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PANDEMIC DECLARATION ACCOUNTABILITY AND OVERSIGHT COMMITTEE

Review of Pandemic Orders

Melbourne—Friday, 13 May 2022

MEMBERS

Ms Suzanna Sheed (Chair)
Mr Jeff Bourman (Deputy Chair)
Mr Josh Bull
Ms Georgie Crozier
Mr Enver Erdogan
Ms Emma Kealy
Ms Harriet Shing
Ms Vicki Ward
Mr Kim Wells

DRAFT

Necessary corrections to be notified to executive officer of committee

WITNESSES *(via videoconference)*

Mr Sam Biondo, Executive Officer, and

Mr Dave Taylor, Policy and Media Officer, Victorian Alcohol and Drug Association.

The CHAIR: I would like to first of all welcome our witnesses today from the Victorian Alcohol and Drug Association: Mr Sam Biondo, Executive Officer, and Mr Dave Taylor, Policy and Media Officer.

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I would like to welcome you all and just introduce you to the committee members that we have with us presently. I am the Chair. We have Ms Crozier in the room, Ms Emma Kealy, Mr Enver Erdogan, Mr Josh Bull and Mr Kim Wells.

I invite you to start by giving a 5-minute presentation in relation to your organisation.

Mr BIONDO: The Victorian Alcohol and Drug Association is the peak organisation for the treatment sector across Victoria. There are approximately 100 services operating in the public system and 2000-odd staff that work in them. We have a range of staff ranging from addiction medicine specialists and psychiatrists to psychologists, nurses, doctors, social workers and peer workers. It is an amalgam of staff with a range of skills working in a psychosocial supportive way and connecting with many other services. That is a general overview of the Victorian treatment system. We have also a range of residential rehab services and detox facilities that operate across Victoria. In terms of a general statement, do you want me to commence that now?

The CHAIR: Yes. Thank you.

Mr BIONDO: Okay. We are very grateful for the opportunity to be presenting today. I would like to commence by acknowledging the traditional owners of the land we are on and meeting on today. I would like to pay my respect to all Aboriginal and Torres Strait Islander people attending today as well as to their elders past and present. I acknowledge that this land was stolen.

The impact of the pandemic and the successive pandemic orders on the alcohol and drug treatment sector has been quite significant. I will work through a number of policy areas as well as the broad issue of changes in sector demand and capacity during the pandemic. Our comments should not be taken as criticism nor as being in support of the pandemic orders; we are neutral. We appreciate the difficulties of rapidly negotiating a highly complex and evolving environment and the challenges in responding to the pandemic.

Overall the pandemic has changed the relationship many people have with alcohol and other drugs, and throughout the heightened periods of restrictions we saw changes in the way people would access services. We saw changes in the composition of substances which people were presenting with, underscored by sector feedback noting that alcohol as the primary drug of concern has increased. We also saw changes in how people were using substances. We know that crisis impacts the use of substances amongst those immediately affected, and we know from research conducted after such crises, such as Black Saturday or the Queensland floods, that people living in impacted areas consume substances with greater frequency long after the crisis has abated. So there is no new knowledge in that. It is proven, there is evidence around it and it has been repeated in nature over many, many years. For instance, in the Queensland floods people in the affected areas were 5.2 times more likely to increase their alcohol consumption, and with Black Saturday a greater proportion of people in the acutely affected areas were drinking at risky levels compared to those residing in low-impact areas.

While the pandemic is a unique type of crisis, we have become aware of some concerning trends. We also note that with the pandemic everyone everywhere has been impacted. While the reporting on the relationship between alcohol consumption and the pandemic has been mixed at a population level, our agencies have seen an increase of consumption amongst those at acute risk. The surging profits from alcohol companies coupled

with the increased access through the proliferation of home delivery indicate that there were a lot of people bulk-buying alcohol for consumption at home during these restrictions. Alcohol manufacturers and retailers have made a 29 per cent increase from 2019 to 2021, amounting to an additional $3.6 billion of alcohol retail sales. The number of people calling helplines for alcohol doubled in that period. We are aware of online liquor traders who offered a discount for purchases made during restrictions. It seems that during the height of COVID alcohol was seen an essential item, and the liquor trade sector was clearly profiting off many people drinking at home, often alone.

I must say I had a conversation with my wife last night, and we reflected on the nightly gin. That tradition has actually remained, and it was not that common pre COVID but it has continued on. For some people who are not as resilient, they consume a lot more. It is just a personal reflection, but it is one that I think is repeated across the community. A VAADA survey of funded treatment agencies has indicated that 70 per cent of treatment agencies noted an increase in the prevalence and severity of alcohol presentation. It was just this week that a colleague from our sector indicated their agency is more regularly seeing clients presenting who are consuming 40 standard drinks-plus on a daily basis. That is an enormous level of consumption. Worryingly, fatal overdose data from the Victorian Coroners Court reveals that 2020 had the highest number of women fatally overdosing from alcohol and, more generally, the highest number of overdoses where alcohol was the sole contributing drug. This Coroners Court data goes back to 2010. Alcohol and other drug treatment agencies relayed to us during this time that there was an increase in the number of people relapsing as well as people who had not previously attended treatment but presented concerned about the alcohol consumption during the pandemic.

Mid to late 2020 saw a reduction in illicit drugs, often sourced through international means, such as heroin and methamphetamine. In both cases, as supplies diminished the price increased and purity decreased. This resulted in people shifting to other substances seeking support, such as opiate replacement therapy or treatment and continued use of a less pure product.

