Submission to the Standing Committee on Health, Aged Care and Sport

Inquiry into the health impacts of alcohol and other drugs in Australia

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VAADA acknowledges the Traditional Owners of the land on which our work is undertaken. Our office stands on the country of the Wurundjeri people of the Kulin Nation. We pay our respects to all Elders past and present and acknowledge their continuing and ongoing connection to land, waters and sky.

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About VAADA

The Victorian Alcohol & Drug Association (VAADA) is a member-based peak body and health promotion charity representing organisations and individuals involved in prevention, treatment, rehabilitation, harm reduction or research related to alcohol or drugs. VAADA aims to support and promote strategies that prevent and reduce the harms associated with AOD use across the Victorian community. Our vision is a Victorian community in which alcohol and other drug (AOD)-related harms are reduced and well-being is promoted to support people to reach their potential.

VAADA seeks to achieve this through:

- Engaging in policy development
- Advocating for systemic change
- Representing issues our members identify
- 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
- Supporting evidence-based practice that maintains the dignity of those who use alcohol and other drugs and related services

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VAADA acknowledges and celebrates people and their families and supporters who have a lived and living experience of alcohol, medication and other drug use. We value your courage, wisdom and experience, and recognise the important contribution that you make to the AOD sector in Victoria.

Executive Summary

The Victorian Alcohol and Drug Association commends *The Standing Committee on Health, Aged Care and Sport* in undertaking this inquiry.

The impact of alcohol and other drugs (AOD) on the community is profound with over 42,000 fatal overdoses having occurred between 2002 – 2022, many being preventable[1].

AOD harms amount to 6.7% of Australia's total disease and injury burden[2].

These harms have a lasting impact on families, the community, social services and the tertiary health system. They illustrate the ongoing lost opportunity to greatly enhance the wellbeing of all Australians by responding to the impacts of AOD regardless of geography, economic means or identity.

VAADA's submission calls for an increase in AOD treatment support, a bold program of drug law reform, the creation of a robust and inclusive system of national governance and strategies to address the deeply inimical outcomes resulting from stigma.

Our submission highlights the consequences associated with an underfunded AOD treatment sector and an overreliance on supply reduction including policing in response to substance use. This imbalance is an ongoing cause of negative outcomes.

Similarly, we highlight how poor data systems continue to let down diverse population groups, whose needs are not met early enough, contributing to greater costs to the community.

Limitations with models of funding, including insecure contracting, cascade into a plethora of workforce challenges that see the AOD sector unable to meet community demand for treatment, an issue which is exponentially more acute in rural and regional areas.

The high rate of fatal overdose, and the absence of a well-resourced harm reduction system, is perhaps the biggest missed opportunity to reduce costs and save lives.

There is a pressing need to create coherence in AOD activity across government jurisdictions and align strategic priorities. Shortcomings in governance, planning, service integration and funding result in the failure to provide the Australian public with optimal AOD support, wherever they may live.

Despite these shortcomings and historic systemic impediments, the Australian Government is presented with a clear opportunity through the next iteration of the National Drug Strategy to progress pragmatic, evidence-informed policies, building in safeguards to secure the AOD treatment system, not only for today but for future generations and provide an impetus for Australia to again be a world leader in responding to AOD use in the community.

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[1] Pennington Institute 2024. Australia's Annual Overdose Report. https://www.penington.org.au/australias-annual-overdose-report-2024/

[2] AIHW 2018. Impact of alcohol and illicit drug use on the burden of disease and injury in Australia: Australian Burden of Disease Study 2011. https://www.aihw.gov.au/reports/burden-of-disease/impact-alcohol-illicit-drug-use-on-burden-disease/summary

