VICTORIAN ALCOHOL & DRUG ASSOCIATION

State 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.

Contact Person: Sam Biondo

Victorian Alcohol and Drug Association
211 Victoria Parade, Collingwood 3066
p. 03 9412 5600 f. 03 9416 2085
vaada@vaada.org.au
www.vaada.org.au
ABN 19 039 293 679

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 organisations 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

The purpose of VAADA's annual state budget submission is to provide the Victorian Government (**Government**) with an overview of initiatives that are necessary reduce AOD related harms across the community.

VAADA acknowledges the considerable investment made by the Government in the AOD sector over recent years: a number of key areas, including residential services, Drug Courts, the Medically Supervised Injecting Room, emergency department Mental Health and AOD Hubs and data collection have received a much-needed focus. However, while such investment is welcome, this uplift has occurred against a continuing backdrop of chronic underfunding of the AOD and associated sectors. An overview of historic funding is provided in **Figure 2**. A key issue arising from prolonged underinvestment is the expansion of significant service gaps across different parts of the Victorian AOD system. These gaps have led to imbalance and areas of dysfunction within the AOD system.

Since VAADA's last state budget submission, the AOD sector has continued to adapt to and implement the swathe of reforms which have been introduced following 2016's Royal Commission into Family Violence. The Royal Commission into Victoria's Mental Health System continues to progress towards the release of its final report and recommendations, which are due in October 2020. Given the enduring association between AOD and mental health, VAADA expects that the Royal Commission's upcoming recommendations will have ramifications for the AOD sector, and particularly for its workforce. The AOD workforce has experienced significant upheaval and strain over recent years due to the incorporation of recommendations resulting from the Royal Commission into Family Violence, changes to child protection legislation, burgeoning forensic demand, and the implementation of SafeScript. The necessary upskilling of the AOD workforce, which is becoming increasingly specialised, heightens the need to address staffing issues, including recruitment, retention, capacity building, training and remuneration through targeted investment.

Forensic clients present a unique challenge to the AOD sector, and some key aspects of this challenge are addressed in this submission. Forensic clients are entering the AOD system at a rate which is displacing voluntary clients, meaning that delays in accessing treatment have become the norm rather than the exception. Given the Government's focus on funding additional prison beds during the past year, coupled with Victoria's high recidivism rate, this situation will worsen without commensurate funding. A bed for bed proposition, with each new prison bed accompanied by a residential rehabilitation bed, would achieve balance in the system.

Until the underlying causes of Victoria's growing prison population is addressed, the over burdening will not abate. VAADA urges the Government to seriously commit to managing the downstream effects of incarceration. A focus on reducing recidivism, meaningful reintegration programs and justice reinvestment are clear, logical, and achievable solutions. As part of this approach it is vital that the AOD sector is funded to adapt to the needs of this particularly vulnerable cohort which experiences extreme rates of often preventable AOD related harm. Consideration of how best to respond to the high rate of fatal overdose amongst recently released people who have been in prison has been a focus for VAADA over the past year. In concert with the Coroners Court of Victoria, VAADA has consulted with a number of stakeholders and explored solutions to this avoidable problem over the past year, which are presented for the Government's consideration as part of this submission.

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

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

Sam Biondo

3. Summary of recommendations

REDUCING RECIDIVISM

Recommendation 1: Increase the number of Assessment and Transition Coordinators within Victorian Prisons in order to meet demand and effectively address complexity of client needs, and to ensure that each person who has been in prison is allocated an Assessment and Transition Coordinator to allow for the establishment of a tailored and comprehensive discharge plan on entry into prison.

Recommendation 2: Make a significant investment in social housing targeting people who have recently been released from prison with limited housing options to assist in community reintegration. This housing would target those at risk of homelessness, mental health issues and alcohol and drug use.

Recommendation 3: Establish a co-located, coordinated suite of support services to assist with the integration of individuals with complex needs who have recently been released from prison. $50M funding should be invested to develop a specialist agency which specifically focusses on mental health, AOD, employment, training and mentoring support for this cohort.

Recommendation 4: Implement a comprehensive harm reduction strategy for people in prison approaching release. This strategy should incorporate enhanced guidance for correctional staff in delivering harm reduction training prior to release, including the provision of Naloxone (and training in how to administer it).

Recommendation 5: Review the Victorian diversion system and the diversion programs available, including eligibility and the availability of community-based support and treatment services available to those eligible for diversion.

STREAMLINING *SAFESCRIPT* TO ENSURE THAT EVERYONE IS SUPPORTED

Recommendation 6: Invest $40M 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 the expansion of addiction medicine, pain management specialists, and the establishment of accessible specialist clinics across Victoria.

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

i) whether the illicit drug market has grown following the implementation of SafeScript; and
ii) the limitations, benefits and impact of SafeScript, on targeted consumers, with particular reference to their healthcare needs, treatment and referral pathways.

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

Recommendation 8: 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 9: 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 10: Apply a loading to all rural and regional AOD staff of 10% above the relevant award to enhance recruitment and better retain quality staff.

Recommendation 11: Convene a rural and regional AOD summit, as a matter of urgency, to engage with rural and regional communities in relation to measures that can be taken to address the range of AOD and system-related issues affecting them. An information gathering exercise should be undertaken to better inform stakeholders in the lead-up to the summit.

ADDRESSING AOD SERVICE AND SYSTEM ISSUES

Recommendation 12: Provide a recurring $16.76M 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 13: Provide increased access to transitional social housing for those whose circumstances require it on exiting formal AOD treatment.

Recommendation 14: 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 15: Establish a special purpose fund of $3M to assist AOD services with unexpected costs associated with the establishment of the VADC over the 2020/21 financial year.

AN ENDURING AND CAPABLE AOD WORKFORCE

Recommendation 16: Invest $1.5M to establish an entity to better coordinate training and enhance the attraction of staff to Victoria's AOD sector. This entity would explore options for micro-credentialing and rapid accreditation of new AOD workers in relevant areas of high need. A central co-ordinating team of two staff would support existing RTOs, and the enhanced workforce training and enhancement initiative.

Recommendation 17: Invest $2M to develop a broad 'industry plan' for the AOD sector which takes into account the specific needs of the AOD sector as well as the AOD-related workforce needs of

related sectors, including mental health, homelessness, child and family support services, Aboriginal, hospitals and forensic health environments.

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

Recommendation 18: Recruit three 'specialist' dual diagnosis clinicians into each AOD region to build the capability of the sector to respond to the needs of acute service users experiencing co-occurring AOD and mental health 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

Recommendation 19: Invest $5M to fund the development of an overarching AOD and mental health integration framework for Victoria. Corresponding protocols, practice guidelines and training opportunities should be developed and implemented to translate the framework to clinical practice.

Recommendation 20: Provide additional addiction psychiatry capacity to Drug and Alcohol Clinical Advisory Service (**DACAS**) at an estimated cost of $300,000 per annum to provide additional support for GPs working with dual-diagnosis presentations.

Recommendation 21: The Victorian Government should subsidise the ORT dispensing fee to increase program engagement and retention.

Recommendation 22: Provide additional funding to train nurse practitioners to become qualified ORT prescribers, targeting poorly serviced rural and regional areas.

Recommendation 23: Fund capacity-building of GPs and nurse practitioners in order to facilitate the prescribing of depot buprenorphine.

Recommendation 24: Provide additional investment in aftercare supports, recovery and outreach services to ensure AOD treatment capacity is able to meet additional demand, with the roll out of AOD & mental health hubs. Careful consideration and investment should be made to ensure seamless and coordinated pathways for clients being stepped down/referred into the AOD treatment system (whether in- or out-patient). Funding would be based on existing infrastructure needs to meet anticipated increases in demand.

Recommendation 25: Establish an additional AOD and mental health hub in a public hospital located in East Gippsland to support communities recently affected by bushfires with specific Addiction Medicine Specialist capacity.

Recommendation 26: Establish a broader network of sub-acute units across each region to support and address the immediate needs of highly dependent individuals who frequent emergency departments. These hospital-based units would stabilise and prepare patients to step down into various community supports with newly enhanced capacity to meet their needs.

Recommendation 27: That community-based and residential AOD treatment services are resourced adequately to handle the increase in referrals flowing from imminent establishment of mental health and AOD hubs.

NECESSARY SUPPORT FOR UNDERSERVICED COHORTS

Recommendation 28: Develop a pilot outreach AOD treatment project to address the gap in AOD services for older 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 29: 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.

SAVING LIVES

Recommendation 30: Implement comprehensive primary health harm reduction services in areas where high risk, service averse cohorts are concentrated, to provide support, stability and referrals.

Recommendation 31: That additional supervised injecting capacity is considered in other high risk regions to meet demand and provide access to this life saving service in other regions with pre-existing levels of high heroin consumption and harms.

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

Recommendation 32: 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.

4. Introduction

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

The community is fast becoming aware of the pervasiveness of AOD-related harm, which affects many Victorian families either directly or indirectly. This harm presents in various forms, including AOD-related dependence, illness (such as cancer[1]), injuries (including overdose), road trauma, and violence (including family violence).

This submission is made in the context of the ongoing Royal Commission into Mental Health, which provides an opportunity to identify and address a range of deficits across the health and welfare sectors in Victoria. Despite the intersection between AOD and mental health issues, there has been a long-standing need for better integration and pathways between the AOD and mental health sectors. The Royal Commission into Mental Health's final recommendations (due for release in October 2020) may provide some direction and impetus for effective, evidence-based reforms aimed at achieving lasting improvements, which are likely to impact the AOD sector.

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

a) AOD treatment in Victoria: the current context

Informing VAADA's understanding of the current state of the AOD sector, and underpinning the various issues raised in this submission, is input from the following sources:

- Analysis of VAADA's annual sector priorities survey, administered to senior managers in the Victorian AOD sector between September and October 2019. The primary issues identified in the survey were:
    - the need for a review the value of the current DTAU;
    - increased demand in specific areas resulting in excessive wait times;
    - a lack of workforce capacity, exacerbated by the expectation of increased capability across a range of areas;[2] and
    - enduring workforce recruitment and retention issues, particularly in rural and regional areas of Victoria.
- Feedback from a recent VAADA forum on heroin-related overdose deaths among people who have recently been released from prison;
- Analysis of relevant literature and data sources; and

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

[2] Including family violence, child protection, pharmaceuticals and forensics

- Consultations with specific experts, networks and groups within the sector.

The following factors are having a particular impact on the AOD sector, and its ability to provide comprehensive services to Victorians.

Population pressure

Victoria is experiencing a period of unprecedented population growth, which is causing significant strain on various 'interface regions' and service delivery across the community sector (including AOD). While there has been a recent increase in various areas of AOD funding in Victoria, a number of system shortfalls and service delivery gaps remain. This places great pressure on the AOD sector and its ability to meet the treatment needs of certain cohorts.

A fully functioning AOD sector must be responsive to the varied needs of a diverse population. A current challenge to timely and effective AOD service delivery in Victoria is the need to provide services which are tailored to the specific needs of various cohorts, including older Victorians, LGBTIQ communities, Aboriginal and Torres Strait Islander communities and various culturally and linguistically diverse (**CALD**) communities. Many in these populations are experiencing significant AOD-related harms yet not engaging with the treatment sector, amounting to a lost opportunity for earlier intervention and improved community outcomes.

