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Dr Mike Freeland, MP
Committee Chair
House of Representatives Standing Committee on Health, Aged Care and Disability
Parliament House
Canberra ACT 2600
Health.Reps@aph.gov.au

Contact
St Vincent de Paul Society NSW
ABN: 91 161 127 340

Charles O'Neill
State Support Office
2C West Street
Lewisham NSW 2049
PO Box 5
Petersham NSW 2049

Telephone: (02) 9568 0262

Email: **Mgr Policy and Advocacy**
[REDACTED]@vinnies.org.au

Dear Committee Chair,

St Vincent de Paul Society NSW (Society NSW) and St Vincent de Paul Society Queensland (Society QLD) welcome the opportunity to make a submission to the Standing Committee on Health, Aged Care and Disability Committee's Inquiry on the health impacts of alcohol and other drugs (AOD) in Australia (the Inquiry). All people residing in Australia should be treated with dignity, afforded the same human rights, and granted access to help when needed, including if they experience AOD use or dependence.¹ As outlined in the National Drug Strategy, the Australian Government must lead holistic, harm reduction-focussed responses to AOD use and dependence that seek to address the harms of AOD as well as improve outcomes associated with the social determinants of health, including, among others, financial stability, housing, education.²

Society NSW's Service Provision

The Society NSW is a leading provider of frontline health, homelessness and domestic and family violence (DFV) support services and in-community support through our members' direct assistance. The Society NSW's statewide Health Services include a broad range of supports from: residential rehabilitation programs, medicated withdrawal services, regional AOD hub, day programs, pre and post treatment supports, outreach, complex support needs service and Continuing Coordinated Care Program. Our residential programs receive referrals from the community and NSW's justice diversionary programs, including the NSW Drug Court and Local Courts via the Magistrate's Early Referral into Treatment programs.

The Society NSW also operates the Matthew Talbot Hostel Primary Health Clinic, a nurse-led service and accredited GP Practice for men who are at risk of experiencing homelessness, many clients are affected by alcohol and drug dependence, in inner city Sydney. Across the Society NSW's Health Services, 1 in 4 are First Nations clients.

The Society NSW is also a leading Specialist Homelessness Service provider across the state, offering crisis accommodation, assertive outreach to people sleeping rough, transitional accommodation, as well as tenancy support programs. Additionally, the Society NSW offers a range of domestic and family violence (DFV) services including crisis accommodation, transitional housing, case management and the Domestic Violence Response Enhancement program.

¹ To find out more about the Society NSW's position, please refer to: St Vincent de Paul Society NSW, *Social Justice Statement: Promoting recovery and reducing drug and alcohol harm* (2024)
https://www.vinnies.org.au/media/h3ijksby/sj_statement_2024_aod_web.pdf.

² Commonwealth of Australia, *National Drug Strategy 2017-2026* (2017) pg. 5, 15.

Society QLD's Service Provision

The Society QLD delivers a broad range of Specialist Homelessness Services across the state, supporting individuals and families who are experiencing or at risk of homelessness. Through short term crisis and transitional accommodation, case management, outreach, and tenancy sustainment programs, the Society QLD provides person-centred, trauma informed case management aimed at achieving long-term housing stability and improved wellbeing. Services operate across metropolitan, regional, and remote communities, often in conjunction with local health, AOD, and community services to ensure collaborative case management. The Society QLD also delivers targeted responses such as the Immediate Housing Response (IHR), with the collective focus on empowering people to become self-reliant and achieving sustainable housing outcomes.

Residential Recovery Services

The Society QLD is funded by Queensland Health to provide residential alcohol and other drug treatment services for people aged over 18 years in six locations across Queensland. Each residential service offers a 12-week structured program that is designed to be needs-based and evidence-informed.

The programs are aligned with the Queensland Alcohol and other Drug Treatment Service Delivery Framework and support clients to develop practical life skills for alcohol and other drug recovery.

We recognise the importance of a person's environment and the multiple influences in their lives throughout their recovery journey. Our approach aims to build on a person's existing resources to support positive change outcomes. We believe that the person is the expert of their own life and working with them results in them driving the support we provide.

Outreach and Continuing Care

The Society QLD is funded by the Australian Government Department of Health, Queensland Health and NQPHN, to provide pre and post residential recovery support at all four locations (Greater Brisbane, Mackay, Townsville, and Cairns).

