vaada news
Victorian Alcohol & Drug Association

June 2017

In this issue

Investment in AOD treatment

It has been a long time in the Victorian AOD treatment sector, since alcohol and other drug issues attracted such ongoing media attention, and since both State and Federal Governments have invested so heavily in a range of new initiatives.

Organisations were delighted to hear recently that Commonwealth funded treatment programs would continue, largely coordinated through local PHNs. Many innovative programs were established under the old NGOTGP strategy, and it was pleasing to see that these will continue during a time of high client demand. It also seemed sensible that some Australian residential programs will continue to be funded directly by the Commonwealth, preventing the need for multiple PHNs to cobble together bits of funding across regions.

Likewise, it has been great to see some of the resources committed under the National Ice Action Strategy begin to flow into Victoria. Although early days, we all look forward to seeing the difference that these targeted services will make in the lives of some very hard to access populations. It is concerning, however, after many years of uncertainty and change, that the terms of new funding contracts are so short. VAADA will continue to lobby for 3-5 year funding arrangements, enabling better planning and workforce security, and greater implementation of project learnings.

You are most likely aware of the new funding committed through the 2017/18 State budget that will enhance the capacity of the Victorian AOD sector. Notably, 30 additional residential beds, and plans for three new regional facilities with a further 60 beds will help ease the unavoidable demand being placed on this part of the treatment system. VAADA and the community have been lobbying for this outcome for many years, given that Victoria has less than half the beds per capita of any other state or territory (with the exception of South Australia). The Victorian budget also committed new resources to support people's transition in and out of treatment, new resources for forensic clients on Community Corrections Orders, increased phone and web-based support, and additional services for families.

With all this new service delivery funding, and with the new Melbourne Drug Court, new Peer Mentoring Programs, the review of the forensic AOD system, and the roll out of recommendations from the Royal Commission into Family Violence, a serious challenge for our sector will be attracting and developing a suitable workforce. This will be exacerbated when Commonwealth Capacity Building funding is transitioned into treatment funding through PHNs later this year. VAADA will continue to lobby for greater investment into the workforce development resources that will be required, and to ensure the best outcomes can be achieved for those who seek our help.

This edition of the VAADA newsletter includes articles on the Peer Led Harm Reduction Overdose Prevention Initiative, Growth Corridors and AOD service demand, and the 2016 acute drug toxicity (fatal overdose) data. It also provides a sector update from Molly O'Reilly who is filling in during our Executive Officer, Sam Biondo's absence.

The months ahead will keep us busy with changes to Intake and Assessment, how AOD data is captured, and how critical incidents are reported and investigated. We wish Sam all the best for a speedy recovery from his back surgery, and we say farewell to staff member Sarah Nikakis who will be leaving VAADA after three years of service.

Stefan Gruenert
Chair VAADA

Sector update

Victorian Alcohol and Drug Collection (VADC)

DHHS has run information forums on the VADC, which will have a phased implementation over the next 18 months, beginning from July 1 2017.

The VADC is defined as a set of data elements which treatment providers will need to collect from their own Client Management Systems (CMS) and then provide to DHHS through its Secure Data Exchange (SDE) internet portal.

In total there will be significantly less data items collected by the VADC, then is currently collected through the legacy ADIS system. The data elements are designed to align with the national minimum data set reporting requirements and current service delivery, with collection happening on a monthly, rather than quarterly basis.

Services will be able to opt into uploading data into the VADC from early in 2017/18 financial year and its use will be mandatory by October 2018. Once all state funded service providers have transitioned to the VADC, ADIS will be decommissioned.

At a recent information DHHS session on the VADC, (15 May) a large turnout of sector representatives were briefed on the VADC and had the opportunity to participate in a Q&A segment. There were a wide range of questions about how this new process would be operationalised, ranging from reporting responsibilities within consortia, and how this new data set will integrate with other federal and state government data sets.

To support the sector in this process VAADA will be running a session at Scots Church on 7 July. The session will aim to bring together funded service providers to discuss how they collect client data, what CMS they use, and for those services that maybe solely reliant on ADIS, what CMS options may be available to them.

Intake and Assessment Reform (IAR)

VAADA recently ran a facilitated workshop on the proposed reforms with sector CEOs and managers on 21 of April. The workshop began with Assistant Director Drug Policy and Reform, Ross Broad giving an overview of the IAR. Following Ross' update, session facilitator Greg Logan, divided the workshop participants into eight groups to consider a range of questions that aimed to tease out sector understanding of the implications of the proposed reforms. Findings from the workshop will be distributed to the sector and DHHS.VAADA would like to thank all who participated in the workshop.

