VICTORIAN ALCOHOL & DRUG ASSOCIATION

State Budget Submission

2018/2019

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).

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Executive Officer's review

Over the past year there has been considerable funding activity related to a number of issues VAADA has advocated for in recent state budget submissions. We highly commend the commitment by Government in seeking to address a number of these issues, which have been priorities for the Victorian AOD sector.

Nevertheless, we need to recognise that overall the Victorian AOD treatment sector has endured chronic underfunding for many years. The chart on page nine of this report clearly identifies 'Health Output Funding for the period 2004-2017'. The inevitable observation which arises from this lack of funding is that significant service gaps have been created across a number of areas in the Victorian AOD system. As a result of this imbalance, a range of system dysfunctions have arisen. One amongst many issues created by this long term deficit - has been the creation of a fertile environment for the encroachment and proliferation of unregulated 'for profit' treatment facilities, many of which are not necessarily driven by quality care, but more so by client desperation.

While the sector continues to recalibrate after the 2014 sector reforms, the subsequent unwinding of certain initiatives such as centralised intake continues to absorb much time and effort. The brunt of much of this activity has been borne not just by the impact on clients and programs, but by the AOD sector 'specialist' workforce which is expected to either 'contract' and or 'grow' depending on the predilections of policy and program directions. As a result VAADA is clearly identifying workforce issues such as attraction, recruitment, retention, training and remuneration as issues of fundamental importance requiring increased attention and investment. Activity such as the Family Violence Royal Commission, changes in Child Protection and the forensic system as well as the pending real time prescription monitoring system all create additional demand and strain on the sector and highlight the need not just for additional investment to address increased demand pressure but also greater capacity building endeavour for this specialist workforce. Furthermore, workforce issues related to rural and regional AOD services, or Aboriginal focussed program activity continue to labour under significant strain and must be addressed.

As in previous years, the necessarily broad brushed approach taken by VAADA in this State Budget Submission, provides an insight to the many issues of concern to the Victorian AOD sector. Underpinning the themes and content of this submission is the need to provide timely access to AOD treatment for all Victorians. To this end, AOD treatment services need to be resourced to meet unavoidable demand. Such demand is directly impacted by broader welfare service system reconfiguration which impacts directly on the AOD sector both in terms of workforce, skills development and programmatic activity.

In this submission, we have identified a number of issues that require special attention. Some of these include: enhancing the 'care and recovery' model; enhancing work being undertaking on the AOD data system; mitigating the harms of Real Time Prescription Monitoring (RTPM); how to reduce AOD related Emergency Department presentations; improving access to AOD services in growth corridors; service access in rural and regional communities; better responses to older adults experiencing AOD issues; improving access pathways for CALD communities; increasing dual diagnosis capacity with additional addiction psychiatry resources; and continued work to addressing Residential Rehabilitation capacity issues.

Sam Biondo

Summary of recommendations

Recommendation 1: the value of a Drug Treatment Activity Unit (DTAU) be increased by 25 percent to account for currently unfunded out of pocket expenses. This increase should also be afforded to those services which are not covered by DTAUs including residential, Aboriginal and youth AOD services.

Recommendation 2: that the Government provide a recurrent $5,304,899 boost to the AOD sector for additional courses of 'Care and recovery coordination' to account for the needs of approximately 25 percent of all AOD service users.

Recommendation 3: That $150,000 be allocated to support the sector in the transition, development and utilisation of the new data systems which would be funded for two years from 1 July 2018.

Recommendation 4: The creation of a Specialist Data Analysis Unit to collate and analyse data and provide advice to agencies and government on a state wide basis through the allocation of $200,000 per annum as well as annually publish AOD data in a manner similar to *Victoria's Mental Health Service Annual Report*.

Recommendation 5: that the government provide $10M to the AOD sector to provide for the additional demand generated by the RTPM and rescheduling. This would also provide for necessary workforce development endeavours and the development of new innovative means of delivering positive treatment outcomes to identified cohorts.

Recommendation 6: that at a minimum an additional four addiction medicine specialists (AMS) and four pain management specialist (PMS) be resourced to cater for the increased demand associated with emerging high risk cohorts identified through the RTPM. It is anticipated that these specialists would work with associated service systems and providers to assist in addressing the needs of complex presentations as well as providing support to GPs and the AOD sector with the AMS also providing additional support to DACAS.

Recommendation 7: that AOD nurse consultants be employed in all Victorian hospitals to provide support, referral and advice to ED patients with accompanying AOD issues, supported by additional AMS capacity which should be determined through consultation with relevant stakeholders, including DACAS.

Recommendation 8: that major hospitals develop a step up/step down model of care which can fast track frequent AOD related ED patients to suitable in-house treatment or other local AOD treatment providers with capacity which will be supported by an addiction medicine specialist, a GP registrar and two AOD nurses.

Recommendation 9: That a recurrent sum of $3 million be made available to each interface region (Melton, Casey, Wyndham, Cardinia, Mitchell and Whittlesea, Yarra Ranges and the Mornington Peninsula) to enhance existing services or establish new services to address AOD related harms in line with rapid population growth and disadvantage.

Recommendation 10: That an additional $10 million is allocated annually to enhance AOD service access and capacity in rural and regional Victoria, prioritising areas identified by local AOD catchment based planning where there are challenges in service access, as well as high levels of morbidity and AOD related harms.

Recommendation 11: That a loading is applied to all rural and regional AOD staff of 10% above the relevant award to enhance recruitment and better retain quality staff.

Recommendation 12: A pilot outreach AOD treatment project should be developed to address the gap in AOD services for older adults throughout Victoria. The project should include outreach, project coordination, medical support coupled with resourcing for research and evaluation.

Recommendation 13: That resourcing is availed for bi-cultural workers to be situated within four AOD catchments in Victoria, supported by two project officers, to increase CALD community access to AOD services and build the capacity of these services to better cater for the needs of these communities.

Recommendation 14: An entity should be established to better co-ordinate training and enhance the attraction of staff to the sector. This entity would explore options for rapid accreditation of new AOD workers and identify areas for micro-credentialing as well as systems to support such training in relevant areas of high need. A central co-ordinating team of 2 staff possibly would be established to support existing RTO's and the enhanced workforce training and enhancement initiative.

Recommendation 15: That additional Addiction Psychiatry capacity be availed to DACAS at an estimated cost of $300,000 per annum to provide additional support to presentations related to co-occurring AOD and mental illness.

Recommendation 16: An additional $2 million allocated annually to an innovation fund to respond to changing needs, facilitate and encourage innovation and enhance the evidence base of the Victorian AOD treatment sector.

Recommendation 17: That the Victorian government develop a plan to direct the necessary increase in capacity of Victorian funded residential rehabilitation services through all of Victoria to lift capacity to a level in alignment with other jurisdictions in Australia. This will necessitate the development of approximately 200 additional beds over the five year period lifting the rate to 1 bed per 10,000 head of population. It is estimated that the operations cost of running these facilities will amount to approximately $70,000 per annum per bed.

AOD treatment: demand and capacity

This submission provides a number of cost effective initiatives which will reduce the harms associated with alcohol and other drugs (AOD) and respond to the increasing demands on the treatment sector. The elements contained herein are costed where possible and provide both a positive social and economic return for government and the broader community.

AOD issues facing the community are becoming increasingly challenging, with the community facing a wide array of entrenched and emerging high risk substances coupled with a rapidly evolving policy space.

