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The impact of the COVID-19 pandemic on the non-government alcohol and other drug sector: future implications

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Summary of findings

The overall aim of this research was to inform future planning and service delivery for NGO AOD services in NSW, ACT and TAS, and thus also other Australian states and territories. This study used survey, focus group, and administrative data to examine the impact of the COVID-19 pandemic (henceforth, COVID-19) on non-government alcohol and other drug (AOD) treatment services. The focus was on 1) business practice impacts; 2) workforce impacts; 3) service delivery impacts; and 4) treatment demand impacts. The future implications of these impacts is explored for NGO services themselves, the peak bodies that support NGOs, and for those who commission and fund AOD treatment.

Business practice impacts

- Around two fifths of NGO AOD services in NSW, TAS and ACT experienced increased costs (37.5%, n=12), particularly due to the need to expend resources in ICT infrastructure and workforce training, personal protective equipment (PPE), and cleaning products and services.
- Two fifths of survey respondents (40.6%, n=13) reported changes to their income, specifically a reduction in donations and in client contributions as a result of reduced bed numbers and occupancy rates.
- The majority of services in NSW, TAS and ACT reported receiving financial support from government (62.5%, n=20) to cover some of these additional costs and their income loss; JobKeeper has been an important form of financial assistance in order to retain staff and services.
- Despite this additional financial support, many services in NSW, TAS and ACT reported that this often was not enough to off-set their costs (37.5%, n=12), leading to more than a quarter of services (28.1%, n=9) needing to draw on their financial reserves during the COVID-19 period.
- Almost every service reported changes to their risk management practices (90.6%, n=29). This was mainly related to the need to implement COVID-19 response plans and measures. Although all services in NSW, TAS and ACT were able to access health guidelines or recommendations, respondents noted that resources came out late, often after services had already out of necessity developed their own health guidelines or recommendations.
- The majority of services reported being supported in adjusting their contracted deliverables or Key Performance Indicators (KPIs) (75%, n=24). The deadlines for data reports were extended or additional data collection sections were added to report on aspects related to COVID-19. Furthermore, over half of the services also reported flexibility on what the funding could be spent on (53.2%, n=17).
- The majority of services considered themselves sustainable (93.5%, n=29) if COVID-19 related issues continued for another 12 months. However, this sustainability would come at a cost; both in terms of services being able to financially support themselves and the toll on the workforce.

Workforce impacts

- The majority of services in NSW, TAS, and ACT reported relatively minor changes in their workforce size; with an exception being the number of volunteers (30.3%, n=10, saw a strong decrease).
- The loss of experienced staff was reported by some services due to some staff retiring earlier than planned and staff not returning due to needing to find additional employment.
- Many services reported that there was an increased workload, for example, due to staff needing to be on sick leave given cold symptoms and getting tested, to staff being required to do additional tasks due to COVID-19 restrictions (e.g. ongoing cleaning of service), and to other services closing and receiving more referrals.

- Across the data sources, we identified new challenges for managers and those in leadership positions. One of these was performance management; in an environment where most staff are under strain, there is a need for role flexibility, and the regular feedback and performance management tasks for those in leadership positions become more complex.
- Stress and anxiety levels of staff were perceived to have increased (97%, n=32) and staff wellbeing (60.6%, n=20) decreased due to COVID-19. It was noted that because of the constant pressure on staff to work at increased capacity, without breaks, it is taking its toll. There is the worry that this will lead to burnout if this continues.
- Despite the additional pressures staff were and are under, respondents noted across datasets that staff generally were very grateful for being able to retain their job (compared to other sectors) and were understanding of the needed changes to services.

Service delivery impacts

- Almost every NGO AOD service in NSW, ACT and TAS that participated in this project adapted their service delivery (91.7%, n=33), and a number embarked on innovative new programs (both technology-based and in-real-life).
- Service providers reported a high level of confidence in the ways they had managed the pandemic and changed circumstances.
- Services in NSW, TAS and ACT reported an increased number of staff being able to work from home (86.1%, n=31), to be able to successfully use video technology (80.6%, n=31) and telephone (77.8%, n=28) for clinical care, reported no problems with switching to internet, telephone and/or video technology for clinical care (77.8%, n=28), increased person-centred practice (52.8%, n=19), switched to online counselling services (50%, n=18), and were able to offer more flexible appointments (50%, n=18).
- Specific barriers and challenges were reported for residential services including the difficulties of not being able to offer outdoor activities; the risk of needing to close down if an outbreak occurs within the service; clients not being allowed to leave the centre for activities or specialist appointments or being in isolation in their room due to symptoms (leading to boredom amongst clients); and maintaining engagement with clients.
- Technology-based services enabled continuity of care during COVID-19, even expanding the reach for some services (particularly rural areas), while protecting service providers from the risk of infection. It also increased communication between staff, and between staff and clients, and allowed for more flexible work arrangements.
- However, it was reported that technology-based services have their limitations (e.g. clients not having access to internet and phone, poor internet connection, reduced engagement with clients, etc.) and are not suitable for all client groups and treatment types; making face-to-face services still a key component of service delivery.

Treatment demand impacts

- The number of new episodes of care (EOC) has declined in NSW; in 2019 there were 20,142 EOC and in 2020 18,431 EOC in the first three quarters of those respective years.
- The decline in the number of new EOC in NSW in association with COVID-19 was not uniform across drug and client type; the largest decline was for methamphetamine presentations, with a smaller decline for alcohol, heroin, and opioids. There was also a decline in both female and male new EOC to treatment in 2020, but the decrease was greater for females than males.

- Longer waiting lists were also reported in NSW, TAS and ACT for both metropolitan (54.2% reported they had lengthened, n=24) and regional services (45.5% reported that waiting lists had lengthened, n=22). But this was less common in rural (27.3%, n=11) and remote (20%, n=5) treatment settings.
- Metropolitan-based services were more severely affected than regional/rural services: the NSW administrative data showed that there was almost no change in the number of new EOC for services located in regional/rural LHDs in NSW between the first three quarters of 2020 and the same three quarters in 2019. However, for metropolitan services there was a decline in 2020.
- The impact of COVID-19 on the number of new episodes of care varied by treatment type: new episodes of care for assessment, information and education decreased (by 14%); day program EOCs decreased by 45%; residential rehabilitation EOCs decreased by 33%; and case management and support EOCs decreased by 23%. On the other hand, counselling EOCs increased by 12% and detoxification EOCs increased by 10%.
- In terms of specific client groups, concern was expressed by service providers in NSW, TAS and ACT about the compounding effects of COVID-19 on an already marginalised and structurally disadvantaged population, particularly Aboriginal and Torres Strait Islander peoples.
- In addition, none of the service gaps for other special population groups, such as women and women with children, culturally and linguistically diverse (CALD) clients, young people, and older clients, is new or unique to COVID-19, but this lack of access has been exacerbated by the pandemic.

Unintended positive consequences

- While there is no doubt that the pandemic has exacted a toll on AOD services, their staff and the clients who attend for treatment, this project has highlighted a number of unintended positive consequences of the pandemic.
- From an organisational point of view, AOD services are now more prepared for future pandemics.
- Another unintended consequence for the workforce is recognition that taking sick leave is an important part of staying healthy.
- The pandemic has forced services to establish new collaborations with other parts of the health system, including with acute care and with testing services.
- The wave of new technology, impacting substantially on better treatment access has also positively impacted on ICT systems of data recording and monitoring. 'Zoom' has also provided the opportunity for more regular management meetings and for group supervision.
- The increased flexibility in working arrangements has been welcomed by the AOD sector.
- For clients of AOD treatment, geography seems to be less of a barrier where ICT solutions can be adopted. Providing flexibility and hybrid (both face-to-face and virtual care) services to better meet client needs has had positive consequences.

Implications for the future of NGO AOD treatment services, their funders and the community – actions required

The above provides a rich description of the experiences of NGO AOD treatment services over the COVID-19 period. These provide the basis for considering what needs to change in order to have a sustainable specialist NGO treatment sector into the future.

COVID-19 has demanded significant changes: to funding arrangements, leadership and strategic planning, the types of care provided, and workforce requirements. It provides the opportunity to review all aspects of NGO AOD treatment services, including the ways in which services are commissioned and funded by governments, and how services are supported, led, and delivered.

It seems clear that some of the COVID-19 impacts have been worsened due to two systemic issues for the sector that pre-date COVID-19:

- the chronic underfunding of treatment; and
- the challenges in recruiting and retaining a specialist workforce.

Both of these long-standing systemic issues require resolution.

At the same time, the innovations with ICT, and engagement with virtual care models has provided the basis upon which to build new ways of providing treatment and responding to client needs with a greater diversity of practices. It is vital that greater investments are made into virtual care models, and their evaluation.

In considering the ongoing lessons being learnt from COVID-19, it is clear that actions are required from multiple parts of the system: governments, treatment funders, peak bodies, treatment providers and managers as well as clinicians.

Thirty-one actions, covering the immediate, medium-term (next 12 months), and long term (next five years) have been derived from the analysis of the survey, focus groups, and administrative data. These immediate, medium, and long-term actions are underpinned by the two long-standing systemic issues for the sector: the chronic underfunding of treatment; and the challenges in recruiting and retaining a specialist workforce.

Immediate actions:

1. Fund the purchase of PPE and other infection control equipment.
2. Re-open programs, notably day programs and outreach services; create awareness of services fully open with treatment places available; ensure that other services are informed of changes to treatment capacity.
3. Develop new service materials (brochures, info sheets, etc.) tailored to clients for the current context and agency website updates.
4. Provide tailored information for clients and their families regarding how technology-enabled care works.
5. Configure clinical spaces for ongoing physical distancing policies.
6. Manage COVID-19 fatigue, anxiety, staff burnout and staff self-care.
7. Support flexibility (i.e. working from home) with clear policies and procedures, and managing staff expectations about flexibility.
8. Support staff to adjust to resumption of face-to-face client work in a COVID-19 risk environment.
9. Ensure appropriate measures are in place for the likelihood of a positive COVID-19 case.

Medium-term actions (next 12 months):

10. Reconnect clinical service networks, and re-establish partnerships with other organisations.
11. Establish and maintain stronger links between government and service providers; improve communication and coordination of AOD services with state governments.

12. Resume fundraising activities and working with donors.
13. Continue infection prevention and control measures for general health and well-being in the workplace.
14. Resource better technology infrastructure; assess and fund costs associated with virtual care delivery, and enhance online capabilities and equipment.
15. Upskill staff members, particularly in the use of technology; and support staff to adapt to a new and ongoing way of doing business.
16. Balance virtual care and face-to-face delivery; have a sustainable model of service delivery using online technology.
17. Engage in strategic and business planning for AOD treatment services; maintain and regularly update business continuity and critical response plans, learn lessons from bushfires and COVID-19; and provide training for strategic and business planning.
18. Review clinical and organisational policies and procedures, e.g. risk management policies; and develop new policies and procedures where required, for example managing privacy and confidentiality online and remotely.
19. Evaluate the impacts and outcomes of online service delivery, including the costs associated with delivery, and impacts on specific populations.
20. Hold planning meetings between NGOs and funders, to discuss the impact of pandemics on service delivery and reporting requirements.
21. Re-negotiate contract agreements and Key Performance Indicators (KPIs), aligned to adapted practices, client numbers, and new service delivery models.
22. Design physical buildings to reduce shared facilities and align with best practices.
23. Improve funding for transportation for clients located in regional, remote and rural locations.
24. Re-establish clinical placements and student placements.
25. Prevent burn-out of staff, improve staff satisfaction and wellbeing post COVID-19; and provide opportunities for revitalization, rest and recuperation of staff, support staff wellbeing.
26. Facilitate access to training opportunities that were cancelled during COVID-19.

Long-term actions (next 5 years):

27. Resolve the chronic underfunding of AOD treatment.
28. Establish and re-build financial reserves in treatment agencies.
29. Ensure preparedness for future major events (e.g. pandemics and bushfires) by the services, the peak bodies and government.
30. Recruit a new AOD workforce, attract people to the sector, ensure availability of experienced staff for succession planning; support career pathways for the AOD workforce.
31. Improve communications between the government and non-government treatment sector with regard to future pandemics and/or future major service disruptions.

Clearly these actions in the immediate, medium, and long-term represent a substantial program of work. It will require work by treatment funders, peak bodies, treatment providers and managers as well as

clinicians. Coordinating some of the work through the peak bodies would make sense. It also requires greater investment from government, in the immediate term (for example funding for PPE) and in the long-term (redressing the significant underfunding of AOD treatment).

Many of the actions listed have already begun. We hope the services will use this list as a way to develop priority actions plans, to recognise what they have already achieved, and what remains to be done both immediately and in the medium term. Likewise, this list of actions can inform government about priorities and how to ensure that AOD treatment continues to meet the needs of those seeking help.

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Introduction

COVID-19 has had significant impacts on alcohol and drug (AOD) use and their supply. Many national and international research projects have been examining the ways in which people have changed their AOD consumption as a result of COVID-19. Australian studies have included an analysis of alcohol consumption and purchasing (Ritter et al., 2020) and drug consumption habits (ADAPT, 2020). While we know much to date about consumption and supply, there has been relatively less focus on the COVID-19 experiences from the treatment perspective. Clearly changes in consumption and harm will impact on treatment services, but these might have a long lead in time if the assumption is that more people develop dependency and require treatment. At the same time, with people finding it more difficult to maintain their supply of alcohol or other drugs, there may be immediate pressures on treatment places. This at the same time as services are forced to reconfigure themselves with reference to COVID-19 safe practices, physical distancing, and staff being unable to attend the workplace.

On an international level, the *European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) Trendspotter Survey* (EMCDDA, 2020a) showed a decline in the availability of European AOD services during the first two months of the pandemic; with some service providers being forced to close down or restrict access. AOD services have faced a continuing range of challenges in maintaining adequate provision and quality care for their clients. Overdose risk for people dependent on AOD who are home-isolating is a particular concern at a time of overloaded healthcare systems (EMCDDA, 2020b). As such, services have had to be innovative and respond rapidly to the new and fast-changing landscape (EMCDDA, 2020a). On a national level, Biddle and Gray (2020) report that one of the greatest unmet needs of Australian in the early stages of COVID-19 (March – May 2020) was for drug and alcohol counselling; cost was more likely to be reported as a barrier, as was not knowing who to contact. In addition, a national survey (N=210) showed that COVID-19 had significantly affected the delivery and operation of 74.5% of NGO AOD services (State and Territory Alcohol and Other Drugs Peaks Network, 2020), such as changing their mode of delivery to technology-based services and reducing client numbers to support appropriate risk mitigation measures (e.g., physical distancing) as a result of COVID-19.

Nevertheless, still relatively little is known about the impact of COVID-19 on AOD services in relation to the following four areas: 1) business practice impacts (e.g. financial impact and data monitoring), 2) workforce (e.g. staff wellbeing and supervision), 3) service delivery (e.g. increase/decrease, changes in mode of delivery), and 4) demand (e.g. # clients, waiting lists). Non-government organisations (NGOs) are one of the main providers of AOD treatment in Australia alongside government services. In 2018/2019, 71% of all episodes of treatment were provided by the NGO sector in Australia (AIHW, 2020) (although this division varies by jurisdiction). Considering the important role of NGOs in providing treatment, the aim of this study was to examine how COVID-19 has impacted the four above-mentioned areas. We start with agencies who provide treatment; exploring how their business practices have been impacted by COVID-19. We then move to the staff within treatment agencies (i.e. workforce), then to the treatment and support services being delivered, and finally to the ways in which changing demand for treatment has impacted services.

In relation to business practices we explore the following:

- The financial impacts of COVID-19;
- The impacts on contracts and relationships with funders;
- Risk management practices; and
- The sustainability of AOD services.

In relation to staff, we explore the workforce impacts including:

- Changes in workforce size;
- Changes in workforce development opportunities;
- Changes in the work environment and working conditions; and
- Staff wellbeing.

In relation to the delivery of treatment, we explore the following:

- The adoption of new service delivery modalities;

- The extent of technology-based solutions; and
- How service delivery may look in the future.

And finally, in relation to the demand for treatment we examine:

- Whether COVID-19 resulted in higher or lower treatment demand;
- The impacts on waiting lists/waiting times;
- Differences between metropolitan and rural services; and
- Impacts for specific client populations.

Methods

This study focussed on the following four research domains: 1) business practice impacts; 2) workforce impacts; 3) service delivery impacts; and 4) treatment demand impacts.