The services operate alongside our residential programs to assist any person in the community requiring assistance transitioning into a residential recovery program and/or on leaving the program. Pre-treatment support provides advice or support through outreach and referrals. If residential recovery is identified as a suitable recovery option, clients are guided with information and strategies on harm reduction, advice on detoxification processes, and any required crisis support while waiting to commence their residential program.

Post-care support commences towards the end of a clients' residential program to empower them to live independently and reintegrate with the community without reliance on substances. Post treatment support incorporates connection with community support groups and practical assistance and support with daily living skills such as finance management, parenting, education, employment, and accommodation. Harm reduction is the overarching approach of our alcohol and other drug services. Our primary purpose is to prevent and reduce harm for clients and the wider community and to support a reduction and/or cessation of use.

This submission was developed with direct insights from frontline leaders and Managers from the Society NSW's Services and from Managers from the St Vincent de Paul Society Queensland's Housing and Homelessness and Health and Wellbeing Services.

Recommendations

To better support individuals, families and the wider community affected by alcohol and other drugs, the Society NSW and Society QLD recommend that the Australian Government, in coordination with state and territory and local governments:

1. *Consolidate funding streams, increasing baseline funding for AOD treatment services and streamlining reporting to ease the administrative burden on NGO providers.*
2. *Increase funding for AOD specialists to operate from primary healthcare settings, or in collaboration with existing AOD NGO providers services.*
3. *Establish new incentives for primary healthcare providers, including general practitioners, nurse practitioners and pharmacies, to become accredited in AOD service provision to facilitate greater access to medical primary interventions in the community, especially in rural and regional areas.*
4. *Include people with AOD dependence, engaging in AOD treatment programs, as a priority population, eligible for subsidised publicly funded oral healthcare services.*
5. *Ensure that local, state and territory governments conduct close consultation with priority populations who may be disproportionately affected by proposed restrictions of AOD consumption in public spaces.*
6. *Identify opportunities to fund initiatives for cross-sector AOD and family and domestic violence collaboration, including education and training programs, to promote prevention and early intervention and to better support victim-survivors.*
7. *Fund post-release exit programs for prisoners with AOD concerns to holistically support their reintegration into the community.*

Each of the following sections variously address the Inquiry's Terms of Reference as well as respond to areas of further interest identified in the Issues Paper published by the previous House Standing Committee for Health, Aged Care and Sport in March 2025.

A. Consolidating funding streams to promote holistic responses to deliver a full continuum of care

The Society NSW and Society QLD reiterate the urgent and critical importance of consolidating and providing certainty of funding streams for AOD treatment service providers operated by non-government organisations (NGOs).

The sustainability of the system and its workforce is severely undermined by short-term contract lengths, differential reporting requirements, inconsistent indexation and a lack of funding for overhead costs. The flow on effects on people seeking treatment are devastating, with considerable wait times leading to compounded illness and complexity in presentations.³ The administrative burden of compliance with reporting requirements inevitably creeps into the load of the AOD workforce and compromises their ability to adequately deliver face-to-face care to all people seeking treatment. Further, funding for providers operating in regional, rural and remote areas must factor in sensitivities to the costs of service delivery to ensure equity of access to AOD treatment across all geographic locations.

³ Australian Alcohol and other Drugs Council, *Submission 45* (30 September 2024) p. 4, <https://www.aph.gov.au/DocumentStore.ashx?id=1d018308-d01c-4fb6-8670-3853d5026351&subId=767089>.

Case study: Funding for Freeman House

Freeman House is operated by the Society NSW in Armidale and provides residential and inpatient AOD treatment to adults experiencing AOD dependence, accepting referrals from across NSW. Its service offering includes a withdrawal management unit; voluntary 3-12 month residential rehabilitation service; independent transitional units that provide vital aftercare support for those who have completed the core group programs, but benefit from supported accommodation in their transition back to the community; Supporting Kids and Independent Parents program, which allows single parents to participate in the residential rehabilitation program, while caring for up to two children under the age of 12. There is a total of 40 beds at Freeman House, including 24 residential rehabilitation beds, 6 beds for withdrawal management, 2 units for people with children, 4 homelessness crisis beds and 4 homelessness units.

