Drug and Alcohol: Evidence Summary

Introduction:

Drug and alcohol is a significant public health issue. Discussion at a Campaspe level acknowledges the strengths of community development approaches to support communities and prevent harm.

Tobacco contributes to 8.5 per cent of Australia's burden of disease, and causes a quarter of all deaths. It is a major contributing factor to the national coronary heart disease burden (22%), lung cancer burden (79%) and chronic obstructive pulmonary disease burden (65%). Alcohol contributes to 2.8% of Australia's burden of disease. It is a major contributing factor to the the national self-harm burden (20%), interpersonal violence burden and (14%) and the unintentional injury burden - other than road transport – (7.5%) is due to alcohol use. Other drug use contribute to 2.6% of Australia's burden of disease. [42]

A recent review of the National Patient Pathways called for reflection that those who focus only on decisions about individual service programmes will usually find that they have limited impact on the outcomes they wish to produce. It outlines, in contrast, that those who think and act at a systems level have a much greater likelihood of making a significant contribution to ameliorating drug problems at both the individual and population levels [38]

Campaspe data:

Smoking

Local Government Area and State Trends

Some people who smoke only do so occasionally. For most purposes, the Victorian Population Health Survey combines daily and occasional smoking to report on 'current' smoking. Compared to Victoria (15.8%), Campaspe (17.2%) had a higher proportion of population aged 18 years and over who were current smokers.

Prevalence of Smoking, Population Aged 18 Years and Over (2011-12)

	Campaspe	Victoria
Current smoker [(a)]	17.2	**15.8**
Ex-smoker	24.3	**25.4**
Non-smoker	58.2	**58.3**

Victorian Population Health Survey (2011-12), Department of Health 2014 [(a)] *A person who smoked daily or occasionally was categorised as a current smoker*

Frequency of current daily smoking (2011-12)

	Daily
Campaspe	16.0%
Victoria	11.9%

Victorian Population Health Survey (2011-12), Department of Health 2014 *[a] A person who smoked daily or occasionally was categorised as a current smoker*

State-wide findings from the 2011-12 Victorian Population Health Survey also indicate that *across Victoria*:

- Males aged 25-34 years were most likely to be current smokers compared to all males and females
- Females aged 45-54 years were most likely to be current smokers, compared to other females, and
- The prevalence of current smokers declined by almost 28% (3.6% per year) between 2003 and 2012.

Compared to Victoria (15.8%), Campaspe (17.2%) had a higher proportion of population aged 18 years and over who were current smokers. Campaspe (16.0%) compared to Victoria (11.9%) had a higher frequency of daily smoking.

Statistical Local Area:

An estimate of the proportion of population that smokes was undertaken in 2008 by the Public Health Information Development Unit at the University of Adelaide, using data from the 2007-08 National Health Survey.

Males from all Campaspe SLAs were more likely to be smokers than the regional Victoria and Victoria average. Within the region, males from Campaspe – Echuca SLA had the highest rate of smoking.

Females from Campaspe - Echuca SLA were more likely to be smokers than the regional Victoria and Victoria average. Within the region, females from Campaspe - Echuca SLA were the most likely to be smokers, followed by Campaspe – South SLA.

Respiratory System Diseases

In 2007/08, Campaspe PCP (31.4) and all Campaspe SLA populations had a higher estimated rate of Respiratory system diseases per 100 population than regional Victoria (30.7) and Victoria (27.3). Within the PCP region, Campaspe – South had the highest rate and Campaspe – Rochester had the lowest.

Prevalence of current asthma (2011-12)

Area	Males	Females	Persons
Campaspe	7.3*	15.1*	10.4*
Loddon Mallee	8.7	12.8	10.6
Rural Victoria	9.3	13.8	11.6
Victoria	9.4	12.4	10.9

Victorian Population Health Survey 2011-12. ** Estimate has a relative standard error between 25 and 50 per cent and should be interpreted with caution.*

COPD

In 2007/08, Campaspe PCP (2.6) and Campaspe – Echuca, Kyabram and South SLA populations (all 2.6) all had a higher estimated rate of COPD per 100 population

than regional Victoria (2.5) and Victoria (2.2). Within the PCP region, Campaspe – Echuca, Kyabram and South SLAs had the equal highest rate and Campaspe – Rochester had the lowest.

Respiratory System Diseases# (2007 – 08)

	Respiratory system		Asthma		COPD	
SLA	**No.**	**Rate***	**No.**	**Rate***	**No.**	**Rate***
Campaspe - Echuca	4,131	31.6	1,375	10.4	366	2.6
Campaspe - Kyabram	3,901	31.3	1,287	10.2	354	2.6
Campaspe - Rochester	2,588	30.9	852	10.1	224	2.5
Campaspe - South	1,223	31.9	389	10.4	116	2.6
Campaspe	11,843	31.4	3,903	10.3	1,060	2.6
Regional Victoria	*430,710*	*30.7*	*142,558*	*10.1*	*37,997*	*2.5*
Victoria	**1,442,803**	**27.3**	**479,498**	**9.1**	**118,482**	**2.2**

*Public Health Information Development Unit- 2011 * average annual rate per 100 population. # Synthetic prediction*

Cerebrovascular Diseases

Between 2003 and 2007, Campaspe (10.2) had the same average annual rate of avoidable mortality from cerebrovascular diseases for population aged 0 to 74 years as regional Victoria (10.2); and a higher rate than Victoria (9.4). Within the PCP region, Campaspe – Echuca SLA had the highest rate and Campaspe – Rochester SLA had the lowest (both were higher than the regional Victoria and Victoria average).

