To; Minister for Health Sarah Courtney

Thank you for the opportunity to recently discuss the need within Tasmania for the creation of four (4) medical detox beds in the north of the State to address a current reduction in capacity at the Inpatient Withdrawal Unit in Hobart, that has and is significantly impacting the level and speed of access of Tasmanians experiencing addiction issues in accessing residential rehabilitation treatment in the North and North West of the State.. Notwithstanding the reduction of beds available during the Covid-19 period and aftermath, there was ample evidence prior to Covid-19 of this need for additional medical detox beds , located specifically in the North of the State, to enable the occupancy of existing State residential rehabilitation services to be maximised for efficiency of operation and client outcomes. It has been recorded in a number of reports that the logistical difficulty for clients in being appropriately transported from the north to the south for detox and then successfully return to a community based or residential rehabilitation, needs to be rectified.

The proposal from Launceston City Mission is that a new purpose built medical centre incorporating the 4 medical detox beds is constructed within the grounds of the Missiondale Therapeutic Community, 75 Leighlands Road, Evandale. This site is proposed because it will enable:

- The provision of medical detox beds for clients on pathways to North West services (new Serenity House, currently 8 beds but 20 beds in operation from Feb 2022, plus the existing Salvation Army residential service at Ulverstone) and the North (Missiondale 34 beds plus 6 beds for our Futures program) at bed cost per day substantially less than the acute care hospital system.
- Better integration with A&E in the North and North West to provide alternative options for patients arriving with non-urgent alcohol and drug issues.
- A seamless transfer for the clients following withdrawal for short to medium term rehabilitation recovery programs, or safe transfer back into the community with appropriate supports.
- In addition a medical centre for provision of primary health care services for both internal and external clients (those on the pathway into the service, or during their pathway back into the community) at no cost to the client. Regional and rural areas have a lower access to GPs and specialist health care, (see the attached report that shows the disparity between metro areas, regional and then rural and remote), therefore the co-location of the medical centre as part of the withdrawal unit will facilitate improvements in access for clients experiencing other primary health issues. For example over 75% of AOD clients now present with a diagnosed or undiagnosed mental health condition within our residential facilities. It is far more efficient, with better client outcomes, to provide the primary healthcare onsite.

Following discussions with MHR Bridgit Archer and Senator Wendy Askew a capital proposal with business case is being prepared for submission to Health Minister Greg Hunt as soon as possible. Master planning and now detailed design is in progress with our consultant partners 6ty.

Background

The need for these dedicated beds in an AOD setting was again listed by the Alcohol, Tobacco and Drug Council of Tasmania in their submission to Minister Jeremy Rockliffe, **COVID-19 Recovery Priorities for the Tasmanian Alcohol, Tobacco and other Drugs Sector, Priority Action 2.4 (refer attached documents)** "Prioritisation of the necessary

feasibility work to identify alternative and / or additional approaches to withdrawal treatment to address the reduced capacity of the Inpatient Withdrawal Unit in Hobart"

The provision of withdrawal services in Tasmania has presented considerable challenge to governments for well over a decade. The ongoing challenge is based around geographical location (current facility is based in the south), models of service (hospital, community or at home) as well as the increase in clients presenting with crystal meth issues and how to accommodate this group. One of the intrinsic concerns is client pathways in and out of withdrawal facilities. The 'client experience accessing and then navigating the service system' narrative is very strong in the reform agenda. Obviously by co-locating withdrawal beds within a residential facility this then ameliorates that issue somewhat.

Then there's the recent reduction in the number of withdrawal beds available to Tasmanians, from nine to six - as a result of physical distancing requirements.

The issue has been covered in three successive reviews of the AOD service system, as well as the Siggins Miller modelling exercise. In each review/process withdrawal services have featured.

Pp15-16, 2008 – makes the case for north, north west coverage and diversity of models of withdrawal
https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0004/38578/ATOD_Future_Service_Directions_-_A_Five_Year_Plan.pdf

Pp33-34 – 2014- makes the case for more withdrawal facilities/bed on NW coast and as a response to a suspected rise in crystal meth use.
https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0005/174848/Final_Report_Review_of_Drug_Use_in_NW_Tasmania.pdf

p14 onwards, 2017 – Siggins Miller Final report (attached)- modelling report
Talks about diversification of models (including community based) and barriers. Says that we have enough beds (that was then though, when capacity was 9 instead of six and prior to increased demand) but that there are limitations to that. Pathways out of withdrawal arew a key consideration.

p18, 2020 Reform Agenda
"long wait-times, and sometimes restrictive criteria, to access services, particularly withdrawal management and residential rehabilitation services; and"
P20, "Through the work of Siggins Miller and Primary Health Tasmania, client/consumers and providers thought there was a need for better integration: • between withdrawal management and residential rehabilitation (and other AOD services);"
P23 – community withdrawal model is mentioned
And there's more!
https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0003/417207/FINAL_Alcohol_and_Other_Drugs_Reform_Agenda_2020_for_website_PDF.pdf

P13-16 – AIHW rural, remote health access to healthcare (attached)

We thank the Minister for her interest in these initiatives proposed for the better integration of medical, withdrawal and rehabilitation services for Tasmanians experiencing addiction issues.

Regards

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A single Tasmanian alcohol and other drugs (AOD) service system framework

Final Report

August 2017

Contents

Overarching main messages

Based on findings and discussions over the course of this project, we provide the following overarching main messages for the Department of Health and Human Services (DHHS) to consider in developing a single AOD Service System Framework for Tasmania:

1. There is strong support across all stakeholders in the AOD sector for system-level and service-type-specific reform and innovation outlined in this report. The change management agenda to implement these reforms is significant, will need the ongoing effort and contribution of all parts of the service system, and be resourced appropriately to implement the necessary change activities.

2. The complexity of the change process, the determinants of access to services, consumers' engagement with services, and the capacity to meet the broad social, employment, and education needs of consumers that are significant parts of their recovery requires a joined-up evidence-based approach to change. We suggest that the collective impact framework outlined in this report be used to guide this change process.

3. Tasmania has a major resource in the depth and commitment of its policy and clinical leadership. This resource needs to be harnessed and well-supported in the change process.

4. There are a number of system-wide issues addressed in this report, such as the need for joined up electronic health records; preparing the system for the national rollout of the My Health Record system; the extended use of telehealth for consultations to improve access for people in remote settings or for service providers to access secondary consultations; and remote monitoring of patients in ambulatory settings.

5. The bulk of Tasmanian AOD services appear to be evidence-based. There are some places where this review was unable to establish the evidence base of some services due to a lack of documentation, and recommendations have been made to address this.

Introduction

The Alcohol and Other Drug (AOD) Service System Framework project is a key initiative which supports three of the recommendations arising from the Review of Drug Use and Service Responses in North West Tasmania (NW Review), and is supported by additional funding of $4.8 million over four years which was announced in May 2015. The DHHS through the Mental Health, Alcohol and Drug Directorate (Directorate) engaged Siggins Miller Consultants to undertake a range of activities and deliver a suite of working papers and reports that culminate in this Final Report which clearly articulates options and recommendations to enable the DHHS, working closely with other service funders and providers within the state of Tasmania, to develop a single AOD Service System Framework for Tasmania. This final report is intended to assist the Tasmanian DHHS and other service funders and providers in identifying options and recommendations to develop a single AOD service system framework for Tasmania.

This final report includes the key findings from each of the commissioned deliverables: the Mapping Paper; Literature Review; Client Pathway; Needs and Gap Analysis; Residential Rehabilitation; and the Withdrawal Management reports, as they relate to:

a. Options and recommendations of how the current Tasmanian AOD service system can be changed or reconfigured to improve client service delivery and cost effectiveness, and service sector efficiency, including opportunities for collaboration/integration within the AOD sector and more broadly where relevant and possible.

b. Options and recommendations of what is needed in the medium and longer term to achieve a recommended single AOD service system framework, including where any new investment or resources are best prioritised.

Methodology

This report integrates findings of the following deliverables provided to the DHHS throughout the course of this project[1]:

1. Literature Review
2. Mapping Working Paper
3. Need and Gap Analysis Working Paper
4. Client Pathways Paper
5. Residential Rehabilitation Report
6. Withdrawal Management Report

Detailed methodologies of these deliverables are outlined in the corresponding reports. A brief description of the methodology of the overall project is outlined below.

Literature review

An overarching literature review of recent research, reports, and evaluations to determine components of an effective and efficient contemporary best practice and evidence-informed AOD treatment system for Tasmania including a focus on stepped care modelling as appropriate was conducted. This literature review was conducted by accessing bibliographic databases that index the academic literature and networked library catalogues for print monographs and related material. All Australian material of direct relevance, as well as a selection of relevant overseas material, in particular peer reviewed systematic

[1] The deliverable "Communications and Project Plan" sets out methodology for each of the project deliverables and does not contain findings per se. Thus, it is excluded from this final report.

reviews of treatment effectiveness, was considered. Reference lists of relevant articles, and other recent major reviews commissioned in the sector, were used to identify potential studies for inclusion. In addition, a search of grey literature using web tools such as Google Scholar and Scopus was conducted.

The residential rehabilitation report expanded on the contemporary best practice and evidence-based residential options contained in the Literature Review, with international and local evidence of what contributes to effective treatment outcomes from drug and alcohol residential rehabilitation treatment services; as well as contemporary clinical practice guidelines and best practice models in regard to residential rehabilitation services as appropriate for Tasmania.

Similarly, the withdrawal management report expanded on the withdrawal management findings contained in the Literature Review, with international and local evidence of withdrawal management models; as well as contemporary clinical practice guidelines in regard to residential rehabilitation services as appropriate for Tasmania.

