VICTORIAN ALCOHOL AND DRUG ASSOCIATION

Submission:
National Drug Strategy 2016-2025

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.

OCTOBER 2015

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.

The content of this submission has been informed by a range of surveys and consultations with the Victorian alcohol and other drug sector as well as reflection on data and evidence of best practice.

Summary of Recommendations

Recommendation 1: a comprehensive assessment of the effectiveness of the resourcing priorities between the three pillars should be undertaken with a view to reallocating resources in line with evidence informed endeavours which will be most effective in addressing AOD related harms.

Recommendation 2: develop linkages within the strategy between the listed activities, expected outcomes and how these outcomes will be evaluated

Recommendation 3: An annual report on the progress of the strategy in achieving listed goals be published annually.

Recommendation 4: The strategy should provide for regular consultation with the state and jurisdictional AOD peak bodies.

Recommendation 5: The strategy should provide for regular consultation with service users and representative organisations

Recommendation 6: The strategy should specifically refer to the National AOD workforce development strategy 2015 – 2018 as a related sub-strategy

Recommendation 7: The strategy should prioritise enhancing service access to AOD treatment.

Recommendation 8: This strategy should take a lead role in reducing stigma and discrimination toward AOD using populations.

Recommendation 9: The strategy does not adequately reflect on the harms associated with pharmaceutical misuse and should provide greater detail and priority toward addressing these harms.

Recommendation 10: The strategy should take a lead role I enhancing health and wellbeing in rural and regional areas of Australia by building AOD service capacity to a level equitable with metropolitan areas.

Recommendation 11: The strategy should prioritise the implementation of justice reinvestment initiatives as a means of early intervention and reducing the harms occurring within vulnerable communities.

Recommendation 12: The strategy should support the enhancement and expansion of programs to divert individuals experiencing AOD related issues from the justice system

Recommendation 13: The strategy should support the expansion of Drug Courts to ensure that access to this program is universal.

Recommendation 14: The strategy should provide leadership on reducing access to alcohol advertising for young people.

Recommendation 15: The strategy should provide leadership on developing a process of phasing out all alcohol advertising occurring at any event hosted, conducted in partnership, funded or with in kind resourcing from all levels of government.

Recommendation 16: The strategy should provide leadership on promoting the evidence of reducing harms through replacing the WET with a volumetric model of taxation and increasing the overall rate of taxation on alcohol.

Introduction

The Victorian Alcohol and Drug Association (VAADA) welcomes the opportunity to provide feedback to the next iteration of the National Drug Strategy. This strategy should play an important role in fostering evidence informed responses to alcohol and other drug (AOD) issues and be a key mechanism in ensuring that there is a coordinated approach to these issues across all levels of government and between the wide range of service sectors which are involved in responding to these issues.

We welcome the ongoing commitment to harm minimisation and the underpinning feature of the strategy, however note that there is a disproportionately large weighting afforded to measures associated with supply reduction and that those associated with harm reduction continue to experience a decline in resourcing. Harm reduction measures play a key role in reducing the harms among highly vulnerable cohorts and provide a significant return on investment to both the federal government and state and territorial jurisdictions.

We welcome the ten year term of this strategy, however, note that measurement tools should provide data at frequent intervals throughout the duration of the strategy. We also note that there should be clear and explicit actions associated with the priorities and each of these actions should be accompanied by a desired outcome and a means of measuring and evaluating this outcome.

We note that, despite the gradual reductions in consumption of most substances, many measures of AOD related harms continue to provide a disturbing upward trend. For instance, in Victoria, both AOD related mortality and ambulance data is indicative of an increase in harms. There is a need for further examination of these trends and appropriate responsiveness from the strategy with regard to highly vulnerable and at risk cohorts within the community.

The process of delivery and coordination of Commonwealth funding needs to be addressed. There is a high level of concern within the range of affected sectors regarding the ongoing commitment of the Commonwealth to continue to make the necessary contributions to AOD treatment and related activity. This concern is adversely impacting upon service users and agencies alike, with the past two funding rounds resulting in significant disarray for agencies with regard to staff retention and strategic planning.