Avoidable Deaths at Ages 0 to 74 Years: Cerebrovascular Diseases (2003 to 2007)

SLA	No.	Rate*
Statistical Local Area		
Campaspe - Echuca	10	14.8
Campaspe - Kyabram	#	**#**
Campaspe - Rochester	5	11.0
Campaspe - South	#	**#**
Local Government Area		
Campaspe	21	10.2
Regional Victoria	*745*	*10.2*
Victoria	**2,246**	**9.4**

*Public Health Information Development Unit- 2011 *Average annual rate per 100,000 population. #Number was not published in the source document as it was too small.*

Substance Abuse and Alcohol Consumption

Alcohol consumption

Regular, excessive consumption of alcohol over time places people at increased risk of chronic ill health and premature death, and episodes of heavy drinking may place the drinker (and others) at risk of injury or death. The consequences of heavy, regular use of alcohol may include cirrhosis of the liver, cognitive impairment, heart and blood disorders, ulcers, cancers and damage to the pancreas.

Victorian Population Health Survey 2011-12

In 2011-12, Campaspe (51.0) had a higher proportion of population that had consumed alcohol at risky or high risk levels for health in the short term compared to the Victoria (45.3) and regional Victoria (50.8) average. In 2008, Campaspe had a higher proportion (12.6) of population that had consumed alcohol *at least weekly* at risky or high risk levels for health in the short term compared to the Victoria average (10.2).

Excessive consumption of alcohol also has wide-reaching consequences on families, communities, workplaces and the economy. Economic impacts include costs to government health and welfare systems and industry through factors such as crime and violence, treatment costs, loss of productivity and premature death.
The 2001 Australian Alcohol Guidelines: Health Risks and Benefits were used for the 2008 Victorian Population Health Survey. The guidelines identified two main patterns of drinking behaviour as creating a risk to an individual's health:
1. excessive alcohol intake on a particular occasion; and,
2. consistent high-level intake over months and years.

The guidelines specified the risks for various drinking levels for males and females over the short and long term. The guidelines categorised risk according to three levels:
1. low risk— a level of drinking at which the risk of harm is minimal and there are possible benefits for some of the population;
2. risky— a level of drinking at which the risk of harm outweighs any possible benefit; and,
3. high risk— a level of drinking at which there is substantial risk of serious harm and above which risk increases rapidly.
Victorian Population Health Survey 2011-12, Department of Health 2014

Risk of Alcohol-Related Harm in the Short Term

The 2001 guidelines indicate that males who drink up to six standard drinks and females who drink up to four standard drinks are at *low risk* of alcohol related harm in the short-term. Males who drink 11 or more drinks and females who consume seven or more drinks are categorised as being at *high risk* of alcohol related harm. Between these levels, alcohol consumption
behaviour is classified as risky in the short-term. *Victorian Population Health Survey 2011-12, Department of Health 2014*

2001 Australian alcohol guidelines for risk to health in the *short-term*(a)

	Low Risk	Risky	High Risk
Males	Up to six on any one day; no more than three days per week	seven to 10 on any one day	11 or more on any one day
Females	Up to four on any one day; no more than three days per week	Five to six on any one day	Seven or more on any one day

Victorian Population Health Survey 2011-12, Department of Health 2014 (a) Quantities in standard drinks

In 2011-12, Campaspe had a higher proportion of population that had consumed alcohol at risky or high risk levels for health in the short term compared to the Victoria and regional Victoria average.

Consumption of Alcohol at Risky or High Risk Levels for Health in the *Short Term (2011-12)**

Location	Males	Females	Persons
Campaspe	63.3	39.1	51.0
Loddon Mallee Region	*58.7*	*41.5*	*50.3*
Regional Victoria	*59.3*	*42.6*	*50.8*
Victoria	**52.6**	**38.3**	**45.3**

*Victorian Population Health Survey 2011-12, Department of Health 2014 *Includes those who consumed alcohol at risky or high risk levels weekly, monthly or yearly*

State-wide findings from the Victorian Population Health Survey also indicate that across Victoria:

- Males are more likely than females to consume alcohol at risky or high risk levels for health in the short term – particularly on a weekly (at least) basis
- Males and females aged 18-24 years were most likely to consume alcohol at risky or high levels for health in the short term
- Males that were: living in a rural area, primary school level educated, employed, earned more than $100,000, or who were current or ex-smoker were significantly more likely to consume alcohol at risky or high risk levels for health in the short term, and
- Females that were: living in a rural area, employed, earning more than $100,000, undertook sufficient times and sessions of physical activity, had excellent/very good self reported health, who were over weight or who were current or ex-smokers were significantly more likely to consume alcohol at risky or high risk levels for health in the short term.

The 2011-12 Victorian Population Health Survey did not provide the frequency of risk/high risk alcohol consumption for health in the short term by LGA. However in 2008, Campaspe had a higher proportion (12.6) of population that had consumed alcohol *at least weekly* at risky or high risk levels for health in the short term compared to the Victoria average (10.2).

Frequency of Drinking Alcohol at Risky or High Risk Levels for Health in the *Short Term* (2008 & 2011-12)

	At least yearly	At least monthly	At least weekly
Campaspe (2008)	26.8	13.0	12.6
Regional Victoria (2008)	*Not available*	*Not available*	*Not available*
Victoria (2008)	**22.0**	**13.0**	**10.2**
Victoria (2011-12)	**22.1**	**13.9**	**9.1**

Victorian Population Health Survey 2008 & 2011-12, Department of Health 2014

Risk of Alcohol-related Harm in the Long Term

Based on the 2001 guidelines, long-term risk of harm due to alcohol consumption is associated with regular daily patterns of drinking alcohol, defined in terms of the

amount typically consumed each week. - *Victorian Population Health Survey 2011-12, Department of Health 2014*

2001 Australian Alcohol Guidelines for Risk to Health in The *Long Term*[a]

		Low Risk	Risky	High Risk
Males	On an average day	Up to 4	5 – 6	7 or more
	Overall weekly level	Up to 28	29 – 42	43 or more
Females	On an average day	Up to 2	3 – 4	5 or more
	Overall weekly level	Up to 14	15 - 28	29 or more

Victorian Population Health Survey 2011-12, Department of Health 2014 [a] *Quantities in standard drinks*

In 2008, compared to the Victoria average (96.3), Campaspe Shire had a smaller proportion (95.9) of population aged 18 years and over that did not consume alcohol at long term risk levels.