Summary of recommendations

1. That a new National AOD Governance Framework be adopted by the Commonwealth Government which supports the integration of activity between levels of government and the AOD sector.
2. Increase core funding to the AADC to provide strategic leadership on AOD impacts in the community and coordinate program and policy development with the Commonwealth Government and the AOD sector
3. Work with First Nations AOD leaders and communities to re-establish a First Nations representative national voice on AOD harms guided by truth-telling and self-determination principles
4. That the Australian Government adopt the recommendation of the Productivity Commission and provide 5-year contracts for service providers and simplify the mechanism for contract renewal to guarantee continuity of service to the community.
5. Create surety for the AOD sector in being able to provide services by developing and applying a consistent and transparent indexation formula that reflects annual increases to CPI and Award Wage adjustments. Indexed rates must be activated from the first quarter of each financial year.
6. That the DATSM be built into core funding for AOD service providers by the Australian Government.
7. Review National Minimum Data Standards as part of new national governance arrangements and scale up solutions like VAADABase and NADABase to capture and share data insights as part of a learning culture within the AOD sector.
8. Increase AOD prevention, treatment and harm reduction funding to create equity in resourcing between each pillar of the National Drug Strategy.
9. That the Commonwealth Government increase its share of investment in providing AOD services to priority communities, including pharmacotherapy and services to rural and regional communities.
10. That the Australian Government develop a National Overdose Prevention Strategy to sit under the National Drug Strategy. This strategy should provide and build a robust system for harm reduction services across Australia.
11. The next iteration of the National Drug Strategy includes a timeline for pragmatic drug law reform, supporting legal options for drug decriminalisation across all Australian States and Territories.
12. The Australian Government develops a National Synthetic Opioids Plan that allows for rapid implementation to mitigate the harms associated with an outbreak of potent synthetic opioids. The plan should have links with each jurisdiction through new national governance arrangements.
13. AOD and allied sectors should be supported and resourced to develop long-term cross-sector partnerships and capability-building programs to ensure that people experiencing multiple risk factors who engage with AOD services can receive comprehensive support.
14. That recommendation 11d from the Rapid Review into family violence prevention approaches relating to cross-sector collaboration between AOD and DFSV services be implemented and funded.

1. An AOD Governance Framework

Without effective governance, good data collection and reliable access to service, Australia is unable to comprehensively address the health impacts of AOD.

The AOD sector provides a return on investment of $7 with some harm reduction measures (such as needle and syringe programs) providing a return of up to $28 for every dollar spent. However, the inequity in investment between the 3 pillars of the National Drug Strategy, where supply reduction has consistently received two-thirds of all funding spent on addressing AOD use in the community impedes achieving this type of return.[3]

Lack of governance mechanisms impedes equitable access and outcomes

National AOD governance mechanisms have been eroded over the past decade impeding effective strategic leadership, oversight and planning to respond to the health impacts of AOD. This has resulted in a patchwork approach to addressing AOD use in the community, without mechanisms for the effective measurement of AOD needs and outcomes.

The National Drug Strategy 2017-26[4] and the National Alcohol Strategy 2018-28 identify governance as being a shared responsibility between health and justice. Under the auspices of the Council of Australian Governments (COAG), the Ministerial Drug and Alcohol Forum and the National Drug Strategy Committee were entities established to promote collaboration and coordination between the states and the Commonwealth and ensure a balanced approach between any potential competing agendas. They were joined by time-limited and expert working groups such as the Tobacco Working Group.

In March 2020 a new National Cabinet was announced with COAG discontinued on 29 May 2020.

Whilst the National Drug Strategy and the National Alcohol Strategy have remained in place together with the National Framework for Alcohol, Tobacco and Other Drug Treatment 2019-2029, the discontinuation of COAG has diminished governance arrangements for the AOD sector and fractured the coordination of both policy and program development between the Commonwealth and the states.

The absence of a mid-term evaluation of both the National Drug Strategy and the National Alcohol Strategy has been a lost opportunity to measure the effectiveness of existing activities and adapt approaches to respond to changing needs. Similarly, the current decision to not review the success or otherwise of the National Drug Strategy before its 2026 expiry date, highlights a continuing failure to learn from practice and evolve how we address the health impacts of AOD use into the future.

Given the erosion of strategic and effective governance during the past decade, the re-establishment of a coordinated approach to governance has been a priority for State & Territory AOD peak bodies since 2021. In a submission to the Commonwealth Government in September 2021 “Towards a new National AOD Governance Framework”, the peaks proposed the development of a new framework to fill the vacuum left by the cessation of

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[3] Ritter, A., Grealy, M., Kelaita, P. & Kowalski, M. (2024) The Australian ‘drug budget’: Government drug policy expenditure 2021/22. DPMP Monograph No. 36. Sydney: Social Policy Research Centre, UNSW. https://doi.org/10.26190/unsworks/30075

[4] National Drug Strategy

COAG. The proposed framework identified a governance structure that required partnerships and shared decision-making, recognising the need for significant input from First Nations people. The details of the proposed framework incorporated design, underpinning values and principles, and state and territory arrangements. Establishing and maintaining a system of coordination that operates between states as well as the Commonwealth continues to be a priority.

The AOD peaks proposal of a governance framework with three tiers of leadership (government, public service and sector), could be adopted as a model to both support the development and implementation of the new National Drug Strategy while ensuring alignment with state-based plans such as the pending Victorian AOD Strategy.

Recommendation 1: That a new National AOD Governance Framework be adopted by the Commonwealth Government which supports integration of activity between levels of government and the AOD sector.

Timely and equitable access to AOD services for all Australians continues to be hindered by poor governance. Below is a summary of policy decisions that compound the effects of poor governance, further eroding the effectiveness of service provision across the community and health outcomes for Australians needing support for their AOD use:

Defunding the Alcohol and Drugs Council of Australia (ADCA) in 2014.

