necessarily support the broader population of service users and but for the 100 workers, these uplifts pre date the pandemic. This persistent underinvestment both in terms of workforce and infrastructure amounts to lost opportunities to effect early

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[6] 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

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

[8] National Treatment Agency for Substance Abuse. n.d. Treat addiction, cut crime. NHS. UK.

[9] VAADA 2021. Waitlist Snapshot. https://www.vaada.org.au/wp-content/uploads/2021/10/REP_VAADA-snapshot-survey_10082021.pdf

intervention, thus leaving the sector with limited capacity to support the cascading demand emerging from the pandemic.

With a backlog in the Court system of over 200,000 cases in February 2021[10] (and many of these cases likely to necessitate forensic AOD interventions across the public system), voluntary clients in particular seeking to enter the system are incurring further pressures and increased waiting times for treatment. The issues and waitlists are further compounded when considering the burgeoning prison population demand, and associated complex AOD needs on release.

A 2019 study carried out by researchers at the National Drug and Alcohol Research Centre (NDARC) into unmet demand for AOD services in Australia reveals the urgent need to increase AOD service capacity nationwide. NDARC revealed 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.[11]

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 as well as bypassing waitlists in the funded sector while providing high-cost programs often with little evidentiary grounding in quality of service. With the Health Complaints Commissioner receiving 49 complaints about these operators from 2017 to May 2018 we are beginning to see a picture of the harms generated through some of these operators. However, due to stigma, limited options for support and the all-consuming experience of supporting a loved one experiencing substance dependence, it is highly likely that there are many more Victorians acutely aggrieved by the unregulated for profit industry.

Experts from the NDARC 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.[12] Compared to the costs of AOD harms — estimated at $55.2B per annum[13] — 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 1** (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.

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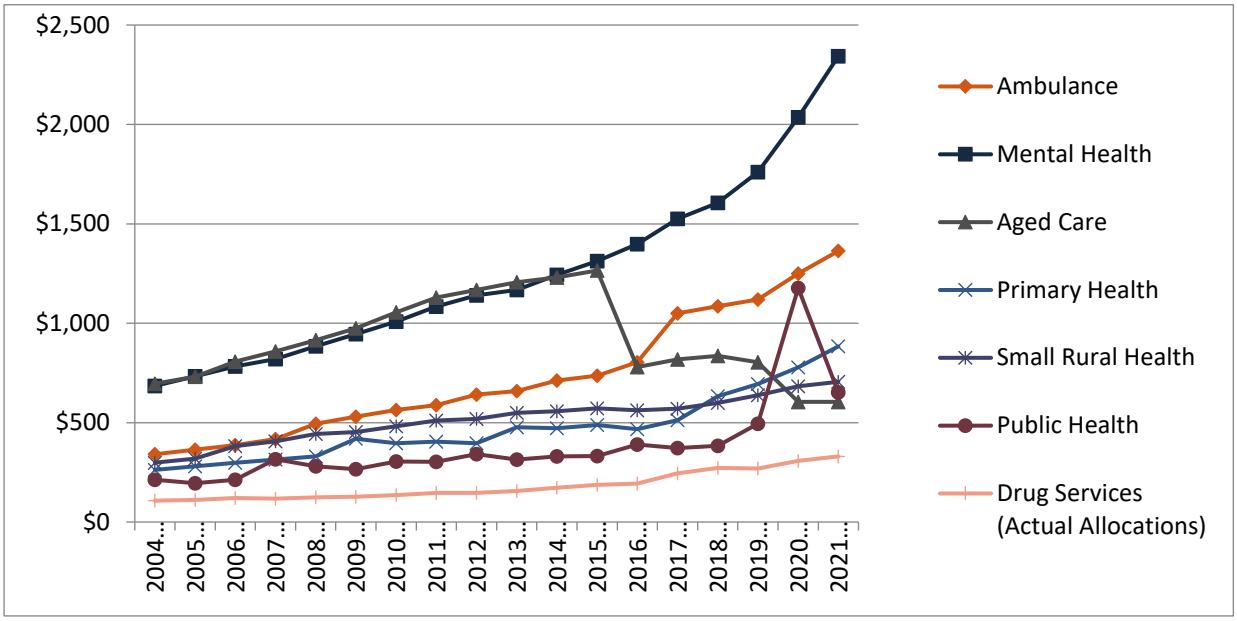
[10] Public Accounts and Estimates Committee 2021. Report on 2021-22 Budget Estimates. Parliament of Victoria. https://www.parliament.vic.gov.au/images/stories/committees/paec/2021-22_Budget_Estimates/Report/PAEC_59-12_2021-22_Budget_Estimates.pdf

[11] 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.

[12] 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.

[13] 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 1: Output funding (health) 2004/05 – 2020/21 (in $millions)[14]



c) AOD treatment works and delivers a strong return on investment

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.[15] 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[16] and hospital emergency department admissions[17]) at a lower rate in the year post- treatment, compared to the year prior to treatment; [18]
- 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[19], which is particularly concerning given that there are 0.74

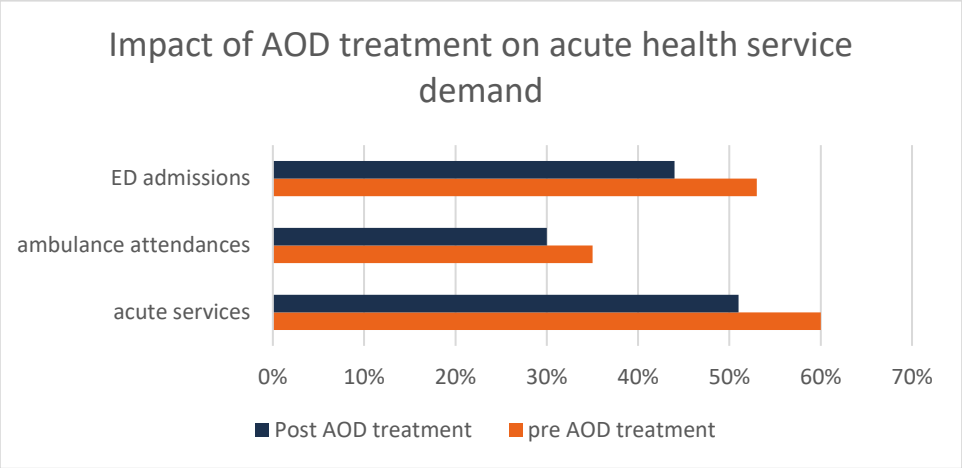
[14] Data for Figure 2 has been obtained from Victorian Government Budget Papers.
[15] J Coyne, V White, and C Alvarez, C, *Methamphetamine: focusing Australia's National Ice Strategy on the problem, not the symptoms*, Australian Strategic Policy Institute, Barton, 2015, p 21.
[16] Ambulance attendances decreased from 35 to 29%
[17] Hospital emergency admissions decreased from 53 to 44%
[18] 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.
[19] 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

residential rehabilitation beds compared to 10.92 prison beds per 10,000 head of population in Victoria; and

- Over two years, the Victorian Drug Court found that it accrued $1.2M in savings through reducing the prison population (which is in addition to any savings accrued through reducing recidivism and improving health and welfare).[20]

In addition to improving outcomes for clients, investment in the AOD treatment sector 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 2: Impact of AOD treatment on acute health service demand (Manning et al. 2017)



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. This should be informed by COVID-19 related increases in demand.

