VICTORIAN ALCOHOL AND DRUG ASSOCIATION

State Budget Submission 2016/17

February 2016

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.

Contents

The Victorian Alcohol and Drug Association

The Victorian Alcohol and Drug Association (VAADA) is the peak body for alcohol and other drug (AOD) services in Victoria. We provide advocacy, leadership, information and representation on AOD issues both within and beyond the AOD sector.

As a state-wide peak organisation, VAADA has a broad constituency. Our membership and stakeholders include 'drug specific' organisations, consumer advocacy organisations, hospitals, community health centres, primary health organisations, disability services, religious services, general youth services, local government and others, as well as interested individuals.

VAADA's Board is elected from the membership and comprises a range of expertise in the provision and management of alcohol and other drug services and related services.

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

VAADA's consultation process

As the peak body on alcohol and other drug issues in Victoria, VAADA has undertaken consultation with the Victorian AOD sector to determine their views on priorities as we move into the new financial year. Members were provided with an opportunity to identify key concerns, strategic priorities and examples via an electronic survey. This feedback has been integrated into our submission to the Victorian State Government budget process for 2015/16.

VAADA wishes to acknowledge that this submission is based on a diverse range of opinions from across our membership. We extend our thanks to those VAADA members, as well as to the VAADA Board, who have generously given their time and professional insight during its development.

While some comments may not reflect the individual opinions of all those who have provided input, there is powerful consensus on the key issues and priorities outlined in VAADA's submission. Any differences in opinion among the Victorian AOD sector have been represented to the greatest extent possible. However, the final analysis in this submission represents the views of VAADA.

Executive Officer's comment

The Victorian Alcohol and Drug Association (VAADA) produces an annual State Budget submission as a means of drawing together a range of innovative ideas as well as specific funding requests to address demand issues and system enhancements. As much as possible we seek to focus on key priorities and areas of emerging need.

Problems associated with alcohol and other drug (AOD) use are widespread, often complex and influenced by a plethora of social and political perspectives. VAADA seeks to manoeuvre through this environment by continuously distilling the voice of the sector, by providing opportunity for input and collaboration. In doing so we seek to represent the interests of our members and the Victorian funded AOD sector. This year's budget submission builds on past submissions in a continuum of issues that affect the sector.

Over the past year the Victorian AOD system has undergone a substantial transformation and it is likely that it will be in a transitionary phase for some time to come. The recent system review undertaken by Aspex consulting highlights a range of issues requiring attention. This comprehensive analysis of the Victorian system provides an insight into many of the current problems besetting the system as well as consideration of what works well and improvements made. Amongst some of the key issues raised for consideration are Care and Recovery Coordination, Data systems and Intake and Assessment which VAADA would concur necessitate special attention and additional investment. In agreement with Aspex it is clear that additional complexity has been built into accessing the AOD system and paradoxically as a result there is increasing concern regarding waiting lists and a drop in throughput of overall client numbers. This submission addresses particular needs arising in these and other areas.

In terms of AOD and Justice related programs we are of the view that expanded state-wide accessibility to the Victorian Drug Court would offer cost savings as well better long term outcomes for those individuals using court services. The benefits to be derived from therapeutic justice interventions in this instance is clear and we see considerable benefit coming to individuals and the community. Elsewhere we focus on the benefits of community development initiatives such as Community AOD action teams which could introduce a range of locality based community initiatives to focus on local AOD issues and system responses which can alleviate AOD related harms. We also raise concern about limited residential rehabilitation capacity in rural and regional Victoria and make a call for long overdue investment in this area.

As in previous years we also make a call for increased support of harm reduction programs, the emerging impact of AOD on an ageing population and the need for specialist program activities. The value of establishing a research fund to assist agencies establish innovative pilots, undertake research or evaluations would provide a long sought after capacity and scope to respond to changing trends in both AOD dependency and new and emerging populations.

Sam Biondo

Summary of Recommendations

Recommendation 1: that the Government provide a recurrent $4,893,283 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: The Victorian Government support the enhancement of AOD treatment data systems to provide for capacity to undertake in depth cross sectional analysis on demographical data pertaining to AOD treatment service engagement.