Whilst resurrected in 2017 through our new national peak body the Australian Alcohol and Other Drugs Council (AADC), a significant amount of capability and knowledge was lost when ADCA was defunded. This occurred at a time when coordination between the Commonwealth Government and the service sector across States and Territories was critical to support the development of the current National Drug Strategy. The ongoing limited and insecure funding for the AADC continues to act as a handbrake on effective national governance in comprehensively addressing the health impacts of AOD across jurisdictions.

Recommendation 2: Increase core funding to the AADC to provide strategic leadership on AOD impacts in the community and coordinate program and policy development with the Commonwealth Government and the AOD sector.

Defunding the National Indigenous Drug and Alcohol Committee (NIDAC) in 2014.

NIDAC had been part of the Australian National Council on Drugs, providing leadership on First Nations issues at senior government levels. Whilst the former Commonwealth Government ultimately included the Chair of NIDAC on the Australian National Advisory Council on Alcohol and Drugs (ANACAD), defunding this important peak body reduced community representation on First Nations issues and has resulted in a lost opportunity to improve cultural safety in health services to address the impacts of AOD for Aboriginal & Torres Strait Islander communities. First Nations people continue to be disproportionally overrepresented in substance use data[5] (being seven to nine times more likely to receive

[5] AIHW 2024. Alcohol and other drug treatment services in Australia annual report. https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-australia/contents/clients/indigenous-australians

treatment for illicit substances) with continuing higher rates of harm,[6] criminalisation[7], poverty[8] and discrimination[9].

Recommendation 3: Work with First Nations AOD leaders and communities to re-establish a First Nations representative national voice on AOD harms guided by truth-telling and self-determination principles.

Redirecting the Non-Government Organisation Treatment Grants Program funds (NGOTGP) to the Primary Health Networks (PHNs) for commissioning from July 2017.

The redirection of these funds was intended to lessen the administrative burden on the Commonwealth and to promote better responses to the needs of local communities. However, the commissioning of services and contract management by the PHNs has created several challenges for AOD providers across catchments:

- Short-term funding cycles and indexation rates impact continuity of service and the ability to apply learnings to better meet community needs

  The lack of funding certainty to PHNs and delays that emanate from Commonwealth government confirmation of budgets which flow through to the contracting/re-contracting of service providers, has often left organisations in the unenviable position of maintaining employment of (temporarily) unfunded positions to ensure continuity of service to the community.

  Furthermore, there have been instances where the delays in re-contracting processes have seen agencies not paid during the delay period. It is completely unacceptable that NGOs are expected to carry the risk and cost of providing essential and life-saving services to Australians.

  Funding agreements should seek to assure continuity of service by extending the term of contracts and simplifying mechanisms for renewal. The Productivity Commission has previously recommended five-year contracts. VAADA notes however, that other jurisdictions, such as South Australia provide greater security of tenure through nine-year contracts and the ACT provides up to ten years of security through a seven by three-year service contract. These options provide greater security for agencies and would allow for comprehensive service and strategic planning activities to be undertaken to maximise outcomes for service users. These more secure contracting arrangements would also be protective factors for service providers relating to workforce retention.

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[6] Coroners Court of Victoria 2023. Fatal overdose among Aboriginal and Torres Strait Islander people, Victoria 2018-2021. https://www.coronerscourt.vic.gov.au/fatal-overdose-among-aboriginal-and-torres-strait-islander-people-victoria-2018-2021

[7] Australian Human Rights Commission. 2021. Australian's Criminal Justice System. https://humanrights.gov.au/sites/default/files/australias_criminal_justice_system_-_australias_third_upr_2021.pdf

[8] AIHW 2024. Aboriginal and Torres Strait Islander Health Performance Framework. Income. https://www.indigenoushpf.gov.au/measures/2-08-income

[9] Victorian Aboriginal Justice Agreement. 2024. Underlying causes of Aboriginal over-representation. https://www.aboriginaljustice.vic.gov.au/the-agreement/aboriginal-over-representation-in-the-justice-system/underlying-causes-of-aboriginal

Recommendation 4: That the Australian Government adopt the recommendation of the Productivity Commission and provide 5-year contracts for service providers and simplify the mechanism for contract renewal to guarantee continuity of service to the community.

The AOD sector and broader health and social service sector continue to labour under increasingly difficult financial circumstances. The cost of doing business, relating to inflation and award wage increases along with the requirement to invest in corporate infrastructure to evolve service delivery means that service providers are trying to do more today with less.

Agencies regularly have to find creative ways to continue to provide support to people, including through philanthropic contributions. It is not acceptable that life-saving interventions need to be subsidised through donations. PHN contracts currently provide only a maximum 1% annual indexation on contracts with agencies. This means that fewer Australians can get the help they need each year, as the real value of investment in AOD treatment and support diminishes.