Stakeholder consultations

Initial Consultations: Regional consultation workshops and consumer and carers focus groups

Initial consultations, in the form of Consumers and Carers Focus Groups and Service Providers Regional Consultation Workshops were conducted over the period of 6 March to 8 March 2017. These workshops and focus groups were conducted in Launceston, Ulverstone and Hobart. A total of 49 service providers and 25 consumers and carers took part in these workshops. Their views on service gap, service integration, accessibility and flexibility of AOD services and the AOD service system were summarised in the Client Pathways Paper.

Targeted Consultations: Interviews with service providers and consumers

Individual and group interviews were conducted with AOD service providers and consumers in Tasmania from 1-19 May 2017. The interviews provided an opportunity for service providers to discuss their perceptions of services and the service system, current service provision arrangements and future needs.

AOD service providers who were invited to participate in individual and group interviews are listed in Table 1. In total, 28 (individual and group) interviews were conducted. In addition, 45 stakeholders were invited to submit a written submission. Of those, 3 organisations submitted written submissions to this review.

Table 1: Stakeholder interviews and written submissions - targeted consultations

Sectors	Stakeholders		
Rehabilitation service providers	Launceston City Mission (Individual interview: 2 participants)		The Salvation Army (Individual interview)
CSOs	Group interview: 13 agencies invited, 5 agencies participated, 1 agency opted for written submission		
Indigenous health service providers	Circular Head Aboriginal Corporation (Individual interview)	Tasmanian Aboriginal Centre (Individual interview)	
Primary health service providers	Primary Health Tasmania (Individual interview)	2 interviews: GPs (Individual interview)	Pharmacy Guild (Individual interview)
Peak organisations	Alcohol, Tobacco and other Drugs Council Tasmania Inc (Individual interview: 3 participants)		Advocacy Tasmania (Individual interview)
Alcohol and Drug service providers	6 Individual interviews: including area manager, pharmacist, Specialist medical practitioners, and staff specialist of the Inpatient Withdrawal Unit		Group interview: 17 invited, 6 participated
Midwives	Group interview: 3 invited, 2 participated		
Mental Health Services	3 Individual interviews: including Mental Health Services project manager, Correctional Primary Health Services,		Group interview: 18 invited, 1 participated.
Child and youth services	Group interview: 12 invited, 1 participated, 1 written submission		
Consumers	Group interview: 3 invited, 1 participated		
Justice related services	Group interview: 10 invited, 1 written submission		
Public Health Services	Group interview: 5 invited, 1 participated		
Other	University of Tasmania (Individual interview)		
Additional written submissions	3 written submissions: provided by Clarence Community Health Wellbeing Advisory Committee, Department of Education, and Bethlehem House		

Note: Consumers were recruited through the consumer and carer focus groups conducted as part of the initial consultation for this project. They represent the Tasmanian Users Health and Support League (TUHSL), a volunteer run organisation representing the needs of AOD consumers. Opportunities were provided to Velocity Transformations to take part in both group and individual interviews. This invitation was declined due to an unforeseen change of management of the organisation. They provided materials to assist in the review following the close of stakeholder consultation period.

In brief, discussions with service providers and consumers covered the following domains:

- Service demand
- Screening of AOD user (if appropriate)
- Service integration with other AOD services and non-AOD services (e.g. for clients' mental health, physical health, and other needs)
- Views specific to withdrawal management services and residential rehabilitation services
- Other comments and feedback

The Drug and Alcohol Service Planning (DASP) Model

The Drug and Alcohol Service Planning (DASP) Model for Australia is a planning tool that aims to assist health planners to meet the needs of people with alcohol and other drug (AOD) problems, and was used to provide benchmark estimates of the resources needed to deliver the range of AOD services required for Tasmania. The architecture of the tool, including its background, model parameters and limitations, are outlined in Appendix 1 of the Need and Gap Analysis Working Paper.

Data on current service provision

As detailed in the Mapping Working Paper and the Need and Gap Analysis Working Paper, a range of administrative data sources were used to profile current AOD service provision and utilisation in Tasmania, across all treatment settings.

The DHHS Health Information Unit also provided hospital separations data, the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS), and Needle and Syringe Program data for the year 2015 – 16 to facilitate the review of AOD treatment services provided in these settings.

For information on residential rehabilitation and withdrawal management treatment approaches, service providers were approached to provide information on their current service delivery and models of care to inform the corresponding reports. Where necessary, additional information was sourced through individual organisations' webpages. Feedback from service providers through individual and group interviews were also used to inform our findings.

Limitations of DASP modelling and data in the Tasmanian context

In terms of other service elements (e.g. after-care), the information available does not allow for analysis of current allocations and activities against the service elements and care packages identified in the DASP. For example, it is impossible to discern the proportion of resources that went to psychosocial interventions, screening and brief intervention, or case management for clients receiving pharmacotherapy. Likewise, for services delivered by the NGO grants, there is no ability to accurately distinguish the proportion of funding allocated to the different service activities undertaken by an organisation, nor was that in scope for this project. As such, the DASP projections should be conceptualised as a guide for proportional investment of future funding and for identification of the profile of outputs required.

Available information also does not allow analysis of current FTEs in Tasmania across all service settings, or how many are providing services to different age groups or across the severity categories.

Options and recommendations

The following sections outline the:

- Key estimates based on the modelling undertaken through this process and the findings from the Mapping Working Paper

- Options for Investment and Resources
- Overarching system wide options and recommendations based on background papers and reports commissioned as part of this review process
- Findings, and options and recommendations specific to Residential Rehabilitation
- Findings, and options and recommendation to Withdrawal Management

Key estimates based on the modelling undertaken through this process and the findings from the Mapping Working Paper

Modelling approach:

- As there are no nationally established conversion rates, the methodology developed by Chalmers et al. (2016)[2] in estimating national AOD service utilisation has been followed. This entails completion of a series of four steps in converting the estimates of treatment utilisation:
    1. Convert treatment service episodes to an estimated number of treatment service recipients within each dataset;
    2. Adjust for double counting of treatment recipients across agencies providing treatment service data within each dataset;
    3. Convert treatment recipient count to an annual figure (only applies to NOPSAD); and
    4. Adjust for double counting of treatment service recipients across multiple datasets.
- In total, 61,321 AOD treatment episodes/sessions are delivered across all treatment settings, which represents between 8,948 and 12,545 people who will receive some form of AOD treatment in any one year (when factoring in access to more than one treatment setting).
- This equates to between 5,759 and 6,550 unique individuals receiving AOD treatment over one year, across the mild, moderate and severe populations, and across all treatment settings.
- The number of individuals in Tasmania who will experience a substance use disorder over one year[3] is modelled as 32,292, of which 12,767 will need some form of treatment.
- This suggests that at a minimum, between 6,217 and 7,008 unique individuals in Tasmania are currently not accessing or receiving AOD treatment.
- A further 5,213 people will need consultation liaison services and 61,547 people will require screening and brief intervention only.
- The total DASP modelled cost of providing treatment services is $46.31 million per annum, which would provide 287.41 FTE staff working in hospitals and the community, and 149 beds for residential rehabilitant and withdrawal management treatment.
- Current expenditure includes a range of State Government funded AOD services that are not included in the DASP modelling:
    - $3.17 million for harm reduction and related activities
    - $4.2 million for Program and Service Development (part thereof)

[2] Chalmers, J., Ritter, A., & Berends, L. (2016). Estimating met demand for alcohol and other drug treatment in Australia. *Addiction, 111*, 2041-2049.
[3] ibid.

- $406,533 for diversion-related activities

- The Commonwealth Government also provides $1.7 million for A&TSI specific AOD treatment services, also not included in the DASP modelling.
- The DASP modelling suggests 125 beds (or places) are needed to provide residential rehabilitation services, and 23 beds to provide withdrawal management in inpatient and detoxification in dormitory settings. All beds modelled are for the severe population.
- The model estimates that for the 12-17 age groups, only 3 beds in total are required for residential rehabilitation and withdrawal management treatment services.
- Tasmania presently has a total 68 beds across the State – 58 residential rehabilitation beds (funded through a mix of state, Commonwealth and CSO funding) and 10 inpatient clinical treatment (the Inpatient Withdrawal Unit). There are also an unknown number of private hospital beds used to provide withdrawal management services.
- There are also 6 Places of Safety and Sobering Up Beds, which is not modelled in the DASP model.

Gaps Identified:

- Current expenditure across all treatment settings is approximately $40.43 million per annum, and DASP modelling indicated a need for $46.31 million per annum is required. This suggests a funding shortfall of around $5.88 million per annum across all treatment settings.
- Due to certain AOD treatment services not being modelled by DASP (i.e. harm reduction activities, program and service development, etc.), as well as the $1.7 million in funding provided by the Commonwealth for A&TSI treatment services not being modelled by DASP, this suggests a far greater funding shortfall across all treatment settings.
- Comparing DASP modelling and currently available beds for the severe population suggests an undersupply of residential rehabilitation beds (Table 2). It also suggests that combined inpatient clinical treatment beds and detoxification (withdrawal management) beds numbers in Tasmania may be appropriate, when taking into account the state Inpatient Withdrawal Unit, and those provided within the private hospitals system.

Table 2: Comparison of DASP estimated resources (beds) and current service utilisation.

Data sources	Inpatient**	Detoxification***	Residential rehabilitation	Total
DASP estimates: All treatment populations*	4	19	125	149
Mapping working paper: current service utilisation	10*		54-58	NA

Note: All beds are for the severe population.
Due to rounding, some numbers may not add exactly to the totals.
*Dedicated inpatient beds in the ADS Inpatient Withdrawal Unit.
**Inpatient identified in DASP are for withdrawal management in a hospital bed.
*** Detoxification beds identified in DASP are for withdrawal management in residential – dorm setting.

