VICTORIAN ALCOHOL & DRUG ASSOCIATION

State Budget Submission

2017/2018

VAADA Vision

A Victorian community in which the harms associated with drug use are reduced and general health and well being is promoted.

VAADA Objectives

To provide leadership, representation, advocacy and information to the alcohol and other drug and related sectors.

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About VAADA

VAADA is a non-government peak organisation representing publicly funded Victorian AOD services. VAADA aims to support and promote strategies that prevent and reduce the harms associated with alcohol and other drug (AOD) use across the Victorian community. VAADA's purpose is to ensure that the issues for people experiencing harms associated with substance use and the organisations who support them are well represented in policy, program development and public discussion.

VAADA's membership comprises agencies working in the AOD field, as well as those individuals who are involved in, or have a specific interest in, prevention, treatment, rehabilitation or research that minimises the harms caused by AOD.

What does VAADA do?

As a peak organisation, VAADA's purpose is to ensure that the issues for people experiencing the harms associated with AOD use and the organisations that support them are well represented in policy and program development and public discussion.

VAADA seeks to achieve this through:

- Engaging in policy development;
- Advocating for systemic change;
- Representing issues our member's identify;
- Providing leadership on priority issues to pursue;
- Creating a space for collaboration within the AOD sector;
- Keeping our members and stakeholders informed about issues relevant to the sector; and
- Supporting evidence-based practice that maintains the dignity of those who use alcohol and other drug services (and related services).

Contents

Executive Officer's comment

As with all past annual State Budget submissions produced by the Victorian Alcohol and Drug Association (VAADA), the essential intent remains one of drawing together a range of innovative ideas as well as specific funding requests to address demand issues and system enhancements.

VAADA seeks to focus on key sector priorities and areas of emerging need. The fact that some issues may carry over from year to year simply signifies that these issues have not yet been addressed and require attention. In this regard this year's submission contains a number of persistent issues which remain in focus as well as new areas requiring attention.

While the complexity of dealing with alcohol and other drug (AOD) issues is well understood and there is a deep commitment by government to streamline, make systems ever more efficient, accessible, and on a range of measures better, the actual quantum of system change is in itself creating its own vortex of system dysfunction. The legacy of particular changes as well as recent sector reform require careful attention as well as investment. In preparation for this submission VAADA draws on its own knowledge of gaps and priorities in the sector, as well as distilling the voice of the sector through a variety of means. In the process we continue to reflect on what is, and what is needed, culminating in this submission which remains a key VAADA activity.

This year our submission and recommendations can be classified into three broad themes, namely 'accessing treatment', 'chronic underfunding', and 'workforce recruitment and retention'. Within each area a number of recommendations are made to address identified issues. Additionally, we have also carried over a number of recommendations related to the implementation of elements identified in the ASPEX review of 2015. Key areas of concern relate to supporting transition within the 'Intake and Assessment' area and improving front end access to AOD treatment system. In addition, 'care and recovery coordination' which is a welcome initiative from the recent reform has a range of significant deficits arising from a gross lack of investment in this treatment type, and resultant high expectations which are difficult to achieve with the current levels of investment. There is also a desire to see better investment in a functional and well supported Data System, which is an essential piece of infrastructure for the sector, and Government.

The submission also outlines other areas including the development of a broad network of services across growth corridors, as well as rural and regional communities. In both areas additional investment is required to address what are very clear deficits in accessible treatment services. Similarly, older persons, as well as culturally and linguistically diverse communities are identified as needing special attention. In particular there is a need for heightened planning and investment in residential rehabilitation beds to address a gross and disproportionate deficit in Victoria's bed numbers in comparison to most mainland states.

In the workforce area there also remains a great need to invest in our specialist workforce especially if the AOD sector is to address growing complexity and an ability to respond to increasingly complex and at risk communities. In as much, VAADA proposes the development of a sector development fund to enhance the skill set of the sector, build cross sector endeavours and effective pathways into treatment for at risk communities.

As in previous years we also make a call for increased support of harm reduction programs, and on this occasion we are proposing a pragmatic solution to deep seated harms resulting from public illicit substance use. In this regard we are recommending that for areas experiencing high levels of entrenched substance related harm there should be an examination and investment in consumption

rooms in line with local need. There is a plethora of international and local evidence supporting the efficacy of such initiatives which can no longer be ignored. Additionally, the specific model should be determined by local services and cohorts which would use these facilities.

The submission also draws the reader's attention to the overall and historic plight of investment in the Victorian AOD sector and calls for greater attention to address funding circumstances

Sam Biondo

Summary of recommendations

Recommendation 1: that the Government provide a recurrent $5,000,975 to the AOD sector for additional courses of 'Care and recovery coordination' to account for the needs of approximately 25 percent of all AOD service users.

Recommendation 2: that appropriate resourcing is afforded to ensure that agencies affected by the implementation of the ASPEX recommendations, including any changes to intake and assessment, are able to maintain client need and optimal service delivery.

Recommendation 3: The Victorian Government support the enhancement of AOD treatment data systems to provide for capacity to undertake in depth cross sectional analysis on demographic data pertaining to AOD treatment service engagement. To achieve this, the Government should provide the following:

I. *The enhancement of AOD data systems through the allocation of $800,000 as a non-recurrent payment;*

II. *The training of staff to input data and otherwise utilise the new data systems through the allocation of $10,000 per annum for each AOD catchment ($160,000 per annum); and*

III. *The creation of a Specialist Data Analysis Unit to collate and analyse data and provide advice to agencies and government on a state wide basis through the allocation of $200,000 per annum as well as annually publish AOD data in a manner similar to Victoria's Mental Health Service Annual Report.*

IV. *that the Victorian Alcohol and Drug Association (VAADA) be resourced to provide sector development support and facilitate sector participation in the progression of implementing ASPEX, the Royal Commission into Family Violence findings and Protecting Victoria's Vulnerable Children up to financial year ending 2019/20 at $150,000 per annum.*

Recommendation 4: That $3 million be made available to each growth corridor region (Melton, Casey, Wyndham, Cardinia, Mitchell and Whittlesea) to enhance existing services or establish new services to address AOD related harms in line with rapid population growth and disadvantage.

Recommendation 5: That an additional $10 million is allocated annually to enhance AOD service access and capacity in rural and regional Victoria, prioritising areas identified in the catchment based planning which experience challenges in service access, as well as high levels of morbidity and AOD related harms.

Recommendation 6: A pilot outreach AOD treatment project should be developed to address the gap in AOD services for older adults throughout Victoria. The project should include outreach, project coordination, medical support coupled with resourcing for research and evaluation.

Recommendation 7: That bi-cultural workers are situated within four AOD catchments in Victoria and supported by a project officer with the goal to increase CALD community access to AOD services and build the capacity of these services to better cater for the needs of CALD communities.

Recommendation 8: That an additional $2 million be available to AOD services across the state to enhance their capacity in order to address emerging local challenges and maximise service access for at risk communities as well as provide for workforce development and training endeavours.

Recommendation 9: That additional Addiction Psychiatry capacity be availed to DACAS at an estimated cost of $250,000 per annum to provide additional support to presentations related to co-occurring AOD and mental illness.