The impacts of reforms

Several major reforms initiated by both State and Federal governments have impacted the community services sector over recent years: these changes extend from the areas of the NDIS, family violence and child protection, SafeScript, mental health, and justice system to name a few. Many of the reform initiatives include improving cross-sector collaboration, often focussing on service users with complex needs. While producing positive outcomes, these substantial reform initiatives place additional layers of demand and strain on the AOD sector. Upcoming changes flowing from, for example, the Royal Commission into Mental Health, and imminent health service reforms associated with AOD & Mental Health Hubs, SafeScript, and Community Hospitals run the risk of creating additional layers to this existing complexity.

There is significant concern in the AOD sector that the downstream impacts of these reforms are overlooked, and as a result, are not being adequately planned for or resourced. These impacts include increased treatment demand and need for additional staff training as well as challenges in terms of workforce recruitment, retention and remuneration. The workforce has been required to broaden its existing skill-set, without commensurate pay. These challenges are perhaps greatest within the rural and regional context, where AOD services experience significant strain associated with workforce issues, further compounded by the tyranny of distance. The pending growth in the mental health sector runs the risk of an exodus of experienced AOD workers to a more highly remunerated and burgeoning sector.

Further, the missed opportunities remain regarding meaningful participation and service co-design from service users. To date, funded activity in this area remains piecemeal and tokenistic; the notion of 'nothing about me without me' is paramount to the development of accessible and effective services.

While the reforms are welcome and necessary, the lack of planning, consumer participation and resourcing has led to increased waiting times, especially for voluntary service users.

Underfunding

While various components of the AOD sector have received increased funding, this uplift has not been consistently applied across the sector. 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. While important, these initiatives do not necessarily support the broader population of service users. Currently, the Victorian AOD sector lacks the capacity to meet demand for low-threshold, early, face-to-face client engagement – which is at the core of a robust, effective and accessible treatment system. This amounts to a lost opportunity to enact an effective early intervention engagement. As a result of the inadequate resourcing of the sector, voluntary clients in particular are incurring increased waiting times for treatment. Such issues and waiting times are further compounded when considering trends such as the burgeoning prison population and their complex AOD needs on release.

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

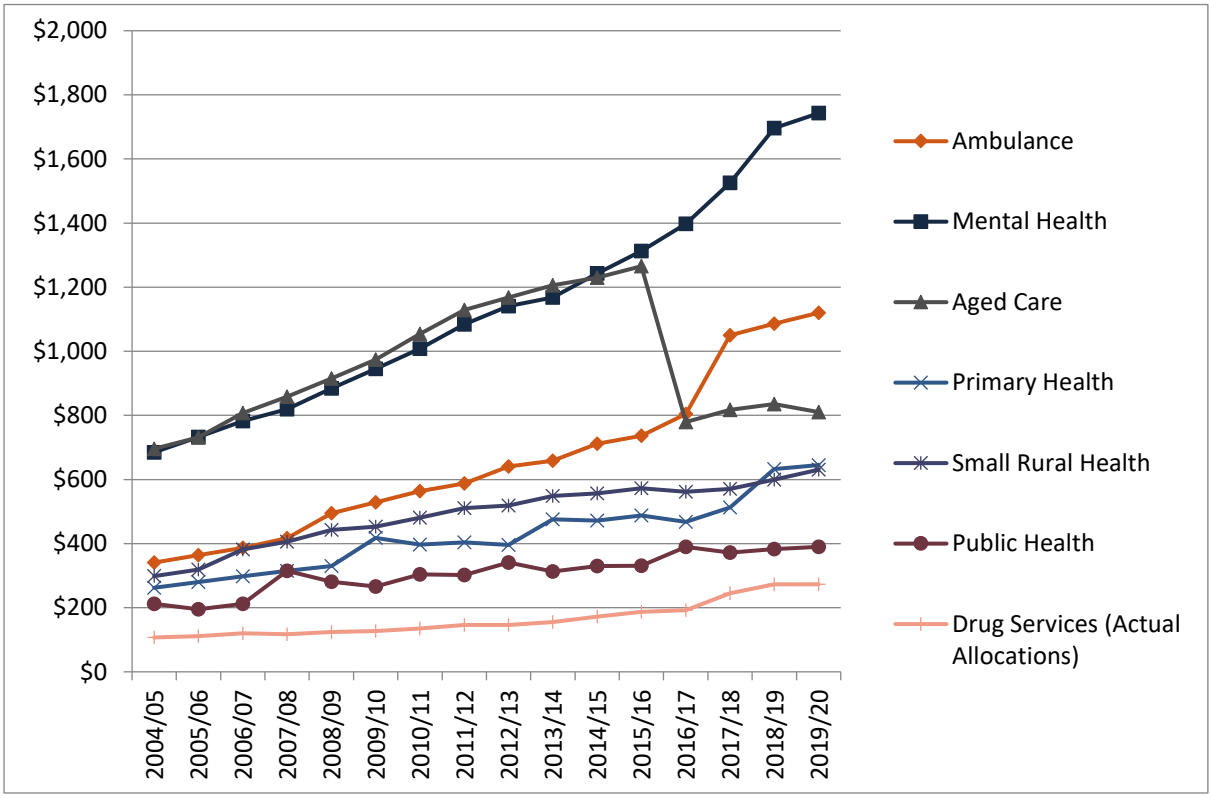
Experts from the National Drug and Alcohol Research Centre have estimated the current shortfall in terms of AOD harms versus investment in services in Australia. Ritter et al estimate current national investment in AOD treatment at around $1.26 billion per year.[3] Compared to the costs of AOD harms — estimated at $55.2B per annum[4] — 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.

[3] 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.

[4] 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.

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

Figure 2: Output funding (health) 2004/05 – 2019/20 (in $millions)[5]



b) What is needed?

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

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

Over a 12-month period, treatment provides a cost benefit ratio of $8 saved for every $1 spent.[6] This is additional to significant benefits for social cohesion and community well-being.

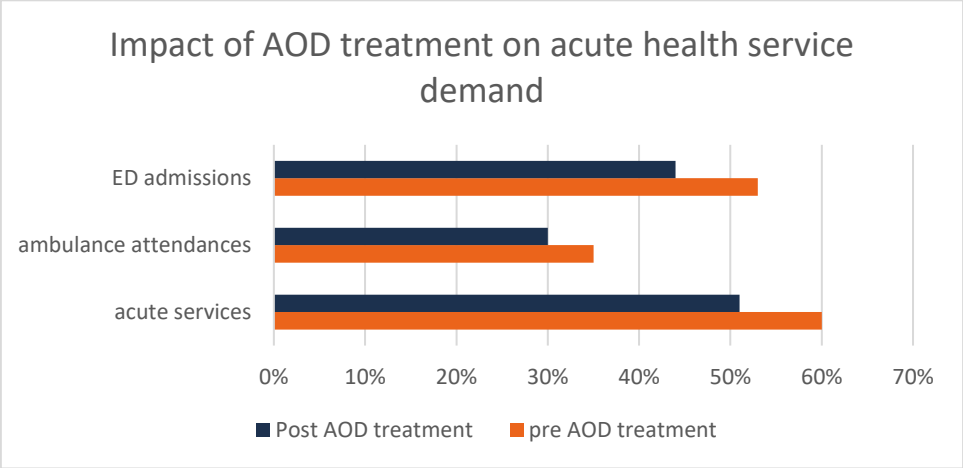
A cost/benefit analysis of AOD investment in Australia shows that:

[5] Data for Figure 2 has been obtained from Victorian Government Budget Papers.
[6] 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.

- individuals who had engaged in AOD treatment were found to access acute health services (ambulance attendances[7] and hospital emergency department admissions[8]) at a lower rate in the year post- treatment, compared to the year prior to treatment; [9]
- 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;[10] and
- Over two years, the Victorian Drug Court found that it accrued $1.2M in savings through reducing the prison population (in addition to reducing recidivism and improving health and welfare).[11]

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

Figure 1: Impact of AOD treatment on acute health service demand (Manning et al. 2017)



[7] Ambulance attendances decreased from 35 to 29%
[8] Hospital emergency admissions decreased from 53 to 44%
[9] 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.
[10] 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.
[11] 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.

c) How will this be achieved?

Appropriate levels of funding based on an assessment of need and implemented in accordance with a comprehensive AOD industry plan.

A 2019 study carried out by researchers at the National Drug and Alcohol Research Centre into unmet demand for AOD services in Australia (**NDARC Study**) reveals the urgent need to increase AOD service capacity nationwide. The NDARC Study showed that between 26.8% and 56.4% of those in need of treatment accessed it. This translates to a demand gap of 43.6 to 73.2%, or 180,000 to 553,000 people nationally.[12]

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

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

In order to expand the AOD system to meet the needs of Victorians in a cost-effective way, the Government must first develop an accurate estimate of those needs. To this end, VAADA recommends that the Victorian Government utilise the Drug and Alcohol Services Planning Model (**DASP Model**). The DASP Model was commissioned by the inter-governmental Ministerial Council on Drug Strategy and developed by the NSW Ministry of Health between 2011 and 2013, this national planning tool estimates future need and demand for AOD treatment services in Australia.[13]

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.[14]

The DASP Model provides estimates on the following outputs:

---

[12] 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.

[13] 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.

[14] Ibid.

- 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.[15]

The DASP Model has been used by several Australian jurisdictions[16] to assess investment need and is a potentially valuable planning tool for Victoria. The identification of the gap between the *need for treatment* and the *availability of treatment* allows for investment that effectively targets areas of greatest need.

The need for a comprehensive AOD industry plan

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

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

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

The Industry Plan should be based on population health planning projections; the DASP Model should be used for this purpose.

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

Further, this Industry Plan should be implemented as part of a broader cross-sectoral push toward greater coordination and enhancement of capacity to facilitate improved access between different services. Currently, access pathways between service areas – eg, from hospital or prison to community-based services, or from detox to a residential-based service are complex and difficult to navigate.

More effective planning and investment is essential to ensure that the continuum of care is not broken for clients progressing through service types or engaging across multiple sectors. In addition

[15] Ibid.
[16] Including Western Australia, Tasmania and the ACT

to the obvious benefit for clients, there is a considerable economic benefit from smoothing out these transition points.

An industry plan, which facilitates cross-sectoral collaboration, will require strong commitment from government in terms of time and funding. The development and implementation of such a plan should be carefully planned and rolled out over several years. It can only achieve its objectives if appropriate human and financial investment in Victoria's core AOD service system occurs.

The establishment of an integrated and co-ordinated system, which can work across sectors and with greater capacity to address community demands arising from a large number of areas (including corrections, youth, family violence, CALD and Indigenous), is a significant yet beneficial endeavour. The issue for government is not whether it considers this an affordable option in the short-term, but rather, what the resulting long-term cost will be if it does not invest in a system, which is equipped to prevent harm and associated expenditure. An appropriately resourced treatment sector will achieve successful treatment outcomes, thereby avoiding tertiary costs such hospital care, criminal justice interventions and fatalities.