- The DASP modelling estimates that the total number of FTEs required over a 12-month period to provide treatment services to all people who will experience a substance use disorder is 287.41, across all treatment settings. It is not possible to estimate the total number of FTEs currently providing services.

Overall, our analysis shows that there is scope for reconfiguration of existing and future resources to better focus on people with severe and complex problems and to ensure balanced investment across the treatment types, defined in the DASP framework.

Options for Investment and Resources

Comparison across treatment settings is challenged by the variety of ways in which treatment provision is recorded. Nonetheless, using the methodology of a recent evaluation of national AOD service utilisation[4], the following findings were noted for the AOD service provision and utilisation in Tasmania:

- The overall expenditure for AOD treatment services in Tasmania for 2015-16 was $40.43 million. The Tasmanian state government contributed an estimated 56.2% of total funding for AOD treatment services, whereas the Commonwealth contributed 22.9%, with the remaining 21.0% of funding originated from private sources (e.g. private hospital admissions, GP co-payments etc).
- In any one year, at least 61,321 AOD treatment episodes/sessions are provided across all treatment settings including both the government and non-government specialist AOD sectors, by GPs, in public and private hospitals, through private opioid pharmacotherapy providers, in government community and residential mental health services, and by psychiatrists and allied health professionals in the mental health sector.
- Consistent with evaluation of national AOD service utilisation, the largest proportion of AOD treatment sessions/episodes are provided through GP consultations (35.2%). Based on national-equivalent estimates, our analysis shows that in general, approximately 2% of national AOD treatment services occur in Tasmania.
- Geographic mapping of services shows that services are typically located in Hobart and Glenorchy in the southern region, Launceston in the northern region, and Devonport, Ulverstone and Burnie in the northwest region of Tasmania.
- Geographic mapping of service utilization data (AODTS-NMDS 2015-16) shows relatively consistent patterns of drug types and treatment types across South, North and Northwest regions in Tasmania.
- Whilst there is only one DHHS-funded stand-alone medically supervised inpatient withdrawal unit in the South, data shows withdrawal management services are also undertaken within public and private hospitals across Tasmania.

Overarching system wide options and recommendations

The following part describes the overarching system wide options and recommendations based on the background papers and reports that were commissioned as part of this review. It includes options and recommendations that are relevant to

(1) the system change and reconfiguration to improve client service delivery and service efficiency, including opportunities for collaboration/integration within the AOD sector and more broadly where relevant and possible; and

(2) what is needed in the medium and longer term to achieve a recommended single AOD service system framework, including where any new investment or resources are best

[4] Chalmers, J, Ritter, A., & Berends, L. (2016). Estimating met demand for alcohol and other drug treatment in Australia. Addiction, 11, 2041-2049.

prioritised. Following the system wide recommendations and options we present the recommendations and options relevant to residential rehabilitation and withdrawal management.

Triangulating the data from all sources used and developed in this review, as outlined in the methodology section above, we provide the following observations, options and recommendations:

- The elements of the Tasmanian AOD system covers all appropriate and evidence based treatment types.

- The main challenges facing the AOD treatment service system in Tasmania that were identified by both consumers and providers during consultations are as follow:

    - A lack of consistent information on how to identify and access appropriate services.
    - Perceived long wait-times and sometimes restrictive criteria to access services, particularly withdrawal management and residential rehabilitation services.
    - Lengthy distances to travel to services, particularly for consumers from North and Northwest regions, as well as travel required between different services.
    - Lack of integration and communication between different services, including perceived lack of communication between government and non-government services.

- As noted in the Client Pathways Paper, consumer's experience the implementation of pharmacotherapy services as too restrictive and not conducive to longer term rehabilitation outcomes. We note that the ADS is undertaking a review of the Tasmanian Opioid Pharmacotherapy Program, Policy and Clinical Practice Standards (TOPP) in the context of the Tasmanian epidemiology and opioid use, to identify barriers (internal and external) and consider alignment with best practice guidelines of other Australian jurisdictions.

Reports from consumers who accessed GP services after developing substance use problems, prior to engaging with specialised AOD treatment reported the interaction with the GP was not beneficial to their recovery from substance use. In line with these reports, service providers at the Regional Consultation workshops identified a need to enhance support to GPs to allow for their increased capacity to deliver AOD treatment services.

Many consumers reported long wait times to access withdrawal management and residential rehabilitation services. Additionally, the wait-time identified by participants in the Launceston and Ulverstone focus groups was notably longer (reportedly over 10-week wait-times) than that reported by the Hobart focus group. Further input by consumers highlighted the need for more aftercare services, particularly following acute episodes of substance use.

There was agreement between both consumers and service providers that there is a need for improved integration and communication between service providers, particularly between government and non-government services. Integration with housing, employment, and the criminal and justice system were also identified as in need of improvement. Integration with mental health services was identified to be a key challenge across all consumers' focus groups and regional consultation workshops, particularly for consumers with mental health issues who are not eligible for public specialised mental health services.

With regard to the responsiveness and flexibility of AOD services and the AOD service system, consumers indicated that they would like to have greater flexibility in opening hours of services and in extending treatment duration. Consumers across all three focus groups indicated that the Tasmanian

pharmacotherapy program lacked flexibility, with consumers providing examples on how it impacts on their health and social needs.

Finally, consumers expressed the need for greater consumer engagement, at the individual treatment planning level, as well as at the higher level of consumer representation. The need for greater consumer representation was also identified by service providers as an area of focus.

While the individual service elements that should exist are present in Tasmania, it was reported by both consumers and providers that coordination between them is poor and some parts of the system are underutilised, for example, GP and other private practitioners.

On this basis, we recommend the following:

- There is a need for reform within the treatment system to ensure that it is client-focused, rather than provider or institution focused, with services designed around client convenience, access and providing support to seek help as close as possible to where they live. This would align the AOD service system with directions and reforms in treatment and support of other equally intractable chronic diseases elsewhere in the broader health system. We suggest that, due to needs of consumers crossing sectoral boundaries across portfolios and across government, non-government and private sector service providers, the system reforms to address the identified problems be guided by the methodology developed within Stanford University, known as A Collective Impact framework. Collective impact occurs when a group of multi-sector stakeholders '*commit to a common agenda for solving a complex social problem… Their actions are supported by a shared measurement system, mutually reinforcing activities, and ongoing communication, and are staffed by an independent backbone organisation*.'[5] The collective impact framework identifies five conditions of collective success:
    - *Common agenda*: All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it though agreed upon actions.
    - *Shared measurement:* Collecting data and measuring results consistently across all participants ensures efforts remain aligned and participants hold each other accountable.
    - *Mutually reinforcing activities:* Participant activities must be differentiated while still being coordinated through a mutually reinforcing plan of action.
    - *Continuous communication:* Consistent and open communication is needed across the many players to build trust, assure mutual objectives, and create common motivation.
    - *Backbone support:* Creating and managing collective impact requires a separate organisation(s) with staff and a specific set of skills to service as the backbone for the entire initiative and coordinate participating organisations and agencies. In the Tasmanian context, we suggest an AOD specialist clinician/nurse practitioner who supports system design, an organisational change management specialist to implement change activities, and a data analyst to support shared measurement activities.

The focus of this multi sector work, in the first instance, should focus on the following:

- **Partnership between government and non-government services:** Relationships between government and non-government services have been identified as an area of focus by both service providers and consumers. Other jurisdictions (e.g. Victoria, NSW and QLD) have

[5] Hanley brown, F; Kania; J; Kramer, M. Channelling Change: Making Collective Impact Work, Stanford Social Innovation Review, 26 Jan 2012.

established sub-acute bed-based mental health services administered by state or territory mental health services or non-government agencies, but generally staffed by a mixture of clinical and non-clinical staff and most commonly located in the community, or a mix of hospital and community based facilities. An example of this service type is the Victorian Prevention and Recovery Care (PARC) service[6]. This partnership model may be considered in the Tasmanian context to provide a transitional bed-based treatment service to AOD consumers with high needs which is less intensive than acute inpatient treatment but more so than traditional community based AOD treatment services. The 6 Places of Safety/Sobering Up Beds may be considered as multi-purpose facilities for this partnership.

- **Consumer representation:** We suggest adopting the model of consumer representation used by the mental health sector in Tasmania to support AOD consumers, and provide consumers with support and training to increase their understanding of the AOD service system and confidence in their abilities to provide meaningful input on ways to improve the AOD system.
- **Management of wait-times:** When necessary actively manage waiting times, through e health support to monitor health status and prioritise those deteriorating.
- **Continuity of care**: Support for clients to improve continuity of care, including supporting clients' transfer from one treatment to another, engage clients while they wait for treatment (e.g. motivation interviewing, improve linkages between treatment elements to improve service integration).
- **Integrated care pathways:** Develop clearly articulated integrated care pathways, provided to service providers and clients developed in partnership with consumers.
- **Support for GPS:** Greater support for GPs not only in their role in OST but withdrawal and ongoing treatment in primary health settings.

The following medium and longer-term activities are also recommended:

- **Workforce reforms:** Tasmania could consider in the medium and longer-term piloting various workforce reforms, including: expanded scope of practice for pharmacists in relation to ambulatory/home-based withdrawal management in partnership with local general practitioners; piloting specialist AOD, nurse practitioner and physician assistant.
- **E-health technologies**: Consider trialling e-health and remote monitoring more broadly around system-wide shared health record (My Health Record) which allows communication from all members of the treating team and client.

