VICTORIAN ALCOHOL & DRUG ASSOCIATION

VAADA 2020

COVID-19 supplementary pre budget submission 2020-21

VAADA Vision

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

VAADA Objectives

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

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1. About VAADA

The Victorian Alcohol and Drug Association (VAADA) is the peak body for alcohol and other drug (AOD) services in Victoria. We provide advocacy, leadership, information and representation on AOD issues both within and beyond the AOD sector.

As a state-wide peak organisation, VAADA has a broad constituency. Our membership and stakeholders include 'drug specific' organisations, consumer advocacy organisations, hospitals, community health centres, primary health organisations, disability services, religious services, general youth services, local government and others, as well as interested individuals.

VAADA's Board is elected from the membership and comprises a range of expertise in the provision and management of AOD services and related services.

As a peak organisation, VAADA's purpose is to ensure that the issues for both people experiencing the harms associated with AOD use, and the organisations that support them, are well represented in policy, program development, and public discussion.

2. Executive Summary

This pre budget supplement submission outlines the impact of COVID-19 and the associated restrictions on both the AOD sector and service users.

This submission aims to provide government with a clear overview of the challenges, adaptations and requirements for ongoing support to cohorts experiencing substance dependence who need to engage treatment services. The submission assesses this information with a focus on:

- extending what works; and
- identifying COVID-19 related service constraints and gaps, articulating where there is a need for additional resources.

The submission draws on feedback from the Victorian responders to a nation-wide survey administered by the state and territory AOD peak bodies which examined these impacts. Additional information has also been gathered from feedback through various events, consultations, meetings and other liaison with treatment providers.

3. Recommendations

Recommendation 1: the recent changes to Victoria's ORT program should be retained; additionally, in order to retain people on ORT, the dispensing fee should be subsidised.

Recommendation 2: a therapeutic approach should be taken to policing activities relating to people who use drugs which prioritises a therapeutic, health focussed and harm reduction response rather than punitive response to street based substance use; this includes the application of diversion rather than infringements.

Recommendation 3: that government provide $10 million to the AOD sector to meet existing and future demand within a contracted AOD service system to maintain face to face treatment options. This funding should also provide for workforce capacity building activity.

Recommendation 4: The Mental Health and Alcohol and Drug Facilities Renewal Fund should be rapidly extended with additional rounds of funding capped at $500,000 per agency to allow agencies to expedite the expansion of their infrastructure to allow for additional capacity while adhering to social distancing measures.

Recommendation 5: There is a need to rapidly increase the shortfall in residential capacity and Infrastructure to account for bottlenecks relating to reduced capacity as well as future COVID-19 related demand. Consideration must also be given to the requisite workforce capacity to meet this expansion to address current and future demand.

Recommendation 6: There is an enduring need to increase the capacity to provide additional Care and Recovery Coordination and bridging support for those waiting to access residential services, as well as those who may otherwise be not engaging the treatment sector as effectively as they did pre-covid. This could include additional non-residential withdrawal capacity. To bring this into alignment with earlier department expectations, a conservative figure of $16.76M is required.

Recommendation 7: Government should establish a COVID-19 innovation fund of $4M to enable agencies to measure the effectiveness of innovative ways of delivering treatment programs and services. This funding would allow agencies to explore and assess innovations in response to COVID-19.

Recommendation 8: The Government should provide for incidentals related to reducing the risk of infection including PPE, sanitiser, IT infrastructure and equipment to enable working remotely amounting to a 2 percent increase in overall sector funding over the next financial year totalling to $5.5M.

Recommendation 9: resource an enhanced treatment offering in the adult, Aboriginal and youth sectors to support those experiencing complexity who are disengaging or at risk of disengaging from AOD treatment. This may involve outreach, peer support and dual diagnosis support. This should amount to at least 3 EFT in each AOD catchment amounting to $4.5M over the next three years.

4. Introduction

COVID-19, with the associated restrictions, continues to impact heavily on people who use drugs (PWUD) as well as restricting the capacity of supporting treatment services.

These impacts relate to the availability of substances and the associated emerging drug trends, the risk of COVID-19 transmission among PWUD, the impact of social distancing and other restrictions on service capacity and access, as well as the enforcement of these restrictions.

While these impacts have been acutely felt during this period, many of the issues as well as emerging harms are likely to peak well after the curve has been flattened.

Pressing challenges which have emerged in the short term include:

- reduced access to various forms of treatment, in particular residential services;
- Limited access to opioid replacement therapy (ORT) for new patients, particularly in some rural and regional areas;
- An increase in alcohol consumption and changing illicit drug consumption patterns; and
- Reduced capacity to support voluntary AOD service users in a timely manner.

There has also been commentary on an increase in the price of some illicit substances, including heroin, which is to be expected in light of COVID-19 related restrictions affecting international illicit substance trafficking, which also impacts upon supply and may result in some people transitioning to other substances[1].

While bed based services indicate restricted access and an increased waiting list as well as substantial future demand, community-based service waiting lists are more difficult to assess because of data limitations. However the AOD sector remains overburdened, with a surplus of demand nationally translating to a gap of 180,000 to 553,000 people.2. This burden will likely increase due to blockages associated with COVID-19 restrictions with an overlay of increased demand through increased at risk substance use, including alcohol consumption.

This submission will outline a number of initiatives to minimise the AOD related harms associated with COVID-19. It will reflect and analyse information currently in the public domain, as well as feedback from AOD treatment agencies through a range of means, including a sector wide survey.