Victoria is currently facing unprecedented population growth which is causing significant strain on various interface regions; aligned with the overall population growth is the expansion of various culturally and linguistically diverse (CALD) communities, some of which are experiencing significant AOD related harms yet not engaging with the treatment sector. The sector continues to undergo significant change, which, while deriving positive outcomes, creates some issues in service access as well as broader issues related to workforce recruitment, retention and remuneration; activity such as the Family Violence Royal Commission, changes in Child Protection and the forensic system as well as the pending real time prescription monitoring system. These each create additional demand and strain on the sector and highlight the need not just for additional investment as has been considered in some areas to address increased demand pressure but also greater capacity building endeavour for this specialist workforce.

Although there have been some welcome developments, rural and regional AOD services continue to labour under significant strain, facing challenges associated with workforce issues and the tyranny of distance.

The various issues raised in this submission have been determined through analysis of the VAADA annual priorities survey, which was administered to senior managers in the Victorian AOD sector during July - August 2017. A working group from the sector has been convened to provide further advice on the development of this submission. We have also consulted with specific experts, networks and groups within the sector on specific issues contained herein.

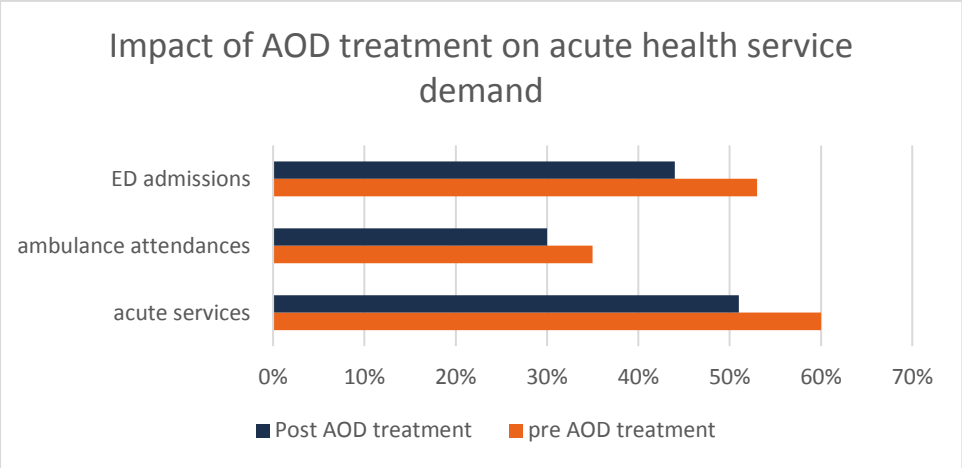
AOD treatment works and is cost effective

- AOD treatment provides a strong return on investment with evidence indicating that over a 12 month period, treatment provides a cost benefit ratio of $8 saved for every $1 spent (Coyne, White & Alvarez 2015);
- A large Australian treatment outcome study showed that individuals who accessed AOD treatment utilized less acute health services in the year after the treatment in comparison to the year leading up to the treatment:
    - Overall demand for acute services among those with AOD dependence issues decreased from 60 to 51 percent
    - ambulance attendances decreased from 35 to 29 percent; and
    - Hospital emergency admissions decrease from 53 to 44 percent (Manning et al, 2017)
    - AOD treatment reduces acute health service demand with a 16 percent reduction in research participants requiring ambulance, ED or hospital admissions in the year post treatment. Further, the authors assert that this is ‘likely to reflect a substantial reduction in health care costs’.

- Evidence indicates that AOD residential rehabilitation is more cost effective than prisons, with the diversion of Aboriginal people to rehabilitation programs achieving a saving of $111,458 per person with additional health related savings associated with lower mortality and better health outcomes valued at $92,759 (ANCD 2012);
- AOD treatment reduces the average duration of heroin use from 20 to 11 years (NHS n.d)
- The Drug Court achieves a cost benefit ratio of 1:5.81 (VAADA 2013); a more recent review of the Victorian Drug Court (KPMG 2014) found that over two years it accrued $1.2M in savings through reducing the prison population (these savings do not account for the range of other benefits including reduced recidivism and improved health and social circumstances

Figure 1 reveals the positive impact of AOD treatment on acute health service demand.

Figure 1: Impact of AOD treatment on acute health service demand (Manning et al., 2017)



Addressing treatment demand

Underpinning the themes and content of this submission is the need to provide timely access to AOD treatment for all Victorians. To this end, AOD treatment services will need to be adequately resourced to meet increasing unavoidable demand. Further to the regular ebbs and flow of service demand, there have been a range of broader welfare service system recalibrations. Some of these areas impacting the Victorian AOD treatment system include, the NDIS, child protection, Real Time Prescription Monitoring, Family violence, justice system changes as well as a range of other issues which have direct consequential impacts on AOD service system demand. A significant concern is that the downstream impacts of many of these areas are often overlooked and therefore not adequately planned for.

There are two issues associated with the challenges of meeting service demand;

- There is a need to increase access to those unsuccessful in seeking treatment
- Additionally, the sector needs to engage with treatment averse populations in need

The solution to these issues lies with additional resourcing and in system adaptation to changing conditions and demands. More broadly, to address increasing complexity in presentations, there is a need to further enhance the capacity of the workforce.

The data cited above highlights the significant benefit to Victoria of increasing access to AOD treatment services, increasing the capacity of the AOD workforce, and treatment sector as a whole. There is also an obvious benefit in implementing a range of initiatives to address the needs of at risk communities and drive innovation throughout the sector.

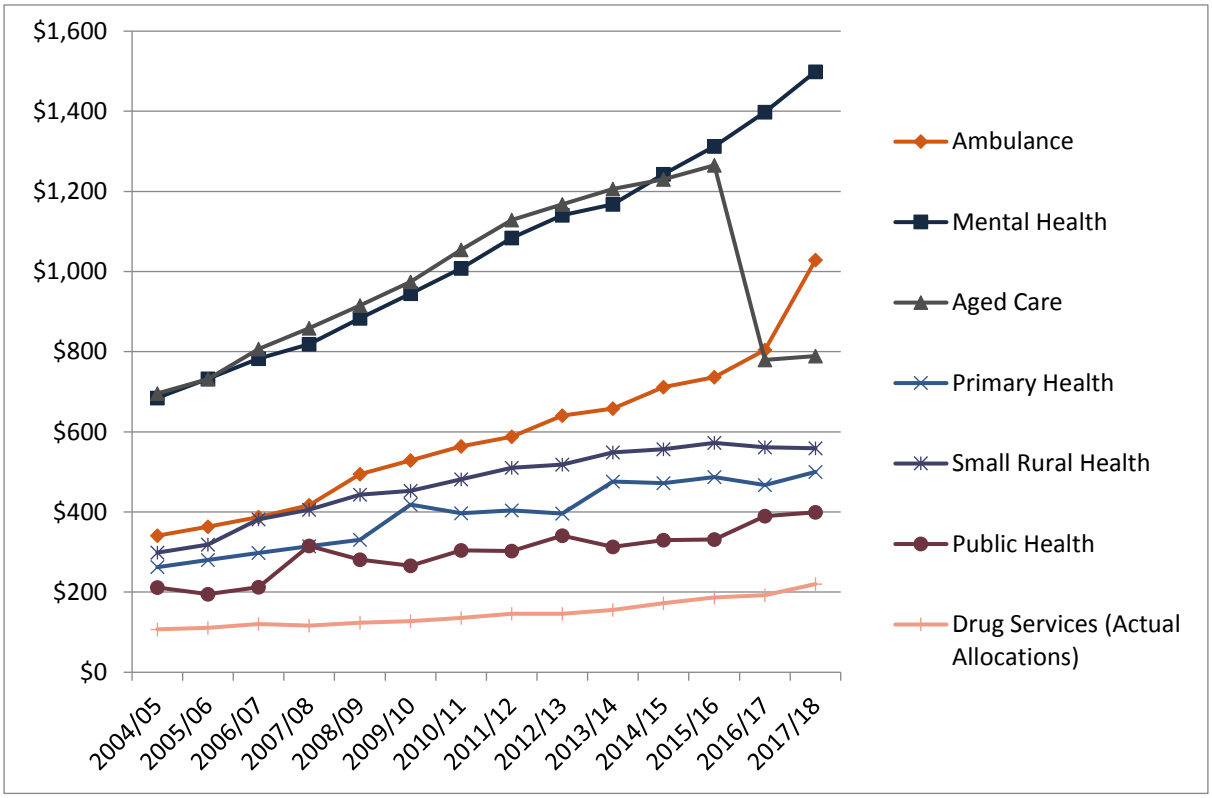
Funding

The AOD treatment sector has endured chronic underfunding for many years. As a result of this lack of funding, significant service gaps have been created, some of which this submission seeks to address. One of the more problematic issues arising through the lack of funding is the development of a fertile environment for the encroachment and proliferation of unregulated 'for profit' treatment facilities.