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

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

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

5. Current AOD sector investment requirements

a) Responding to increased demand

i. Responding to increased demand: forensic clients

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

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

which show that approximately 37% of Victorian AOD clients are forensic clients[17], with VAADA sector surveys indicating that some regions maintain a caseload consisting of 80% forensic demand.

With the release of the Government's 2019 state budget, which included funding for new prison infrastructure amounting to 1,600 new prison beds, demand from forensic service users exiting prison and requiring AOD treatment will only increase in coming years.[18] Reportedly, Government projections show that the prison population is expected to increase from **8,110 in 2019** to **11,130 in 2023**.[19] Greater AOD forensic capacity will curb this figure through reducing recidivism.

The rise in presentations by forensic clients has had an enormous impact on the AOD sector by displacing voluntary clients. The DTAU funding model in relation to forensics requires adjustment to cater for a high rate of forensic demand which is presenting with increasing complexities. The DTAU should be adequate to allow for 'realistic' remuneration, training and support to retain high quality staff. The attractiveness of the AOD sector as a career option (in conjunction with increased retention of the existing workforce) must be boosted. The failure to cater to the needs arising from this growth has the potential to seriously destabilise the AOD sector.

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.[20] While incarceration often improves 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.

Continuity of care is critical in supporting a person's recovery and therefore in reducing recidivism. Literature suggests that continuity of care for people leaving prison in Australia is inadequate.[21] [22] 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 released from prison transitioning back into community increases the likelihood of

[17] VAHI data 2018/19

[18] Corrections Victoria, 'Corrections Budget for 2019-20', *Department of Corrections* [website] https://www.corrections.vic.gov.au/corrections-budget-for-2019-20-released accessed 14 January 2019.

[19] R Millar and H Vedelago, 'Prisons are booming as Victoria pays for its 'tough on crime' stance', *The Age* [website], 27 June 2019, https://www.theage.com.au/national/victoria/prisons-are-booming-as-victoria-pays-for-its-tough-on-crime-stance-20190627-p5220f.html, accessed 7 November 2019.

[20] 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.

[21] 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.

[22] 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.

recidivism and healthcare costs, as well as placing a significant economic burden on our community.[23]

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.

Essential elements of an increased forensic capacity in the AOD sector would include:

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

Pre-release discharge planning

There is a critical need to improve discharge planning within prisons. A discharge plan, tailored to the needs of people in prison, is fundamental to ensuring the safe and effective re-integration back into the community, and to mitigate the likelihood of recidivism. Discharge planning should commence as soon as a person enters prison, not only to ensure appropriate services are in place within prison, but to ensure that links to appropriate services have been established prior to exit. To facilitate discharge planning, each person entering custody should be linked with a skilled Assessment and Transition Coordinator to develop a plan for their release. Discharge plans must address necessary requirements related to health, welfare and adequately resourced support services, and facilitate access to appropriate social housing, AOD and mental health treatment (including continuity of pharmacotherapy where necessary), social support, and education, training or employment, and any other relevant needs.

Recommendation 1: **Increase the number of Assessment and Transition Coordinators within Victorian Prisons in order to meet demand and effectively address complexity of client needs, and to ensure that each person who has been in prison is allocated an Assessment and Transition Coordinator to allow for the establishment of a tailored and comprehensive discharge plan on entry into prison.**

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

Post-release housing

Stable housing is key to a person's safe and successful reintegration into society after leaving prison: it reduces substance use, the likelihood of future contact with the criminal justice system, and the risk of injury-related death (including overdose). In 2018, a third of people entering prison were homeless in the month prior to incarceration. Half of those released from prison expected to be homeless upon re-entering the community.[24] Given the benefits of stable housing, the current failure to provide this vital form of stability is a lost opportunity to prevent crime, decrease post-release costs and improve the prospects for successful re-integration for people leaving prison.

The provision of *appropriate* social housing options is key to improved outcomes for people leaving prison. Often, the only housing option available for single prison leavers is rooming houses. These are unsafe, and exposure to substance use is common. Many people choose to leave rooming houses in favour of living on the street, which they consider a safer option.

This situation is not conducive for successful community reintegration. For many, housing instability or homelessness, AOD use, and entry to prison can become a chronic cycle.[25] Housing forms the basis for increased life stability and this should be prioritised as a key mechanism to improving AOD (and other) outcomes for people leaving prison.

Recommendation 2: Make a significant investment in social housing targeting people who have recently been released from prison with limited housing options to assist in community reintegration. This housing would target those at risk of homelessness, mental health issues and alcohol and drug use.

Access to support services

Second to housing, access to primary health care, AOD treatment, and support for mental health are crucial for people exiting the prison system. However, those leaving prison often experience multiple barriers to service engagement following release. This includes the effect of institutionalisation, which can make navigating the world outside of prison very difficult for those recently released from prison.

To increase access to these health and wellbeing supports, it is imperative that the Government invest in wrap-around models of support for people exiting prison. Referrals and linkages should be made prior to exit from prison, as part of a robust discharge planning process embedded in Victorian prisons.

---

[24] Australian Institute of Health and Welfare, *Prisoners more likely to be homeless, unemployed and suffer poor mental and physical health* [media release], 30 May 2019, https://www.aihw.gov.au/news-media/media-releases/2019/may-1/prisoners-more-likely-to-be-homeless-unemployed-an, accessed 20 November 2019.

[25] E Whittaker et al, 'Multiply disadvantaged: Health and service utilization factors faced by homeless injecting drug consumers in Australia', *Drug and Alcohol Review*, vol. 34, no. 4, 2015, pp. 379-387.

Services with a coordinated approach to clients with complex needs are more effective compared to disparate service delivery.[26]

Recommendation 3: Establish a co-located, coordinated suite of support services to assist with the integration of individuals with complex needs who have recently been released from prison. $50M funding should be invested to develop a specialist agency which specifically focusses on mental health, AOD, employment, training and mentoring support for this cohort.

Provision of Naloxone

As part of a broad harm reduction strategy aimed at reducing the incidence of post-release overdose, VAADA recommends providing people exiting prison (and their families) with increased access to Naloxone. Naloxone (administered by either injection or nasal spray) can be a life-saving intervention in the event of overdose: it blocks opioids from attaching to opioid receptors in the brain, and in doing so can restore a person's breathing.

Given the high rate of heroin-related, post-release overdose deaths, VAADA recommends investing in programs that provide Naloxone in the lead up to release. Internationally, such programs operate Scotland, Wales, Canada and others with high rates of success. In Scotland, the rate of overdose deaths among people formerly in prison in the four weeks following release reduced by 36% following the introduction of prison-based Naloxone programs. [27] As Naloxone cannot be misused and has no other effects, this is a low-risk, high-benefit option.

A 2018 study of 400 men in prison in Victoria with a history of regular injecting drug use found an overwhelming willingness among this cohort to participate in a take-home Naloxone program. 81% of study participants were willing to undertake take-home Naloxone training prior to their release from prison and 94% were willing to resuscitate a friend in the event of an opioid overdose using take-home Naloxone if they had received training.[28]

VAADA is confident that a similar program in Victoria has the potential to significantly reduce opioid-related deaths among those exiting prison.

Recommendation 4: **Implement a comprehensive harm reduction strategy for people in prison approaching release. This strategy should incorporate enhanced guidance for correctional staff in delivering harm reduction training prior to release, including the provision of Naloxone (and training in how to administer it).**

---

[26] Luchenski S et al, 'What works in inclusion health: overview of effective interventions for marginalised and excluded populations', *The Lancet*, vol. 391 no. 10117, 2018, pp.266-280, cited in M Willoughby, S Biondo and J Young, 2019 'Improving health and preventing mortality among justice-involved homeless people with substance use issues', *Parity*, vol. 32, no. 6, 2019, p 7.

27 S Bird, A McAuley, S Perry, and C Hunter, "Effectiveness of Scotland's national naloxone programme for reducing opioid-related deaths: a before (2006–10) versus after (2011–13) comparison", *Addiction*, Vol. 111 No. 5, 2016, pp. 883-91.

28 M Curtis et al. 2018, 'Acceptability of prison-based take-home naloxone programmes among a cohort of incarcerated men with a history of regular injecting drug use', *Harm Reduction Journal*, vol. 15, no. 48, 2018.

Increase access to diversion

Illicit drug offences are the second most common category of criminal offence among Victorians in prison: at 30 June 2019, 14% of people in Victoria prisons (a total of 1,162 out of 8,101) were serving a custodial sentence for a drug offence.[29]

In order to reduce this number, and the associated burden on the justice and correctional systems, VAADA recommends the increased use of diversion programs. Diversion programs direct offenders away from the criminal justice system and, where appropriate, into the AOD treatment system. This approach has a high therapeutic value which addresses the cause of offending, and reduces recidivism rates. 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.[30] [31] 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 in therapeutic diversion program, particularly in rural areas. In 2019, Dr Caitlin Hughes of the National Drug & Alcohol Research Centre led a study of the barriers and facilitators to the expansion of diversion in the Australian context (**Hughes Study**). 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.*[32]

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.*[33]

VAADA sees value in increasing the availability of diversion, and the associated community-based support and treatment services, for those who fit eligibility criteria. This will require an identification of the existing barriers to accessing in Victoria, and subsequent investment to remove those barriers.

More broadly, VAADA recommends a review of Victoria's current diversion system. A particular aspect of Victoria's diversion system requiring scrutiny is the fact that it relies on police's use of discretion in determining which offenders may be granted diversion. The use of discretion has led to inconsistencies in the use of diversion programs for Victorian offenders: the Hughes Study notes that

---

[29] Australian Bureau of Statistics, *Prisoners in Australia, 2019 – Victoria*, cat. no. 4517.0, 30 June 2019, https://www.abs.gov.au/, accessed 14 January 2019.
[30] 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.
[31] 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.
[32] 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.
[33] Hughes et al, *Criminal Justice Response*s, pp. 51-52.

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'.[34] 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: Review the Victorian diversion system and the diversion programs available, including eligibility and the availability of community-based support and treatment services available to those eligible for diversion.

ii. Responding to increased demand: SafeScript

*Real Time Prescription Monitoring (**RTPM**) provides an opportunity to address harms related to pharmaceutical medications occurring within a largely hidden cohort. The benefits of RTPM may be undermined if support is not provided to enable a coordinated response from the AOD, pain medicine and mental health sectors.*

Victoria's RTPM system, SafeScript, has been operating since 1 April 2019, 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.[35] If this ratio is applied across the state, it would suggests that 47,933 Victorians are likely to be identified through this system in the first six months.[36] Some other relevant facts include:

- This figure is approximately 50% greater than the number of Victorians who were engaged AOD treatment in 2017/18;
- The Australian Criminal Intelligence Commission's 2019 Waste Water Analysis has revealed regional Victoria has a high rate of pharmaceutical opioid use compared to the rest of Australia;[37] and
- Victoria has a burgeoning 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.