1. Study design

The project utilised both quantitative and qualitative approaches, involving three components:

- (1) An organisational survey targeted at NGO AOD services located in NSW, TAS and ACT.
- (2) Online focus groups with NGO AOD service providers in NSW; and
- (3) An analysis of the administrative treatment data from the NADAbase (NSW data).

Quantitative and qualitative methods were combined. The quantitative methods (the survey and administrative data) were useful for generating summaries and comparisons of the impact of COVID-19 on NGO AOD services, while the qualitative methods (the focus groups and open-ended responses in the survey) generated contextual information which allowed for greater and deeper understanding of the data. The rigor of the findings were strengthened by the triangulation of the quantitative results with the richness of the qualitative results (Flick, 2018). We also triangulated methods as the outcomes of the survey (conducted first), informed the focus groups.

1.1 Survey instrument

An online organisational survey was developed targeted at NGO AOD services located in New South Wales (NSW), Tasmania (TAS) and Australian Capital Territory (ACT). The survey was informed by other COVID-19 surveys in related areas (e.g. EMCDDA trendspotter COVID-19 and AOD survey, Commonwealth Department of Health COVID-19 and AOD survey) and developed in consultation with the Network of Alcohol and other Drugs Agencies (NADA) (NSW), Alcohol Tobacco and Other Drug Association ACT (ATODA) (ACT), and Alcohol, Tobacco and other Drugs Council Tasmania (ATDC) (TAS). These are the three peak bodies for the NGO AOD sector representing the above mentioned jurisdictions. The survey was piloted amongst people working in the AOD service sector (n=7) and revised accordingly before being launched (a copy of the survey is available from the first author). In addition to multiple choice questions across the four domains of interest, all questions provided free-form/open-ended responses for respondents to complete. These texts were analysed qualitatively. The survey was administered between August and September 2020.

The survey link was sent to NGO AOD services located in NSW (n=60), TAS (n=14) and ACT (n=9). NADA, ATODA and ATDC agreed to support recruitment by sending out an invitation letter to their members in their jurisdiction. In addition, follow-up emails were sent out, and the survey was advertised via the newsletters of the three Peak organisations. In total 36 NGO AOD services completed the survey, representing a participation rate of 43.4%. Of the 36 NGO AOD services, 29 were located in NSW (participation rate of 48.3%), 4 in TAS (participation rate of 28.6%), and 8 in ACT (participation rate of 88.9%). It is not possible to assess the representativeness of the agencies that responded to the survey.

1.2 Focus groups

In order to collect in-depth information on the short- and long terms impacts of COVID-19, and in order to gain better insights on the impact of COVID-19 on rural, regional and remote NSW services and specific client populations (e.g. Aboriginal and Torres Strait Islander peoples, women and women with children, and youth), four semi-structured online focus groups were conducted in October 2020. The focus groups were conducted with service providers of NGO AOD services located in NSW. The stakeholder list was developed in consultation with NADA to ensure we had representations across the range of AOD treatment types, the size and geographical location of sites, and specific client populations. Letters of Invitation were sent to the people on the stakeholder list by NADA. Services could then contact the researchers if they were interested in participating.

The questions posed during the focus groups were not only informed by the four research domains but also by the preliminary survey results. Interesting survey results were discussed during the focus groups to be

able to conceptualise the data. For example, almost 78% of the survey respondents considered their service to be highly or somewhat sustainable if COVID-19 related issues continue for another 12 months, but what does it mean for a NGO service to be sustainable? Of the four focus groups one specifically focussed on the impact of COVID-19 on rural, regional and remote NSW services; with another examining the impact on specific client populations.

Participants in the focus groups could speak knowledgeably about the subject matter under investigation. In total 37 people were contacted of which 17 service providers consented to participate in one of the focus groups. Each focus group included around 3-6 stakeholders.

1.3 NADAbase

Administrative treatment data of the NADAbase was obtained from NADA. The NADAbase is a comprehensive system for client data collection and reporting for AOD services located in NSW. This database contains de-identified records of treatment episodes, including the number of episodes, and within each episode the type of treatment, the average length of treatment, the referral source, the treatment setting, and the drug type being treated. Records from 1st January 2019 through to the 30th of September 2020 were obtained.

The NADAbase data covered 60 NGO AOD services located in NSW. Any identifying information was removed from the database by its administrator prior to it being provided to the research team. The commencement date of all episodes of care was taken as the key variable to examine patterns of admissions over time.

2. Data Analysis

The survey data and NADAbase data were analysed using SPSS and Excel. Descriptive statistics were used to summarise the impact of COVID-19 on the four research domains. The qualitative data in the open-ended survey responses and focus groups (i.e. the transcripts) were examined to construct themes using a reflective, iterative process. Regular meetings were set up with NADA to identify common patterns and emergent themes, and to conceptualise the qualitative and quantitative data. The data derived from the organisational survey, focus groups and NADAbase was triangulated and analyses were focussed on:

- The impacts of COVID-19 on all four domains; and
- Recommendations, driven from the data and co-developed with NADA, identify immediate issues that need attention in the coming weeks, medium-term issues (next 12 months), and long term issues (next 5 years).

3. Ethics approval

Ethics approval was obtained from the Human Research Ethics Committee at UNE Australia (HE20-157) and the Community Mental Health Drug and Alcohol Research Network (CMHDARN) Research Ethics Consultation Committee.

Results

1. Business practice impacts

NGO AOD treatment services experienced changes to their costs, changes to their income, and changes to the levels of financial support received from funders. Each of these is addressed in turn.

1.1 Changes to costs of AOD services

In an already tight financial situation, NGO AOD treatment providers experienced budget strain:

“The combination of increasing staff wages (as per award), increased costs of operations to support service delivery incl. consumables and ICT, etc., have put pressure on our budget.”
(Survey)

While 37.5% of services reported an increase in their costs as a result of COVID-19, a similar proportion (40.6%) in NSW, TAS and ACT reported that while their costs in some areas, they had also reduced in other areas. See Table 1.

Table 1: Changes to costs of service delivery

Costs of service delivery	n	% of respondents (N=32)
Reduced	3	9.4%
Increased	12	37.5%
Reduced in some areas, increased in others	13	40.6%
No impact	2	6.3%
Don't know/unsure	2	6.3%

Respondents noted that additional costs were particularly related to the implementation of COVID-19 policies and workforce development, while at the same time travel costs were reduced due to the increased use of technology-based services.

Costs due to the implementation of COVID-19 policies

Additional costs were mainly related to ensuring services abided by COVID-19 restrictions, such as the costs of transitioning to technology-based services and investing in ICT infrastructure (e.g. purchasing laptops for staff and investing in online programs), and the increased need for personal protective equipment (PPE) and cleaning:

“It has had a major impact, has caused the diversion of resources from service delivery to developing COVID-19 safe practices and to purchase the various chemicals and PPE to keep everyone safe. This should have been funded by Health.” (Survey)

“I think the total cost of COVID-19 for [name service] in addition was about a quarter of a million. That was the costs of hotel accommodation, costs and staffing, costs of PPE, costs of inventory. So, we moved to a position where we wanted to keep three months of inventory across PPE and food for resi services in case of supply change risk.” (Focus group)

“Yeah we had some – obviously some reasonable costs in terms of additional technology so you know tablets and even just upgrading some of our networks, our internet connections and our Wi-Fi needed to be upgraded to be able to reach [deidentified; name property]. Because we were running groups in the isolation houses we had to have those connections working where they previously just needed a phone line, so there's been expenditure in that space [...]” (Focus group)

It was also noted that staff costs per client increased due to people needing to go in isolation:

“Staffing costs per participant increase when we have to have people in isolation - more strain on staff, etc.” (Survey)

One focus group respondent also noted additional costs related to brokage of transport and accessing assets:

“And the other thing too is – would be brokerage for transport and brokerage for accessing assets and operational costs of platforms to be able to remain engaged in care.” (Focus group)

This is in line with the State and Territory Alcohol and Other Drugs Peaks Network (2020) survey which showed that NGO AOD services experienced additional costs due to accessing PPE, additional cleaning fees, and due to technology costs. Other costs that were noted were related to insurance, increased management/labour costs, transportation costs, brokage costs and resource development.

Workforce development costs

When looking at the three jurisdictions, for most services workforce development costs either increased (33.3%, n=11), or reduced in some areas while increasing in others (48.5%, n=16). Although some reported no impact (15.2%, n=5) or even a reduction (3.0%, n=1), there were particularly increased costs due to increased investment in workforce development, in relation to upskilling IT skills of staff.

“Initial costs higher due to investment in IT, platforms, increased professional development. Ongoing costs likely to be similar to prior.” (Survey)

“[...] Increased costs (time and money) for professional development to help provide a balanced working week [...]” (Survey)

Reduced costs

It was however noted that there was a reduction in travel costs due to the uptake of technology; in terms of delivering services and workforce-related activities (e.g. supervisory meetings):

“Zoom culture both internally and externally. Reduced travel time and costs due to zoom meetings.” (Survey)

Some residential services also reported they had less costs related to food and utilities due to reduced client numbers.

“[...] We had reductions in people on site so we had less on food and utilities so we reinvested that into staffing costs and things like that.” (Focus group)

1.2 Changes to income of AOD services

The survey data shows that although the majority of services in NSW, TAS and ACT did not see a change to their income (53.1%, n=17), two fifths of respondents (40.6%, n=13) did report changes to their income, with 6.3% (n=2) being unsure. A particular issue that was noted was the reduction in donations, for example, because of not being able to organise fundraising events.

“[...] But charities have been hit hard by this too. ... a lot of you know like donations were hit hard. Some of the things they do to get donations in shops, you know second-hand shops that would bring in revenue that could sort of add to the organisation and the infrastructure. It's been hit hard as well you know they've had a loss too [...]” (Focus group)

“All our fundraising events have been cancelled. Our gala dinner was cancelled. So our fundraising hole is absolutely huge [...]” (Focus group)

Another reported income source that was affected were client contributions due to reduced bed numbers and occupancy rates as a result of COVID-19 restrictions.

“Operational income reduced due to lowered residential numbers, client contributions, and an increase in cleaning costs.” (Survey)

“[...] It’s a cost for us also because we do have co-contributions from our participants where our funding probably only covers only half of what it costs to actually run the program. So if we didn’t have the co-contributions we wouldn’t be running the program” (Focus group)

“I think from our perspective it wouldn’t hurt to have a bit more income from the funding bodies itself. As I said we are reliant to some extent on our occupancy levels. If we don’t have – we’d see them – you know we are actually running at a shortfall. So for us that – with our residential side that’s really important.” (Focus group)

This was also confirmed by many of the survey respondents; 47.2% (n= 17) noted a reduction in bed numbers. This reduced income from client fees was also noted in the State and Territory Alcohol and Other Drugs Peaks Network (2020) survey.

1.3 Financial support provided to AOD services

When looking at the three jurisdiction, the survey data showed that although the majority of services did receive financial support from government sources (62.5%, n=20), often this was not sufficient to off-set all additional costs related to COVID-19 (37.5%, n=12). See Table 2.

Table 2: Financial support from government sources

Financial support	n	% of respondents (N=32)
Yes, which covered our additional costs	8	25.0%
Yes, but not enough to off-set our costs	12	37.5%
No	6	18.8%
Don’t know/unsure	6	18.8%

Agencies were disgruntled that they did not receive funding to cover PPE costs:

“All government agencies did not offer and refused to offer any PPE. Only the [name funder] provide support.” (Survey)

“This should have been funded by Health [this refers to PPE]” (Survey)

Some agencies were however able to secure additional government funding:

“So, we obviously had a fair bit of cost of inventory and the cost of telehealth and transformation. I think the unfunded cost of that was about \$40K and the rest was covered through stimulus payments, most though DCJ [NSW Department of Communities and Justice]. So, we got funding for the hotel beds and we got funding for deep cleaning. They actually gave us stimulus payments to get our programs and service deep cleaned by accredited experts through the procurement portal” (Focus group).

“We are grateful we were supported by funders to be able to keep staff on.” (Survey)

Financial support dependent on the jurisdiction

In terms of government support, participants perceived that the level of financial support was dependent on the jurisdiction; with some jurisdictions being very quick with rolling out additional funding whereas others were slow in their response.

“Respondent 1: The only stream of our organisation that didn’t get funding to support with COVID-19 was the drug and alcohol stream. Every other stream got stimulus payments to support with either deep cleaning or PPE or food or the hotel accommodation. But the New South Wales AOD treatment system, we didn’t get anything and that was the only stream of the organisation where we didn’t get funding or support. Which I thought was a little bit annoying [...]

Respondent 2: I’ll back you [respondent 1] up on all of that that never happened. Queensland Health contacted all the resi services up there and said you know kind of put in what you need so that you can respond to the COVID-19 situation. So they did grants immediately, it was a very simplified grant process and it was very quick in rolling out the money [...] (Focus group)

JobKeeper: an important source of income

Respondents noted that JobKeeper has been an important form of financial assistance in order to retain staff and services were grateful for the additional funding received in order to retain staff.

“[...] in all honesty, if it wasn’t for JobKeeper – that’s really what kept us afloat and the extra payment from Centrelink which also came to us. Those two things have matched what we would do in fundraising throughout the year. So as soon as that stops – we actually thought we were going to miss out this month and we managed to get through on a technicality, which was great. But yeah, if it wasn’t for that, you know, we would have a massive hole.” (Focus group)

“JobKeeper is a great financial assistance. The costs are still yet to be identified.” (Survey)

“We have not had to draw down on reserve yet as our contracts have remained in place and we have received some stimulus payments from government including JobKeeper.” (Survey)

The importance of the JobKeeper scheme was also confirmed by the national NGO AOD survey (State and Territory Alcohol and Other Drugs Peaks Network, 2020), which found that 26.2% reportedly accessing the JobKeeper scheme.

There is concern, however, that changes to JobKeeper will negatively impact on the financial circumstances of treatment services:

“[...] having half capacity is impacting us financially. JobKeeper has been a bit of a savour in that regard. That sort of has topped up that particular group. [...] But the ongoing costs are going to be interesting now that JobKeeper’s being dialled back a little bit. We’re going to start to see a bit of a short fall I think unless we can bring our numbers back up too closer to you know 75 percent sort of capacity.” (Focus group)

Financial support from philanthropy, charities, or other non-government sources

In terms of financial support from philanthropy, charities, or other non-government sources, the majority of services (62.5%, n=20) did not receive additional financial support with reference to COVID-19. See Table 3. However, as also noted above, philanthropies and charities seem to be particularly hit hard due to their conventional methods of collecting donations being heavily impacted. This issue has also been noted in relation to other sectors (Cahan, 2020).

Table 3: Financial support from philanthropy, charities, or other non-government sources

Financial support	n	% of respondents (N=32)
Yes, which covered our additional costs	3	9.4%
Yes, but not enough to off-set our costs	6	18.8%
No	20	62.5%
Don’t know/unsure	3	9.4%

1.4 Risk management practices

Like all health services, and indeed all organisations and services, COVID-19 forced a change to risk management practices. Changed risk management practices for the vast majority of NGO AOD treatment services were related to the usual COVID-19 measures that needed to be implemented such as establishing and following COVID-19 safety/response/outbreak management/disaster plan; increased risk management reviews; the need for using masks; temperature screening; COVID-19 questions for staff and clients; physical distancing measures; infection control measures; and more awareness of hygiene practices.

It was noted that infection control became and still is a constant preoccupation of services as this risk could lead to services (temporarily) being closed down. As NSW focus group participants noted for residential services it was particularly acute for staff members who had to go in and out the facility.

“[...] really trying to hammer home to the workforce that in the residential settings that they [staff] were the threat to the residents because the residents were confined to the facility. So, the only people who came into the facility were people either doing deliveries and we handled them at the gate so to speak, where the staff who worked with the clients. [...] So, keeping people aware around infection control in relation to COVID-19, so as not to bring infection into the TC, became a prominent aspect of our work. So, we instituted weekly meetings with all of our managers, so you know Zoom conferences with all of our managers across all sites. Where we developed our action plan and we reported back on action points, the managers then would go from that meeting and meet with their staff.” (Focus group).