Ritter et al (2014) indicate current investment in AOD treatment in Australia at around $1.26 billion per annum. When this figure is considered against the costs of AOD issues across the country per annum ($24 billion: Collins and Lapsley 2008) it is evident that greater investment is necessary to address the overwhelming harms.

Figure 2 details a spread of health sector funding streams from 2004/05 to 2017/18. Despite the recent welcome funding announcements from the state government it is evident from Figure 2 that the duality of a low annual budget restrained by low annual growth is resulting in a virtual flat line for the AOD sector. It is clear that the AOD sector continues to lag well behind other health sectors.

Figure 2: Output funding (health) 2004/05 – 2017/18 (in $millions)[1]



[1] Data for Figure 2 has been obtained from Victorian Government Budget Papers.

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Background to submission – sector feedback

VAADA administered a survey to senior management across the AOD sector. There were 40 responses which have informed the development of this submission.

VAADA's 'Sector priorities survey' identified a range of issues, many entrenched and some evolving. Issues pertaining to workforce remain a paramount concern for the sector, especially as activity progresses creating the expectation of increased capability across a range of areas, including family violence, child protection, pharmaceuticals and forensics. Recruitment and retention challenges also featured heavily, particularly in rural and regional areas of Victoria.

There was a general sense within the sector that funding was more secure than 2016, although serious concerns were raised with regard to the adequacy of the Drug Treatment Activity Unit. This means of funding is seen as inadequate. Furthermore, there are concerns from those providing services which were out of scope from the 2014 reforms that the funding provided is insufficient to deliver specified services.

Issues relating to excessive demand and wait times remain key challenges for the sector. We have sought to contribute a range of initiatives in this submission which might address these issues. The following section highlights key areas we consider to require attention.

Enhancing the AOD treatment System

AOD service access is vital in improving community health and wellbeing and reducing cost to government. The following measures detailed below, relating to outstanding issues associated with the recommissioning, data systems, Real Time Prescription Monitoring and challenges associated with regional and interface areas.

Prioritising the implementation of ASPEX

The government commissioned report into the reformed service sector outlined a range of issues and proposed a number of remedies which should still be considered by government. This has occurred during a period of community anxiety regarding service access. There is a need to continue to build on the actions resulting from the *Aspex* (2015) report.

Drug Treatment Activity Units

- *The value of DTAU is inadequate and should increase by 25 percent to account for the range of unfunded activities necessary in providing treatment*

ASPEX (2015) identified a number of concerns regarding Drug Treatment Activity Units and recommend that a review be undertaken to explore this issue. Since publication of the ASPEX report, VAADA has found that the broad sector experience indicates that the DTAU is inadequate and unrealistic in its expectation of covering all expenses associated with providing funded treatment. The VAADA sector Priorities Survey (2017) revealed that 85 percent of the responders noted that the DTAU is inadequate, and identified the following areas where it is deficient:

- Administrative tasks including reporting requirements
- Follow up of service users who do not attend treatment, especially with forensic service users
- Increased complexity in presentations, including family violence related presentations, not receiving additional weighting
- Travel times, particularly in rural and regional areas
- Higher pay rates for certain types of professionals providing treatment services
- Various Awards generating salary increases at a higher rate than the annual increase for DTAUs.

The funding formula applied in determining the value of the DTAU accounts for workforce training and development, however in application and practice, this is an unrealistic expectation. Agencies have consistently reported that the value of the DTAU is inadequate to cover training and development expenses, as well as associated costs such as backfill and travel costs.

The limitations with regard to the model funding extend beyond DTAUs, to also include those service types which were out of scope for the 2014 reforms (residential, Aboriginal and youth services). It is apparent that the arrangements in providing these services are tenuous and therefore we would recommend that an increase in the value of a DTAU be matched with a commensurate increase in the funding provided to these out of scope services.

Recommendation 1: the value of a Drug Treatment Activity Unit (DTAU) be increased by 25 percent to account for currently unfunded out of pocket expenses. This increase should also be afforded to those services which are not covered by DTAUs including residential, Aboriginal and youth AOD services.

Care and Recovery Coordination

- *Care and Recovery Coordination is a valued yet under-resourced treatment type requiring additional capacity to meet community demand*

Aspex (2015) highlighted a significant deficit in care and recovery coordination. This treatment type is applicable at the more complex end of the treatment spectrum and provides overall coordination and service integration for people experiencing a range of issues who need to access the AOD and other related service sectors. A recent review on integrated working between the AOD and non-AOD sector describes international research evidencing the long term benefits of co-ordinated care in terms of improved functioning and well-being as well as AOD, mental health and medical outcomes (Savic et al, 2017). This treatment type is crucial within the context of increasingly complex presentations. For instance, survivors of family violence, who may be juggling AOD, housing and legal issues, would greatly benefit from this service type. The Royal Commission into Family Violence (2016) indicates that a range of services, including but not limited AOD services, interact with individuals experiencing family violence. The value of an enhanced Care and Recovery model which is appropriately funded could have great benefits across this and a range of other areas including youth, CALD, Aboriginal and forensic.

Unfortunately, this treatment type at the time of recommissioning was grossly under resourced. Despite 70 percent of respondents asserting that this treatment type was inadequately resourced to meet demand in 2014 (VAADA 2014) - which has increased in the 2017 survey - current limitations have not been addressed.

The government has earlier predicted that up to one third of AOD service users would require this treatment type (Department of Health and Human Services 2013). However, the allocations indicate that there was only capacity for 3804 individuals to access care and recovery coordination. With 31,714 Victorians engaging the AOD treatment sector (as per the 2015/16 figures [Australian Institute of Health and Welfare 2017]), we contend that up to 10,000 individuals would require this treatment type. It is evident that the expectations of government surpasses the limited resourcing available for this crucial treatment type. Under such circumstances the intent of this innovative and highly effective intervention is significantly undermined.

At this stage, we would support a prudent approach, such as increasing the capacity of this treatment type to cater for 7,000 courses of treatment. This would necessitate the resourcing of an additional 3,196 courses of treatment according to the 2013/14 figures. Following this, we are of the view that a further uplift occur based on development work related to this activity type and a more detailed assessment of demand as the role develops to meet the level of client need.

We note that the 2017/18 price for a DTAU is approximately $754.48[2] and that the weighting on Care and Recovery Coordination is 2.22 DTAUs. In order to provide an additional 3,196 courses of treatment there is a need to fund 7095 DTAUs at an overall cost of $5,304,899.