Recommendation 10: That the Victorian government develop a plan to direct the necessary increase in capacity of Victorian funded residential rehabilitation services through all of Victoria to lift capacity to a level in alignment with other jurisdictions in Australia. This will necessitate the development of approximately 300 beds over the five year period lifting the rate to 1 bed per 10,000 head of population. It is estimated that the operations cost of running these facilities will amount to approximately $70,000 per annum per bed.

Recommendation 11: that areas experiencing high levels of entrenched substance related harm to be resourced to developed consumption rooms in line with local need. The specific model should be determined by local services and cohorts which would use these facilities.

Recommendation 12: An additional $1 million allocated annually to an innovation fund to respond to changing needs, facilitate and encourage innovation and enhance the evidence base of the Victorian AOD treatment sector.

The initiatives detailed in this submission aim to reduce the harms associated with alcohol and other drugs (AOD) and subsequently reduce the AOD burden on acute health and justice systems and associated costs to government. The foundation to this submission is the cost effectiveness of, and positive outcomes associated with, AOD treatment detailed in a summary of the evidence noted below.

The various issues raised in this submission have been determined through analysis of the VAADA annual priorities survey, which was administered to senior managers in the Victorian AOD sector during June – July 2016. A working group from the sector has been convened to provide further advice on the development of this submission, as well as reviewing content. We have also consulted with specific experts, networks and groups within the sector on specific issues contained herein.

AOD treatment works and is cost effective

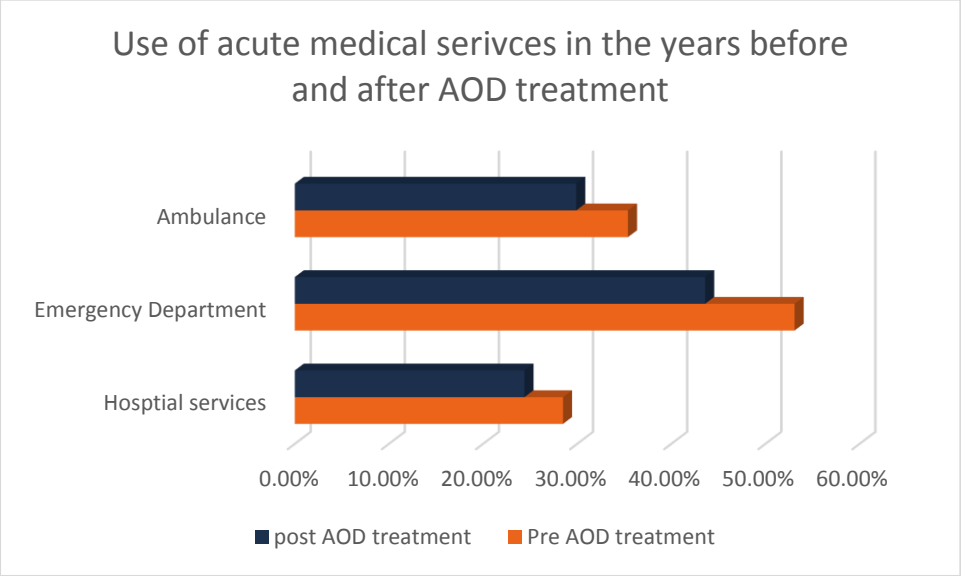
AOD treatment provides a strong return on investment with evidence indicating that over a 12 month period, treatment provides a cost benefit ratio of $8 being saved for every $1 spent (Coyne, White & Alvarez 2015).

There is a growing body of evidence which indicates that engagement in AOD treatment services reduces demand for acute health services. *The Patient Pathway's Project* (Lubman et al 2014), which follows AOD service users both prior to and post treatment, noted that service users who have accessed AOD treatment utilized less acute health services in the year after the treatment in comparison to the year leading up to the treatment:

- Demand for hospital services among those with AOD dependence issues decreased from 28.5 to 24.4 percent for those who have, in the past year, attended AOD treatment;
- For the same population, ambulance attendances decreased from 35.4 to 29.9 percent; and
- Hospital emergency admissions decrease from 53.1 to 43.6 percent

Figure 1 reveals the positive impact of AOD treatment on acute health service demand.

Figure 1: Impact of AOD treatment on acute health service demand



Lubman et al (2014) highlight the positive impact of AOD treatment on acute health service demand, noting that overall there was a 16 percent reduction in research participants requiring ambulance, ED or hospital admissions in the year post treatment. Further, they assert that this is 'likely to reflect a substantial reduction in health care costs'.

Needle and syringe programs provide a significant return on investment, with a national study indicating that between 2000 and 2009 these programs have, nation-wide, averted 32,050 HIV infections and 96,667 hepatitis C infections and achieved a net cost saving of over $1 Billion. Over a ten year period, the return on investment amounts to $4 for every $1 spent (DOHA 2009).

Recent evidence indicates that AOD residential rehabilitation is more cost effective than prisons. The NIDAC study (ANCD 2012) found that, when compared with prison, the diversion of Aboriginal people to rehabilitation programs achieved savings of $111,458 per prisoner with additional health related savings associated with lower mortality and better health outcomes of $92,759. Savings to the justice system also occur through the use of the Drug Court, with a cost benefit ratio of 1:5.81 (VAADA 2013); a more recent review of the Victorian Drug Court (KPMG 2014) found that over two years it accrued $1.2M in savings through reducing the prison population (these savings do not account for the range of other benefits including reduced recidivism and improved health and social circumstances. In light of this, the pending additional Drug Court capacity is most welcome.

International evidence indicates a return on investment for AOD treatment in the USA of $4 in health care and $7 for justice related expenses for each dollar spent (Office of National Drug Control Policy 2012); evidence from the UK indicates a £2.50 saving for each pound spent (National Treatment Agency for Substance Abuse 2012).

Despite the breadth of evidence indicating the health, financial and social benefits of AOD treatment, research indicates that, across Australia, the sector would need to provide for 200,000 to 500,000 individuals who are in need of treatment meet national demand (Ritter et al 2014). Many of these people will be falling through the cracks, ending up in our justice systems, our acute health systems or our morgues. In light of this, the Australian Institute of Health and Welfare (2016) notes that, nationally, there were 38,636 overnight hospitalizations for AOD, totaling a daunting 299,829 bed days nationally throughout 2013/14.

Addressing treatment demand

Underpinning the themes and content of this submission is the need to provide timely access to AOD treatment for all Victorians. To do this, AOD treatment services will need to be resourced to meet demand, and the various service systems recalibrated to maximize access for disadvantaged and marginalized community groups. There are two issues inherent with demand; the first is ensuring access to those in need of treatment yet are unable to access it for a range of reasons. The second is creating means of access for those who are in need of treatment but do not engage the system. Additional resourcing is part of the solution, as is system reform. More broadly, in response to increasing complexity in presentations, there is a need to further enhance the capacity of the workforce.

The data highlights the significant benefit to Victoria as a whole through increasing access to AOD treatment services, increasing the capacity of the AOD workforce and sector as a whole and the implementation of a range of initiatives to provide for the needs of at risk communities and drive innovation throughout the sector.

Underpinning themes

The three themes of 'accessing treatment', 'chronic underfunding', and 'workforce recruitment and retention' outlined below are central to identifying the prevailing challenges facing the AOD treatment sector and service users.