At present, there are 71 active inquiries moving through assessment and processing and 20 people on the waitlist to engage in treatment at Freeman House. However, despite having 5 different funding streams, 9 rehabilitation beds remain unfunded. The Society NSW's Regional Manager for North West Health Services, Jessica Toole, has publicly stated: "We're always doing reports, and we've got different KPIs for each funding stream. So it means that we also have gaps in the funding as well...Nothing's at full capacity [across the sector] because the funding doesn't reach full capacity".⁴

B. Access to addiction specialists, AOD trained GPs and nurse practitioners and other medical practitioners, including mental health specialists, in community

There is an urgent need for increased access to a multidisciplinary, collaborative, harm reduction-focused approach in primary healthcare responses to support people with AOD dependence.

At present, universal access to pharmacotherapies, referrals to addiction specialists and other harm minimisation services are limited by the availability and affordability of services from AOD trained general practitioners (GPs) and nurse practitioners (NPs).⁵ This especially disadvantages people experiencing AOD issues in regional, rural and remote areas across the country, where rates of risky alcohol consumption and illicit drug use are higher.⁶

Without adequate access at the primary healthcare stage, medical interventions may be limited and positive outcomes unsustainable. This leads to increased presentations to emergency departments for crisis interventions related to overdose or secondary complications from AOD use and dependence.⁷

More general practitioners (GPs) and nurse practitioners (NPs) must be incentivised to complete training in AOD responses to increase the availability of early medical intervention in primary healthcare for the population of people impacted by AOD.

⁴ Hartley, T., Mockler, R., 'NSW is struggling to service drug users who want to get into rehab centres, with regional areas the worst hit' (31 October 2024) *ABC News* [online] <https://www.abc.net.au/news/2024-10-31/nsw-drug-users-cannot-access-rehab-drug-summit/104538822>.

⁵ Booker, C., "Crisis looming": GP calls for help as small band of doctors do heavy lifting on opioid treatment' (16 April 2022) *The Age* [online] <https://www.theage.com.au/national/victoria/crisis-looming-gp-calls-for-help-as-small-band-of-doctors-do-heavy-lifting-on-opioid-treatment-20220415-p5adr6.html>; Salvation Army, 68.1: *Supplementary to submission 68* (2024) Inquiry into the health impacts of alcohol and other drugs in Australia [online] <https://www.aph.gov.au/DocumentStore.ashx?id=14967adf-06db-4a51-9825-988fbe4509ec&subId=767148>.

⁶ Australian Institute for Health and Welfare (AIHW), 'Use of alcohol and other drugs in Major cities, regional areas, and remote areas' (29 February 2024) *National Drug Strategy Household Survey 2022-2023* [online] <https://www.aihw.gov.au/reports/rural-remote-australians/alcohol-drugs-geographic-areas>.

⁷ Glover-Wright, C., Coupe, K., Campbell, A. et.al., 'Health outcomes and service use patterns associated with co-located outpatient mental health care and alcohol and other drug specialist treatment: A systematic review' (April 2023) *Drug and Alcohol Review*, vol. 42(5) <https://pmc.ncbi.nlm.nih.gov/articles/PMC10946517/pdf/DAR-42-1195.pdf>.

Researchers at the National Drug and Alcohol Research Centre (NDARC) have found that without further incentives for GPs and NPs to complete additional training to prescribe opioid pharmacotherapies, access to, engagement in and retention in opioid agonist treatment programs will remain inequitable across the country.⁸ At present, the prescribing load for opioid agonist treatment, a crucial harm reduction approach, falls on single providers, both due to the reduced financial benefit to GPs when compared to patients who are not bulk-billed as well as the perceived risk and stigmatisation of people using AOD disturbing staff and other patients in medical clinics.

Without these measures, there is no guarantee that people needing support for their AOD dependence in community will be sustained and their recovery journey may be compromised. GPs already offering AOD primary healthcare in regional areas, where providers and services are sparse, are at capacity and are forced to turn away patients seeking support. Further, when existing patients have developed relationships with GPs and NPs who eventually retire or move out of areas, their continuity of care is put at risk.