We ascertained early in the pandemic that with policing activities related to breaches of restrictions there was a disproportionately large number of people in breach who were also charged with lesser substance-related offences. While it is hard to know what level of profiling was occurring, this demonstrated that there was little contingency in place to support people potentially experiencing dependency and safely adhering to the restrictions. We have seen an increase in the use of a number of other substances, such as cannabis and GHB, as well as the rise of novel benzodiazepines which typically seek to replicate those benzodiazepines which are accessible via script and which have had a long-time impact on the Victorian death rate as well. Earlier in the pandemic, agencies and other health services reported an increasing prevalence of GHB and related harms. We remain uncertain as to whether the use of this substance was accelerated by COVID-19 or already an emerging trend. Treatment agencies have indicated an increase in the presence of these novel benzos throughout the pandemic, during which we have seen a dramatic increase in fatal overdose involving these substances, and it goes from zero deaths in 2017 to 28 deaths in 2020. We await with trepidation for what the 2021 coroner's data may reveal, but I suspect it will be higher.

It is difficult to say how the various peaks and troughs in restrictions impacted on people's motivations to seek help. It is perhaps intuitive to think that many would have sought to remain at home and put off help-seeking behaviour during the most stringent restrictions, perhaps seeking support as the restrictions eased. Overall treatment demand has increased throughout the pandemic. VADA sector surveys seeking to capture the length of waiting lists indicate in September 2020 there was a daily waiting list of 2385 people across the state, and this increased by 50.9 per cent in July 2021 to 3599 people. That is an upward trend which, on what we are hearing, is continuing. We anticipate that these figures will become available later this month, and we can make that data available to the committee.

Agencies have also reported an increase in mental health, family violence and pandemic-related concerns amongst those presenting for treatment. In 2021 VADA surveyed Victorian AOD treatment agencies, and we were informed that 95 per cent had indicated an increase in mental health co-occurrence to treatment, 90 per cent indicated an increase in COVID-19 factors in treatment demand and 75 per cent indicated that there was an increase in family violence impacting upon treatment demand.

During the restrictions, residential rehabilitation and associated withdrawal services experienced an approximate 20 per cent reduction in capacity due to limited infrastructure and the space available in services,

layout limitations and staffing issues. In light of Victoria having the second-lowest per capita residential rehabilitation bed capacity in the country, the impact on wait times was dire. Unfortunately, reporting this can be difficult, as people often drop off waiting lists in frustration or due to a range of reasons their use would escalate and the small window of opportunity to seek help would slam shut.

Earlier this year, when the omicron wave was at its peak, a number of residential withdrawal services had to temporarily shut down. This was due to staff being infected, being close contacts or having clients attend who were infected. This created further significant blockages in our service system and service access for those seeking support such as resi rehab. These bottlenecks exacerbated pre-existing capacity deficits that continue.

Like many health services, previously face-to-face support such as counselling had to be provided through a telehealth or online mode of delivery. There has been no clear consensus from the sector regarding a preference for this means of delivering, but there is an overall view that it should remain an option. The online option means that for some people it was easier for them to attend, and for them there were greater completion rates and participation, including amongst forensic clients being directed to us from the justice arena. While this has held promise for outcomes, because positive outcomes from treatment are dose-related, meaning greater engagement results in better client outcomes, it nevertheless contributed to a blowout in wait times as a far greater than anticipated number of people were in treatment for longer. Online means of treatment are also problematic for some clients who may not have had consistent online or telephone access or who may have sensitivities regarding where they live and what they can say.

Outreach services were heavily curtailed during the restrictions, impacting upon those who may not engage in face-to-face or telehealth treatment. Outreach is a staple for youth AOD support, and we wait to see the impact the curtailment of this service type has had during the restriction period.

We are also aware of increasing demand for family support during the pandemic, no doubt heightened by lengthy periods in which people were living in close proximity. During the pandemic, closing the waiting list for treatment became more frequent, with a more common refrain of agencies being that they had to close the counselling books for a couple of weeks. This was not isolated to a single region or agency, rather becoming increasingly ubiquitous throughout this pandemic period.

The CHAIR: Sam, are you getting near the end? Because we are all keen—

Mr BIONDO: No, I am about two-thirds through.

The CHAIR: I wonder, can we just move to asking you questions, because it has been almost 15 minutes.

Mr BIONDO: Yes.

The CHAIR: I think probably you are answering a lot of the questions we would like to ask, so perhaps we will move to the questions. Feel free to refer to anything that remains there in responding to the questions. We have all got about 8 minutes each to ask you some questions, and I will perhaps start.

It is pretty clear that the impact has been very significant. I am just wondering, given that we are tasked to look at the orders—you know, their impact on people's human rights and the like—but that they have been very progressively wound back, and significantly, whether you can describe what the situation is at the present time for you under the existing situation, which is much less restrictive of course. I suppose when I ask that it is in terms of all those agencies and organisations—how are they going in getting back to some sort of way to operate that is effective?

Mr BIONDO: Overall, referrals are continuing to accumulate in waiting lists around the residential rehab and detox services. Many agencies and general community treatment services have also got waiting lists across a range of areas. Those figures in the thousands that I mentioned are continuing on persistently, so there is a continuing backlog. We are very concerned around the court waiting lists of 100 000 people, because approximately 10 000 people a year enter our service system annually from the forensic area. That waiting list will create further congestion, we expect. Coupled with the hopeful sign that we actually received funding during the COVID period to increase the number of staff in the sector—and there was somewhere between 100 and 125 people taken into the sector and some fast-track training established to put them into the field—that funding was removed in the last budget, so we will lose that. That is concerning in light of the potential—I do

not know whether to call it cannibalisation or identification of the valuable skills that our workforce has for the mental health system as it grows, which makes it an easy touch to absorb our people at a much higher wage level into that sector, which would leave the community-based system in a definite diminished state. These are all issues that just seem to be compounding as a result of COVID. It has really been quite problematic.

The CHAIR: Sam, just on that issue of staffing, are you finding that it is very difficult in your organisations to recruit the people you need to fill positions, and is that different in metropolitan areas as compared to regional areas?