A key challenge facing Victorians experiencing AOD dependency is **accessing treatment**. This has been extensively reported on throughout the media for a number of years, and has been attributed to the rise of unregulated 'for profit' treatment facilities to fill the glut of demand (4 Corners 2016). This issue of unmet demand is also outlined in the research by Ritter et al (2014) noting that between 200,000 to 500,000 individuals experiencing dependency do not access treatment, with current service provision responding to the needs of between 26 to 48 percent of current demand. Over 75 percent of VAADA Annual Sector Priorities Survey (2016) respondents[1] indicated that the AOD sector is not accessible or easy to navigate, reinforcing the notion that access is a major issue.

The Victorian AOD sector has endured **chronic underfunding**. The lack of funding creates significant challenges in providing for vulnerable and at risk community groups as well as meeting general demand. Inadequate resourcing also creates barriers to delivering services. It should also be noted that limitations in resourcing impact upon treatment outcomes. Manning et al (2016) note that continuous care treatment models are more cost-effective than providing episodic treatment. In simple terms, continuous care necessitates more involvement with service users and therefore more resources. It also necessitates the development of referral pathways between service sectors.

The 2016/17 Annual VAADA Sector Priorities Survey (2016) identified **workforce recruitment and retention** as key challenges for the sector. This enduring issue, which has been evident for many years, has been made more pressing in light of an exodus from the sector following ongoing uncertainty in federal funding and the significant changes resulting from State initiated recommissioning, exacerbating difficulties in recruitment and retention, especially in rural and regional areas of Victoria.

[1] The 2016/17 VAADA Annual Survey was administered to senior staff from the Victorian AOD sector in June – July 2016, with 44 responses.

Enhancing Access to AOD treatment

AOD service access is vital in improving community health and wellbeing and reducing cost to government. The following measures will improve AOD service access.

Prioritising the implementation of ASPEX

The government commissioned report into the reformed service sector outlined a range of issues and proposed a number of remedies which should be considered by government. This has occurred during a period of high community anxiety regarding service access, particularly with reference to methamphetamine. There is a need to rapidly and comprehensively respond to the challenges outlined in the *Aspex* (2015) report.

The new arrangements for the AOD treatment sector commenced over two years ago. The system reforms initially erected significant additional barriers to the service sector with a resultant reduction in service access by 21 percent. This figure, canvassed in the government commissioned report (Aspex 2015), does not represent a reduction in demand, but rather a reduction in service access. The system defects, in part due to the regional intake and assessment process, need to be remedied.

Broadly, there is a need to 'unscramble the egg' with a range of reform initiatives as identified in the Aspex report. One key area amongst many is that of Intake and Assessment which has set up a range of barriers and inefficiencies in the general public gaining timely access to treatment. Over the past year sector representatives have made considerable efforts to re-affirming Aspex recommendations around the return of Intake and Assessment functions to agencies and away from the centralised model. While deliberations are currently in their final stages it will be essential that appropriate resourcing be made available to support the orderly transition back to a much more workable solution. A failure to achieve an orderly transition could be highly problematic and only exacerbate the untenable current circumstances. As other aspects of the ASPEX report are addressed consideration should be given to appropriate resourcing to assist with these additional changes.

Addressing service gaps in the sector

The Victorian alcohol and other drug (AOD) sector continues to labour under austere conditions which are compounded by a number of reform defects which have further impeded access to treatment for the community resulting in preventable harm. This continues to be played out in increasing fatal overdoses, AOD related ambulance callouts, hospital attendances and law and order related activity. International evidence indicates that AOD treatment provides a robust return on investment through reduced acute health and justice related expenses.

Care and Recovery Coordination

Aspex (2015) highlighted a significant deficit in care and recovery coordination. This treatment type is applicable at the more complex end of the treatment spectrum and provides overall coordination and service integration for people experiencing a range of issues who need to access the AOD and other related service sectors. This treatment type is crucial at a time where the presentations to treatment are increasingly more complex and that much of the broader community service sector continues to operate in siloes. For instance, survivors of family violence, who may be juggling AOD,

housing and legal issues, would greatly benefit from this service type. The Royal Commission into Family Violence (2016) indicates that a range of services, including but not limited AOD services, interact with individuals experiencing family violence. Existing service types which can enhance linkages within and across service sectors should be enhanced in order to progress the recommendations resulting from the Royal Commission.

Unfortunately, this treatment type has been grossly under resourced. This was highlighted by the sector though a VAADA sector survey in 2014 that revealed that 70 percent of respondents asserted that this treatment type was inadequately resourced to meet demand (VAADA 2014).

The government has earlier predicted that up to one third of AOD service users would require this treatment type (Department of Health and Human Services 2013). However, the allocations indicate that there was only capacity for 3804 individuals to access care and recovery coordination. This is despite the expectation that approximately 30,000 Victorians would engage the ADO treatment sector (as per the 2013/14 figures [Australian Institute of Health and Welfare 2015]), suggesting that up to 10,000 individuals would require this treatment type. It is evident that the expectations of government surpasses the limited resourcing available for this crucial treatment type.

At this stage, we would urge a prudent approach, such as increasing the capacity of this treatment type to cater for 7,000 courses of treatment, accounting for closer to one quarter of AOD service users. This would necessitate the resourcing of an additional 3,196 courses of treatment according to the 2013/14 figures. Following this, an assessment on the demand for this treatment type could be undertaken and allocations made appropriately.

We note that the 2015/16 price for a Drug Treatment Activity unit (DTAU) is approximately $705[2] and that the weighting on Care and Recovery Coordination is 2.22 DTAUs. In order to provide an additional 3,196 courses of treatment there is a need to fund 7095 DTAUs at a cost of $5,000,975.

Recommendation 1: that the Government provide a recurrent $5,000,975 to the AOD sector for additional courses of 'Care and recovery coordination' to account for the needs of approximately 25 percent of all AOD service users.

Intake and Assessment

The intake and assessment function of the AOD treatment sector is likely to undergo change in the next 12 months which, in light of the size of this element of the treatment sector, will have a significant impact on agencies as they realign to these new circumstances. There is a need to ensure that the transition proceeds in a smooth manner which does not impede the daily operations of affected agencies and their service users. Client pathways into the sector should be prioritised with any reform related activity enhancing the sectors capacity to address unmet need. Appropriate funding should be afforded to effectively progress this transition.

Recommendation 2: that appropriate resourcing is afforded to ensure that agencies affected by the implementation of the ASPEX recommendations, including any changes to intake and assessment, are able to maintain client need and optimal service delivery.

[2] We note that this is the 2016/17 figure. This will likely increase in the 2017/18 financial year as in previous years.

Data systems

The Aspex review (2015) highlights a disturbing and comprehensive range of issues which bring into question the integrity of AOD-related data. This in part echoes the finding from the Victorian Auditor General (2011) regarding the limitations in data and is demonstrative of a lack of progress in this area. This work is also explored through VAADA initiated research. Some of the immediate concerns are: there is an absence of data, for instance, on the journey undertaken by those diverted from the system. There is nothing recorded on where and if they seek assistance, and whether they re-emerge back into the treatment system at a later date with more acute AOD issues. There are significant limitations in measuring the differences between the new arrangements and the old treatment system. VAADA is of the view that this lack of data perpetuates a significant human and economic cost, with acute drug toxicity mortality climbing from 342 in 2010 to 420 in 2015 (Coroners Court 2016). Many of these deaths are preventable and good data systems are a crucial part of the foundations necessary to address elements driving this toll. While there might be considerable current Departmental focus on 'outcomes', 'outputs', 'performance management' and the like, the real untapped value of such data systems is to help drive down the number of preventable deaths and morbidity.