Adult Population That Did Not Consume Alcohol at Above *Long Term* Risk[a] Levels (2008)

Location	%
Campaspe	95.9
Regional Victoria	*95.5*
Victoria	**96.3**

Victorian Population Health Survey 2008, Department of Health 2010 [a] *Quantities in standard drinks*

Consumption of Alcohol at Risky or High Risk Levels for Health in the *Long Term (2011-12)**

Location	Males	Females	Persons
Campaspe	N/A	N/A	6.8
Loddon Mallee Region	*4.8*	*2.7*	*3.7*
Regional Victoria	*4.8*	*3.0*	*3.9*
Victoria	**4.2**	**2.5**	**3.4**

Victorian Population Health Survey 2011-12, Department of Health 2014 **Includes those who consumed alcohol at risky or high risk levels weekly, monthly or yearly*

State-wide findings from the Victorian Population Health Survey also indicate that *across Victoria*:

- Males and females aged 18-24 were most likely to be consuming alcohol monthly or more frequently at above short-term risk levels, and
- Males aged 45-54 years and females aged 25-34 years were most likely to be consuming alcohol at high risk levels for long term alcohol-related harm.

Hospital Separations for Drug or Alcohol Problems

In 2010/11, there were 95 hospital separations for Campaspe residents who had alcohol-related conditions or injuries (not necessarily as the major diagnostic category) and this figure made up 0.52% of all separations for Campaspe residents. Compared to Victoria, there was a slightly higher proportion of separations for Campaspe residents who had alcohol-related conditions or injuries .

There were 72 hospital separations for Campaspe residents who had a drug-related condition or injury (not necessarily as the major diagnostic category) and this figure made up 0.40% of all separations for Campaspe residents. Compared to Victoria,

there was a slightly higher proportion of separations for Campaspe residents who had a drug-related condition or injury.

Note: Figures include both separations where alcohol or drug consumption was the primary diagnosis and admissions where alcohol or drug consumption was considered *relevant to the primary diagnosis* (e.g. intoxicated person falling out of a tree and breaking a leg).

People Treated for Alcohol or Drug Problem During Episode of Care (2010/11)

	Campaspe		Victoria
	No.	*% of all admissions*	*% of all admissions*
Alcohol problem	95	0.52	**0.49**
Drug problem	72	0.40	**0.37**

Source: Victorian Admitted Episode Dataset (VAED) 2010/11 (Public and Private Hospital files)

Emergency Department Presentations for Drug or Alcohol Problems

In 2010/11, there were 56 hospital Emergency Department (ED) presentations for Campaspe residents who had an alcohol problem *as the primary diagnosis* and this figure made up 0.42% of all ED presentations for Campaspe residents. Compared to Victoria, there was a lower proportion of ED presentations for Campaspe residents who had an alcohol problem *as the primary diagnosis* .

In 2010/11, there were 25 hospital Emergency Department presentations for Campaspe residents who had a drug problem *as the primary diagnosis* and this figure made up 0.19% of all ED presentations for Campaspe residents. Compared to Victoria, there was a lower proportion of ED presentations for Campaspe residents who had a drug problem *as the primary diagnosis*.

ED Presentations Treated for Drug or Alcohol Problem (2010/11)

	Campaspe		Victoria
	No.	*% of all admissions*	*% of all admissions*
Alcohol problem	56	0.42	**0.53**
Drug problem	25	0.19	**0.22**

Source: Victorian Admitted Episode Dataset (VEMD) 2010/11 (Public Hospital files) – commissioned data

Drug and Alcohol Clients

In 2009/10, Campaspe had a higher rate of population (6.3) that had received treatment from drug and alcohol treatment services in that year, compared to Victoria (5.3). Figures refer to the number of individuals and not the completed courses of treatment.

Drug and Alcohol Clients per 1,000 Population (2009-10)

Campaspe	Victoria
6.3	**5.3**

2010 Local Government Area Statistical Profiles, DoH 2011

Alcohol Related Harm

Between 2002/03 and 2003/04, Campaspe residents were more likely, compared to the Victorian figures, to have been involved in an alcohol-related family incident, serious road injury or death.

Alcohol-related Assault and Injuries per 10,000 Population (2002/03 – 2003/04)

	Assault		Family incidents		Serious road injury		Medical hospital admissions**		External cause hospital admissions#		Deaths	
	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*
Campaspe	62	8.4	124	16.9	27	3.6	74	20.0	58	15.8	28	2.4
Victoria	**9,445**	**9.7**	**15,46**	**15.8**	**3,346**	**3.4**	**13,23**	**26.9**	**7897**	**16.1**	**2,879**	**1.5**

*The Victorian Alcohol Statistics Handbook Volume 7 (Turning Point Alcohol and Drug Centre - 2005) * per 10,000 ** Alcohol-related 'medical' hospital admissions are typically those associated with long-term heavy alcohol consumption such as stroke, hypertension, cancer, and mental and behavioural disorders due to the use of alcohol. #'External cause' hospital admissions are those hospital admissions where environmental events, circumstances and conditions have resulted in poisoning, injury or other adverse effects. They include road injuries, alcoholic beverages poisoning, fall injuries, suicide, assault and child abuse. Figures do not include emergency department presentations where patient is not admitted*