---

[34] Victorian Parliamentary Inquiry into Law Reform, cited in Hughes, p. 50.
[35] 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.
[36] Australian Bureau of Statistics, *Australian Demographic Statistics, Mar 2019,* cat. no. *3101.0*, https://www.abs.gov.au/ausstats/abs@.nsf/mediareleasesbyCatalogue/CA1999BAEAA1A86ACA25765100098A47 accessed 5 November 2019
[37] Australian Criminal Intelligence Commission 2018, *National Waste Water Drug Monitoring Program – report* 5, Australian Criminal Intelligence Commission, https://www.acic.gov.au/sites/g/files/net3726/f/nwdmp5.pdf?v=1538721816 accessed 9 October 2018

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 Victorians affected by it are likely to require additional support. In instances where treatment is not immediately available, VAADA is aware of cases of families opting to utilise the unregulated sector of private, for-profit treatment services for their loved ones' pharmaceutical-related dependency issues. In this regard there have been an increasing number of consumer complaints of the services offered;
- an increased number of people using alternate (and more risky) means of procuring various substances, including engaging with illicit street-based markets, legal highs or the Dark Web; and
- a potential increase in heroin-related overdoses. Although state-based RTPM programs in operation in the United States have produced modest reductions in pharmaceutical-related overdoses, there has been a correlated increase in fatal overdoses involving heroin.[38] While it is difficult to draw causative links, the results are nonetheless alarming. Given the high rates of heroin-related harms in Victoria, there is a need to reflect very carefully on how any unintended consequences of SafeScript's full implementation will be responded to.

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 sectors. 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.

<u>Recommendation 6</u>: Invest $40M 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 the expansion of addiction medicine, pain management specialists, and the establishment of accessible specialist clinics across Victoria.

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

> **i) whether the illicit drug market has grown following the implementation of SafeScript; and**

[38] National Institute on Drug Abuse, *Overdose death rates*, USA, 2018, https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates accessed 9 October 2018.

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

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.

Victoria's population is currently expanding at a higher rate than any other state or territory within Australia.[39] Victoria's growth rate is 2.2% compared to the national average of 1.6%[40] and has a higher population density than any other state at 23.54 people per square kilometre.[41] 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).[42] These regions will face increased harms if investment in services, including AOD, does not meet this level of growth.

According to the 2015 *Dropping off the Edge* report (**DOTE Report**) commissioned by Jesuit Social Services and Catholic Social Services Australia, many of Victoria's growth corridor regions experience high levels of disadvantage.[43] Whittlesea, Casey, Cardinia, and Mitchell score high in various measures of social disadvantage. Although the DOTE Report does not provide details on AOD-related harms or issues, we know that communities experiencing high rates of poverty, homelessness, mental illness and criminal justice involvement are more likely to experience AOD-related harms.[44]

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.

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;

---

[39] Australian Bureau of Statistics, 2019.
[40] 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.
[41] Population Australia, *Population of Victoria* 2019, http://www.population.net.au/population-of-victoria/ accessed 30 October 2019.
[42] 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.
[43] T Vinson and M Rawsthorne, *Dropping off the Edge 2015: Persistent Communal Disadvantage in Australia*, Jesuit Social Services/Catholic Social Services Australia, 2015, https://dote.org.au/findings/full-report/ accessed 15 January 2020.
[44] D Lubman et al, *A study of patient pathways in alcohol and other drug treatment,* Turning Point, Fitzroy, 2014.

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

Additional resourcing must be allocated to growth corridors in line with population growth to address AOD-related harms and curtail increasing social problems in these communities. The allocation of resourcing must be in accordance with a comprehensive plan which identifies funding priorities, access issues and service delivery issues.

Recommendation 8: 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.

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.[45] 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 rate of health professionals decreases as remoteness increases.[46]

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

Hospitalisations related to illicit substance use in regional Victoria increased by approximately 80% in the four years leading to 2016/17 (see Figure 4 below).

Figure 4: Rural & regional alcohol related hospitalisations - Victoria

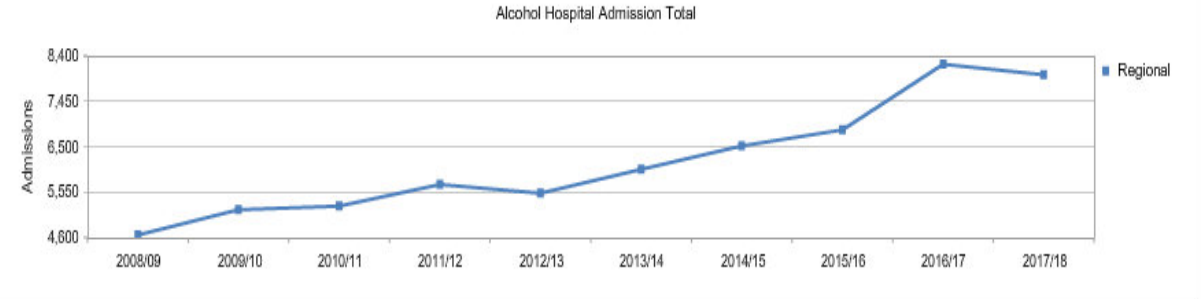
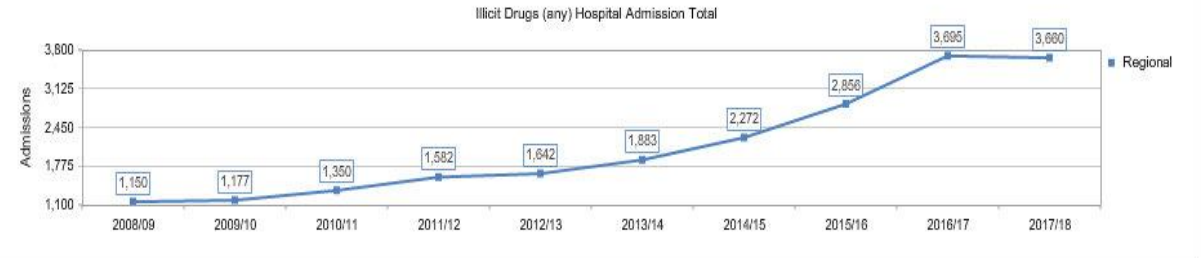


Figure 5 reveals that rural and regional illicit substance hospitalisations more than doubled over the same period, with a 28% increase between 2015/16 to 2016/17.

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



(Turning Point 2020)

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

The VAADA 2019 Sector Priorities Survey revealed that, due to funding, many AOD employment opportunities in rural Victoria are part-time and short-term. Skilled workers are often reluctant to move to rural areas for the promise of an isolated part time job in a position that may only be funded for a limited duration.

As indicated in VAADA's Sector Priorities Surveys for the previous three years, 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 recent bushfires across Victoria. Bushfires of this magnitude, which are likely to become an increasingly common feature of the Australian environmental landscape, are known to

increase the incidence and severity of mental illness and problematic substance use in affected communities.[47] 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 psychosocial programs in the wake of Black Saturday, those experiencing mental illness and problematic substance use, the government response was not adequate.[48] A study of the response suggested that policymakers must target areas suffering high distress to ensure that appropriately-trained professionals are available to provide the support required.[49] Following the recent fire devastation across East Gippsland and the High Country, investment into support services must be increased to assist with the non-physical detriment which has been caused, and which will continue to manifest once the immediate fire risk has abated. It is vital that additional investment is made to increase support services, rather than relocating existing practitioners, thereby leaving gaps in service provision in other locations.

VAADA recommends the Government consider additional resources for East Gippsland to increase capacity to deal with the likely increase in mental health and AOD-related harms in the wake of the recent bushfires. The deployment of these resources should be informed by evolving need, as the harms and trauma associated with the bushfires emerge. A vital element is ensuring that support is available when required alleviating the risk of a more acute response at a later date.

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

- increased access to AOD treatment in rural and regional areas;
- equitable access to treatment for issues such as alcohol, methamphetamine, heroin and pharmaceuticals; and
- increased opportunities for cross sector collaboration, crucial in areas with limited service availability.

Recommendation 9: 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 10: Apply a loading to all rural and regional AOD staff of 10% above the relevant award to enhance recruitment and better retain quality staff.

Recommendation 11: Convene a rural and regional AOD summit, as a matter of urgency, to engage with rural and regional communities in relation to measures that can be taken to address the range of AOD and system-related issues affecting them. An information gathering exercise should be undertaken to better inform stakeholders in the lead-up to the summit.

[47] Psychological outcomes following the Victorian Black Saturday bushfires p. 643.
[48] Psychological outcomes following the Victorian Black Saturday bushfires p. 643.
[49] Psychological outcomes following the Victorian Black Saturday bushfires p. 643.

iv. Responding to increased demand: Care and Recovery Coordination

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

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

The utility of a CRC approach to treatment was recognised by the 2016 Royal Commission into Family Violence, which recommended that a range of services, including but not limited to AOD services, are needed by people experiencing family violence.[50] 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.

Unfortunately, CRC at the time of recommissioning was grossly under-resourced and has been for some time. The 2015 Aspex Report highlighted a deficit in the resourcing of care and recovery coordination.[51] Almost 50% of respondents to VAADA's 2019 Sector Priorities Survey considered that funding for CRC was insufficient.

While the Government predicted in 2013 that up to one third of AOD service users would benefit from CRC, current estimations suggest there is only capacity for 3804 individuals to access CRC support annually.[52] 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 $16.76M.

There is also a pressing need to evaluate the current value of the CRC DTAU rate. The 2019/20 price for a DTAU is $820.99, and the weighting on CRC currently sits at 2.22 DTAUs. It is apparent that this current rate is insufficient to cover the actual costs associated with providing CRC treatment, and therefore a review should be undertaken, with a view to increasing the current rate from 2.22 DTAUs.

To facilitate longer-term planning, the Government should undertake a comprehensive assessment of demand for this treatment type, using the DASP Model as earlier recommended. This would likely

---

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

[51] 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.

[52] 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.

allow for additional capacity to maintain a continuum of care beyond the course of treatment, and provide a safety net to support people who may struggle to maintain positive treatment outcomes, based on relevant data.

Increased funding is also needed to enhance the resources necessary to provide CRC treatment: specifically, supported housing. Supported housing is a key element of CRC treatment, as it provides complex clients the stability they require in the period immediately following formal treatment, when risk of relapse is it its highest. During this time, many return to their former using environments and social groups, and supported housing can assist by providing an alternative environment which complements the recovery process.[53] International research has indicated that supported housing has been associated with a range of positive treatment outcomes, including reductions in substance use, fewer arrests, and an increased likelihood of obtaining permanent housing and employment.[54]

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

<u>Recommendation 12</u>: Provide a recurring $16.76M 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.

<u>Recommendation 13</u>: Provide increased access to transitional social housing for those whose circumstances require it on exiting formal AOD treatment.

[53] 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.
[54] 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.

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 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.[55]

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

In theory, the formula determining the value of the DTAU should account for costs associated with workforce training and development. However, in practice, this does not occur. The workforce needs of the AOD sector expand each year, to cater for the growing demand in forensic, family violence, child protection, homeless, CALD, LGBTIQ, older people, pharmaceuticals and dual-diagnosis.