Findings, and options and recommendations specific to Residential Rehabilitation

Findings

Informed by international and Australian peer-reviewed literature and clinical guidelines, this report analysed current residential rehabilitation services in Tasmania against contemporary benchmarks and service providers' feedback to identify potential areas of improvement.

Three rehabilitation models were identified: 1) long term residential care (defined as 24-hour care for a minimum of 60 days); 2) short-term residential care (generally defined as less than one-month of treatment); 3) and non-residential (day program) care.

[6] Adult prevention and recovery care (PARC) services framework and operational guidelines, (2010). Mental Health, Drugs and Regions Division, Victorian Government, DHHS of Health, Melbourne, Victoria.

Generally, for residential or outpatient treatment participation, 90 days or less is of limited effectiveness. The evaluation literature suggests that short term residential treatments may not be effective unless they incorporate a progression to structured options such as supervised half-way house accommodation or daily/weekly participation in non-residential programs. The evidence on the effectiveness of short term residential rehabilitation treatment is in its early stages. Non-residential rehabilitation treatment options may be more viable for clients who have supportive environment and/ or are on a waiting list for a residential treatment bed and need help and support while they wait.

In Tasmania, services are provided by three organisations in four locations, with up to 58 beds available for AOD residential rehabilitation. There are also six beds available in Places of Safety and Sobering Up facilities providing overnight or very short term stay across Tasmania. One of which (Serenity House) has been multi-purposed by Launceston City Mission and The Salvation Army to provide short-stay (i.e. 2-week) for clients, with assessments and psychosocial support prior to entering longer-term residential treatment. Based on 2015-16 data, despite having a relatively small proportion of residential rehabilitation beds (21%, 12 beds), the Northwest region recorded most of the rehabilitation treatment episodes (42.3%; 220 episodes), noting however that the majority of rehabilitation episodes were provided in outreach settings.

By examining international and Australian examples of evidence-based treatment guidelines and principles, together with the peer reviewed literature, this paper identified the elements of best practice against which to assess the current service delivery in Tasmania. The emerging key themes from the evidence base as reflected in the service provider feedback included:

- A shortage of residential rehabilitation beds available in Tasmania, and a lack of appropriate services for youth and women with children who require residential rehabilitation for substance use issues.
- A lack of coordinated admission processes and a pathway from withdrawal management to residential rehabilitation.
- A lack of clarity about treatment models and structured aftercare for some services.

Based on the available evidence from the three organisations (Launceston City Mission, The Salvation Army and Velocity Transformations/ Pathways Tasmania) there are varying degrees of alignment with the elements of best practice in residential rehabilitation services. This evidence, together with the Drug and Alcohol Service Planning (DASP) modelling of demand for residential rehabilitation beds results in the following conclusions:

Key areas of service gap/ need identified by this review:

- These is evidence to support an increase in the capacity of residential rehabilitation services in Tasmania;
- There is evidence of potential unmet demand for residential rehabilitation services for youth in Tasmania. The quantum of service that would be required to satisfy this demand is not sufficient to warrant a standalone residential facility. Services could explore the feasibility of extending current intake criteria and to adopt a more flexible approach to program delivery to provide residential rehabilitation services appropriate for youth. Services could also consider forming partnerships with other service providers (e.g. Housing Connect and women's shelters) to provide in-reach and/or e-health services for young people that require residential rehabilitation treatment;

- There may be a need to explore the feasibility of providing women with children rehabilitation services in residential settings. This may include a small amount of infrastructure work to fit-out current facilities for them to be suitable for children (e.g. converting one existing unit to be able to cater for women with children on a flexible basis). Alternatively, or as well, the system could consider how to form partnerships with other human service providers that cater to women with children such as shelters to provide in-reach and/ or e-health based services for women with children in those other settings.

Options and recommendations for system reconfiguration, cost effectiveness, efficiency and collaboration and integration

Drawing on the evidence from all sources, we suggest the following improvements:

1. There was no suitable information available to the review on one service provider, Velocity Transformations and therefore, no judgement can be made about the alignment of its model of care with the evidence base. We recommend it be independently reviewed in the short term.
2. Develop a more standardised and coordinated approach to admit clients to residential rehabilitation treatment and improve the continuum of care. This would better ensure that places go to the people in most need and more efficiently utilise resources currently available. Integrated care pathways, based on the UK NHS, from initial assessment to short stay or long stay residential rehabilitation program are suggested as appropriate models (see Figures 2 & 3; Chapter 7 of the Residential Rehabilitation Report).
3. Examine the structure and feasibility of short-term residential treatment models and the possibility of using Places of Safety and Sobering-up beds as multi-purpose facilities to provide flexible short term residential treatment.
4. Consider the option of providing residential step-up/step-down treatment, along the lines of Mental Health models, which provide a less structured treatment approach compared to short term residential rehabilitation treatment.
5. Treatment methods used in the program should be clearly identified and available to clients and stakeholders. Consequences of negative behaviours also need to be clearly identified for clients but handled in a way that keeps the client engaged with the service or with some part of the treatment service system.
6. From the information available, treatments provided at two rehabilitation services appear to be evidence based, using appropriate treatment methods aligned with contemporary best practice guidelines. Further review of the treatment provided by the third service, including its assessment and discharge procedures, and its length of stay, is recommended.
7. Services should ensure that language used to describe their treatment demonstrates respect for clients' choice.
8. Organisations differ in their approaches to manage waiting lists. While clients with moderate substance use dependency may also benefit from residential treatment, best practice guidelines state that people with more severe substance use dependence and/or complex issues should be the target population for this type of treatment. As such, residential rehabilitation treatment should be prioritised for people with more severe and/or complex issues.
9. Examine the structure and processes of enrolling clients into residential rehabilitation services, focusing on identifying ways to minimise waiting times and, where they are unavoidable, ensuring support is provided in the interim. Provide assertive outreach to engage people as soon

as places become available. Services should consider the use of e-health technologies to provide support and monitor clients' progress while they wait, and then as necessary prioritise entry to those that rapidly deteriorate or whose circumstances change significantly putting their health at risk.

10. Consider using standardised assessment tools to track clients' progress and assist with service evaluation, benchmarking and reporting at the state-wide level. For example, extend the use of the Alcohol and Drug Outcome Star and the Mental Health Outcome Star to track and report clients' progress in all three organisations.
11. Ensure adoption of the Quality Assurance Framework developed at the national level in all services in Tasmania.
12. Further review approaches to transition and aftercare to ensure clients who complete rehabilitation treatments are provided structured continuing care to support maintenance of treatment gains as they re-enter the community making maximum use of e-health options where appropriate and possible.
13. Review the rehabilitation service provider workforce's qualifications to ensure that all staff have appropriate training in AOD issues.
14. Set funding at levels that will allow for appointment of suitably qualified staff, ensuring a career path and providing strong support and supervision.
15. Develop strategies to link drug treatment services and other services that are critical to clients' quality of life and to clients' recovery. Suggestions are included in the Residential Rehabilitation Report.
16. Consider better ways to manage co-existing problems (e.g. mental and physical health). Detailed suggestions are included in the Residential Rehabilitation Report.

Options and recommendations for medium and longer-term activities

Based on the findings of this review, we developed and recommend a model of a service framework incorporating both short and longer-term stays, and day programs for rehabilitation treatment in Tasmania (Figure 1). In addition to the service elements identified in this model, an integrated AOD service system that provides a continuum of care should provide a step-up/step-down program to bridge ambulatory services and inpatient/residential services.

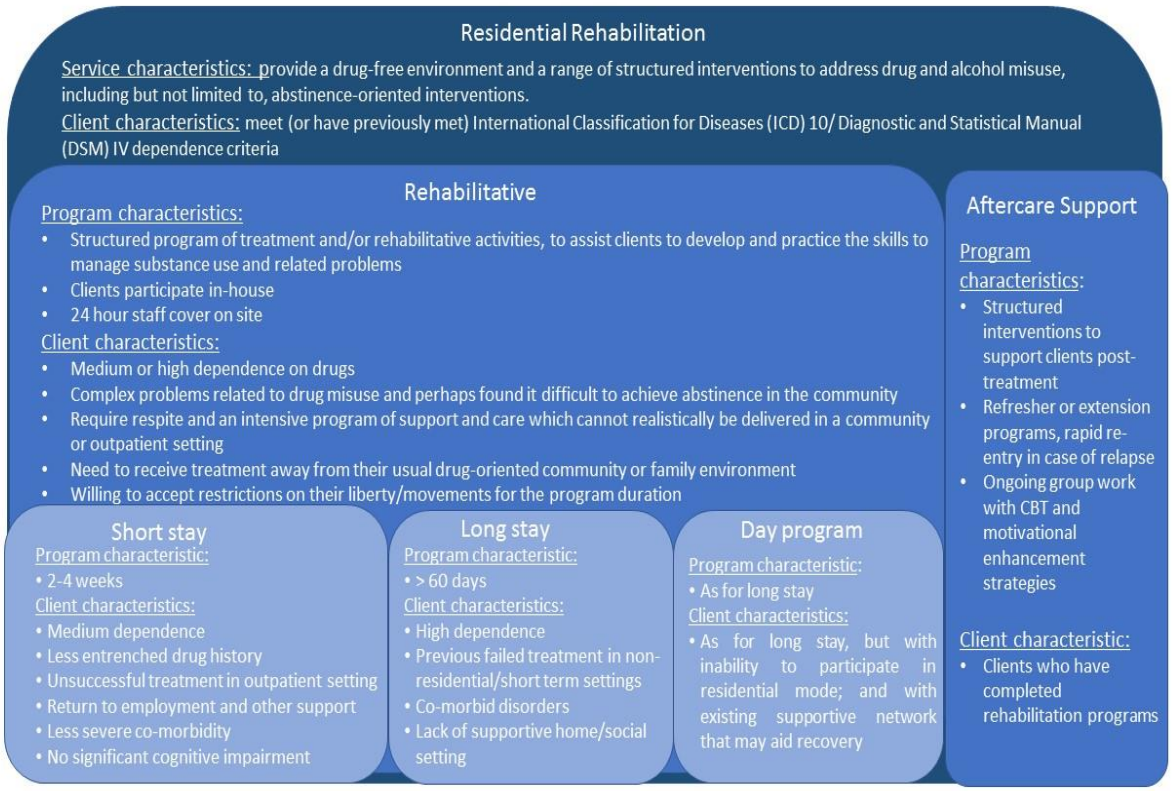

Figure 1: Draft Framework for rehabilitation treatment in Tasmania

Findings, and options and recommendation to Withdrawal Management

Findings

Informed by international and Australian peer-reviewed literature and clinical guidelines, this report analysed current withdrawal management services in Tasmania against contemporary benchmarks and service providers' feedback to identify potential areas of improvement.