Policy Review:

Legislation

Severe Substances Dependence Treatment Act 2010
"The Severe Substances Dependence Treatment Act (SSDTA) 2010 provides for court-ordered detention and treatment of people with a severe substance dependence where this is necessary as a matter of urgency to save their life or prevent serious damage to their health" [27]

Drugs, Poisons and Controlled Substances Act 1981 and the Drugs, Poisons and Controlled Substances Regulations 2006 [54]
For licenses and permits for schedule 8 medications

Data Collection

The National Drug Strategy Household Survey (NDSHS) 2013 outlines current trends and use. Collecting information on alcohol and tobacco consumption, and illicit drug use, it surveys people's attitudes and perceptions relating to tobacco, alcohol and other drug use. The Survey is conducted amongst the general population and the findings relate mainly to people aged 14 years or older [20].
Multiple other data sets and sources are available and listed at the Department of Health [35]

National Strategies

The National Drug Strategy (NDS)
The National Drug Strategy (NDS) 2016-2025 is currently under development by the Intergovernmental Committee on Drugs (IGCD). The Draft NDS[18] is open for public consultation at the time of writing. The Draft NDS outlines its aim to "contribute to ensuring safe, healthy and resilient Australian communities through minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities"[18]. Once finalised, the 2016-2025 NDS will provide a framework to guide actions by governments, communities and service providers to minimise drug and alcohol related harms. This ten year term has a commitment to harm minimisation, addressing;

- Demand reduction
- Supply reduction
- Harm reduction

This approach is underpinned by key principles of partnership, coordination and collaboration, evidence informed responses with national direction and jurisdictional implementation[18].
Priority populations are as listed, including; Aboriginal and Torres Strait Islander people; people with a mental illness; young people; older people; people in contact with the criminal justice system; culturally and linguistically diverse populations; and people who identify as gay, lesbian, bisexual, transgender or intersex [18].
Sub-strategies sit under the National Drug Strategy 2016-2025, and they include;

- National Aboriginal and Torres Strait Islander Peoples Drug Strategy
- National Alcohol Strategy
- National Tobacco Strategy
- National Illicit Drugs Strategy[18]

The most recent publication on the outcomes of the 2010-2015 NDS are contained in the 2013-14 Report, outlining the following future priorities;

- Development of the aforementioned National Drug Strategy 2016-2025
- Alcohol-related injury, violence and harms
- Preventing Fetal Alcohol Spectrum Disorder and reducing alcohol consumption during pregnancy
- Responding to changing patterns of alcohol advertising, promotion and sponsorship activity and changing patterns and trends in alcohol access and availability
- Implementation of the New Psychoactive Substances Framework
- Responding to increasing drug overdose trends
- Developing a reporting framework and baseline report to inform reporting of the ten outcome indicators under Part Seven of the National Tobacco Strategy 2010-1816 (see below)
- Methamphetamine Use [17]

The National Aboriginal and Torres Strait Islander Peoples Drug Strategy [39]

The National Aboriginal and Torres Strait Islander Peoples Drug Strategy 2014-2019 as a sub-set of the NDS is as this community experiences a disproportionate amount of harm from alcohol and other drugs, contributing a significant role in the difference in life expectancy[39]. Consistent with the NDS, it has the three pillars of supply reduction, harm reduction and demand reduction [39]. Principles of ownership of solutions, holistic and safe, competent and respectful cultural approaches, whole-of-government partnerships and provision of resources on the basis of need [39]. Four priority areas are identified;

- Build capacity and capability of the AOD service system, particularly Aboriginal and Torres Strait Islander community-controlled services and its workforce, as part of a cross-sectoral approach with the mainstream AOD services to address harmful AOD use.
- Increase access to a full range of culturally responsive and appropriate programs, including prevention and interventions aimed at the local needs of individuals, families and communities to address harmful AOD use.
- Strengthen partnerships based on respect both within and between Aboriginal and Torres Strait Islander peoples, government and mainstream service providers, including in law enforcement and health organisations, at all levels of planning, delivery and evaluation.
- Establish meaningful performance measures with effective data systems that support community-led monitoring and evaluation.

Each priority area has outcome and example actions associated with the priority, however, the diversity of the population acknowledged, and the strategy does not intend to be prescriptive [39].

The National Alcohol Strategy

The National Alcohol Strategy 2016-2025 is being developed and is being undertaken by the IGCD under the formation of their NDS 2016-2025.

Responding to the Impact of Fetal Alcohol Spectrum Disorders (FASD) in Australia: A Commonwealth Action Plan 2013-4 to 2016-7 aims to work in the following areas;

- Enhancing efforts to prevent FASD
- Secondary prevention targeting women with alcohol dependency
- Diagnosis and management, with the development of a FASD Diagnostic Tool
- Targeted measures supporting prevention and management of FASD within Indigenous communities and families in areas of social disadvantage
- National coordination, research and workforce support [33]

The National Tobacco Strategy

The National Tobacco Strategy 2012–2018 16 is a policy framework for the Australian Government, and State and Territory Governments to work with non-government agencies to reduce the burden of tobacco-related harm in Australia. The goal of the strategy is to improve the health of Australians though reducing the smoking rate, and the health, social and financial costs associated with tobacco use. It outlines the size of the problem, the policy context, the challenges, goals, targets and nine priority areas.