“Once residents are in the bubble, when they don’t have COVID-19 and whatever, they’re okay with each other. It’s just when you’re bringing people into the bubble or out of the bubble, that’s when you have to have a process in place and the biggest risk probably is staff because staff – I mean, our main residential in [name location] has been a continuous hotspot over the time, so our biggest risk to our residents was actually our staff, so that thing, bringing people into the bubble.” (Focus group)

Some services had to also (temporarily) close down, stop admissions and/or adjust their service delivery to put a COVID-19 safety plan into place.

“Well the biggest risk to the residential services, of course, was getting you know a confirmed case within the resident group because then at that point you know we will either go out of business in terms of having to shut down or we’d become lockdown, without the type of support that an aged care facility might get from the Federal Government in relation to their lockdown. Which you know for us was just an unacceptable risk so we had to stop admissions for a little while, while we took stock about what was going on. Then we developed our kind of, well you know COVID-19 safety plan for want of a better expression, but so we had to stop admissions for a period of time.” (Focus group)

Furthermore, several participants noted the difficulty of handling symptoms of sickness as every symptom needs to be treated as serious and possible related to COVID-19. As a result, staff are forced to take sick leave, even with the slightest cough or sore throat, leading to a reduced workforce (see also section 2.3 on increased workload).

“I think one that we’re currently grappling with, and I was talking with the manager yesterday, is workforce issues, the old adage of, you know, “Just soldier on and push through” is not something that we can now have happen. So, anyone who gets the slightest cough or sore throat or whatever is legitimately not at work anymore. When you run a residential setting, a residential facility, you rely on a certain amount of staff to ensure safety and to ensure program continuity and that is really challenging now. I imagine staff are going to soon start to hit up against that, you know, “I’ve used up all my sick leave” because we’re saying to them, “As soon as you’ve got a sore throat, you’ve got to go home.” (Focus group)

Access to health guidelines

When looking at all three jurisdictions, all survey participants reported having access to health guidelines or recommendations, particularly national guidelines and/or recommendations (100%), followed by resources from the peak body to support service provision (81.3%) to developing their own guidelines and/or recommendations (78.1%). See Table 4.

Table 4: Access to health guidelines and/or recommendations

Access to health guidelines and/or recommendations	n	% of respondents (N=32)
National guidelines and/or recommendations	32	100.0%
International guidelines and/or recommendations	4	12.5%
We produced our own guidelines and/or recommendations	25	78.1%
We received resources from Peak body to support service provision	26	81.3%
Other	4	12.5%

Note: responses are not mutually exclusive, hence sum greater than the sample size as one AOD organization can have sites located in multiple jurisdictions.

Although all services were able to access health guidelines or recommendations, respondents noted that resources came out late, often after services already had developed their own health guidelines or recommendations out of necessity. In addition, as reported in the NSW focus groups, protocols also varied depending on the type of program and government agency.

“Respondent 1: I think the resi treatment standards, the resi COVID-19 safe standards came out in what like late August-early September from the Ministry.

Respondent 2: I’ll back you [respondent 1] up on all of that that never happened [...] The guidelines that came out from New South Wales Health were actually based on the aged care guidelines that had been issued by the Federal Government because we got a hold of them about two months before the New South Wales Health did. We amended those to inform what we were doing at all of the residential sites including you know kind of the outbreak management committee and stuff like that is contained in that. So, that’s where all that came from the New South Wales Health ones, they came from aged care.” (Focus group)

“[...] Then we saw a completely different response required from state-based programs and federally based programs. We were in a position where we had four or five different working protocols from different government agencies in terms of how to respond and some came four or five months after the others.” (Focus group).

“So we were on version six of those standards before Health came out with version one for drug and alcohol [...]” (Focus group)

1.5 Contract management

At a time of great upheaval, flexibility in contract management is required.

Adjustments of Key Performance Indicators (KPIs)

Survey data showed that the government funders supported adjusting contracted deliverables or Key Performance Indicators (KPIs) (75%, n=25). For example, data reports being extended or being altered by funders who wanted to understand changes to service delivery and solutions needed.

“Ours [funders] have been similar as well. They’ve been very good. We had a couple extend the reporting period. We were able to record data but the virtual data versus the in person data which is something they asked for as well and a couple of them have extended that into the next annual plan as to have like a – still have a COVID-19 section where looking at what sort of

limitations are and how much virtual service delivery we're still providing as opposed to face to face and that sort of thing. So it's sort of ongoing." (Focus group)

"We actually had some reports that were actual pushed back in terms of delivery times and whatnot. And they've been fantastic in terms of just communicating around "Look we understand you've been operating at a lower capacity and don't fret about occupancies and those things", when we're reporting." [...] (Focus group)

Flexibility on what the funding could be spend on

The majority of survey participants in NSW, ACT and TAS also reported that their government funder supported increasing funding flexibility (53.2%, n=17). For example, one respondent noted that one of the funders allowed them to buy phones for their clients due to some face-to-face services dropping off because of COVID-19.

"[...] there's a lot of homelessness as well as drop-ins to the office and none of them have phones generally. So that was a huge barrier for treatment for the staff Because I was actually talking to one of our funders about it and they thought it would be a good idea to include in the funding provision to buy phones for people. Which was good." (Focus group)

Another aspect noted by respondents was the extent to which funders would take into account the extra pressure COVID-19 has put on services and which has impacted their data collection practices and direct service delivery (e.g. ability to see less clients). Allowing flexibility in reporting around what services are doing to cope with the COVID-19 restrictions was therefore considered important.

"Reporting should be able to give us the freedom to do, you know show the kind of work we're doing, not the KPIs on bed occupancy or the number of clients who are in resi. Because when we have changed the program of half resi and supporting them outside and things like that, there should be more room for you know that kind of ability to represent that." (Focus group)

One respondent also noted that it was important for arrangements to be formalised by funders to reduce feelings of insecurity:

"[...]Like it would be good to get some sort of acknowledgment from them that yes you can continue in the manner that you see fit with your funding into the future until we otherwise say so or something. I guess there's that for me as a CEO it feels a little bit "oh God I hope they really are okay with me doing this, what I'm doing and for how long will they be okay with that before they will review"." (Focus group)

Anxiety about the future of contract obligations

There was the worry about how funding bodies would assess performance data in the future.

"Yeah, I just sort of wonder about the communication with [name funder] moving into the future of what they're expectation is on us cause I haven't had any direct communication, I've told them well this is what we're doing and they've gone "good on ya!" and that's kind of like it. So, I have varied my funding agreement with them and if they're happy for me to do this, or if they're happy for the sector to respond how they believe, based on their individuality and the program they're presenting in this time [...]" (Focus group)

[...] So we've been asked to see this many people in treatment, yet we're not allowed to see them because of the COVID-19 guidelines. So for example, you need x amount of beds for funding but you can't actually physically have that many beds because it's not COVID-19 safe. So they've said yes it's fine, it's fine, you know don't worry about it for now, but there's been no forward projection in terms of what it will look like moving forward because nobody knows. [...] I would hope that they're [funding bodies] evaluating the performance data that's coming

through in terms of their forward work planning. I think I did some work for the PHN and based on the population growth for central and also Sydney PHN if the prevalence rates stay the same in the PHN you would still be looking at like 4,000 more episodes of care in the drug and alcohol space just from population growth alone. So, all of these kinds of pre-pandemic factors haven't been addressed and then all the changes in terms of how we're adapting to what we're seeing on the ground isn't being considered as well. Then there's the admin overhead in terms of actual feasibility incorporating the collection methods." (Focus group)

" [...] There is still a sense like that you know that they'll only go for so long and eventually there's going to be a requirement around okay well when "When are you going to get back up to your full capacity or your occupancy level?" [...] So you know while reporting stuff has been fantastic recently you still get that sense that there would come a time where it's going to be an expectation that if you're not delivering on this sort of stuff you know then where are we up to with contracts? Fortunately because we're in the middle of a three year contract we we're going nowhere any time soon but you know these things don't go away. They always get looked back on at some point." (Focus group)

One respondent also reported the risk of losing their budget due to not be able to expend funding on their usual services.

"Difficult to expend funding for community engagement, health promotion, social wellbeing activities due to restrictions in place around group gatherings. Risk of excess underspends and losing funding that we just haven't been able to spend per budget plans." (Survey)

Ability to collect data

Although the majority of survey respondents did not see changes in their data collection practices (71.9%, n=23), one quarter of services (25.0%, n=8) in NSW, ACT and TAS did notice changes. Although there were no major changes in their ability to collect, changes had to be made in the way the data were collected, which for some increased the administrative burden of collecting data. This arose as a result of needing to move to online platforms, as noted in the NSW focus groups.

"I think there's two things is that it's the data we're collecting and then how we're collecting it. I think we were able to collect all the PREMs and PROMs and performance data that we required to digitally and we have to do that through CoviU. So, for example, things like Zoom you can't have a client use a touch screen to fill out a K10. So, we had to find the right platform that would allow us to collect all this information and we did find that.[...] So using things like SurveyMonkey and SMS and texts and stuff, but that came with an administrative burden. So we've seen about between a 30% to 50% increase in the amount of time taken to do the admin because it's digital and not face to face." (Focus group)

"Yeah. Actually, we had to transition I guess how we collected that information. We had to change our consent forms to being online because we would also see new clients and they wouldn't be able to physically sign the form. We changed our assessments, so we would do like a block of assessments for people and we changed that to be a link that you fill out and then it comes back to us. So that was quite good. It took a while to get it done." (Focus group)

For the survey respondents who selected yes for noticing changes in their data collection practices (N=8), reasons for noticing changes were related to (See Table 5):

Table 5: Changes in data collecting practices

Change in data collecting practices	n	% of respondents (N=8)
Technical issues	8	100.0%
Clients exiting unexpectedly	5	62.5%
Collection issues	4	50.0%
Time/priority issues	3	37.5%

Note: responses are not mutually exclusive, hence sum greater than the sample size as one AOD organization can have sites located in multiple jurisdictions.

1.6 Collaboration, communication and coordination between relevant stakeholders

One of the impacts of COVID-19 has been the necessity of greater communications between parts of the health system. As one respondent explained:

"[...] we had to work closely with DCJ [Department of Communities and Justice], with the hospital, local hospital to support us and that kind of isolation and they agreed to do that. Also, you know we spoke to the local, once we said okay we'll open now because taking in more clients because we had the bed and because the demand was rising. We again spoke to the detox centres that they would keep them for 14 days and then we bring them in. Some places it happened and some places it couldn't happen, so we had to have one room exclusively." (Focus groups)

COVID-19 testing for current and prospective clients of AOD treatment also entailed the establishment of new collaborations:

"[...] We developed a partnership with the LHD initially to be able to do COVID-19 testing on the way into treatment and then as the COVID-19 pop up clinics have become prolific we just get young people to do that on their way into treatment. So, we developed some really clear protocols on how we managed containment of infection so that we could manage operations [...]" (Focus group)

The vast majority of services did not report reduced collaboration with other services (83.3%, n=36); almost half of services (44.4%, n=36) even reported improved collaboration with other services.

"We have improved collaboration with some services and reduced with others." (Survey)

"Greater collaboration with government agencies, government policy areas and public health units/authorities." (Survey)

1.7 Sustainability of AOD services

The majority of services either felt somewhat (51.6%, n=16) or highly sustainable (41.9%, n=13) if COVID-19 related issues continue for another 12 months. See Table 6.

Table 6: Sustainability of services if COVID-19 related issues continue for another 12 months

Sustainability of services	N	% of respondents (n=31)
Highly sustainable	13	41.9%
Somewhat sustainable	16	51.6%
Not really sustainable	2	6.5%
Unsustainable	-	-
Don't know/unsure	-	-

Although many participants reported that they felt that they could sustain themselves if COVID-19 related issues continued for another 12 months, a key consideration is how services are able to support themselves in the long-term.

“Just a comment back on just the thing around you know kind of organisations saying they’d been sustainable for 12 months or they’d be able to operate under COVID-19 conditions for 12 months. You know I think it would be a brave organisation that would go, no if COVID-19 continues we won’t be able to operate. I think it’s a question from my perspective that you would always get a yes from as an answer. But how they operate, what the impact across you know particularly those four domains that you mentioned at the beginning. You know like the workforce, the business, the service delivery and then the one that we really you know have no control over is the kind of level of demand, we only get control over how we manage that demand.” (Focus group)

Many respondents noted that this “sustainability” would come at a cost; both in terms of finances and workforce (see below).

Financial sustainability

The survey data showed that more than one quarter of service respondents in NSW, ACT and TAS (28.1%, n=9) had to draw on financial reserves during the COVID-19 period. Respondents also noted that they had to restructure their service to ensure that the service would still be viable in the long-term.

“Cash reserves, we have a rainy day fund and it was pretty rainy outside. So and yeah obviously that’s not a long term thing. We were just lucky that we had that you know. We have quite strong cash reserves that we could draw down on. But I think as treatment modality has changed you know it also changes our cost base long-term. You know as you’ve got issues around keeping and remaining with telehealth, for example, or investment in infrastructure. You know even for us, one of the things we did, we actually lost a management role so we could reinvest into frontline service delivery because demand has exploded so much. The only way we could pay for it was by spending more boots on the ground and less boots in management really and that’s one of the things we did.” (Focus group)

“So, I think from a sustainability piece when you’re trying to do significantly more with comparatively less, is you’ll see a lot of organisations go through restructures. Again we are seeing a couple of agencies already starting to do redesign work at play in order to kind of prepare for a new normal. That will obviously put a lot of volatility into the sector as well and I don’t think there’s really the cost efficiencies that could be found long-term. So, I think that’s my thoughts on the long term, so I don’t think it’s suitable.” (Focus group)

Almost every respondent noted that AOD treatment was underfunded, independently from the pandemic situation. But there were particular circumstances that highlighted the inadequate funding. One example was the early release from prisons associated with the pandemic:

“More people were released from prison on bail and yet there was not a corresponding increase in support and resources to respond to those people’s needs.” (Survey)

Furthermore, it is important that costs outside of service delivery, such as transport, are covered to ensure the delivery of quality care. However, this issue of the full costs of service delivery not being covered, including infrastructure (e.g. transport), capacity building (e.g. workforce development) and workforce (e.g. salary increases), is a long-standing issue (van de Ven et al., 2020); something which has been exacerbated due to COVID-19.

“I just wanted to speak to the question that you had earlier about what we would require from the funding body to continue to provide a quality service in the community. [...] We have two or three programs that although transport is not the primary function it’s a big piece of the service delivery in terms of allowing participants who are without public transport and without means to actually access you know psychiatry appointments and things like that that were unable to go ahead. So and a lot of people who miss out on a lot of care in that particular period. And the

other thing too is – would be brokerage for transport and brokerage for accessing assets and operational costs of platforms to be able to remain engaged in care. That would make a really big difference for our service delivery.” (Focus group)

As such, as one respondent noted, to ensure the sustainability of the AOD service sector it is important to support the rebuild of services:

“This has been an extraordinarily challenging year, like no other. We need to know that the sector is support(ed) to rebuild when this crisis is over.” (Survey)

In July 2020, a national coalition of AOD organisations called on governments to extend pandemic-related changes to telehealth, digital access, and pharmacotherapy, and develop a national response to AOD needs that covers investment in rural and regional services, workforce training, and more effective data gathering (St Vincent’s Health Australia, 2020). Inadequate funding is however a long-standing issue within the AOD treatment service sector (Ritter et al., 2014; Roche & Pidd, 2010; van de Ven et al., 2020); not only in terms of shortages but also in the way services are procured (e.g. competitive tendering, short contract lengths) (van de Ven et al., 2020). These additional accrued costs due to COVID-19 therefore further exacerbate the existing funding issues experienced by AOD services.

The toll on workforce

It was noted that in order to ensure the sustainability of services, measures need to be put in place against the increased stress levels staff have experienced and still are experiencing (see also section 2.4 on staff wellbeing). Due to staff working at increased capacity with no breaks, there is the risk that it will impact the wellbeing and vitality of the AOD workforce in the long-term.

“So the initial month or so was an absolute sprint. We just basically dropped everything. We were in meetings all day trying to work out what to do and the lack of information at that time, how can you get infected, you know, flat surfaces and how long and how close do you have to be, like it was just an absolute sprint whereas ... I do feel like the last sort of five months say, particularly with the low cases numbers in New South Wales, we’ve gone into more of a jog, like it’s work and it’s tiring but we’ve sort of found a bit of a rhythm. So I can understand what the other participants were saying. We could do this for another 12 months now. We’ve sort of found our rhythm but having said that, my staff are absolutely bugged and they’re really starting to talk about who’s taking a significant amount of leave over Christmas and “How are we going to stagger that?” because they need a break. So I can see what they’re saying. It is sustainable but people are tired. Organisations are stretched also, not just people, it’s the business as well.” (Focus group)

Future outbreaks

Participants also noted that this constant state of heightened alertness is a drain on services, which is not likely to go away soon unless the pandemic is truly finished.