Further, the current DTAU is based on the erroneous notion that AOD presentations are unencumbered with other issues.

VAADA reiterates the recommendation included in the ASPEX Report, that the suitability of the DTAU should be assessed against the real needs of the sector. VAADA recommends that a careful appraisal of adequacy of the set price against the actual criteria underlying the DTAU formulation be undertaken.

Recommendation 14: 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. Enhancing the AOD sector: Data systems

*The benefits of the Victorian Alcohol and Drug Collection (**VADC**) data system will be lost unless greater capacity to better review and analyse the data is supported.*

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

During 2019, the implementation of the VADC has generated a significant financial and human resource burden on AOD agencies across Victoria. VADC's initial rollout, as well as the subsequent series of revisions and modifications, have created an unplanned multi-million dollar financial burden on services.

In April 2019, VAADA circulated a survey amongst its member services to improve our understanding of agencies' experiences of the VADC. The survey results, which were presented in VAADA's subsequent *VADC Impact Report* in May 2019, highlighted the heavy drain on financial and human resources that has been required as part of the VADC's implementation, through generation of unfunded activity which subsequently increased many agencies' administrative burden. Agencies incurred significant costs associated with either updating existing data systems or purchasing new systems to facilitate data collection under the VADC. Of agencies that purchased a new system, over three quarters spent more than the $10,000 subsidy allocated by the Department of Health and Human Services to assist the agencies with the VADC transition. Costs exceeded $100,000 for 28% of agencies surveyed. Several providers indicated unplanned expenditures in the vicinity of $100-250,000 or more each.[56] These services require financial relief for additional expenditures incurred because of the VADC.

There is a need to ensure that measures such as the VADC do not result in continued unplanned and unsustainable financial burdens for treatment providers, taking scarce resources away from the core business of supporting vulnerable Victorians and their families.

<u>Recommendation 15</u>: Establish a special purpose fund of $3M to assist AOD services with unexpected costs associated with the establishment of the VADC over the 2020/21 financial year.

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

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

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

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

[56] Victorian Alcohol and Drug Association, VADC Impact Report, VAADA, Collingwood, May 2019.

As reforms continue to affect the AOD sector, and the forensic demand is expected to grow, there is an urgent need to establish mechanisms to efficiently upskill the Victorian AOD workforce on an ongoing basis.

VAADA recommends the development of a fast track system to address challenges associated with securing, training and allocating staff to a suitable service. This should focus on training and experiential learning, coupled with 'micro-credentialing': the delivery of training units relating to family violence, children and youth, dual diagnosis, and other key areas of expertise.

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

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

The benefits to the sector and the community of a more highly skilled, specialised and stable AOD workforce would be significant, providing greater capability to supporting an increasing complex cohort of service users.

To complement these efforts, and to ensure the ongoing efficacy and sustainability of the Victorian AOD sector, as mentioned above, there is a pressing need to develop an alcohol and other drug treatment sector 'Industry Plan'. VAADA recommended this in its submission to the Royal Commission into Victoria's Mental Health System.[57]

<u>Recommendation 16</u>: Invest $1.5M to establish an entity to better coordinate training and enhance the attraction of staff to Victoria's AOD sector. This entity would explore options for micro-credentialing and rapid accreditation of new AOD workers in relevant areas of high need. A central co-ordinating team of two staff would support existing RTOs, and the enhanced workforce training and enhancement initiative.

<u>Recommendation 17</u>: Invest $2M to develop a broad 'industry plan' for the AOD sector which takes into account the specific needs of the AOD sector as well as the AOD-related workforce needs of related sectors, including mental health, homelessness, child and family support services, Aboriginal, hospitals and forensic health environments.

[57] Victorian Alcohol and Drug Association, *Submission to the Royal Commission into Victoria's Mental Health System*, VAADA, Collingwood, 2019.

iv. Enhancing the AOD sector: Increasing dual diagnosis capacity

One in three individuals experiencing AOD dependency also experience at least one co-occurring mental health disorder.58 The increasing complexity of cohorts engaging with frontline services highlights the need for greater capacity coupled with an increase in highly specialised workers to effectively respond to dual-diagnosis, and comprehensively address co-occurring issues.

Co-occurring AOD and mental health disorders are the norm rather than the exception among individuals engaged with or needing AOD treatment:

- Approximately 35% of individuals experiencing AOD dependency also experience 'at least one 'affective or anxiety disorder, representing approximately 300,000 Australians';
- Those presenting with co-occurring AOD and mental health issues are more likely to experience more severe symptoms and are less likely to have positive outcomes than those with either condition alone; and
- 62% of individuals using AOD daily experienced a mental disorder over the past 12 months[59] and more than one in five people who have used an illicit drug within the past month have experienced psychological distress.[60]

Further, there is a high rate of co-occurring AOD dependence, mental health diagnosis, and contact with the criminal justice system: data provided to VAADA from Australian Community Support Organisation, shows 50% of offenders assessed for alcohol and other drug treatment have a mental health diagnosis.

Despite the common overlap of these issues amongst AOD service users, they are too often dealt with in isolation or the client does not access any support from either service sector[61]. In recognition of the high rates of co-morbid mental health and AOD conditions, it is important to consider the best way of providing more coordinated and effective responses to those with co-occurring needs. The challenges associated with assisting those with co-occurring mental illness require innovations which build on existing expertise in the sector.

Integrated Care

Integrated care is widely recognised as the best-practice model for treating people with co-occurring mental health and AOD needs.[62] Integrated care is comprised of two components: systems integration and operational integration.

While the mental health and AOD sectors should not be conflated, there is value in integrating the respective service systems at the operational level. The Productivity Commission's Draft Report into

---

[58] C Marel et al, *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions,* p 12.
[59] C Marel et al, *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions,* p 12; Productivity Commission, *Draft Report – Mental Health* 2019, p 323-324
[60] State of Victoria, *Royal Commission into Victoria's Mental Health System, Interim Report,* 2019, p 35
[61] Productivity Commission, *Draft Report – Mental Health* 2019, p
[62] K Minkoff, 'Developing standards of care for individuals with co-occurring psychiatric and substance use disorders', *Psychiatric Services* 52, 2001, pp. 597–599.

Mental Health notes that the separate governance and funding arrangements impair service integration, which are further degraded through 'fragmented responsibilities ..., stigma and discrimination, and suitable support [being] difficult to find…'[63]

The process to drive service integration should both recognise and support the individual strengths of each sector.[64]

Dr Kenneth Minkoff, a leading academic with expertise in addiction psychiatry and dual diagnosis, has recommended AOD and mental health integration be implemented by:

- Outreach services that address client motivation;
- Case management provided from a single site or service;
- provision of care by a clinician trained in both AOD and mental health; and
- Ensuring that client needs are managed in a coordinated way.[65]

To achieve integration between sectors, the Government should undertake a cross sector capacity-building endeavour.

VAADA recommends AOD agencies in each Victorian region host three 'specialist' dual diagnosis treatment clinicians. The same approach could be considered within the community mental health sector.

These cross sector capable workers would work with highly complex service users, consisting of those who may be too unwell to solely engage either sector, as well as supporting other clinicians. This would supplement the micro-credentialing approach to workforce development detailed above.

Prioritising an integrated care approach that utilises multidisciplinary expertise across the health and welfare sectors should be a priority for the Victorian Government following the Royal Commission into Victoria's Mental Health System.

<u>Recommendation 18</u>: Recruit three 'specialist' dual diagnosis 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 concerns.

<u>Cost per region</u>:

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

Overarching AOD and Mental Health Framework

In addition to increasing capacity and providing a highly specialised arm to treat dual-diagnosis at an operational level, there is also a need to strengthen and entrench integration at a systems level. This

[63] Productivity Commission, *Draft Report – Mental Health* 2019, p 328
[64] Ibd 329
[65] Minkoff, 'Developing Standards of Care'.

need is particularly relevant to the AOD and mental health sectors, but also applies to other sectors. As recommended by VAADA in its submission to the Royal Commission into Mental Health, this should take place through the implementation of an overarching integration framework which guides the AOD and mental health sectors in how to work together to provide a client-centred treatment approach with their respective clients.

VAADA recommends that the Government invest $5M in the AOD sector and $5M in the mental health sector to facilitate a joint approach to the development of the framework

The development of an integration framework would empower both sectors to retain their distinct values and frameworks, while building on the areas of overlap between the two.

Recommendation 19: Invest $5M to fund the development of an overarching AOD and mental health integration framework for Victoria. Corresponding protocols, practice guidelines and training opportunities should be developed and implemented to translate the framework to clinical practice.

Drug and Alcohol Clinical Advisory Service

The Drug and Alcohol Clinical Advisory Service (**DACAS**) is a free telephone-based support service which provides general practitioners with expert advice from addiction medicine specialists in respect of AOD-related health presentations. This support service would be greatly enhanced by the addition of Addiction Psychiatry expertise, which would provide much-needed support to GPs working with co-occurring AOD and mental health issues.

Recommendation 20: Provide additional addiction psychiatry capacity to Drug and Alcohol Clinical Advisory Service (DACAS) at an estimated cost of $300,000 per annum to provide additional support for GPs working with dual-diagnosis presentations.

c) Improving access to AOD treatment

i. Improving access: Opioid replacement therapy

The Australian Institute of Health and Welfare (**AIHW**) reveal that 14,304 Victorians accessed opioid replacement therapy (**ORT**) in 2018, a slight increase from 2017.[66] This amounts to 22 service users per 10,000 head of population, a near doubling of the rate in 1998 (12 per 10,000).

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.[67]

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

Conservatively two thirds of people engaged on ORT are on welfare benefits. As such, ORT dispensing fees may be more than 10% of a client's weekly income.[68] 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.[69]

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.[70]

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

In addition to prohibitive costs, rural and regional Victorians face a lack of access to prescribing doctors and dispensing pharmacies. The Australian Criminal Intelligence Commission's wastewater analysis, shows that many opioids are used at a higher rate in rural and regional Victoria compared to urban centres and most regions in Australia.

At present, the gap between the number of people receiving ORT and the number of those in need is between 30 - 50%.[71] A key factor in this lack of availability of ORT is the shortage of GPs registered

---

[66] Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2017–18*, Cat. No. HSE 224, Canberra, 2019b, https://www.aihw.gov.au/getmedia/07f18cb6-c391-417d-90cc-dc8a06bb4b78/aihw-hse-230.pdf.aspx?inline=true

[67] 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.

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

[69] Pennington Institute, *Chronic Unfairness*.

[70] 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.

[71] D Hendrie, 'With prescription opioids seemingly ubiquitous, why is heroin making a comeback?', Royal Australian College of General Practitioners, 8 July 2019, https://www1.racgp.org.au/newsgp/clinical/with-prescription-opioids-seemingly-ubiquitous-why accessed 15 January 2020.

as prescribers of ORT in rural and regional areas, an issue which may be attributed to a reluctance to engage with patients experiencing substance use issues.[72]

To address this, VAADA calls for a greater focus increasing the number of prescribers and dispensers of ORT in rural and regional Victoria, including financial incentives.