Four withdrawal management models were identified: 1) ambulatory home-based withdrawal management; 2) community residential withdrawal management (with or without medical supervision); 3) inpatient withdrawal management; and 4) rural and regional withdrawal management.

Contemporary best practice guidelines highlight that ambulatory withdrawal management should be considered the first option, as it is the least restrictive option for the patient. Patients should only be referred to hospital when withdrawal may be complicated by its severity or other medical or psychiatric problems, or when no other suitable option is available, noting that the suitability of ambulatory withdrawal management services differs by drug type and complexity of presentations, and they are unsuitable for those individuals who do not have a home environment that is conducive to withdrawal management.

In Tasmania, withdrawal management services are mainly provided by the single Inpatient Withdrawal Management Unit in Hobart, with limited capacity of ambulatory home-based withdrawal management provided by The Salvation Army. Hospital separations data also shows a significant proportion of inpatient withdrawal management occurred in public and private hospitals throughout Tasmania.

Recently, the Launceston City Mission and The Salvation Army has formed a partnership to provide withdrawal management (without medical supervision) for clients with less complex presentations at the Sobering up/Places of Safety Beds at Serenity House.

Table 3 below presents a high-level summary of the resources (clinical FTEs and beds) modelled to provide ambulatory and inpatient withdrawal management in Tasmania.

Table 3: High level summary of clinical staff and bed estimates for withdrawal management modelled in the DASP model

Settings	Clinical staff FTEs		Beds	
	Clinical Staff FTEs	Clinical Staff FTE cost $mill	Beds	Bed overheads cost $mill
Ambulatory				
Ambulatory - standard	4.3	0.6	-	-
Ambulatory – complex (addition)	0.4	0.0	-	-
Detoxification				
Detox	6.8	1.0	19.3	1.3
Detox-caretaker	4.3	0.5	-	-
Inpatient				
Inpatient	9.8	5.6	4.5	0.3

Note: Caretaker Clinical Staff are a small additional component of Clinical staffing FTE resources and costs, in residential rehabilitation and withdrawal (residential – dorm) bed settings. Within withdrawal management context, caretaker clinical staff are modelled based on NAH category.

Comparisons between current service provisions against the DASP modelling of demand for withdrawal management services shows resources (clinical staff FTEs and beds) for inpatient withdrawal management approximates that modelled in the DASP, noting a lack of information on resources available for inpatient withdrawal management in private hospitals. Our comparison shows a significant gap of separations needed for inpatient withdrawal management. Clinical staff FTEs available for ambulatory home-based withdrawal management was not available; however, documentation available points to a significant gap. This interpretation is also consistent with stakeholders' views provided in individual and group interviews. Resources budgeted to provide consultation liaison (CL) services for withdrawal management approximate that modelled by the DASP.

Comparisons between current service provisions against the DASP modelling of demand for withdrawal management services, taking into account feedback provided by service providers and consumers through targeted consultations, results in the following recommendations:

Options and recommendations for system reconfiguration, cost effectiveness, efficiency and collaboration and integration

Taking together the information from the literature review, client pathway consultations and the DASP modelling (based on the specific DRGs code for withdrawal management[7]) it would appear that the resources available for inpatient withdrawal management are adequate to meet the needs of the

[7] The following DRGs are: V60A Alcohol Intoxication and Withdrawal with complications; V60B Alcohol Intoxication and Withdrawal without complications; and V61Z Drug Intoxication and Withdrawal

Tasmanian population. However, there is a question remaining about the data provided to this review. Comments received from the DHHS at the end of the review process about the coding practices of the hospital in relation to the client load of the In-Patient Withdrawal Unit (IPWU), where a proportion of the unit workload is coded to the following DRGs:

- V62Z Alcohol Use and Dependence
- V63Z Opioid Use and Dependence
- V64Z Other Drug Use and Dependence

This, therefore, leaves open the possibility that this unit is providing a mixture of inpatient withdrawal services and treatment services, or that there is a problem with the coding practices. This issue cannot be resolved within the timeframe or scope of this review. We recommend that the DHHS include a review of coding practices as part of the overall review of the IPWU.

- The review of the IPWU should focus on understanding the barriers to accessing the unit including opening hours for the admission of patients.

- The review will include bringing the sector together to work out the seamless client pathways from withdrawal management to other services and mutually agreed processes and protocols to support that client pathway. The review also needs to ensure that the client pathway does not need to meet the requirement that the consumer have a pre-determined post withdrawal destination as a condition of admission, but rather includes the determination of the clients' pathway post withdrawal management during the withdrawal period.

- The review should consider the benefits and/or disadvantages of transfer of the management and clinical governance of the IPWU to the Royal Hobart Hospital, based on: the need to improve access to medical and nursing staff on a 24/7 basis; to allow for more user-friendly operating hours and therefore potential to increase the capacity for training for general medical, nursing and allied health staff in addiction medicine management; opportunities for the training of specialist AOD medical and other staff; and the most cost-effective use of the existing highly specialist staff of the IPWU in the provision of supervision, training and consultation liaison services into the hospital and secondary consultation services to the broader treatment system.

Options and recommendations for medium and long-term activities

In addition, in relation to options and recommendation so what is needed in the medium and longer term to achieve an integrated approach to withdrawal management within a single AOD service system framework, we suggest that:

- **Model of care**: A model of care for withdrawal management services in Tasmania that clearly identifies treatment approaches for withdrawal management is required. This model of care should include the adoption of contemporary clinical guidelines such as those recently developed in Victoria, Queensland and New South Wales for all withdrawal management settings in Tasmania, including but not limited to inpatient and ambulatory home-based settings.
- **Withdrawal management in private hospital settings**: Reviewing the capacity of private hospitals to provide withdrawal management services in Tasmania, and whether it might be a

cost-effective option for the public system to consider purchasing public admissions in private facilities rather than increasing public sector investment in infrastructure and staffing.

- **Ambulatory home-based withdrawal management**: Increasing the capacity for ambulatory withdrawal management services in Tasmania. Many service providers considered that the provision of ambulatory, home-based withdrawal management services would provide clients with less complex presentations with more treatment options to undergo withdrawal management. Existing resources of the Inpatient Withdrawal Unit (IPWU) may be used to support GPs and home-based withdrawal nurses in the delivery of ambulatory home-based withdrawal management.
- **Community residential withdrawal management**: Community residential withdrawal management (with or without medical supervision) has been identified as suitable for patients with less complex presentations, or those in need of a more stable care environment. Tasmania DHHS may want to consider the use of other Places of Safety/Sobering Up beds as multi-purpose facilities to provide community residential withdrawal management.
- **Inpatient withdrawal management in general hospital beds**: Due to resource limitations, the DHHS may also consider enhancing the capacity of hospitals and other clinical facilities to manage a small number of cases in areas outside of Hobart.
- **Youth**: Addressing the need for inpatient withdrawal management services appropriate for youth. DASP estimates for inpatient withdrawal management for youth indicated that there is not enough demand to warrant a stand-alone facility. Alternative options for youth inpatient withdrawal management should be considered.
- **Transition from withdrawal management**: Withdrawal services should meet with ongoing care and work out how to ensure smooth and timely transition from withdrawal to ongoing outpatient and inpatient care after withdrawal including identification and resolution of barriers.
- **Mersey Community Hospital:** We note the recent transfer of the Mersey Community Hospital back to the Tasmanian state government. The establishment of a level 4 service at the Mersey Community Hospital in the Northwest, as noted in the *Delivering Safe and Sustainable Services* White Paper, would allow the development of Addiction Medicine Services. The capacity of this service, as well as the opportunity to use general hospital beds in this facility for inpatient withdrawal management, should be considered in the development of withdrawal management services state-wide.

Australian Government
Australian Institute of Health and Welfare

Rural & remote health

Web report | Last updated: **22 Oct 2019** | Author: **AIHW** |

Citation

AIHW

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On average, Australians living in rural and remote areas have shorter lives, higher levels of disease and injury and poorer access to and use of health services, compared with people living in metropolitan areas. Poorer health outcomes in rural and remote areas may be due to multiple factors including lifestyle differences and a level of disadvantage related to education and employment opportunities, as well as access to health services.