To meet Victoria's share of national unmet demand, the government needs to support a raft of reforms to the sector. This goes beyond the necessary expansion of the core AOD system to cater for surging pre-existing and COVID-19 related demand, including access to residential rehabilitation and withdrawal AOD services. The system needs to be geared to cater for various at risk cohorts,

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2020, https://www2.deloitte.com/au/en/pages/economics/articles/cost-prison-vs-residential-treatment-offenders.html, xi.

[20] 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.

including those in need but not engaged with the system, emerging new populations such as those identified through SafeScript, victim survivors and people experiencing mental health concerns among others. The system needs to ensure that the workforce has the capability to support increasing complexities and trauma among 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, there is a need to accurately estimate of local community need. 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.[21]

The DASP Model was developed with two primary aims:

1. estimating future population need for AOD treatment; and
2. providing a basis to achieve consistency of health planning across Australian states and territories.[22]

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.[23]

The DASP Model has been used by several Australian jurisdictions[24] 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.

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[21] 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.
[22] Ibid.
[23] Ibid.
[24] Including Western Australia, Tasmania and the ACT

The need for a comprehensive AOD industry plan

To guide this necessary shift in capacity to meet demand a well-researched and appropriately funded Industry Plan for the AOD sector should be developed.

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 and forecasting future demand and subsequent workforce needs.

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.[25].

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.

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 community need), 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, key issues which the sector has identified requiring urgent investment remain. 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.

[25] 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.

5. Current AOD sector investment requirements

a) Responding to increased demand

i. Responding to increased demand: forensic clients

Demand for forensic AOD treatment continues to increase, with the sector at capacity even during the less demanding period where the Courts were shut. As forensic clients are prioritised, any increase in forensic demand increases wait times for voluntary clients.

With the Courts reopening, and processing a backlog of up to 200,000 cases as of February 2021[26], the sector is not adequately resourced to cater for increasing demand going forward. Forensic clients 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). Further, it reduces the rate of overdose deaths amongst people who have formerly been in prison.

Despite the Courts slowdown of throughput, VAADA's 2021 Sector Priorities Survey revealed that 55.17% of sector AOD agencies responding experienced an increase in forensic demand, with just 10.34% noting a decrease. Of note is the fact that approximately 37% of Victorian AOD clients are forensic clients[27], with VAADA surveys indicating that some regions maintain a caseload consisting of 80% forensic demand. It is likely that these percentages are set to rise.

Despite a dip in the rate of imprisonment in Victoria due to COVID-19, the broader pattern of demand across the correctional system and 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 forensic client presentations has had an enormous impact on the AOD sector by displacing voluntary clients. The limitations in funding through the current model have reduced capacity and reportedly led to a worrying reports of Courts referring forensic clients to the unregulated for profit sector.

There is a need for an immediate uplift in forensic capacity across the state to cater for standard demand levels as well as the Court related surge. This should consist of an uplift of 4 EFT per region, contingent on demand, over the next five years

[26] PAEC 2021. Report on the 2021/22 Budget Estimates. Parliament of Victoria. https://www.parliament.vic.gov.au/images/stories/committees/paec/2021-22_Budget_Estimates/Report/PAEC_59-12_2021-22_Budget_Estimates.pdf

[27] VAHI data 2018/19

Recommendation 3: Resource an additional 4 EFT of forensic capacity in each AOD catchment to account for increased Forensic client demand. This would amount to $450,000 per catchment in the first year then $400,000 each year after plus CPI.

State-wide estimated cost

17 regions X 4 forensic workers + establishment costs:	**2022/23:**	**$7,650,000**
17 regions X 4 forensic workers	**2023/24:**	**$6,800,000**
17 regions X 4 forensic workers	**2024/25:**	**$6,800,000 + CPI**

Post release prison support

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.[28] While incarceration may temporarily improve an individual's health, 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.

In the past year, the Coroners Court listed a number of recommendations highlighting serious deficiencies in the governance of care arrangements for people discharged from prison following the fatal overdose of a person soon after release from prison. The Coroner recommended an overhaul of post release prison health, effectively recommending to excise Corrections and put Health in charge. The Coroner also recommended the establishment of a committee to advise on matters relating to post release prisoner health as well as the publication of relevant data for people up to a decade following release from prison.[29]

Continuity of care is critical in supporting a person's recovery and therefore in reducing recidivism and can provide the health infrastructure which may prevent fatal overdose. Literature suggests that continuity of care for people leaving prison in Australia is inadequate.[30] [31] In consultations held by VAADA with the Victorian AOD sector, inadequate discharge planning prior to release was identified as a major disrupter of continuity of care. A lack of adequate support for people recently

[28] 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.

[29] Coroner Jacqui Hawkins. 2021. Finding into Death without Inquest of Shae Harry Paszkiewicz, Victorian Coroners Court. https://www.coronerscourt.vic.gov.au/sites/default/files/2021-02/Finding_Paskiewicz_COR20176235.pdf

[30] 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.

[31] 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.

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.[32]

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 4: Additional resourcing is provided to enable a continuum of care for people exiting prison to enhance health outcomes and reduce overdose risk. This should include an enhanced ORT offering as well as wrap around support aligned with individual needs.