Recommendation 2: that the Government provide a recurrent $5,304,899 boost to the AOD sector for additional courses of 'Care and recovery coordination' to account for the needs of approximately 25 percent of all AOD service users.

[2] We note that this is the 2017/18 figure. This will likely increase in the 2018/19 financial year as in previous years.

Data systems

- *The benefits of the Victorian Alcohol and Drug Collection* (*VDAC) will be minimised unless additional capacity to assist in the transition, development and utilisation of the new data systems is funded.*

AOD agencies are expected to meet the requirements of the Victorian Alcohol and Drug Collection (VDAC) by October 2018. Many agencies are exploring various data platforms and systems to accommodate the requirements; others are likely to build on existing data platforms to meet the requirements. Historically, there have been limitations in the usefulness of data systems supporting the AOD treatment sector with these systems not necessarily providing assurance. The Victorian Auditor-General (2011) in their report on the AOD system noted that:

- the data reported was at times inaccurate;
- there was little return for the time spent on data entry;
- the data did not provide for service planning; and
- Data does not reflect the work undertaken by the sector.

There is a need to ensure that these findings do not remain as the new system progresses. To that end, we would recommend that support be provided by way of resources applied in each DHHS catchment to maximise data system integrity, feedback loops and support to agencies. This will greatly assist agencies in service planning and more broadly assess treatment related outcomes which can be used to inform future service design.

Recommendation 3: That $150,000 be allocated to support the sector in the transition, development and utilisation of the new data systems which would be funded for two years from 1 July 2018.

Recommendation 4: The creation of a Specialist Data Analysis Unit to collate and analyse data and provide advice to agencies and government on a state wide basis through the allocation of $200,000 per annum as well as annually publish AOD data in a manner similar to *Victoria's Mental Health Service Annual Report*.

Increased demand through new reforms: Real Time Prescription Monitoring system & rescheduling of codeine

- *the potential of Real Time Prescription Monitoring (RTPM) provides an opportunity to address pharmaceutical related harms occurring with a largely hidden cohort, unfortunately this will be stymied if the AOD sector is not appropriately resourced to cater for the increase in demand*

In 2018, the landscape as it relates to pharmaceutical related harms in Victoria will undergo a significant shift through the rescheduling of codeine and the implementation of Victoria's RTPM system. Both reforms seek to address pharmaceutical related harms. They both also imply a significant failure in the oversight, prescribing and dispensing of various pharmaceuticals which is reflected through the year on year burgeoning harms evident in various data sources including, in Victoria:

- the Coroners Court (2017) which identified 372 fatal overdoses involving pharmaceuticals in 2016, as well as
- Turning Point ambulance dataset (2017) which noted 9,941 pharmaceutical related ambulance attendances in 2014/15.

The data indicates that pharmaceutical harms are increasing however, pharmaceutical related presentations in AOD treatment are low, suggesting that individuals experiencing pharmaceutical harm and dependence are under-represented among AOD treatment recipients. This lack of engagement in AOD treatment potentially relates to the low level of referrals from general practice to AOD treatment, with less than 1 percent of referrals to AOD treatment being made from primary health. Should the number of referrals increase there would be a serious impact on the Victorian AOD system.

The RTPM system will provide GPs and pharmacists patient data in real time in relation to certain listed substances which will inform the prescribing and dispensation of certain medications for specific cohorts. While it will identify those patients who are actively seeking high risk prescription substances from multiple GPs, it will also assist in identifying poor prescribing practices. It is likely that this will identify a large cohort of individuals who are at high risk of experiencing pharmaceutical related harm as well as dependency through the poor management and support of various conditions including chronic pain.

As a result of RTPM, referrals will be made to various support services which will also include engagement with GPs who practice opioid replacement therapy. Endeavours are underway to assist GPs and pharmacists with training and in providing referrals to support services and otherwise supporting patients identified by the RTPM system as being high risk. Separate to this, is the growing concern that at this stage, $916,000 has been allocated to the AOD sector over the next four years in response to demand related to RTPM. We are, at the time of writing uncertain on both what this funding is intended to deliver and how this figure was determined. Furthermore, despite recent modest increases in the number of GPs and pharmacists who respectively prescribe and dispense opioid replacement therapy, there are still regions where access to this life saving program is limited. Some regions are reliant on the tenuous situation where a small number of GPs taking on hundreds of patients or face the reality where engagement on this program necessitates hours of travel to receive a daily dose. It is therefore conceivable that RTPM will likely increase pressure on existing pharmacotherapy services.

The prevailing concern regarding RTPM is the absence of comprehensive consideration of how AOD treatment services are positioned to cater for a significant increase in demand from a cohort who may be less inclined to engage in the specialist AOD system due to differences in perceived identity among those using prescribed and illicit drugs. There has been minimal consideration of determining workforce capability to provide treatment to this new cohort or to how AOD services and the 'broader system' is configured. With many treatment types in many regions currently maintaining extensive waiting times, it is likely that for many, this reform will present a lost opportunity to provide treatment to newly identified cohorts of at risk Victorians as they get caught up in lengthy waiting lists to treatment services or other specialist services resulting in disengagement.

Some of the 'at risk' individuals may fall into may result in individuals seeking alternate (and more risky means) of procuring various substances, including engaging with illicit street based markets, legal highs or the Dark Web. Some individuals will alternatively, engage the unregulated private sector - an expensive option with uncertain results. We note that similar RTPM systems, implemented in various international jurisdictions, have generated mixed results. In the USA, a number of states host various forms of RTPM which have been implemented in response to dire pharmaceutical related harms. While there has been a reduction in pharmaceutical opioid related overdose, an increase in heroin related fatal overdoses has occurred (Nam et al 2017). While we do not seek to draw a causal connection between the various responses to reduce pharmaceutical related harms and the increased uptake of heroin in some of these jurisdictions, it is evident a lack of system wide preparedness has likely displaced individuals to potentially much greater risk. Within Victoria given the recent spate of increasing heroin related harms, there is a need to reflect very carefully on any potential risks and the means by which to mitigate such harms.

In essence, the potential positive impacts of the RTPM will be significantly muted if this reform is not supported by a robust and highly capable AOD sector, as well as greater support across a range of impacted service sectors. There is a dire need to provide additional capacity to the AOD sector to respond to the pending increase in demand and allow for additional capability within the workforce to work with this new cohort.

Recommendation 5: that the government provide $10M to the AOD sector to provide for the additional demand generated by the RTPM and rescheduling. This would also provide for necessary workforce development endeavours and the development of new innovative means of delivering positive treatment outcomes to identified cohorts.

Recommendation 6: that at a minimum an additional four addiction medicine specialists (AMS) and four pain management specialist (PMS) be resourced to cater for the increased demand associated with emerging high risk cohorts identified through the RTPM. It is anticipated that these specialists would work with associated service systems and providers to assist in addressing the needs of complex presentations as well as providing support to GPs and the AOD sector with the AMS also providing additional support to DACAS.

Reduce AOD related Emergency Department presentations

- *Research indicates that 35% of Emergency Department (ED) attendees experience AOD issues with seven per cent requiring extensive treatment – there are cost effective measures to break the repetitious cycle of ED attendances among this cohort*

Acute health and ambulance services continue to labour under the strain of increasing demand highlighting the need to action endeavours to reduce the quantity and severity of these admissions.

Research from NSW illustrates an alarming trend in the overall contribution of AOD related issues to hospital ED with 35 percent of patients surveyed experiencing problematic AOD issues with seven percent experiencing more serious AOD issues (Butler et al 2015; Reeve et al 2016). Evidence indicates that providing an AOD nurse consultation to support, provide advice, or brief interventions and referrals to these vulnerable repeat ED attendees can achieve financial savings through a reduction of time and costs associated with future presentations.

