VICTORIAN ALCOHOL & DRUG ASSOCIATION

Victorian Alcohol and Drug Association
Submission into the

Parliamentary Joint Committee on Law Enforcement Inquiry into Crystal Methamphetamine (Ice)

VAADA Vision

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

VAADA Objectives

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

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About VAADA

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

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

What does VAADA do?

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

VAADA seeks to achieve this through:

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

Introduction

The Victorian Alcohol and Drug Association (VAADA) welcomes the opportunity to contribute further to this inquiry. We note that there has been limited progress with regard to the rollout of resourcing to enhance treatment responses as outlined in the National Ice Action Strategy, although some of the associated endeavours have commenced.

We also note that methamphetamine continues to contribute to AOD related harms despite the application of the National Ice Action Strategy and various state-based endeavours.

In this submission, we will provide a brief update on methamphetamine related harms within Victoria and highlight some emerging challenges. We will reflect on the progress of the National Ice Action Plan and provide some additional innovations for consideration.

We note that a Victorian Coronial Inquest is being undertaken which is reflecting on means to prevent heroin related fatal overdose within the region of North Richmond, Victoria. Although this inquest is directed toward heroin, poly drug use is a highly common and harmful phenomena occurring within at risk cohorts and therefore recommend that the findings of this inquest be considered by this committee.

The national AOD peaks are preparing a joint submission which we support in full.

Specifically, this submission will provide responses to the following questions from the Committee:

(e) the nature, prevalence and culture of methamphetamine use in Australia, including indigenous, regional and non-English speaking communities;

(f) strategies to reduce the high demand for methamphetamines in Australia; and

Additional to these enduring queries raised in the earlier Tor for this inquiry, we will also respond to the following questions posed by the committee:

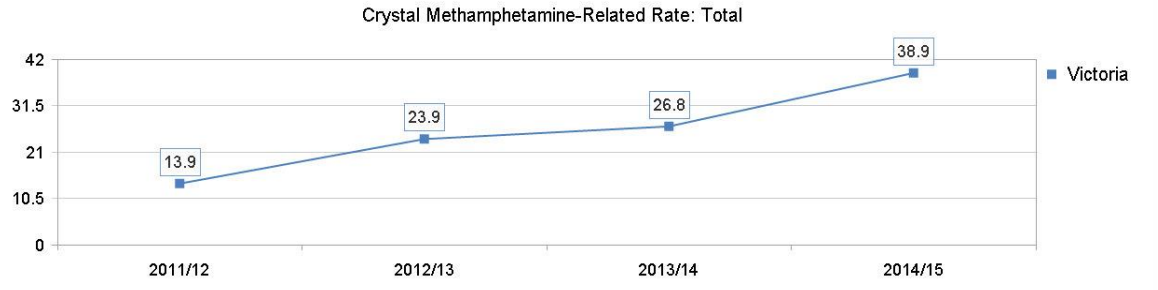
- the National Ice Taskforce's (NIT) Final report;
- the government's response to the NIT report,
- the National Ice Action Strategy 2015 endorsed by the Council of Australian Governments on 11 December 2015; and
- any other developments relating to crystal methamphetamine.

The nature, prevalence and culture of methamphetamine in use Australia, including indigenous, regional and no-English speaking communities

Methamphetamine related harms – contemporary Victorian data

Recently released ambulance data (Victoria) identifies a year on year increase in the rate of (crystal) methamphetamine related ambulance callouts as noted in figure 1 below:

Figure 1: Crystal methamphetamine related ambulance attendances – Victoria (rate per 100,000 head of population)



(Turning Point 2016)

Data from the Victorian Coroners Court also highlights an increase contribution to fatal overdose from methamphetamine in 2015, with the first 4 months of 2016 lifting this trend further.

Figure 2: methamphetamine contributions to Victorian acute drug toxicity mortality

	2009	2010	2011	2012	2013	2014	2015	2016*
Methamphetamine	23	14	29	36	51	53	72	40 (120)

(Coroners Court 2016)

*the 2016 data only includes methamphetamine contributions to acute drug toxicity mortality between January 1 2016 and April 30 2016 which amount to 40 (the first four months of 2016). An annual estimate is provided by multiplying this figure by three, amounting to 120.