Increase access to diversion

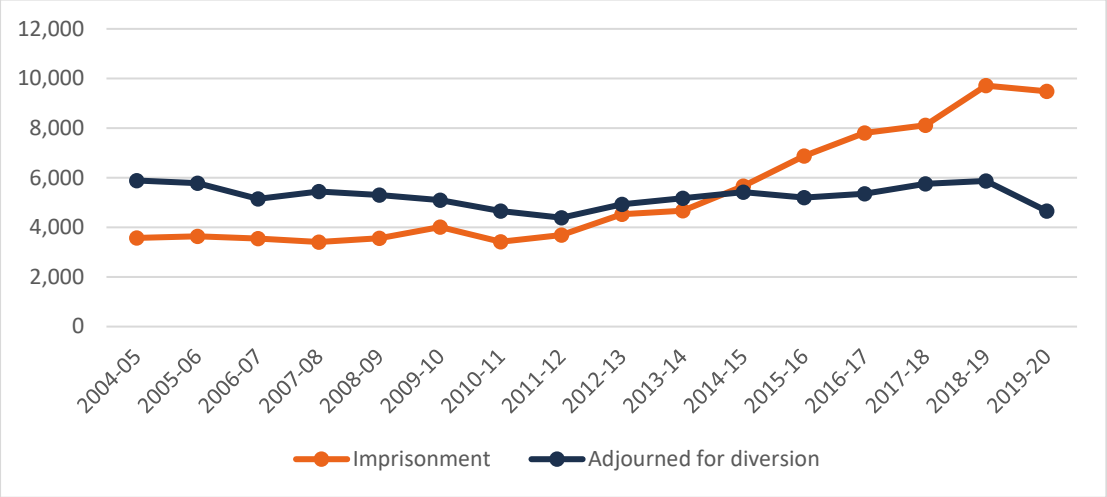
Illicit drug offences are the second most common category of criminal offence among Victorians in prison. As of December 2021, 14.7% of people in Victoria prisons (a total of 1,056 out of 7,180) were serving a custodial sentence relating to a drug offence.[33] The rate of offences recorded for drug use 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 been declining from 66% (2010/11) to 62% (2014/15).[35] It is evident that although the Victorian justice system is increasingly more punitive toward drug related offending, there is little evidence that it is curbing the illicit drug market.

The benefits of diversion are well established, including a reduction in recidivism, improved treatment engagement, a reduction in the use of court and police resources and improved social outcomes[36]. Figure 2 highlights that the use of diversion has been in decline from 8.1% of percentage of cases sentenced in the Magistrates Court in 2004/05 (5,888 sentences) to 6.4% in 2019/20 (4,652 sentences)[37]. During the same period, the use of imprisonment more than doubled from 4.9% (3,577) to 13.1% (9,490) of all sentences. The Australian Criminal Intelligence Commission notes that cannabis accounted for 46% of all drug arrests, with consumer arrests accounting for 91% of all cannabis arrests in 2019/20. While one in three cannabis arrests resulted in diversion, infringement or a caution, 42% resulted in a summons.[38] It is evident that Victoria has undergone an

[32] Victorian Alcohol and Drug Association, *Submission to the Royal Commission into the Mental Health System in Victoria*, 2019.
[33] Australian Bureau of Statistics. 2021, *Prisoners in Australia, 2021,* 9 December 2021, https://www.abs.gov.au/statistics/people/crime-and-justice/prisoners-australia/latest-release#data-download.
[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] SAC. 2021. Sentencing outcomes in the Magistrates Court. https://www.sentencingcouncil.vic.gov.au/sentencing-statistics/sentencing-outcomes-magistrates-court
[38] ACIC 2021. Illicit Drug Data Report 2019/20. https://www.acic.gov.au/sites/default/files/2021-10/IDDR%202019-20_271021_Full_0.pdf

increasingly punitive period with harsher sentencing reforms and a reduction in the use of therapeutic options which can divert people away from the justice system.

Figure 3: Sentencing – Prison and Diversion 2004/05 – 2019/20 (SAC 2021)



The surge in imprisonment has been accompanied by a diminished use of diversion.

In 2019, Dr Caitlin 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%) as well as improving housing and employment outcomes when compared with standard correctional responses.[39]

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.[40] [41] 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.*[42]

[39] ibid
[40] 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.
[41] 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.
[42] 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.

And

> *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.*[43]

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'.[44] 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 5: All individuals charged with drug possession and use offences should be eligible for Diversion; to accommodate additional demand there should be a subsequent increase in the availability of community-based support and treatment services to support diversion participants in need of treatment.

ii. Responding to increased demand: SafeScript

*Victoria's Real Time Prescription Monitoring (**RTPM**) system, 'SafeScript' provides an opportunity to address harms related to pharmaceutical medications 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 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.[45] Following an FOI by the ABC, it was revealed that between 1/1/20 to 30/6/20, 69,201 Victorians

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[43] Hughes et al, *Criminal Justice Responses*, pp. 51-52.
[44] Victorian Parliamentary Inquiry into Law Reform, cited in Hughes, p. 50.
[45] 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.

were identified through the system.[46] We understand that the Department has no assurances as to what supports if any were provided to these people.

Additional considerations include:

- This figure is approximately 50% greater than the number of Victorians who were engaged AOD treatment in 2019/20;
- Benzodiazepines continue to contribute to over half of all fatal overdoses in Victoria[47];
- The Australian Criminal Intelligence Commission's 2021 Waste Water Analysis, which was undertaken after SafeScript became mandatory, has revealed the ongoing trend of regional Victoria has a high rate of pharmaceutical opioid use compared to the rest of Australia;[48]
- Pharmaceuticals have consistently contributed to just under eight in 10 fatal overdoses[49]; and
- Victoria has an enduring opioid market in both illicit and pharmaceutical opioids 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. In the short term, this reduces the likelihood of pharmaceutical-related harms, including overdose.

However, beyond the above data, little is known about the subsequent impacts on those monitored under SafeScript. There is a pressing need to examine their journey beyond the general practice or pharmacy: this will provide information about 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:

- an increased demand for support services, as many Victorians affected by it are likely to require some form of additional support. This is compounded by the reported increase in demand due to the pandemic; 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 novel psychoactive substances or the Dark Web. For instance, VAADA is aware of increasing usage of various novel benzodiazepines, which has translated to a rapid increase in fatalities, from one in 2018 to 28 fatal overdoses in 2020[50]. This concern is exacerbated through pandemic related changes to the illicit drug market.