Cat. no: PHE 255

Findings from this report:

- In 2017–18, potentially preventable hospitalisation rates in Very remote areas were 2.5 times as high as Major cities
- In 2016, people in Remote areas were more likely to report barriers accessing GPs and specialists than Major cities
- In 2015–2017, life expectancy for both males and females decreased as remoteness increased
- In 2015, the total disease burden rate in Remote and very remote areas was 1.4 times as high as Major cities

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Summary

Rural and remote Australia encompasses many diverse locations and communities and people living in these areas face unique challenges due to their geographic isolation. Those living outside metropolitan areas often have poorer health outcomes compared with those living in metropolitan areas. For example, data show that people living in rural and remote areas have higher rates of hospitalisations, mortality, injury and poorer access to, and use of, primary health care services, compared with those living in metropolitan areas.

Health inequalities in rural and remote areas may be due to factors, including:

- challenges in accessing health care or health professionals, such as specialists
- social determinants such as income, education and employment opportunities
- higher rates of risky behaviours such as tobacco smoking and alcohol use
- higher rates of occupational and physical risk, for example from farming or mining work and transport-related accidents.

Despite poorer health outcomes for some, the Household, Income and Labour Dynamics in Australia (HILDA) survey found that Australians living in small towns (fewer than 1,000 people) and non-urban areas generally experienced higher levels of life satisfaction compared with those in urban areas (Wilkins 2015). Rural and remote Australians also report increased community interconnectedness and social cohesion, as well as higher levels of community participation, volunteering and informal support from their communities (Ziersch et al. 2009).

How is remoteness area classified?

This report uses the Australian Statistical Geography Standard Remoteness Structure, 2016, which defines remoteness areas into 5 classes of relative remoteness across Australia:

- *Major cities*
- *Inner regional*
- *Outer regional*
- *Remote*
- *Very remote.*

These remoteness areas are centred on the Accessibility/Remoteness Index of Australia which is based on the road distances people have to travel for services (ABS 2018a).

In this report, the term 'rural and remote' covers all areas outside Australia's *Major cities*. Due to small population sizes, data for *Outer regional*, *Remote* and *Very remote* as well as *Remote* and *Very remote* areas are sometimes combined for reporting (ABS 2018b). Based on available data, these results have been presented as low level as possible.

What is missing from the picture?

Gaps exist in the availability and coverage of health data in rural and remote areas, and in information available at local level. For example, the Australian Bureau of Statistics' National Health Survey, which provides information on the prevalence of long-term health conditions and health risk factors but, does not include *Very remote* areas of Australia.

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Profile of rural and remote Australians

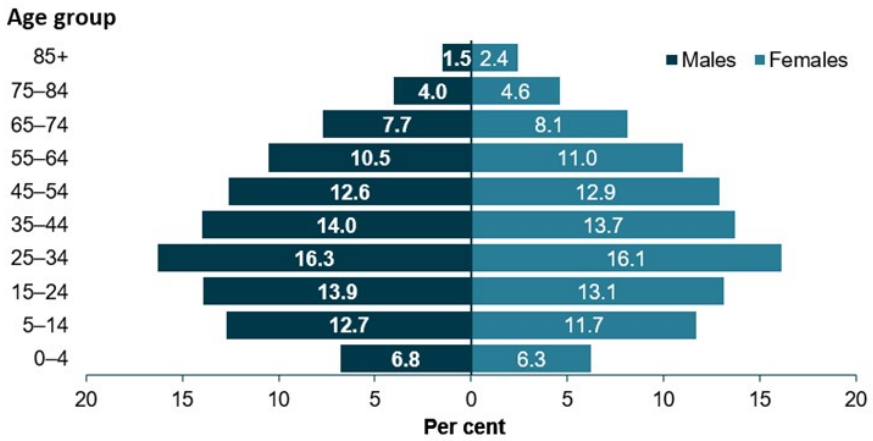
Overall, more Australians live in *Major cities* compared with rural and remote areas. In 2017, the proportion of Australians by area of remoteness was:

- 72% in *Major cities*
- 18% in *Inner regional areas*
- 8.2% in *Outer regional areas*
- 1.2% in *Remote areas*
- 0.8% in *Very remote areas* (ABS 2019b).

On average, people living in *Remote and very remote* areas were younger than those living in *Major cities* (figures 1a and 1c).

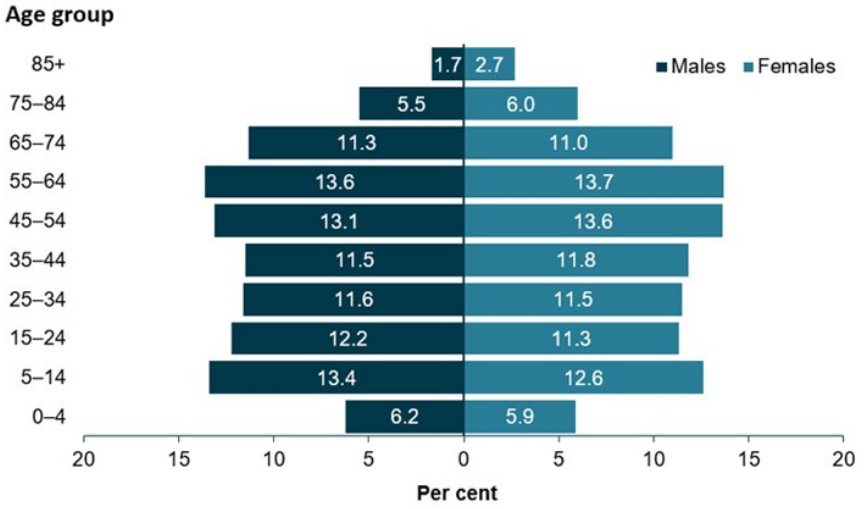
Australians aged 25–44 were more likely to live in *Remote and very remote* areas and *Major cities* compared with *Inner regional and outer regional* areas. However, a higher proportion of people aged 65 and over lived in *Inner regional and outer regional* areas and *Major cities,* compared with *Remote and very remote* areas (figures 1a, 1b and 1c).

Figure 1a: Australian population, by age group and sex residing in Major cities, 2017



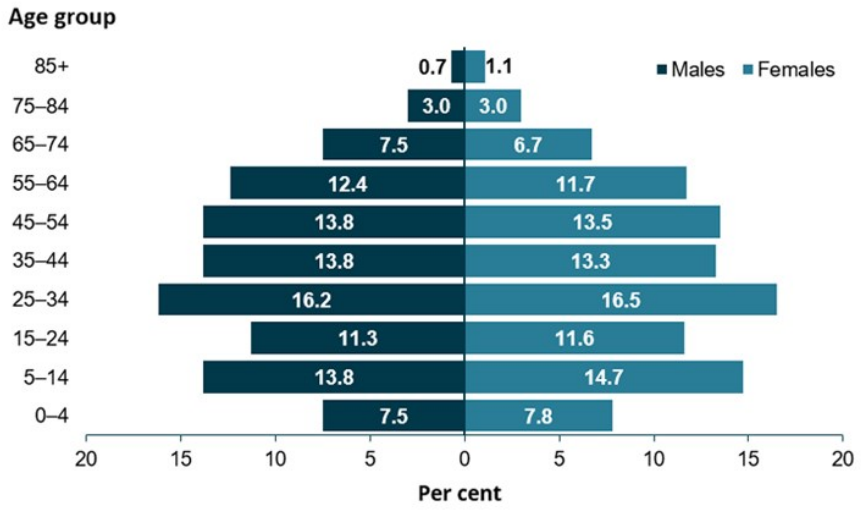
Source: ABS 2018c; Table S1.

Figure 1b: Australian population, by age group and sex residing in Inner regional and outer regional areas, 2017



Source: ABS 2018c; Table S1.

Figure 1c: Australian population, by age group and sex residing in Remote and very remote areas, 2017



Source: ABS 2018c; Table S1.

Aboriginal and Torres Strait Islander people are more likely to have higher rates of chronic conditions, hospitalisations and poorer health outcomes than non-Indigenous Australians (AIHW 2015). The differences in health outcomes in *Remote* and *Very remote* areas may be due to the characteristics of these populations. The proportion of the population that is Indigenous, is much higher in more remote areas (ABS 2018b) (Table 1). However, more Indigenous Australians live in *Major cities* and *Inner regional* areas (61% of Indigenous Australians) compared with *Remote* and *Very remote* areas (19%) (ABS 2018b).

Table 1: Proportion of people in each remoteness areas that are Indigenous Australians and non-Indigenous Australians, 2016

	Major cities	**Inner regional**	**Outer regional**	**Remote**	**Very remote**
Indigenous	1.7%	4.4%	7.9%	18%	47%
Non-Indigenous	98%	96%	92%	82%	53%
Total	100%	100%	100%	100%	100%

Source: ABS 2018b.

For more information on Aboriginal and Torres Strait Islander health by remoteness see: *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples: 2015* and the *Aboriginal and Torres Strait Islander Health Performance Framework (HPF) report*

Social determinants of health

In general, people from poorer social or economic circumstances:

- are at greater risk of poor health
- have higher rates of illness, disability and death
- live shorter lives than those who are more advantaged (Mackenbach 2015).