The increasing contribution from methamphetamine to acute drug toxicity deaths aligns with a recent increasing presence of illicit substance contribution, particularly heroin. In light of this, and the growing prevalence of at risk poly substance use, we would recommend that activity consider the broader array of substances rather than solely methamphetamine to achieve a fulsome and effective response to this issue.

Culturally and linguistically diverse communities

VAADA's (2016) CALD AOD Project released the final report in March 2016 which detailed some of the challenges experienced by CALD communities in utilising AOD treatment services. The report identified that CALD communities are significant under-represented in the AOD treatment system, with only five percent of closed treatment episodes in Victoria (2013/14) being applied to individuals being born overseas despite, in 2011, 26 percent of Victoria's population being born overseas. The report further identifies that this is due to an under-utilisation of services by CALD communities rather than a lack of demand. Furthermore, it notes that a large portion of the CALD community members engaging in AOD treatment are entering the system through forensic pathways, which suggest that there are missed opportunities for many of these individuals to have, at an earlier stage, engaged with the non-forensic AOD system.

Harm minimisation

Harm minimisation which consists of the three pillars, supply reduction, demand reduction and harm reduction, has informed AOD policy for over three decades. We note, however, 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). Despite this positive return on investment, the AOD treatment sector remains under resourced and overburdened, with research indicating (Ritter et al 2014) indicating that between 200,000 to 500,000 individuals experiencing dependency do not access treatment, with current service provision responding to the needs of between 26 to 48 percent of current demand. Much of this unmet demand spills over into our justice and acute health systems, at great cost and harm.

Strategies to reduce the high demand for methamphetamines in Australia

We note, further to that continued in our earlier submission, the following should be considered with regard to reducing methamphetamine related harms within Australia.

Hospital triage model

AOD related harms engender a significant burden for our emergency services. As evident from figure 1 above, methamphetamine contributions to ambulance attendances have increased markedly over the past four years. This increase is even more acute in rural and regional Victoria, where ambulance attendances for methamphetamine have increased from 6.6:100,000 head of population in 2011/12 to 31.8:100,000 head of population in 2014/15 (Turning Point 2016). We are becoming more aware that of this cohort, there are a number of individuals who regularly utilise ambulance services and frequently attend emergency departments in relation to AOD harm. These regular users of emergency services are enduring significant and regular acute health issues at great public expense. We would recommend that, in order to address this, withdrawal and other support services are

appended to major hospitals or existing services expanded to cater for individuals regularly utilising emergency services. Voluntary fast tracked referrals would be necessary to ensure that individuals experiencing regular acute AOD related harms who may benefit from treatment would receive ready access. The either in-hospital or external support services (which would include residential withdrawal capacity) would allow the flexibility to respond to the individuals need with level of support calibrated with the patients' needs in a step up/step down model.

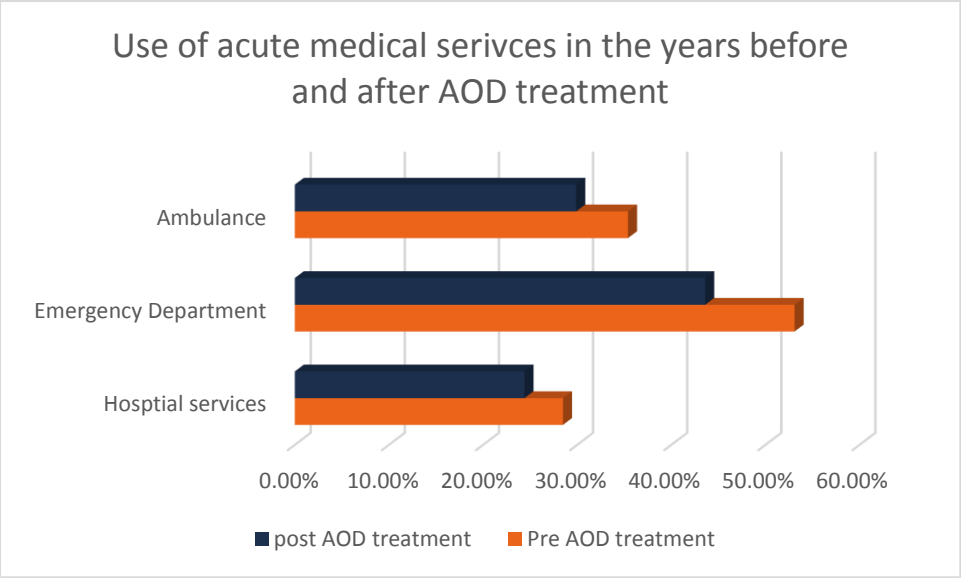
This approach would also provide the benefit of engaging with cohorts which are in need of treatment but do not access the system, by linking emergency services with the AOD treatment sector.