The long term absence of a clear focus on building AOD data systems and a reliable data-set has been very problematic both in planning around demand factors as well as program evaluation. There is a need to urgently build stronger data systems with a careful selection of variables and indicators to assist the AOD treatment system to better inform policy development reducing the AOD toll and the burden on acute health services as well as justice services. This would involve developing and enhancing data systems which can categorise nuanced demographic and outcome related data which could provide detailed cross sectional analysis across a range of variables. A vitally important link in this work is capacity building of the sector around cultural factors leading to widespread acceptance of the new data system, as well practical aspects of data input and utilisation. We are confident with the correct investment and an orderly transition the enhanced data system would contribute strongly to service planning. Additionally, to further assist in the collation and assessment of this data, there is a need for the development of a centralised data analysis unit.

We note that the government has recently released *Victoria's Mental Health Service Annual Report 2015/16* (Victorian Government 2016) in which there is an intention in publishing relevant data annually going forward. A similar endeavour should be progressed for the AOD treatment sector.

Supporting the sector through ongoing reform

There are a number of significant reforms currently occurring within Victoria and going forward which involve, in varying degrees, the AOD sector. The timelines on the implementation of these reforms (including ASPEX, Vulnerable Children and the Royal Commission into Family Violence) are varying, but are likely to be active going forward up to and beyond 2020.

Cross sector involvement in these significant and in part, intertwined reforms involves identifying key agencies in the respective sectors, drawing together relevant representatives, and working through the various issues related to workforce development, cross sector capability, funding and other high level issues.

The breadth of these reforms, occurring while the AOD sector is providing care to a cohort of service users presenting with increasing complexities, creates significant difficulties in responding to increasing demand which accompany the aforesaid reforms.

Most peak bodies are afforded funding to provide sector development support to their respective sector, assisting in sector wide reforms and development and taking a lead role in liaising between government and the sector. Unlike most peaks, VAADA has experienced only sporadic funding for this role over the past few years and, despite the broad array of reform activity and increasing expectations on the AOD sector, currently is not funded to provide sector development.

The return to government and community is significant, with this position playing a key role in drawing the sector together and eliciting the views and experiences of agencies. To assist with the raft of current reforms, VAADA should be resourced to provide sector development support to the AOD sector.

Recommendation 3: The Victorian Government support the enhancement of AOD treatment data systems to provide for capacity to undertake in depth cross sectional analysis on demographic data pertaining to AOD treatment service engagement. To achieve this, the Government should provide the following:

I. **The enhancement of AOD data systems through the allocation of $800,000 as a non-recurrent payment;**

II. **The training of staff to input data and otherwise utilise the new data systems through the allocation of $10,000 per annum for each AOD catchment ($160,000 per annum); and**

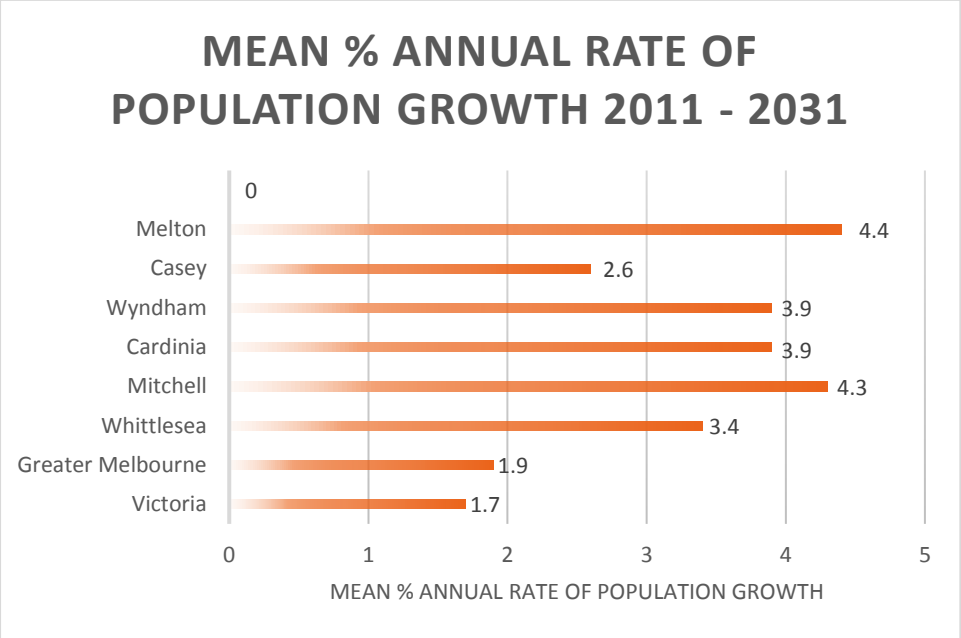
III. **The creation of a Specialist Data Analysis Unit to collate and analyse data and provide advice to agencies and government on a state wide basis through the allocation of $200,000 per annum as well as annually publish AOD data in a manner similar to *Victoria's Mental Health Service Annual Report*.**

IV. **that the Victorian Alcohol and Drug Association (VAADA) be resourced to provide sector development support and facilitate sector participation in the progression of implementing ASPEX, the Royal Commission into Family Violence findings and Protecting Victoria's Vulnerable Children up to financial year ending 2019/20 at $150,000 per annum.**

Service access: Growth corridors

Victoria's population is currently expanding at a higher rate than any other state or territory within Australia (ABS 2016), with a growth rate of 1.9% where the national average is 1.4%. Greater Melbourne's average growth rate will average 1.9% up to 2013 (Environment, Land, Water and Planning 2016). We note that, from 2011 – 2013, the growth rate for the 'growth corridor' regions of Melbourne is estimated to be, for all regions but Casey, more than double the average growth rate for Greater Melbourne and almost three times the average population growth rate for Australia (1.4%) (ABS 2016).

Figure 2: Growth corridors in Victoria – mean percentage rate of population growth per annum



According to the Jesuit Social Services report, *Dropping of the Edge* (DOTE) (Vinson and Rawsthorne 2015), many of the growth corridor regions are experiencing high levels of disadvantage. Parts of Whittlesea, Casey, Cardinia, Mitchell and essentially most of Melton and Whittlesea rate highly in the various scores for disadvantage. Although DOTE does not provide details on AOD related harms or issues, it is evident that communities experiencing various forms of disadvantage, such as homelessness, mental health and involvement with the justice system are more likely to experience AOD related harms (Lubman et al 2014). These areas, experiencing rapid growth (in most cases more than twice that of greater Melbourne), with minimal health infrastructure, will perpetuate disadvantage, creating enduring burgeoning pockets of extreme disadvantage. These under-resourced areas may effectively lead to Melbourne becoming a two tiered city, with a widening gulf evident between a rapidly expanding, under-resourced outer ring and more advantaged and serviced middle and inner regions.

Additional resourcing must be allocated to these growth corridors in line with population growth coupled with indicators of disadvantage, to prevent AOD related harms and assist in curtailing the increasing challenges evident in these communities. This would provide not only for the demands associated with a rapidly expanding population but also allow for additional capacity address the needs of particular demographic elements evident in these regions and associated expenses including set up costs, outreach, travel and community development.