Finally, this is a limiting factor in the success of innovative treatments such as home detoxification programs, which have high rates of satisfaction for both patients and healthcare providers.⁹ This is particularly concerning considering the long wait times for residential withdrawal. In NSW, 50% of people waiting to complete residential withdrawal experience a delay of 12 to 26 weeks.¹⁰ While non-residential withdrawal may not be appropriate for all people, its wider availability will ensure that people who are ready to enter the program, or require detox before commencing rehabilitation programs, do not face delays. This is particularly important to ensure the time people may relapse before engaging with AOD treatment is reduced. Importantly, at home withdrawal is more culturally inclusive, as First Nations People can remain on Country and close to kin while receiving withdrawal treatment and support.

In addition to accessing GPs and NPs, improving access to other medical practitioners, such as dentists, whether in residential treatment programs or in community, could dramatically improve outcomes throughout people's recovery journey. Evidence shows that stigma associated with poor oral health, which is often compromised due to drug use, is an inhibiting factor in engaging with the health system generally, as well as negatively impacting opportunities for employment and social interaction.¹¹ Governments must address the structural barriers to seeking oral health treatment, including accessibility and stigma associated with drug use, which limits people's help-seeking and may increase their anxiety.

One example of an integrated model of care that connects people experiencing AOD dependence is Sydney Local Health District's Drug Health Services Strategy, which focuses on harm reduction and involves access oral health services.¹² A collaborative, multidisciplinary model of care, integrated into existing AOD treatment programs, that facilitates access to oral and other health services, while mitigating stigma attached to AOD use and dependence, will improve health and wellbeing outcomes.

⁸ Groothuizen, M., 'Engaging with OAT in NSW: A mixed-methods exploration of treatment access and retention' (29 August 2025) National Drug and Alcohol Research Centre UNSW [online] <https://www.youtube.com/watch?v=h94MtS7myE>.

⁹ Davis, C., 'Home detox – supporting patients to overcome alcohol addiction' (3 December 2018) *Australian Prescriber*, vol. 41(6), <https://australianprescriber.tg.org.au/articles/home-detox-supporting-patients-to-overcome-alcohol-addiction.html>.

¹⁰ Barrett, L., Ritter, A., 'Measuring the wait for NGO AOD treatment in NSW' (15 November 2024) Drug Policy Modelling Program UNSW, <https://www.nada.org.au/wp-content/uploads/2025/03/NADA-wait-time-survey-September-2024-Final-v4.pdf>.

¹¹ Uthurralt, N., Ajwani, S., Kiel, R., Chandra, S., Lama Rumba, B., Day, C., 'Providing better access to oral health care for people receiving substance use treatment: A timely discussion' (18 September 2024) *Drug and Alcohol Review*, vol. 43(1), <https://onlinelibrary.wiley.com/doi/10.1111/dar.13753>.

¹² Sydney Local Health District, *Drug Health Services Strategic Plan: 2023-2026* (2023) NSW Government, p. 6, <https://slhd.health.nsw.gov.au/sites/default/files/2023-10/Drug-Health-Strategic-Plan.pdf>.

Additionally, it is well known that the comorbidity of AOD use and dependence and mental health concerns is high – between 50-76% of people entering AOD treatment programs in Australia are eligible for a diagnosis for at least one other mental illness.¹³ However, it is well known that the unmet need for psychosocial support for people in the community, who do not receive support via the National Disability Insurance Scheme, is not only high but continues to grow. In 2022-2023, only 31% of people with severe mental illness (a total of 335,800) received support and 16% of people with moderate mental illness (311,500) accessed services.¹⁴ What is particularly worrying, is that the Productivity Commission significantly underestimated the unmet need for people with severe mental illness, by around 76,500 people.

The mental health and AOD sectors must receive adequate, flexible funding package to provide tailored support for people with a dual AOD/mental health diagnosis to facilitate for the co-location of mental health practitioners, including psychologists, and addiction specialists to work from service sites.

A multidisciplinary model of care recognises that addressing a person’s AOD use or dependence requires simultaneously responding to their physical healthcare needs, which may in turn affect social determinants of health, including employment and social engagement.

C. Impact of AOD restrictions in public spaces on people sleeping rough

As SHS providers operating in metropolitan centres, the Society NSW and Society QLD, have regular engagement with people who have experienced repeat periods of sleeping rough and aware of the impacts of alcohol bans in public spaces. Whether police are only authorised to confiscate the alcohol or are empowered to issue infringements or fines, for populations that are already over policed,¹⁵ these bans, when enacted without community consultation, are often punitive in nature. First Nations Peoples, low-income earners and people experiencing homelessness are disproportionately impacted and the flow-on effects can be severe.