[1] Dietze PM & Peacock A. 2020. Illicit drug use and harms in Australia in the context of COVID-19 and associated restrictions: anticipated consequences and initial responses. Drug and Alcohol Review. 39:4. Pp 297-300; Shine R. 2020. Methamphetamine-related hospital admissions drop due to coronavirus restrictions has doctors worried. ABC. 30 May. https://www.abc.net.au/news/2020-05-30/meth-hospital-admissions-down-amid-wa-coronavirus-restrictions/12293230

[2] 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.

5. Natural disasters and AOD harm

A range of studies on the immediate and longer term impact of local, national and international crises have been conducted. While there is limited evidence on the impact of pandemics of the magnitude of COVID-19, recent studies highlight the financial and social effects of recent bushfires and floods. These have similar far-reaching impacts in generating displacement, anxiety and the harms associated with a contraction in broader employment as well as the devastation of local communities.

The studies provide a benchmark of the long standing harms including the association between AOD use and crises, which is found to increase in the aftermath of such events. The difference between these disasters and COVID-19 is that the latter has spanned all corners of the nation, with no industry or community untouched.

The ramifications are devastating, with governments at all levels implementing various stimulus and associated policy to prop up the economy as well as a range of social supports.

The data below highlights these harms from an AOD perspective, noting that substance use increases in affected regions during and after a crisis at great social and financial cost.

- 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;[3]
- Alcohol use was 1.4 times higher in fire affected areas following Black Saturday amounting to an estimated lifetime cost of $190 million;[4]
- 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[5] amounting to a lifetime cost of $20 million[6]

'More than 1 in every 10 people exposed to natural disasters are reported to develop psychological distress with some persisting for the rest of their lives.'[7]

[3] Bryant et al. 2018. Longitudinal study of changing psychological outcomes following the Victorian Black Saturday bushfires. ANZJP. 52(6). Pp 542-551.
[4] 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
[5] Turner et al 2013. Impact of the 2011 Queensland Floods on the use of Tobacco, Alcohol and Medication. 37 (4).
[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] Ibid. p. 48.

5.1 What we know about AOD use and COVID-19

ALCOHOL RELATED ISSUES:

- One in ten workers admit to drinking alcohol during business hours while working from home[8];
- Alcohol ads appear online once every 35 seconds during COVID-19 pandemic[9];
- One in five people reported buying more alcohol than usual and seven in 10 people reported consuming more alcohol since the COVID-19 pandemic commenced;
- One in three are now drinking daily[10], up from six percent (just over one in twenty) pre COVID-19[11];
- Almost three in 10 Australians (28 percent) are drinking alcohol on their own with the same number drinking to relieve stress and anxiety;[12]
- Data sources indicate that the rates of at risk drinking among women is increasing more rapidly compared with males, with two data sources noting an increase in alcohol consumption among women of 18 percent and 31.8 percent;[13]
- Service providers also report an increase in alcohol use across the board as access to other substances is reduced, as well as evidence of increased alcohol consumption within the broader community. There have also been reports from service providers' of increased relapse among those who had made significant progress in their recovery prior to COVID-19. Job loss, financial stress, family pressures, declining mental health and a loss of structure and routine has been cited as some of the factors associated with relapse during the pandemic; and
- There is concern of a significant rise in demand for AOD services from and a new cohort of clients.

ILLICIT SUBSTANCE RELATED ISSUES:

- Increased unemployment, impacted mental health and isolation can all impair recovery increasing the risk of relapse[14];
- The restrictions accompanying COVID-19 in the short term may reduce the street based drug market changing the means of procuring substances; however they will also generate drug taking practices which increase risk such as:
    - stockpiling substances;

[8] Burgess M. 2020. Workers not Home Free. Herald Sun. 18 June.
[9] Fare 2020. Alcohol Ad every 35 seconds during COVID-19. http://fare.org.au/alcohol-ad-every-35-seconds-during-covid-19/
[10] Fare 2020. Alcohol Sales and use during COVID-19. http://fare.org.au/wp-content/uploads/COVID-19-POLL.pdf
[11] NADK 2020. How often do Australians drink alcohol?. NCETA. https://nadk.flinders.edu.au/kb/alcohol/consumption-patterns/frequency-consumption/how-often-do-australians-drink-alcohol/
[12] Ibid 10
[13] Arunogiri S et al 2020. Women are drinking more during the pandemic, and it's probably got a lot to do with their mental health. The Conversation. https://theconversation.com/women-are-drinking-more-during-the-pandemic-and-its-probably-got-a-lot-to-do-with-their-mental-health-139295
[14] Dietze PM & Peacock A. 2020. Illicit drug use and harms in Australia in the context of COVID-19 and associated restrictions: anticipated consequences and initial responses. Drug and Alcohol Review. 39:4. Pp 297-300.

- taking opioids in isolation;
- not accessing harm reduction services such as NSP or supervised injecting facilities;
- transitioning to more risky substances; and
- an increased risk of unplanned and unsupervised withdrawal,[15] which is echoed in the survey:

"Incidental withdrawal due to disruption in supply of methamphetamines. Increase in alcohol consumption and more risk behaviours with using alone."