Recommendation 3: that $20,000 per AOD catchment (totalling $320,000 be allocated annually to provide various supports for individuals at risk but assessed as unsuitable for engagement of the AOD treatment system.

Recommendation 4: That $200,000 be allocated to research and develop practice guidelines on non-residential withdrawal services in Victoria.

Recommendation 5: Drug Courts should be established in each of the 16 AOD catchments. This could conservatively save over $15 million on an annual basis and result in better health, wellbeing and community safety outcomes for Victorians.

Recommendation 6: 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 7: Resourcing is provided for the establishment of 'AOD action teams' in each of the eight DHS regions to develop a team which would consist of a range of professionals, totalling 4EFT in line with the specific needs of each region. The estimated initial allocation for the first year for each team would amount to $450,000 (which includes the purchase of a motor vehicle) and $420,000 annually thereafter. Each team would be situated within an appropriate agency.

Recommendation 8: That the Victorian government provide additional resourcing for the establishment of two AOD residential rehabilitation facilities located in areas of greatest need in rural and regional Victoria. These 30 bed facilities would provide for up to 12 weeks of residential treatment and would combined cost up to $4.8 million to provide for 240 service users per annum, not including capital costs. It is anticipated that the capital expense in establishing these facilities could cost up to $9.6 million.

Recommendation 9: That a single allocation of $1.8 million be made to increase state wide access to NSPs and maximise parity.

Recommendation 10: 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.[1]

Recommendation 11: 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.

[1] Associated costs are detailed on page 18.

Introduction

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 AOD treatment detailed in a summary of the evidence noted below.

The items in this submission have been separated into two tiers by way of priority, in part to highlight those issues which are urgent in nature.

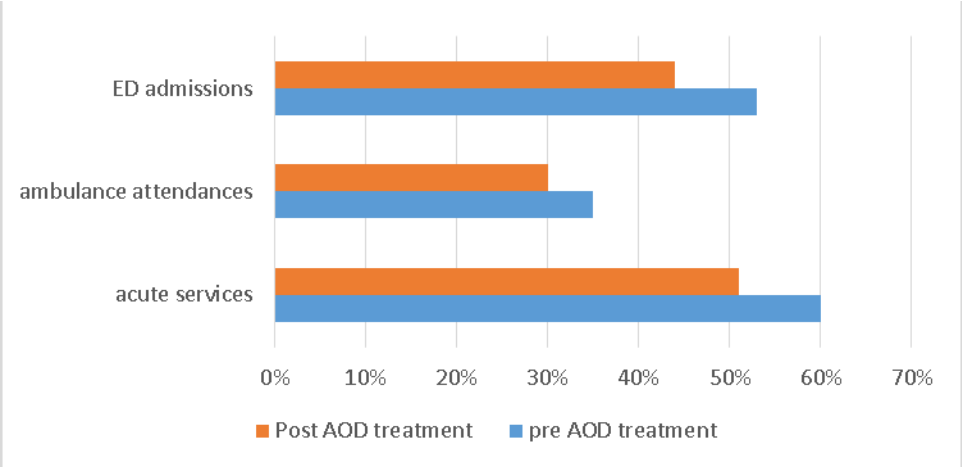
AOD treatment provides a strong return on investment with evidence indicating that over a 12 month period, treatment provides a cost benefit ratio of $8 being saved for every $1 spent (Coyne, White & Alvarez 2015).

There is a growing body of evidence which indicates that engagement in AOD treatment services reduces demand for acute health services. Preliminary research indicates that individuals 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 acute services among those with AOD dependence issues decreased from 60 to 51 percent for those who have, in the past year, attended AOD treatment;
- For the same population, ambulance attendances decreased from 35 to 30 percent; and
- Hospital emergency admissions decrease from 53 to 44 percent (Manning 2013)

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. Lubman et al (2014, pp. 42-43) continue noting 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, with regard to the diversion of Aboriginal people to rehabilitation programs, when compared with prison, savings of $111,458 per prisoner were achieved 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).

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).

This 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.

Tier 1 Initiatives

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.