There is a high correlation between risky consumption of alcohol and housing instability or homelessness.¹⁶ Additionally, research and anecdotal evidence shows that AOD use is a common factor in the social context of people experiencing homelessness.¹⁷ This is significant as with a higher rate of injury for people experiencing homelessness, and particularly for those sleeping rough, social connection to the community of people experiencing homelessness acts as protection to reduce safety concerns.¹⁸ As such, many people currently sleeping rough or those in social housing come together socially to use AOD. However, due to financial constraints, they are more likely to congregate in public spaces than in licensed venues.

¹³ Mills, K., Marel, C., Madden, E., Teesson, M., ‘Lessening the Burden of Comorbid Substance Use and Mental Disorders through Evidence-based Care: The Case for a National Minimum Qualifications Strategy’ (2019) Submission to the Australian Government Productivity Commission Mental Health Inquiry, Matilda Centre for Research in Mental Health and Substance Use, University of Sydney, https://www.pc.gov.au/__data/assets/pdf_file/0003/240798/sub280-mental-health.pdf.

¹⁴ Health Policy Analysis, *Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme* (15 August 2024) pp. 7-10, <https://www.health.gov.au/sites/default/files/2024-08/analysis-of-unmet-need-for-psychosocial-supports-outside-of-the-national-disability-insurance-scheme-final-report.pdf>.

¹⁵ Justice and Equity Centre, ‘Reducing unfair fines and over-policing from alcohol-free zones’ (29 July 2024) *News* [online] <https://jec.org.au/homelessness/reducing-unfair-fines-and-over-policing-from-alcohol-free-zones/>.

¹⁶ AIHW ‘Clients with problematic drug and/or alcohol use’ (13 February 2024) *Specialist Homelessness Services Annual Report 2022-2023* [online] <https://www.aihw.gov.au/reports/homelessness-services/shs-annual-report-22-23/contents/clients-problematic-drug-alcohol-use>.

¹⁷ Rhoades, H., Wenzel, S., Golinelli, D., Tucker, J.S., Kennedy, D.P., Green, H.D., Zhou, A., ‘The Social Context of Homeless Men’s Substance Use’ (November 2011) *Drug Alcohol Dependence*, vol. 118(2-3), p. 2, <https://pmc.ncbi.nlm.nih.gov/articles/PMC3177996/pdf/nihms298279.pdf>.

¹⁸ Fazel, S., Geddes, J., Kushel, M., ‘The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations’ (2014) *The Lancet*, vol. 384(9953), pp. 1529-1540.

When local councils implement alcohol-free zones, AOD use by people experiencing homelessness or those with insecure social housing tenancies is more likely to occur indoors. For social housing tenants, AOD use indoors and the compounding effects of AOD on anti-social behaviours and punitive approaches by landlords, create an increased likely likelihood of termination and eviction.¹⁹ This can be devastating for people who have experienced repeat episodes of homelessness and may not be eligible to apply again to social housing registers.

Failing to consider the social determinants of people's health, including housing and homelessness, when developing policy responses to AOD use will complicate people's long-term health and wellbeing outcomes. Coordinated health responses focussed on harm minimisation must always be prioritised, rather than adopting a punitive-based law enforcement approach in public spaces as secondary, unintended consequences can jeopardise positive outcomes for people who use or are dependent on AOD, such as commencing a tenancy, building social capital through friendships or engaging in AOD treatment.²⁰

As the Network for Alcohol and Other Drug Agencies outlined: "responses that are co-designed with community, health and other services...is important to ensure that responses will reflect the needs across vulnerable groups and the needs in different locations".²¹ Public bans on AOD use must be highly targeted, localised and implemented in direct consultation with community, including members of priority populations, such as people sleeping rough and those in social housing through lived-experience advisory groups.

D. People exiting correctional settings

A large proportion of people entering prisons in Australia have a history of risky AOD use and dependence.²² Further, the healthcare costs for people exiting prison, a cohort with a higher rate of AOD dependence and mental illness, are over two times greater than the general population.²³ Corrective and justice health services have a duty to improve the health and wellbeing outcomes for people experiencing AOD dependence who voluntarily seek support by connecting them with appropriate and available treatment services, both during their incarceration and as part of release planning.