The Victorian Government is currently finalising an arrangement where a formula incorporating CPI and Fair Work Wage determinations are reflected in annual adjustments to service contacts for the non-government sector. This type of approach goes some way to improving transparency regarding how indexation is determined. While this is vital, there is also a need to ensure that the amount provided through indexation is disclosed before the finalisation of annual budgets, with indexed rates paid within the first quarter of the new financial year.

Recommendation 5: Create surety for the AOD sector in being able to provide services by developing and applying a consistent and transparent indexation formula that reflects annual increases to CPI and Award Wage adjustments. Indexed rates must be activated from the first quarter of each financial year.

Issues with staff retention in the AOD sector are grounded in insecure contracting and rates of pay that are lower than comparative systems in the care economy. The Drug and Alcohol Treatment Services Maintenance (DATSM) program has been implemented in a number of two-year instalments to accommodate the transition by the community sector to align with modern industrial awards over the last decade. Unfortunately, DATSM funding is yet to be "guaranteed" as part of core funding despite being essential to meeting the costs of providing services today. The ongoing need to re-prosecute the case for the continuation of DATSM at the end of each grant cycle is an inefficient use of time and resources. The DATSM must be incorporated into ongoing core funding for AOD service providers.

Recommendation 6: That the DATSM be built into core funding for AOD service providers by the Australian Government.

Lack of access to good data and evidence inhibits a learning culture in AOD practice.

Inconsistent data collection practices across jurisdictions mean that we do not adequately capture the health impacts of AOD, including treatment demand, harms and outcomes. There is limited data collected about the health impacts of AOD outside of treatment, which undermines the needs of cohorts that face barriers to accessing pathways to support, such as refugee and migrant communities.

Reporting differences between the PHNs and the Victorian Alcohol and Drug Collection (VADC) data system for example, also create administrative burdens for agencies. This often forces agencies to shift scarce resources from service provision to focus on reporting across multiple systems and contracts. There needs to be a review of data standards as part of new national governance frameworks to ensure that the health impacts of AOD are well understood across all communities.

Case Study - VAADABase

VAADABase is a data collaboration pilot project providing means for participating AOD services and VAADA to access timely and relevant service data in Victoria. While currently using the Victorian AOD data system, the Victorian Alcohol and Drug Collection (VADC), there is an opportunity to expand our data sources to include new and valuable data sets. Such an endeavour in part seeks to realise the original intentions of the VADC to assist services in service planning, which it has not achieved[10].

VAADABase offers up to date (monthly) data insights for both participating organisations (through individual dashboards) and the broader sector (through a dashboard that shows aggregated data). The data dashboards can support the sector and organisations to make informed decisions, improve service delivery and support policy change.

While the National Minimum Data Set (NMDS) provides an annual data snapshot, VAADABase can fill the gap by offering monthly data as well as demographics, client numbers, region, drugs of concern, referral pathways and any mental health diagnosis. There is scope to build in additional data sources, such as family violence. We are continuously refining our dashboards to ensure they meet the needs of AOD services participating in the pilot.

There is a strong desire among AOD organisations to understand the broader context of their work, both locally and statewide. By leveraging data-sharing and collaborative frameworks, AOD organisations can advocate for improved services, understand client needs, and inform decision-making. Federal investment in data-sharing and collaborative frameworks would play a crucial role in driving these outcomes.

We can learn from existing AOD databases like NADABase and VAADABase to develop effective data-sharing and analysis practices. These initiatives provide valuable insights at local, regional, statewide, and national levels.

Recommendation 7: Review National Minimum Data Standards as part of new national governance arrangements and scale up solutions like VAADABase and NADABase to capture and share data insights as part of a learning culture within the AOD sector.

[10] Victorian Auditor-General. 2022. Victoria's Alcohol and Other Drug Treatment Data. Victoria's Alcohol and Other Drug Treatment Data (audit.vic.gov.au)

2. Drug law reform impedes program effectiveness

The criminalisation of currently illicit substances creates a framework which prioritises AOD funding toward supply reduction measures such as policing and law and order.

This is illustrated in the funding difference between the supply, demand and harm reduction pillars in the National Drug Strategy, with supply reduction consistently receiving two-thirds of the total expenditure in addressing the health impacts of AOD, despite providing no evidence that it reduces harm in the community. A range of surveys of people who use drugs (PWUD) consistently find that most substances are either easy or very easy to procure[11].

Prioritising law and order responses to AOD undermines the efficacy of harm reduction, prevention and treatment measures which are proven to provide a better return on investment.