The savings achieved through employing an AOD nurse consultant amounts to a conservative estimated saving of $100,000 per year per hospital (Butler et al 2016). Ideally, this model should be applied broadly through the Victorian system accepting that some hospitals already have various similar supports in place. Furthermore, some hospitals may only require a part time consultant depending on demand. Regions supporting smaller hospitals should receive additional AMS capacity which could be provided to individual sites remotely or on periodic basis to provide clinical support and supervision to the AOD nurses.

Larger hospitals with greater AOD related ED throughput could consider an enhanced variant with in-house residential withdrawal services with a step up/step down model of care targeting frequent AOD related ED presentations. This model could work from existing infrastructure where possible, and assist in developing linkages with community AOD treatment services and other necessary support services. The in-house service would be supported by an addiction medicine specialist, a GP registrar and two AOD nurses. This capacity would not only support the ED but would provide for greater enhancement and support to regional primary health at a period which, through RTPM and the re-scheduling of codeine, will experience greater AOD related demand.

Recommendation 7: that AOD nurse consultants be employed in all Victorian hospitals to provide support, referral and advice to ED patients with accompanying AOD issues, supported by additional AMS capacity which should be determined through consultation with relevant stakeholders, including DACAS.

Recommendation 8: that major hospitals develop a step up/step down model of care which can fast track frequent AOD related ED patients to suitable in-house treatment or other local AOD treatment providers with capacity which will be supported by an addiction medicine specialist, a GP registrar and two AOD nurses.

Estimated cost per region:

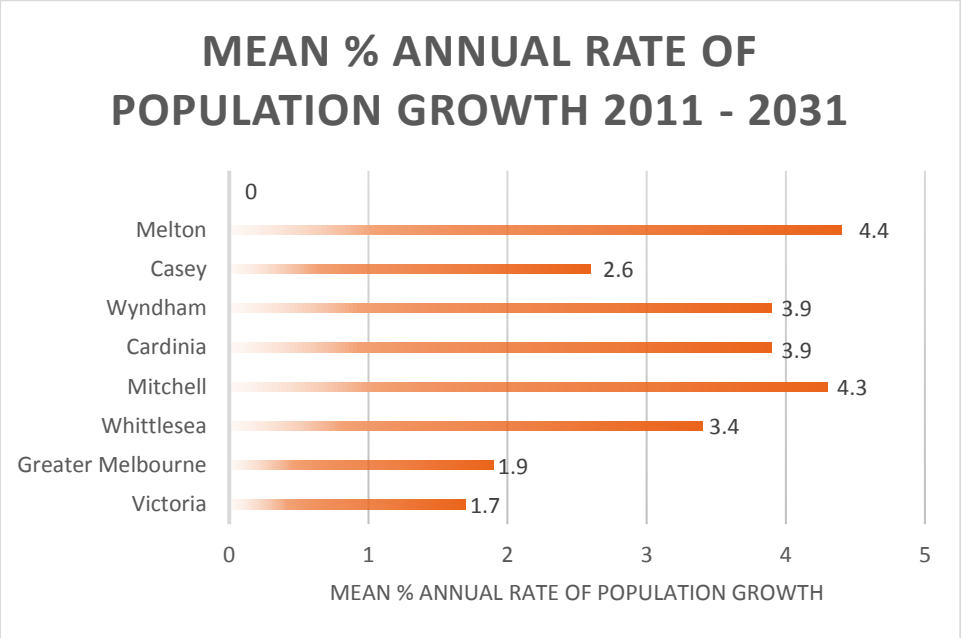
Addiction Medicine Specialist	**$300,000 PA**
GP Registrar	**$150,000 PA**
AOD Nurse x2	**$120,000 x2 PA**

Service access: Growth corridors

- *Population growth in many of the interface regions of Melbourne is outstripping the supply of various health and welfare services, including AOD treatment, necessitating additional capacity to provide services for a rapidly growing population.*

Victoria's population is currently expanding at a higher rate than any other state or territory within Australia (ABS 2016), with a growth rate of 1.9% where the national average is 1.4% (Environment, Land, Water and Planning 2016). We note that, from 2011 – 2031, the growth rate for the 'growth corridor' regions of Melbourne is estimated to be, for all regions but Casey, more than double the average growth rate for Greater Melbourne and almost three times the average population growth rate for Australia (1.4%) (ABS 2016).

Figure 3: Growth corridors in Victoria – mean percentage rate of population growth per annum



According to the Jesuit Social Services report, *Dropping off the Edge* (DOTE) (Vinson and Rawsthorne 2015), many of the growth corridor regions are experiencing high levels of disadvantage. Parts of Whittlesea, Casey, Cardinia, Mitchell and essentially most of Melton and Whittlesea, rate highly in the various scores for social disadvantage. Although DOTE does not provide details on AOD related harms or issues, it is evident that communities experiencing various forms of disadvantage, such as homelessness, mental illness and involvement with the justice system are more likely to experience AOD related harms (Lubman et al 2014). These areas, experiencing rapid growth, with minimal health infrastructure, will perpetuate disadvantage, creating enduring burgeoning pockets of extreme disadvantage. These under-resourced areas may effectively lead to Melbourne becoming a two-tiered city, with a widening gulf between a rapidly expanding, under-resourced outer ring and more advantaged and serviced middle and inner regions. There is a sense that the approach taken is build first, with health and social planning undertaken at a later date.

AOD treatment providers operating in those areas identify a range of issues which impact on service access, including:

- limited capacity for outreach, which is viewed as a priority service type in light of the limited transport related infrastructure, and distances involved;
- limited capacity to provide after-hours service provision, which is necessary in light of the extensive travel times necessary for those employed, many which are travelling over two hours per day to retain employment;
- limited availability of suitable facilities for treatment providers;
- limited capacity for specialist outreach to address the needs of various high risk CALD communities;
- a very high proportion of forensic AOD service users (in some cases, 80 percent of all service users), indicating that there are a large number of people who are bypassing the voluntary system which may have prevented the need for a forensic intervention; this also highlights the inadequacy in service capacity to attend to voluntary demand
- Limited pharmacotherapy dispensers and prescribers, limiting service access and necessitating lengthy travel times into other areas; and
- Additional capacity and weighting to provide for flexible service models to accommodate the challenges in providing in an emerging growth corridor.

Additional resourcing must be allocated to these growth corridors in line with population growth coupled with indicators of disadvantage, to prevent AOD related harms and assist in curtailing the increasing challenges evident in these communities.

Recommendation 9: That a recurrent sum of $3 million be made available to each interface region (Melton, Casey, Wyndham, Cardinia, Mitchell and Whittlesea, Yarra Ranges and the Mornington Peninsula) to enhance existing services or establish new services to address AOD related harms in line with rapid population growth and disadvantage.