To achieve this, opportunities to train in and dispense pharmacotherapy should be increased, especially for nurse practitioners. These dispensers should be located in healthcare facilities which are accessible by the public.

A further opportunity to reduce the burden associated with prescribing and dispensing of ORT, is through the use of depot buprenorphine. Depot buprenorphine is a slow-release form of ORT administered via injection by a health professional on a weekly or monthly basis. This removes the need for daily dosing, thereby reducing demand on both prescribers and dispensers. Depot buprenorphine was listed on the PBS on 1 September 2019,[73] and should be considered for prescription in a range of settings, including custodial settings. VAADA suggests investing in capacity-building for prescribers in order to facilitate the take up of this option amongst those undertaking ORT.

Recommendation 21: The Victorian Government should subsidise the ORT dispensing fee to increase program engagement and retention;

Recommendation 22: Provide additional funding to train nurse practitioners to become qualified ORT prescribers, targeting poorly serviced rural and regional areas.

Recommendation 23: Fund capacity-building of GPs and nurse practitioners in order to facilitate the prescribing of depot buprenorphine.

[72] T Vishwanath, et al 'A narrative review of Pharmacotherapy Treatment for Opioid Addiction and Application in a Community-Based Model in Victoria, Australia', *International Journal of Mental Health and Addiction*, 2018 https://www.researchgate.net/profile/Tejaswini_Patil4/publication/325583485_A_Narrative_Review_of_Pharmacotherapy_Treatment_for_Opioid_Addiction_and_Application_in_a_Community-Based_Model_in_Victoria_Australia/links/5ba4276e92851ca9ed1a0d0c/A-Narrative-Review-of-Pharmacotherapy-Treatment-for-Opioid-Addiction-and-Application-in-a-Community-Based-Model-in-Victoria-Australia.pdf accessed 15 January 2020.

[73] D Hendrie, 'Advocates hail 'game changing' PBS listing of buprenorphine,' Royal Australian College of General Practitioners, 26 August 2019, https://www1.racgp.org.au/newsgp/clinical/advocates-hail-game-changing-pbs-listing-of-long-a accessed 2 December 2019.

ii. Improving access: Reducing AOD-related Emergency Department presentations

Research indicates that 35% of Emergency Department attendees experience AOD issues, with 7% requiring extensive treatment. Cost effective measures to break the revolving door of ED attendances among this cohort are available.

People with severe and comorbid substance dependence, present frequently at Emergency Departments (**EDs**) with complex health and social problems.[74] This complexity, combined with the lack of integration between EDs and community AOD sectors, create barriers that prevent a best-practice continuum of care.

Research from NSW illustrates an alarming trend in the overall contribution of AOD to EDs with 35% of patients surveyed experiencing problematic AOD issues and 7% experiencing more serious AOD issues.[75]

VAADA welcomes the upcoming roll-out of AOD and mental health and hubs (**Hubs**) at EDs in six Victorian hospitals. This means those who present at EDs with acute mental health and/or AOD issues will be seen by mental health and/or AOD experts. At the very least, it should be an expectation that cross-service linkages and pathways will continue to be established between service sectors.

The enduring challenge of retaining highly complex individuals within a treatment environment is likely to remain. In many cases, this will necessitate a therapeutic residential environment coupled with a highly skilled and capable workforce. In light of several issues raised by the Royal Commission into Mental Health, it is critically important to consider how best to maximise positive outcomes for complex cohorts through investing in and building the structural machinery to create a cohesive therapeutic service response.

To achieve this VAADA recommends that a standard suite of AOD services should be available at each hospital. This should consist of:

- direct or indirect access to an expanded Addiction Medicine Specialist service across Victoria to assist in building the capacity of primary health providers to work with AOD clinicians as well as support highly vulnerable service users;
- access to sub-acute intensive supports (acute AOD and withdrawal) — capacity for which needs to be developed in each Victorian region;

---

[74] D Nambiar, T Spelman, M Stoove, and P Dietze, 'Are people who injecting drugs frequent users of emergency department services? A cohort study (2008-2013)', *Substance use and misuse*, vol 53, no 3, 2018, pp 457 – 465.

[75] Butler, K et al, 2015, 'The hidden costs of drug and alcohol use in hospital emergency departments' *Drug and Alcohol Review*, vol. 35, no. 3, May 2016, pp. 359-366; Reeve, R et al, 'Evaluating the impact of hospital based drug and alcohol consultation liaison services', *Journal of Substance Abuse Treatment*, Vol 68, 2016, pp. 36 – 45.

- Accessible step-down facilities be established to augment the treatment response; and
- Graduated entry into community based AOD services, which have the capacity to manage client flows in an efficient and timely manner, as well as residential services.

<u>Recommendation 24</u>: Provide additional investment in aftercare supports, recovery and outreach services to ensure AOD treatment capacity is able to meet additional demand, with the roll out of AOD & mental health hubs. Careful consideration and investment should be made to ensure seamless and coordinated pathways for clients being stepped down/referred into the AOD treatment system (whether in- or out-patient). Funding would be based on existing infrastructure needs to meet anticipated increases in demand.

<u>Recommendation 25</u>: Establish an additional AOD and mental health hub in a public hospital located in East Gippsland to support communities recently affected by bushfires with specific Addiction Medicine Specialist capacity.

<u>Recommendation 26</u>: Establish a broader network of sub-acute units across each region to support and address the immediate needs of highly dependent individuals who frequent emergency departments. These hospital-based units would stabilise and prepare patients to step down into various community supports with newly enhanced capacity to meet their needs.

<u>Recommendation 27</u>: That community-based and residential AOD treatment services are resourced adequately to handle the increase in referrals flowing from imminent establishment of mental health and AOD hubs.

iii. Improving access: Looking after our older people

Older people experiencing AOD dependency experience significant yet preventable AOD-related harms and are currently underserviced. A specialist AOD service catering for older people needs to be piloted.

The proportion of Australians aged over 65 years is steadily increasing. Older adults 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.[76] AOD-related harms appear to be becoming more prevalent, particularly in light of Victoria's aging population:

[76] 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.

- More than 15% of Victoria's population is aged over 65. This population will treble by 2058,[77] and population growth in the older demographic in Victoria is forecast to increase more rapidly than any other age group;[78]
- 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;[79] and
- Despite the facts that drug-induced deaths among older people have been increasing since 1999,[80] older adults are less likely to access traditional services due to stigma and mobility limitations.[81]

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

Currently, there is only one AOD treatment program in Victoria specifically servicing older 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.

<u>Recommendation 28</u>: Develop a pilot outreach AOD treatment project to address the gap in AOD services for older 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:[82]

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

[77] Department of Health and Human Services, *Ageing,* Victorian Government, 2019, https://dhhs.vic.gov.au/ageing accessed 21 January 2019.
[78] Department of Planning and Community Development, *Victoria in Future: 2008*, Melbourne, 2009.
[79] Coroners Court of Victoria, *Average Annual Overdose Death Rate, Victoria 2009 – 2017*, Coroners Prevention Unit, Southbank, 2018.
[80] Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2017–18*.
[81] 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.
[82] This pilot program outline has been adapted from VAADA's 2014/15 State Budget Submission

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

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

People from CALD communities are currently under-represented in the AOD treatment system. Data shows that only 14% of closed treatment episodes for Australians in 2017-18 applied to clients born overseas, yet in the general population, 29% of people living in Australia were born overseas.[83]

In 2016, VAADA conducted an analysis of the extent of AOD harms among CALD populations in Victoria,[84] which identified a number of challenges including:

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

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

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

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

- Promoting culturally appropriate models of service delivery while strengthening ties between CALD communities, ethno-specific agencies and AOD treatment services.[85]

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

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

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

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

<u>Recommendation 29</u>: Provide resourcing to establish a pilot program which places two bi-cultural liaison workers in four AOD catchments in Victoria. Bi-cultural liaison workers would be supported by two capacity building project support officers, to increase CALD community access to AOD services and build the capacity of catchment services to cater for the needs of these communities.

Indicative program components and costs include:

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

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

v. Improving access: Supporting at-risk cohorts to engage in AOD treatment and additional primary health harm reduction services

A cohort of individuals, while experiencing a range of morbidities, are reluctant to engage in the AOD treatment system, and remain at high risk of harm. There is a need for community-based primary health harm-reduction services to effectively support individuals and generate opportunities for engagement with the AOD treatment sector.

Of the estimated 200,000 Australians who are in need of AOD treatment but are not engaging, there is a small sub-group of AOD-dependent individuals who frequently experience acute AOD related harms.[86] This cohort can be resistant to service engagement: their involvement may be limited to needle and syringe programs. They are also likely to be involved with the justice system crisis-support, acute health or crisis housing services.

The AIHW found that those engaging in both AOD and homelessness services experienced a greater severity in various morbidities and sought treatment for more substances than those who engaged solely with AOD services.[87] This is indicative of the challenges associated with providing care for people with severe and complex disadvantage.

In order to meet the needs of complex clients, a holistic approach should be taken to service provision. Services that provide a coordinated approach to support and treatment for people with complex needs— poor health, social isolation, chronic housing instability, legal assistance and problematic AOD use are found to be more effective than when these services are delivered independently.[88]

Earlier this year, VAADA co-authored a report into homelessness and AOD use: *Improving health and preventing mortality among justice-involved homeless people with substance use issues*. This report noted a high level of correlation between AOD dependence, and mental health issues amongst homeless people in Australia and other high-income countries.

In order to address these concerns, this proposal recommends investment in services which provide targeted, wrap-around responses for individuals who are classified as high-risk and experience acute mental health, AOD use and housing changes. However, in order to best support this vulnerable cohort, the existing support services outlined above must be supplemented. These primary health harm reduction services should be implemented in areas with high population density, including

---

[86] A Ritter et al, '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.

[87] Australian Institute of Health and Welfare, *Alcohol, Tobacco and other drugs in Australia – Homeless people*, 2018, https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/homeless-people accessed 12 October 2018.

[88] Luchenski S et al, 'What works in inclusion health: overview of effective interventions for marginalised and excluded populations', *The Lancet*, vol. 391 no. 10117, 2018, pp. 266-280, cited in M Willoughby, S Biondo and J Young, 2019 'Improving health and preventing mortality among justice-involved homeless people with substance use issues', *Parity*, vol. 32, no. 6, 2019, p. 19.

transport hubs where various indicators of disadvantage such as homelessness, unemployment and problematic AOD use, are concentrated.

The workforce composition would depend on whether this service would be appended to an existing organisation such as a community health centre (a preferable option) or as a standalone agency.

Recommendation 30: Implement comprehensive primary health harm reduction services in areas where high risk, service averse cohorts are concentrated, to provide support, stability and referrals. These services — ideally appended to an existing service — should comprise:

Role	EFT	Cost per annum
Nurse	2	$200,000
CD/peer worker	2	$180,000
General Practitioner	0.4	$150,000
Coordinator	1	$125,000
	TOTAL	**$655,000.00**

vi. Improving access: Enhancing support and referrals at the MSIR

VAADA welcomes the establishment of a Medically Supervised Injecting Room (**MSIR**) in North Richmond. The MSIR is receiving strong patronage, and while the further release of data is pending, there are indications that the staff have reversed a large number of overdoses and that there have been many referrals to various support services.