Guidelines and Performance Management Framework

DHHS have developed new Alcohol and other drugs (AOD) program guidelines in response to the ASPEX review of the recommissioning of adult community-based AOD services. The completed guidelines will apply from 1 July 2017. VAADA encourages all service providers to familiarise themselves with the guidelines prior to their implementation date.

VAADA PHN Activity

North Western Melbourne Primary Health Network (NWMPHN) Workforce Project

VAADA has been commissioned by the NWMPHN to undertake capacity building with service providers in the NWPHN region. The project's aim is to increase the effectiveness of client care by enhancing AOD workforce capacity via workforce development and sustainability initiatives. The project will include education and training sessions, with a focus on the development of a network of all AOD treatment providers across the north-western region, and ultimately a community of practice. VAADA has just finalised the recruitment of a worker for the project with work to begin early in the 2017/18 financial year.

Western Victoria Primary Health Network (WVPHN) Service Development Coordination Project

VAADA has been engaged to deliver a Service Development Coordination Project with the Western Victorian PHN. The project will see VAADA coordinating and supporting the PHN funded AOD services to integrate their services with regional referral pathways, including state funded intake services; establish the model of Brief Intervention through model development and articulation and assist in the promotion and establishment of relationships with Primary Care services in each subregion. VAADA will support the design of an evaluation across the broad WVPHN region and also support services through, and workforce development initiatives.

Living on the edge

The municipalities at the edge of greater Melbourne are collectively referred to as 'interface councils'. They constitute new urbanisation with pockets of former semi-rural communities.

Melbourne's social demographic no longer characterised by municipalities with pockets of affluence and relative disadvantage enabling all residents equal access to local social and community infrastructure. To pursue the dream of owning a house many young families need to move out to the urban edge. Despite the advertisements you find new housing estates denuded of foliage, mushrooming in barren paddocks, far from adequate public transport and lacking facilities such as libraries, neighbourhood houses and recreational hubs that serve to form community and reduce social isolation. Schools tend to be few and massive, struggling to cope with burgeoning enrolments and not able to provide the community focus of more established areas. Childcare is scarce, meaning that parents are required to commute further to just drop-off their children. Councils are hamstrung by rate caps in their efforts to give effect to their planning priorities. Woefully inadequate road infrastructure adds hours to the workplace commute. This has the perverse effect of increasing their need for childcare, further eroding both finances and quality family time.

All these extra costs bite savagely into young families' financial viability. Many live on the edge of their budgets and fear of mortgage failure, being an interest rate rise or job loss away from default and destitution.

For some, the tyranny of distance and other social and economic stressors engender illness or fatigue, tempting people to use physical stimulants or the cheaper forms of numbing.

Our AOD service, operating from several sites in an interface municipality to maximise access, sees a demographic at times subtly and then vastly different from inner-city services. You won't find the soup vans for the homeless visible in the city. Our homeless are couch-surfing or sleeping in their cars. For us, 'no fixed address' means that their car no longer works. With no regional housing shelters, our clients are much more vulnerable to adverse domestic situations.

Breadwinners working in trades or logistics often report using ice to simply have the energy to keep going, to work at the pace required. Then, they will use alcohol to unwind.

Unlike the inner city, most of our service users live in a family context. This means that our service is much more likely to need to manage intimate partner violence, child abuse and neglect, and elder/parent abuse. Participation in regional Risk Assessment and Management Panels is a vital and welcome addition to more effectively managing these serious risks.

Many of the young people impacted by their parents' misuse are visible congregating at railway stations and local shopping malls. The pace of population growth has far outstripped the AOD youth outreach capacity in interface regions.

Another factor in youth alienation is the higher population of CALD families in these areas, drawn by the cheaper housing. Many refugee families have experienced trauma, with insufficient access to local specialist services. They are more likely to endure under- or unemployment despite their desire for stable employment. Parents are isolated by limited English language skills, with some facing the powerlessness and frustration of not being able to provide adequately for their families. Members of these families can succumb to substance misuse and to mental health issues amidst cultures that are not health literate and unfamiliar with how to seek treatment. This is exacerbated by the high levels of stigma associated with substance use.

Our service regularly works with these multi-faceted families. We continually re-assess our service delivery models, communicating with funding bodies to ensure they understand the treatment needs of our clients, and actively engage with councils and other community service organisations to maximise our contribution to the wellbeing of our fellow citizens.