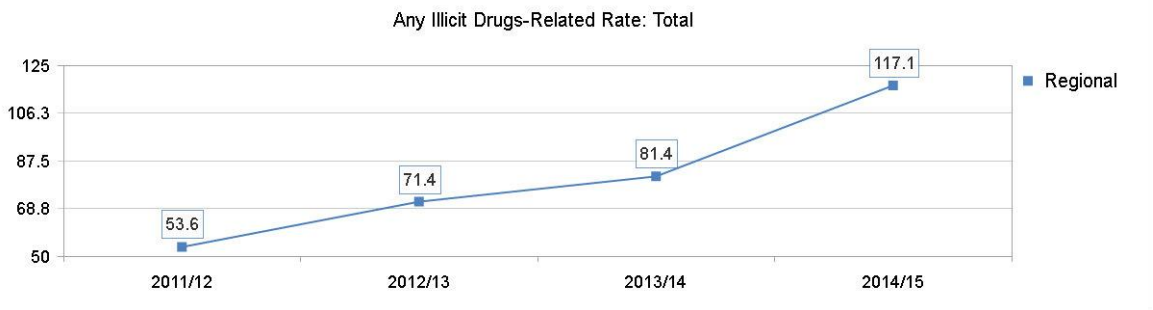
Service access: Rural and regional

- *Demand for rural and regional AOD services outstrips capacity which is coupled with significant challenges in recruiting and retaining quality staff. Inducements to work in rural and regional areas together with a broad ranging increase in capacity is necessary to address these challenges.*

Rural and regional areas of Australia experience greater disadvantage and poorer socio economic circumstances when compared with metropolitan areas (National Rural Health Alliance 2012; Vinson and Rawsthorne 2015).

These areas also experience limited access to general practitioners, with only half the GP services available in very remote areas per person in comparison to metropolitan areas (Duckett and Breadon 2013). AOD related hospitalisation rates in major cities are set at approximately 160:100,000 head of population whereas remote areas are 294:100,000 head of population (Australian Institute of Health and Welfare 2016). Buykx et al (2013) indicate that in rural and regional areas less than 30% of those requiring AOD treatment access treatment, likely contributing to the disproportionately high rate of AOD related measures of AOD harm, such as illicit substance related ambulance attendances, which has more than doubled in the years leading up to 2014/15 (see Figure 4 below).

Figure 4: rate per 100,000 population; rural & regional illicit substance ambulance attendances



(Turning Point 2017)

The National Rural Health Alliance (2015) reports that the portion of the population consuming illicit drugs increases in line with the remoteness of the cohort, from 14.8% of the population in major cities to 18.8% in remote and/or very remote areas, with the rate of remote community amphetamine consumption twice that of major cities.

Some rural and regional AOD Catchment Based Planners have identified significant gaps in service capacity. Rural and regional AOD services tend to experience a limited distribution of services, transportation issues and workforce issues. Specifically, the VAADA 2017 Sector Priorities Survey revealed a trend in responses relating to the sheer difficulty in recruitment. In many cases, the allocation of funding and geographical expanse of rural regions provides only for part time opportunities; it is apparent that skilled workers are often reluctant to move to rural areas for the promise of an isolated part time job in a position that may be funded for a limited duration.

Additional challenges relate to accessing NSP, pharmacotherapy and withdrawal services (National Rural Health Alliance 2012) which was echoed in VAADA's Sector Priorities Survey (2017). RTPM will exacerbate the challenges associated with pharmacotherapy.

Most rural and regional providers noted in VAADA's Sector Priorities Survey that demand outstrips capacity (VAADA 2017). They noted stigma, anonymity and AOD service engagement are also common challenges. Rural and regional providers often work to account for this in service and programmatic design. They highlighted costs associated with travel times and also backfilling.

Additional capacity is required to increase access to AOD treatment in rural and regional areas, to enable equitable access and respond to issues such as ice as well as enhance cross sector collaboration to reduce AOD related harms and associated disadvantage. This would equate to an expansion across a range of service types, specific to each region, in line with local need. It is also imperative that high quality staff are employed in rural and regional areas. To that end, we would recommend that a loading of 10 percent be applied to the salaries of these staff and that this is realised through the DTAU.

Recommendation 10: That an additional $10 million is allocated annually to enhance AOD service access and capacity in rural and regional Victoria, prioritising areas identified by local AOD catchment based planning where there are challenges in service access, as well as high levels of morbidity and AOD related harms.

Recommendation 11: That a loading is applied to all rural and regional AOD staff of 10% above the relevant award to enhance recruitment and better retain quality staff.

Responding to older adults experiencing AOD issues

- *Older people experiencing AOD dependency experience significant yet preventable AOD related harms and are currently underserviced. A specialist AOD service catering for older people must be piloted.*

The portion of people aged over 65 years in Australia is steadily increasing. Older adults experience greater health problems than younger cohorts, consume more medication and are likely to be experiencing significant life transitions, including exiting the workforce and losing a life partner. As an individual ages, their physiological tolerance of AOD diminishes, eliciting a greater risk of substance related harm. Despite the diminishing tolerance, the proportion of older people drinking at risky levels has increased by 31 percent since 2001, while the rate of illicit drug use among older people has increased by 36 percent between 2010 and 2013 (AIHW 2014). Currently, there is only one AOD treatment program in Victoria specifically targeting older people. In addition to this, we would recommend the development of two outreach teams operating throughout Victoria providing specialised AOD treatment to older adults. The demand and efficacy for this program should be evaluated with a view to future service planning. Some of the underlying factors creating a focus on this cohort include:

- The Department of Environment, Land, Water and Planning (2016) identifies that the number of Victorians aged 65 years and over will treble from 2011 to 2051;
- Population growth in the older demographic in Victoria is forecast to increase more rapidly than any other age group with 40 per cent of the population growth between 2006-2036 consisting of people over the age of 65[3] (Department of Planning and Community Development 2009);
- Use of illicit drugs has increased 36% among adults aged 50-59 years and 27% in adults aged over 60 years from 2009-2013. (AIHW 2014).
- With ageing comes a reduced tolerance to substance use and an increase in other morbidities which may exacerbate the harms associated with harmful AOD use (Taylor and Grossberg 2012);
- Older adults are less likely to access traditional services due to stigma and mobility limitations (Nicholas et al 2015);
- Older people are using more substances and experiencing greater harms:
    - The average age of a person engaging in AOD treatment is increasing; over the past decade, the number of people over 40 years of age engaging in AOD treatment increased from 27 percent to 32 percent of all recipients (AIHW 2017);
    - the National Drug Strategy Household Survey (2017) notes that there are more women aged over 50 than those aged up to 24 who are consuming alcohol at risky levels;

[3] Victoria's population is estimated to increase by 2.27 million from 2006 – 2036; from that, 910 000 will be over the age of 65 years.

- The ABS (2017) notes that generally the rate of Australians experiencing fatal overdose aged 45 and over is increasing;
- the average age of fatally overdosing from heroin has increased from just under 30 years of age to 41 years of age over the past two decades (Dwyer 2016, cited in the ABC 2016); and

- Even if the rates of AOD use remain stable, older people will experience greater AOD related harms due to the rapid increase in older populations.

Costs associated with ageing will increase, including healthcare and welfare provisions, and productivity will decrease as Australia experiences a larger portion of the population which are not actively employed. It is incumbent upon government to reduce these costs where possible.

In 2009/10, of the nearly three million hospital separations for Australians over the age of 65 years approximately 84,000 can be attributed to sustaining a fall (Australian Institute of Health and Welfare 2013). Furthermore, one in 10 days spent in hospital by a person aged 65 years and over was attributed to sustaining a fall (AIHW 2013). Many of these falls will be related to AOD use.

International research has demonstrated a link between AOD use and older people experiencing a fall (Coutinho et al 2008) including involvement in up to 50 percent of hip fractures (Lader 2011). Increasing AOD use among other factors, complicated by co-morbidities related to older people's physiological status, points to a silent crisis for the Victorian health sector. The AOD service system is not adequately resourced to be able to cater for the growing demands of this population, nor are there adequate broader community and institutional systems in place to maximise service access to older people.

An evaluation of the sole older persons AOD treatment program in Victoria identified a significant increase in older adults accessing AOD treatment in the region, a reduction in risky alcohol consumption and general improvements in mental health with the outreach component providing for home visits was also viewed positively among the service users (Mugavin and Berends 2013).