The high level of demand for the MSIR suggests that greater supervised injecting capacity would be beneficial in further reducing heroin related harms. A number of data sources point to increasing heroin issues in Victoria, including the ACIC's Waste Water Analysis indicating Melbourne has the highest estimated rate of heroin usage in Australia; this trend was evident prior to the implementation of the MSIR[89].

Recommendation 31: That additional supervised injecting capacity is considered in other high risk regions to meet demand and provide access to this life saving service in other regions with pre-existing levels of high heroin consumption and harms.

89
https://acic.govcms.gov.au/sites/default/files/national_wastewater_drug_monitoring_program_report_3.pdf?acsf_files_redirect p 30
https://www.acic.gov.au/sites/default/files/national_wastewater_drug_monitoring_program_report_8_2019_pdf.pdf?v=1571983781 p 32

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

The demand for residential rehabilitation services across Victoria is increasing, fuelled by the paucity of publicly-funded beds in combination with increasing demand. Budget announcements from the Government have made positive headway in addressing the lack of residential rehabilitation capacity, including rural and regional Victoria. However there remains a dire need to ensure equity of access as Victoria remains underserviced in comparison with similar jurisdictions.

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 that recent studies provide consistent evidence supporting effectiveness of residential treatment (including therapeutic communities and integrated mental health treatment) across various outcomes.[90] 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.[91] The then Australian National Council on Drugs notes 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.[92] Other studies note a conservative net economic benefit of approximately $1M per person.[93]

Despite the clear economic and social benefits of this treatment modality, the number of beds available in Victoria remains limited.

Despite the welcome increase in funding from the Government for this treatment type families relay to VAADA that significant barriers to access for this treatment remain.

We estimate that, based on approximately 450 beds soon to be operating, Victoria's residential bed capacity is forecast to increase from 0.45 to 0.7 beds per 10,000 population (the latter 2019 estimate represented in purple in Figure 5 below).[94] Despite this welcome increase, this remains inadequate to address demand. As Figure 5 shows, Victoria has the second lowest ratio of residential rehabilitation beds per head of population nationally.

---

[90] 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.

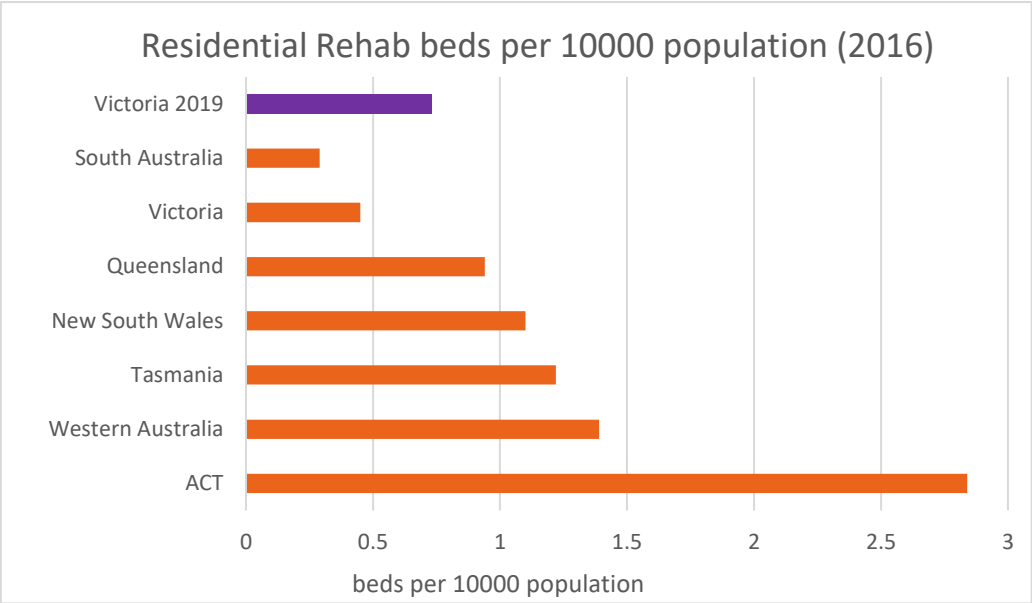
[91] D Lubman et al, *A study of patient pathways in alcohol and other drug treatment,* Turning Point, Fitzroy, 2014; S Ciketic, R Hayatbakhsh, R Mcketin, CM Doran, and JM and Najman, 'Cost-effectiveness of counselling as a treatment option for methamphetamine dependence', *Journal of Substance Use*,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

[92] 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.

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

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

Figure 5: Residential rehabilitation beds per 10,000 head of population by state/territory



This reflects an ongoing disjuncture between community demand and sector capacity.

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

VAADA recommends that the Government implement a minimum benchmark for residential rehab sector capacity. A prudent benchmark should be set at ratio of 1: 10,000 population, which is still below the national average, however, 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 third 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 $75,000 per annum.

In addition to increased resourcing, a number of barriers to access must be addressed to allow residential rehabilitation to fully achieve its potential benefit. Staffing capacity is an ongoing issue.

<u>Recommendation 32</u>: 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.

6. References

4 Corners 2016, *Rehab Inc: The high price parents pay to get their kids off ice*, Australian Broadcasting Corporation [website], 12 September 2016, http://www.abc.net.au/4corners/stories/2016/09/12/4535254.htm accessed 15 September 2016.

Abbott P, Magin P, Lujic S, Hu W, '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, 268-76.

Acumen Alliance, *Benefit and cost analysis of the Drug Court Program*, final report, Department of Justice, Victoria, 2006.

Australian Broadcasting Corporation, *Victorian Heroin Overdose deaths spike: average age of victim rises*, 18 April 2016, http://www.abc.net.au/news/2016-04-18/victoria-sees-spike-in-heroin-overdose-deaths/7333640 accessed 27 September 2017.

Australian Bureau of Statistics, *Prisoners in Australia, 2019 – Victoria*, cat. no. 4517.0, 30 June 2019, https://www.abs.gov.au/, accessed 14 January 2019.

Australian Bureau of Statistics, *Australia's population projected to double by 2075*, [media release] 26 November 2013, http://www.abs.gov.au/ausstats/abs@.nsf/lookup/3222.0Media%20Release12012%20(base)%20to%202101 accessed 27 November 2015.

Australian Bureau of Statistics 2016, *3101.0 – Australian Demographic Statistics, Dec 2015*, cat. No. 3101.0, Australian Bureau of Statistics, Canberra, http://www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0 accessed 20 September 2016.

Australian Bureau of Statistics 2017, *3303.0 – causes of death, Australia 2016*, Australian Bureau of Statistics, http://www8.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2016~Main%20Features~Drug%20Induced%20Deaths%20in%20Australia~6# accessed 2 October 2017.

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.

Australian Bureau of Statistics, *Australian Demographic Statistics, Mar 2019,* cat. no. *3101.0*, 2019, https://www.abs.gov.au/ausstats/abs@.nsf/mediareleasesbyCatalogue/CA1999BAEAA1A86ACA25765100098A47 accessed 5 November 2019

Australian Bureau of Statistics – M*edia release: Growth in Australia's capitals remains steady*, 27 March 2019, 2019 https://www.abs.gov.au/AUSSTATS/abs@.nsf/mediareleasesbyReleaseDate/F531FDF82DE090E6CA25827800196C09?OpenDocument

Australian Institute of Health and Welfare 2013, *Hospitalisations due to falls by older people, Australia 2009/10*, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129542822 accessed 29 January 2016.

Australian Institute of Health and Welfare, *National Drug Strategy Household Survey detailed report 2013*, Drug statistics series no. 28. Cat. no. PHE 183. Canberra, 2014.

Australian Institute of Health and Welfare, *The health of Australia's prisoners 2015*, Cat. no. PHE 207, Canberra, 2015.

Australian Institute of Health and Welfare, *Healthy Communities: hospitalisations for mental health conditions and intentional self-harm in 2013-14*, Cat. No. HSE 177, Canberra, 2016.

Australian Institute of Health and Welfare 2016a, *Expenditure on Specialised Mental Health Services*, Mental Health Services in Australia, http://mhsa.aihw.gov.au/resources/expenditure/specialised-mh-services/ accessed 14 November 2016.

Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2015–16*, Cat. no. HSE 187, Canberra, 2017.

Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia: 2016–17*, Drug treatment series no. 31. Cat. no. HSE 207. Canberra, 2018.

Australian Institute of Health and Welfare, *Alcohol, Tobacco and other drugs in Australia – Homeless people*, 2018, https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/homeless-people accessed 12 October 2018.

Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2016–17: state and territory summaries*, 2018 https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2016-17-state-territory-summaries/contents/victoria accessed 21 January 2019.

Australian Institute of Health and Welfare, *Rural and Remote health*, 2019, https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health/contents/summary accessed 29 October 2019.

Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2017–18*, Cat. No. HSE 224, Canberra, 2019, https://www.aihw.gov.au/getmedia/07f18cb6-c391-417d-90cc-dc8a06bb4b78/aihw-hse-230.pdf.aspx?inline=true

Australian Securities and Investments Commission, *National Waste Water Drug Monitoring Program – report* 5, Australian Criminal Intelligence Commission, 2018, https://www.acic.gov.au/sites/g/files/net3726/f/nwdmp5.pdf?v=1538721816 accessed 9 October 2018.

Bird, S., McAuley, A., Perry, S. and Hunter, C, "Effectiveness of Scotland's national naloxone programme for reducing opioid-related deaths: a before (2006–10) versus after (2011–13) comparison", *Addiction*, Vol. 111 No. 5, 2016, pp. 883-91.

Butler, K et al, 2015, 'The hidden costs of drug and alcohol use in hospital emergency departments' *Drug and Alcohol Review*, vol. 35, no. 3, May 2016, pp. 359-366.

Butler, K, Reeve, R, Viney, R & Burns, L 2016, 'Estimating prevalence of drug and alcohol presentations to hospital emergency departments in NSW, Australia: impact of hospital consultation liaison services', *Public Health research and practice*, Vol. 26, No 4.

Buykx, P, Ward, B, & Chisholm, M, *Planning alcohol and other drug services in rural and remote areas: the role of spatial access*, University of New South Wales Sydney, NSW, 2013.

Ciketic, S, Hayatbakhsh, R, Mcketin, R, Doran, CM and Najman, JM, 'Cost-effectiveness of counselling as a treatment option for methamphetamine dependence', *Journal of Substance Use*, Vol 20, no 4, 2015, pp. 239 – 246.

Collins, D 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.

Coroners Court of Victoria, *Pharmaceutical drugs and fatal overdose: lessons from the Coronial Jurisdiction*, presented at 'A bitter pill to swallow', Melbourne, 17 June 2015.

Coroners Court of Victoria, *Finding without Inquest into the death of Frank Edward Frood*, Coroners Court of Victoria, 2016, http://www.coronerscourt.vic.gov.au/resources/2c8acec4-54f0-44e8-b1ad-c4b1bd701c14/frankedwardfrood_408012.pdf accessed 23 November 2016.