The National Tobacco Indicators Baseline Data: Reporting under the National Tobacco Strategy 2012–2018 outlines these, with the goals of the Strategy, acknowledging the social determinants of health [48]

The National Illicit Drugs Strategy

The National Ice Action Strategy will be a key component complementing the NDS 2016-2025, which, as previously mentioned, is under development. The National Ice Taskforce developed in 2015, delivered its Final Report with multiple recommendations across five priority areas, which are, as outlined in the Ice Action Strategy 2015;

- Support families, communities and frontline workers
- Target prevention
- Tailor services and workforce
- Strengthen law enforcement
- Data, research and reporting 19, 34

Victorian Context

Reducing the Alcohol and Drug toll: Victoria's Plan 2013-2017 - Strategy

This policy outlines a 15 point action plan to "promote the safe, healthy and responsible use of alcohol, tackle the misuse of pharmaceutical drugs, reduce illegal drug use, and assist the care, treatment and recovery of people with drinking and drug problems" pp 3, 44 .

It aims to do so by addressing the following;

- Alcohol
    - Reducing alcohol-related violence, antisocial behaviour and drink-driving
    - Effective liquor regulation
    - Changing drinking culture
    - Better health promotion in education
    - Better, earlier healthcare for alcohol problems
- Pharmaceutical drugs
    - Better controls and evidence on misused pharmaceutical drugs
    - Improved clinical, prescribing and dispensing practices
- Illegal drugs
    - Strong laws to protect the community from drug trafficking
    - Better referral of drug users to treatment
    - Improved harm-reduction services and targeted prevention
- Care, treatment and recovery
    - New directions in alcohol and drug treatment services
    - Better person-centred care through social services, especially for vulnerable families
    - Community-based action on social factors driving substance misuse
    - Promoting successful recovery and reducing stigma in the community
- Leadership
    - Leadership to reduce the toll

The Victorian Public Health & Wellbeing Plan (2015-2019)

The Plan outlines the government's key priorities over the next four years to improve the health and wellbeing of all Victorians, particularly the most disadvantaged. The health and wellbeing priorities for 2015-19, relevant to Drug and Alcohol are:

- Priority 2. Tobacco-free living – Strategic Direction
    - Continue to further reduce smoking rates with the ultimate aim of achieving a tobacco-free Victoria.
    - Continue legislative and non-legislative approaches to tobacco reform, such as smoking cessation support, in order to continue the downward trend in smoking rates.
    - Focus on smoking cessation support at the community level (via hospitals, GPs and community health services).
    - Target smoking cessation measures for those groups with

disproportionately high smoking prevalence, particularly Aboriginal Victorians.

- Priority 3. Reducing harmful alcohol and drug use - Strategic Direction
    - Develop strategies across government to reduce the risk of short-term harms due to the misuse of alcohol, and minimise the chronic health problems associated with long term unhealthy drinking patterns.
    - Continue to address the impacts of illicit drug use, for example, through the Ice action plan.
    - Develop a Victorian pharmaceutical misuse strategy and education program to reduce problematic use of prescription medications.
    - Improve alcohol and drug education in schools and access to early intervention services for people with alcohol and drug use issues.

Local Government Area

Shire of Campaspe Health and Wellbeing Plan 2013-2017 [51]

- Reducing the impact of alcohol and other drugs
- Reducing Tobacco Use.

Clinical Guidelines:

Effective structural policy or strategies are often hard to implement due to political or economic factors[6] – this includes limiting outlet density, trading hours and increasing cost [5]

- NHRMC approved Guidelines for the Treatment of Alcohol Problems[12]
- NHRMC approved Australian Guidelines to Reduce Health Risks from Drinking Alcohol [10]
- National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn (NSW Health) [32]
- Pharmacotherapy National Clinical Guidelines for Medication-Assisted Treatment of Opioid Dependence – approved by SCoH and released May 2014 [17]
- Guidance for cultural competence for antenatal smoking cessation in ATSI (research paper) [28]
- Supporting smoking cessation: a guide for health professionals (RACGP)[31]
- Guidelines for screening, assessment and treatment in problem gambling[45]
- Central Victoria Region Mental Health Service Pathways [46]
- Alcohol Related Brain Injury Guide – General Practitioners and other Health Workers
- National Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opoid Dependence [53]

Evidence based strategies/ Intervention evidence:

Protection and Health Promotion:

'Policymakers who focus only on decisions about individual service programmes will usually find that they have limited impact on the outcomes they wish to produce. In contrast, policymakers who think and act at a systems level, and do so in light of the emerging evidence based on the nature and impact of systems, have a much greater likelihood of making a significant contribution to ameliorating drug problems at both the individual and population level'[6]

- Encouraging the general public to adopt healthier lifestyles with information (alcohol consumption guidelines[10] - National Health and Medical Research Council). There is evidence to suggest that most Australians are not aware of the existence of these guidelines, or they are unsure about the thresholds, which are often dismissed as unrealistic, are misunderstood, or regarded as irrelevant [5, 11]
- Education alone (community-based or school based) in indigenous community leads to positive change in initiation rates, but not consumption rates [29]
- Community based approaches to reduce consumption [38]
- Examples such as the "Hello Sunday Morning" movement towards a better drinking culture.
- Protect public health policy, including tobacco control policies, from tobacco industry interference
- Continue to reduce the affordability of tobacco products
- Bolster and build on existing programs and partnerships to reduce smoking rates among Aboriginal and Torres Strait Islander people
- Strengthen efforts to reduce smoking among populations with a high prevalence of smoking
- Eliminate remaining advertising, promotion and sponsorship of tobacco products
- Consider further regulation of the contents, product disclosure and supply of tobacco products and alternative nicotine delivery systems
- Reduce exceptions to smoke-free workplaces, public places and other settings
- Provide greater access to a range of evidence-based cessation services to support smokers to quit.

- Strengthen mass media campaigns to: motivate smokers to quit and recent quitters to remain quit; discourage uptake of smoking; and reshape social norms about smoking.
- Advocate for reduced density of alcohol outlets – The availability of alcohol has a direct correlation with consumption/dependency – see [18]

LOCAL CONTEXT: Echuca Moama Community Against Drugs; Rochester and Elmore District Health Service ICE project.