"There has been a change in substance use as some drugs become less available and more expensive. A rise in pharmaceuticals to supplement use. Benzos have increased along with cannabis and alcohol.[16]"

- The Ecstasy and Related Drug Reporting System (EDRS) in surveying a cohort of PWUD, note that 35 percent of users transitioned to new substances and 23 percent were concerned about not being able to access their preferred substances;[17]
- The EDRS reported an increase in alcohol, cannabis and tobacco use during the pandemic, with these results similar in the Australian drug use: adapting to pandemic threats (ADAPT) study which noted increases in both alcohol and cannabis;[18]
- The ADAPT study also reported that one in four PWUD stockpiled substances, which would generate greater risk of harm through overdose as well as a risk of increased penalisation;[19]
- While there have been reports of reduced access to opioid replacement therapy (ORT) from some regions, the service enhancements including increased takeaway dosing and third party pick up have been beneficial and should be retained;
- ORT aligns with best practice in supporting those experiencing opioid dependence and generates additional benefits relating to adherence to social distancing during this period. The dispensing fee however is a deterrent to both service engagement and retention and should be subsidised, at a minimum through this period of pandemic;
- With reports of reduced opioid use[20], combined with the mandatory application of SafeScript, people may transition to other substances; ORT provides an opportunity to assist people to manage opioid dependence and experience greater stability;
- Data from Safescript will be vital in informing AOD trends with a number of agencies noting an increase in benzodiazepine use;
- A number of AOD service providers have reported that service users have been subject to heavy policing and infringements associated with social distancing, with some service users

[15] Ibid.
[16] This has similarly been observed in Europe; see EMCDDA. 2020. Impact of Covid-19 on help seeking and drug services in Europe. Trend spotter briefing. https://www.emcdda.europa.eu/system/files/publications/13073/EMCDDA-Trendspotter-Covid-19_Wave-1-2.pdf
[17] Peacock et al. 2020. Impacts of COVID-19 and associated restrictions on people who use illicit stimulants in Australia: preliminary findings from the Ecstasy and Related Drugs Reporting System 2020. NDARC. UNSW Sydney.
[18] Ibid; Sutherland R et al 2020. Key findings from the 'Australians' drug use: adapting to pandemic threats (ADAPT) study. Adapt bulletin no. 1. Sydney NDARC, UNSW.
[19] Sutherland R et al 2020. Key findings from the 'Australians' drug use: adapting to pandemic threats (ADAPT) study. Adapt bulletin no. 1. Sydney NDARC, UNSW.
[20] Ibid 18

incurring multiple infringements. The deterrence value of these infringements is questionable with certain cohorts of PWUD, particularly those who are homeless and living on the streets and who may already have accumulated significant debt with additional fines compounding existing economic disadvantage. Greater access to treatment, with seamless entry into ORT would be more effective than infringements for adherence to social distancing measures with this group.

"A number of our clients that are experiencing homelessness have been issued with infringements related to breaking social distancing and movement restrictions."

RECOMMENDATION 1: the recent changes to Victoria's ORT program should be retained; additionally, in order to retain people on ORT, the dispensing fee should be subsidised.

Recommendation 2: a therapeutic approach should be taken to policing activities relating to people who use drugs which prioritises a therapeutic, health focussed and harm reduction response rather than punitive response to street based substance use; this includes the application of diversion rather than infringements.

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6. AOD treatment provides a return on investment and prevents long term harm

VAADA's 2020/21 budget submission notes the following:

- individuals who had engaged in AOD treatment were found to access acute health services (ambulance attendances[21] and hospital emergency department admissions[22]) at a lower rate in the year post- treatment, compared to the year prior to treatment; [23] and
- 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.[24]

Furthermore, international evidence indicates:

- that AOD treatment provides a seven to one ratio of benefits to costs;[25] and
- AOD treatment reduces the duration of substance dependence from an average of 20 years to 11 years.[26]

[21] Ambulance attendances decreased from 35 to 29%
[22] Hospital emergency admissions decreased from 53 to 44%
[23] 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.
[24] National Indigenous Drug and Alcohol Committee, 'An economic analysis for Aboriginal and Torres Strait Islander offenders prison vs residential treatment', Australian National Council on Drugs research paper no 24, accessed 13 January 2020, https://www2.deloitte.com/au/en/pages/economics/articles/cost-prison-vs-residential-treatment-offenders.html, xi.
[25] Office of the National Drug Control Policy. 2012. Cost benefits of investing early in substance abuse treatment. USA. https://obamawhitehouse.archives.gov/sites/default/files/ondcp/Fact_Sheets/investing_in_treatment_5-23-12.pdf
[26] National Treatment Agency for Substance Misuse. n.d. Treat addiction, cut crime. NHS. – UK.

7. AOD peaks network COVID-19 survey - Victoria

All State Peak AOD bodies administered the survey to AOD treatment agencies across Australia in the fortnight leading to Friday 5 June 2020. The survey lists a core set of questions as well as supplementary questions chosen by each Peak which were disseminated to agencies in their particular jurisdiction.