The success of connecting people to the most appropriate AOD treatment supports and interventions during incarceration, requires choice and control. Only 9.7% of people exiting prison have accessed alcohol treatment programs from prison clinics, 14% have a referral or appointment with AOD services or counsellors and 5.6% have a referral to a pharmacist or opioid substitution therapy provider.²⁴ Worryingly,

¹⁹ Martin, C., Habibis, D., Burns, L., Pawson, H., *Social housing legal responses to crime and anti-social behaviour: impacts on vulnerable families* (June 2019) Australian Housing and Urban Research Institute, p. 64, <https://www.ahuri.edu.au/sites/default/files/migration/documents/AHURI-Final-Report-314-Social-housing-legal-responses-to-crime-and-anti-social-behaviour-impacts-on-vulnerable-families.pdf>.

²⁰ Adams, L., *In the Public Space: Addressing the negative impact of laws regulating public space on people experiencing homelessness* (2014) The Winston Churchill Memorial Trust of Australia and Justice Connect Homeless Law, p. 8, <https://apo.org.au/sites/default/files/resource-files/2014-08/apo-nid40792.pdf>.

²¹ Keyes, C., 'Alcohol Consumption in Public Places (Liberalisation) Bill 2024' (12 August 2024) Legislative Council Portfolio Committee No.1 - Premier and Finance, p.3, <https://www.parliament.nsw.gov.au/lcdocs/transcripts/3352/D24%20041611%20%20Transcript%2012%20August%202024%20-%20PC1%20Alcohol%20Consumption%20in%20Public%20Places%20-%20Corrected.pdf>.

²² Alcohol and Drug Foundation, 'Prison, alcohol and drug use' (7 May 2025) *Insights* [online] <https://adf.org.au/insights/prison-aod-use/>.

²³ Snow, K., Petrie, D., Young, J. et.al., 'Impact of dual diagnosis on healthcare and criminal justice costs after release from Queensland prisons: a prospective cohort study' (2022) *Australian Journal of Primary Health*, vol 28(3), pp. 264-270.

²⁴ AIHW, 'Continuing care' (15 November 2023) *The health of people in Australia's prisons 2022* [online] <https://www.aihw.gov.au/reports/prisoners/the-health-of-people-in-australias-prisons-2022/contents/health-services/continuing-care>.

21% of prison dischargees were not at all involved in treatment decisions while at prison clinics.²⁵ Positive health outcomes can only be sustained long-term when they directly involve patients who are well informed about the benefits and risks of specific interventions and whose choice and control have been prioritised.

The Society NSW has had multiple clients who have been placed on the Opioid Treatment Program (OTP) by NSW's Justice Health, despite not having used opioids for years. Additionally, treatment choices during incarceration are not considered in conjunction with available in-community supports when developing continuity of care plans. For example, prison discharge health summaries must account for, if relevant, the availability of a dischargee's preferred pharmacotherapies in the area they intend to live, current waitlists for local AOD services, the feasibility of dischargees accessing services out-of-area (i.e. travel costs and impact on family, particularly childcare) and identification of local harm reduction services. This should involve coordination and collaboration with local health districts, AOD treatment providers and other relevant stakeholders.

As outlined above, waitlists for AOD services are currently stretched, so referrals to and funding of programs or hubs that offer before-care or transitional supports is critical. The Society NSW's Regional AOD Hub in Armidale sees many prison dischargees and as one peer worker noted, connecting with the hub often serves to "keep their head above water" before they can access other AOD programs. This is particularly important for areas in which AOD treatment services are sparse.

Release planning is a critical stage to address a person's AOD support needs as well as other social determinants of their future health, with a particular focus on establishing housing stability. With 48% of prison dischargees expecting to be homeless once released, establishing a post-release plan that focuses on housing stability and coordinating a holistic healthcare response is paramount.²⁶

When any element in the support system fails, whether it is housing or healthcare, the sustainability of positive outcomes is jeopardised and the risk of crisis, relapse, overdose or reincarceration escalates.