“Participant 3: [...] we are just working literally on our feet because although New South Wales seems safe, anything can go on. So, it’s like always in the precaution mode. Yes, we are going pretty well but if something has to come we’ll have to roll back slowly. That’s how we are operating now.

Participant 2: That last point that [name participant 3] made is a really, really important point in that we’re all on this kind of heightened alertness to make sure that our service, our residents and staff or our clients and staff in day programs remain safe. We don’t, we don’t become the kind of next hotspot you know. So, there’s no kind of relaxing and we will be in this heightened state until you know the pandemic is finished, which could be you know a year or 18 months, two years or whatever. I think that’s a really important point because that’s resource-draining for any organisation, it doesn’t matter what size or what service type. It’s not just resource-

draining in terms of you know financial and physical resources but there's that kind of emotional type of you know drain that happens for staff and residents. There's that continual reminding of people not to relax [...]" (Focus group)

To prevent this it is important to develop measures to be able to quickly respond in case of new outbreaks.

"At some point there will have to be localised containment lines and bubbles or businesses and services will be shut down again every time there is a new outbreak. We will have to be able to respond quickly in these events. The difficulty in our residential service is if there is one positive the whole service shuts and will we be supported to do that possible again and again." (Survey)

However, survey respondents did note that they either feel somewhat (48.4%, n=15) or highly prepared (51.6%, n=16) in case of future disruptions of services.

2. Workforce impacts

The NGO AOD treatment workforce impacts included changes to the size of the workforce, the level of experience, and workforce development needs. The difficulties of retaining and recruiting experienced and qualified staff, particularly in rural and remote areas, is an ongoing issue in Australia (e.g. see NADA, 2008; Roche, O'Neill, & Wolinski, 2004; Roche & Pidd, 2010). Reported reasons amongst others are poor salary, terms and conditions of employment; lack of professional and career development opportunities; high workloads and work stress; complexity of roles; poor public profile (stigma associated with the work); difficult work environments; uncertainty of tenure due to short-term funding; limited clinical supervision and managerial support; and limited recognition for effort (e.g. see Duraisingam et al., 2006; NADA, 2008). Nevertheless, an added layer is that due to COVID-19 some experienced staff have taken early retirement.

2.1 Changes in workforce size

The majority of respondents (see Table 7) reported relatively few changes in the size of their paid workforce as a result of COVID-19 but for many (one third) both a slight decrease and increase was noted. In addition, 30.3% (n=10) saw a strong decrease in the number of volunteers.

Table 7: Changes in workforce size

Workforce size	Changes in workforce size (N=33)				
	Strong increase	Slight Increase	No change	Slight decrease	Strong decrease
Number of people	-	27.3%	42.4%	30.3%	-
FTE Paid staff	-	21.2%	57.6%	21.2%	-
Casuals	-	30.3%	42.4%	24.2%	3.0%
Volunteers	-	9.1%	54.4%	6.1%	30.3%

NSW focus group respondents noted that this reduction in volunteers was related to some volunteers being older and therefore for safety reasons the volunteers could not continue to support the services, and because of a reduction in student placements.

“We’ve definitely noticed [a reduction in volunteers], well for a period of time because a lot of volunteers are older as well.” (Focus group)

“That’s the same for students also. This year we had much less student placements because the universities didn’t and then because of lockdown we couldn’t let them because we don’t know where they are staying. I mean students require great support but then with you know with no students it becomes very difficult because of a lot of extra pressure on the staff.” (Focus group)

2.2 Changes in workforce development opportunities

In terms of supervision, there appeared to be little change as a result of COVID-19 (See Table 8) but more respondents reported a slight increase in supervision opportunities than reported a decrease in supervision opportunities. At the same time, there was a reportedly strong increase in opportunities for training for staff (24%) and similarly a strong increase (24%) in accommodating the needs of staff during COVID-19. Promotional opportunities and career advancement did not change. There was a perceived slight decrease in team building opportunities reported by 39.4% of respondents, and a similar proportion (36.4%) reported a slight increase in team building opportunities.

Table 8: Changes in workforce development opportunities

Workforce development opportunities	Changes in workforce development opportunities (N=33)					
	Strong increase	Slight Increase	No change	Slight decrease	Strong decrease	N/A
Hours of clinical supervision	6.1%	21.2%	60.6%	6.1%	6.1%	-
Hours of cultural supervision	-	12.1%	66.7%	-	6.1%	15.2%
Accommodating special needs of staff	24.2%	30.3%	27.3%	6.1%	12.1%	-
Opportunities for training	24.2%	30.3%	15.2%	18.2%	12.1%	-
Opportunities for formal education	6.1%	21.2%	48.5%	9.1%	15.2%	-
Opportunities for career advancement/promotion	-	15.2%	72.7%	6.1%	6.1%	-
Team building opportunities	6.1%	36.4%	12.1%	39.4%	6.1%	-

2.3 Changes in work environment

Recruitment and retainment issues

A particular concern noted by many respondents in NSW, ACT and TAS was the retention of qualified and experienced staff. One respondent in the survey put this down to the experience of working from home, other respondents noted retirement earlier than planned, and staff not returning due to needing to find additional employment. In addition, 21.2% (n=7) of the survey respondents also reported loss of work for casual staff and 18.2% reported reduced hours for staff (n=6). Luckily, most services did not report job losses or non-renewal of contracts (93.9%, n=31) or reduced pay for staff or pay freezes (93.9%, n=31).

The survey data also show that almost two fifth of (39.4%, n=13) of respondents reported difficulties in recruiting new staff, and for almost one third (30.3%, n=10) there was a hold on all staff recruitment. One reported reason for the difficulties of recruiting new staff was the reduced number of new entrants to the AOD workforce due to reduced training opportunities.

“With limits on the wider community and some learning institutions suspending or reducing training hours/events there may be a reduction or gap in the number of new entrants to the AOD workforce. Also people that have had to find other or additional employment may chose not to return.” (Survey)

Many respondents noted that workforce recruitment and retention was a future-directed concern:

“Hopefully we can still retain our experienced staff. Hopefully be able to recruit to vacancies easier. Increase casual pool again [...]” (Survey)

“Services particularly worry about retaining experienced staff.” (Survey)

“Likely staff turnover in the interim, reduced experienced workforce to recruit from.” (Survey)

Some survey respondents however did note that there might be a slight increase in staff working in the AOD sector and an increased recruitment pool.

“My thoughts are that it will be slightly larger in terms of people studying the sector and looking for ground-level opportunities or a career change.” (Survey)

Increased workload

Many participants also reported that there was an increased workload due to other services closing and receiving more referrals; staff resigning due to COVID-19 risk of working in high risk setting; staff needing to be on sick leave due to cold symptoms and getting tested; older or health compromised paid staff and volunteers being on less hours, had to step back, or were working from home to keep them safe; the need for putting staff on rotating roster, and additional tasks being added due to COVID-19 restrictions (e.g. screening of all visitors, ongoing cleaning of service). However, despite the increase in workload, only for the minority of services was additional overtime left unpaid (15.2%) (n=5).

There were many ways in which workloads increased for AOD services at this time. For some services the increased workload reflected the need to provide greater support to clients:

“Outreach supports were increased during this reporting period and offered to all clients that contacted [name service]. Many [clients] called in crisis and reported feeling anxious and isolated. The decision was made to offer outreach support to all clients in need, not just pre and post program clients, to assist them with safety and well-being at this time. While the increased workload was a challenge, no clients were turned away during this difficult time. It was a major achievement for the team that all clients were able to be offered supports in a flexible and responsive manner. There was increased push by the AOD staff to check in with clients in the community around their safety at home, with a predicted increase in stress, AOD use and domestic and family violence (DFV) related to so many people isolated at home.[...]” (Survey)

“More groups offered internally to participants that we used to source in the community due to other services closures/disruptions.” (Survey)

The perceived need for greater clinical interventions due to complex presentations at this time was also noted:

“Our organization provide psycho-social supports, but with COVID-19, we have been left to provide support to riskier client groups (complex polysubstance and comorbid presentations) that normally would have been supported by clinical government services. Government services reduced their outreach support, which means our NGO workload increased in this space.” (Survey)

In some cases there were simply more clinical tasks to do:

“..Changes to legislation to allow increased take home Methadone doses and use of an agent to collect when a client was in quarantine/isolation. Change in visitor processes, inclusion of screening tools for assessment of all visitors to sites before the visit and on the day [...]” (Survey)

Another reason for the increased workload was because there were fewer staff available to work in any one shift:

“Our workforce planning/rostering changed significantly to put in place discrete teams on a rotating roster to ensure if there was a case/suspected case, not all staff would be impacted and thereby impacting program delivery. Some staff were redeployed from areas where service slowed/ceased due to COVID-19 restrictions, and utilized their skills elsewhere. Reduced cross-site interaction of clients and staff again to minimize any cross contamination/community infection” (Survey).

“I think for me it’s going to be the staffing, both short term and long term and how we then start to staff our facilities, knowing that we’re going to have a percentage of staff who are unwell but not unwell to the point that they, you know, I’ve got a nurse who was not in yesterday because her kids had coughs and colds and sniffles and she ultimately has gotten it

and she said, "Look, I need to let you know I do have a really sore throat." I said, "Well, you need to go and get yourself tested." She's already contacted me and said, "I'm clear but I'll need to feel better before I come back so it might be a couple of days." Now, that's someone who normally before COVID-19 times would have gone, "Look, I'm fine. I'm just feeling a little bit rundown but I'll push through." So I think there's a big workforce question and something we're going to wrestle with short term and long term." (Focus group)

Another factor reported to impact on workload was the increase in administration work:

"But also and clients yeah, I mean we're doing collecting the data and we've mostly been doing it by phone because it's not the client filling it in but the care coordinator will. But it does take the amount of time in admin has increased [...]" (Focus group)

There was a constant vigilance required in relation to infection control:

"So keeping people you know figural in their mind around infection control in relation to COVID-19 so as not to bring infection into the TC became a prominent aspect of our work" (Focus group)

Finally, the time spent on cleaning was also noted:

"[...] the amount of cleaning time is also going to take its toll on people. You know in terms of cleaning office spaces because we don't have cleaners that come in and you know twice a day wipe all the high touchpoints. You know it's the staff that will be doing that." (Focus group)

"[...] So staff work faster and harder whilst they're doing their normal hours. We have people multi-tasking. I've got staff who are trained up who aren't RNs [registered nurses] or even AINs [Assistant in Nursing] but they're able to administer medications and things like that. So now they're doing the nurse's job when they normally would have been the support work role job but they still have to do that one, so they're running fast between [...]" (Focus group)

Accrued annual leave

A particular worry noted by several respondents was the issue of accrued leave and this further impacted the reduced staff numbers.

"[...] Some staff have accrued annual leave due to cancellation of holiday plans or bookings, will need to have clear staff leave planner." (Survey)

"We have leave accumulated and we are telling staff to take leave. But at any moment you know we don't know if we can be short-staffed also. So it is a balance we'll have to see as we are going okay this week this is why no long term planning for now at least where staff leave is concerned." (Focus group)

To avoid this issue, some services have requirements for staff to take leave (27.3%) (n=9).

Difficulties of working from home

It was also noted that due to needing to work from home staff were missing out on those informal conversations (reducing the opportunity for informal and easy briefings about client issues), the isolation impacted the mental health of staff members, and were easily distracted (e.g. needing to take care of children).

"But yeah, there's been a range of issues, firstly with people working from home and not having that kind of informal – a bit similar to what [name] was saying with the clients, it's the same with staff, you know, like you're getting a coffee, having a chat about some issues, somebody is

annoying or whatever. They weren't having that easy access to informative briefing and even face-to-face supervision was online. So yeah, it was very challenging [...] (Focus group)

"In fact the biggest thing I've noticed we've had staff – we had one staff member who moved from South Australia up here, to commence her work day on the first day that we put in a hundred percent work from home. And so those little corridor conversations that you'd normally have with your staff about "Hey you know where do you put that file and what happens with this?" You know so we have to implement more clinical supervision, more frequent contact and planned contact because there were no incidental contacts happening. So we start with doing you know like little touch base catch ups, things like that, with all the teams. It just is a space to sit there and take place with that. So yeah and we have had some staff report that they feel that their mental state hasn't been well. They've reported engaging in treatment for their mental state as well. And we've just been able to support them through that." (Focus group)

"But yeah it was a tough time, particularly for the more extroverted Outreach staff as well because they – if they were living by themselves they had no one to talk to except their cat or whatever and you know people working at home with children as well – small children. Yeah so you'd see them running backwards and forwards behind them and very distracting to try and manage both at once". (Focus group)

Managers and leadership

Across the data sources, we identified new challenges for managers and those in leadership positions. One of these was performance management; in an environment where most staff are under strain, there is a need for role flexibility (noted elsewhere), the regular feedback and performance management tasks for those in leadership positions become more complex:

"I've got caseworkers who will pick up extra groups because they're peer is unwell and I've got quite a few staff who are tapping out at the end of their sick leave now. I can't question it. I have to go, "Oh, okay." So again, there's that management thing of before, there was a wisdom where you go, "Okay. Look, you've had quite a few days. I need to have a yarn with you about that." Now, I don't believe I can do that." (Focus group)

From another perspective, there was a challenge for managers in working with clinicians in implementing the rules and regulations around COVID-19. For clinicians, whose mission is to serve the population in need, the frustrations of not 'being allowed' to do so were evident to managers:

"[...] I think the staff are used to being really autonomous, very, very skilled staff set who aren't – are not used to receiving a lot of restrictions from management. And at the time that the March restrictions came into place and they were instructed not to provide services that caused a lot of tension in the teams and a lot of animosity towards management in posing these restrictions. And as the restrictions eased in modular steps it just frustrated people. I got a lot of frustration from staff. So there was a lot of that going on." (Focus group)

Prioritising clinical service delivery (over management functions) was noted. One service reported that with the loss of a management position, they replaced it with a clinical position ("*...spending more boots on the ground and less boots in management..*" Focus group).

Despite an "overwhelming" tiredness expressed from managers of NGO treatment services, there was recognition of some positive changes to come out of this period, such as increased frequency of management meetings and a greater sense of the leadership team:

"[...] We've got some good things that have come out of COVID=19, like we actually have a Zoom management team meeting twice a week now. It used to be once a fortnight. We're a lot more engaged as a management team, which is really good and you get things sorted out quite quickly and move onto the next thing [...]" (Focus group)

2.4 The impact of COVID-19 on staff wellbeing

Stress and anxiety levels of staff were perceived to have increased (97%, n=32) and staff wellbeing (60.6%, n=20) decreased due to COVID-19. It was noted that because of the constant pressure on staff to work at increased capacity, without breaks, it is taking its toll. Particularly there is the worry that this will lead to burnout if this continues. Even before COVID-19, worker wellbeing has been a key issue facing many AOD organisations in Australia (Nicholas et al., 2017). This is concerning as poor worker wellbeing does not only affect client outcomes but also has major economic impacts. It results in substantial human and financial costs on individuals, organisations and healthcare systems (Nicholas et al., 2017).

“The impact is not so much on the budget because we can’t put more staff on the backfill. The impact is on the mental health and wellbeing and for staff who are still there [...]” (Focus group)

“[...] across some of the other services as well and particularly in residential, it’s like people haven’t really been able to have time off. It’s been quite a traumatic year, like it was quite scary around that time and you’re watching you know media and you know trying to put things in place. It got quite intense workload wise and kind of still is now in the resuming. So it’s now we are going back to resuming so it’s sort of like it’s, and I think it’s been quite a hefty traumatic kind of stressful year really in many ways. I think that has an impact you know.” (Focus group).