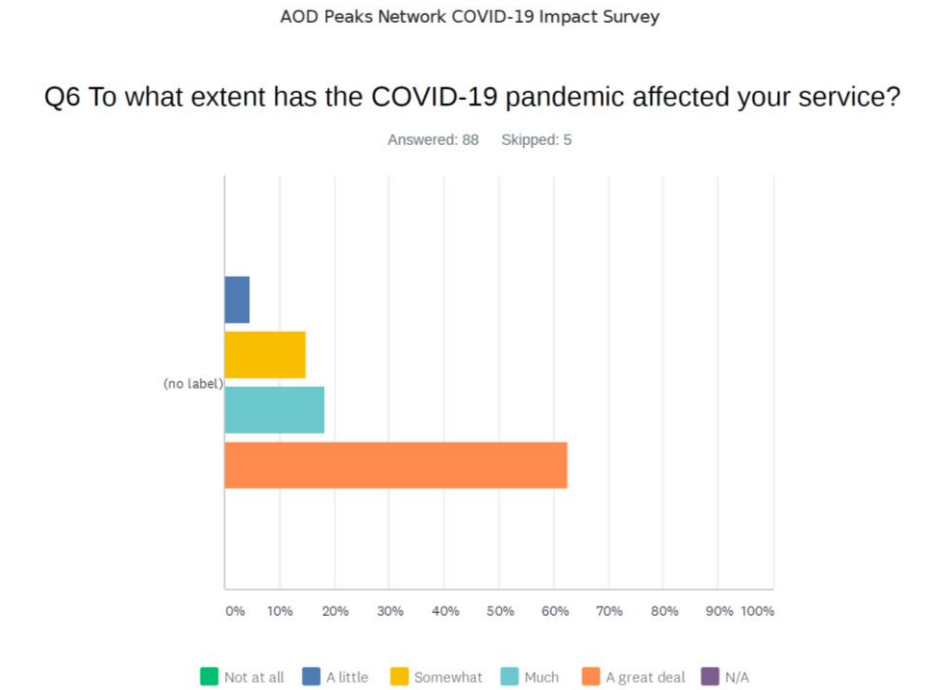
Victoria enjoyed the greatest engagement rate with 93 agencies responding to the survey. These agencies provided feedback on the impacts of COVID-19 on AOD treatment, trends, innovations and reflections on service user experience. The content and recommendations contained herein reflect strongly on the survey results.

7.1 Survey results

The Victorian responses from the survey provided the following insights:

1. **The impact was great:** Evident from Figure 1 below, all respondents indicated that COVID-19 affected their service, with 62.50 percent of responders noting 'a great deal' of impact

Figure 1: service impact of COVID-19



	NOT AT ALL	A LITTLE	SOMEWHAT	MUCH	A GREAT DEAL	N/A	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	4.55% 4	14.77% 13	18.18% 16	62.50% 55	0.00% 0	88	4.39

2. **Most agencies transitioned to a telehealth model:** 93.18 percent adopted telehealth (phone or online) which accounted for over 80 percent of the service delivery provided by seven in 10 agencies;
3. **Many agencies had to reduce client numbers:** 45.25 percent of agencies had to reduce their client numbers to accommodate risk mitigation measures;

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

8. Priority issues

Through reflection on the data, the survey results and broader sector feedback VAADA has identified five priority issues which, if unattended, present a significant current and future risk to treatment sector access, capacity and functionality. Addressing these issues enables strong, reliable and consistent service user support while adhering to the various restrictions, including social distancing.

These five priority areas will need to:

I. Meet an expected increased yet currently suppressed demand as COVID-19 restrictions ease and ensure that agencies can maintain social distancing and be COVID safe; this includes supporting new service users who will have developed substance dependence issues triggered by COVID-19 related anxieties or adverse personal circumstances, such as unemployment
II. Ensure that residential (rehabilitation and withdrawal) services remain accessible within an environment of social distancing and address the backlog of demand which accumulated over the past three months which may continue to accumulate going forward without additional infrastructure / capacity
III. Enable flexibility in the treatment offerings to maximise service user choice which includes the provision of telehealth and online supports where appropriate and applicable. The recent changes to ORT should also be retained to maximise retention.
IV. Provide the necessary hardware and telephony related equipment to both agencies and service users to safely deliver online and telehealth treatment services where appropriate
V. Ensure that treatment remains available to the community and that those who may have disengaged during this period are supported in accessing suitable treatment; this may necessitate increasing agency infrastructure to accommodate social distancing requirements.

8.1 Meet increased demand as COVID-19 restrictions ease

The restrictions imposed to limit the spread of COVID-19 affect the way treatment is provided with various treatment types contracting and others requiring online or telephone based modalities to maintain capacity, with an overall reduction in treatment availability. Compounding the limitations in capacity, COVID-19 related stress and anxiety, including deteriorating economic conditions and unemployment, will likely manifest in greater AOD demand, which may be apparent in the short, medium and long term. This demand may consist of those in recovery experiencing relapse, as well as the emergence of cohorts new to the treatment system.

For some, there is a real fear that treatment may not be available and, due to potential changes in the availability of some illicit substances, there is a looming concern for many of unsupported withdrawal.

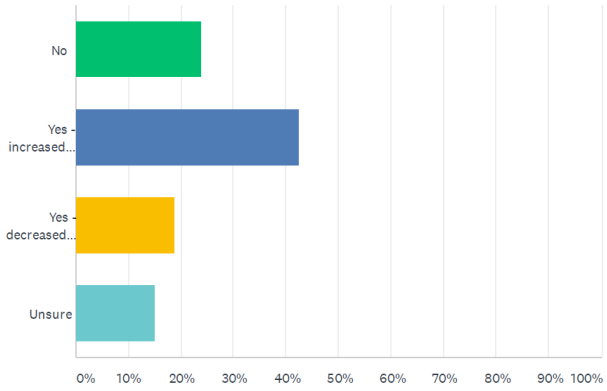
Reduced service capacity combined with the rise of these concerns creates the risk of increasing demand for support from a sector that has reduced capacity. Figure 2 bears this out with 42.5 percent of survey responders noting an increase in demand since the COVID-19 restrictions came into place, with 18.75 noting a decrease in demand.

Figure 2: COVID-19 related changes in service demand

AOD Peaks Network COVID-19 Impact Survey

Q22 Have there been changes in the demand for the AOD service you provide since the beginning of March?

Answered: 80 Skipped: 13



ANSWER CHOICES	RESPONSES	
No	23.75%	19
Yes - increased demand	42.50%	34
Yes - decreased demand	18.75%	15
Unsure	15.00%	12
TOTAL		80

"Demand has increased for current clients and re-engaging clients."