Case study: Post Release Support Accommodation (St Vincent de Paul Society Queensland)

The St Vincent de Paul Society Queensland's Post-Release Supported Accommodation (PRSA) program provides safe, supported prisoner release accommodation to assist people with complex needs on parole begin their transition back into the community. The program focuses on holistic, strengths and client-based care, recognising that connecting back to community requires building a system of supports, through referrals to community services and setting up long term housing stability, as well as building an individual's confidence, independent living skills and social connection to family.

PRSA case managers have a pre-release appointment with clients, which allows them to build rapport and begin thinking about developing a goal plan. While the program only lasts 12 weeks, its outcomes are significant, with 80% of clients exiting to long-term stable housing, including private rentals, and successfully applying for support, usually for the first time, through the National Redress Scheme, National Disability Insurance Scheme and Disability Support Pension. Further, clients are encouraged to explore their own interests and goals, from creative arts to cooking, reconnecting with family, building their confidence and social capital.

²⁵ AIHW, 'Satisfaction with health services' (15 November 2023) *The health of people in Australia's prisons 2022* [online] <https://www.aihw.gov.au/reports/prisoners/the-health-of-people-in-australias-prisons-2022/contents/appropriateness-of-health-services/satisfaction-with-health-services>.

²⁶ AIHW, 'Homelessness' (15 November 2023) *The health of people in Australia's prisons 2022* [online] <https://www.aihw.gov.au/reports/prisoners/the-health-of-people-in-australias-prisons-2022/contents/socioeconomic-factors/homelessness>.

With many clients only receiving 5 days' worth of medication for chronic conditions or not leaving prison with prescriptions for opioid agonist treatment, it is critical that PRSA case managers facilitate visits to GPs and specialists to provide the continuity of support needed after release to avoid crisis. While waitlists for AOD support services may be long, PRSA provides pre-treatment non-clinical support, linking them to in community primary healthcare, which may be limited, especially in regional areas.

E. Intersection between family, domestic and sexual violence (FDSV) and AOD

Evidence over the past ten years has shown a correlation between substance use and domestic violence perpetration.²⁷ The Society NSW's own data shows that referrals for AOD services regularly come from family and domestic violence support services. Additionally, its intersection has been acknowledged in National Strategies on drugs and ending violence against women and children.²⁸ Whether AOD use or dependence are causal factors in domestic violence perpetration or reinforcing risk factors, it is vital that both the AOD and FDSV sectors collaborate to:

- Support victim-survivors with their own AOD treatment and/or to provide interventions to enhance their safety after they or their perpetrator have contacted AOD or FDSV support services, and
- Identify opportunities to intervene early to avoid domestic violence incidents by treating or working with perpetrators.

The Commonwealth, state and territory governments have a leading role in facilitating collaboration across the AOD and FDSV sectors to support victim-survivors impacted by perpetrators using AOD and by enhancing safety through referring perpetrators to AOD treatment programs, men's behaviour change programs (MBCPs) or other early intervention programs. This can be facilitated by:

- Including funding for education and training programs for AOD and FDSV workers to upskill workers and develop best practice responses to support both victim-survivors and respond to perpetrators who use or are dependent on AOD,²⁹
- Funding additional FDSV specialist supports to be directly integrated into AOD treatment services, including counselling,
- Establishing a national governance structure to facilitate sector inclusive virtual integration of care, across and between AOD and FDSV sectors, between providers and agencies to facilitate holistic responses to FDSV, for example through referrals to women's domestic violence advocacy services or MBCPs, for victim-survivors or perpetrators engaged in AOD treatment services, to provide a true 'no wrong door' and 'flexible fit' approach in practice,³⁰
- Funding interventions to work with perpetrators who use or are dependent on AOD who are currently engaged in AOD treatment (for example, co-location of MBCPs within existing residential and non-residential AOD services),
- Funding primary prevention initiatives that involve representatives from both AOD and FDSV sectors,

²⁷ AIHW 'Factors associated with FDSV' (2025) *Family, domestic and sexual violence* [online]

<https://www.aihw.gov.au/family-domestic-and-sexual-violence/understanding-fdsv/factors-associated-with-fdsv>.

²⁸ Commonwealth of Australia (Department of Health), *National Drug Strategy 2017-2026* (2017) p4 [online]

<https://www.health.gov.au/sites/default/files/national-drug-strategy-2017-2026.pdf>; Commonwealth of Australia (Department of Social Services), *National Plan to End Violence against Women and Children* (2022) p. 34 [online] <https://www.dss.gov.au/system/files/resources/national-plan-end-violence-against-women-and-children-2022-2032.pdf>.