Recommendation 4: That $3 million be made available to each growth corridor region (Melton, Casey, Wyndham, Cardinia, Mitchell and Whittlesea) to enhance existing services or establish new services to address AOD related harms in line with rapid population growth and disadvantage.

Service access: Rural and regional

Rural and regional areas of Australia experience greater disadvantage and poorer socio economic circumstances when compared with metropolitan areas (National Rural Health Alliance 2012). These areas also experience reduced access to general practitioners, with only half the GP services available in very remote areas per person in comparison to metropolitan areas (Duckett and Breadon 2013). Additional to the access issues for primary health, people residing in remote areas of Australia are more likely to 'skip' various medical tests, medications and treatments due to cost (Duckett and Breadon 2013). Rural and regional areas of Australia experience greater rates of AOD related hospitalisations, with the rate in major cities set at approximately 160:100,000 head of population and remote areas 294:100,000 head of population (Australian Institute of Health and Welfare 2016). Buykx et al (2013) indicate in their research that less than 30% of those requiring AOD treatment access treatment in rural and regional areas, likely contributing to the disproportionately high rate of AOD related hospitalisations. Vinson and Rawsthorne (2015) study of disadvantage in Australia note that the majority of the most disadvantaged areas in Victoria are situated in rural and regional areas of the state.

The National Rural Health Alliance (2015) reports that the portion of the population consuming illicit drugs increases in line with the remoteness of the cohort, from 14.8% of the population in major cities to 18.8% of the population in remote and/or very remote areas. The portion of the population in remote and/or very remote areas consuming amphetamine-type substances is double that of major cities.

The Catchment Based Planning identified, within a number of rural and regional areas of Victoria, significant gaps in service capacity. AOD services operating in rural and regional areas tend to experience a limited distribution of services, transportation issues and workforce issues. There are challenges in accessing NSP, pharmacotherapy and withdrawal services in rural and regional areas (National Rural Health Alliance 2012). There are issues associated with anonymity and AOD service engagement in rural areas which are exacerbated by stigma and discrimination toward individuals experiencing AOD dependency. Rural and regional providers often work to account for this in service and programmatic design.

Rural and regional providers responding to the VAADA Sector Priorities Survey (2016) noted that access was a major issue, as well as the costs associated with travel times. They highlighted the enduring issue for rural and regional AOD services of providing replacements for unwell or staff otherwise on leave. They noted that there are issues with regard to ready access to individuals seeking to engage in pharmacotherapy, with, in some regions, limited prescribers and dispensers.

Additional capacity to increase access to AOD treatment in rural and regional areas should be afforded to allow equitable access to treatment across Victoria. This would equate to an expansion across a range of service types, specific to each region, in line with local need. This would provide capacity to respond to emerging levels of acute demand, associated with methamphetamine and allow greater capacity to affect cross sector collaboration to reduce AOD related harms and more broadly associated disadvantage.

Recommendation 5: That an additional $10 million is allocated annually to enhance AOD service access and capacity in rural and regional Victoria, prioritising areas identified in the catchment based planning which experience challenges in service access, as well as high levels of morbidity and AOD related harms.

Responding to older adults experiencing AOD issues

The portion of people aged over 65 years in Australia is steadily increasing. Older adults experience greater health problems than younger cohorts, consume more medication and are often likely to be experiencing significant life transitions, including exiting the workforce and losing a life partner. As an individual ages, their physiological tolerance of alcohol and other drugs diminishes, eliciting a greater level of risk and harm through substance use. Yet the proportion of older people drinking at risky levels has increased by 31 percent since 2001, while the rate of illicit drug use among older people has increased by 36 percent between 2010 and 2013 (Australian Institute of Health and Welfare 2014) Currently, there is only one AOD treatment program in Victoria specifically for older people. In addition to this program, we would recommend the implementation of two outreach teams operating throughout Victoria providing specialised AOD treatment to older adults. The demand and efficacy for this program should be evaluated with a view to future service planning.

- Use of illicit drugs has increased 36% among adults aged 50-59 years and 27% in adults aged over 60 years from 2009-2013. Risky drinking has increased 31% among adults aged over 60 years between 2001 and 2013 (AIHW 2014).
- The ABS (2013) notes that by 2040, the population of individuals aged over 85 years will treble from the 2012 figures;
- Population growth in the older demographic in Victoria is forecast to increase more rapidly than any other age group with 40 per cent of the population growth between 2006-2036 consisting of people over the age of 65[3] (Department of Planning and Community Development 2009);
- With ageing comes a reduced tolerance to substance use and an increase in other morbidities which may exacerbate the harms associated with harmful AOD use (Taylor and Grossberg 2012);
- Older adults are less likely to access traditional services due to stigma and mobility limitations (Nicholas et al 2015); and
- Even if the rates of AOD use remain stable, older people will experience greater AOD related harms due to the rapid increase in older populations.

Costs associated with ageing will increase, including healthcare and welfare provisions, and productivity will decrease as Australia experiences a larger portion of the population which are not actively employed. It is incumbent upon government to reduce these costs where possible.

In 2009/10, there were nearly three million hospital separations for Australians over the age of 65 years; it is estimated that injuries resulting from an older person sustaining a fall contributed to almost 84,000 separations during that time (Australian Institute of Health and Welfare 2013). One in 10 days spent in hospital by a person aged 65 years and over was attributed to sustaining a fall

[3] Victoria's population is estimated to increase by 2.27 million from 2006 – 2036; from that, 910 000 will be over the age of 65 years.

(Australian Institute of Health and Welfare 2013). Many of these falls will have been related to the use of AOD.

International research has demonstrated a link between AOD use and older people experiencing a fall noting that AOD use can significantly increase the risk of injury (Coutinho et al 2008) including hip fractures by up to 50 per cent (Lader 2011). VAADA's position paper entitled 'Responding to Older AOD users' (2011) notes the very low levels of AOD treatment for older people combined with high levels of chronic pain and the highest levels of pharmaceutical use of any age group. As noted above, alcohol and illicit drug consumption has increased among older adults. This constellation of factors, complicated by co-morbidities related to older people's physiological status, points to a silent crisis for the Victorian health sector. The AOD service system is not adequately resourced to be able to cater for the growing demands of this population, nor are there adequate broader community and institutional systems in place to maximise service access to older people.

A recent evaluation of the sole older persons AOD treatment program in Victoria illustrated a number of health and welfare benefits for service users, including a significant increase in older adults accessing AOD treatment in the region, a reduction in risky alcohol consumption and general improvements in mental health; the outreach component providing for home visits was also viewed positively among the service users (Mugavin and Berends 2013). This highlights the demand for specialist older person AOD treatment services with the near absence of such services resulting in demand not being met.

To prevent this emerging crisis, VAADA recommends the development of a pilot outreach service with additional resourcing allocated for evaluation and research. This service would consist of two teams, which would provide outreach throughout Victoria and ideally be attached to existing service providers including AOD treatment and Home and Community Care providers. The research and evaluation component would complement the demand modelling functionality in each AOD region, assisting in locating hidden populations of vulnerable older people with AOD dependency and provide ongoing evaluation.