FORENSIC AOD DEMAND

Forensic demand has been increasing over the past few years and, as forensic service users are priority clients, this increase has led to reduced capacity for support voluntary service users. Feedback from agencies indicates a slightly higher throughput in forensic assessments and a significantly greater level of subsequent engagement through telehealth offerings during the pandemic. This has occurred despite a downturn in most types of offending.

As Victoria emerges from the COVID-19 restrictions, it is probable that greater forensic demand will ensue, further driving down capacity to support voluntary service users. Feedback from the survey has highlighted this concern, with the risk of further forensic demand emerging as the Courts return to full capacity.

"There has been an increase in demand for forensic client support and slowing of voluntary referrals."

Additional capacity is required to offset the structural limitations in the system to support voluntary clients exacerbated by COVID-19. It would be problematic if access to services such as residential withdrawal were increasingly limited to either forensic service users or those with a rehabilitation plan.

WORKFORCE AND COVID-19

A level of anxiety relating to COVID-19 is evident within the AOD treatment workforce, as in the early stages, clinicians continued to perform their duties within an environment with limited PPE. Agencies developed plans to mitigate COVID-19 related restrictions as well as outbreaks. Regarding the latter, which remains an ongoing risk, various thresholds of infections would necessitate service closure. The capacity for an agile agency response to increased infection in large part relies on the capacity of the workforce to adapt and take on new roles as other staff may be forced into quarantine or take leave due to illness. A rotational training program which allows staff to obtain work experience in different clinical roles as well as cross sector capability would enable greater sector agility in responding to COVID-19 infection and result in a more capable workforce going forward.

There is also growing evidence from AOD services of the cumulative impact of delivering AOD treatment and support via working from home arrangements for non-residential clinicians across the sector. These impacts are include:

- Impacts of staff wellbeing due to managing people in crisis and distress from within one's home environment;
- An increase in the pace of work and reduced 'down time' between client phone calls;
- Increased and more frequent client contact to support people during a time of upheaval; and
- Increased administrative burden associated with increased communications, information and a felt need to be 'available' all the time.

INCREASED DEMAND, SOCIAL DISTANCING AND AGENCY INFRASTRUCTURE

Like most health and community services, the design of AOD treatment facilities has not been configured to accommodate social distancing practices. The current directions on social distancing will inhibit the capacity of agencies to take on a full complement of both clinicians and service users for any face to face treatment modalities.

Agencies are applying a number of innovations, including flexible hours of operation and telehealth offerings. While telehealth options are working for many, consideration needs to be given to supplementing these service types with additional resources and infrastructure. The Mental Health and Alcohol and Drug Facilities Renewal Fund, which concluded in 2018/19, should be extended, with a rapid application process applied. Furthermore, the fund maintained a variance in the caps applied to mental health ($500,000) and AOD ($200,000); this inexplicable disparity should be overhauled with $500,000 available during a COVID-19 related fund extension.

For some service types to function unimpeded, greater infrastructure and capital works to create more space will be required to maintain adherence to social distancing requirements.

"… staff needing to physically distance in the office meaning less staff available to work at any one time…"

Recommendation 3: that government provide $10 million to the AOD sector to meet existing and future demand within a contracted AOD service system to maintain face to face treatment options. This funding should also provide for workforce capacity building and training.

Recommendation 4: The Mental Health and Alcohol and Drug Facilities Renewal Fund should be extended and with additional rounds of funding capped at $500,000 per agency to allow agencies to expedite the expansion of their infrastructure to allow for additional capacity while adhering to social distancing measures.

8.2 Ensure that residential (rehabilitation and withdrawal) remain accessible

Victorian residential services have traditionally been over burdened and despite the recent uplift, Victoria maintains the second lowest number of residential rehabilitation beds per capita across Australia. COVID-19 restrictions have exacerbated these pre-existing limitations, with social distancing limiting the ability to maintain full capacity in both residential rehabilitation and withdrawal. Similar to the European experience[27], residential treatment providers are subsequently running services with reduced numbers. Providers did not receive admissions to residential rehabilitation during the earlier phases of the pandemic. As a consequence, waiting lists are longer and less people are accessing this treatment type.

There are greater complexities in engaging residential services, with admission processes complicated by COVID-19 restrictions and the risk that with the second wave, temporary closure of facilities is possible, displacing a large number of vulnerable people. As a contingency, greater bridging support, through Care and Recovery Coordination, should be afforded for those on waiting lists as well as capability to taking on a surge of service users displaced by service closure. VAADA's 2019/20 budget submission highlights an enduring deficit in Care and Recovery Coordination capacity, noting the need for a significant uplift. COVID-19 makes the progression of this recommendation a priority. Beyond an uplift in Care and Recovery Coordination support, there is also a need to consider expanded capacity in relation to non-residential withdrawal to assist those who may not be able to access residential withdrawal facilities.