WORKSHOP DISCUSSION: Consideration to be given to alcohol outlet density across Campaspe.

Illness Prevention

Screening

- Smoking status and interest in quitting should be assessed for every patient over age 10 years[3] and offered smoking cessation advice[4]
- Screening for risk levels of alcohol consumption and appropriate intervention systems should be widely implemented in general practice and emergency departments[12]
- General Practice (and primary care settings) are an ideal place to screen for alcohol consumption (AUDIT, AUDIT-C) [5,40]. They are also the setting to provide brief interventions which have been shown to be effective - one 5-minute intervention can reduce harmful alcohol consumption by nearly one-third [5,40,9]
- Under-screening: in routine general practice that lacks specific screening techniques, up to 70 per cent of risky and/or high risk drinkers are not detected, and typically only 25 per cent of admitted hospital patients with alcohol use disorders are detected[12]
- All patients should be asked about the quantity and frequency of alcohol intake from age 15 years[7]. Brief advice to reduce intake for those with at-risk patterns of alcohol consumption should occur[7,8]
- Use of validated screening tools, especially with dual Mental Health and AOD diagnosis [1]
- Use of the DHHS suite of screening tools [50]
- Indirect biological markers (liver function tests or carbohydrate-deficient transferrin) should only be used as an adjunct to other screening measures as they have lower sensitivity and specificity in detecting at-risk people than structured questionnaire approaches (such as AUDIT) [12].

- People with high risk gambling problems, including those presenting for assessment or treatment of these problems should be screened for other problems, including mental health, alcohol and drug dependence [45].

WORKSHOP DISCUSSION: What screening opportunities could be applied?

Primary Care/Secondary Care Tertiary Care/Quaternary Care:

Brief Interventions

Early and brief interventions (BI) for ATOD [1], motivational interviewing may assist people to quit smoking[13], overall, BIs lower alcohol consumption[15]. Brief interventions may suit some young people drinking excessively and/or experiencing alcohol-related harms [12]

- Literature supports that few Victorian providers report proactive AOD BI delivery[9] – client, system and program level barriers exist.
- Brief interventions should be implemented in emergency departments and trauma centres; in general practice and other primary care settings [12]. Brief interventions may consist of the five components of the FLAGS acronym: feedback, listening, advice, goals, and strategies (or equivalent). Brief interventions are effective in reducing alcohol use in people with risky pattern of alcohol use and in non- dependent drinkers experiencing alcohol-related harms and should be routinely offered to these populations [12]
- Motivational interviewing (used as a first-line or stand-alone treatment, or as an adjunct to other treatment modalities in addressing patient's ambivalence to change their drinking or other behaviours), cognitive behavioural and family therapies (including behaviour couples therapy) have been shown to be of benefit in reducing alcohol and other drug use and related harms [12]

WORKSHOP DISCUSSION: Brief Interventions – scope for application in Campaspe; what barriers does this present?

Multidisciplinary Approaches – Engagement with Community Sector

- Behavioural support for those using pharmacotherapy with NRT (Tobacco) has a small but important effect[2]
- It has been found that the strongest treatment predictors of abstinence "are completion of the index treatment, a treatment journey including residential rehabilitation and involvement with mutual aid groups" pp vx [38] Mutual aid groups are often recommended as an adjuvant to treatment [5, 41]. Psychosocial interventions such as motivational interviewing and cognitive behavioural therapies are important and effective elements in the management of alcohol dependence [43]

- Promote the importance and benefit of accessing AOD treatment and strengthen pathways into treatment, workforce models that enhance rates of treatment completion and continuity of care [38]
- Active engagement with individuals with meth/amphetamine use into treatment [38]
- Encourage services in the assertive follow up of clients [38]

Workforce

- Documented low uptake of the General Practitioner prescribing of pharmacotherapy is in part likely to be due to the lack of access to specialist support, lack of practical application, resulting in low confidence in prescribing pharmacotherapy and managing alcoholism [5]
- Stigma associated with diagnosis, gender (females less likely to receive treatment), shorter consultations, self-perceived skills and scepticism about the benefit of treatment[7]
- Despite significant investment to increase GP detection and intervention for lifestyle risk factors, accurate detection of smoking, risky alcohol consumption and overweight and obesity occurs for less than two-thirds of all patients [52]

WORKSHOP DISCUSSION: Is access to specialist services adequate for the Campaspe area?

Service Availability

- Increase availability of rehabilitation places and reduce the waiting list for long-term residential care [38]
- Care coordination [38] – supports to this is the Victorian Service Coordination Framework [46]
- Specialist AOD services should develop and promote interventions and pathways to aftercare, noted for alcohol-dependent clients, and efforts to have pathways tailored to make use of community services, mutual aid/support and aftercare [38]
- AOD treatment is a good investment. For every $1 invested in alcohol or drug treatment, society gains $7 (Ettner et al., 2006 in Ritter et al, 2014 [42]). AOD treatment has been shown to:
    - Reduce consumption of alcohol and other drugs
    - Improve health status
    - Reduce criminal behaviour
    - Improve psychological wellbeing
    - Improve participation in the community [42]

Tertiary Care/Quaternary Care

Guidelines **For Treatment of Alcohol12**

See all evidence-based approaches on pp vii-xix of the, those listed below are the highest evidence base.