In short, the positive impacts of the RTPM will be at risk if this reform is not supported by a robust and highly capable AOD sector, as well as increases to supports across a range of related service

[46] Department of Heath 2021. Safescript. FOI February
[47] Coroners Prevention Unit 2021. Overdose deaths, 2011 – 2020 Victoria. Coroners Court of Victoria.
[48] Australian Criminal Intelligence Commission 2021, *National Waste Water Drug Monitoring Program – report* 14, https://www.acic.gov.au/sites/default/files/2021-10/National%20Wastewater%20Drug%20Monitoring%20Report%2014.pdf
[49] Coroners Prevention Unit 2021. Overdose deaths, 2011 – 2020 Victoria. Coroners Court of Victoria.
[50] ibid

sectors. Greater specialist capacity needs to be employed, with clear referral pathways from primary care to AOD and other support services. As these impacts were not accounted for in the design of SafeScript. VAADA recommends urgent consideration of these issues as part of a review, as a matter of priority.

Recommendation 6: Invest $5M in the AOD sector to provide for the additional demand generated by SafeScript and other reforms aimed at pharmaceutical harm-reduction measures. This would provide for necessary workforce capacity-building, including greater capacity for Victoria's pharmacotherapy system, the expansion various specialisations to support people experiencing harms from pharmaceuticals across Victoria.

Recommendation 7: Undertake research and a review of the impacts of SafeScript, which includes an assessment of:

- **i) Patient outcomes following identification;**
- **ii) the limitations, benefits and impact of SafeScript, on targeted consumers, with particular reference to their healthcare needs, treatment and referral pathways; and**
- **iii) The breadth and range of service system enhancements required to meet demand arising from pharmaceutical related harm**

Benzodiazepines

This is particularly focussed with regard to benzodiazepines, which are regularly used and often accompanied by silent harms. Clinical advice indicates that they should not be prescribed for more than four weeks but feedback from the sector indicates that there are many people who have been using them for years. Despite a parliamentary inquiry into benzodiazepines in 2007[51] (which was largely neglected). This report detailed a number of pragmatic recommendations relating to medical training for GP, nurses and other health staff, community education including harm reduction activities as well as an uplift in specialist AOD treatment capacity for benzodiazepines, emphasising regional capacity. The report highlighted the need to build a systemic model of care around benzodiazepines. These recommendations have been largely ignored by successive governments while the overdose toll from benzodiazepines has been surging.

Recommendation 8: Invest $750,000 recurrently to support training across the sector and primary health to respond, refer and support people presenting with issues relating to benzodiazepines. This includes:

1. **$350,000 for providing training state wide ($300,000 each year after);**
2. **$400,000 recurrently0 for providing specialist support for benzodiazepine dependency through counselling and other support services**

[51] Drugs and Crime Prevention Committee 2007. Inquiry into abuse / misuse of benzodiazepines and other pharmaceuticals. Parliament of Victoria. https://www.parliament.vic.gov.au/images/stories/committees/dcpc/pharmaceuticalmisuse/Benzo_Final_web_web_res.pdf

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[52].

Prior to COVID-19, Victoria's population was expanding at a higher rate than any other state or territory within Australia.[53] Victoria's growth rate is 1.8% compared to the national average of 1.4%[54] and has a higher population density than any other state at 23.54 people per square kilometre.[55] 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).[56] 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[57].

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.

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;

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

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

[54] 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.

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

[56] 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.

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

- 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 9: Invest a sum of $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 10: Infrastructure funding to establish and expand services within growth corridors should be availed to ensure that treatment facilities are suitable for clinical purposes.

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.[58] 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.[59]

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

Infrastructure Victoria

Furthermore, Infrastructure Victoria, in recommending additional residential rehabilitation facilities in neglected parts of regional Victoria[60], 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).

While VAADA supports Infrastructure Victoria's recommendations, 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, both general and for specific populations. 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

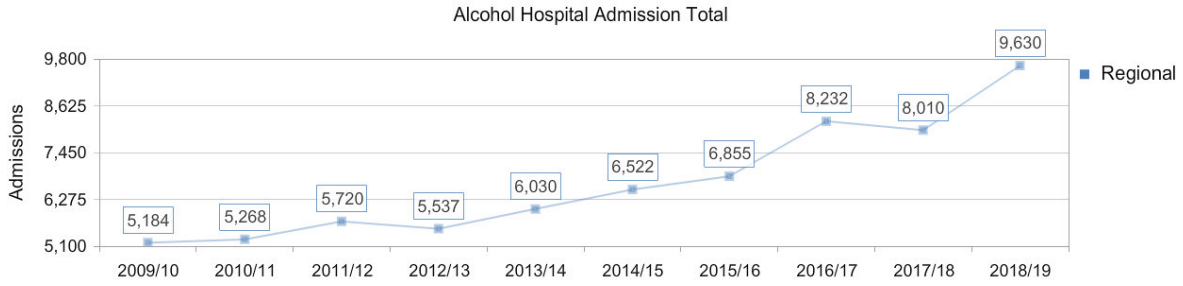
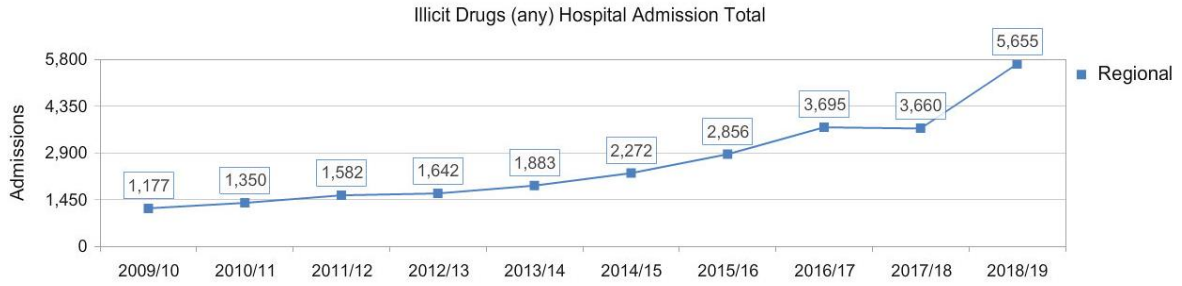


Figure 5 reveals that rural and regional illicit substance hospitalisations have increase by more than 50% in the year leading to 2018/19.

[60] 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 (recruitment and retention) issues.

VAADA's 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 in Victoria, are known to increase the incidence and severity of mental illness and problematic substance use in affected communities.[61] 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.[62] 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.[63] 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 harms 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.

[61] Psychological outcomes following the Victorian Black Saturday bushfires p. 643.
[62] Ibid
[63] 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 11: Invest an interim sum of $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 12: Avail a range of incentives such as salary supplementation, re-location allowances, housing support, scholarships and graduate training incentives to build the attraction and capacity of the rural workforce.