The opportunity cost of continuing to prioritised law and order responses to AOD is the annual burden of disease related to AOD which is carried by the community at an estimated annual cost of $70B per annum[12]. The financial burden of a law-and-order response to AOD is also reflected in other data sources, for instance, the justice response to cannabis was estimated to be $2.4B in 2015/16[13] and methamphetamine $3.25B in 2013/14.[14]

These costs and the related harms could be greatly reduced through a more evenly balanced approach to the way we fund actions to address the health impacts of AOD. The imbalance in funding across the three pillars of the National Drug Strategy has been identified by the Joint Committee on Law Enforcement, which recommended that the levels of resourcing across the pillars be reviewed and that any significant shortfall in demand and harm reduction funding should be addressed[15]. With the treatment system currently under significant strain, many people are unable to access treatment at a time when they are most ready for support.

In Victoria, recent waitlist data revealed that between June and July 2024, 4615 people were waiting for treatment on any given day, up from 2385 in September 2020[16]. Furthermore, research indicates that across the nation, up to 500,000 people who have a clinical need for AOD treatment are unable to access the system[17].

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[11] Wilson J, & Dietze P. Victorian Drug Trends 2023: Key Findings from the Ecstasy and Related Drugs Reporting System (EDRS) Interviews. Sydney: National Drug and Alcohol Research Centre, UNSW Sydney; 2023. DOI: 10.26190/6eap-tp19; Wilson J, & Dietze P. Victorian Drug Trends 2023: Key Findings from the Illicit Drug Reporting System (IDRS) Interviews. Sydney: National Drug and Alcohol Research Centre, UNSW Sydney; 2023. DOI: 10.26190/ry0f-gr29

[12] Rethink Addiction and KPMG, Understanding the Cost of Addiction in Australia (2022) Rethink Addiction, Richmond, Victoria. https://www.rethinkaddiction.org.au/understanding-the-cost-of-addiction-in-australia

[13] Whetton, S et al. 2020. Quantifying the Social Costs of Cannabis Use to Australia in 2015/16, Tait, R.J., Allsop, S. (Eds.). ISBN 978-0-6487367-4-5, Perth, WA, National Drug Research Institute, Curtin University

[14] Tait, R and Allsop, S 2017, The price of ice: The social and economic costs of methamphetamine to Australia, NDRI. https://www.connections.edu.au/researchfocus/price-ice-social-and-economic-costs-methamphetamine-australia

[15] Joint Committee on Law Enforcement. 2024. Australia's illicit drug problem: Challenges and opportunities for law enforcement. https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Law_Enforcement/IllicitDrugs/Report

[16] https://www.vaada.org.au/treatment-delayed-is-treatment-denied/

[17] https://www.unsw.edu.au/research/sprc/our-projects/new-horizons-review-alcohol-drug-treatment-australia

The high levels of demand are exacerbated by a lack of equity in access, contributing to extensive wait times. For instance, Victoria's Infrastructure Strategy (2021-2051) has identified several regions in Victoria where there is an absence of AOD residential rehabilitation facilities recommending an uplift in those regions to build more equity into the system[18]. These regions remain bereft of this treatment type with Victoria having the second lowest rate of residential rehabilitation beds in Australia.

Similar challenges face Victoria's opioid pharmacotherapy program; currently supporting 15,106 service users[19]. Victoria's system is acutely overburdened with a small number of mature-aged general practitioners supporting thousands of service users. This results in a handful of individuals trying to hold together a fragile pharmacotherapy system.

While the 2023/24 Australian budget committed $377.3M to reform the system, notably removing the burden of dispensing fees for service users, little has been done to address the workforce crisis and build the capacity of the sector overall through appropriate national planning to account for levels of need for pharmacotherapy. This challenge is a shared responsibility between the Commonwealth and the States, and resourcing an increase in system capacity requires joint commitment across jurisdictions.

Recommendation 8: Increase AOD prevention, treatment and harm reduction funding to create equity in resourcing between each pillar of the National Drug Strategy.

Recommendation 9: The Commonwealth Government increase its share of investment in providing AOD services to priority communities, including pharmacotherapy and services to rural and regional communities.

Australia needs an overdose prevention strategy

Harm reduction has not been a core part of our response to the impacts of AOD for decades, rather sitting as a series of programs loosely cobbled together. This in part contributes to the ongoing neglect of a raft of evidence-informed harm reduction programs that if properly resourced, would make significant inroads into reducing Australia's surging overdose toll. There has been an almost 100% increase in national overdoses over the past two decades, increasing from 1231 in 2002 to 2356 in 2022.[20] At the same time, overall national funding for harm reduction support has declined from 3.9% in 2002/03 to 1.6% in 2021/22 of the total AOD spend[21]. The reduction in the overall proportion of harm reduction expenditure is reflective of how we are not adapting to changing patterns of drug use.