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 on 1 September 2014. System reforms have erected 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, with reference to the Aspex report, there is a need to ensure that allocations are made to action the recommendations contained therein in a timely and efficient manner. A careful analysis should be undertaken on a region by region basis to identify regional priorities so as to tailor the application of the Aspex recommendations to specific community needs. The likely result of a regional analysis of the AOD reforms is the application of varying priorities for each region and the retention of programs which are providing positive outcomes for the local community with the possibility of transferring those learning to other regions.

Care and Recovery Coordination

Aspex (2015) highlighted a significant deficit in a new and welcome treatment modality, 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.

Unfortunately, this treatment type has been grossly under resourced. This was highlighted by the sector though a 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 $695.94[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 $4,893,283.

Recommendation 1: that the Government provide a recurrent $4,893,283 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.

Data systems

Aspex (2015) highlights a disturbing range of comprehensive 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. Disturbingly, the absence in activity on building AOD data systems impairs the necessity to adequately review service access in light of the new arrangements, making it difficult to clearly articulate the demand. 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. This lack of data perpetuates a significant human and economic cost, with acute drug toxicity mortality climbing from 342 in 2010 to 384 in 2014 (Coroners Court 2015). Many of these deaths are preventable and good data systems are a crucial part of the foundations necessary to address elements driving this toll.

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. Agencies would need to be supported to enhance existing systems and provide training to staff to input data and other use these systems. 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.

[2] We note that this is the 2015/16 figure. This will likely increase in the 2016/17 financial year as in previous years.

Recommendation 2: The Victorian Government support the enhancement of AOD treatment data systems to provide for capacity to undertake in depth cross sectional analysis on demographical 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 $50,000 per AOD catchment ($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 implementation of a Centralised Data Analysis Unit to collate and analyse the data and provide advice to government on a state wide basis through the allocation of $200,000 per annum.**

Intake and Assessment

Individuals seeking AOD treatment will be screened at the point of intake to determine the severity and complexity of their AOD and related issues. The current Intake process involves the administration of a standardised screening tool and application of a tiered model where the severity of an individual's AOD issues will be rated from one to five with a low rating of one or two resulting in the individual being directed away from the AOD treatment system to engage in activities such as self-help or a brief intervention from a GP. In many cases these interventions do not provide adequate support for the individual in need. To ensure that individuals who are screened out of the treatment do not re-emerge in a more vulnerable state at a later date, options for more robust support must be provided. This should include the provision of brief interventions, supported referrals and single counselling sessions being available to those assessed as tier one or two. An additional allocation should be provided to cater for these treatment types, which can be costed against the existing DTAU - which in 2015/16 is costed at $695.94 - as follows:

a. Supported referral: 0.091 DTAU

b. Brief intervention: 0.091 DTAU

c. Single counselling session: 0.781 DTAU

We would recommend an initial allocation of $20,000 per catchment which would cater for up to 300 individuals, depending on the treatment type administered. This endeavour should be assessed with any modifications based on evaluation results and service demand.

Recommendation 3: that $20,000 per AOD catchment (totalling $320,000 be allocated annually to provide various supports for individuals at risk but assessed as unsuitable for engagement of the AOD treatment system.

Non-residential withdrawal

Non-residential withdrawal services provide individuals with the opportunity to cease or reduce alcohol and other drug use within a non-residential setting. This treatment type was not discussed in the Aspex report, however, VAADA's (2015) sector survey, which provided some coverage on this treatment type, noted that over 50 percent of respondents indicated that the demand for this service type had reduced. This is unlikely to be due to a reduction in demand in real terms, but rather due to a number of systemic issues which are impeding access to this valuable program.

The new intake and assessment system is cited as potentially creating additional barriers. Although this is perhaps part of the problem, an overriding issue is the lack of guidelines detailing best practice with non-residential withdrawal. The development of these guidelines would provide much needed consistency within the delivery of this treatment type and overall enhance its' efficacy.

Recommendation 4: That $200,000 be allocated to research and develop practice guidelines on non-residential withdrawal services in Victoria.