“Yeah, so I think the other thing that I’ll just float on connect with something that [name participant] mentioned before, was around people taking leave and being refreshed and restored. Even if you take leave, you’re not coming back to work firing on all cylinders saying “yeah I’m refreshed, I’m restored” there’s just this pervasive level of anxiety through everything that we’re doing. That’s to the general community, it’s not just to our sector, I think everybody’s just “I can’t take anymore, I can’t problem solve another thing, I can’t...” just really exhausted and I think that’s a general community thing.” (Focus group)

The presence of fatigue and stress was not limited to the clinical workforce:

“[...] the decrease in resident numbers have made it very difficult to maintain engagement for residents and staff. The constant vigilance in terms of ensuring precautions are adhered to and concern about potential outbreak has been stressful and has led to some fatigue by all concerned. Some staff have adjusted to the telehealth model and working from home well other staff have found it incredibly difficult.” (Survey)

2.5 Gratefulness amongst the AOD workforce

Despite the additional pressures staff were and are under, respondents across datasets noted that staff generally were really grateful for being able to retain their job (compared to other sectors) and were understanding of the needed changes to services.

“Overall our staff are very grateful to have been looked after and have a job. [...] We are very fortunate that we are funded by government and the funders were supportive of people keeping their jobs so the service could operate as and when it can and has to with restrictions in place.” (Survey)

“It’s been tiring but overall the staff have been positive and adapted positively to change.” (Survey)

“Interestingly staff really appreciated getting back to work on-site after several weeks working from home, staff mentioned missing interactions with their peers and the routine of coming in to work. Moving towards July 2021, the majority of the workforce will be happier to have a job and be able to put their skills and experience into practice that had been taken for granted pre COVID-19.” (Survey)

3. Service delivery impacts

Almost every NGO AOD service in NSW, ACT and TAS that participated in this project reported being forced to adapt their service delivery (91.7%, n=33).

3.1 Adaptation of service delivery models

Perhaps this quote from one of the NSW focus group participants summarises the various challenges that services faced:

“But we had to do some rapid pivoting I guess in a way, so we had to, for example, install NBN in all of our community houses where people were in treatment so they could access telehealth for example. We had to look at the whole supply chain challenge of how do we get food into these houses, how do we get PPE into these houses where there’s men in drug and alcohol treatment trying to kind of change. Then the access piece as the upstream larger scale residential rehabs had to go into lockdown of their own accord and they had to kind of deconcentrate and work within COVID-19 safe guidelines. Then there’s less people coming out of treatment at the other end of that which impacted on the numbers that were coming into our program in that perspective.” (Focus Group)

It highlights that AOD treatment is a system of care, and when one part of the system is impacted (in the quote above residential rehabilitation services) there are flow on effects throughout the system.

For some the focus of the treatment and support service itself changed, in that in some cases it became more about helping clients to get through COVID-19 and managing the exacerbated mental issues that resulted from this.

“It’s been quite a lot I think on the clients as well because they went into kind of a suspension mode I found. For many, the support became more about helping people get through COVID-19 and manage and just harm minimisation around drug and alcohol use for people that were still using. Because the treatment options, and this is no criticism, but just things really just had to level out and slow down and stop so that it could get contained.” (Focus group)

In addition, COVID-19 restrictions amongst others led to needing to delay appointments, limiting the number of people allowed in buildings and/or treatment programs, the need for clients to quarantine and therefore delaying treatment, changing visiting procedures, and the need to adapt service delivery (e.g. switch to technology-based services).

“COVID-19 prevention and outbreak preparedness practices have provided significant impact on services and interventions such as: screening before in-person contact and sometimes delaying appointment; limited number of people in room/area/building at one time; community-based in-person groups suspended; reduced drink/drug drive course numbers and confidentiality concerns regarding web-based programs; allocating areas for isolation/quarantine and 'green zone' for potential outbreak in residential services have reduced bed numbers; all new admissions required to quarantine initially (extra demand on staff and isolating way to be introduced to rehab); residents and staff at different sites not allowed to mix (in-person) to reduce potential cross-contamination; recreational and community activities for residents ceased or reduced; alternating, reduced staff numbers on roster to have 'reserve' staff in case of an outbreak; management of residents/clients and staff identified as 'vulnerable' (some staff unable to return to work whilst COVID-19 a threat; staff additional sick time due to testing and symptoms-free requirements (although staff not coming to work with mild symptoms has been a good thing); significant change of practice for staff; telephone or web-based interventions (additional training and clinical supervision required); increased risk providing non or reduced in-person treatment in the community; home withdrawal program significantly affected as home is an uncontrollable environment, thereby carries the most potential COVID-19 transmission risk; dilemma of using alcohol based sanitizers in AOD treatment services [...]

Projects to implement new treatment options suspended; recruitment temporarily suspended (open now); and unable to use casual staff pool if they work in other services.” (Survey)

“While we were quick to adapt to using phone & online communication during the period of enforced isolation, over 90% of our clients have opted to resume their usual face-to-face counselling and case management now restrictions [name state] are reduced.” (Survey)

“Increased use of phone calls and zoom for clients in residential to see family members more regularly (especially given face to face visits were put on hold in the peak time of COVID-19 infection rates). Increased use of zoom/phone calls with young people (many commenting that they preferred this and were more actively engaged). Conversion of some programs to better suit online or offsite (from home) treatment.” (Survey)

Barriers and challenges for residential services

Specific barriers and challenges were reported for residential services including the difficulties of not being able to offer outdoor activities; the risk of needing to close down if an outbreak occurs within the service; clients not being allowed to leave the centre or being in isolation in their room due to symptoms (leading to boredom amongst clients); maintaining engagement with clients; and not being able to bring clients to certain services (e.g. mental health specialist) or attend certain activities (e.g. Church on Sundays and family visits).

“Restrictions on activities that we are able to take the clients to. Months on end of not leaving the Centre [...]” (Survey)

“[...] The residential program, again, we have the capacity and we kept our clients engaged during this time really well. But one of the hardest things for them is the fact that they can’t go on weekend leave like they used to. They used to go from church Sunday morning to church Sunday night, home with their families. They’re not getting to do that. So we created a Zoom meeting so people can talk to their families. But as you know, that’s not the same as being in the house and having dinner. So there’s a little bit of fatigue there, not to the degree we have to stop but definitely for the program, that’s been one change.” (Focus group)

“The worst thing for us, we don’t have an RN [registered nurse] on site so when we do a COVID-19 test, as soon as somebody is sniffing, you know, they’re locked in a little bedroom for three days before we get our results back and that’s quite mind-numbing for them. There’s no TV in the bedroom so it’s quite boring.” (Focus group)

Despite these challenges, residential services tried to adapt their services as much as possible to accommodate clients, such as expanding outreach support, conducting assessment over phone or online, providing workbooks and readings via email or by printing them off, and/or by making special arrangements for clients to be able to see their children (often online but some were still able to offer face-to-face).

“[...] The two residential houses were temporarily compressed into one, allowing the other to be used for quarantining incoming clients, isolation of ill clients, and provision of a safe space for interstate child visits. This allowed clients to be supported regularly and assisted them to continue as many of their usual activities as possible. Intakes were limited into residential programs, for safety reasons, so outreach supports were expanded to ensure these clients were still intensively supported. [...] Where possible, assessments were completed over the phone or via video link. The AOD service also received a number of calls for support from clients that had previously been with the service, looking for supports to help them avoid relapse during such traumatic times. The Day Program continued operating, however ceased the usual group format and started operating on an individual basis to clients remotely. Case management and counselling supports were also offered remotely. The [named specific group program] was offered in conjunction with (telephone) individual counselling and has been delivered in a

flexible manner. For some clients, {program name} content made up a small portion of their regular telephone counselling session and has been delivered over an extended period of time and for others it has made up the majority of their counselling session. Content workbooks and readings were emailed to clients and for those who did not have the ability to view these on a computer, the content was printed out and posted to them [...]" (Survey)

"[...] To counter the isolation experienced by our residential clients, we developed guest Wi-Fi access in [name service] and allowed increased FaceTime opportunities with family. While out-of-state child visits had to put on hold briefly, these were reinstated as soon as it was possible". (Survey)

It was also noted that there was a lack of support for attaining sufficient isolation of clients before entering residential treatment.

"[...] Lack of support from referring agencies in helping with attaining sufficient isolation prior to coming in. In early months of COVID-19 we asked hospitals for a test prior to referral and were met with 'we can only test if there are symptoms". AOD services are not seen to be 'front-line' services." (Survey)

For existing clients of residential rehabilitation, the COVID-19 restrictions impacted on the program being offered, leaving on respondent to be concerned about 'institutionalisation':

"For us, I reckon it has had impact on participants and their outcomes. When we were on a lockdown, we had hardly anyone leave us. They stayed and stayed. But my fear was they were becoming institutionalised. People were very comfortable here. They went to groups, we had in-house meetings, we continued to have all of that but they weren't being challenged with the day-to-day experiences that living brings you, you know, going to the doctor's and being told, "It's an hour and a half wait. Suck it up, Princess" or you know, going to family house where they expected this but they were met with that and how did that manage it? They were living in this sort of unrealistic bubble of, "Oh, everything is fine." (Focus group)

Innovative and creative approaches to service delivery

COVID-19 meant that services had to adopt innovative and creative approaches in order to continue to provide services. A particular innovative approach mentioned by one respondent was the training of youth advocates in podcasting and creating online content for a digital program on Instagram. This service provider also sourced donations for laptops and internet dongles and distributed them to clients and families to assist them to stay connected and supported. Another service implemented a hybrid offering of face-to-face and telehealth services in which they provided "warm referrals" via video link to help reduce barriers for clients wanting to access treatment. Another service developed an online education app for their clients. However, not all creative solutions were necessarily technology-based; for one service due to restrictions new on-site activities had to be initiated to replace off-site activities. This had a positive impact on residents as it enhanced the residents' connections and positive engagements with each other.

"Prior to COVID-19 the program conducted a number of regular off-site activities. Due to the "lockdown" new onsite activities have been initiated and these have had an extremely positive impact on residents. Additionally, the program has been full to capacity with only a few exits and admissions over the 6 months which has enhanced the resident's connections and positive engagements with each other. This has had an extremely positive impact on individual's wellbeing and outcomes." (Survey)

3.2 Adoption of technology-based services

Technology-based services refer to services that use any form of technology, including, but not restricted to videoconferencing, internet and telephone, as an alternative to face-to-face services. In the State and Territory Alcohol and Other Drugs Peaks Network (2020) survey it was noted that nearly 4 in 5 AOD services

indicated that they moved from face-to-face delivery to telehealth (online or telephone) as a result of the COVID-19 pandemic. When looking at the three jurisdictions, survey respondents noted that particularly video calls (52.8%, n=19) and phone calls (47.2%, n=17) were effective for improving client care, with one quarter (25.0%, n=9) finding text messages not effective at all. Technology-based services have enabled continuity of services during COVID-19, even expanding the reach for some services (particularly rural areas), while protecting service providers from the risk of infection. It also increased communication between staff, and between staff and clients, and allowed for more flexible work arrangements.

However, our data shows that technology-based services have their limitations (e.g. clients not having access to internet and phone, poor internet connection, etc.) and are not suitable for all client groups and treatment types; making face-to-face services still a key component of service delivery. These findings are consistent with other health studies which have investigated the use of technology-based services in response to the COVID-19 pandemic (e.g. see Hirko et al., 2020; Novara et al., 2020; State and Territory Alcohol and Other Drugs Peaks Network, 2020).

Advantages of technology-based services

A positive impact that was mentioned by the majority of respondents was the accelerated uptake of technology-enabled services (which some noted was long overdue). It was particularly noted that it helped to facilitate staff supervision and communication; increased access (specifically for remote communities) and helped to stay connected to client; reduced “no shows” and increased attendance rates; and increased flexibility of service delivery.

“Running [name treatment program] online for clients’ capacity to support clients in regional remote areas has increased via phone or video calls.” (Survey)

“The staff supervision via Zoom has been extremely helpful. We have been able to get the same level of care without going to visit. Specialist appointments via zoom is a much safer way for our clients to engage rather than face-to-face. I hope it continues after COVID-19.” (Survey)

“[...] Increased use of phone calls and zoom for clients in residential to see family members more regularly (especially given face to face visits were put on hold in the peak time of COVID-19 infection rates). Increased use of zoom/phone calls with young people (many commenting that they preferred this and were more actively engaged). Conversion of some programs to better suit online or offsite (from home) treatment.” (Survey)

“Facilitating support online or by telephone has meant that there have been less “no shows”.” (Survey)

It also allowed services to be able to facilitate family meetings; involving specialist staff via online mechanisms; and more flexible working arrangements.

“Our service remained open. We have used Zoom to facilitate family meetings Zoom for specialist and psychologist has been an added bonus.” (Survey)

“[...] a number of learnings - in relation to options to increase flexibility, integrate telehealth into service offerings, consider more flexible working arrangements. Use of video to support “warm referral”: e.g. video meetup with young person and their youth worker to help break down barriers. Increased awareness of and use in using and providing online platforms to provide education sessions for: e.g., parents/ other services and for team to access professional development opportunities with reduced time commitment for travel.” (Survey)

However, one respondent noted that to ensure that technology-based interventions can remain there is a need to increase capacity for internet for regional and rural services:

“The service sector has adapted well to continue delivering residential services. It would be helpful to access support to increase capacity for internet for regional and rural services. This would enable online platforms to function well.” (Survey)

Suitability of technology-based services for clients

While technology-enabled services brought many positives, respondents noted that its suitability was dependent on the type of client, treatment, and type of technology-based service offered. Video-based services (e.g. Zoom) seemed to be a particularly useful method for young people, while it was less useful for older clients, complex clients, clients with cognitive impairments, and clients experiencing homelessness.

“For young people, the transition to phone or web-based contact was smooth. Some YP still require in-person contact and access to mobile phones can be limited for some (we purchased phones for YP so we could provide service/treatment) [...]” (Survey)

“[...] Also, it has been difficult for some clients to shift to telehealth, particularly those with cognitive impairment or experiencing homelessness.” (Survey)

“I keep saying, anyone my age and younger did okay with it and anyone older than myself struggled with it. I think I was just at the cut-off for – so older clients, either they didn’t know how to use it, it was too problematic so they didn’t like it, they didn’t feel comfortable with it or they didn’t have it, they didn’t have access to a computer or the other stuff that you might need, even a headset or what have you or stable internet. There was things that you probably wouldn’t think of but you realised they’re quite big barriers. I had an older client who had somebody else who would set it up for them and they would go into the room and then that person would leave. So it was actually quite difficult for them to even just set up.” (Focus group)

“We stopped seeing people face-to-face, transfer them to phone and we got a lot of pressure from funding bodies to start doing Zoom groups and all that sort of stuff. Clients just weren’t interested, they were not interested. Then even when I went to the local health district drug and alcohol program manager and said are you getting this push to do kind of your sort of group and education stuff by Zoom or whatever and he said yeah we are you know. I said well “how is that going?” and he said they’re not interested, he said and my bosses won’t listen.” (Focus group)

It was also noted that technology-based services were not easily adaptable for all types of treatment and support services, particularly group therapy.

“The group treatment, it seems really simple on the surface is what we’ve all said. But when you drill into it, it’s really complex like when we created our group space rooms. There were decisions on like the field of view from the cameras. So, how do you kind of seamlessly pull people in, like for example like if you have a look here we are just about to mount that on the wall, we have like a 290-degree field of view on the camera. So you can have everyone in and you can pretend as much as possible you’re in a group space or what kind of software application doesn’t require a client to download an app that is multi-platform.” (Focus group)

Adding to this is that certain risks are different from face-to-face contact, for example, around the risk of self-harm and suicide.

“Risk of, you know, self-harm and suicide and how that’s managed, you know, how you’re assessing that if somebody’s isolated and are not going to services and also just having colleagues to be able to debrief and talk to about certain situations and collaborating on ideas, just needing more of an effort to do it when we’re not in the same office.” (Focus group)

Reasons noted for clients favouring technology-based services more broadly were the convenience of accessing these services (e.g. no need to travel, be in the comfort of your own home), reducing the initial

barrier of contacting a service, and increasing privacy of clients (e.g. the risk that you run in to someone you know when going in to the service building). In relation to phone-based services specifically it was noted by one NSW focus group participant that cultural reasons were an important factor as to why this was preferred over other forms of technology by culturally and linguistically diverse (CALD) clients as, for example, for some cultures it is not appropriate to be on video. Another focus group respondent also noted that from all forms of technology-based services, using the phone was likewise preferred by their Aboriginal and Torres Strait Islander clients.