- Pharmacotherapy should be considered for all alcohol-dependent patients, in association with psychosocial supports.
- Antipsychotic medications should be used to control agitation of alcohol withdrawal as an adjunct to (not instead of) adequate benzodiazepine doses.
- Benzodiazepines should be used to achieve light sedation. Oral diazepam or lorazepam loading until desired effect is the treatment of choice. Intravenous diazepam or midazolam is appropriate if rapid sedation is needed.
- Anticonvulsants are not effective in preventing further seizures in the same withdrawal episode.
- Loading with benzodiazepines (diazepam, lorazepam) and close monitoring for at least 24 hours is recommended after an alcohol withdrawal seizure.
- Chlormethiazole, barbiturates, alcohol, beta-blockers, clonidine and gamma-hydroxybutyric acid (GHB) are not recommended in the routine management of alcohol withdrawal.
- Antipsychotic medications should only be used as an adjunct to adequate benzodiazepine therapy for hallucinations or agitated delirium. They should not be used as stand-alone medication for withdrawal.
- There is no benefit in adding anticonvulsants to benzodiazepines to manage alcohol withdrawal.
- Phenytoin and valproate are not effective in preventing alcohol withdrawal seizures and are not recommended.
- Carbamazepine is safe and effective as an alternative to benzodiazepines, although it is not effective in preventing further seizures in the same withdrawal episode.
- Benzodiazepines are the recommended medication in managing alcohol withdrawal. In Australia, diazepam is recommended as 'gold standard' and as first-line treatment because of its rapid onset of action, long half-life and evidence for effectiveness.
- Alcohol withdrawal scales (CIWA-Ar, AWS) can be used to assess withdrawal severity, to guide treatment (such as symptom-triggered medication regimens) and to aid objective communication between clinicians; but should not be used as diagnostic tools.
- Successful completion of alcohol withdrawal does not prevent recurrent alcohol consumption and additional interventions are needed to achieve long-term reduction in alcohol consumption.

Strategies and evidence outlined in the National Drug Strategy (NDS)

The NDS 2016-2025 (draft) states that evidence informed approaches to address **demand reduction** include;

- Treatment
- Build community knowledge and change acceptability of use
- Restrictions on promotion
- Price mechanisms
- Diversion
- Targeted approaches to priority populations, including Aboriginal and

Torres Strait Islander people
- Social determinants of Health
- Workforce - see strategies on pp 14-5 [18]

LOCAL CONTEXT: "Breakthrough Training" offered at Echuca Regional Health by Turning Point is a good local example.

The NDS 2016-2025 (draft) states that evidence informed approaches to address **supply reduction** include**;**
- Regulating retail sale
- Age restrictions
- Border control
- Regulating or disrupting production and distribution
- Supporting workers at the point of supply
  - Examples: alcohol - bottle-shops, hotels, restaurants, festivals, clubs; tobacco – service stations, supermarkets, tobacco speciality stores;
- Supporting prescribers and dispensers
  - *Examples: strategies to identify methamphetamine use*
- Enforcing legislation
- Intelligence
- Workforce – see strategies on pp 19-21 [18]

The NDS 2016-2025 (draft) states that evidence informed approaches to address **harm reduction** include**;**
- Safer settings
  - *Australian Drug Foundation promotes the Good Sports Program and their Workplace Services supports workplace based programs, education and corporate events. Youth Drug Alcohol service schools based activities.*

- Replacement therapies
  - *Campaspe: Methadone accessible at Echuca Primary Care Clinic, Echuca AMCAL Pharmacy,*
  - *Campaspe: Buprenorphine accessible at Tongala Pharmacy.*
  - *Campaspe: General Practitioners at Echuca Primary Care Clinic*

  LOCAL CONTEXT: Echuca Regional Health provides a Pharmacotherapy clinic with the support of local GPs and pharmacies. Tongala Pharmacy also able to administer.

- Safe transport and sobering up services
- Diversion

  LOCAL CONTEXT: Echuca Regional Health provides Drug Diversion Program

- Blood borne virus prevention
  - *Needle syringe exchange programs*

    LOCAL CONTEXT: Campaspe: needle exchange programs are at Echuca Regional Health, Kyabram District Health Service and Rochester Elmore and District Health Services, Weller & Barlow Pharmacy, Shire of Campaspe depots in towns

- Safe injecting practices *such as the Harm Reduction Victoria Peer Network Program [56] which is planning to expand into regional areas*
- Periods of increased risk
- Reduce driving under the influence of alcohol and other drugs

  LOCAL CONTEXT: Campaspe: Drink Driver Program at Echuca Regional Health

- Workforce.

Programs and Services:

Current local service access

The Victorian Department of Health and Human Services outlines that treatment for alcohol and other drugs is delivered through "treatment streams" within each catchment area, and for Campaspe, this being the Loddon Mallee catchment area. The treatment streams include;

- Intake
- counselling,
- Withdrawal (residential and non-residential),
- Rehabilitation (residential and therapeutic day rehabilitation)
- care and recovery coordination,
- youth services,
- aboriginal services, and,
- pharmacotherapy[21]

Access to services:

Cost is generally free, however, some residential services may incur a fee.