State-wide access to the Victorian Drug Court

With an increasing prison population, limitations in sentencing options and the high prevalence of AOD evident among prison entrants (Gaffney and Payne 2012), expanding the Victorian Drug Court is an innovative and cost effective means of addressing these challenges. There have been a number of reviews, most recently by KPMG, which in chorus indicate that the Drug Court provides a robust return on investment, through reduced prison days, reduced recidivism and increased wellbeing among participants.

In line with recommendation 33 of the Victorian Methamphetamine Inquiry (Parliament of Victoria 2014), Drug Courts should be rolled out throughout Victoria. It would be prudent to allocate a Drug Court to a suitable Magistrates Court within each AOD catchment in Victoria. An early review of the Victorian Drug Court indicates a return on investment of $5.81 for every $1 spent on Drug Courts (Acumen Alliance 2006). More recently, KPMG has released a report which illustrates the unambiguous and clear benefits of the Victorian Drug Court:

- 34 percent reduction in reoffending among Drug Court participants in comparison to a similar cohort within two years;
- Among those reoffending, the severity of offending from Drug Court participants is less than a similar cohort; and
- Over a two year period, the Drug Court of Victoria saves 4492 days of prison amounting to a saving of $1.2 million for Victoria (this figure does not take into account the reduction in recidivism, and other indicators of improved wellbeing) (KPMG 2014).

Expanding the Drug Court would greatly reduce immediate demand on the prison system and provide a longitudinal reduction in prison demand through reduced recidivism.

Recommendation 5: Drug Courts should be established in each of the 16 AOD catchments. This could conservatively save over $15 million on an annual basis and result in better health, wellbeing and community safety outcomes for Victorians.

Sector development

There are a range of vulnerable groups which, for a number of reasons, experience difficulty accessing AOD treatment. These groups include but are not limited to Aboriginal, CALD and LGBTI communities. There are also various challenges apparent for rural and regional communities in accessing AOD treatment. These challenges are exacerbated by the increased complexity evident in service presentations and the near absence of joined up service responses to this complexity. This is further challenged by the impact on the AOD workforce by both the reform activities and uncertainty emerging from previous iterations of federal funding rounds. 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.

The recently released 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 and, conversely, 22.2 per cent indicating that the reforms had improved the workforce (VAADA 2015).

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 informed practices in responding to the treatment needs of service users for substances such as methamphetamine.

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:

- In 2011, the ABS reported that 26.2 percent of all Victorians were born overseas (ABS 2011); despite this, only 11 percent of all AOD presentations fit within this cohort. Further, in 2012/13, 29,319 individuals were estimated to be engaged the Victorian AOD sector

(Australian Institute of Health and Welfare 2015), however there were only 99 onsite and telephone interpreter bookings reported (Department of Health and Human Services 2015)[3];

- Conservatively, in Victoria during 2013/14, Aboriginal people consisted of 6.5 percent of AOD service users (Australian Institute of Health and Welfare 2015) while making up only 0.9 percent of Victoria's entire population (Health*info*Net 2015);

- Research indicates that harmful AOD use and dependency in LGBTI communities is more prevalent than the general community. This includes binge drinking, tobacco smoking and the use of illicit drugs (Ritter et al 2012; Lea et al 2013 and Leonard et al 2008); and

- Individuals from remote and very remote areas are twice as likely to smoke, consume alcohol in risky quantities and consume methamphetamines when compared with metropolitan populations (Australian Institute of Health and Welfare 2014).

There are a number of challenges to address in order to enhance service delivery and subsequent outcomes with each of these populations. Broadly, there is a need to build linkages with a range of related service sectors, a goal which the Community Drug Action Teams (CDAT) proposed in this submission would contribute to. Providing the sector with the capacity to enhance the effectiveness of related service sectors in a holistic manner in working to address AOD and associated issues would derive significant benefit for the community. AOD services are linked in with local CALD communities, with specific pathways and culturally sensitive service delivery would improve community health. Further developing links between mainstream AOD services and the ACCHO's would improve service outcomes with Aboriginal communities. LGBTI sensitivity support should be provided to AOD services which would improve service access for these communities and should further assist in delivering the necessary harm reduction messaging. Enhancing rural service delivery with a view to building the capacity of agencies to better respond to increasing complexity would improve rural health. These endeavours could be progressed through the provision of a flexible capacity building fund.