We also assert our support for the joint submission from the state and jurisdiction peaks.

Harm minimisation

Harm minimisation has been central to the operation of the previous iterations of the National Drug Strategy for 30 years. The pillars of supply, demand and harm reduction provide a comprehensive means and multifaceted approach to minimising the harms associated with AOD use. This approach provides a clear and unified policy structure which spans across all levels of government, government departments and relevant service sectors. It provides a consensus on strategy, evidence and provides the framework for actions across a wide range of responses in a coordinated manner.

Redressing the imbalance between the three pillars

However, we note that the resourcing across the pillars is unbalanced, with a disproportionately large amount of resourcing directed towards supply reduction. Current estimates indicate that 64.1 percent of AOD budget allocations are directed toward activity associated with supply reduction (Ritter, Mcleod and Shanahan 2013). This is occurring despite the wavering evidence supporting elements of supply reduction such as imprisonment and the failure of significant seizures of methamphetamine in hindering the supply of this substance. For instance, despite the emphasis on methamphetamine and the subsequent increase in the quantity seized by authorities (a 27 fold increase in weight seized from 2009/10 to 2012/13), 86 per cent of drug users report that methamphetamine is either easy or very easy to procure (AIHW 2015; Cogger, Dietze and Lloyd 2014). There is a need to comprehensively evaluate the impact of these supply reduction measures, and establish the satiation point where the return through deterrence and supply reduction from policing endeavours has peaked and additional activity beyond that peak is returning a declining benefit to the community.

The allocations made to demand and harm reduction are far smaller, with the latter experiencing a significant decrease between 2002/03 and 2009/10 (Ritter et al 2013) despite the robust evidence base supporting such programs as NSP. This highlights the opportunity cost associated with the prioritisation of supply reduction endeavours and the need to redress the balance between the three pillars of harm minimisation.

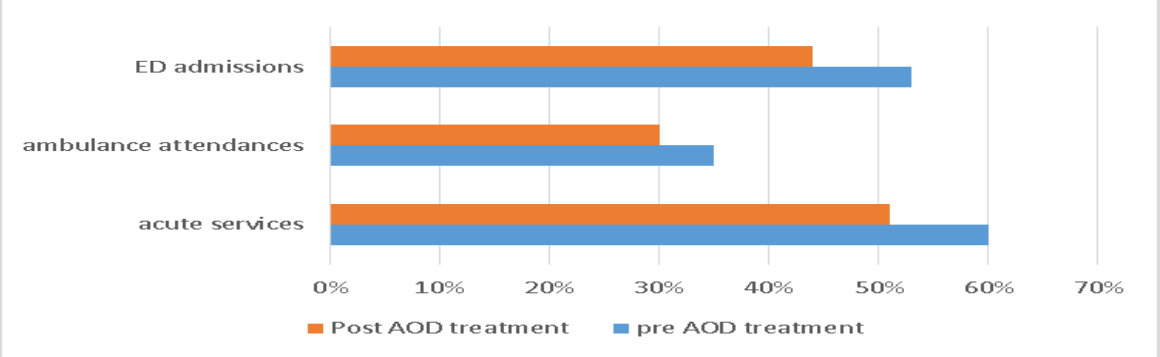
AOD treatment, as an element of demand reduction, provides a strong return on investment with evidence indicating that over a 12 month period, treatment provides a cost benefit ratio of $8 being saved for every $1 spent (Coyne, White & Alvarez 2015).

Preliminary Australian research indicates that individuals who accessed AOD treatment utilized less acute health services in the year following treatment in comparison to the year prior to 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;
- 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



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.