Recommendation 13: resource AOD agencies in disaster affected areas with a 20% increase to existing funding levels to support increased demand over three years.

v. 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.

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. It could also benefit those in recovery living in social housing or experiencing difficulties following release from prison. People experiencing AOD dependency have been largely neglected within the recent housing uplifts, despite suitable and stable housing being paramount to positive recovery[64]. CRC could support an approach to more coordinated care for people concluding AOD treatment episodes as they enter into new housing arrangements.

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

[64] Duff, C., Hill, N., Blunden, H. valentine, k., Randall, S., Scutella, R. and Johnson, G. (2021) Leaving rehab: enhancing transitions into stable housing, AHURI Final Report No. 359, Australian Housing and Urban Research Institute Limited, Melbourne, https://www.ahuri.edu.au/research/final-reports/359, doi: 10.18408/ahuri53211.

coordination.[65] Almost 60% of respondents to VAADA's 2021 Sector Priorities Survey noted that demand had increased for this program and 66% of agencies noted 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.[66] 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 $18M.

There is also a pressing need to evaluate the current value of the CRC DTAU rate. The 2021/22 price for a DTAU is $882.32, and the weighting on CRC currently sits at 2.22 DTAUs. This current rate is insufficient to cover the costs associated with providing CRC treatment, and therefore a review should be undertaken, to ascertain a more suitable rate which reflects to value of CRC.

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 a suitable level of capacity to maintain a continuum of care beyond the course of treatment, and provide a safety net to support people who experience setbacks in recovery.

Increased funding is also needed to enhance the resources necessary to provide CRC treatment: specifically, supported housing which provides service users with stability in the period immediately following an episode of treatment, when risk of relapse is at its highest. During this time, many return to their former using environments and social groups; supported housing can assist by providing an alternative environment which complements the recovery process.[67] Victoria's Big Build, which has allocated $5.3B in response to housing affordability, should prioritise a portion of housing for AOD service users. 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.[68]

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 process. VAADA recommends that the Government consider funding targeted at increasing staffing levels within supported housing for those undertaking CRC.

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[65] 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.
[66] 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.
[67] 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.
[68] 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.

Recommendation 14: Provide a recurring $18M 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 15: Prioritise AOD service users for a portion of social housing from Victoria's Big Build with CRC facilitating the necessary support services.

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.[69]

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 also add a greater burden of complexity for AOD agencies. Activities relating to service integration following the Royal Commission into the Mental Health System need to be accounted for as an ongoing item in determining the value of treatment through the DTAU.

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. Specifically, over two thirds of agencies responding to VAADA's 2021 sector priorities survey identified a range of unfunded activity, some of which includes:

- liaising and supporting service users with the NDIS;
- secondary consults;
- referring to other AOD agencies;
- mental health as well as family violence supports
- Providing crisis support to people who attend without going through the intake system;

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

- Aftercare;
- Family work;
- Collation of information relating to referral to withdrawal services;
- Intake inquiries that don't progress to referral;
- Follow up with clients who do not engage in counselling;
- MARAM secondary consults;
- Education about AOD services;
- Crisis calls relating to mental health;
- Housing, especially as there is often a scarcity of suitable stock;
- Calls to GPs and hospital based secondary consultations;
- Supporting clients through Court;
- Various compliance activities;
- Liaison with Child Protection;
- Community engagement and educational activities; and
- Extensive travel duration particularly in rural and regional areas.

The current value attributed does not account for this extra work. The changes in service delivery necessitated through COVID-19 have exacerbated these issues as services users present with increasingly complex issues and the burden of establishing remote work stations and ensuring services users can accommodate online/telehealth models of care.

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 16: 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 and evidence-based cost of service delivery.

ii. Finding tomorrow's AOD workforce

There is a mounting crisis in recruiting suitable AOD workers. While this issue is state-wide, rural and regional areas experience the greatest difficulty. There are not enough qualified workers to fill all the available positions. This is coupled with a high rate of burn out and the greater appeal of well remunerated expanding sectors, such as mental health. We need to secure our existing workforce and put in place the building blocks to recruit tomorrow's workforce.

- AOD agencies responding to VAADA's 2021 sector priorities survey report that recruitment is the most significant challenge currently facing the sector;
- While agencies compete for a dwindling pool of quality workers, many workers look abroad to larger, more secure and better remunerated sectors; the growth in the mental health sector may have devastating impacts on recruiting and retaining skilled AOD clinicians;
- Retaining workers will require regular upskilling/training as well as competitive remuneration and employment conditions.

As in previous years, the 2021 VAADA Sector Priority Survey revealed enduring concerns regarding recruitment, retention and remuneration of staff in the AOD sector. Recruitment again featured as the most prominent concern identified by the sector, with two thirds of all agencies responding to VAADA's 2021 sector priorities survey listing this as the most pressing issue. This was more pronounced among organisations located in rural and remote communities.

Agencies report that many workers have been exhausted by the pandemic, with increasing rates of workforce attrition. The sector is increasingly expected to demonstrate greater expertise and capability across a range of areas and populations, including family violence, child protection, youth, Aboriginal and Torres Strait Islander and CALD communities with no additional capacity to account for the burden of these expectations adding to staff burnout as well as a greater strain on agencies.

These challenges are exacerbate by the pandemic – not only with the service users but also with the staff and their families.

The AOD sector is also facing greater competition for staff from other sectors, such as mental health, providing greater stability and higher remuneration, taking workers away from AOD.

Already, agencies report that they have to readvertise positions - multiple times – and often have no choice but to employ someone who requires considerable support to carry out the work. In many cases, after more than a year of additional support and training, the now upskilled worker may seek more highly remunerated work in other sectors.

An uplift in industrial conditions across the sector should be progressed to allow greater competitiveness with other sectors in both wages and conditions.

There is an urgent need to establish and maintain mechanisms to efficiently upskill the Victorian AOD workforce on an ongoing basis as well as ensure that there is a sufficient supply of workers going forward.

In alignment with the Victorian Government COVID-19 100 workers initiative, VAADA has been funded to provide training to new and current AOD workers. This funding being associated with the 100 workers initiative is therefore at risk of concluding in 2022. This should be continued to provide the necessary upskilling opportunities to existing and new AOD workers into the future.