There is a need for the sector to be able to action local responses and flexibly adapt to local challenges. To this end, we would recommend the implementation of a capacity building fund.

Recommendation 6: 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.

[3] Some agencies have queried this departmental data indicating that it is an underestimate.

Community AOD action teams

There is a need to establish a locality based mechanism which provides a range of community related AOD focussed activities that can contribute to positive health outcomes for local communities. Such a mechanism is not currently catered for by either treatment services, local government nor the State or Federal government. Essentially AOD action teams would be locality based, utilise grass roots community development, outreach, community education and prevention activities, and also develop resources regarding the service system and provide policy advice on a range of local issues. They would be the conduit between the AOD related local issues, the local community and other stakeholders. The primary goal of such teams would be to reduce the harms arising to individuals and local communities. We propose that eight teams would be established across Victoria in line with the DHS regions.

There are varying drug trends and needs across the regions of Victoria. These are often underpinned by complex issues and vulnerabilities which are entrenched in the fabric of local communities. While the provision of AOD treatment assists individuals and their families, there are significant limitations with regard to addressing vulnerabilities within the community which may be contributing to the underlying drivers of AOD use, dependence and harms.

Specialised local teams could assist communities in building resilience through a range of prevention, early intervention, community development and advocacy responses. They would also be ideally placed to provide key policy advice to both local and the Victorian government in reducing AOD related harms across the community.

Additionally, these teams could, in partnership with consumer organisations, assist in the development of consumer groups. This would result in more informed community development, education and policy activities and more broadly seek to address issues related to stigma, which impact adversely on service access and overall community wellbeing. This may involve working collaboratively, coordinating activity with other service sectors and stakeholders to action a specific campaign through a range of means to reduce stigma.

Ideally, these teams would consist of a combination of:

- Outreach AOD workers
- Community development workers
- Policy/project workers
- Community education workers

These teams would contribute to the demand modelling activities currently undertaken in each catchment.

Recommendation 7: Resourcing is provided for the establishment of 'AOD action teams' in each of the eight DHS regions to develop a team which would consist of a range of professionals, totalling 4EFT in line with the specific needs of each region. The estimated initial allocation for the first year for each team would amount to $450,000 (which includes the purchase of a motor vehicle) and $420,000 annually thereafter. Each team would be situated within an appropriate agency.

Increase residential rehabilitation capacity in rural and regional Victoria

Individuals living in rural and regional Victoria continue to face significant challenges in readily accessing residential rehabilitation services. Most rural and regional catchments cannot cater locally for treatment needs involving residential rehabilitation. Residential treatment provides a return on investment for government and currently, in comparison with other regions, there is only a very small quota of residential beds in Victoria. To this end, VAADA is calling for the establishment of two residential rehabilitation facilities to be established in the areas of greatest need in Victoria.

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. While NSW has approximately 800 beds, Victoria has approximately 220 permanent beds, despite the fairly similar population levels. Most of these beds are located within metropolitan areas. Individuals residing in rural and regional areas of Victoria who require residential rehabilitation services often need to travel to metropolitan areas. There are significant benefits in providing local residential beds in line with more effectively transitioning people back into the local community, which can reduce the length of stay (a financial saving) and enhance positive long term outcomes.

Currently, in light of the limited rural residential beds, individuals in rural Victoria will likely be attending a residential rehabilitation facility which is up to four hours away from local support bases such as friends and family, impacting upon retention and therefore overall treatment outcomes. There is likely to be an extensive waiting period, well beyond one month, further impeding access.

Recommendation 8: That the Victorian government provide additional resourcing for the establishment of two AOD residential rehabilitation facilities located in areas of greatest need in rural and regional Victoria. These 30 bed facilities would provide for up to 12 weeks of residential treatment and would combined cost up to $4.8 million to provide for 240 service users per annum, not including capital costs. It is anticipated that the capital expense in establishing these facilities could cost up to $9.6 million.