Recommendation 6: A pilot outreach AOD treatment project should be developed to address the gap in AOD services for older adults throughout Victoria. The project should include outreach, project coordination, medical support coupled with resourcing for research and evaluation.

Indicative program components and costs include:[4]

Pilot outreach (two teams statewide)

Item	EFT	Cost
Establishment costs - vehicle		$27,600 per team
Establishment costs- office/IT		$11,400 per team
Staffing – outreach team	3 inclusive of 0.5 team leader per team	$412,000 per team PA
Project coordination	1 coordinator, training and development	$156,250 PA
Research and evaluation	1 research and evaluation officer	$129,000 PA

[4] This pilot program outline has been adapted from VAADA's 2014/15 State Budget Submission

Enhancing pathways for CALD communities to AOD treatment

People from culturally and linguistically diverse (CALD) communities are under-represented in the AOD treatment system. Data shows that only 13 percent of closed treatment episodes for Australians in 2014-15 applied to clients born overseas (AIHW 2016). Within the general population, 28% of people living in Australia were born overseas. It is evident that a disproportionately small number of CALD individuals attend AOD treatment services.

While the available research indicates that AOD use is generally lower in CALD communities compared to the general population (Donato-Hunt, Munot and Copeland 2012), it is also clear that that the low admission rates of CALD clients into AOD treatment is also due to an under-utilisation of services rather than just a lower need.

VAADA's (2016) CALD AOD project identified a number of challenges currently facing the AOD sector with regard to adequately servicing CALD communities within Victoria:

- There is inadequate data detailing the prevalence of AOD use within CALD communities;
- Low admissions rates for individuals from CALD backgrounds is due to an under-utilisation of services rather than a lower need (Beyer & Reid 2000);
- Many CALD communities experiencing AOD issues face additional challenges associated with adjusting to a new culture including feelings of dislocation and isolation, which is compounded through the potential shame that may be associated with problematic AOD use;
- Many individuals from CALD backgrounds engaging the AOD system are engaging it through the forensic system, highlighting lost opportunities to engage them in the voluntary system; and
- Resulting from the recommissioning of the AOD sector some services have indicated that they have experienced a reduction in capacity to work effectively with CALD communities.

At present, there are multiple service barriers and socio-cultural norms making it difficult for CALD individuals and families to access treatment. A notable example is the reluctance of many people from CALD communities to come forward, for fear of being ostracised both within the family as well as the community more broadly. Other key factors include a lack of trust in mainstream services, language difficulties and low levels of health literacy (including knowledge of AOD harms).

Working with CALD clients in need of AOD support requires a targeted and multi-faceted approach, which appears to be happening only on a piecemeal basis.

The VAADA (2016) CALD AOD Project, (a Victorian Department of Health funded initiative) recommend that resources be directed into establishing CALD specific community development positions consisting of 1 – 2 bi-cultural workers per catchment, funded for at least three years during a pilot phase, whose role will be to:

- Engage CALD communities and agencies with the emphasis on relationship building and cross-sector collaboration
- Raise awareness of available supports while facilitating access to AOD treatment for individuals and families from CALD communities
- Liaise with CALD community members and/or representatives about their specific health literacy needs, experiences navigating the AOD sector and ways to improve the system

- Promote culturally appropriate models of service delivery while strengthening ties between CALD communities, ethno-specific agencies and drug treatment services

It is recommended that these practitioners be located in AOD agencies within in specific catchments where there is the greatest need.

Throughout the pilot phase of the program (years 1 – 3) key learnings from the program will be documented and recommendations forwarded to the Victorian Department of Health, with a view to scoping out opportunities to replicate the program in other catchments across the state.

VAADA also recommends that sitting alongside the community development component of the program resources be directed into a capacity building stream, staffed by one project officer located at VAADA, whose role will be to:

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

Recommendation 7: That bi-cultural workers are situated within four AOD catchments in Victoria and supported by a project officer with the goal to increase CALD community access to AOD services and build the capacity of these services to better cater for the needs of CALD communities.

Indicative program components and costs include:

Years 1 – 3: CALD AOD community development (for four catchments) Item	**EFT**	**Cost**
Establishment costs – vehicle		$21,100 per catchment
Establishment costs – office/IT		$8,755 per catchment
Staffing	1 – 2 bi-cultural workers per catchment	$100,000 - $200,000 per catchment PA

Workforce Development – a sustainable AOD workforce

A consistent theme evident in the VAADA Sector Priorities Survey (2016) were the challenges agencies are facing in both workforce retention and recruitment. These issues have been exacerbated by the State initiated reforms as well as uncertainty regarding Commonwealth funding streams. There is a need for the AOD sector to enhance its capacity to respond to at risk communities and complexities in a more nuanced and targeted manner. There is also a need for the AOD workforce to be revitalised, with additional training and development activity, particularly in rural and regional Victoria. To this end, VAADA proposes the development of a sector development fund to enhance the skill set of the sector, build cross sector endeavours and effective pathways into treatment for at risk communities.

Released in 2015, the Independent Review of MCHSS and Drug Treatment Services (Aspex 2015, p 11) notes that the 'capacity and capability of the workforce has been depleted, with a loss of experienced staff and challenges to recruitment'. This concern is echoed in surveying undertaken by VAADA (2015) where roughly two thirds of respondents (AOD agencies) indicated that they had experienced issues in recruiting staff following the reforms coupled with a sense of job insecurity. In the same sector survey, almost half of all respondents (46.7 per cent) indicated that the new AOD system did not engender a strong and competent workforce; conversely, 22.2 per cent indicating that the reforms had improved the workforce (VAADA 2015).

This theme carried into the 2016 Sector Priorities Survey, where the sector noted that retention and recruitment were significant challenges.

Further strengthening the AOD workforce should be a priority in light of the impact of the reforms and to this end, a number of endeavours should be implemented, including the establishment of a training calendar, scholarships and a range of training events. Local, national and in some cases, international experts should be sourced, to enhance the sector and provide for the most up-to-date evidence based practices in responding to the treatment needs of service users for substances such as methamphetamine. There is also a need for the AOD sector to work effectively within the broader human services sector, accounting for significant reform and subsequent expectations in addressing family violence and working with vulnerable children.

This will provide for local needs with allocations for training and workforce development activities being available both statewide and via AOD catchment.

Building the capacity of the workforce will assist in addressing the significant yet preventable harms occurring within a number of populations. These harms would in part be ameliorated through the application of broad sector development endeavours across the AOD sector with a view to enhancing service delivery to these populations through a more specialised workforce. The data below provides a snapshot of the harms across these at risk populations:

Recommendation 8: That an additional $2 million be available to AOD services across the state to enhance their capacity in order to address emerging local challenges and maximise service access for at risk communities as well as provide for workforce development and training endeavours.

Dual Diagnosis

Research indicates that at least one in three individuals experiencing AOD dependency also experience at least one co-occurring mental health disorder (Marel et al 2016). Despite the issues pertaining to co-occurring AOD dependence and mental illness being well recognised broadly throughout the community, the increasing complexity among cohorts engaging with frontline services highlights the need for greater capacity and support to be provided across the AOD and associated sectors.

Co-occurring AOD and mental health disorders is a very common phenomena and highly prevalent among cohorts in need of AOD treatment:

- Approximately 35 percent of individuals experiencing AOD dependency also experience 'at least one 'affective or anxiety disorder, representing approximately 300,000 Australians' (Marel et al 2016, p 12); and
- 62% of individuals using AOD daily experienced a mental disorder over the past 12 months (Marel et al 2016).