Mr BIONDO: There is obviously great difficulty in recruiting people in regional areas. It is difficult enough to get them in the city—in the metropolitan areas. We have a range of staff, and at different levels it is really difficult to get them. You cannot find an addiction medicine specialist or a psychiatrist specialising in addiction. It is very difficult to get psychologists coming into our sector. This week we were speaking to a nurse prescriber who is one of those 100 who is possibly going to lose their position. They do not grow on trees. They have really put in eight years of hard labour to get where they are. We are fortunate that they have come in, but we may end up losing them. This is all setting us up for great complexity in the near future, and the rural and regional workforce strategy is problematic. It is like we need an industry plan to actually help sort out a range of pipeline blockages and workforce issues in the AOD system in Victoria.

The CHAIR: Thanks, Sam. We are hearing that very widely—that recruitment is such a challenge across so many areas. I am just wondering, and I think you have probably answered it: just in terms of people who were on programs—say you were on a methadone program during the pandemic—did a lot of people just drop off, drop away because of the inability to access ongoing prescriptions and treatments that they needed during those times, or were there facilities put in place?

Mr BIONDO: It took a couple of weeks and months. There were some innovations brought about in the pharmacotherapy arena, such as the introduction and increased use of takeaways to people's homes with methadone so they would be able to get a script and have less frequent visits to a pharmacy. We also saw the coincidental introduction of long-lasting injectable buprenorphine that could last for a week or up to a month for some people depending on the form they took. These are all welcome innovations which we hope can be maintained into the future. However, for some they still went out onto the street and, as I described earlier, ended up with fines, seeking substances wherever they could.

Mr TAYLOR: Can I add to that?

The CHAIR: Go on.

Mr TAYLOR: Can I add to that also that with those welcome changes to Victoria's pharmacotherapy system, where there was basically greater access to takeaway dosing and so forth, we saw a reduction in fatal overdoses involving methadone. Typically the thought has been that easing access to those substances runs the risk of increasing overdoses, and that has not happened; it has been the opposite. So that has been a very welcome change and strong evidence that we can seriously consider maintaining these eased modes of access to pharmacotherapy.

The CHAIR: Thank you. I am just wondering what particular challenges—in the little time I have left—your organisation has had as a peak body in sort of maintaining your role across the sector and keeping in contact with agencies and doing the work that you needed to do.

Mr BIONDO: We had some of these systems in place. We often get our CEOs together. We pivoted across to online fairly rapidly and created the means for people to have the conversation of how they were going to tackle issues. We worked with the department to identify key areas that needed intensive, careful attention, and there was a collaboration between us as sector representatives and the department to come up with possible solutions. We became an early warning system. That was a two-way warning system, both from the sector to the department and from the department to the sector, and we often held broader events just to keep everyone in the loop.

The CHAIR: Thank you. I will move now to Ms Ward for questions. No, sorry, she is not with us—it is Josh. Thanks, Josh.

Mr J BULL: Thanks, Chair. Thanks, Sam and David, for presenting to the committee today and for a really comprehensive introductory statement. As the Chair noted, I think many of the questions that I have for you both you have covered quite well in the introductory remarks. But I did just want to take the opportunity to thank you and the team and everyone that has been involved for the critical work that you have done over these past 2½ years, because it has been a very challenging time for our state and indeed the nation. I just wanted to take the opportunity to thank you both, and if you could pass that on to the team, that would be terrific.

I wanted to ask you both about the royal commission into mental health. There has been a significant investment—over $5 billion—over two budgets into mental health within this state, on the back of the royal commission. I wanted to get a sense of your view on not just the royal commission but on the investments that have resulted from the royal commission, what engagement you have through that process and I guess the ongoing engagement, which, Sam, you spoke about, with the department.

Mr BIONDO: Other than occasional conversations with the department I do not have any engagement on the mental health royal commission. We do have a staffer who is involved in aspects of their integration and guidance framework development. We received some funding—substantial funding, I must admit—to put that skilled officer in place, and we are very grateful for that. There are committees that we have created to try and work internally with the sector focused on mental health issues and developments, as well as cross-sector committees which we have instigated to try and keep people in the loop. While there is a lot of talk in the integration framework about the [Zoom dropout] most of the funding goes into the mental health side. It is a different language, a different approach.

The Victorian alcohol and drug system for a number of years has actually done what I think is some really good work, which was identified by the royal commission, around the diagnosis of co-occurring issues in our sector. We have tended to work via a psychosocial approach rather than working with the diagnosis-only approach that the mental health system seems to have adhered to, and the royal commission rightly identified that the mental health sector needed to adapt to incorporate some of this approach in their thinking.

However, I am concerned that the AOD sector, because of our size being so minute compared to mental health, may—how do I put this politely? It is like getting into bed with a bear. You do not know what is going to happen. It can be very uncomfortable. But you know, we have to talk these things through because many, many people in our sector see the value of working in a collaborative approach to deal with co-occurring care in a care-coordinated manner, and it is important to do so. We just need to find our way through the paperwork and all the developments going forward.

Mr J BULL: And the bear needs to be kind and respectful and work with you and the important work that you do. So that is a very good description. Thank you.

I wanted to just ask about the organisation's work—you mentioned that you pivoted through COVID and some of the work that was done online. It builds on the Chair's question around the support for the individual and how those challenges were met, because obviously the support that you provide is critical to recovery and to rebuilding in many respects. But I want to get a sense of how that challenge was overcome or in some instances perhaps not overcome through the height of the pandemic, 2020 and 2021.

Mr BIONDO: It was not solely an endeavour of pivoting once, it was continuously adapting and changing and finding a balance in how you deliver. You know, to welcome donations of some phones is good, but then you have to create a process around phones so people can have access to online support. Some got it, some did not. Some did not want to use it, because they did not have a place to speak freely. Some were embarrassed about where they were living. So there was only so far you could go in this, and you had to find other means of engagement.

There was a whole range of issues around access to PPE, and then there were a range of issues of whether we were eligible or not. While we are sort of ostensibly part of the health system, for some things we are and for other things we are not, and that was a constant through this. With goodwill, both at the department and ours, we got through most of it. But there was a degree of discomfort on an ongoing basis about, 'Are we part of this? Are we not?', 'What's happening with this?', 'Where can we get access?', 'Who do I speak to?'. There was a lot of good work done at the departmental level and at our level, and I am glad we are through the worst of it, hopefully.