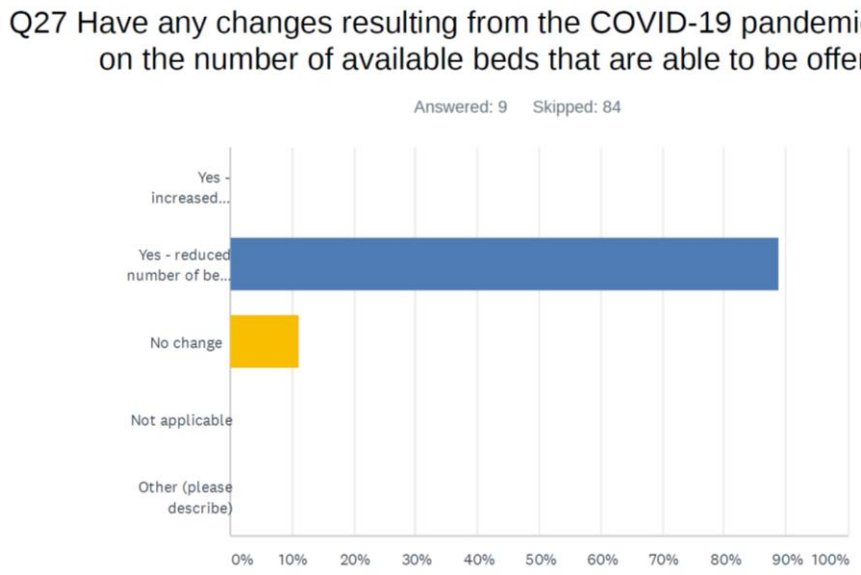
To maintain service, even with the reduced number of service users, staffing levels need to remain the same, with some additional capacity necessary to account for the risk of infection among staff, sanitation as well as activities such as food preparation. VAADA's 2018/19 budget submission highlights that, despite the recent uplift, residential rehabilitation capacity lags behind most jurisdictions. The COVID-19 related reduction in service provides a necessary impetus to increase residential rehabilitation capacity to a per capita rate of one bed per 10,000 head of population, in line with other similar states (NSW and Queensland). Victoria maintains a rate of 0.69 beds per 10,000 head of population. Reflecting on a conservative estimation of a 25 percent cut in bed availability due to COVID-19 this figure reduces to 0.54 beds per 10,000 head of population. Any uplift should prioritise regional areas currently bereft of residential rehabilitation capacity.

The pre-existing lack of capacity is exacerbated by COVID-19, with Figure 3 revealing that 88.89 percent of agencies providing residential services noted a decline in availability. Clearly, this not only affects current service access but also creates bottlenecks for future access. There is also a concern that clients without a longer-term rehabilitation plan will experience reduced capacity to access residential withdrawal as capacity is reduced across the system. Clients who are seeking longer-term

[27] EMCDDA. 2020. Impact of Covid-19 on help seeking and drug services in Europe. Trend spotter briefing. https://www.emcdda.europa.eu/system/files/publications/13073/EMCDDA-Trendspotter-Covid-19_Wave-1-2.pdf

non-residential treatment options such as counselling and group programs, should not be disadvantaged in accessing residential withdrawal services.

Figure 3: COVID-19 related changes in residential rehabilitation capacity



ANSWER CHOICES	RESPONSES	
Yes - increased number of beds able to be offered	0.00%	0
Yes - reduced number of beds able to be offered	88.89%	8
No change	11.11%	1
Not applicable	0.00%	0
Other (please describe)	0.00%	0
TOTAL		9

A number of residential services are currently running at 50 percent capacity in adherence to social distancing, greatly reducing service access.

"Due to 1.5 m distancing and staff needing to be 1 staff per 4 meter squared (gov legislation / worksafe vic) it is impossible to have everyone working from the office as previously"

Residential providers have had to re calibrate their rosters to minimise the risk of shut down should infection occur within a facility. This requires a greater body of staff and oversight to support a smaller number of service users. While some agencies may have applied for support from the *Working for Victoria* fund, the duration of these restrictions will surpass the duration of employment permitted in the program. Furthermore, efforts to induct these new staff will require internal resources.

Those on the expanding waiting lists need to remain engaged and supported to minimise the risk of disengaging from the treatment system while waiting for residential support. Additional capacity must be afforded for this purpose. With the ballooning of waiting lists for residential services, there

is a risk that many may seek to engage unregulated for profit services, which carry a number of risks[28], as well as the possibility of not being adherent to social distancing.

Recommendation 5: There is a need to rapidly increase the shortfall in residential capacity and Infrastructure to account for bottlenecks relating to reduced capacity as well as future COVID-19 related demand. Consideration must also be given to the requisite workforce capacity to meet this expansion to address current and future demand.

Recommendation 6: There is an enduring need to increase the capacity to provide additional Care and Recovery Coordination and bridging support for those waiting to access residential services, as well as those who may otherwise be not engaging the treatment sector as effectively as they did pre-covid. This could include additional non-residential withdrawal capacity. To bring this into alignment with earlier department expectations, a conservative figure of $16.76M is required.

[28] These risks may include exorbitant costs, the absence of a model of care, potentially unsafe infrastructure and a lack of regulatory oversight.

8.3 Enable flexibility in treatment offerings

The survey indicated that over 19 in 20 agencies reported that COVID-19 had affected their service in a range of ways which necessitated rapid adaptations. Some of these changes included:

- the need to deliver remote support;
- transitioning the workforce to operate at home;
- addressing sanitation and PPE;
- responding to complexity in supporting staff
- a number of agencies reporting reduced engagement with families; and
- The cessation of group work.

These changes have occurred during a period of changing service user presentations, with some reports of greater engagement but also an increase in presentations with family violence, mental health and financial concerns.

Agencies also highlighted challenges new service users face in attempting to navigate the COVID-19 impacted service system.

"… there are concerns about how to access 'new' populations – promotion, referral pathways etc – who are now potentially using in problematic ways but may not have accessed service system before."

The sector must be supported to adapt to a new business environment in a COVID safe manner while supporting a cohort presenting with greater complexity. Innovation should be encouraged and evaluated.