The financial benefits are evident through reflection of *The Patient Pathway's Project* (Lubman et al 2014), which follows AOD service users both prior to and post treatment. This project noted that service users who have accessed AOD treatment utilized less acute health services in the year after the treatment in comparison to the year leading up to the treatment:

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

Figure 3 reveals the positive impact of AOD treatment on acute health service demand.

Figure 3: Impact of AOD treatment on acute health service demand



The proposed step up/step down hospital triage model would greatly reduce future emergency service demand among a high risk cohort of individuals.

Increasing residential rehabilitation capacity across Victoria

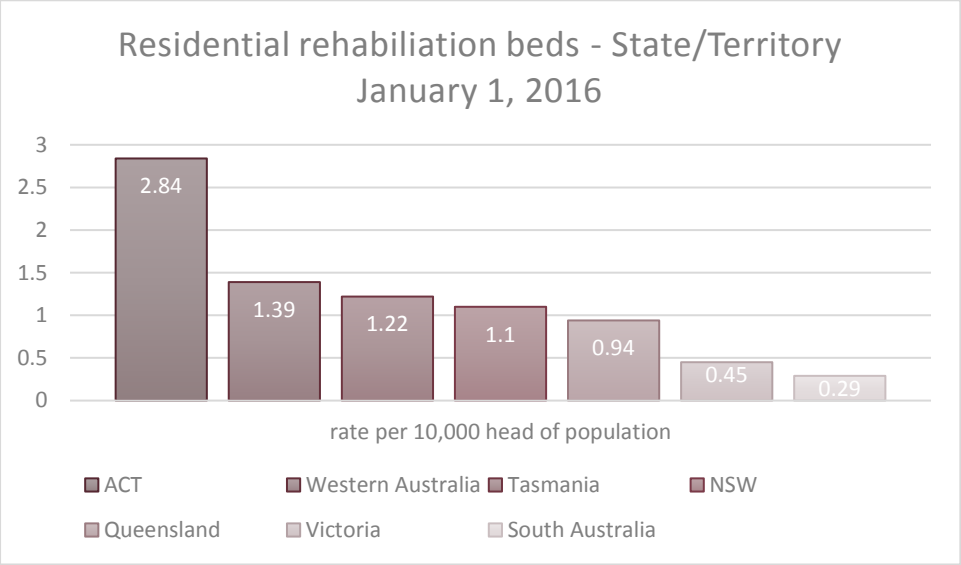
The demand for residential rehabilitation services across Victoria has increased dramatically. This is in part fuelled by the paucity of publicly funded beds available combined with an increase perception within the community that residential rehabilitation is the most ideal treatment option for certain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

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

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

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

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



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

To address this capacity deficit, there is a need for Government to develop a plan to increase the capacity of residential rehabilitation across the state. This significant commitment, which will need to be adequately resourced, will necessitate the development of a plan which will account for gaps in service, demand by region and opportunities evident through partnerships and existing capacity.

We recommend, in Victoria, that the number of residential beds per 10,000 head of population be increased to 1:10,000 necessitating approximately 300 new beds in order to achieve a level of parity nationally and to address the overwhelming demand for this treatment type.

The National Ice Taskforce (NIT) – final report

The National Ice Action Strategy, which was released almost a year ago at time of writing, detailed a broad range of actions in line with the recommendations from the *Final Report of the National Ice Action Taskforce.* As the Victorian AOD peak, we will reflect generally on those elements which relate to AOD treatment.