Recommendation 12: A pilot outreach AOD treatment project should be developed to address the gap in AOD services for older adults throughout Victoria. The project should include outreach, project coordination, medical support coupled with resourcing for research and evaluation.

Indicative program components and costs include:[4]
Pilot outreach (two teams statewide)

Item	EFT	Cost
Establishment costs - vehicle		$27,600 per team
Establishment costs- office/IT		$11,400 per team
Staffing – outreach team	3 inclusive of 0.5 team leader per team	$412,000 per team PA
Project coordination	1 coordinator, training and development	$156,250 PA
Research and evaluation	1 research and evaluation officer	$129,000 PA

[4] This pilot program outline has been adapted from VAADA's 2014/15 State Budget Submission

Enhancing pathways for CALD communities to AOD treatment

- *CALD communities are less likely to engage AOD treatment services for a range of reasons, contributing to avoidable AOD related harm among some cohorts; community development workers should be employed to engage with identified high risk cohorts to affect better linkages and pathways between those communities and AOD services*

People from culturally and linguistically diverse (CALD) communities are under-represented in the AOD treatment system. Data shows that only 13 percent of closed treatment episodes for Australians in 2014-15 applied to clients born overseas (AIHW 2016). Within the general population, 28% of people living in Australia were born overseas. It is evident that a disproportionately small number of CALD individuals attend AOD treatment services.

VAADA's (2016) CALD AOD project identified a number of challenges currently facing the AOD sector with regard to adequately servicing CALD communities within Victoria:

- There is inadequate data detailing the prevalence of AOD use within CALD communities;
- Low admission rates for individuals from CALD backgrounds is due to an under-utilisation of services rather than a lower need (Beyer & Reid 2000);
- Many CALD communities experiencing AOD issues face additional challenges associated with adjusting to a new culture including feelings of dislocation and isolation, compounded through the potential shame that may be associated with problematic AOD use and service engagement;
- Many individuals from CALD backgrounds engaging in the AOD system enter it through the forensic system, highlighting lost opportunities of engagement in the voluntary system; and
- Resulting from the recommissioning of the AOD sector some services have indicated that they have experienced a reduction in capacity to work effectively with CALD communities.

At present, there are multiple service barriers and socio-cultural norms making it difficult for CALD individuals and families to access treatment, including a lack of trust in mainstream services, language difficulties and low levels of health literacy (including knowledge of AOD harms).

Working with CALD clients in need of AOD support requires a targeted and multi-faceted approach, which appears to be occurring on a piecemeal basis.

The VAADA (2016) CALD AOD Project recommend that resources be directed into establishing CALD specific community development positions consisting of two bi-cultural workers per catchment, funded for at least three years during a pilot phase, whose role will be to:

- Engage CALD communities and agencies with the emphasis on relationship building and cross-sector collaboration
- Raise awareness of available supports while facilitating access to AOD treatment for individuals and families from CALD communities
- Liaise with CALD community members and/or representatives about their specific health literacy needs, experiences navigating the AOD sector and ways to improve the system
- Promote culturally appropriate models of service delivery while strengthening ties between CALD communities, ethno-specific agencies and AOD treatment services

It is recommended that these practitioners be located in AOD agencies within specific catchments where there is the greatest need. Throughout the pilot phase of the program (years 1 – 3) key learnings from the program would be documented and recommendations forwarded to DHHS, with a view to scoping out opportunities to replicate the program in other catchments.

VAADA also recommends that resources be directed into a capacity building stream, staffed by two project officers located at VAADA, whose role would be to:

- Support, capacity build, document and report on the activities undertaken within each catchment
- Develop resources and other initiatives which support AOD and allied agencies in the delivery of culturally responsive services to CALD individuals and family members requiring AOD support
- Work with stakeholders in each catchment to identify barriers and gaps in service delivery as well as measures to address them
- Oversee the program's evaluation and disseminate findings to key stakeholders

Recommendation 13: That resourcing is availed for bi-cultural workers to be situated within four AOD catchments in Victoria, supported by two project officers, to increase CALD community access to AOD services and build the capacity of these services to better cater for the needs of these communities.

Indicative program components and costs include:

Years 1 – 3: CALD AOD community development (for four catchments)	**Item**	**Cost**
Establishment costs –	vehicle	$21,100 per catchment
Establishment costs –	office/IT	$8,755 per catchment
Staffing	2 bi-cultural workers per catchment	$200,000 per catchment PA
	Project Officers (state wide)	$200,000 PA
	Office Expenses	$30,000 PA

Workforce Development – a sustainable AOD workforce

- *The AOD workforce is expected to continue to increase its expertise and demonstrate strong competence and capability across a range of areas. AOD sector clinicians are expected to be capable in a range of areas, including family violence, forensics, mental health, youth, CALD and child protection among others. Despite these expectations, agencies still labour under enduring limitations in workforce development activity.*

The VAADA sector survey (2017) revealed enduring concerns regarding recruitment, retention and remuneration. These challenges will be further exacerbated by the increasing expectation on the sector to demonstrate capability across a range of areas, including family violence and child protection. Furthermore, the sector is being further beleaguered with a deluge of forensic demand, with some regions citing upwards of 80% of forensic demand without a commensurate allocation for capacity building to support the workforce to address increasing complexity among this cohort.

There is an urgent need to establish a mechanism to efficiently upskill the workforce to provide for these expectations. This is coupled with the need to ensure that new AOD staff can be rapidly upskilled to meet the minimum standards (Cert IV in AOD) as well as being capable in additional areas of specialisation. A fast track system should be developed to address the multiple needs associated with securing, training and allocating staff to a suitable service. A fast track system of training and experiential learning, coupled with 'micro-credentialing' would involve the delivery of relevant units of training related to a range of areas such as family violence, child protection or forensic issues in addition to the Cert IV in AOD. This approach would be particularly beneficial during a time of rapid expansion and would build on existing sector RTO and training resources with additional funds to assist with recruitment, experiential learning, and student placements.

New staff could be taken offline for the period of training and experiential placements within such a fast tracked learning system if required. This training could occur with an aggregation of new staff at predefined times during the year, but could be flexible enough to meet different levels of demand through calibrating the frequency of delivery to meet demands relating to new policy initiatives and reforms.

Experienced qualified staff members could also enrol in unit/s of competence associated with the micro-credentialed options listed above. This would broadly allow for this program to increase cross sector capability. It could also rapidly increase the skill base of new and or existing staff in line with increasing complexity and or AOD demand pressures.

A number of agencies and sector champions could be employed to assist with placement during and/or at the conclusion of the micro-credentialing of various staff. To drive this and address other workforce issues, there is a need for additional capacity to provide state-wide coordination which would involve convening sector network meetings, coordinating consultation forums, identifying education and training opportunities and strengthening intra-sectoral communication and relationships. Further, these roles will also maintain and support a network of funded AOD registered training organisations (RTOs) with the express purpose of increasing workforce capability. This role would also seek to generate greater interest in working in the AOD sector.

The benefits to the sector in recruiting and retaining staff through providing additional training capacity would be significant, which would result in broader community benefits through a more highly skilled and specialised stable AOD workforce.

Recommendation 14: An entity should be established to better co-ordinate training and enhance the attraction of staff to the sector. This entity would explore options for rapid accreditation of new AOD workers and identify areas for micro-credentialing as well as systems to support such training in relevant areas of high need. A central co-ordinating team of 2 staff possibly would be established to support existing RTO's and the enhanced workforce training and enhancement initiative.