Regarding harm reduction initiatives, needle and syringe programs also provide a strong return on investment. NSP is highly effective in reducing the spread of blood borne viruses among injecting drug users; between 2000 and 2009 it is estimated that 96,667 hepatitis C and 32,050 HIV infections were averted. 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 (UNSW 2009). The evidence indicates that availing sterile injecting equipment to individuals does not increase drug use with some studies indicating that NSP can result in increased engagement with AOD treatment. NSP does not create areas of high density injecting drug use and is not associated with increases in discarded injecting equipment (ANCD 2013). Further, on harm reduction, we note the definitional changes evident between the 2010 – 2015 National Drug Strategy and this current draft and that these changes relate to a broader definition of harm reduction. We note that there is an encroachment of various elements which may be more suitable for demand reduction and that the responsibility of reducing harm is being shifted to the substance user, rather than government.

The financial and social returns noted above with regard to harm and demand reduction highlight the opportunity cost of an over emphasis on supply reduction endeavors and the need for a rebalancing of the resourcing between the three pillars of harm minimization.

Recommendation 1: a comprehensive assessment of the effectiveness of the resourcing priorities between the three pillars should be undertaken with a view to reallocating resources in line with evidence informed endeavours which will be most effective in addressing AOD related harms.

Monitoring

The draft strategy fails to provide a clear link between the various themes and endeavours listed and specific improvements in the measures utilised in assessing AOD related harms. The draft strategy provides an overall list of the various activities which are undertaken yet does not adequately champion those measures which derive significant gains in reducing AOD related harm.

A wider array of sources should be utilised in assessing the progress of the strategy which should include state and jurisdictional sources with a view to further enhancing and expanding the measurement tools. Further, it is necessary that a population planning approach be adopted to inform service planning.

Innovative means of interpreting data should be employed, to better identify vulnerabilities and assist in the targeted allocation of resources. For instance, innovations in data collection and assessment may assist in identifying overdose ‘hotspots’, where it is evident that a cluster of deaths have occurred in a specific location within a region. This data could be better used to enhance service response, identify high risk environmental factors as well as at risk populations.

A comprehensive report detailing the progress of the strategy should be developed annually, providing a snapshot identifying areas where progress is evident as well as where challenges still remain.

Recommendation 2: develop linkages within the strategy between the listed activities, expected outcomes and how these outcomes will be evaluated

Recommendation 3: An annual report on the progress of the strategy in achieving listed goals be published annually.

Governance

The draft strategy provides a brief overview of the associated governance structures yet does not provide clear details on governance processes, including community consultation. The draft strategy does not provide for ongoing consultation with the various state and jurisdictional AOD peak bodies and regularly do so with government and other stakeholders. The AOD peak bodies can provide vital insight into the various AOD related challenges, trends, harms and at risk populations to better inform the strategy's progress. The peak bodies also have strong linkages into the broader AOD sector and continue to provide a crucial link between government and AOD treatment service providers. In order to ensure that the strategy better reflects the needs of the community, we recommend that greater specificity be provided on the means of relaying the expertise from a range of community groups, including service users and providers as well as other stakeholders, such as AOD peak bodies and treatment agencies.

We note with concern the absence of a workforce development sub-strategy. Such a strategy would provide a leading role in the necessary endeavours of workforce development, ensuring that the AOD workforce is sufficiently skilled to respond to the increasing complexities in service user presentations. It would also provide an overarching structure to facilitate cross sector capacity building contributing to improved treatment outcomes.

The sub strategy more broadly could canvas the various challenges facing certain workforces beyond AOD treatment, such as first responders and provide a structure for enhancing the skill base of the necessary service sectors.

Recommendation 4: The strategy should provide for regular consultation with the state and jurisdictional AOD peak bodies.

Recommendation 5: The strategy should provide for regular consultation with service users and representative organisations

Recommendation 6: The strategy should specifically refer to the National AOD workforce development strategy 2015 – 2018 as a related sub-strategy

Priorities

Service access

An enduring theme within at least the Victorian context is the issue of service access. Despite the stated intention of the recent recommissioning to provide clarity on waiting times through the implementation of regional intake and assessment, there remains a lack of clarity with regard to the specifics of waiting times to access AOD services. Feedback from services and regular anecdote from a range of public sources indicate that issues of access remain a key barrier to the delivery of AOD treatment services. Encouragingly, the draft strategy notes as a priority the need to increase 'access to treatment services, including new approaches to responding to emerging issues' (ICGD 2015). We would welcome further clarity on how this will be achieved and measured.