Coroners Court of Victoria, *Real Time Prescription Monitoring – some disquiet on the implementation front*, presented at Turning Point Symposium, 10 October 2017, Victoria.

Coroners Court of Victoria, *Average Annual Overdose Death Rate, Victoria 2009 – 2017*, Coroners Prevention Unit, Southbank, 2018.

Coutinho, ESF, Fletcher, A, Bloch, KV and Rodrigues, LC 2008, 'Risk factors for falls with severe fracture in elderly people living in a middle-income country: a case control study', *BMC Geriatrics*, vol 8, no 21.

Coyne, J., White, V. & Alvarez, C., *Methamphetamine: focusing Australia's National Ice Strategy on the problem, not the symptoms*, Australian Strategic Policy Institute, Barton, 2015.

Curtis, Michael et al, 'Acceptability of prison-based take-home naloxone programmes among a cohort of incarcerated men with a history of regular injecting drug use', *Harm Reduction Journal*, vol. 15, no. 48, 2018.

Department of 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.

Department of Environment, Land, Water and Planning 2016, *Victoria in the Future,* Victorian Government, https://www.planning.vic.gov.au/__data/assets/pdf_file/0014/14036/Victoria-in-Future-2016-FINAL-web.pdf accessed 24 November 2017.

Department of Health and Ageing, 2009*, Return on Investment 2*, Department of Health and Ageing, Canberra, 2009, http://www.health.gov.au/internet/main/publishing.nsf/Content/C562D0E860733E9FCA257648000215C5/$File/return2.pdf accessed 17 October 2013.

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.

Department of Health and Human Services, *Ageing,* Victorian Government, 2019, https://dhhs.vic.gov.au/ageing accessed 21 January 2019.

Department of Planning and Community Development, *Victoria in Future: 2008*, Melbourne, 2009.

Donato-Hunt, C, Munot, S & Copeland, J, 'Alcohol, tobacco and illicit drug use among six culturally diverse communities in Sydney', *Drug and Alcohol Review*, vol. 31, no. 7, pp. 881-889, 2012.

Ducket, S and Breadon, P, *New solutions for GP shortages in rural Australia*, Grattan Institute, Melbourne, 2013.

Fazel, S, I Yoon and A Hayes, 'Substance use disorders in prisoners: an updated systematic review and meta-regression analysis in recently incarcerated men and women', *Addiction*, 2017, vol. 110, no. 10, pp. 1725-39.

Garaycoechea, Juan et al, **'**Alcohol and endogenous aldehydes damage chromosomes and mutate stem cells**',** *Nature,* 2018.

Health*info*Net, *What details do we know about the indigenous population?*¸ 2015, *http://www.healthinfonet.ecu.edu.au/health-facts/health-faqs/aboriginal-population* accessed 2 December 2015.

Hepatitis Victoria 2018, *Be Free from Hep* C, https://www.hepvic.org.au/page/1135/be-free-from-hep-c accessed 26 October 2018.

Hendrie, D, '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.

Hendrie, D, 'With prescription opioids seemingly ubiquitous, why is heroin making a comeback?', Royal Australian College of General Practitioners, 8 July 2019, https://www1.racgp.org.au/newsgp/clinical/with-prescription-opioids-seemingly-ubiquitous-why accessed 15 January 2020.

Hendrie, D 'Advocates hail 'game changing' PBS listing of buprenorphine,' Royal Australian College of General Practitioners, 26 August 2019, https://www1.racgp.org.au/newsgp/clinical/advocates-hail-game-changing-pbs-listing-of-long-a accessed 2 December 2019.

Hughes, C 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.

Hunter, B 2011, *Older people and alcohol and other drugs*, Prevention Research Quarterly, Australian Drug Foundation, http://www.druginfo.adf.org.au/reports/prq-older-people?utm_source=ADF+Master+List&utm_campaign=b76e104a1b-DrugInfo_email_alert_11_09_2013&utm_medium=email&utm_term=0_fe135ee49e-b76e104a1b-306436061 accessed 21 October 2013.

Jamieson, A, *Coronial finding into the death of Samuel Jack Morrison*, Coroners Court of Victoria, 2018.

Kelsall, J, King, T, Kirwin, A, and Lord, S, *Opioid pharmacotherapy fees: A long-standing barrier to treatment entry and retention,* CREIDU, 2015.

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.

Larney, S 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.

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

Manning, V 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, pp. 177-189.

Marel, C et al, *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*, National Drug and Alcohol Research Centre, University of NSW, Sydney, 2016. https://www.health.gov.au/internet/main/publishing.nsf/Content/F669373C89CBFF50CA257FCD001658E2/$File/Comorbidity-Guidelines-2016.pdf

McGowan, M, 'Australia's rural drug use tops city consumption: crime commission analysis', The Guardian [website], 28 October 2019, https://www.theguardian.com/australia-news/2019/oct/28/australias-rural-drug-use-tops-city-consumption-commission-analysis, accessed 21 January 2019.

Mental Health Australia, *Joint Letter regarding PC review of NDIS*, 19 May 2016, , http://www.vicserv.org.au/images/Joint_letter_regarding_PC_Review_of_the_NDIS_Mental_Health_Australia_and.pdf accessed 27 September 2016.

Minkoff, K, 'Developing standards of care for individuals with co-occurring psychiatric and substance use disorders,' *Psychiatric Services* no 52, 2001, pp. 597–599.

Mugavin, J and Berends, L, *Older wiser lifestyles (OWL) programs evaluation final report*, Turning Point, 2013.

Nam, Y.H., Shea, D.G., Shi, Y., Moran, J.R., 'State prescription drug monitoring programs and fatal drug overdoses'. *American Journal of Managed Ca*re, vol 23 no 5, 2017, pp. 297-303.

Nambiar, D, Spelman, T, Stoove, M and Dietze, P 2018, 'Are people who injecting drugs frequent users of emergency department services? A cohort study (2008-2013)', *Substance use and misuse*, vol 53, no 3, 2018, pp 457 – 465.

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.

National Health Service, *Treat addiction, cut crime*, National Treatment Agency for Substance Misuse, United Kingdom, 2012.

National Institute on Drug Abuse, *Overdose death rates*, USA, 2018, https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates accessed 9 October 2018

National Rural Health Alliance, *Illicit drug use in rural Australia*, Fact Sheet 33, 2015, http://ruralhealth.org.au/sites/default/files/publications/nrha-factsheet-illicit-drugs-0615.pdf accessed 26 September 2016.

National Treatment Agency for Substance Abuse 2012, *Cost benefits of investing early in substance abuse treatment*, 2012, http://www.whitehouse.gov/sites/default/files/ondcp/Fact_Sheets/investing_in_treatment_5-23-12.pdf accessed 7 November 2014.

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

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.

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.

Office of National Drug Control Policy, *Alcohol and drugs prevention, treatment and recovery: why invest?*, Public Health England, 2012, http://www.nta.nhs.uk/uploads/why-invest-2014-alcohol-and-drugs.pdf accessed 7 November 2014.

Parliament of Victoria, *Inquiry into the supply and use of methamphetamine in Victoria*, 2 vols, Law Reform, Drugs and Crime Prevention Committee, Melbourne, 2014.

Payne, J and Gaffney, A 2012, *How much crime is drug or alcohol related? Self-reported attribution of police detainees?*, Australian Institute of Criminology, No. 439, Canberra.

Penington Institute, *Chronic Unfairness*, Penington Institute, Carlton, 2015.

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

Premier of Victoria, 'More rehab beds for Western Victoria' [media release], 23 January 2019, https://www.premier.vic.gov.au/more-rehab-beds-for-western-victorians/ accessed 5 November 2019.

Premier of Victoria 2016, *Greater Transparency for Mental Health Services,* Victorian Government, press release, 23 November, *http://www.premier.vic.gov.au/greater-transparency-for-mental-health-services/*

Premier of Victoria 2018, *Grampians alcohol and other drug rehab beds soon to open*, [press release] 5 July 2018, Victorian Government, https://www.premier.vic.gov.au/grampians-alcohol-and-other-drugs-rehab-beds-soon-to-open/

Productivity Commission, *Economic implications of an ageing Australia*, Commonwealth of Australia, 2005, http://www.pc.gov.au/__data/assets/pdf_file/0006/13587/ageing1.pdf accessed 18 October 2013.

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

Reeve, R et al, 'Evaluating the impact of hospital based drug and alcohol consultation liaison services', *Journal of Substance Abuse Treatment*, Vol 68, 2016, pp. 36 – 45.

Ritter A, et al, '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.

Ritter A, Chalmers J and Gomez M, '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, pp. 42-50.

Savic, M., Best, D., & Manning, V. 'Strategies to facilitate integrated care for people with alcohol and other drug problems: a systematic review', *Substance Abuse: Treatment, Prevention, and Policy*, vol 12, no 19, 2017.

Taylor, M 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.

Victorian Alcohol and Drug Association, *Challenges & opportunities: key findings from VAADA's alcohol and other drug (AOD) sector recommissioning survey*, Victorian Alcohol and Drug Association, Collingwood, 2015.

Victorian Alcohol and Drug Association, *Sector Survey – state budget*, Victorian Alcohol and Drug Association, Collingwood, 2017.

Victorian Alcohol and Drug Association, *Sector Survey – state budget*, Victorian Alcohol and Drug Association, Collingwood, 2018.

Victorian Alcohol and Drug Association, *Sector Survey – state budget*, Victorian Alcohol and Drug Association, Collingwood, 2019.

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.

Victorian Auditor-General, *Managing Drug and Alcohol Prevention and Treatment Services*, Melbourne, 2011.

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

Vishwanath, T et al 'A narrative review of Pharmacotherapy Treatment for Opioid Addiction and Application in a Community-Based Model in Victoria, Australia', *International Journal of Mental Health and Addiction*, 2018 https://www.researchgate.net/profile/Tejaswini_Patil4/publication/325583485_A_Narrative_Review_of_Pharmacotherapy_Treatment_for_Opioid_Addiction_and_Application_in_a_Community-Based_Model_in_Victoria_Australia/links/5ba4276e92851ca9ed1a0d0c/A-Narrative-Review-of-Pharmacotherapy-Treatment-for-Opioid-Addiction-and-Application-in-a-Community-Based-Model-in-Victoria-Australia.pdf accessed 15 January 2020.

Whittaker E, et al, 'Multiply disadvantaged: Health and service utilization factors faced by homeless injecting drug consumers in Australia', *Drug and Alcohol Review*, vol. 34, no. 4, 2015, pp. 379-387.

Willoughby, M, S Biondo and J Young, 'Improving health and preventing mortality among justice-involved homeless people with substance use issues', *Parity*, vol. 32, no. 6, 2019, pp. 17-21.

Young J et al, , Dual diagnosis of mental illness and substance use disorder and injury in adults recently released from prison: a prospective cohort study, *Lancet Public Health* vol 3, 2018, e237–48.

Young, J, 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.

Zlodre J and Fazel S, 'All-Cause and External Mortality in Released Prisoners: Systematic Review and Meta-Analysis', *American Journal of Public Health*, vol 102 no 12, 2012, pp. e67-e75.

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