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Mr J BULL: That is very pleasing to hear that those conversations and those challenges were in many instances overcome. You mentioned in your introduction the home delivery of alcohol. I know in my community it is something that has changed over the past couple of years and the availability of shop-to-door services. What are your thoughts in terms of regulation in that space?

Mr BIONDO: As I have said publicly and on radio, I am not a wowser, but I find it somewhat perplexing that, on the back of a royal commission recommendation in the family violence space a few years ago, there was one recommendation which required us to look at liquor control, and that led to extended availability of alcohol into people's homes and takeaways. So the end result of that is obviously there will be more people attending—due to family violence—our facilities, as I tried to describe, as our agencies are describing. There are a number of issues in the alcohol and drug space: one is we need the means to actually do the treatment effectively; the other is we need pragmatic policies that can make a difference. And often the pragmatic policies I think are really difficult for governments to tackle and do the right thing, so the consequence of that is it lands with us in an impoverished system with not enough staff and with all the complexity that goes with it. And we do not wear uniforms, so we do not get what we deserve to get to work with these people's lives.

Mr J BULL: I completely—

The CHAIR: Josh, your time is up, but Dave, if you want to make a contribution, please do.

Mr TAYLOR: I was just going to very quickly mention that the alcohol industry has really capitalised on the pandemic with its marketing activities. Those profits, which Sam mentioned in his opening speech, have not been accidental, and we know—there has been strong evidence for a number of years—that there is a small portion of people who drink at very heavy levels who are consuming a huge amount, and little has been done to address those harms. We are seeing that at our doorstep, and certainly the agencies I talk to; we hear that as a constant refrain, week on week.

The CHAIR: Thank you. We will go down to Ms Crozier.

Ms CROZIER: Thank you very much, Chair. Thank you both very much for being before the committee this morning. We do appreciate your time and the evidence you are providing to us, very important evidence. Mr Biondo, you said earlier that there were changes in consumption of substances that people were presenting with, and you have just spoken, Mr Taylor, about the alcohol consumption. Throughout COVID when we were in lockdown—and there was lockdown after lockdown, and we know that there was despair, we know that the mental health impacts were very significant—what was your feedback to government about the impacts of lockdown and your concerns regarding an increase in the consumption of alcohol for Victorians who had to experience those continual lockdowns?

Mr BIONDO: We regularly do state budget submissions and submissions on particular issues. We have incidental contact with the department and discuss whatever is happening, and we were reporting this sort of issue as well. Certainly conversations around GHB, other substances being used, impacts on services, waiting lists growing, the need for more staff—they are all things that have been discussed and put forward to the government.

Ms CROZIER: You talk about having incidental discussions, but—

Mr BIONDO: Well, it is regular, sorry.

Ms CROZIER: I appreciate that. They are very serious issues that you are raising. You have said how the trends are increasing in consumption, yet you are just having incidental discussions about these impacts. What was the government's response to you? I cannot understand, if it was such a big issue—the impact that these lockdowns were having—and you were having those discussions regularly, why they were not doing something about it or taking that on board more seriously. Because now what you are seeing, and I presume what you were saying, is this is going to have a greater impact on the services, as you have described, because you were seeing it. You were actually watching those trends occur.

Mr BIONDO: Yes. Well, we have been party to other groups and working with them in putting forward positions on these issues as well, particularly around the alcohol situation. The government was informed of what our concerns have been.

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Ms CROZIER: Did they respond, though? What I am trying to get at is, we have got evidence now of the profound impacts of the continual lockdowns. Did they listen to you? Did government listen to you?

Mr BIONDO: Well, not as much as they should have.

Ms CROZIER: Right. Thank you.

Mr TAYLOR: Ms Crozier, we have made a number of media statements. As Sam mentioned, there have been budget submissions. So we have, I think as robustly as we can, put forward our positions, our concerns, and the evidence we have been seeing and what our agencies have been seeing to government. You know, there have been a number of items in the budget—most notably the 100 workers, which has sadly just concluded.

Ms CROZIER: Thank you. Budget submissions are one thing, but you are living this day in, day out. You were seeing the trends throughout the last two years. My point is that you have said you were having these incidental, frequent discussions with government about what was going on and they did not act. You just admitted that. So I appreciate the submissions. I appreciate the frustrations, because I think, as you have alluded to, this issue is not going away. You are dealing with a very significant issue. We just heard from other witnesses this morning—the Shadow Pandemic—who were talking about teachers, parents, paediatricians, doctors, psychiatrists and children, of the impacts on children. I am interested if you have seen a change in the cohort of your consumers as described by some of the previous witnesses this morning?

Mr BIONDO: There is a range of new consumers coming in, a range of older consumers attending more frequently. So, yes, there have been those changes.

Mr TAYLOR: We have had feedback that there has been an increase in—some agencies have reported—mums and dads who may have found themselves increasing substance use or who have may have been on the cusp earlier and have increased their use now and they are now seeking help. We have also had feedback, anecdotal from our agencies, that there has been an increase in relapse of people who were previously in recovery. These are concerns we have relayed to government.

Ms CROZIER: Thank you very much. I think you are right. I think there is this major concern, and as you said, the trends are there. It will be interesting to get those figures that you spoke of. When are those figures that you said were due out—the increase in the helplines; I think it has doubled in 2019–20—due to be released?

Mr TAYLOR: The increase in the helplines, that is national data with regard to alcohol consumption. That data is available and I can find that and source that for the committee if that is desired.

Ms CROZIER: Is it broken down by state, if it is national data?

Mr TAYLOR: I have seen the national figures. There would be state figures, and I can have a look at that as well on direct line, which is our helpline, which we could look at. I can provide that afterwards if that is what people want.

