Victorian Alcohol and Drug Association
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Victorian state disability plan 2017-2020
Office for Disability
Department of Health and Human Services
50 Lonsdale Street
GPO Box 4057, Melbourne 3000

5 July 2016

To: the Office for Disability,

Response: Victorian state disability plan 2017 - 2020

The Victorian Alcohol and Drug Association (VAADA) welcomes the opportunity to contribute to the next iteration of the Victorian Disability Action Plan (2017 – 2020). We note that this plan will be active during a transformational period for the disability sector, with the roll out of the NDIS throughout not just Victoria but nationwide. There is much work to be done in ascertaining the impact of this and ensuring that the interface between the NDIS and the community services sector is both seamless and coordinated. Our contribution to this review will be reflective of our role as peak body for the Victorian alcohol and other drug (AOD) sector.

Our response reflects on the relatively scarce available data to highlight both challenges, system-wide deficits and at risk populations. The data available identifies the issues with regard to individuals with disability engaging and remaining in AOD treatment and a heightened risk of harms within subpopulations of this cohort, including engagement with the justice system.

Meeting demand for AOD treatment among individuals with disability

There is an absence of population based data available on the nexus between AOD and broadly, disability (McGillivray and Newton 2016), with the data available only reflecting on various trends apparent with certain types of disability. Of the data available, there are indications that substance 'use' is less prevalent among those experiencing intellectual disability (ID) when compared to the general population. However, there are heightened risks among adults with ID engaging in substance 'abuse' (McGillivray and Newton 2016) and potentially greater harms. This highlights the need to foster responses which can address the challenges evident in working with a vulnerable cohort who may not necessarily engage with the various support services and in many cases, it may be evident that these services may not retain the capability to cater for these individuals.

McGillivray and Newton (2016) highlight a link between AOD use and offending behaviour among individuals experiencing ID and note that this cohort is over-represented in the justice system. They continue, citing international research which indicates that many of the treatment services lack the capacity to deliver optimal interventions to this cohort and, perhaps as a consequence, individuals with ID and AOD issues are less likely to remain in treatment (McGillivray and Newton 2016; Chapman and Wu

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2012). This may be due to difficulties in coping with the demands of treatment services, and consequently becoming disillusioned by the process (McGillivray and Newton 2016). It is evident that there is a need to enhance the capacity of the AOD treatment sector to be able to better cater for the treatment needs of individuals with disability, from ensuring that physical amenities of all facilities are readily accessible to ensuring that the treatment provided aligns with best practice in working with individuals with disability.

We note that there is a co-occurrence of AOD use and acquired brain injuries (ABI), with two thirds of individuals presenting with a 'trauma' related ABI being intoxicated at the time of injury (ADF 2016). We also note that harms associated with AOD use can result in disability, for instance with the occurrence of an acquired brain injury resulting from a non-fatal overdose (ARBIAS 2016). It is evident that high risk AOD use increases the risk of experiencing an ABI. Also, it is evident that individuals with an ABI may experience additional challenges through at risk AOD use in a manner similar to individuals with an ID.

McGillivray and Moore (2001) note that individuals with ID have less awareness of the effects of excessive AOD use in comparison to the general population, highlighting a need to enhance both prevention and harm reduction activities related to AOD.

There is an ongoing need for the AOD sector to enhance its' capacity to provide optimal service to individuals experiencing disability. More broadly, this strategy should provide leadership in delivering a joined up service response to vulnerable individuals with disability who experience AOD dependence. The strategy should also provide support to build the capacity of the AOD sector to optimise service delivery to individuals with disability with a view to increasing the rate of treatment completion and therefore the efficacy of the treatment provided.

Additionally, this strategy should provide for the development of public health and prevention campaigns targeting individuals with disability who may be at risk of harmful AOD use. Careful, evidence informed and tailored harm reduction endeavours should also be supported by this strategy.

Stigma and discrimination – barriers to social connectedness and AOD treatment

We note that AOD dependence occurring among those experiencing disability can further exacerbate a sense of social exclusion and stigma. Individuals experiencing disability experience discrimination and a reduced sense of social connectedness (Family and Community Development Committee 2014), as well as a broad range of adverse social determinants as noted in the Discussion Paper (Victorian Government 2016). The Companion Paper (Victorian Government 2016a), reflecting on Victorian Equal Opportunity and Human Rights Commission (VEOHRC) data, notes that disability discrimination generates the largest single number of complaints. Similarly, individuals with AOD dependence and engaging with treatment services also often experience stigma, marginalisation (Room 2005). Marginalisation and stigma can engender significant impediments to service access resulting in poorer health and social outcomes, especially if it is occurring within a cohort already experiencing high levels of disadvantage.

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This strategy should seek to ameliorate the marginalisation and discrimination evident with individuals experiencing AOD issues with a disability through a range of means including public messaging and support of consumer organisations.

NDIS

There is a need to determine how the NDIS will impact upon demand for AOD treatment. Individuals experiencing comorbid AOD and mental health issues may not meet the eligibility criteria for the NDIS as their mental health condition might be deemed as periodic in nature rather than enduring. In such as case, they may be excluded from the NDIS and may not be able to access other services, effectively 'falling through the gaps'. It should be noted that large reforms and service system changes often experience teething issues, where there may be issues in accessing services while the new systems become established and embedded, and the providers become accustom to the new arrangements. In such cases, it may be possible that there is a shift in demand to the AOD - or other - sectors. It is crucial that this shift in demand is identified and assessed, with resourcing commensurate to the increase in demand applied to relevant sectors, including AOD.

This strategy should provide for the oversight of the implementation and application of the NDIS with regard to how it impacts upon the demand for other service sectors. Service gaps which emerge in light of the NDIS should be identified and addressed.

We appreciate the opportunity to provide feedback on the discussion paper and look forward to the development of the next iteration of this strategy.

Should you have any queries, please contact the undersigned on 9412 5600.

Sincerely,

Sam Biondo
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Victorian Alcohol and Drug Association

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