In the long term, to ensure that there is an adequate pool of skilled AOD workers, there is a need for greater incentives to entice students to engage AOD qualifications. An entity (run by a team of at least two staff members) should be established and work with VAADA's Elevate program to coordinate student placement on behalf of the AOD sector. This entity would play a vital role in developing pathways to increase sector involvement in student placements to enable greater competency among the emerging workforce.

Recommendation 17: Invest $1.5M to extend the activity of VAADA's Elevate program to better coordinate training, streamline student placements and enhance the attraction of staff to Victoria's AOD sector. This entity would progress options for micro-credentialing, course development and opportunities to upskill new and existing AOD workers. A central co-ordinating team of at least two additional staff would support the Elevate program.

Recommendation 18: Invest $2M to develop a broad 'industry plan' for the AOD sector which undertakes an assessment of the core elements of the Victorian AOD system, current and future demand as well as forecasting future workforce and infrastructure need.

Recommendation 19: Improve industrial and wellbeing conditions of the AOD workforce in alignment to similar changes in the mental health workforce to improve workforce attraction and retention.

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

The reforms which are progressing from Royal Commission into Victoria' Mental Health System are both far reaching and momentous. The policy reform and accompanying systemic changes will modify the way many people are supported. There are however significant implications to existing service systems as the reforms prioritise service integration and dislocate existing workforces.

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[70].

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 and service system.

This approach does not accommodate the complexities in the lives of people who use AOD treatment services. Trauma, associated with a range of issues including family violence are evident with many people presenting to AOD services with mental health concerns for support. Many people presenting may be experiencing PTSD or personality disorders, which may not have been diagnosed but remain a factor. Progressing service integration should accommodate service user trauma and the AOD treatment model of care should not be superseded by the mental health bio-medical model which could inadvertently pare back the supports many people need.

While the mental health sector already has dual diagnosis capacity, to ensure that there is an effective translation into practice across both sectors, additional similar capacity should be afforded to the AOD sector.

The allocation of additional capacity to address these issues should not be solely directed toward the mental health sector. AOD should be viewed as an equal partner and AOD should not be excluded in uplifts in capacity to address current gaps in broader service support. The AOD model is vital to the

[70] Royal Commission into Victoria's Mental Health System 2021. Vol. 3. p. 308. https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_Vol3_Accessible.pdf

wellbeing of thousands of Victorians experiencing a broad spectrum of trauma and to that end, greater capacity should be afforded to the AOD sector with specialist capability in trauma as well as co-occurring AOD and mental health issues.

The 2021 VAADA sector survey revealed a consensus across the sector regarding the risk of being set aside as these reforms progress, with AOD service users and providers being seen as a footnote in the broader service system. There is a need to provide a key point of leadership within the AOD sector which could also assist in supporting the sector through the broader reform / service integration process. Additional to this is the need to capture best practice regarding the integration processes adopted within each region from an AOD perspective and ensure that these learnings can be utilised to ensure best practice going forward.

A role should be developed to work with VAADA's current mental health reform project worker which would capture and subsequently develop advice on successful service integration models.

It could also advise on effective processes that would also ensure that vital aspects of the AOD sector, such as those encapsulating harm reduction, are not lost throughout the reform process.

Recommendation 20: Recruit three 'specialist' dual diagnosis and trauma clinicians into each AOD region to build the capability of the sector to respond to the needs of service users experiencing acute co-occurring AOD and mental health and other concerns.

Cost per region:

Year 1:	**3 x dual diagnosis clinician**	**$450,000 per region**
Year 2 +	**3 x dual diagnosis clinician**	**$400,000 per region + CPI**

Recommendation 21: that $2.5M be provided on a recurrent basis to support and maintain service integration across the eight mental health and wellbeing regions.

Recommendation 22: The AOD peak body is funded for two years to deliver a sector transition role to support the sector, monitor the process and respond to issues arising from the integration of the AOD and mental health services.

Year 1	**2 x project worker**	**$260,000**
Year 2	**2 x project worker**	**$260,000 + CPI**

c) Improving access to AOD treatment

i. Improving access: Opioid replacement therapy

Even prior to COVID-19, Victoria's opioid replacement therapy (ORT) program was teetering on the edge of collapse as it is increasingly propped up by a smaller number of general practitioners prescribing to thousands of people. The pandemic 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 14,968 Victorians accessed opioid replacement therapy (**ORT**) in 2020.[71] This has increased to 22 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, it is probable that during the latter part of 2020 with the downturn in the heroin market, there was an increased uptake in this program. A number of factors have been contributing to this, including the temporary reduction in purity and increase in price of heroin[72] 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, is likely to increase demand for ORT[73].

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.[74]

Despite the unambiguous benefits associated with this long-standing treatment, the Victorian model is on the brink of collapse with an ageing population of prescribing general practitioners nearing retirement and a paucity of new practitioners opting in. There are a number of immediate, mid-term and longer term endeavour that needs to be progressed.

Of pressing need is responding to the instability in prescribing practitioner numbers. We have heard that 14 prescribing practitioners with sizable caseloads have ceased prescribing in the past 14 months. Victoria's system is unique in that it relies almost entirely on prescribing practitioners opting in to prescribe methadone or buprenorphine; all other regions have a blended model which provides a bulwark against attrition in prescribing practitioner numbers. We need to urgently consider building capacity in public hospitals and community health centres. If clients are unable to find a stable prescribing practitioner they are likely to re-engage with the illicit drug market.

Some regions already have limited capacity and are at risk of single practitioners with huge caseloads retiring or otherwise unable to continue prescribing. While nurse practitioners are providing support in some regions, the funding availed through Medicare is insufficient to solely maintain this model of care. The nurse practitioner model must be made financial viable.

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[71] AIHW. 2021. National Opioid Pharmacotherapy Statistics Annual Data collection. https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics/contents/clients

[72] 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

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

[74] 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.

Greater incentives should be considered for practitioners, especially in regional areas where there are gaps, to take on more patients.

Beyond capacity issues, the system also discourages engagement, with clients encountering multiple barriers to access. This ranges from discrimination in healthcare settings, difficulty finding prescribing practitioners 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 and other costs amount to one eighth (12.5%) of their income.[75] Payment of dispensing fees can also cause conflict between pharmacist and ORT clients. This can lead to the accumulation of debt and may lead to the discontinuation of treatment.[76]

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.[77]

With almost 15,000 Victorians accessing ORT, the annual cost of covering dispensing fees would be approximately $30M per annum.

Recommendation 23: establish a funding model that makes the nurse practitioner model a viable support, especially in those areas where there is an acute shortage of prescribing practitioners.