The challenges associated with this cohort require innovations that build on existing expertise and provide greater support to the sector. The Drug and Alcohol Clinical Advisory Service (DACAS) currently enables telephone based support to general practitioners from addiction medicine specialists. The effectiveness of this support could be further augmented through the addition of Addiction Psychiatry expertise availed through this helpline. This would enhance support to those working with individuals presenting with highly complex co-occurring AOD and mental health issues and increase the capacity of DACAS.

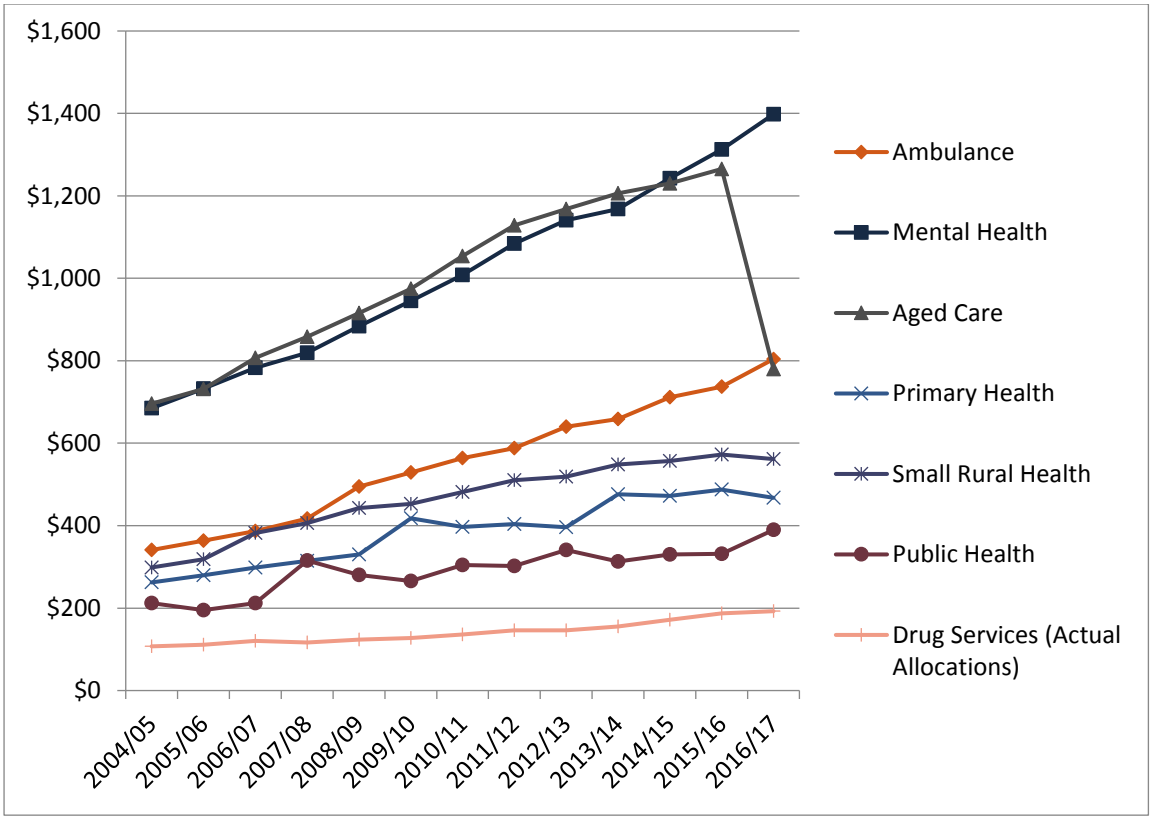
Recommendation 9: That additional Addiction Psychiatry capacity be availed to DACAS at an estimated cost of $250,000 per annum to provide additional support to presentations related to co-occurring AOD and mental illness.

Funding

The AOD treatment sector has endured chronic underfunding for many years. The lack of funding has compounded over many years to create significant service gaps to which this submission seeks to address. The lack of funding has created a fertile environment for the encroachment and proliferation of unregulated 'for profit' treatment facilities.

Figure 3 details a spread of health sector funding streams from 2004/05 to 2016/17. Evident from Figure 3 is the duality of a low annual budget restrained by low annual growth resulting in a virtual flat line for the AOD sector. It is clear that the AOD sector continues to lag well behind other health sectors.

Figure 3: Output funding (health) 2004/05 – 2016/17 (in $millions)



This section of the submission outlines a number of endeavours which are related to funding shortfalls.

Increase residential rehabilitation capacity throughout Victoria – a case for parity with the rest of Australia

The demand for residential rehabilitation services across Victoria has increased dramatically. This is in part fuelled by the paucity of publicly funded beds available combined with an increase perception within the community that residential rehabilitation is the most ideal treatment option for certain presentations. The lack of residential rehabilitation services is keenly felt across much of rural and regional Victoria, where there is a dire need to ensure equity of access to the

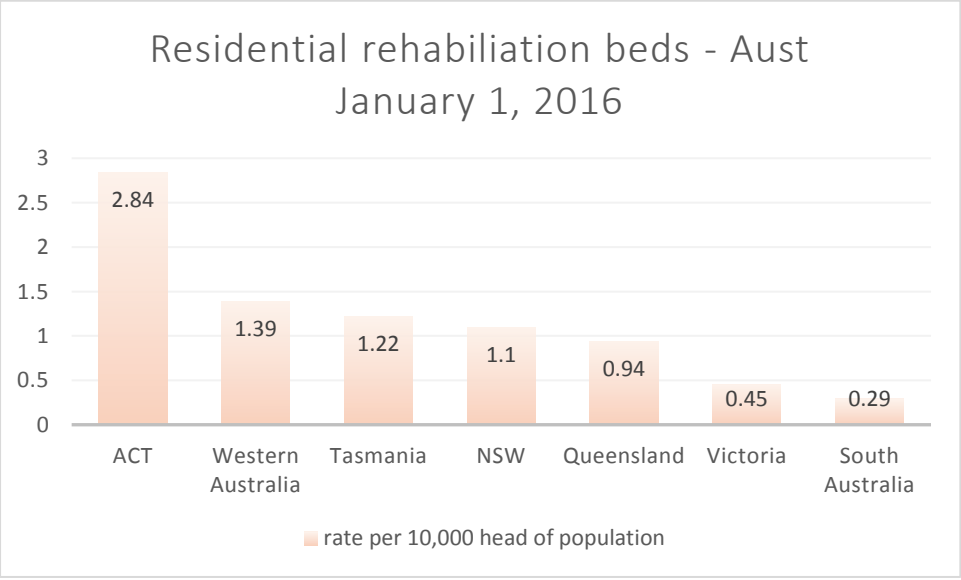
necessary services. There is an immediate and pressing need to increase the capacity of residential rehabilitation beds across the state, ensuring that this service is equitably available across Victoria.

There is a growing body of evidence that supports the efficacy of residential rehabilitation as an effective means of addressing AOD related harms. Lubman et al (2014) and Ciketic et al (2015) note that residential rehabilitation is cost effective in addressing methamphetamine related presentations. Research undertaken by the then Australian National Council on Drugs (2012) notes that, when compared with the cost of prison, for Aboriginal populations, residential rehabilitation provides a saving of $111,458 per offender, with additional savings of $92,759 when accounting for lower mortality and improved health related quality of life.