LIMITATIONS OF TELEHEALTH

While telehealth models of care are popular, there are some limitations, which need to be considered. The survey has found mixed results in service user engagement through telehealth. While engagement has improved among some cohorts, including forensic service users, enhanced through the convenience of not having to travel and a level of anonymity, a number of limitations were identified, including:

- High risk service users experiencing a range of complexities may be reluctant/unable to engage through telehealth;
- Vulnerable youth appear to not be engaging through telehealth treatment offerings at the same frequency of other groups;
- clinical practice which can be impacted as it can be more difficult to identify certain cues which determine risk of harm or relapse;
- difficulties building initial relationships with service users over telehealth;
- confidentially; while the anonymity of not having physically enter an agency providing forensic treatment, service user confidentiality may be at risk while conducting telehealth support in a domestic environment;
- service users may be anxious in using visual telehealth options as they feel that they will be judged adversely due to their home environment;
- group programs such as day programs, which have largely been suspended and cannot easily be replaced by telehealth options; these offerings need to be enhanced to cater for social distancing;

- some agencies have limited IT infrastructure to support the staff working remotely, which has made the transition to working remotely more challenging, at times impacting upon treatment offerings and employee activity; and
- Concerns that the most complex clients are falling through the gaps at the current time

Telehealth should not be viewed as a means to supplant outreach or any other service types (which have been heavily diminished due to the restrictions), which are necessary to engage service users presenting with complex issues and high risk

"The more complex clients have been impacted negatively by the absence of outreach and practical support. For clients that are not 'therapy' ready and present with complex trauma often require connection with workers to build trust. This is impeded by the inability to provide in person service increasing risk of disengagement. Also for the more chaotic clients, technology is a barrier for them. Not having a phone or credit to call back has posed issues."

The survey findings indicate that significant evaluation of telehealth models should be progressed.

Recommendation 7: Government should establish a COVID-19 innovation fund of $4M to enable agencies to measure the effectiveness of innovative ways of delivering treatment programs and services. This funding would allow agencies to explore and assess innovations in response to COVID-19.

8.4 Support telehealth AOD treatment options and other means to prevent transmission

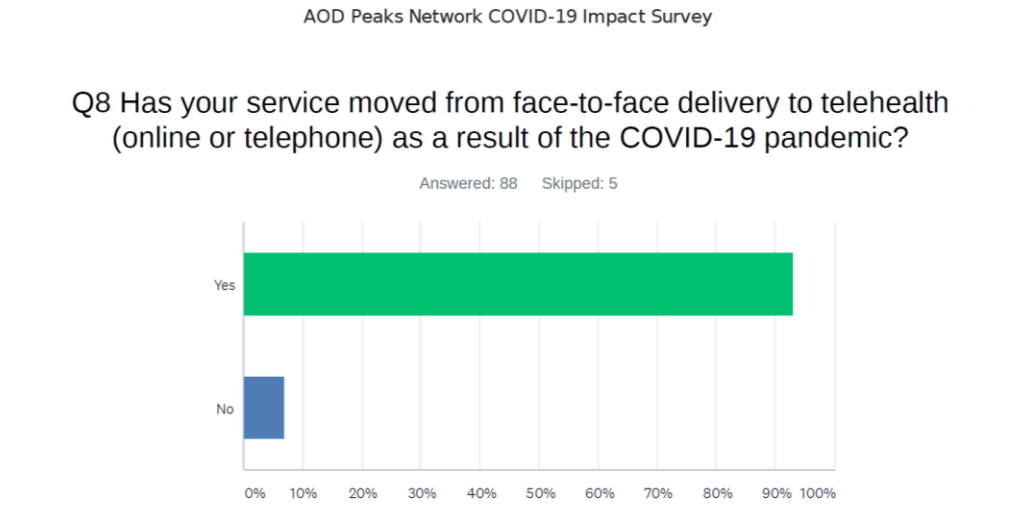
Agencies have identified a range of additional costs in maintaining a COVIDsafe environment to deliver treatment services. Specifically, agencies highlighted the following additional expenses:

- technology (83.12 percent);
- sanitation (46.75 percent);
- PPE (48.05 percent);
- Reduced income from service user fees (18 percent); and
- OH and S, COVID-19 policies and procedures, suitable service user IT/communication equipment and training.

The majority of these items present a rolling financial burden to agencies which will be required to budget for these from existing funding sources. They will remain an expense throughout the period of the pandemic and associated restrictions.

The most reported expense relates to technology, which largely relates to the use of remote online and telephone means of communication and service user support. Not surprisingly, the majority of services have transitioned at least some of their services to a telehealth model:

Figure 4: portion of services transitioning to telehealth



ANSWER CHOICES	RESPONSES	
Yes	93.18%	82
No	6.82%	6
TOTAL		88

The success of the rapid transition to telehealth modalities of care hinges on both service user and clinician access to suitable IT equipment. Many service users experience poverty, including digital poverty. They may not have ready access to a functional mobile phone or computer. One responder succinctly summarises these issues:

"ICT costs to the organization providing equipment to staff working from home. Clients not having data or equipment."

Some agencies found the transition difficult, with issues such as suitable home internet connection and IT infrastructure to support the new working arrangements lacking:

"The speed at which we had to transfer to work from home meant that we could not effectively implement video services. Also as we are in a rural area internet and phone connection proved to be problematic for some practitioners and clients."

They also highlighted the expense of supporting employees to work remotely with 85 percent noting increased expenditure on 'technology costs'

"Insufficient resourcing for 'working from home' - had to purchase laptops etc to support.

Increased electricity, gas, water and telephone bills. Upping my personal phone storage amount to download additional apps such as zoom, and genius scan (a brilliantly simple little app which convert photos, and documents to PDF). Extension leads, chargers etc."