Recruitment of staff qualified and skilled to work with our clients is a continual challenge. People considering employment with us are often deterred by the same challenges that our community members experience: poor public transport and long commutes impacting their family life and finances.

Both the challenges and solutions associated with AOD service demand in growth corridors are equally complex. To address the challenges associated with these evolving populations, services need the capacity to be flexible and responsive to emerging community need.

Victor Bilous
Odyssey House

VAADA Service Providers Conference

On 26 May, VAADA and DHHS held the first service providers conference for 2017. The conference was well attended, with approximately 200 representatives primarily from AOD treatment agencies and DHHS. The conference provided the opportunity collectively update the sector on the various imminent changes as well as exploring the implementation and impact of the various endeavours detailed in the 2017/18 Victorian state budget.

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Stefan Gruenert, (VAADA President) opened the conference and introduced Perry Wandin who delivered an engaging Welcome to Country. This was followed by a comprehensive plenary detailing the next 12 months delivered by Ross Broad, DHHS. Ross identified the following priorities in his presentation:

- Implementation of new budget initiatives
- Monitoring Intake and Assessment changes
- Implementation of VADC
- Retendering of NSP warehouse contracts
- Family Violence Specialist Advisory Pilot Program
- Forensic AOD Service Model
- Responses to Parliamentary Inquiries
- Review of Pharmacotherapy Networks
- Delivery of new Harm Reduction initiatives
- Service planning – Tier 1 – 2; Peer Support; Family Support
- Review of Emergency Department Initiative

After morning tea the conference broke into concurrent sessions covering the response to Family Violence, the new Victorian Alcohol and Drug Collection and Workforce Development before bringing the sector back together for an update on the Peer Led Overdose Prevention Networks.

Following a productive and collegiate lunch, the conference concluded with another set of concurrent sessions, covering the Dark Web and Harm Minimisation, Forensic AOD service delivery, the new Intake and Assessment tool and an update on the progress on Victoria's pending Real Time Prescription Monitoring (RTPM) system.

This conference provided a vital opportunity to convene the sector and provide key information on the wide range of activity related to the sector. As always, VAADA will reflect on the feedback from the sector in the planning of the next conference later this year.

We would like extend our thanks to DHHS in resourcing this important event and to our presenters for taking the time to provide this necessary information to the broader sector.

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Release of 2016 acute drug toxicity data (fatal overdoses) – Victoria

Data released by the Victorian Coroners Court earlier this year in their submission to the Victorian Parliament Inquiry into Drug Law Reform indicates that the number of fatal overdoses in Victoria has increased year on year from 2010 (342 fatal overdoses) to 2016 (477 fatal overdoses)*. Notable trends among the data include the increase in the portion of multiple substance contributions to fatal overdose (over 70% of all fatal overdoses involve two or more substances) and the alarming increase in illegal substance contributions to fatal overdose.

The overall frequency of contribution from illegal substances increased by 57% from 2014 (164 fatal overdoses) to 2016 (257 fatal overdoses).

The overall frequency of contribution from illegal substances increased by 57% from 2014 (164 fatal overdoses) to 2016 (257 fatal overdoses). This trend can be largely attributed to increase fatal overdoses involving methamphetamine and heroin and to a lesser degree MDMA and cocaine.

Despite the increasing contribution of illegal substances to fatal overdoses, pharmaceuticals continue to make the greatest contribution, being involved in approximately 80% of all fatal overdoses. Benzodiazepines are involved in more than 50% of these fatalities. Diazepam, a benzodiazepine, was the highest single substance contributor to fatal overdoses in 2016 (200), followed by heroin (190). Other pharmaceuticals of note include quetiapine, an antipsychotic, which has increased in contribution to fatal overdoses by 65% from 2009 to 2016. The presence of pharmaceutical opioids has fluctuated over the period of assessment, contributing to 212 fatal overdoses in 2012 and 183 in 2016.

The contribution from alcohol has steadily increased from 80 fatal overdoses in 2012, to 118 in 2016.

Table 1 below lists the top six substances contributing to fatal overdose.

The data also highlight the rate of fatal overdose by local government area (LGA). The average rate of fatal overdose in metropolitan areas amounts to 6.9 per 100,000 population. LGAs experiencing a high rate of fatal overdose include Yarra (23.7:100,000); Port Phillip (19:100,000); Melbourne (16.4:100,000) and Maribyrnong (12.5:100,000).