Increasing dual diagnosis capacity

Research indicates that at least one in three individuals experiencing AOD dependency also experience at least one co-occurring mental health disorder (Marel et al 2016). Despite the issues pertaining to co-occurring AOD dependence and mental illness being well recognised throughout the community, the increasing complexity among cohorts engaging with frontline services highlights the need for greater capacity and support to be provided across the AOD and associated sectors.

Co-occurring AOD and mental health disorders is a very common phenomena and highly prevalent among many individuals in need of AOD treatment:

- Approximately 35 percent of individuals experiencing AOD dependency also experience 'at least one 'affective or anxiety disorder, representing approximately 300,000 Australians' (Marel et al 2016, p 12); and
- 62% of individuals using AOD daily experienced a mental disorder over the past 12 months (Marel et al 2016).

The challenges associated with this cohort require innovations that build on existing expertise and provides greater support to the sector. The Drug and Alcohol Clinical Advisory Service (DACAS) currently provides free telephone based support to general practitioners from addiction medicine specialists. The effectiveness of this support needs to be further enhanced through the addition of Addiction Psychiatry expertise availed through this helpline. This would enhance support to those working with individuals presenting with highly complex co-occurring AOD and mental health issues and increase the capacity of DACAS.

Recommendation 15: That additional Addiction Psychiatry capacity be availed to DACAS at an estimated cost of $300,000 per annum to provide additional support to presentations related to co-occurring AOD and mental illness.

Establish a research and innovation fund

- *The development of innovative treatment programs must be supported on an ongoing basis through the establishment of an innovation fund. AOD treatment agencies should be provided with the capacity and scope to respond to varying AOD trends. Evaluation of each allocation should be publicly available to inform program development and future tendering priorities.*

A funding pool of $2 million should be provided through a submission process, with agencies in each region encouraged to apply for funds to implement new and innovative programs and approaches as well as have resourcing available to undertake evaluation activity. Submissions should reflect on evidence of local need and on the efficacy of the proposed new program. The funding could also be targeted to addressing specific issues as they arise within treatment settings, challenges occurring

within specific demographics or trends in substance use. A portion of the allocation should be set aside for evaluation and the continuation of some programs.

Recommendation 16: An additional $2 million allocated annually to an innovation fund to respond to changing needs, facilitate and encourage innovation and enhance the evidence base of the Victorian AOD treatment sector.

Increase residential rehabilitation capacity– a case for parity with the rest of Australia

- *The demand for residential rehabilitation services across Victoria is increasing, in part fuelled by the paucity of publicly funded beds combined with a community perception that residential rehabilitation is the ideal treatment option. Recent budget announcements from the Victorian Government have made positive headway in addressing the lack of residential rehabilitation capacity in rural and regional Victoria, however there still remains a dire need to ensure equity of access to the necessary services. Despite these welcome announcements, Victoria is still underserviced in this area in comparison with similar jurisdictions.*

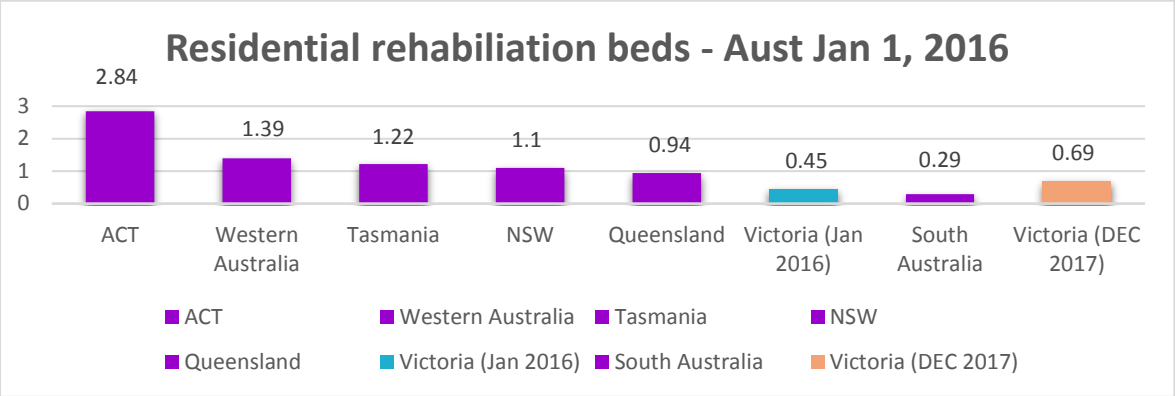
There is a growing body of evidence that supports the efficacy of residential rehabilitation as an effective means of addressing AOD related harms. Lubman et al (2014) and Ciketic et al (2015) note that residential rehabilitation is cost effective in addressing methamphetamine related presentations. 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 in residential rehabilitation there is a conservative net economic benefit of approximately $1M (Rae 2013). Lubman et al (2014) notes that individuals in the patient pathways study who participated in residential rehabilitation achieved 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 from the Victorian Government to resource additional capacity for this treatment type, including the purchase of property in three regional areas of Victoria to build additional facilities, there still remains significant barriers into this treatment modality.

In light of recent government announcements, we estimate that, based on approximately 420 beds either taking demand or soon to be commissioned, Victoria's rate of residential bed capacity is forecast to increase from 0.45 beds in 2016 to 0.69 beds per 10,000 population at time of writing.[5] Despite this welcome increase, Victoria still retains the second lowest ratio of residential rehabilitation beds per head of population nationally, as evident from Figure 5 below:

[5] This figure reflects the 2016 estimation of beds listed in Figure 5 in combination with additional capacity outlined in various Victoria Government statements, leading to an estimation of approximately 420 residential rehabilitation beds either committed or operating. Based on a population of 6,030,000 this amounts to 0.69 beds per 10,000 head of population.

Figure 5: residential rehabilitation beds per 10,000 head of population by state/territory



Despite recent increased capacity, there remains a disjuncture between community demand and sector capacity. Part of the unmet demand for this treatment type is currently being met through an unregulated expanding private sector, while some unmet demand is engaging the justice system and some would be facing acute health issues in light of untreated dependence, resulting in preventable morbidity and mortality.

To address this capacity deficit, there is an ongoing need for Government to continue to plan and 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 broad plan which will account for gaps in service, demand by region, the necessary uplift in workforce capacity and opportunities evident through partnerships and existing capacity. Further consultations should be given to the composition of, and expertise availed to running these facilities. The plan should involve content on addressing the needs of specific cohorts, including CALD communities, older people and acute co-occurring mental health and AOD presentations. The plan should identify specific opportunities which can minimise establishment expenses.

This plan should provide for the staged increase in residential rehabilitation capacity over a five year period with a view to increase the capacity of the Victorian funded residential rehabilitation system to 1: 10,000 head of population, necessitating investment in approximately 200 extra beds. Such an endeavour, which would provide for an additional 800 Victorians annually, would result in Victoria having the third lowest number of residential rehabilitation beds per capita but well within the range of other jurisdictions in Australia. The overall ratio of beds to population would of course need to be revised regularly in light of continuing community demand, population growth, waiting times, and unforeseen developments with the impact of the AOD markets.

We note currently that the cost per bed varies depending on whether it is delivering forensic or voluntary treatment. An average derived from the current providers suggests the cost per bed (three to four episodes delivered each year) amounts to $70,000 per annum.

Recommendation 17: That the Victorian government develop a plan to direct the necessary increase in capacity of Victorian funded residential rehabilitation services through all of Victoria to lift capacity to a level in alignment with other jurisdictions in Australia. This will necessitate the development of approximately 200 additional beds over the five year period lifting the rate to 1 bed per 10,000 head of population. It is estimated that the operations cost of running these facilities will amount to approximately $70,000 per annum per bed.

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