“There was a surprise in that we had attendance going up, like demand going up but also attendance and engagement going up was really interesting to see [...] I think with AOD stuff, it was just easier because they could be in their pyjamas basically, you know, they could be in their living room, it was easier to make the session and that would be a big barrier, “I’ve got to get up and...” If they’ve used or something, then the idea of getting the train and coming in was too much to handle whereas they could turn up to sessions easier. So I felt like that was really good. There’s also the possibility that with some clients, if they’re not fully comfortable with their sexuality or their gender diversity, coming into the office is very outing. In that they come in and – even though that might not be the case but just in their heads it’s walking into that building, it’s saying something, so that removes that barrier for people who might just want as much privacy as possible.” (Focus group)

Barriers and challenges to using technology-based services

Poor and limited access to ICT infrastructure

Barriers mentioned for using technology-enabled services was that not all services or clients had access to the technology equipment required; poor internet connection; clients not having enough credits on their phone; and clients simply not having the skills to use it.

“[...] A small number of participants have been unable to access particular outreach programs (e.g., group or day programs) due to lack of technology.”

“[...] Often the phones our participants do have, are lower on the tech scale, not having video capacity or not having the phone credit to have data to do video calls.” (Survey)

“[...] We have set up the ability to have zoom support meetings with ex-residents but that is only useful for those with the credit and technology. So the most vulnerable are the ones with the least services available to them in the COVID-19 world.” (Survey)

“But there’s been a big challenge as others have mentioned in terms of clients not having the data, having old phones, they don’t have computers. There’s also the skill, I mean you can think it’s quite easy; it is click on a link but when you’re not used to a computer if you click on the wrong link and it takes you to somewhere else and you don’t know how to come back like it’s just. Then trying to give IT phone support to a client over the phone and you can’t Zoom you can’t get in, like go in TeamViewer and get into their computer to go here.” (Focus group)

In addition, some respondent noted that the services simply did not have the ICT infrastructure in place, nor had the funding to build this.

“Our beds we’re dramatically reduced, and we also found that moving to an online platform was really difficult for us because we didn’t have the infrastructure or the finances for the IT, for the availability to be able to do that. And so, our existing technology wasn’t able to support the use of the online hosting. We also needed things like smart TVs to sort of streamline that process but we we’re also told that it wasn’t in the budget, we didn’t have the budget for that for IT and that it wasn’t built in for the funds, which we didn’t have that built in for the IT. That was a big problem.” (Focus group)

Issues with safety and confidentiality

Issues were also reported in terms of confidentiality; not being able to find a safe and/or private space; and ensuring the cultural safety of services.

"[...] I did one assessment with somebody and I asked them about their partner and then they turned and said, "I don't know" and they asked the partner and I was like, "Oh God. The partner's in the room." So there was things like around confidentiality and privacy and also just yeah, actually focusing where they might get distracted – sometimes you'd have a client who was in bed." (Focus group)

"Not possible to run therapeutic groups online to same standard as face-to-face. Issues with safety and confidentiality are a major concern." (Survey)

"Challenges of rapport and cultural safety in engaging Aboriginal and Torres Strait Islander clients via technology" (Survey)

"[...] Reluctance to use video (for some young people). Managing risk when using telehealth - and organising emergency support if working remotely. Having a confidential space if isolating at home. Having an appropriate space/ lack of distractions for counselling [...]" (Survey)

"I think a key question with telehealth is the safety of people where they're at and having a confidential space in order to engage in treatment. So, if you're in a boarding house, for example, you don't have a private space it's really difficult. Like we would have people who would try to attend a counselling session and they are sitting on the train with no headphones. It's like how are you going to have a private counselling session if you're catching the T4 line out to Bankstown or something like that." (Focus group)

Reduced engagement with clients

Importantly, although technology-enabled services increased access, some respondents noted that it was more difficult to engage with clients compared to face-to-face services, particularly young people, and that clients would get more easily distracted.

"While most clients have phones and we have some capacity to purchase basic phones and credit for clients most clients didn't have the capacity for video calls, either the technology equipment or skills which limited options for visual support of clients, it has been more difficult to engage with some clients by phone and keep clients engaged when the referral options were limited." (Survey)

"[...] The youth services provided by our services are outpatient and as the pandemic led to lock down there was no face-to-face counselling/case management. It was difficult to keep young people engaged on a continuous especially with TXT messaging and phone counselling. (Survey)

Respondents also noted that for this reason face-to-face services could never be fully replaced, as it generally was considered the most effective way for engagement, and more suitable for certain therapies (particularly group therapy).

"We will definitely keep some of the initiatives going (e.g. [name digital program]) and some more flexibility in service delivery, and more flexibility with working from home and telephone and online outreach service provision. But face-to-face service delivery is still the preferred and most effective way to engage, particularly with our Aboriginal clients and families." (Survey)

"It is too soon to tell what measure will remain in place. Zoom meetings with staff are useful and cut down a lot of travel time, however, zoom meetings with some clients do not seem to be as effective as face-to-face engagement. Also, remote sessions with staff and clients are reported to be not as personable as face-to-face sessions. Face-to-face groups will be reinstated

as remote groups do not function as well and have proved to be difficult to sustain bigger groups and 1:1 contact.” (Survey)

Furthermore, it was noted that the social interactions that clients normally have with one another (e.g. when living in the same house) now get lost due to technology-based services. The human emotion and connection gets lost.

“I’ve got a bunch of guys who are now in our transitional housing. I know that they will rev each other up, “Oh, we’re going to go to this meeting together. I’ll come by and pick you up and then we’ll head off to Macca’s on the way there and we’ll do this and we’ll do that.” So there’s all of that and then the crescendo is they’re in a meeting together doing, whether it’s SMART Recovery or AA or NA or some relapse prevention group or they’re connecting around some social – it’s all of that rather than just the event of, “Okay. We’re on this Zoom meeting for an hour... we haven’t had a coffee together, we haven’t said, “Where are you from? What’s happening?” There’s none of that real human connection and emotion, which as we know, the opposite of addiction is positive human connection and I don’t think we’re achieving that through Zoom and I’ve even seen that here onsite where if we’ve got people in sickbay now, absolutely they Zoom into their morning groups, they’re not really part of the group. Everyone goes, “Hi, how are you? I hope you’re feeling better” and they all sort of then go back to their conversation and forget the person who’s there. I as a facilitator struggle with that too. I keep going, “Oh, what do you think, mate? How do you think with that?” Yeah, so I think there is a challenge in using that technology.” (Focus group)

“One of the things that I’ve noticed over the last couple of years, there’s a bit of money or grants into how to do online connection with clients, you know, get on this app and they’ll be clean and sober. Connectivity is so much greater than just, “I logged into an app and I said I’m doing this.” That’s where, you know, I’m sure we would all agree that there’s such a place for residential rehab, community programs, that connection with actual people, having somebody stand in front of you and say, “You’re doing okay. I know you dropped the ball but pick up your feet and let’s go forward.” That human connection really just overrides so much more.” (Focus group)

In addition, one respondent also noted that social cues get lost in technology-based services.

“When you talked about the quality of service, I thing with Zoom that you can struggle with is that the eye contact is not correct. [...] So I can see where your eyes are but if I look up at the picture, I’m actually making eye contact with you. But you don’t do that. So there’s a missing of that eye contact that you get in face-to-face. A friend of mine mentioned this but even just the body language, you can see a lot of it but you can’t see people’s legs. Just if they’re anxious, sometimes they can transfer their anxiety into their lower half and that’s where they’re kind of shaking their leg up and down but they can keep this part quite calm.” (Focus group)

On the other hand, some treatment providers have perceived a very positive response to the new technology used to provide treatment:

“Surprisingly, the AOD treatment-seeking cohort of our service (community based) has increased via use of the phone. This hasn’t deterred people using the service (instead of face to face).” (Survey)

“[...] The use of tele-health in addition to face-to-face has increased access for some people.” (Survey)

3.3 The future of service delivery: what is going to be the new normal?

Respondents noted that many of the COVID-19 related practices will be retained (e.g. temperature checking) until, for example, a vaccine is developed.

“After the restrictions are lifted, we don’t know, what you know they’re now calling COVID-19 normal function, is actually going to look like. There will still always be that element of risk until there’s a sense in which there’s maybe like you know broad base vaccinations out in the community and infection levels are reduced to a kind of what you might expect for you know seasonal communicable diseases, such as flu or cold symptoms for argument’s sake. So that part of it just kind of a little bit unknown, but in terms in future practising I think you know screening, temperature checking all that sort of stuff that’ll still be part of the way moving forward [...]” (focus group)

Several respondents also noted that the flexibility in treatment modalities and blended modalities will be retained going forward.

“[...] I think long term we will definitely be keeping a mix, definitely keeping a blend of services because there’s a few clients that really enjoy the safety of engaging in treatment from their own home. We’ve set up three blended rooms, so we can do a mixture of face-to-face and group work. So, for example, we can run a SMART recovery group where there’s people who are online but also in face-to-face in line with social distancing requirements. I think we will very much keep that moving forward and we are setting up a little group around helping people who have really poor telehealth literacy skills to learn how to use platforms like Coviu or Zoom or things like that, so they can remain engaged in treatment.” (Focus Group)

4. Demand impacts

Data on the number of new episodes of care were available for NSW (from the NADAbase) enabling a comparison of the first three quarters of 2019 with the first three quarters of 2020.

4.1 The impact of the number of new episodes of care

A comparison of the first three quarters of 2019 (Jan to Sep) with the first three quarters of 2020 (Jan to Sep) from the NADAbase, for NSW revealed that the number of new episodes of care (EOC) has declined. In 2019 there were 20,142 EOC in the first three quarters of that year. In 2020, there were 18,431 EOC in the first three quarters, as shown in Table 9 and Figure 1.

Table 9: Number of new EOC, 2019 compared to 2020

	Q1 (Jan to Mar)	Q2 (Apr to Jun)	Q3 (Jul to Sep)	Total new EOC
2019	6766	6545	6831	20,142
2020	7073	5635	5723	18,431

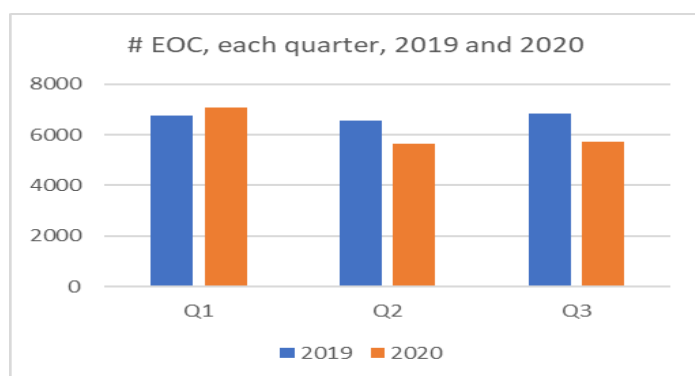


Figure 1: Number of new EOC, by quarter, 2019 compared to 2020

The monthly pattern, see Figure 2, shows that the fewest new EOC commenced in April 2020, followed by May 2020 – at the height of the physical distancing measures in NSW (lockdown commenced on the 23rd March for 6 weeks).

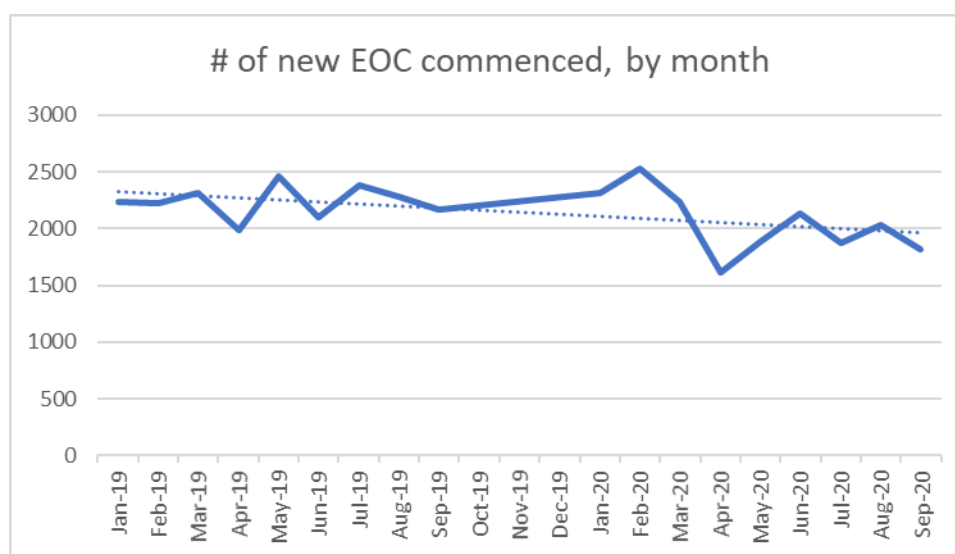


Figure 2: Number of new EOC by month, 2019 compared to 2020

The decline in the number of new EOC in association with COVID-19 may not be uniform across drug type. Table 10 shows the change in number of new treatment entrants by drug types. As can be seen, the largest decline was for methamphetamine presentations, with a smaller decline for alcohol, heroin and opioids.

Table 10: Drug types, # of new EOC 2019 compared to 2020 (Q1, 2, 3 for both years)

	2019	2020	Change in EOC	Percent change
Alcohol	6156	5822	-334	-5.7%
Cannabis	3266	3326	60	1.8%
Meth/amphetamine	7072	5820	-1252	-21.5%
Heroin	1299	1125	-174	-15.5%
Opioids	464	360	-104	-28.9%
Cocaine	390	418	28	6.7%
Benzo's	285	333	48	14.4%
Tobacco	193	276	83	30.1%
Other	274	334	60	18.0%
Missing/unknown	743	617	-126	-20.4%
Total	20142	18431	-1711	-9.3%

In terms of the available client demographics, there was no difference in the average age at treatment commencement between the first three quarters of 2019 (34 years of age) and the same period in 2020 (34 years of age).

There was a decline in both female and male new EOC to treatment in 2020, but the percentage change (decrease) was greater for females than males (see Table 11)

Table 11: Change in new EOC by gender, 2019 and 2020

	2019	2020	Change in EOC	Percent change
Female	7419	6581	-838	-11%
Male	12641	11773	-868	-7%
Other/missing	82	77	-5	-6%
	20142	18431	-1711	

The decline in the number of new EOC over the COVID-19 period could be attributed to a number of factors:

1. Fewer people may have been seeking treatment during this period;
2. Services had to reduce the availability of treatment places during this period; and
3. Some service types (for example residential rehabilitation) were more severely constrained in their ability to provide treatment, whereas outpatient services were less so. That is, the overall net decline in the number of new treatment episodes in the first three quarters of 2020 may not have been evenly distributed by treatment type or treatment setting. Another important factor to consider is differences between metropolitan and regional/rural service experiences. We explore each of these factors below.

4.2 Reductions in numbers seeking treatment

Firstly, were fewer people seeking treatment during the COVID-19 period? There are no administrative records of the numbers of people seeking treatment but survey respondents were asked about their perceptions of treatment seeking numbers and issues associated with waiting lists – an indirect measure of treatment seeking.

The majority of survey respondents (56.8%, n=21) in NSW, TAS, and ACT reported an increase in the number of people seeking treatment and support at AOD services. However, some services reported a decrease in treatment seeking (21.6%, n= 8) or no change (21.6%, n= 8) (we explore this further below with reference to types of treatment).

One way in which demand was constrained was the difficulty for prospective clients in travelling safely to, or between, treatment services. This was a combination of interstate and within-state travel restrictions, reduced availability of public transport, and the increased risk of infection when public transport was used.

“It was difficult for people to be able to travel to access services.” (Survey)

“Our area has public transport but it is in no way reliable nor regular. Buses may only be available hourly or people may need to take four buses over the course of two hours to get across town. This is always a barrier for our participants, however, noticeably increased risk for people.” (Survey)

“[...] Travel restrictions and border closures have impacted participants’ ability to attend residential services [...]” (Survey)

In the majority of cases, survey respondents in NSW, TAS and ACT reported that the waiting lists/waiting times of AOD services lengthened (51.4%, n= 19). Many survey respondents noted that an increased waiting list applied particularly for residential and withdrawal services due to the reduced bed availability:

“Our residential services have reduced to allow for COVID-19 person spacing” (Survey)

“Harder for people to access our service due to the limitations of detoxes to be able to accommodate people.” (Survey)

“Shared rooms at our short stay residential service were reduced to single rooms reducing bed numbers from 10 to 6.” (Survey)

Services employed several strategies to ensure that clients would not drop off because of the waiting lists.