Recommendation 7: The strategy should prioritise enhancing service access to AOD treatment.

Reducing stigma and discrimination

Stigma and discrimination toward AOD service users and AOD using populations create additional harms. Populations experiencing stigma will be less likely to engage with services and less likely to disclose information related to AOD use. Stigma and discrimination can also impact in an adverse manner on family relationships, employment and more broadly across the gamut of activity associated with community participation. The draft Strategy does not address this issue.

Recommendation 8: This strategy should take a lead role in reducing stigma and discrimination toward AOD using populations.

Pharmaceuticals

We note the telling absence of pharmaceuticals in the Forward, governance and priorities in the draft strategy. In Victoria, pharmaceuticals contribute to more fatal acute drug toxicity deaths than both alcohol and illicit substances combined (Coroners Court 2015). Benzodiazepines, as well as contributing to approximately half of all acute drug toxicity deaths in Victoria, also contribute to more ambulance attendances than any other substance with the exception of alcohol (Lloyd et al 2015). There has been a significant increase in fatalities associated with oxycodone, coupled with a massive increase in the number of prescriptions completed for this substance. In 1999, 95.1KG of oxycodone was prescribed nationally in Australia – by 2008, this had increased 13 fold to 1270.7KG (ADF 2014). The National Drug Strategy Household Survey (2014) notes that, in 2013, while there has been a slight decrease in the consumption of most substances, pharmaceutical misuse has increased from 4.2 percent to 4.7 percent of the population. Despite this, there is no reference to pharmaceuticals within the governance section of the draft strategy. If this absence remains, the national drug strategy will remain ignorant of an expanding source of significant harm which is impacting upon a wide range of populations, many which are not necessarily engaging with the service sectors related to AOD.

Recommendation 9: The strategy does not adequately reflect on the harms associated with pharmaceutical misuse and should provide greater detail and priority toward addressing these harms.

Rural and regional communities

Individuals in rural and regional areas generally experience greater disadvantage, disease rates, health risks and mortality, as well as poorer economic circumstances in comparison with their metropolitan counterparts (Duckett & Breadon 2013 2013; National Rural Health Alliance 2012).

There is a greater rate of preventable hospital admissions in rural areas, with 70:1000 compared to 30:1000 head of population in metropolitan areas and only half the rate of GP utilization (Buykx, Ward and Chisholm 2013). This creates a scenario where there is poorer health, limited service access and limited service capacity within rural areas. These issues are compounded by the tyranny of distance as well as issues, specifically for the AOD sector, of privacy within small town settings.

Extensive long term planning and resourcing to build service capacity is necessary for achieving equity with community health and service access. There is a need to ensure that the needs of Victorians and the various issues pertaining to service access are prioritized in service planning. Big picture reform activities need to ensure that service users are strongly engaged and can participate in the processes to make sure that reformed service systems better cater for the needs of the community.

Recommendation 10: The strategy should take a lead role I enhancing health and wellbeing in rural and regional areas of Australia by building AOD service capacity to a level equitable with metropolitan areas.

Justice reinvestment

Many of those populations which are experiencing harms through AOD use also experience a range of vulnerabilities and risk factors. For instance:

- approximately 80 percent of individuals experiencing AOD issues report a history of mental illness (Bouverie 2013); and
- The Australian Institute of Criminology provide an estimate that 52 percent of all offending behaviour is attributable to substance use (Payne and Gaffney 2012);
- Alcohol is involved in approximately 50 percent of all violence between partners (Laslett et al 2010)

Recent work from Tony Vinson on mapping disadvantage illustrates that vulnerabilities within communities often cluster within certain communities. Adopting a justice reinvestment approach would provide for holistic enhancement of community resilience through the additional provision of services to address the identified vulnerabilities. This would, as a means of early intervention, in the mid to long term, result in a reduction in demand on justice as well as acute health services and contribute to a greater sense of community wellbeing.