The burden of supporting clinicians with suitable IT equipment, as well as ensuring an adequate skill base to effectively use this equipment and navigate the various online programs has been identified as an issue.

Despite this, many in the sector view telehealth offerings as a vital component of a modern treatment system with the majority indicating that they will retain elements of these going forward. The survey indicated strong support for telehealth and the expectation of retaining telehealth as a means of more flexibly supporting service users going forward:

- Over nine in 10 responders have transitioned from face-to-face to telehealth:
    - The majority of this group shifted over 80 percent of their treatment programs to telehealth; and
    - Over eight in 10 have indicated that they will retain these changes (in varying degrees) following the COVID-19 pandemic.

Some service users experiencing digital poverty may have limited access to home internet and phones with paid up plans. Within the current environment, these service users may quietly disengage. These service users should be provided with resourcing to participate in telehealth options, such as a mobile phone and the provision of data to participate in telehealth models of treatment.

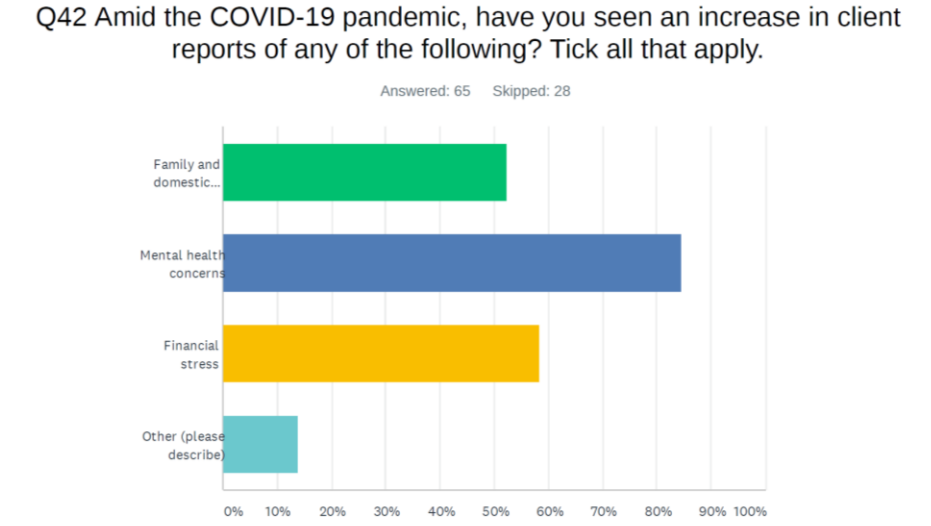
Recommendation 8: The Government should provide for incidentals related to reducing the risk of infection including PPE, sanitiser, IT infrastructure and equipment to enable working remotely amounting to a 2 percent increase in overall sector funding over the next financial year totalling to $5.5M.

8.5 Ensure treatment and support remains available to those who have disengaged

Treatment agencies have indicated that there are some cohorts exhibiting a greater risk profile including co-occurring issues who have had reduced engagement with AOD treatment services during this period. This was evident in Europe, where it was found that those with multiple morbidities were less likely to engage through telehealth modalities.[29] Some service users have not adapted to, or lack the means to engage in, telehealth offerings which has been compounded by variations in the delivery of other community services.

The acute risk profiles are evident from the observations made by responders who noted significant increases in family violence, mental health and financial concerns as noted in figure 5 below:

Figure 5: co-occurring harms in service user presentations



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

Additional cohorts that experienced reduced engagement during this period include:

- Vulnerable youth presenting with higher levels of complexity who are not engaging well through telehealth; supporting this cohort through available means and adhering to COVID-19 restrictions remains a challenge;
- Aboriginal community members who have experienced an increased policing focus resulting in infringements; and

[29] EMCDDA. 2020. Impact of Covid-19 on help seeking and drug services in Europe. Trend spotter briefing. https://www.emcdda.europa.eu/system/files/publications/13073/EMCDDA-Trendspotter-Covid-19_Wave-1-2.pdf

- Those who may rely on disability support, including at home support, which has diminished during this period.

"Disability support services home support or groups stopped"

There is a need for a flexible funding model which can provide targeted support to high risk cohorts disengaging due to COVID-19 with enhanced resources to accommodate the various restrictions currently hampering the treatment system. This model should employ the services of workers experienced in engaging with hard to reach cohorts who may be treatment adverse and harbouring multiple morbidities; expertise should align with peer work, outreach and dual diagnosis specialisation.

Recommendation 9: resource an enhanced treatment offering in the adult, Aboriginal and youth sectors to support those experiencing complexity who are disengaging or at risk of disengaging from AOD treatment. This may involve outreach, peer support and dual diagnosis support. This should amount to at least 3 EFT in each AOD catchment amounting to $4.5M over the next three years.

9. Conclusion

The AOD sector will continue to adapt as the impact and fallout from COVID-19 unfolds. It is evident that agencies have been forced to enact drastic changes to maintain service and support vulnerable Victorians. The changes have resulted in service contraction and a significant shift in the interface between AOD treatment and the community. Social distancing will continue to create limitations in conducting face to face treatment.

The expectation, reflecting on other disasters, is that harmful AOD use and dependence will ensue as the pandemic progresses. These harms will remain long after the curve has flattened. Already, research indicates an increase in alcohol consumption and the use of some illicit substances.

This submission provides a framework of recommendations necessary to support the sector as much as possible in maintaining business as usual and will also mitigate the harms which will emerge as various bottlenecks become apparent.

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