Regarding specific recommendations:

- Recommendation 1-13; 15; 31-34, 35(d) and 38 are supported, however, we would recommend that these recommendations be implemented following consultation with the AOD sector;
- Recommendation 24-30; 35 (a-c); 36-37 which are related to law enforcement should be considered in light of the pressing need to re-balance the pillars of harm minimisation to enable

a more equitable funding distribution; it should be noted that law enforcement endeavours have to date, appeared to have little impact upon the availability of methamphetamine;

- Recommendation 14 is related to the introduction of a national methamphetamine phone line; this service is already provided within each state/territory and would therefore duplicate existing services and add to community confusion in service access;
- Recommendation 16 relates to increasing access to specialist AOD treatment services for individuals experiencing AOD dependency. We support this recommendation but note that an overemphasis on the role of GP's may result in access issues for populations which do not regularly use GPs
- Recommendation 17 relates to the implementation of a national quality framework; this has been attempted previously with minimal success. Most agencies have already implemented quality management systems so additional activity at a national level in this space would elicit minimal benefit;
- Recommendation 18, relating to further investment in AOD treatment services is strongly supported. We note that the Joint National Peaks have provided briefings to government on issues relating to the commissioning and delivery of this funding;
- Recommendation 19 relates to necessary planning for AOD services operating in areas in line with demand; this recommendation is supported but we note that there are varying processes being undertaken across the 31 PHNs in Australia. The commissioning process should be reviewed.
- Recommendation 20, which calls for longer funding periods is crucial to increasing stability within the sector;
- Recommendation 22, which refers to improving access to integrated, evidence based, culturally appropriate services for indigenous Australians is strongly supported;
- Recommendation 23 is supported in full with the view that a broader approach in line with the evidence should be applied to addressing AOD issues in correctional settings. Governments should be encouraged to adopt a justice reinvestment approach and prioritise programs which are supported by a robust evidence base.

We note that this Final Report (and Ice Taskforce response) does not adequately support consumer led initiatives including consumer involvement. In line with that, neither endeavour adequately reflects on the harms associated with stigma and discrimination, which make significant contributions into AOD related harms including broader health and welfare service access, government policy and overall wellbeing.

Many of the endeavours listed under treatment and workforce are still in development so we are unable to gauge those elements of the Strategy. We do, however, expressly support the majority of the measures listed under treatment and workforce, with the exception of a national quality framework – this endeavour has been attempted previously and would create significant complexities in light of the majority of agencies already adhering to various quality frameworks.

Increased investment in the AOD sector, including indigenous-specific drug and alcohol services is most welcome, although we note that despite these allocations, there is still a significant gulf between agency capacity and community demand. There is a pressing need to greatly increase the capacity of the sector; within Victoria, for example, challenges in timely access to residential rehabilitation services has resulted in the rapid expansion of the unregulated for profit industry,

which, for many people desperate for immediate access to this treatment modality, is viewed as the only option available.

The resourcing related to this Strategy toward AOD treatment has not yet been allocated with the Victorian PHNs still developing the commissioning process. We note that contact between the AOD sector, the AOD peak and PHNs has been varied depending on the specific regions and would suggest that greater endeavour needs to be applied in building relations and enhancing communication between the AOD sector and PHNs.

There appears to be a lack of consistency between the 31 PHNs with regard to tendering, output and outcome measures, as well as the value and duration of contacts. While this may be in line with local placed-based responses, it does create challenges across regions with regard to process, especially for those agencies seeking to tender across regions.

There is a need for the PHN's to have a greater understanding of the AOD sector and the broader demand for AOD treatment and associated harms in order to avoid the possibility of a two tiered system, whereby there is duplication and disjuncture between state funded and Commonwealth funded activities.

With the funding being allocated on a region (PHN) by region basis, we maintain concern regarding the longevity specific endeavours which provide services on a state-wide remit. We would suggest that there should be opportunities with the commissioning processes to provide for state-wide activity.

Notwithstanding these issues, many which are likely to resolve in time, the allocation of resources through the PHNs is likely to provide positive results in the mid to long term, as the associated planning functions develop and there is greater awareness of the needs of each region.

Conclusion

The final report and subsequent National Ice Action Strategy provide a largely positive framework from which to build significant activity to reduce the harms associated with methamphetamine as well as other substances. We note that there are a number of issues related to the commissioning, including inconsistency across the PHNs, as well as a disproportionate allocation toward law and order measures, which in some cases are scant on evidence; to that end, we note that, within Victoria, the costs of imprisonment presents a significant burden to the state and perpetuates a range of harms going forward. This strategy should enhance various diversionary schemes and promote a justice reinvestment approach to responding to law and order related issues, thereby driving down the demand for punitive and ineffective law and order responses while promoting evidence informed health and social policy. There is a need to emphasise the issues relating to stigma and discrimination, and adopt a more inclusive approach to service users in service and policy design. This, and other measures contained herein, would pave the way for fostering a safer and more inclusive community.

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