Ms CROZIER: I think it would be helpful for the committee to understand the trends that you are describing, so if we could see that, that would be very helpful. Thank you very much.

There was one other thing I wanted to mention. You mentioned the increase in benzos and other prescription drugs. Certainly I was hearing from pharmacists who were really concerned about women who were presenting with prescriptions—you know, young women in their 20s and 30s—and they described to me their concerns about how, as the lockdowns went on, those numbers increased. Is that your experience too?

Mr BIONDO: We have heard anecdotally of a lot more prescribing going on. We are also aware that many people that are getting red-flagged by the SafeScript system have been, let us say, less than adequately dealt with by medical practitioners and find themselves in a state where we do not know what they do, because there has been no research undertaken with people that have been red-flagged. We have sought formerly, on earlier occasions, that there is a need to research what happens to these people after they get red-flagged. How are they treated? Where do they go? Do they go to the street? Do they go online?

Ms CROZIER: Or in the EDs, in the emergency departments, I suspect.

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Mr BIONDO: And do they go to ED once they access other sources?

Ms CROZIER: I think I am out of time. Am I?

The CHAIR: Pretty much.

Mr TAYLOR: Coronial data indicates that traditionally pharmaceuticals, of which most are on SafeScript, contribute to about eight in 10 fatal overdoses. That trend has maybe gone down to around 7.5 in 10, so it has not made the difference which maybe we would have anticipated. In the absence of any forthcoming data, it is hard to know what the expectations of that program are.

Ms CROZIER: Thank you both very much.

The CHAIR: Thank you. We will now go to Mr Erdogan.

Mr ERDOGAN: Thank you, Chair, and thank you, Sam and Dave, for joining us today and giving the perspective of the Victorian Alcohol and Drug Association to the committee. There has been a lot of discussion about the impacts of the pandemic, and obviously increases, anecdotally at least, in alcohol and drug issues since early 2020 is an Australia-wide issue. So it is not only in Victoria that we have heard that; in other jurisdictions there have been spikes in these issues. What measures do you think have worked during this pandemic to alleviate this issue? Like I say, have you seen a change in the models of delivery of services or treatments that have assisted?

Mr BIONDO: Agencies are constantly looking at ways to make things work with the limited resources they have got. Our system has no hope of being able to meet the community demand that is required. Nationally there are 200 000 to 500 000 people that need to access the treatment services every year. I think some of the things that were tried during the pandemic period are great innovations—the telehealth is a great thing to maintain and have access to. It does not necessarily solve all issues, because you actually work differently face to face with someone. We think that the takeaways in the changes to the methadone availability are really important. We think that the long-lasting buprenorphine is a great program to be extending further. Often these are done on the smell of an oily rag and in the pharmacotherapy area at great expense, often to the individual, the recipient.

Mr TAYLOR: I might add also there was a little-known program. When a lot of the people early in the pandemic were supported with temporary housing in various hotels, there was an in-reach program which was largely unfunded and was providing people support to get on pharmacotherapy, support with treatment for illnesses such as hepatitis C, among a cohort who may not have otherwise sought help. So there were opportunities to perhaps increase health support to some folk which would not otherwise have been made available. So whilst that is, I guess, a welcome silver lining, it would be good to see those sorts of endeavours funded going forward, and I am very happy to provide further details to the committee on that.

Mr ERDOGAN: Thank you for that. Talking about models of delivery, are there examples in residential care that have been, I guess, enhanced through this process?

Mr BIONDO: There has been growth in the number. There have been some recent announcements about additional beds coming on stream through launches and openings in different rural-regional communities. Overall that is very welcome, and it is a big investment, but we still find ourselves second from the bottom on a per capita basis nationally, which has been a persistent feature for many years.

Mr ERDOGAN: The way you described it was interesting—the competing interests between mental health and alcohol and drug issues.

Mr BIONDO: Well, I do not know whether they are competing interests, but certainly we have a lot in common. A lot of the people that visit AOD services have a mental health issue. I would say maybe 70 or 80 per cent of the people we see—do not quote me, but it is a very high proportion—would have some form of mental health issue. We deal with largely anxiety and depression. In the mental health area a large proportion of the people they see would have an AOD issue, but they are not as well prepared or do not have the appropriate means to deal with the alcohol and drug issue. Largely schizophrenia and psychosis end up within the mental health system. We get this debate about fixing up your drug problem before we fix up your mental health

problem. We do not have the capacity to do the intensive work for the more complex mental health clients in our system, because as you can see, it is stretched as it is just for the ones that are the standard—

Mr ERDOGAN: Yes. You have already made some suggestions, but what other recommendations do you have that we as a committee can take on board that can address some of the alcohol and other drug addiction impacts of the COVID-19 pandemic?

Mr BIONDO: We need to invest in people, infrastructure and access. It needs to occur across the state. It is not just a metropolitan problem, it is a rural-regional problem. We need to ensure that there is a workforce that is trained and continuously skilled up to achieve this. Our workforce can work with other workforces quite effectively. There need to be greater collaboration and co-care arrangements put in place. We need to work with the courts, which are frustrated, and the justice system, which is frustrated with access to our system. We need to work with family violence services, where there is mutual frustration at the lack of ability for family violence services to take on our clients when they have an alcohol and drug issue. They often get turned away and end up going back to the perpetrator because there are no facilities able to take them. Likewise, there is only so much we can do if they have got children. I could go on. At each one of these levels there is a pipeline of work that comes our way. We need to straighten up the pipeline and ensure that there is a seamless offering for these individuals.

Mr ERDOGAN: I have one final question that came out of one of our earlier witnesses from the morning about the lived experience and importance of that. They referenced that in this respect the Self Help Addiction Resource Centre is an important body that we could also turn to. Are they a member of your association?

Mr BIONDO: I do not know who they are.

Mr TAYLOR: SHARC.