Referral can be self-referral, or facilitated by a service provider, and occurs through one of two avenues;

- 1. DirectLine, which is also an information portal for health professionals, and counselling service. Contact to this service is by a 1-800 number, or website. It is operating 24hrs/7days/week. Its website offers the online screen which can be completed [27].
- 2. Access treatment through local intake and assessment providers[21] - for the Loddon Mallee Catchment, this is Australian Community Support Organisation (ACSO) - Loddon Mallee[37]. Clients may access AOD treatment outside of their residential catchment boundaries[27].
    - Contact to this service is through email, or a 1-300 number Monday to Friday, 9am-5pm. Voicemail is available after hours.
    - Catchment coverage:
        - Hub - 28 Pall Mall, Bendigo
        - Satellite coverage: Mildura and Swan Hill
        - In-reach services co-located in: Echuca, Robinvale, Maryborough, Castlemaine and Kyneton
    - Referral by a health professional to this service can occur through a e-referral form on their website.
    - An "Self Complete Initial Screen for Alcohol and Other Drugs"[22] is available on their website, and contains initial needs identification, and validated screening tools (ASSIST, AUDIT, DUDIT, K10).
        - This Screener states that where drug or alcohol issues are identified by those agencies using the Service Coordination Tool Templates

"Single Page Screener of Health and Social Needs", this should trigger use of the "Self Complete Initial Screen for AOD"[22]

- This Screener is requested by ACSO to be downloaded, filled in online (or scanned) and emailed.
- ACSO has written intentions to explore secure messaging with reporting that the are registered with S2S and exploring interoperability with ConnectingCare[23] – to date, they are not listed on ConnectingCare, and while Central intake is on S2S, this is unable to be accessed by Camapspe users.

Service Eligibility - "Intake and assessment providers offer services to people aged 16 years and older. Young people aged up to 25 years must also be offered the choice to attend a youth specific AOD service, as appropriate. There is no upper age limit in place for AOD services" [27]

Priority - "Priority for alcohol and drug treatment services will be given to people identified with significant issues regarding risk and/or life complexity. Those at highest priority will typically be complex clients screened at Tier 5.
Consideration of priority should also apply to people who:

- have dependent children who are reliant on them for their safety and wellbeing
- are in contact with the justice system, particularly those referred to treatment by courts, corrections, police or parole boards
- have a history of long-term homelessness
- are Aboriginal8
- have a co-existing intellectual disability or acquired brain injury; and/or
- have a mental illness" [27], pp10

Screening processes - Wherever possible, screening should not be duplicated at intake and assessment [27]

Other Services - Community Offenders Advice and Treatment Service (COATS) - ACSO continues to undertake the majority of intake for these consumers [27]. Drug Diversion Appointment Line (DDAL) - referrals from Victoria Police [27]

Care Recovery and Coordination – where a key worker from Partners In Recovery/Services Connect is in place and providing support (a holistic model which intends to reconnect the client with family and the community sector after formal treatment ends [38]), they will take the lead role [27]
Family Supports – depending on needs, referrals should be made to generalist counselling, and support and/or peer groups, programs and forums where available [27]Waitlist Support [27].

Current service access – what is available locally/regionally/ city

Non-Residential Withdrawal

Non-residential withdrawal services are one of the treatment streams for people who require alcohol and other drug treatment in Victoria. Non-residential withdrawal involves a clinical withdrawal assessment and withdrawal treatment in the person's home or at an alcohol and other drug treatment service or in association with a rural hospital. Withdrawal services also provide referral and information face to face and by telephone.

Residential Withdrawal

Nova House (Bendigo) - Bendigo Community Health Service (21+yrs)[25]

LOCAL CONTEXT: Rochester and Elmore District Health Service currently receive funding for the Rural Drug Withdrawal program and support acute/hospital based alcohol detox/withdrawals. Kyabram District Health Service were supporting acute/hospital ICE withdrawal however have reassessed due to risks and will no longer provide this service. Presentations to Emergency Department at Echuca Regional Health for drug and alcohol affected persons is significant.

Non-Residential Rehabilitation

- Campaspe
    - Bendigo Health Aged Persons Mental Health Service (65yrs+)
- Other areas
    - Catalyst AOD Rehabilitation Program (Coburg) – ReGen/Uniting Care (18yrs+)

Residential Rehabilitation

- Campaspe
    - None available
- Other areas
    - North West Metro Area
        - Odessey House Circuit Breaker Residential (near Benella) - Odessey/Uniting Care ReGen [24]
        - Odessey House (Lower Plenty) - Odessey/Uniting Care ReGen
    - Hume Region
        - Goulburn Valley Withdrawal Service (Shepparton)[36]
        - Odessey House (Shepparton) [36]
    - Loddon Mallee Region Area
        - Connect Transformations Bendigo (Bendigo) - Connect Transformations/Connect Church [25]
        - Teen Challenge Inc (Kyabram) - Teen Challenge Victoria (16yrs+)[36]
        - Bendigo Bridge Program (Bendigo) - The Salvation Army (18-30yrs)[36]

Treatment under the Severe Substances Dependence Treatment Act 2010

- St Vincent's Health (Melbourne)[27]

24 Residential Rehabilitation – Indigenous Support

- Baroona Healing Centre (Echuca)
- Yitjawudik Mens Recovery Centre (Toolamba)[36]

Community Services

- Echuca Regional Health's Alcohol and Other Drug Services (AOD) - Echuca [36]
- Rochester Elmore and District Health Services – Alcohol & Withdrawal Worker – Rochester
- Odesesey House/Uniting Care ReGen, the AOD Service Provider for the North & West Metro, provides community services at Odyssey Care and Recovery and Counselling – Shepparton **[24]**
- Northern District Community Health Service – Cohuna, Pyramid Hill, Kerang, Boort [36]
- Primary Care Connect – Shepparton [36]
- Bendigo Community Health Services – Bendigo, Kangaroo Flat [36]

Youth

- headspace – Shepparton, Bendigo, Swan Hill [36]
- YSAS: Youth Support and Advocacy Services [36]

Mutual Aid Services

- Alcoholics Anonymous – Echuca, Kyabram, Tongala
- Other services such as Salvation Army, St Vincent de Paul etc.

Helplines

- Information lines/Websites for **Health Professionals**
  Directline
  Drug and Alcohol Clinical Advisory Service (DACAS) – Turning Point Clinic

- Information lines for **families**
  Family Drug Helpline
  Counselling On Line

- Information lines for **women**
  Directline
  HealthDirect Australia
  Pregnancy Birth and Baby Helpline

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