Recommendation 11: The strategy should prioritise the implementation of justice reinvestment initiatives as a means of early intervention and reducing the harms occurring within vulnerable communities.

Enhanced diversion from the justice system

Within Victoria, there has been a significant expansion in the prison population, from 4500 in 2010 to over 6100 in 2015. There are a range of factors which have contributed to this increase which are not necessarily related to an increase in offending, including reform in sentencing, parole and bail. There is a need to increase access to diversionary schemes, bail and a range of court-based options including drug courts. The Victorian Drug Court, and more broadly the range of Drug Court models both nationally and internationally, enjoy significant success in reducing AOD related offending, including methamphetamine related offending. Specifically, over a two year period, the Victorian Drug Court was found to have saved 4492 prison days in Victoria, netting a saving of $1.2 million for Victoria. This saving does not account for the reduction in recidivism (34 percent lower than the control group), and other health related benefits (KPMG 2014). The Victorian Parliamentary Inquiry into the supply and use of methamphetamine (Victorian Government 2014) indicated that Victoria, which currently has one Drug Court, should look to implementing another four Drug Courts throughout the state. Ensuring that all regions of Australia maintain an accessible Drug Court is essential in responding to AOD related offending.

Recommendation 12: The strategy should support the enhancement and expansion of programs to divert individuals experiencing AOD related issues from the justice system

Recommendation 13: The strategy should support the expansion of Drug Courts to ensure that access to this program is universal.

Reducing alcohol related harms

Research indicates that alcohol advertising is associated with the commencement of drinking among children who have not otherwise consumed alcohol and an increase in the level of consumption among pre-existing drinkers (O'Brien et al 2015). Currently alcohol advertising can be aired on free TV after 830 PM or during a televised sporting event, many of which are viewed by children. Reducing exposure of children to alcohol advertising will reduce alcohol related harms among this cohort. Importantly, it is widely accepted that delaying the first alcoholic beverage consumed by young people reduces the harms (ADF 2013). This notion should be central to all deliberations of government policy in this area. We also note with concern the increasing presence of alcohol advertising and promotion occurring through various social media platforms. Carah (et al 2015) have identified frequently occurring content on industry lead social media platforms that promote and glamorise excessive consumption of alcohol with multiple images depicting individuals well under the age of 25 years. This is a vexed issue which needs to be addressed.

The strategy should also detail a process of phasing out all alcohol related advertising at any event hosted or conducted in partnership, funded or with in kind resourcing from federal government, state and territory governments and local government.

An approach which has a consensus from a wide range of evidence bases is utilising cost as a means for reducing demand for alcohol. Vaaramo et al (2012) found a direct correlation between reducing taxation of alcohol and an increase in alcohol related mortality in Finland. Fare commissioned a report to which two approaches to alcohol taxation were modelled; both included removing the wine equalisation tax (WET) and replacing it with a taxation approach based on a volumetric model. It was estimated that replacement of the WET with a volumetric taxation model would derive benefits to the community worth $230 million per annum (Marsden and Jones 2012). Carragher and Chalmers (2011) cite a United States study which highlights that a doubling the taxes on alcohol would elicit a 35 percent reduction in alcohol related mortality, reduce traffic accidents by 11 percent, sexually transmitted diseases by six percent, violence by two percent and crime by 1.4 percent. There is a need to replace the WET with a volumetric taxation model, bringing the taxation on wine in line with other alcoholic substances and increasing the taxation on alcohol to further reduce alcohol related harm.

Recommendation 14: The strategy should provide leadership on reducing access to alcohol advertising for young people.

Recommendation 15: The strategy should provide leadership on developing a process of phasing out all alcohol advertising occurring at any event hosted, conducted in partnership, funded or with in kind resourcing from all levels of government.

Recommendation 16: The strategy should provide leadership on promoting the evidence of reducing harms through replacing the WET with a volumetric model of taxation and increasing the overall rate of taxation on alcohol.

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