Mr BIONDO: Oh, SHARC. SHARC are a member, and we do work closely with them. As you may be aware, the Victorian alcohol and drug system was built on the back of people with lived experience. Some figures indicate that something like 60 per cent of the people working in the AOD sector have a lived experience to one level or another. In many ways that has been our strength, which was not necessarily reflected in the mental health side of things, and it is often forgotten that it was a self-help movement in the AOD space, frankly. I think that mental health is moving in that direction, and all strength to them, but it will take some years to establish those mechanisms internally.

Mr ERDOGAN: Thank you for that, Sam. My time is up.

The CHAIR: Thanks, Mr Erdogan. We will go now to Ms Kealy.

Ms KEALY: Thank you very much, Suzanna. Thanks very much, Sam and Dave, and to the people who work in your sector, because they have done an incredible job during trying circumstances over the pandemic, particularly through the lockdowns and restrictions.

Firstly, just some housekeeping: Sam or Dave, can you send through your opening remarks so that we may be able to table them, please—and if there are links to any statistics that you are able to provide—because if we have that evidence we are able to consider it in our final reporting. So if you could provide that, that would be greatly appreciated—please.

Mr BIONDO: Yes, no problem.

Ms KEALY: Thank you. We have heard a lot of evidence today that gives the impression that the government feel that the pandemic is over, and that has been felt through different organisations seeing that funding to COVID-based programs that would try and meet the surge demand over the pandemic would be met, and then that has been cut from 1 July. Would you say that the pandemic has ended?

Mr TAYLOR: No, at least not for those experiencing substance dependence issues. We are aware of evidence that habits can form, and they can be long lasting. And it might be that there are habits forming during the imposition of some of the restrictions that do not manifest in people needing clinical treatment for a number of years. So we are anticipating a pretty long sting in the tail with this, where there will be COVID-related demand generated for the sector in years to come, and that aligns with what Sam mentioned in his opening

comments about the Black Saturday fires and so forth and how increased usage continued beyond the expiration of that crisis. What we are seeing there leaves us with grave concerns that the 100 workers will be concluding later this year. We do not feel it is a time to be reducing alcohol and drug treatment capacity—amongst increasing waitlists.

Ms KEALY: Yes, it is concerning seeing that data around the increasing waitlists. The data that you have got here is that there were nearly 3600 in September last year. Is it fair to say the demand is still increasing? Are we still seeing an increase in demand for drug and alcohol support services, or is it starting to plateau?

Mr TAYLOR: We anticipate releasing some data very soon—to be able to share it with the committee—and we are anticipating that data will show a greater increase still.

Ms KEALY: For waitlists for rehabilitation in particular or for all support services and therapies?

Mr TAYLOR: The data which we have offered captures the aggregate waitlists for people waiting for all treatment types, from intake to assessment to counselling to residential withdrawal to non-residential withdrawal to residential rehabilitation.

Ms KEALY: Across the board.

Mr TAYLOR: Across the board, statewide, and it is conservative. It is based on agencies responding, and we do not always get a full response. If every agency responded, it would probably be marginally higher. All the big agencies have responded, so we are confident in its accuracy, but it would be a small underestimate.

Ms KEALY: I mean, is it fair to say, then, of the cut you got it in this year's budget last week, that 100 EFT of support workers sounds like exactly what people need? It could not come at a worse time, could it, to have that significant level of funding cut—nearly $40 million out of the sector?

Mr BIONDO: It is a massive disruption. Of course some of that relates to the postponement of the intoxication response—the decriminalisation of intoxication—but the bulk of it relates to this COVID project. Like some other COVID projects, they sort of draw a line under it. It is very concerning, as I indicated, in terms of replenishment. Because we have recruited, we need to replenish staff and we need to possibly build staff that have got skills and capacity to also work across into mental health. It does not look like it is anyone's consideration at this point. We are very worried about the future directions of the pressures on our Victorian workforce.

Ms KEALY: One of the focuses that we touched on today in the royal commission's report was around removing those silos between mental health and alcohol and other drugs. It is concerning that you have not been front and centre. Is that something that you have advocated to the minister on—to try and be more involved—particularly as, from recollection, recommendations 8, 35 and 36 specifically focus on better integration of AOD and addiction and the mental health sector?

Mr BIONDO: A lot of the focus that we are involved with is around this integration guidance framework that is being established. A large part of the conversation happens within the AOD sector to the AOD sector. At an agency level we have engaged with the mental health sector to converse around these integration issues, but I think they have got so much on their plate at the moment that it is from one thing to another, and the level of engagement may happen at some stage in the future. I think a lot of weight has been put into the establishment of the statewide service that Turning Point has received. That may move the discussion to a different level, though you would have to ask Turning Point what they are doing with it and government where they are going with it, because we have only got a sort of headline understanding.

Ms KEALY: Can I also ask around a number that you mentioned—there are 100 000 people on the court waitlist—what is the impact on the AOD sector from having court waitlists that are that long?

Mr TAYLOR: 116 000 according to the *Herald Sun*.

Mr BIONDO: It is probably more like 116 000 from what David has just pointed out. The impact on us is that a proportion of those will come our way. We do not know what the proportion is, because data to our sector is very, very poor. It is very difficult to model what comes our way. The department seems to be focusing on mental health increasingly and not necessarily on a whole range of issues that impact our sector,

such as this forensics issue or the pharmacotherapy system or you name it. There is any number of issues in our sector. So we would be grateful for a more in-depth conversation with justice and the department about how we are going to manage this workflow and whether it just comes on top of everything else we are seeking to manage. Given that we are losing staff, it looks really problematic.

Ms KEALY: Sam, I just wanted to ask as well around the impact on women. I think in your opening remarks you spoke about a record number of women fatally overdosing with alcohol in their system, which was reported by the Coroners Court of Victoria—if you can provide a link to that report for the committee's purposes. Have you seen an overall escalation in demand for AOD services by women?