²⁹ For example, the NSW Government has partnered with the Network for Alcohol and other Drug Agencies (NADA) to develop webinars for AOD workers to support victim-survivors of FDSV: NADA, 'Domestic and family violence' (2020) Youtube video, <https://nada.org.au/resources/domestic-and-family-violence/>.

³⁰ Merkes, M., Lewis, V., Canaway, R., 'Supporting good practice in the provision of services to people with comorbid mental health and alcohol and other drug problems in Australia: describing key elements of good service models' (2010) 10(325) *BMC Health Services Research* pg. 1-2; D. Howard, *Report – Volume 2*, Special Commission of Inquiry into crystal methamphetamine and other amphetamine-type stimulants, pg. 558.



- Establishing regular government roundtables with representatives from the AOD and FDSV sectors,
- Setting specific goals in national AOD and FDSV strategies (particularly in considering outcomes for a new *National Drug Strategy*) to reduce the rate of FDSV incidents that involved substance use.

It is especially important to continue funding AOD programs that are based on a holistic model of care, that focus not only on reducing the severity of AOD dependence, but on addressing goals around the use of violence. This is particularly important for justice diversion programs, including Drug Court Programs, whether a person has a history of FDSV charges or not. It also includes before and aftercare support programs that involve case management and will allow people to be referred to programs that involve therapeutic interventions for FDSV.³¹

Conclusion

The Australian Government must lead holistic responses to AOD use in Australia and focus on harm minimisation; universal access to a full continuum of treatment supports; and collaboration with partners to address the social determinants affecting AOD use and dependence. Working together we can deliver a more just and inclusive Australia that supports all people impacted by alcohol and other drugs. Everyone matters - every day.

The Society NSW and Society QLD would welcome the opportunity to provide further insight into the issues raised in this submission at an inquiry hearing. If you have any questions, please contact Jonathan Edwards, Manager, Policy and Advocacy, at the Society NSW, at Jonathan.Edwards@vinnies.org.au.

Yours sincerely,



Brett Macklin
Executive Director (Acting)
Vinnies Services
St Vincent de Paul Society NSW



Jackie Youngblutt
General Manager of Programs, State
St Vincent de Paul Society QLD

About the St Vincent de Paul Society NSW

The St Vincent de Paul Society NSW is a member and volunteer-based organisation that has been assisting people experiencing disadvantage and hardship in NSW for 140 years.

The St Vincent de Paul Society NSW currently has close to 12,000 members and volunteers across the state, giving tirelessly of their time. In total, we have 368 local member networks, referred to as conferences, present in communities across NSW.

Our members, volunteers and staff assist people experiencing disadvantage with resources including food parcels and vouchers, financial assistance, help with energy bills and other expenses, budget counselling, school items for children, and the provision of other material items such as furniture, clothing, bedding and any other household items.

³¹ For example, the Continuing Coordinated Care Program provided by the Society NSW: NSW Health, 'Continuing Coordinated Care Program' (2024) NSW Government, <https://www.health.nsw.gov.au/aod/resources/Pages/continuing-coordinated-care-program.aspx>.



St Vincent de Paul Society
NSW
good works



St Vincent de Paul Society
QUEENSLAND
good works

The St Vincent de Paul Society NSW is also a leading provider of frontline services, with 100 local services across the state. These deal with a range of issues including homelessness, domestic and family violence, disability, disaster relief, youth wellbeing, refugee and migrant inclusion, rehabilitation and addiction.

About the St Vincent de Paul Society Queensland

St Vincent de Paul Society Queensland (Society QLD) is a leading community-based organisation committed to offering a hand up to people experiencing disadvantage, poverty, and social exclusion.

Guided by the mission of serving with compassion, respect, and hope, the Society QLD provides a wide range of supports including homelessness and housing services, domestic and family violence and alcohol and other drugs, disaster relief, youth and family programs, wellbeing supports, and assistance with food, clothing, and financial hardship.

Through a combination of professional services and the efforts of hundreds of dedicated members and volunteers across the state, the Society QLD works to strengthen communities, uphold human dignity, and advocate for systemic change to reduce hardship and homelessness in Queensland.