Since the introduction of Needle and Syringe Programs in response to HIV in the 1980s, there has been little progress in building the harm reduction sector and little political will to engage in meaningful drug law reform. With lip service paid to address stigma, the application of a long-term funded approach has not materialised, with a raft of government-

[18] Infrastructure Victoria 2021. Victoria's infrastructure strategy 2021-2051. https://www.infrastructurevictoria.com.au/infrastructure-strategy
[19] AIHW 2024. National Opioid Pharmacotherapy Statistics Annual Data collection. https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics/contents/opioid-pharmacotherapy-clients
[20] Penington Institute (2024). Australia's Annual Overdose Report 2024. Melbourne: Penington Institute.
[21] Ritter, A., Grealy, M., Kelaita, P. & Kowalski, M. (2024) The Australian 'drug budget': Government drug policy expenditure 2021/22. DPMP Monograph No. 36. Sydney: Social Policy Research Centre, UNSW. https://doi.org/10.26190/unsworks/30075

funded campaigns to address the health impacts of AOD continuing to willfully promote stigmatising messages[22].

In Victoria, there have been some welcome developments over the past decade including the introduction of the Medically Supervised Injecting Room (MSIR) which evidence shows has prevented 63 fatal overdoses (as of 2023)[23], has had over 500,000 visits, managed 9,115 overdoses, and provided almost 160,000 supports onsite which includes commencing 1,096 people onto opioid pharmacotherapy[24]. Despite these significant achievements, the MSIR has been plagued with adverse public commentary, unrealistic expectations and erroneously seen as a contributor to amenity issues including public drug use.

Much of the public commentary has been overshadowed by the application of stigmatising stereotypes which were commonly utilised in recent commentary on a second MSIR in Melbourne's CBD. This led to the abandonment of the second MSIR, despite being recommended by Ken Lay AO APM, due to challenges finding the right location which strikes a balance between the needs of people who use drugs and the needs of the broader community.[25]

More recently, the Victorian Government has committed to implementing mobile and fixed site drug-checking which is a welcome reform, especially with the increasing frequency of potent synthetic opioids and the trend of increasing fatal overdose.

Those working in the AOD sector remain on edge regarding stigmatising commentary which undermines effective action. It is the politicisation of fear and stigma which often results in evidence-informed AOD policy being implemented only after a catastrophe or crisis, rather than in advance to prevent or reduce the related harm.

The challenge with AOD policy is for governments to have the courage to listen to the evidence, prioritise human rights, and champion policies that work to reduce the health impacts of AOD.

The development of a funded national overdose prevention strategy would be a step forward in national leadership, developing and implementing a lifesaving harm reduction framework to support all States and Territories. A national overdose prevention strategy should garner the support of State and Territory governments and provide resources to support necessary policies, programs and reforms.

Recommendation 10: That the Australian Government develop a National Overdose Prevention Strategy to sit under the National Drug Strategy. This strategy should provide, and build a robust system, for harm reduction services across Australia.

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[22] https://theconversation.com/the-polices-new-scare-campaign-wont-stop-people-from-using-drugs-but-it-will-increase-stigma-171303

[23] Ryan et al 2023. Review of the Medically Supervised Injecting Room. https://www.health.vic.gov.au/publications/review-of-the-medically-supervised-injecting-room-2023

[24] NRCH 2024. Reducing public injecting, improving amenity and saving lives. https://nrch.com.au/services/medically-supervised-injecting-room/

[25] Willingham R and Rollason B 2023. Victorian government scraps plans for a second supervised injecting room in Melbourne. ABC. https://www.abc.net.au/news/2024-04-23/melbourne-cbd-safe-injecting-room-scrapped-drug-service/103756920

Drug law reform has stalled in Australia

Up until recently, there has been little progress in drug law reform in Australia. Recent reforms in the ACT, Queensland and NSW show promise and have seen some modest change. This is despite increasing support for drug law reform, with a reduction in opposition to the personal use of illicit drugs and a reduction in support for law enforcement in response to illicit drug use[26].

It is evident that the current array of drug laws across most of Australia are not fit for purpose and increasingly out of step with international evidence and related trends.

It is widely accepted that the "war on drugs" has failed[27] leading to an increasing number of Australians being criminalised for consuming drugs, putting almost one in five Australians aged 14 years and over, at risk of prosecution given they have consumed an illicit drug in the past year[28].

Despite growing policing budgets, authorities appear to not have impeded the supply of drugs in Australia. The ease of procurement despite significant policing efforts, results in a high volume of arrests for possession and consumption-related offences, with for instance 90% of the 66,285 cannabis arrests nationally in 2020/21 relating to possession[29]. This results in huge numbers of Australians being dragged into the justice system and criminalised for predominantly consumption of a substance. This is increasingly a key reason for drug law reform internationally.