	Unit capacity	***annual through put PA***	***Cost PA***
Unit 1:	***30 beds***	***120 service users***	***$2.4 million***
Unit 2:	***30 beds***	***120 service users***	***$2.4 million***

Tier 2 initiatives

Reducing harms through increased access to sterile injecting equipment

There is a consensus of evidence that NSPs are highly effective in reducing the spread of blood borne viruses among injecting drug users. In order to maximize the benefits of NSPs, there is a need to ensure that there is equitable state wide access to this valuable program, which should be provided through a range of means, including the provision of services through shopfront, outreach and dispensing machine models.

Between 2000 and 2009 it is estimated that 96,667 hepatitis C and 32,050 HIV infections were averted through the provision of sterile injecting equipment. This achieves a return in investment of over $4 for every $1 spent over a 10 year period, through a reduction in health care costs due to the prevention of illness (DOHA 2009). The evidence indicates that the provision of sterile injecting equipment to individuals does not increase drug use with some studies indicating that NSPs can result in increased engagement with AOD treatment. NSPs do not create areas of high density injecting drug use and is not associated with increases in discarded injecting equipment (ANCD 2013).

The Victorian Ice Action Plan provided for a single payment of $1.8M to 20 NSP sites which dispense the highest volume of syringes. It is anticipated that this will contribute to a range of actions, including the installation of dispensing machines, which will assist in provision of sterile equipment after business hours. An additional allocation of $1.8 million should be provided to those NSP sites which were exempt from this single payment to provide an equal level of coverage. Such a measure may assist in responding to unmet demand and provide for hidden populations of intravenous substance users, including those in rural and regional areas of Victoria.

This should complement rather than supplant existing modes of NSP service as the benefits of safer injecting practices and referral to other services is supported by the NSP model of contact with trained specialist NSP staff.

Recommendation 9: That a single allocation of $1.8 million be made to increase state wide access to NSPs and maximise parity.

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 tolerance towards alcohol and other drugs diminishes, eliciting a greater level of risk and harm through substance use. 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[4] (Department of Planning and Community Development 2009); and
- With ageing comes a reduced tolerance towards substance use and an increase in other morbidities which may exacerbate the harms associated with harmful AOD use (Taylor and Grossberg 2012).

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 (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

[4] 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.

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 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 10: 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:[5]
Pilot outreach (two teams statewide)

Item	EFT	Cost
Establishment costs - vehicle		$26,800 per team
Establishment costs- office/IT		$11,110 per team
Staffing – outreach team	3 inclusive of 0.5 team leader per team	$400,100 per team PA
Project coordination	1 coordinator, training and development	$151,700 PA
Research and evaluation	1 research and evaluation officer	$125,400 PA

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

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 11: 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.

References

ABS 2013, *Australia's population projected to double by 2075*, media release, 26 November, viewed 27 November 2015, http://www.abs.gov.au/ausstats/abs@.nsf/lookup/3222.0Media%20Release12012%20(base)%20to%202101

Acumen Alliance 2006, Benefit and cost analysis of the Drug Court Program, final report,

ANCD 2012, 'An economic analysis for Aboriginal and Torres Strait Islander offenders prison vs residential treatment', National Indigenous Drug and Alcohol Committee, viewed 7 November 2014, https://www.deloitteaccesseconomics.com.au/uploads/File/NIDAC_Deloitte%20Access%20Economics%20Report(1).pdf

Australian Institute of Health and Welfare 2012, *Alcohol and other drug treatment services in Australia 2010-11: Report on the National Minimum Data Set*, Drug treatment series no. 18, Australian Institute of Health & Welfare, Canberra.

Australian Institute of Health and Welfare 2013, Hospitalisations due to falls by older people, Australia 2009/10, AIHW, viewed 29 January 2016, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129542822

Australian Institute of Health and Welfare 2014*, National Drug Strategy Household Survey detailed report 2013*, Drug statistics series no. 28. Cat. no. PHE 183. Canberra: AIHW.

Coroners Court of Victoria 2015, *Pharmaceutical drugs and fatal overdose: lessons from the Coronial Jurisdiction*, presented at 'a bitter pill to swallow, Melbourne, 17 June.