Mr TAYLOR: Look, it is hard to know, Emma. In part we have to speak to agencies directly. Some I think have made comment along that regard. One of the concerns which we have is that we do not count those people who do not seek help, and there will be a lot of people who do not seek help because of stigma and so forth. I would hazard a guess that there might be a number of women and men who have children who might be reluctant to come to get help for fear that they might incur unwelcome attention from child protection. So it can be hard to know exactly what the impact is because there is no means to count people who do not seek support.

Ms KEALY: Yes, absolutely.

The CHAIR: On that note, Emma, you are out of time.

Ms KEALY: Thank you, Sam and Dave.

The CHAIR: We will move now to Vicki Ward. Thank you.

Ms WARD: Thank you. Thanks, Sam and Dave, for coming along today. Thanks for taking time out of a very stretched schedule. We really do appreciate you sharing your insight and lived experience—what you have seen on the ground—with us. Dave, can I circle back to what you were saying earlier around the housing supports that were given to people earlier on in the pandemic and the starting of wraparound services and how you would welcome the opportunity to elaborate on that a bit more and how that could be [Zoom dropout]. Is that better? Sorry. It is my wi-fi. I think I should be on the better wi-fi now.

Mr TAYLOR: I think I got the gist of the question. It relates to the earlier comments I made on when there were people experiencing homelessness and perhaps other issues who were temporarily supported with housing in the hotels. There was an interdisciplinary approach from a couple of agencies working together. My understanding was that there was an addiction medicine specialist and, I think, a peer worker and perhaps another worker, who I gather just doorknocked and spoke to a number of people who had otherwise experienced significant harms but never engaged with the system. And a small number of them were able to engage. You know, having people engage on pharmacotherapy or treat for hepatitis C or perhaps even more immediate things such as addressing issues such as vein damage and so forth, the value to the health system and to the wellbeing of people from providing these opportunities is really strong.

And so this program was something which, by my understanding, was cobbled together between a couple of agencies and largely unfunded, so it was internal initiatives from those agencies. It has obviously fallen away now because the circumstances have changed, but it was just an example of innovation and the right people at the right time and them responding to a particular crisis—a small silver lining.

Ms WARD: Thank you. But clearly something to learn from, though—there would have been learnings that agencies would have come away with from that experience around that integration of services.

Mr TAYLOR: I think so. Part of the issue was, I think, that at least the addiction medicine specialist was unfunded. I think the others were able to cobble together existing funding. Certainly there are learnings. It would be fantastic to be able to in some way, shape or form count the impact of that. But also to provide sustainability for these sorts of innovations we need to be able to pretty rapidly look at models of funding and support for the agencies doing this.

Ms WARD: Yes. Thank you. Now, there was $54.4 million in the budget for integrated care in health services, including alcohol and other drugs. Now, I know that from a clinical perspective it is less focused on

the work you are doing, but how can you see that you might be a part of that, or how would you tap into that in terms of how to utilise that in the best way for integrated services?

Mr TAYLOR: This is with relation to the mental health royal commission and activity there, so that probably includes elements such as the [inaudible] service in Traralgon; the facilities fund, where I think there was $5 million to $10 million; I think what Sam mentioned before with regard to the progression of activities which Turning Point will be leading. So I guess it is pretty early to tell how that will impact. Certainly there are elements there which we knew were coming with regard to the royal commission. It was obviously very welcome that the facilities fund was continued, because, I think as Sam intimated earlier with some of the issues which the sector is facing with regard to the pandemic, our services, residential services certainly, were not designed for social distancing—as a lot of services were not. So the provision of that funding in particular—the infrastructure funding I think it is called—is most welcome.

Ms WARD: Based on what you have both seen over the last two years and the feedback that you have had from the people around you, what would be your recommendations in terms of next steps for us as a community, as well as at a government level? What would you like to see happen to add to those supports, particularly around the integration and connection between mental health and alcohol and other drug dependencies?

Mr BIONDO: The impact of alcohol and drugs in the Victorian community, if not the Australian community, is all pervasive. It impacts not only on the individual but a whole range of people and the community around them. Currently I think the way in which many of our problems are dealt with is piecemeal. There is no national leadership or focus on alcohol and drugs. We have entered a stage in our existence where we see that recovery from COVID is an alcohol-led recovery—and it is spoken of in those terms.

We need to actually get our head around how we stop the damage and how we stop imprisoning people who have alcohol and drug issues only to come out uncared for, with a lack of housing and assistance to help stabilise them and reintegrate them back with the community effectively. We can learn from what places like the Netherlands and Norway have done with reintegration guarantees at least at that prisoner level, but we need to actually put in place a much stronger, much more comprehensive alcohol and drug system on the ground in Victoria, if not Australia. That requires partnership with the feds and an increased focus at the state level looking at the value of a much more strengthened pointy-end AOD system as well as how we work in that collaborative sense with other systems, including housing, mental health, women's services, youth services and the justice system. It is a big problem.

Ms WARD: Yes. Thank you. And just quickly, if I can tease from you the earlier comment—you said that the alcohol industry has really capitalised on the pandemic. Can you expand on that a little bit further, please?

Mr TAYLOR: Sam mentioned in his opening comments the profits which the alcohol industry has made, and throughout the pandemic we have seen calls from the industry to reduce taxes and so forth. We saw a debate about that most recently in the federal space a few months back, and thankfully that did not proceed with a cut to the tax on alcohol. Certainly in 2020 we saw people rushing to the supermarkets to buy toilet paper. When they had bought out all the toilet paper they rushed to the liquor stores to buy alcohol. The liquor industry was quick to say the following month's sales went down. Much like toilet paper, it did not mean they were not using the alcohol when they were not buying. They bought in bulk; it was being consumed through the pandemic, we suspect. It is a clever artifice of the figures by some to capitalise on their profits and to try to entice people to deal with the stresses of the pandemic and the restrictions through having a drink, even if it is on your own or with your family at an earlier time at home. And we know of people who purchase in bulk that if you have a whole lot of alcohol, you are probably going to drink more. That is why the industry rewards you through cheaper prices if you purchase in bulk.