For each individual engaging residential rehabilitation there is a conservative net economic benefit of approximately $1M (Rae 2013). Lubman et al (2014) notes in the *Patient Pathways* national project that individuals who have participated in residential rehabilitation experience greater rates of abstinence. Despite the economic and social benefits of this treatment modality, there are only a limited number of residential beds in Victoria, with anecdotal reports from services indicating up to a six month wait for access. Despite the welcome commitment form the Victorian Government to resource an additional 18 – 20 residential beds in the Grampians region, individuals residing in rural and regional areas of Victoria who require residential rehabilitation services will still face issues accessing this service locally and will often need to travel to metropolitan areas. There is a need to ensure that the various Catchment Plans are referred to in the allocation of additional beds.

Victoria currently has the second lowest ratio of residential rehabilitation beds per head of population nationally, as evident from Figure 4 below:

Figure 4: Number of residential rehabilitation beds per 10,000 head of population by state/territory



Besides South Australia, every other state/territory has over double the number of residential beds per head of population in comparison to Victoria. This has contributed to a disjuncture between community demand and sector capacity, and resulted in a number of adverse circumstances. Part of the unmet demand for this treatment type is currently being met through an unregulated expanding private sector, while some unmet demand is engaging the justice system and some would be facing acute health issues in light of untreated dependence, resulting in preventable mortality.

To address this capacity deficit, there is a need for Government to develop a plan to increase the capacity of residential rehabilitation across the state. This significant commitment, which will need to be adequately resourced, will necessitate the development of a plan which will account for gaps in service, demand by region and opportunities evident through partnerships and existing capacity. It should account for the complexities apparent in providing these services, and further consultations should be given to the composition of, and expertise availed to running, these facilities. The plan should involve content on addressing the needs of specific cohorts, including CALD communities, older people and acute co-occurring mental health and AOD presentations. The plan should identify specific opportunities which can minimise establishment expenses.

This plan should provide for the staged increase in residential rehabilitation capacity over a five year period with a view to increase the capacity of the Victorian funded residential rehabilitation system to 1: 10,000 head of population, necessitating approximately 300 extra beds. Such an endeavour, which would provide for an additional 1200 service users annually, would result in Victoria having the third lowest number of residential rehabilitation beds per capita but well within the range of other jurisdictions in Australia.

We note currently that the cost per bed varies depending on whether it is delivering forensic or voluntary treatment. An average derived from the current providers suggests the cost per bed (four episodes delivered each year) amounts to $70,000 per annum.

Recommendation 10: That the Victorian government develop a plan to direct the necessary increase in capacity of Victorian funded residential rehabilitation services through all of Victoria to lift capacity to a level in alignment with other jurisdictions in Australia. This will necessitate the development of approximately 300 beds over the five year period lifting the rate to 1 bed per 10,000 head of population. It is estimated that the operations cost of running these facilities will amount to approximately $70,000 per annum per bed.

Implement consumption rooms in areas experiencing high levels of substance related harm

Among health experts, there is consensus on the effectiveness of consumption rooms, such as the Medically Supervised Injecting Centre (MSIC) in Sydney, as well as those operating in Vancouver and many other places. Some findings arising from research and evaluations include:

- Reduces fatal overdose (KPMG 2010; Marshall et al 2011)
    - Marshall et al (2011) identify a reduction of 35% in fatal overdose deaths within the vicinity of the Vancouver Supervised Injecting Centre, compared to a reduction of

9.3% across the city. We note also that there has not been a single overdose fatality occurring within the Sydney MSIC.

- Reduces public injecting (KPMG 2010)
    - KPMG (2010) cite surveys of both business owners and residents within Kings Cross (Sydney) where they observe a significant reduction in public injecting.
- Improves amenity through a reduction in publicly discarded injecting paraphernalia (KPMG 2010; Wood et al 2005)
    - KPMG (2010) cite surveys of both business owners and residents within Kings Cross (Sydney) where they observe a significant reduction in publicly discarded syringes
- Provides a return on investment (KPMG 2010)
    - KPMG (2010) note that, conservatively, the Sydney MSIC saves at least $658,000 per annum in comparison to the provision of similar health outcomes elsewhere in the health system;
- Reduces high risk injecting practices, such as sharing needles (Marshall et al 2011; SAHA 2008)
    - Approximately 75,000 clean injections are undertaken at the Sydney MSIC per year where, in the absence of the MSIC, many of these would have been undertaken with shared equipment (SAHA 2008)
- Creates referral pathways into various health and welfare services, including AOD treatment (KPMG 2010; Small et al 2008; Marshall et al 2011)
    - Small et al (2008) note that consumption rooms provide low threshold access to nursing staff to assist with injecting related infections ;
    - KPMG (2010) note that 40% of those attending the Sydney MSIC have not previously accessed AOD treatment or the broader service system. This population has greater means to access the necessary services with 8,508 referrals to other services, with 3,871 being to AOD treatment services from 2001 to 2010.
- Increases accessibility for high risk service averse cohorts who often engaged in public intravenous substance use (Wood et al 2005)
    - Wood et al (p. 128, 2005) note that individuals who frequently inject heroin (in public places) who have experienced non-fatal overdose are ‘significantly associated with subsequent initiation of SIF use’

Wood et al (2006) reflect on the potential negative impacts associated with the operation of a consumption room; their study of a number of evaluations from the Vancouver SIF found drug dealing within the vicinity of the SIF did not increase and public drug use declined; crime rates did not change. Utilisation of AOD services increased and there was no change in the rates of relapse or cessation of substance use. Milloy et al (2008), in their study of the occurrence of non-fatal overdose at the Vancouver SIF, found no statistical evidence linking non-fatal overdose with utilisation of a consumption room.

It is apparent that consumption rooms reduce the likelihood of fatal overdose, reduce public substance use and publicly discarded injecting equipment. They enhance linkages between necessary services and an often service averse cohorts. They do not impact upon crime or increase drug trafficking or use.

Recommendation 11: that areas experiencing high levels of entrenched substance related harm to be resourced to developed consumption rooms in line with local need. The specific model should be determined by local services and cohorts which would use these facilities.

Establish a research and innovation fund

An innovation fund of $1 million should be provided on an annual basis. The ongoing development of innovative treatment programs must be supported on an ongoing basis. Resources must be allocated to ensure that AOD treatment agencies are provided with the capacity and scope to respond the changing trends in both AOD dependency and new and emerging populations. Evaluation of each allocation should be publicly available to inform program development and future tendering priorities.

A funding pool of $1 million should be provided through a submission process, with agencies in each region encouraged to apply for funds to implement new and innovative programs as well as have resourcing available to undertake evaluation activity. Submissions should reflect on evidence of local need and on the efficacy of the proposed new program. The funding could also be targeted to addressing specific issues as they arise within treatment settings, challenges occurring within specific demographics or trends in substance use. A portion of the allocation should be set aside for evaluation and the continuation of some programs.

Recommendation 12: An additional $1 million allocated annually to an innovation fund to respond to changing needs, facilitate and encourage innovation and enhance the evidence base of the Victorian AOD treatment sector.

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