Recommendation 24: increase the stability of the Victorian ORT system through resourcing community health centres to maintain capacity to prescribe in each region.

Recommendation 25: The Victorian Government should subsidise the ORT dispensing fee to increase program engagement and retention;

Recommendation 26: undertake a review of the ORT system to ascertain viable and sustainable future model.

[75] Tran, AD et al 2021. Economic analysis of out-of-pocket costs among people in opioid agonist treatment: A cross-sectional survey in three Australian jurisdictions. International Journal of Drug Policy. 99:2022.
[76] Pennington Institute, *Chronic Unfairness*.
[77] 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.

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[78]. With evidence linking the enduring AOD and mental health impacts to crisis or disasters[79], enhanced support for AOD and mental health concerns for young people experiencing COVID-19 related stressors will be a solid investment for the future. The support afforded should be broader than AOD and mental health, to better represent the whole person and the range of issues presenting. Youth AOD agencies regularly report to VAADA that AOD is one (often prominent) issue among many which young people are seeking help for. Greater capacity within the AOD youth sector to support the whole person should be provided.

These roles would work with other sectors to support the young person and could liaise with out of home care and other areas where vulnerable young people are engaging.

Youth AOD treatment provides a conservative return on investment of $4.66 for each dollar spent.[80]

The Royal Commission into Mental Health will implement 13 Infant, Child and Youth Services. Aligned with the prioritisation of service integration with these services, there is a need to immediately invest in additional AOD youth complex care, including dual diagnosis and clinical capacity.

Recommendation 27: Resource over the next four years an additional 10 AOD youth complex care workers (approximately $2M p/a).

Most young people spent a significant period over the past two years engaging in home learning or otherwise being separate from various support services and therefore may not have been able to

[78] 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. 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

[79] 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

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

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 targeted schools would affect a robust early intervention which would reduce future demand for both youth and adult AOD treatment, as well as other support or interventions going forward.

Not dissimilar to the Government's initiative to ensure that every Victorian school has access to psychological supports, AOD clinicians/practitioners would be able to provide the necessary support to 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 support for families.

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 metropolitan and one regional area and supported through an established AOD treatment provider with expertise in youth AOD work.

The First Response Program provided improvements in wellbeing and a reduction in suicide ideation and distress[81].

Recommendation 28: pilot and evaluate over a three year period a metropolitan and regionally based AOD support worker to work with at risk young people within a school (or cluster of schools) to support with counselling, referral and family support.

Many young people seek to engage support in external settings rather than attending a specific service. While there remains some outreach capacity in metropolitan settings, young people in regional Victoria cannot access this service type. Outreach treatment approaches support the young person in their preferred environment and can allow for greater anonymity which is often a factor in regional areas where small population sizes and townships detract from attending a shopfront service.

Outreach can also provide support to young people waiting for residential support, which is also limited in capacity, particularly in regional Victoria. Equity of access of all service types irrespective of region should be prioritised.

Recommendation 29: increase regional youth outreach capacity to meet demand and support people awaiting residential support.

5 Regional outreach workers	**5 x $110,000 P/A**	**$550,000 + CPI P/A**

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

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. 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.[82] 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,[83] and population growth in the older demographic in Victoria is forecast to increase more rapidly than any other age group;[84]
- 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;[85] and
- Despite the facts that drug-induced deaths among mature aged people have been increasing since 1999,[86] they are less likely to access traditional services due to stigma and mobility limitations.[87]

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.

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[82] 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.
[83] Department of Health and Human Services, *Ageing,* Victorian Government, 2019, https://dhhs.vic.gov.au/ageing accessed 21 January 2019.
[84] Department of Planning and Community Development, *Victoria in Future: 2008*, Melbourne, 2009.
[85] Coroners Court of Victoria, *Average Annual Overdose Death Rate, Victoria 2009 – 2017*, Coroners Prevention Unit, Southbank, 2018.
[86] Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2017–18*.
[87] 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.

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 30: 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:[88]

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 per annum**

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.[89]

In 2016, VAADA conducted an analysis of the extent of AOD harms among CALD populations in Victoria,[90] 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);

[88] This pilot program outline has been adapted from VAADA's 2014/15 State Budget Submission
[89] Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2017–18*.
[90] 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.

- 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
- Promoting culturally appropriate models of service delivery while strengthening ties between CALD communities, ethno-specific agencies and AOD treatment services.[91]

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;

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

- 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.

Recommendation 31: 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 per annum

v. Supporting LGBTIQ communities with community ran specialist services

The Victorian AOD treatment system has limited capacity in LGBTIQ specialisation with a number of regions not in receipt of any targeted support. There are increased substance related harms amongst many LGBTIQ communities with many of these community members maintaining reservations regarding accessing mainstream services. There is a need to progress specialist LGBTIQ community controlled AOD organisations which are readily accessible across Victoria.

While not uniform, it is generally accepted that people from LGBTIQ communities experience greater levels of AOD related harm[92]. For instance, homosexual and bisexual people are 3.2 times more likely to use cannabis, 5.8 times more likely to use ecstasy and 3.7 time more likely to use cocaine when compared with the general community[93].

[92] Amanda Roxburgh et al, 'Sexual Identity and Prevalence of Alcohol and Other Drug Use among Australians in the General Population' (2016) 28 *International Journal of Drug Policy* 76; Hill AO et al. 2021. Writing themselves in 4; the health and wellbeing of LGBTIQ young people in Australia. Latrobe University.
[93] Hill AO et al. 2020. Private Lives 3; health and wellbeing of LGBTIQ people in Australia. Latrobe University.

Just under a quarter of young people from LGBTIQ communities were concerned about their own drug use with only 11.8% seeking professional help[94]. While views were mixed (with a number of participants not expressing a view, four in 10 participants stated a preference for mainstream services with LGBTIQ specialisation or specific LGBTIQ AOD services.

More broadly, one in six people from LGBTIQ communities are concerned with their alcohol consumption; however, only 18.3% of that cohort sought help[95]. Regarding service preferences with regard to LGBTIQ community members who have used drugs in the past 12 months, over half (56.4%) would prefer to use an AOD agency that is LGBTIQ capable or a specialist LGBTIQ AOD service should the need arise[96].

It is evident that there are higher rates of AOD use and related harm within LGBTIQ communities and relatively low rates of service engagement. While the data available is indicative that a portion of people from LGBTIQ communities are happy with mainstream AOD support, there is also a significant portion who have a preference of AOD services with greater specialisation or specific LGBTIQ run agencies providing support. Specialist services would increase service engagement among these communities.