Coutinho, ESF, Fletcher, A, Bloch, KV and Rodrigues, LC 2008, 'Risk factors for falls with severe fracture in elderly people living in a middle-income country: a case control study', *BMC Geriatrics*, vol 8, no 21.

Coyne, J., White, V. & Alvarez, C. 2015, *Methamphetamine: focusing Australia's National Ice Strategy on the problem, not the symptoms*, Australian Strategic Policy Institute, Barton.

Department of Health and Human Services 2013, *Service specification for the delivery of selected alcohol and drug treatment services in Victoria*, Advertised call for submissions No. 2487.

Department of Planning and Community Development 2009, *Victoria in Future: 2008*, Melbourne.

Donato-Hunt, C, Munot, S & Copeland, J 2012, 'Alcohol, tobacco and illicit drug use among six culturally diverse communities in Sydney', *Drug and Alcohol Review*, vol. 31, no. 7, pp. 881-889.

DOHA 2009*, Return on Investment 2*, Department of Health and Ageing, Canberra, [online] viewed 17 October 2013, http://www.health.gov.au/internet/main/publishing.nsf/Content/C562D0E860733E9FCA257648000215C5/$File/return2.pdf

Health*info*Net 2015, *What details do we know about the indigenous population?¸viewed 2 December 2015, http://www.healthinfonet.ecu.edu.au/health-facts/health-faqs/aboriginal-population*

Hunter, B 2011, *Older people and alcohol and other drugs*, Prevention Research Quarterly, Australian Drug Foundation, viewed 21 October 2013, http://www.druginfo.adf.org.au/reports/prq-older-

people?utm_source=ADF+Master+List&utm_campaign=b76e104a1b-DrugInfo_email_alert_11_09_2013&utm_medium=email&utm_term=0_fe135ee49e-b76e104a1b-306436061

KPMG 2014, *Evaluation of the Drug Court of Victoria, FINAL* REPORT, Magistrates Court of Victoria, viewed 17 April 2015, http://www.magistratescourt.vic.gov.au/sites/default/files/141218%20Evaluation%20of%20the%20Drug%20Court%20of%20Victoria.pdf

Manning V, 2014, *Patient Pathways,* in proceedings of the 2014 Turning Point Annual Symposium, Melbourne, Turning Point, 13 August.

Mugavin, J and Berends, L 2013, *Older wiser lifestyles (OWL) programs evaluation final report*, Turning Point.

National Health Service 2012, *Estimating the crime reduction benefits of drug treatment and recovery*, National Treatment Agency for Substance Misuse, United Kingdom.

National Treatment Agency for Substance Abuse 2012, *Cost benefits of investing early in substance abuse treatment*, viewed 7 November 2014, http://www.whitehouse.gov/sites/default/files/ondcp/Fact_Sheets/investing_in_treatment_5-23-12.pdf

Office of National Drug Control Policy 2012, *Alcohol and drugs prevention, treatment and recovery: why invest?*, Public Health England, viewed 7 November 2014, http://www.nta.nhs.uk/uploads/why-invest-2014-alcohol-and-drugs.pdf

Parliament of Victoria 2014, *Inquiry into the supply and use of methamphetamine in Victoria*, 2 vols, Law Reform, Drugs and Crime Prevention Committee, Melbourne

Payne, J and Gaffney, A 2012, *How much crime is drug or alcohol related? Self-reported attribution of police detainees?*, Australian Institute of Criminology, No. 439, Canberra.

Productivity Commission 2005, *Economic implications of an ageing Australia*, Commonwealth of Australia, viewed 18 October 2013, http://www.pc.gov.au/__data/assets/pdf_file/0006/13587/ageing1.pdf

Rae, J 2013, *Economic impact of residential treatment for alcohol and other drug addiction in therapeutic community (TC),* Odyssey House, Victoria.

VAADA 2014, *Sector Survey – state budget*, Victorian Alcohol and Drug Association, Collingwood.

VAADA 2015, *Challenges & opportunities: key findings from VAADA's alcohol and other drug (AOD) sector recommissioning survey*, Victorian Alcohol and Drug Association, Collingwood.

Victorian Auditor-General (2011) Managing Drug and Alcohol Prevention and Treatment Services, Melbourne.

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