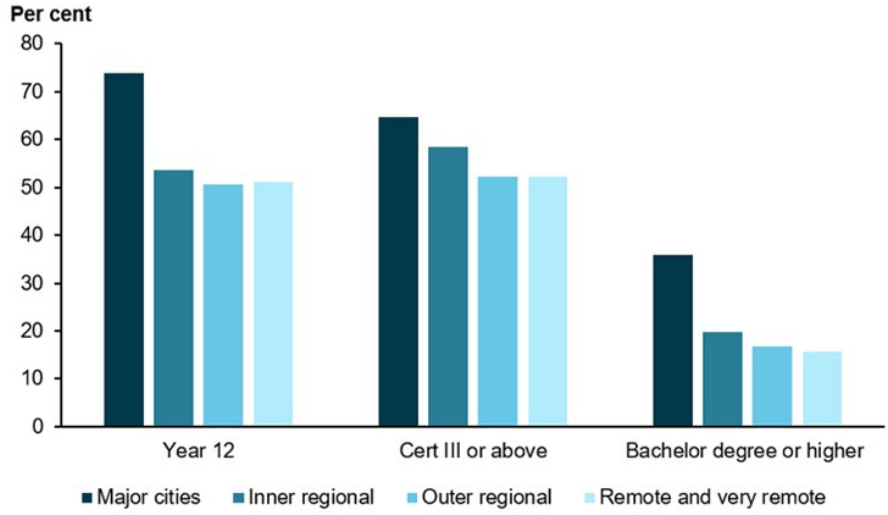
Indicators such as education, occupation and income can be used individually or combined to define socioeconomic position. There is a complex interplay between health and welfare, where social factors such as an individual's education, employment, and relationships can impact their overall health, and vice versa.

Education

In 2018, people living in rural and remote areas were less likely than those in *Major cities* to have completed Year 12 or a non-school qualification (Figure 2). Around half of people living in *Inner regional, Outer regional* and *Remote and very remote* areas had completed Year 12, compared with nearly three-quarters (74%) of those in *Major cities*.

Likewise, fewer people living in *Inner regional* (20%), *Outer regional* (17%) and *Remote and very remote* (16%) areas had completed a Bachelor's degree or above, compared with those in *Major cities* (36%).

Figure 2: Proportion of 20–64 year olds with a Year 12 certificate or above, by remoteness area, 2018

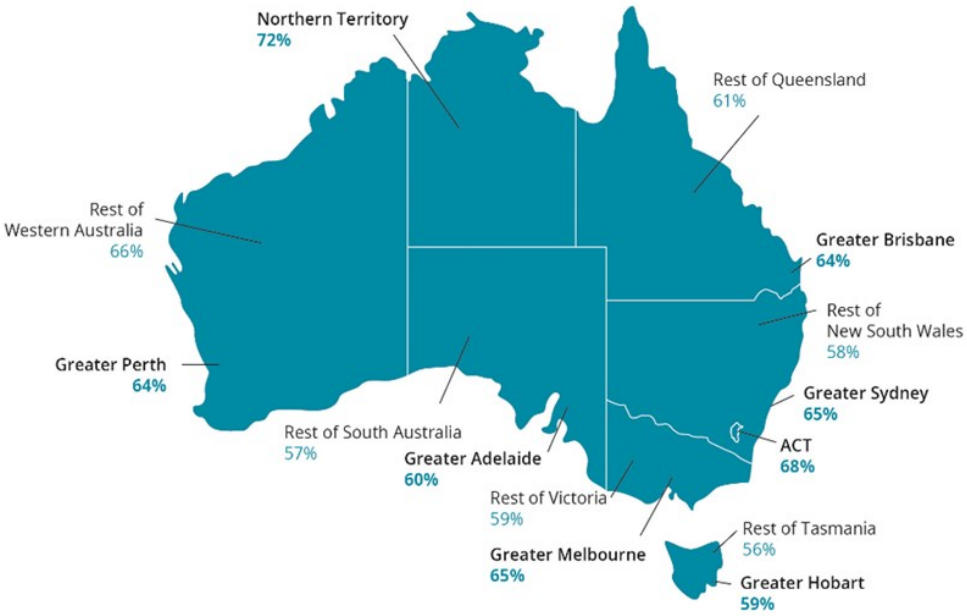


Source: ABS 2018a; Table S2

Employment

The employment-to-population ratio shows the proportion of a country's working-age population, aged 15 and over that is employed. As at December 2018, the employment- to-population ratio across Australia was 63%. With the exception of Greater Perth, greater metropolitan areas had a higher proportion of employed people than did the rest of the states and territories (Figure 3). This may be due to lower levels of access to work outside of metropolitan areas and decreased range of employment and career opportunities in these areas (ABS 2019a; NRHA 2013).

Figure 3: Employment-to-population ratio, by greater metropolitan areas and the rest of states and territories, 2018



Source: ABS 2019a; Table S3.

Income

People living in rural and remote areas generally have lower incomes but have to pay higher prices for goods and services (NRHA 2014). In 2015–16, Australians living outside of capital cities had, on average, 18% less household income per week compared with those living in capital cities, and 29% less mean household net worth (ABS 2017).

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Health status and outcomes

Health risk factors

Health risk factors are attributes, characteristics or exposures that increase the likelihood of a person developing a disease or health disorder. Many health problems can be prevented by reducing exposure to modifiable risk factors such as:

- tobacco smoking
- poor eating patterns
- risky alcohol consumption
- not getting enough exercise.

For more information see Risk factors.

Based on self-reported data from the ABS National Health Survey (NHS) 2017–18, after adjusting for age, the prevalence of many risk factors was higher for *Inner regional* and *Outer regional and remote* areas than for *Major cities* (Figure 1).

Smoking

- People living outside of *Major cities* had higher rates of current daily smoking. About 1 in 5 in *Outer regional* and *remote* (19.6%) and *Inner regional* (16.5%) areas smoked tobacco daily, compared with 12.8% in *Major cities*.

Overweight and obesity

- More adults in *Inner regional* (71%) and *Outer regional and remote* (70%) areas were overweight or obese, compared with *Major cities* (65%), based on measured height and weight.

Diet

- People living in *Inner regional* and *Outer regional and remote* areas (53%) were less likely to eat the recommended number of serves of fruit per day, compared with *Major cities* (48%).
- Less than 1 in 10 people ate the recommended serves of vegetables in all remoteness areas.
- People in *Outer regional and remote* areas were more likely to consume sugar sweetened drinks daily (14%) than *Major cities* (8.3%).

Alcohol consumption

- People in *Outer regional and remote* (24%) and *Inner regional* (19%) areas were more likely to consume alcohol at levels that put them at risk of lifetime harm, compared with *Major cities* (15%).

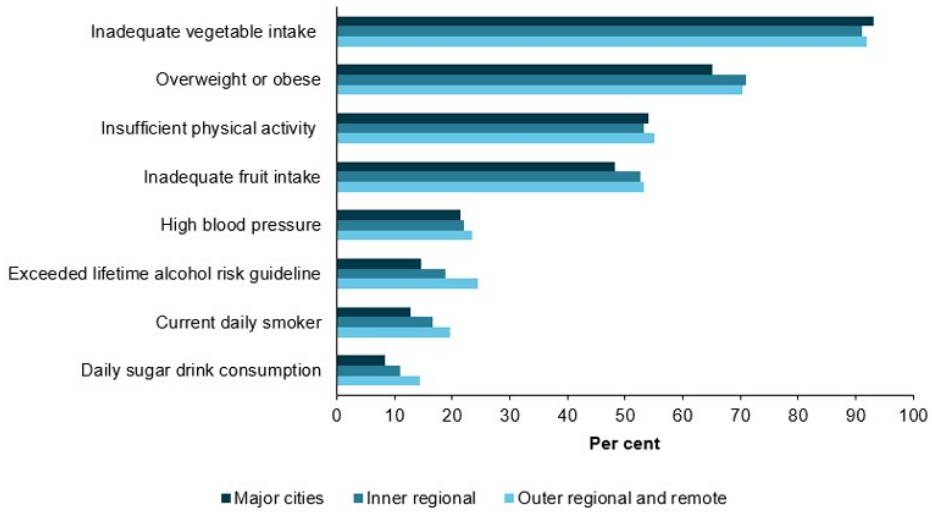
Physical activity

- Just under half of people met the physical activity guideline in all remoteness areas.

High blood pressure

- The proportion of people (about one quarter) with measured high blood pressure (hypertension) was similar across all remoteness areas.

Figure 1: Prevalence of health risk factors, by area of remoteness, 2017–18



Notes

1. Proportions were age standardised to the 2001 Australian standard population.
2. Excludes *Very remote* areas.

Source: AIHW analysis of ABS 2019; Table S4.

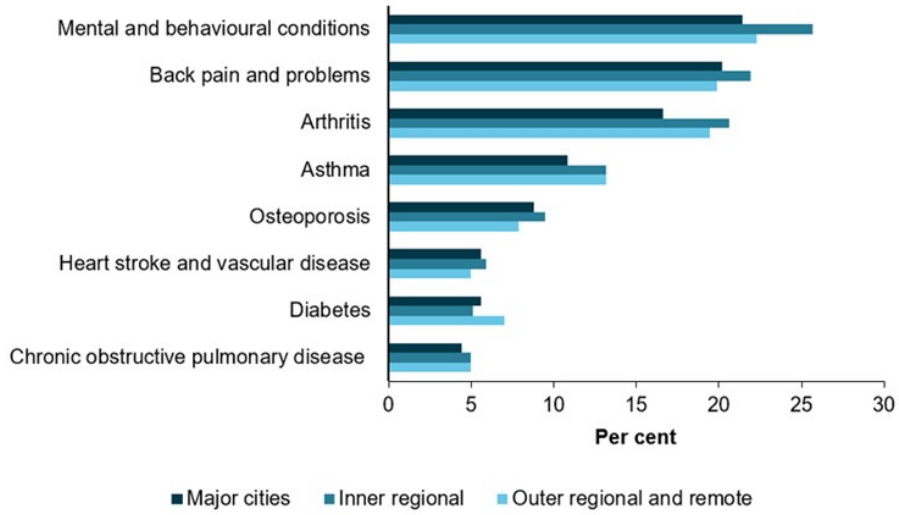
Chronic conditions

Based on self-reported data from the ABS NHS, the prevalence of many chronic conditions was similar across all remoteness areas in 2017–18, after adjusting for differences in population age structure.