The average rate in regional areas of Victoria amounts to 6.6 per 100,000 population. Regional LGAs experiencing a high rate of fatal overdose include Glenelg (12.8:100,000); Latrobe (10.2:100,000); North Grampians (9.6:100,000) and Shepparton (9:100,000).

Various coroners have, over the years, with reference to this data made a number of recommendations with a view to preventing fatal overdoses. These recommendations are listed in their submission to the inquiry.

To access the submission, see: www.coronerscourt.vic.gov.au/find/publications/submission+to+the+inquiry+into+drug+law+reform

** Please note that the State Coroner has detailed through an opinion piece in Fairfax Media that the total number of overdoses listed is conservative and the final figure is likely to amount to approximately 500 fatal overdoses for 2016.*

Table 1: fatal overdose by individual substance

Substance	2009	2010	2011	2012	2013	2014	2015	2016	Total (2009-2016)
Diazepam	104	109	124	133	164	169	192	200	1195
Heroin	127	139	129	111	132	136	172	190	1136
Alcohol	94	85	88	80	94	94	106	118	759
Codeine	76	57	66	93	71	54	64	47	528
Methadone	50	55	72	75	70	67	67	70	526
Meth (ice)	23	14	29	36	51	53	72	116	394

Calendar

7 JULY

Victorian Alcohol and Drug Collection – information session

VAADA
Melbourne
Registration: https://vadcinfosession.eventbrite.com.au

24 JULY

The Neuroscience of Addiction: A Workshop for Practitioners; Marc Lewis

360 Edge
Melbourne
Registration: www.360edge.com.au/events/#marc-lewis-tour

27 JULY

Working with Cognitively Impaired AOD clients

Turning Point
Information & registration:
www.turningpoint.org.au/education/professional-development.aspx

9 & 15 AUGUST

Intake and Assessment Workshops (New Model)

Turning Point
Fitzroy (9 August), Ballarat (15 August)
Information & registration: michellei@turningpoint.org.au

11 AUGUST

DANA Drug and Alcohol Nurses Forum 'Endurance'

DANA
Sydney
Information & registration:
www.danaonline.org/2017-dana-endurance-forum/

17 AUGUST

Quitting Cannabis: A Brief Cognitive Behavioural Intervention for Cannabis Dependence

Turning Point
Registration & information:
www.turningpoint.org.au/education/professional-development.aspx

17-18 AUGUST

Australian Youth AOD Conference 2017

YSAS
Melbourne
Information & registration:
www.youthaod.org.au/conference2017

12-15 NOVEMBER

Australian Youth AOD Conference 2017

APSAD Conference
Melbourne
Registration & information:
www.apsad.org.au/apsad-conference/current-conference

The VAADA website now hosts an online calendar where events can be uploaded and sighted. To access this free online service, go to www.vaada.org.au/events

Peer Led Harm Reduction Overdose Prevention Initiative

Star Health is one of six agencies in the identified 'hotspots' in metropolitan Melbourne funded to deliver Peer Led Overdose Prevention Projects. The projects are linked to a governing partnership between Harm Reduction Victoria (HRV) and the Association of Participating Service Users (APSU). Star Health's project development was activated by the incident of three overdose deaths and 20 hospital admissions for the toxic effects of an unknown substance that those taking it thought to be MDMA, in the Stonnington/ Port Phillip area (13 – 15 January 2017).

The project aims to deliver harm reduction overdose prevention strategies targeting 'party' drug related harm in late night venues (LNVs) through Peer Leaders. The project will develop the Alcohol and Drug (AOD) Peer workforce through training, and supporting formal and informal networks in the project's target communities.

The project is being developed and implemented in partnership with the Victorian AIDS Council (VAC), and in collaboration with the Local Liquor Accords in each LGA of Stonnington and Port Phillip, DanceWize and Victoria Police. The project will access the practical experience and networks of Peer Leaders to reduce drug related harm in these municipalities. The harm reduction focus of the project is on:

- Overdose prevention and response/referral as required
- Training co-design, development and delivery
- Resource development (e.g. posters, brochures and online materials)
- Policy and Procedure Development as required
- Development of social media notification for novel psychoactive substances
- Peer Network development

The target groups include;

- Nightclub owners and staff, including security people who use party drugs and other substances
- Nightclub patrons
- Local Government authorities
- Victoria Police

This exciting project is the first of its kind to be conducted specifically in the Chapel Street Late Night Venue precinct. The project evaluation logic is being co-designed with Penington Institute as part of a broader evaluation of all of the Peer Led Overdose Prevention projects.

Molly O'Reilly, Star Health