“Facilitator: So how did you do that? How did you make sure that people didn’t drop off?”

Participant: Without any extra money? We did a few different things. We run groups as well as individuals so we started running reports on the rates of participants in programs and in activity rates and move staff towards encouraging participants to pay it forward and move into groups and let new people who required need to come through. [...] really it’s just about asking staff to acknowledge the increase in wait list and calling people and acknowledging the referral and making that first contact and you know providing them with a safety plan so that they can come into our programs.” (Focus group)

4.3 Differences between metropolitan and regional/rural services

Longer waiting lists were reported in NSW, TAS and ACT for both metropolitan (54.2% reported they had lengthened, n=24) and regional treatment services (45.5%, n=22). But this was less common in rural (27.3%, n=11) and remote (20%, n=5) treatment settings (the majority of providers in rural and remote areas reported that waiting lists remained much the same, respectively 54.5%, 40%). These perceived differences in waiting times for access to treatment between metropolitan/regional compared to rural/remotely located services was not mirrored in perceptions of changed demand. A greater proportion of the rural (45.5%, n=11) and remote (60%, n=5) service providers in NSW, ACT and TAS noted an increase in the number of people being treated during the COVID-19 period compared to those metropolitan and regional service providers in the survey (of which 33.3% and 36.4% respectively noted an increase in the number of people being treated).

The NSW administrative data sheds more light on differences between metropolitan and non-metropolitan services.¹ As can be seen in Figure 3; there was almost no change in the number of new EOC for services located in regional/rural LHDs in NSW between the first three quarters of 2020 and the same three quarters in 2019. However, for metropolitan services there was a decline in 2020.

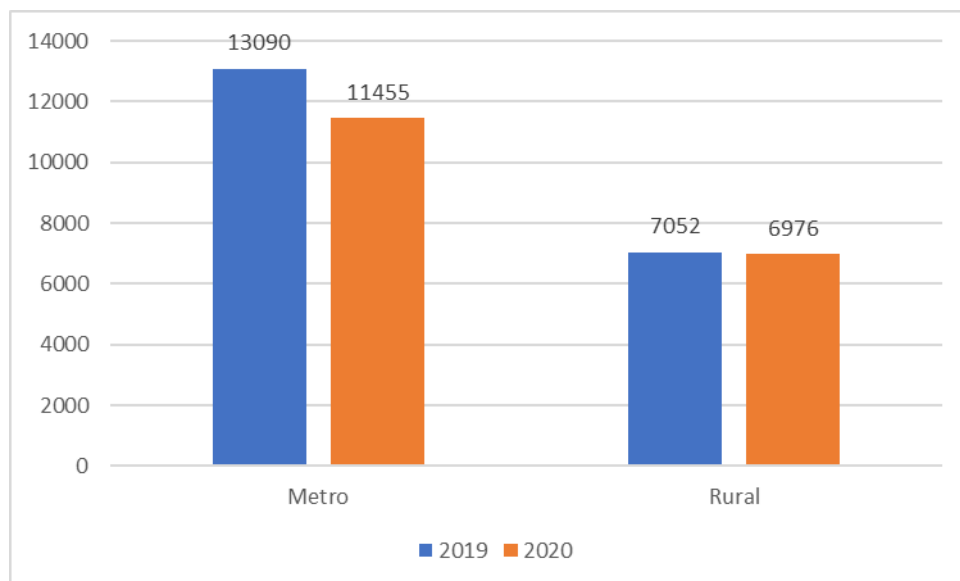


Figure 3: Comparison of metro vs regional/rural treatment services, number of new EOC (Q1, 2, 3)

In a more detailed examination, by quarter, Figure 4 (below) shows that regional/rural services did experience a decrease in new EOC for Q2 in 2020 but Q1 in 2020 was higher than the equivalent for 2019 (hence the almost equal numbers of EOC over the whole period). Whereas for metropolitan services, there has been a progressive decline in the number of new EOC across the three quarters of 2020.

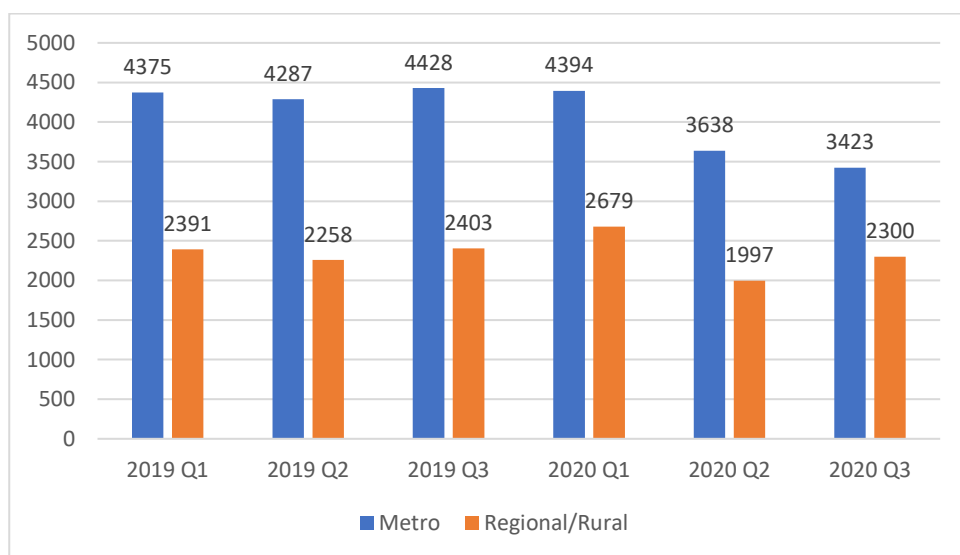


Figure 4: Number of new EOC, quarterly 2019 and 2020, comparison of metro vs regional/rural

That regional/rural services were less severely impacted was supported in the survey and focus group data.

“Less challenges due to being in a rural location with very low transmission rate.” (Survey)

¹ The NADAbase new episodes were coded into either a metropolitan LHD or a rural/regional LHD based on the NSW Health distinction. Thus direct comparison between the survey data and the EOC data is not possible as the distinction between regional, rural and remote was not readily possible from the NADAbase.

“Our regional status meant that we were not in a hotspot area which allowed more freedom during program (most of the time).” (Survey)

In addition, the greater availability of space in regional/rural services worked to these services advantage when physical distancing requirements demanded greater space. Several respondents also noted that their location (often rural), and having standalone buildings, made it easier to spread out residents and abide by social distancing regulations compared to services located in cities. As such, the building environment of these services was an advantage during COVID-19.

“In terms of business model and sustainability I think, we kind of share the luxury of having a lot of space here. You know as soon as we brought in kind of those temporary houses and dongers and things like that to make up capacity and people could just kind of separate. But you know we’re kind of lucky in that we could do that.” (Focus group)

“I think we can certainly sustain this across the next 12 months. I think we’re in a very blessed position out here. I think geography has made it easier for us to be able to manage the impact of COVID-19, you know, we’re on [deidentified; describing a large piece of land with many individual buildings] which bring their own challenges but equally on the COVID-19 side of things, they bring great positives.[...] So that impact is probably less on us. [...] But we were blessed by the building environment to be able to take the impacts that, you know, for our brother or sister services in Sydney, it’s very different because you’ve got a building that’s so many floors high and everyone is stuck in this one area, and all the rooms are the size of a broom closet.” (Focus group)

And metropolitan services were forced to reduce access for COVID-19-related reasons, including the need for clients to be able to return home if they tested positive, and ‘hotspot’ locations of some clients:

“We had to prioritize people within the Sydney metropolitan area due to COVID-19 policy and protocols that stipulated that the client may have to return home if unwell or has a positive COVID-19 test result. Clients in COVID-19 ‘hot spots’ were not given access to a residential bed until the situation in that area resolved and the client produced a negative COVID-19 test result with 48 hours of admission date.” (Survey)

“Our geographical location [metropolitan area] increased barriers as we are located between the various hotspots. Locals were able to access services however those coming from various regional and [other] metro locations were not able to access.” (Survey)

“We had the very same problems in fact, we could only take clients from within the Sydney metropolitan area because we had to be able to ensure that they could get home swiftly if something happened”. (Focus group)

So, while the overall picture is that regional and rural services were less affected, as demonstrated in the episodes of care data and the perceptions of focus group and survey participants, this does not mean that the clients themselves who live in regional/rural areas secured greater access to treatment (there are no data on the geographic location of clients, only of services). As one person noted, rural clients were potentially disadvantaged:

“We had the very same problems in fact, we could only take clients from within the Sydney metropolitan area because we had to be able to ensure that they could get home swiftly if something happened. And that became increasingly problematic for people that are in rural areas.” (Focus group)

4.4 Reduced availability of treatment places

The second factor explaining the reduction in the number of episodes of care in the first three quarters of 2020 concerns reduced number of treatment places. As discussed in detail above, services were forced to close treatment places to new clients. This resulted in a decrease in the number of EOC for 2020. The increase in some capacity via on-line/ICT solutions did not offset the overall reduction in numbers of new EOC. But in this analysis, service type matters, which we turn to next.

Reductions for some service types

Survey data revealed that residential treatment services in NSW, TAS and ACT were particularly impacted by bed closures. Of note, a higher proportion of residential rehabilitation services (54.8%, n=31) reported a decrease in the number of people being treated. For other treatment types, such as withdrawal, the perceptions were mixed: some providers indicated a decrease in client numbers, others reported an increase. Analysis of the administrative data on new EOC for 2020 compared to 2019 can shed further light on these perceptions. Firstly, examining the residential versus the non-residential treatment setting reveals that there has been a sharper decrease in residential EOC but an increase in outpatient treatment settings (see Table 12 and Figure 5):

Table 12: Residential vs outpatient treatment settings, change in new EOC 2019, 2020

	2019	2020	Percent change
Outpatient setting	10311	10619	3%
Residential setting	6877	4755	-45%

This confirms the service provider perceptions of significant impacts to residential treatment services. In addition, the State and Territory Alcohol and Other Drugs Peaks Network (2020) survey also reported that a majority of residential services experienced reduced bed capacity, whereas those services that provided non-residential services, a minority reported a reduced number of available appointments.

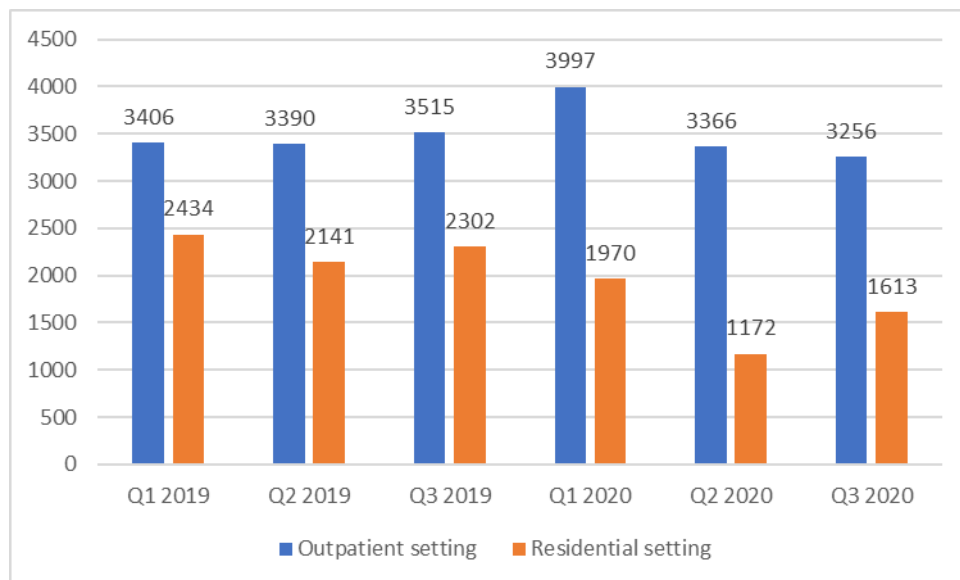


Figure 5: Changes in number of new EOC (Q1,2,3) 2019 and 2020 for outpatient versus residential services

In terms of treatment types, we focussed on assessment information and education; counselling; day programs; detoxification; residential rehabilitation; and support and case management (opioid substitution therapy (OST) is not well captured as most service is provided in primary care settings who do not report into the NADAbase). Table 13 provides the data on the changes by treatment type.

Table 13: Changes in treatment types, 2019 compared to 2020

	Assessment I and E	Counselling	Day program	Detox	Resi Rehab	Support and CM
2019	3952	5239	531	1469	4881	2796
2020	3462	5931	367	1627	3666	2268
Percent change	-14%	12%	-45%	10%	-33%	-23%

As can be seen, assessment, information and education EOCs have decreased (by 14%); day program EOCs have decreased by 45%; residential rehabilitation EOCs have decreased by 33%; and support and case management EOCs decreased by 23%. On the other hand, counselling EOCs have increased by 12% and detoxification EOCs have increased by 10%.

The survey data revealed that a number of services have been discontinued. Out of the sample of 36 NGO treatment providers, 1 residential rehabilitation program was forced to discontinue, 3 outreach services were discontinued, and two day programs were discontinued. The many other factors for reduced services, discussed above, accord with the decline in new EOC over the COVID-19 period.

The increase in new counselling EOC is consistent with the survey and focus group data concerned with technology-enabled service delivery. The increase in detoxification EOC, however, is not consistent with other data reported heron. In general, the survey data and the focus group data suggest that detoxification services were similarly constrained during COVID-19. The EOC data cannot be explained by the use of home detoxification (this did not change). But there was a distinctly different pattern between metropolitan and regional/rural new withdrawal EOCs. For metropolitan services, the number of new EOC for withdrawal declined between 2019 and 2020 (first three quarters), whereas in NGOs located in regional/rural local health districts (LHDs) in NSW, withdrawal EOCs significantly increased (see Table 14). This was especially true for Q3, the July to September 2020 period.

Table 14: Withdrawal EOC, 2019 vs 2020 (Q1 to Q3), metropolitan vs regional/rural

	Metropolitan	Regional/rural	Total
Q1 2019	325	159	484
Q2 2019	313	172	485
Q3 2019	333	167	500
2019 sub-total	971	498	1469
Q1 2020	394	160	554
Q2 2020	255	248	503
Q3 2020	167	403	570
2020 sub-total	816	811	1627

Overall, however, withdrawal episodes of care only make up 3% of all EOCs (with counselling as the largest proportion at 28% of EOCs). Analysis by quarters gives a picture of the weight of numbers (See Figure 6):

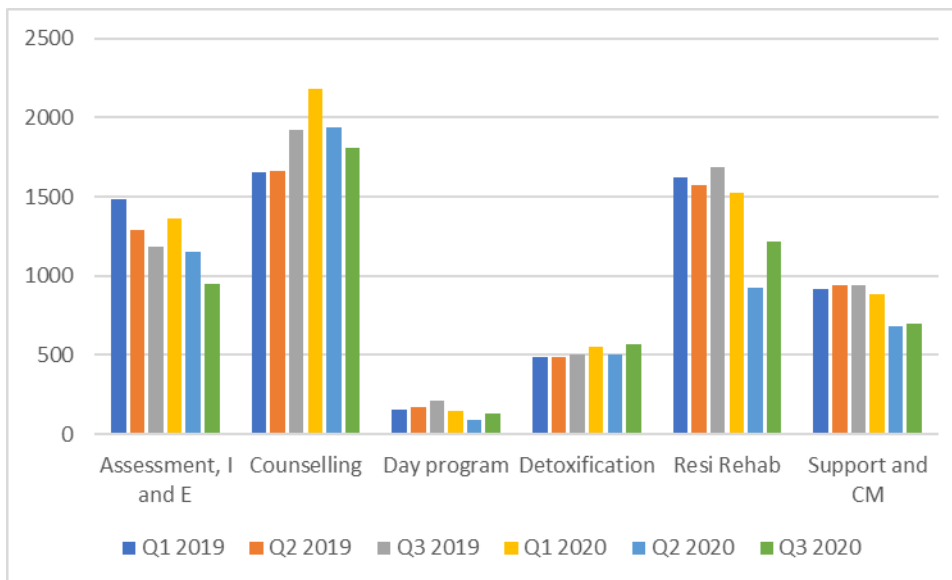


Figure 6: Analysis by quarter of EOCs, by treatment type

These data also go some way to explaining why, in the online survey, some service providers reported an increase (32.4%, n=37); some a decrease (45.9%, n=37), and some no change (21.6%, n=37) in the number of people being treated at AOD services. It varied by treatment type and by treatment setting.