The recent report from ACT Health highlighted that recently enacted cannabis law reform saw no changes in cannabis-related trafficking or cultivation offences, paramedic or hospitalisations. There has been no impact on price, with stable consumption levels (people in Canberra continue to consume cannabis at rates lower than the national average)[30]. This means that concerns of decriminalisation increasing drug use are unfounded and that justice interventions negatively impact addressing the health impacts of AOD.

Recommendation 11: The next iteration of the National Drug Strategy includes a timeline for pragmatic drug law reform, supporting legal options for drug decriminalisation across all Australian states and territories.

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[26] AIHW 2024. National Drug Household Survey 2022-2023. https://www.aihw.gov.au/reports/illicit-use-of-drugs/alcohol-drug-policy-support

[27] Stenstrom et al 2024. "It should be hard to be a drug abuser" An evaluation of the criminalization of drug use in Sweden. International Journal of Drug Policy. 133 (2024) 104573; Brian D. Earp, Jonathan Lewis, Carl L. Hart & with Bioethicists and Allied
Professionals for Drug Policy Reform (2021): Racial Justice Requires Ending the War on Drugs, The American Journal of Bioethics, DOI: 10.1080/15265161.2020.1861364; Lubman, D. 2022. It's time to decriminalise personal drug use. Here's why. https://lens.monash.edu/2022/03/09/1384519/its-time-to-decriminalise-personal-drug-use-heres-why

[28] AIHW 2024. National Drug Household Survey 2022-2023. https://www.aihw.gov.au/reports/illicit-use-of-drugs/alcohol-drug-policy-support

[29] NCETA 2024. Cannabis. https://nadk.flinders.edu.au/kb/cannabis/cannabis-crime

[30] ACT Government. 2024. Review of the operation of the Drugs of Dependence (Personal Cannabis Use) Amendment Act 2019

Potent synthetic opioids

In recent years, Australia has seen an increase in potent synthetic opioid adulteration of traditionally illicit substances and pharmaceuticals, including MDMA, cocaine, methamphetamine and oxycodone (purchased from an unregulated market), with a gradual increase in the number of fatal overdoses associated with these substances.

These substances have contributed to hundreds of thousands of deaths in other jurisdictions with 74,702 fatal overdoses in the USA attributed to fentanyl in 2023[31]. There has also been an increased rate of harm occurring in parts of Europe associated with nitazenes, such as in Dublin in November 2023 where there were 57 overdoses recorded amongst people who use heroin[32] in a five-day period.

With nitazenes already in the Australian drug market many take the view that it is only a matter of time before there are similar mass overdose events, to which Australia is ill-prepared to adequately respond. VAADA and Harm Reduction Victoria developed a paper calling for the Victorian Government to develop a potent synthetic opioid plan. The paper recommended that the Victorian Government:

Establish a synthetic opioids taskforce under the direction of the Chief AOD Officer to develop and operationalize a Potent Synthetic Opioids Plan, drawing on this framework to ensure that any harms which may occur due to a surge in potent synthetic opioids in Victoria are mitigated.[33]

There is a pressing need for the Australian Government to develop a similar plan given that the supply of illicit drugs and the presence of potent synthetic opioids are not limited to jurisdictional boundaries as has been evidenced through recent cases in NSW, ACT, Victoria and SA.

Recommendation 12: The Australian Government develop a National Synthetic Opioid Plan that allows for rapid implementation to mitigate the harms associated with an outbreak of potent synthetic opioids. The plan should have links with each jurisdiction through new national governance arrangements.

3. System Integration

The relationship between substance use and other co-occurring issues such as mental health has been well established, and for decades AOD services have provided treatment, care and support for consumers with complex needs. Consistent feedback from the Victorian AOD treatment sector highlights the increasing complexity of needs among service users. This was highlighted in the VAADA 2022 sector priorities survey, which revealed that client complexity was the second most pressing challenge behind workforce retention. Not surprisingly, the Royal Commission into Victoria's Mental Health System (RCVMHS) notes that between 50 to 76% of AOD clients experience at least one co-occurring mental

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[31] National Centre for Health Statistics 2024. U.S. overdose deaths decrease in 2023, first time since 2018. https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2024/20240515.htm#:~:text=Provisional%20data%20from%20CDC's%20National,111%2C029%20deaths%20estimated%20in%202022.

[32] Killeen et al 2024. The emergency of nitazenes on the Irish heroin market and national preparation for possible future outbreaks. Addiction. 119/9. 1657-58.