Greater capacity of LGBTIQ community owned services should be availed to ensure that there is equitable access across the state. This should include a specialist residential withdrawal and rehabilitation service which could be conducted in partnership with an existing residential AOD service with LGBTIQ community members provided peer support. Mainstream AOD agencies should be provided with support to increase LGBTIQ community capability to ensure that all AOD services are culturally safe.

Recommendation 32: Expand LGBTIQ community controlled AOD counselling and care and recovery coordination capacity across metropolitan Melbourne and regional Victoria to ensure equitable access to specialist support for LGBTIQ communities at an approximate cost of $750,000 P/A.

Recommendation 33: In partnership with an existing residential rehabilitation provider, develop a specialist LGBTIQ community controlled residential rehabilitation facility, consulting with LGBTIQ communities and agencies to ascertain the most suitable organisational structure.

[94] Hill AO et al. 2021. Writing themselves in 4; the health and wellbeing of LGBTIQ young people in Australia. Latrobe University.
[95] Hill AO et al. 2020. Private Lives 3; health and wellbeing of LGBTIQ people in Australia. Latrobe University.
[96] ibid

vi. Improving access: Increasing residential rehabilitation capacity– a case for parity with the rest of Australia

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 in 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. This is acutely evident with the lack of regional withdrawal services, particularly for young people and Aboriginal and Torres Strait Islanders.

There is growing evidence that supports the efficacy of residential rehabilitation as an effective means of addressing AOD-related harms. De Andrade et al note consistent evidence supporting effectiveness of residential treatment (including therapeutic communities and integrated mental health treatment) across various outcomes.[97] Research has also demonstrated the cost effectiveness of residential rehabilitation: both Lubman et al and Ciketic et al found residential rehabilitation to be cost effective in addressing methamphetamine-related presentations.[98] 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.[99] Other studies note a conservative net economic benefit of approximately $1M per person.[100]

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 in previous budgets from the Government for residential rehabilitation is welcome, families continue to inform VAADA that significant barriers to this treatment type remain. Furthermore, due to COVID-19, much of the benefits associated with the uplift have been lost as agencies reported a 20% reduction in capacity.

We estimate that, based on 492 beds soon to be operating, Victoria's residential bed capacity is 0.74 beds per 10,000 head of population. Despite this welcome increase, this remains inadequate to address demand, especially with the COVID-19 triggered blow out. As Figure 6 reveals, in 2021, Victoria maintains the second lowest ratio of residential rehabilitation beds per head of population nationally.

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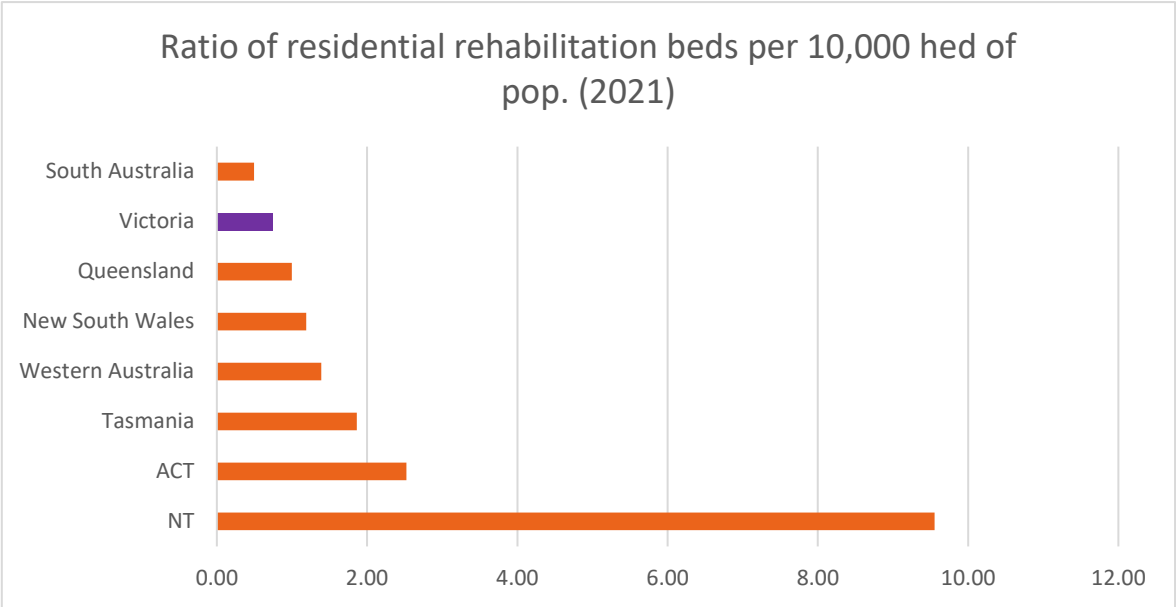
[97] De Andrade et al, 'The effectiveness of residential treatment services for individuals with substance use disorders: A systematic review' *Drug and Alcohol Dependence* vol. 201, 2019, pp. 227-235.
[98] D Lubman et al, *A study of patient pathways in alcohol and other drug treatment,* Turning Point, 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.
[99] 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.
[100] Rae, J, *Economic impact of residential treatment for alcohol and other drug addiction in therapeutic community (TC),* Odyssey House, Victoria, 2013.

Figure 6: Residential rehabilitation beds per 10,000 head of population by state/territory 2021



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 over the next two years 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 but would lift Victoria to be the equal second lowest ranking 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 $66,000 per annum.

Residential withdrawal

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 seamless treatment pathway. This should include both community and hospital based withdrawal capacity.

There is a need to have Aboriginal and Torres Strait Islander withdrawal capacity increased, particularly in a number of areas in regional Victoria. This has been a persistent need with consistent feedback from the sector that there is inadequate capacity to support demand. We would

encourage engagement with Aboriginal Community Controlled Health Organisations to inform on demand, service design and location.

The dispersal of youth residential withdrawal is inequitable with significant limitations in some regional areas. An audit should be undertaken ascertaining which regions have limited capacity in line with observations from Infrastructure Victoria's observations of a lack of equity in residential services across Victoria.

Recommendation 34: 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 35: Increase residential withdrawal capacity, particularly in regional Victoria, with some of this increased capacity developed to separately support both young people as well as Aboriginal and Torres Strait Islanders.

The Victorian Alcohol and Drug Association Inc. acknowledges the support of the Victorian Government.