4.5 Impacts for specific client populations

Aboriginal and Torres Strait Islanders comprise around 17% of all treatment episodes in Australia (AIHW, 2020). Concern was expressed by service providers about the compounding effects of COVID-19 on an already marginalised and structurally disadvantaged population:

"[...] Indigenous people already faced barriers with aboriginal specific treatment services. COVID-19 added an extra barrier for many as bed numbers were reduced at our services and aboriginal specific services were located some distance from the local community.[...]" (Survey)

In the survey data, however, impressions about the impact on Aboriginal and Torres Strait Islander people were mixed: 42.9% of respondents in NSW, TAS and ACT perceived that treatment for Aboriginal and/or Torres Strait Islander people had increased under COVID-19, contrasted with 33.3% of respondents who felt that it had decreased.

The NADAbase data, on new episode of care, showed that while there was a decline in the numbers receiving treatment under COVID-19 compared to 2019, the decrease was greater for non-Indigenous people than Indigenous (see Table 15).

Table 15: Indigenous status, new EOCs, 2019 compared to 2020

	2019	2020	Change in EOC	Percent change
Indigenous	3959	3807	-152	-4%
Non-Indigenous	15290	13764	-1526	-10%
Not stated	893	860	-33	-4%
	20142	18431	-1711	-8%

There is a complicated pattern of changes when one takes into account the type of treatment, coupled with metropolitan versus regional/rural services and indigenous versus non-indigenous status of clients. As can be seen in the below table, for assessment, information and education, regional/rural new EOCs were significantly down compared to metropolitan services, which increased. For counselling, there was a small (6%) decline in new EOCs for regional/rural indigenous clients, but otherwise EOCs numbers were up. For

day programs, there was a significant decline in metropolitan areas only, and a moderate increase in rural areas, with little difference in indigenous and non-indigenous client numbers. For withdrawal, as discussed earlier, there was an increase in regional/rural services (45% and 37% indigenous and non-indigenous respectively). The only decline in new EOCs for withdrawal, occurred for metropolitan non-indigenous clients. The number of new EOCs for indigenous clients in regional/rural services increased in residential rehabilitation (17%) but for both client groups in metropolitan settings for residential rehabilitation there was a substantial decrease in new EOCs (49% and 44%). Lastly, for support and case management, there were declines in both metropolitan and regional/rural settings and for non-indigenous and indigenous clients, with the exception of indigenous clients in regional/rural services (See Table 16).

Table 16: Number of new EOC 2019 and 2020, by treatment type, metro versus regional/rural services and indigenous and non-indigenous clients

Treatment type	Metro vs RR	Indigenous vs Non-indigenous	2019	2020	% change
Assessment, I and E					
	Metro	Indigenous clients	431	556	22%
	Regional/rural	Indigenous clients	493	299	-65%
	Metro	Non-indigenous clients	1844	1879	2%
	Regional/rural	Non-indigenous clients	1099	663	-66%
Counselling					
	Metro	Indigenous clients	370	439	16%
	Regional/rural	Indigenous clients	599	565	-6%
	Metro	Non-indigenous clients	3048	3436	11%
	Regional/rural	Non-indigenous clients	924	1021	10%
Day program					
	Metro	Indigenous clients	42	13	-223%
	Regional/rural	Indigenous clients	69	80	14%
	Metro	Non-indigenous clients	205	70	-193%
	Regional/rural	Non-indigenous clients	159	168	5%
Withdrawal					
	Metro	Indigenous clients	140	143	2%
	Regional/rural	Indigenous clients	84	153	45%
	Metro	Non-indigenous clients	796	669	-19%
	Regional/rural	Non-indigenous clients	387	618	37%
Residential Rehab					
	Metro	Indigenous clients	695	465	-49%
	Regional/rural	Indigenous clients	252	303	17%
	Metro	Non-indigenous clients	3241	2254	-44%
	Regional/rural	Non-indigenous clients	577	565	-2%
Support and CM					
	Metro	Indigenous clients	245	195	-26%
	Regional/rural	Indigenous clients	406	487	17%
	Metro	Non-indigenous clients	1246	832	-50%
	Regional/rural	Non-indigenous clients	705	662	-6%

Another population of concern for service providers in NSW, TAS and ACT has been those people subject to the criminal justice system (CJS). The unanticipated early release of some people from custody (in association with COVID-19 safety measures) placed additional pressure on AOD services.

“For people exiting corrections: residential treatment demand has been high especially for people in custody wanting to get released to attend rehabilitation centres. This has increased with people during pandemic. They have to isolate once out have a clear test for COVID-19 before entry [...]” (Survey)

Release from custody is a known high risk time for people with drug problems. Participants felt that this had been exacerbated with COVID-19:

“People exiting prison are more vulnerable - increased difficulty accessing services and isolation.” (Survey)

“Working with people exiting prison has been severely impacted by COVID-19 safe measures. Often, participants are not contactable and this has increased with COVID-19. [...]” (Survey)

“The prison stopped access to clients so AOD staff could not get in to deliver services and programs to them. Intake closed temporarily stopping intakes for all. Interstate visitations from family and children were stopped.” (Survey)

The NADabase referral data show that there was a greater decline in referrals from the CJS in the first three quarters of 2020 compared to the same time period in 2019. This decline (19% change) was greater than the decline in self-referrals or referrals from family members (See Table 17).

Table 17: Selected referral sources, 2019 compared to 2020

Referral source	2019	2020	Change in # of EOC	Percent change
Self	7383	6973	-410	-6%
Family member	1101	954	-147	-13%
Criminal Justice System	2988	2408	-580	-19%

The third population group of concern for service providers was women and children. This is a known gap in AOD treatment services (e.g. see Fonti, Davis, & Ferguson, 2016; NADA, 2016)

“[...] Women and children. Lack of services in rural areas: difficult to provide stepped care as there is no residential treatment services for women especially women with children. Where they are available the waiting lists are long. Rural areas also often don't have more intensive programs such as Day Programs. During COVID-19 women are reporting increased levels of domestic violence and feel more trapped as there is nowhere to go immediately for help longer term especially with children.[...]” (Survey)

“Reduced capacity impacted on those who wished to enter treatment broadly. Most affected were parents with children particularly those involved with care and protection agencies.” (Survey)

In addition, young people were identified as a particularly vulnerable population group:

“We have seen an increase in referrals from parents of young people in even or heightened states of anxiety than prior to COVID-19 seeking support for themselves and their young person [...]” (Survey)

“[...] Access to mental health services and/or hospital admission when needed - even harder than prior to COVID-19 - service holding risk for increasingly numbers of young people with complex needs.” (Survey)

“We are seeing an increase in referrals from parents - both for themselves and seeking support for their young people. We are seeing an increase in adolescent violence towards parents [...]” (Survey)

“[...] Our data for the South Coast tells us that YP are using more substances and in higher volumes, their quality of life has decreased (environmental and psychological) and their K10 results have increased [...]” (Survey)

Service providers have also perceived an increase in the complexity of presentations to treatment services during COVID-19. An increase was noted in mental health issues, comorbidities, trauma, poly-drug use, and AOD use due to the restrictions of COVID-19 leading to isolation, clients not having access to their usual support systems, accumulation of major events (i.e. drought, bushfires and COVID-19), and job loss.

“Increase in AOD use and risk behaviours noticed following the Bushfires and then COVID-19 (still significant issues). Bushfire trauma still an active issue with the young people and very little supports are available to, or suitable for, them in a timely manner. COVID-19 had significant negative impact on the community's ability to heal and recover as community gatherings not allowed and schools closed for significant time. Have noticed that students suspended or expelled from schools has had more negative affect on their drug use and problematic behaviours (further increasing social isolation) than previously experienced, prior to Bushfires and COVID-19.” (Survey)

“A number of clients reported their alcohol consumption increasing during the COVID-19 lockdown period, as they reported feeling anxious, isolated and without the usual levels of accountability in place, such as attending school or work. Clients also reported it was extremely challenging not being able to follow their usual plans for maintaining sobriety or general wellbeing, such as seeing family, attending groups, or safe places such as libraries and gyms.” (Survey)

“[...] I think the data that we were seeing in terms of the clients themselves we saw a five-point increase in K10. So, we saw an average percent in K10 go from 25 to 30 over COVID-19.” (Focus group)

Importantly, as one participant eloquently stated, none of the gaps for special population groups is new or unique to COVID-19:

“No difference pre or post COVID-19. There has always been an inadequate amount of treatment services for specific clients. Aboriginal women and children services are grossly inadequate as there are none. What there was in [name location] was closed with no more service offered anywhere on far North Coast for Aboriginal women and children. There are almost no services for young people unless justice related. [...] Also, where are the services for people with disabilities and intellectual disabilities being forced by support service to stop smoking cannabis, sex offenders or violent offenders there are even barriers to arsonists, people on OTP, and people with psychiatric illness on depo's? The list goes on and on. [...]” (Survey)

5. Unintended positive consequences

While there is no doubt that the pandemic has exacted a toll on AOD services, their staff and the clients who attend for treatment, this project has highlighted a number of unintended positive consequences of the pandemic.

From an organisational point of view, AOD services are now more prepared for future pandemics. Infection control procedures have been significantly enhanced and staff awareness of risks and behaviours has been heightened such that rate of infection (for all types) will decline in AOD treatment settings. Another unintended consequence for the workforce is recognition that taking sick leave is an important part of staying healthy. The pandemic has forced services to establish new collaborations with other parts of the health system, including with acute care and with testing services. These new relationships will stand AOD services in good stead for better managing client need into the future.

The wave of new technology, impacting substantially on better treatment access has also impacted on ICT systems of data recording and monitoring. Using online data collection platforms, new ways of conducting assessments and the potential for streamlined data collection processes have been noted. As with many other sectors and industries, staff have been forced to become much better end-users of collaborative software and internet and telephone service delivery. This means greater future flexibility for both staff and staff meetings and for clinical care. Zoom has provided the opportunity for more regular management meetings and for group supervision, according to some. Increased number of supervisory meetings can be a key approach to enhancing worker wellbeing (Nicholas et al., 2017). Indeed, the provision of clinical supervision has an important protective effect on AOD workers and links them more closely to the organisation and AOD treatment sector (Roche et al., 2007).

The increased flexibility in working arrangements due to technology, in terms of accessing workforce development opportunities and the flexibility around working from home has been welcomed by the AOD sector. Some of these new ways of working have the potential to reduce stress and burnout. Improved access to workforce development opportunities can enhance the capacity and quality of clinical care. As can occur in times of crisis, the workforce has experienced a strong sense of support and connectedness between them. As noted by one participant: *“caring for one another has increased”* (survey).

For clients of AOD treatment, geography seems to be less of a barrier where ICT solutions can be adopted. Providing flexibility and hybrid (both face-to-face and telehealth) services to better meet client needs is all part of the ‘new normal’. This has particularly positive consequences for people in rural and remote areas, where physical access to treatment has been a long-standing barrier to receiving care. Access for clients located in rural and remote areas has been less affected than for metropolitan services.

In addition, COVID-19 has reportedly led to stronger connections between clients, and between clients and staff. The perception of AOD treatment services being responsive and available during times of adversity, has potentially enhanced their reputation (survey). And it seems that for some, clients have been more open to peer support during this time (survey).

6. Future implications and actions required

The above provides a rich description of the experiences of NGO AOD treatment services over the COVID-19 period. These provide the basis for considering what needs to change in order to have a sustainable specialist NGO treatment sector into the future.

COVID-19 has demanded significant changes: to funding arrangements, leadership and strategic planning, the types of care provided, and workforce requirements. It provides the opportunity to review all aspects of NGO AOD treatment services, including the ways in which services are commissioned and funded by governments, and how services are supported, led, and delivered.

It seems clear that some of the COVID-19 impacts have been worsened due to two systemic issues for the sector that pre-date COVID-19:

- the chronic underfunding of treatment; and
- the challenges in recruiting and retaining a specialist workforce.

Both of these long-standing systemic issues require resolution. At the same time, the innovations with ICT, and engagement with virtual care models has provided the basis upon which to build new ways of providing treatment and responding to client needs with a greater diversity of practices. It is vital that greater investments are made into virtual care models, and their evaluation.

In considering the ongoing lessons being learnt from COVID-19, it is clear that actions are required from multiple parts of the system: governments, treatment funders, peak bodies, treatment providers and managers as well as clinicians.

Thirty-one actions, covering the immediate, medium-term (next 12 months), and long term (next five years) have been derived from the analysis of the survey, focus groups, and administrative data. These immediate, medium, and long-term actions are underpinned by the two long-standing systemic issues for the sector: the chronic underfunding of treatment; and the challenges in recruiting and retaining a specialist workforce.

Immediate actions:

1. Fund the purchase of PPE and other infection control equipment.
2. Re-open programs, notably day programs and outreach services; create awareness of services fully open with treatment places available; ensure that other services are informed of changes to treatment capacity.
3. Develop new service materials (brochures, info sheets, etc.) tailored to clients for the current context and agency website updates.
4. Provide tailored information for clients and their families regarding how technology-enabled care works.
5. Configure clinical spaces for ongoing physical distancing policies.
6. Manage COVID-19 fatigue, anxiety, staff burnout and staff self-care.
7. Support flexibility (i.e. working from home) with clear policies and procedures, and managing staff expectations about flexibility.
8. Support staff to adjust to resumption of face-to-face client work in a COVID-19 risk environment.
9. Ensure appropriate measures are in place for the likelihood of a positive COVID-19 case.

Medium-term actions (next 12 months):

10. Reconnect clinical service networks, and re-establish partnerships with other organisations.

11. Establish and maintain stronger links between government and service providers; improve communication and coordination of AOD services with state governments.
12. Resume fundraising activities and working with donors.
13. Continue infection prevention and control measures for general health and well-being in the workplace.
14. Resource better technology infrastructure; assess and fund costs associated with virtual care delivery, and enhance online capabilities and equipment.
15. Upskill staff members, particularly in the use of technology; and support staff to adapt to a new and ongoing way of doing business.
16. Balance virtual care and face-to-face delivery; have a sustainable model of service delivery using online technology.
17. Engage in strategic and business planning for AOD treatment services; maintain and regularly update business continuity and critical response plans, learn lessons from bushfires and COVID-19; and provide training for strategic and business planning.
18. Review clinical and organisational policies and procedures, e.g. risk management policies; and develop new policies and procedures where required, for example managing privacy and confidentiality online and remotely.
19. Evaluate the impacts and outcomes of online service delivery, including the costs associated with delivery, and impacts on specific populations.
20. Hold planning meetings between NGOs and funders, to discuss the impact of pandemics on service delivery and reporting requirements.
21. Re-negotiate contract agreements and Key Performance Indicators (KPIs), aligned to adapted practices, client numbers, and new service delivery models.
22. Design physical buildings to reduce shared facilities and align with best practices.
23. Improve funding for transportation for clients located in regional, remote and rural locations.
24. Re-establish clinical placements and student placements.
25. Prevent burn-out of staff, improve staff satisfaction and wellbeing post COVID-19; and provide opportunities for revitalization, rest and recuperation of staff, support staff wellbeing.
26. Facilitate access to training opportunities that were cancelled during COVID-19.

Long-term actions (next 5 years):

27. Resolve the chronic underfunding of AOD treatment.
28. Establish and re-build financial reserves in treatment agencies.
29. Ensure preparedness for future major events (e.g. pandemics and bushfires) by the services, the peak bodies and government.
30. Recruit a new AOD workforce, attract people to the sector, ensure availability of experienced staff for succession planning; support career pathways for the AOD workforce.
31. Improve communications between the government and non-government treatment sector with regard to future pandemics and/or future major service disruptions.

Clearly these actions in the immediate, medium, and long-term represent a substantial program of work. It will require work by treatment funders, peak bodies, treatment providers and managers as well as clinicians. Coordinating some of the work through the peak bodies would make sense. It also requires greater investment from government, in the immediate term (for example funding for PPE) and in the long-term (redressing the significant underfunding of AOD treatment).

Many of the actions listed have already begun. We hope the services will use this list as a way to develop priority actions plans, to recognise what they have already achieved, and what remains to be done both immediately and in the medium term. Likewise, this list of actions can inform government about priorities and how to ensure that AOD treatment continues to meet the needs of those seeking help.

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