[33] HRVic and VAADA. 2024. Keeping Victorians Safe: we need a potent synthetic opioids plan. https://www.vaada.org.au/vaada-and-harm-reduction-victoria-press-release-victoria-needs-a-potent-synthetic-opioids-plan/

disorder[34]. More recent findings aggregated from 29 Victorian AOD agencies revealed that 83% of AOD clients were either formally diagnosed or had symptoms of a mental health condition.[35] Despite the investments delivered through the RCVMHS, there remains limited support for the AOD sector to support people with co-occurring mental health and AOD issues. This is evidenced by the variance in investment between AOD and mental health residential services, where a dual diagnosis bed is funded four times more than an AOD residential bed. This inequity in funding impacts the type and level of care and support offered to AOD service users that can support their recovery.

The Improved Services Initiative implemented by the Commonwealth addressed some of the issues associated with providing integrated care through the development of local relationships and partnerships, however, these benefits were lost when this funding ceased. There was no incentive for treatment services to continue to capacity-build their organisations on an ongoing basis, as there was no overarching directive to do so by the Commonwealth, nor any other monitoring reporting requirements against target performance indicators.

VAADA's report, 'Care and Complexity: towards a re-designed Victorian AOD Service System' echoed the long-standing sector issue regarding the lack of resourcing to support the sector with intersecting systems of care[36]. This has long been neglected, with at best, short-term resourcing provided for a specific project, occurring in the absence of any statewide/national strategic planning.

A lack of coordination between the Commonwealth and the Victorian Government in 2014 contributed to the implementation of an AOD sector reform that resulted in rigid treatment types that differed from the Commonwealth and a centralised intake and assessment system that further reduced collaboration between services and hindered accessibility for consumers[37]. There was no attempt at alignment regarding system design between the Commonwealth and Victorian governments during or since this significant reform.

The regression in the provision of AOD and MH integrated care was highlighted by the RCVMHS which received many submissions from AOD treatment services, mental health services and consumers and carers all highlighting and outlining the ongoing challenges experienced by consumers in accessing integrated care.

These issues included:

- A lack of integration at the service level between AOD and MH services
- Consumers are often "bounced" between the systems and agencies, with limited coordination between sectors, often being treated by separate disciplines for interrelated issues
- The provision of limited services for families and carers

[34] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Volume 3: Promoting inclusion and addressing inequities, Parl Paper No. 202, Session 2018–21 (document 4 of 6). https://www.vic.gov.au/royal-commission-victorias-mental-health-system-final-report
[35] Rogers, N. & Pritchard, E. The Prevalence and Treatment of Mental Health Conditions in the AOD Sector. Melbourne: Cleugh Consulting.
[36] Victorian Alcohol and Drug Association (2024). Care and Complexity: Towards a re-designed Victorian AOD Service System, Melbourne.
[37] ASPEX Consulting 2015. Independent review of MHCSS and Drug Treatment Services. DHHS.

- the lack of continuity of resourcing to drive service integration between the AOD and other sectors. Often integration is viewed by the government as requiring only short-term funding, rather than recurrent resourcing which is necessary to build and maintain vital sector coordination and strategic collaboration.

AOD agencies provide a significant amount of integrated care to clients with other co-existing issues such as family violence and homelessness. These issues are often complex due to factors associated with intersectionality and require significant resources and workforce development. In the VAADA Workforce Survey undertaken in April 2023, "workers perceived themselves to be less confident and capable in relation to co-occurring issues and interfacing work with other service systems, including mental health and family violence."

Separately, the Australian Government has flagged alcohol regulation as a priority in the Rapid Review of Prevention Approaches to End Gender-Based Violence[38] recommending restrictions on alcohol sales, advertising and delivery timeframes. While focus on these regulatory aspects is welcome, there is a need to respond to substance dependence and ensure that the service systems respond to substance dependence where domestic, family and sexual violence (DSFV) is involved. This is recognised in the Rapid Review which recommends strengthening cross-sector collaboration between the AOD and specialist DFSV to reduce the occurrence of violence.

This recommendation must be actioned as a priority as part of National Cabinet's commitment to take action on alcohol as one of four key strategic priorities emanating from the Rapid Review.

Recommendation 13: AOD and allied sectors should be supported and resourced to develop long-term cross-sector partnerships and capability-building programs to ensure that people experiencing multiple risk factors who engage AOD services can receive comprehensive support.

Recommendation 14: That recommendation 11d from the Rapid Review into family violence prevention approaches relating to cross-sector collaboration between AOD and DFSV services be implemented and funded.

[38] Department of the Prime Minister and Cabinet. 2024. Report of the Rapid Review of Prevention Approaches to End Gender-Based Violence. https://ministers.pmc.gov.au/gallagher/2024/report-rapid-review-prevention-approaches-end-gender-based-violence#:~:text=The%20Rapid%20Review%20highlighted%20a,them%20where%20they%20are%20at