Ms WARD: Yes. Just a quick one: have you seen an increase in alcohol advertising as we have been seeing with gambling advertising?

Mr TAYLOR: There was a study about a year and a half back, I think, from FARE—and again I can find information on this—where I think there was an ad every 36 seconds or something like that, but I will find that specific data and send it through. I have not seen something recently.

Ms WARD: Thank you very much.

The CHAIR: We will go now to Mr Wells.

Mr WELLS: Thanks for both presenting. I might just continue on with the topic that Vicki Ward was on just then in regard to the opening of bottle shops during the pandemic. You are obviously opposed to that, so what steps did you take as an organisation to put that to government?

Mr TAYLOR: We are part of a committee of agencies called Alcohol Change Victoria, and through that medium we have made a number of efforts to highlight some of the harms with regard to alcohol generally and the need for reform to reduce supply and reduce advertising. We have written to various politicians both state and federal on matters relating to alcohol. We recently had an opinion piece in the *Herald Sun* on some of these concerns. We make frequent public comment on these harms, which reflects the experience which our agencies are seeing.

Mr WELLS: I understand a public comment, but did you directly approach one of the ministers to say that the opening of bottle shops during a lockdown is wrong?

Mr TAYLOR: We would need to check if we have got any written correspondence on that. It does feel in the general day-to-day business of the organisation that we are making a lot of comments. Certainly there are discussions with departmental staff on these sorts of things. I cannot recall specifically, Mr Wells, as to whether we made a direct representation to the minister on opening bottle shops during the pandemic. We can certainly check for you if that is desired.

Mr WELLS: Well, I would like to know, because obviously a lot of the presentations are in regard to alcohol and alcohol abuse, and I would have thought that during the lockdown that would have been one of the priorities—that you were able to get access directly to the minister to at least protest or otherwise about that specific point. But by the sounds of it that did not happen.

Mr TAYLOR: If I can add, Mr Wells, we certainly have made comment about how part of it is not just the proliferation of bottle shops—that is a factor—but it is also extended hours of operation, the ease of accessing alcohol online, rapid delivery, whether people who have ordered alcohol rapidly are perhaps intoxicated or under-age and the safeguards in place there. Those representations have been made to the minister and other parliamentarians.

Mr WELLS: Sure. Which minister?

Mr TAYLOR: We would need to check. We have written to quite a few, but I can check that for you.

Mr WELLS: And you will come back to the committee with that?

Mr TAYLOR: Yes. I can come back to the committee with that.

Mr WELLS: Thanks. Along a similar theme, the 100 workers being cut in the budget—sorry, being the last person in the line to ask questions you may have already covered part of it, with Zoom dropping in and out. My understanding is that in the last budget by the government handed down a month or so ago there will be 100 less workers being funded by the government. Did I understand that to be right?

Mr BIONDO: That funding is not continuing, because it was for an 18-month period. Our hope was that given all the effort that has gone into finding people, recruiting them, training them and having them give some value back into the system and given the community demand, which has not really gone away, they would have maintained that if not continued that sort of program.

Mr WELLS: And with the link between mental health and addiction, and the government's commitment to a massive boost in mental health funding, I thought it would have been a given that the funding for that extra 100—while you already have them in the system and, as you said, trained—would have continued. So I find that a bit perplexing.

Mr BIONDO: Yes. There are lots of perplexing things that happen in the AOD space. I think that the circumstances around whether there is thinking that, 'Oh, well, if we stop the funding here they'll just get absorbed somewhere else', that may also be a consideration, but it is not an optimal way to run an orderly program, I think.

Mr TAYLOR: We would have welcomed the continuation of that funding, and we are concerned that with that funding going and those workers going, the waitlists will increase. And we know with waitlists they are not static. People do not remain there; they might drift on and off those waitlists as their health fluctuates. So we start moving towards harms that we cannot count, but they still might well manifest in emergency departments or our forensics system or, you know, in the most extreme cases the Coroners Court.

Mr WELLS: So again, a similar sort of question: have you protested directly to the minister in regard to that funding cut?

Mr BIONDO: I was fortunate to be invited to speak with the minister, and I put forward to him how disappointed we were that the funding cut occurred and I could not understand the logic of it.

Mr WELLS: No, neither can I. Just on a different topic, one of the complaints I have had come into my electorate office around people that are in facilities is that visitation during lockdown to families seems to have been a significant issue—they were not able to visit. Did you get much of that information coming into your organisation?

Mr BIONDO: I do not know how to answer that. I know that agencies and services would have been extra careful during lockdown because of the limitations of the environments that they work in. It is not ideal. The facilities generally are not purpose built. The newer ones are, but the other ones are just adaptations. They would have been highly protective of those that had got through into the facility, but to ensure there was no infection they would have created all sorts of systems to prevent that happening. It is one of those issues that would be best answered by some of these services.

Mr TAYLOR: I note, Mr Wells, that during January I think at least two of our residential detox services temporarily closed their doors because of matters of infection and so forth. The agencies were quite alive to the risks on that. As a slight side issue, we note that the same thing happened within the prison system, and the prison system adapted by allowing people to have Zoom calls and so forth to maintain a level of communication. I understand that is easing off, which is a real disappointment. It would be good if that innovation, like other silver linings of COVID, could be maintained.

Mr WELLS: Thank you, and thanks, Chair.

The CHAIR: Thank you. I would like to thank you both for attending today and giving evidence and thank you for the work that you do. You are certainly coordinating a large group of service providers across the state, and I am sure we all appreciate that. You will receive a copy of the transcript of the hearing within the next week for review, including lists of any questions taken on notice. And I notice, Dave, that you have offered to provide quite a bit of material, and you too, Sam, so it would be terrific to get that, because a lot of that is statistics and of course your full statement that we did not listen to. If we could have all of that, the committee will be able to continue to consider it.

At this stage I will conclude the hearing. I thank everyone who has attended today—members as well—and to all of those who have watched the proceedings today, thank you.

Committee adjourned.

DRAFT