There were exceptions:

- mental and behavioural problems were higher in *Inner regional* areas (26%) compared with *Outer regional and remote* areas (22%) and *Major cities* (21%)
- arthritis was higher in *Inner regional* areas (21%) and *Outer regional and remote* areas (20%) compared with *Major cities* (17%)
- asthma was higher in *Inner regional* and *Outer regional and remote* areas (13%) compared with *Major cities* (11%)
- diabetes was higher in *Outer regional and remote* areas (7.0%) compared with *Major cities* (5.6%) (Figure 2).

Figure 2: Prevalence of the population with selected chronic conditions, by area of remoteness, 2017–18



Notes

1. Proportions were age standardised to the 2001 Australian Standard Population.
2. Excludes *Very remote* areas.

Source: AIHW analysis of ABS 2019; Table S5.

Cancer

The incidence of all cancers combined was highest in *Inner regional* and *Outer regional* areas in 2010–2014 (513 and 511 per 100,000 people, respectively), after adjusting for age. Incidence was:

- slightly lower in *Remote* areas (490) and *Major cities* (488);
- lowest in *Very remote* areas (445) (AIHW 2019b).

The lower incidence rate in *Remote* and *Very remote* areas may be partly due to lower population screening participation rates, later detection of a cancer and lower life expectancy due to death from other causes (Fox & Boyce 2014; AIHW 2019d).

However, the 5-year observed survival rate for all cancers combined decreased with increasing remoteness, from 62% for *Major cities* to 55% for *Very remote* areas.

Types of cancers diagnosed also varied by area, with people in rural and remote areas more likely to be diagnosed with low survival cancers, such as lung and unknown primary site cancers (AIHW 2019b).

For more information see: Cancer in Australia 2019.

Family, domestic and sexual violence

Family, domestic and sexual violence is a major health and welfare issue in Australia. The Australian Bureau of Statistics 2016 Personal Safety Survey estimated that 2.2 million adults had been victims of physical and/or sexual violence from a partner since the age of 15 (ABS 2017).

People living outside *Major cities* were 1.4 times as likely to have experienced partner violence than those living in *Major cities*. Additionally, people living in *Remote* and *Very remote* areas were 24 times as likely to be hospitalised for domestic violence as those in *Major cities* (AIHW 2019c).

For more information see: Family, domestic and sexual violence in Australia.

Burden of disease

Burden of disease measures the impact of disease and injury in a population. The summary measure 'disability-adjusted life years'

(DALY) combines the years of healthy life lost due to living with and dying prematurely from disease and injury.

In 2015, after adjusting for age, the total burden of disease increased with increasing remoteness. *Major cities* experienced the least burden per population, whilst *Remote and very remote* areas experienced the most. The total burden rate in *Remote and very remote* areas was 1.4 times as high as that for *Major cities*.

This pattern was mostly driven by fatal burden (years of life lost due to premature death). In *Remote and very remote* areas, rates were 1.7 times as high as *Major cities*, while non-fatal burden was 1.2 times as high.

For most disease groups, total burden rates increased with increasing remoteness. There was some variation by disease. A clear trend of greater burden rates was seen with increasing remoteness for:

- coronary heart disease
- chronic kidney disease
- chronic obstructive pulmonary disease (COPD)
- lung cancer
- stroke
- suicide
- self-inflicted injuries
- type 2 diabetes.

In contrast, anxiety disorders, dementia and depressive disorders showed lower rates of burden in more remote areas (AIHW 2019a).

For more information see: Australian Burden of Disease Study 2015.

Deaths

People living in rural and remote areas are more likely to die at a younger age than their counterparts in *Major cities*. They have higher mortality rates, higher rates of potentially avoidable deaths and lower life expectancy than those living in *Major cities*.

In 2017, age-standardised mortality rates increased as remoteness increased for males and females:

- males living in *Very remote* areas had a mortality rate 1.4 times as high as those living in *Major cities* (Table 1a)
- females living in *Very remote* areas had a mortality rate 1.8 times as high as those living in *Major cities* (Table 1b).

Overall, the difference in mortality rates between *Major cities* and regional and remote areas remained similar for the period 2013 to 2017.

Median age at death also decreased with increasing remoteness for males and females (tables 1a and 1b).

Table 1a: Median age at death, mortality rate and rate ratio for males, by remoteness area, 2017

	Major cities	Inner regional	Outer regional	Remote	Very remote
Median age at death (years)	79	78	76	73	68
Age-standardised rate (deaths per 100,000)[(a)]	592	662	722	763	822
Rate ratio[(b)]	1.0	1.1	1.2	1.3	1.4

a. Rates are age-standardised to the 2001 Australian standard population.
b. Rate ratio is the age-standardised mortality rate for each area divided by the age-standardised rate for *Major cities*.

Source: AIHW 2019d.

Table 1b: Median age at death, mortality rate and rate ratio for females, by remoteness area, 2017

	Major cities	Inner regional	Outer regional	Remote	Very remote
Median age at death (years)	85	84	82	79	69
Age-standardised rate (deaths per 100,000)[(a)]	426	477	486	505	748
Rate ratio[(b)]	1.0	1.1	1.1	1.2	1.8

a. Rates are age-standardised to the 2001 Australian standard population.
b. Rate ratio is the age-standardised mortality rate for each area divided by the age-standardised rate for *Major cities*.

Source: AIHW 2019d.

Potentially avoidable deaths

The rate of potentially avoidable deaths increased as remoteness increased.

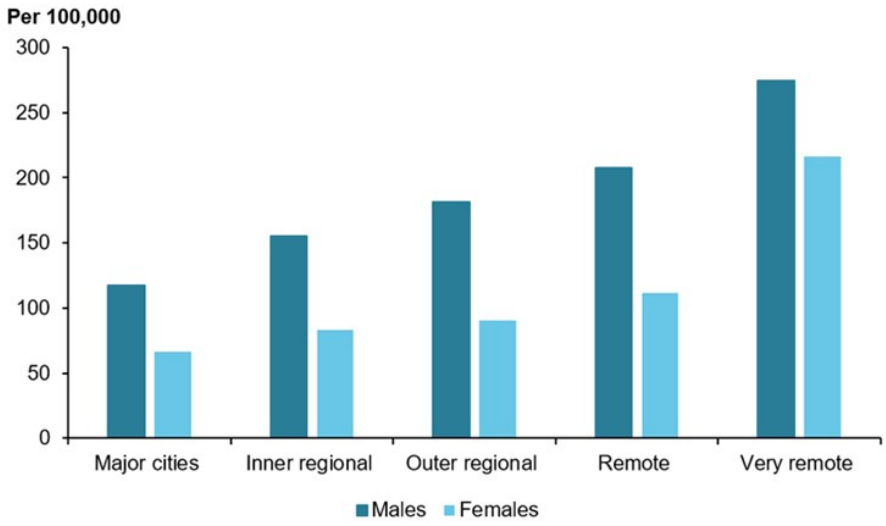
These are deaths among people aged 75 and under from conditions considered potentially preventable through individualised care, and/or treatment through existing primary or hospital care. For example, transport accidents and cancers that can be detected early through screening programs (such as breast, cervical and colorectal cancers).

For more details on examples and definitions of potentially avoidable deaths see: Potentially avoidable deaths International Classification of Disease (ICD–10) codes.

In 2017, potentially avoidable deaths made up 17% of all deaths in Australia. For males and females, the rate increased with remoteness. The rate for:

- females in *Very remote* areas was 3.3 times as high as *Major cities* (216 per 100,000 population compared with 67)
- males in *Very remote* areas was 2.3 times as high as *Major cities* (275 per 100,000 population compared with 118) (Figure 3).

Figure 3: Potentially avoidable deaths per 100,000, by remoteness area and sex, 2017



Note: Rates are age-standardised to the 2001 Australian standard population.

Source: AIHW 2019d.

Leading causes of death

Figure 4 shows the 10 leading causes of death for each remoteness area for the period 2013–2017, with comparison to mortality rates for Australia overall (AIHW 2019d).

In this period:

- The top 7 causes of death were the same for *Major cities*, *Inner regional* and *Outer regional* areas.
- Coronary heart disease was the leading cause of death across all remoteness areas. Age-standardised rates were higher in *Very remote* (1.5 times) and *Remote* areas (1.3 times) than for Australia overall.
- People living in *Remote* and *Very remote* areas were more likely to die from diabetes (1.8 and 3.5 times respectively), compared with Australia overall.
- Suicide was one of the top 10 leading causes of death in *Outer regional, Remote* and *Very remote* areas. Australians living in *Remote* and *Very remote* areas were about twice as likely to die from suicide when compared with Australia overall. The rate of suicide was 11 per 100,000 population in *Major cities* and increased with remoteness and was highest for *Remote* (19) and *Very remote* areas (24).
- Land transport accidents were a leading cause of death in *Remote* and *Very remote* areas. The rate of dying due to land transport accidents was nearly 3 times as high for *Remote* areas and nearly 4 times as high for *Very remote* areas, compared with Australia overall (AIHW 2019d) (Figure 4).

Figure 4: Leading cause of death by remoteness area, with comparison mortality rates with Australia overall, 2013–2017

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
1	Coronary heart disease	Coronary heart disease	Coronary heart disease	Coronary heart disease	Coronary heart disease
2	Dementia & Alzheimer disease	Dementia & Alzheimer disease	Dementia & Alzheimer disease	Lung cancer	Diabetes
3	Cerebrovascular disease	Cerebrovascular disease	Cerebrovascular disease	Chronic obstructive pulmonary disease	Chronic obstructive pulmonary disease
4	Lung cancer	Lung cancer	Lung cancer	Dementia & Alzheimer disease	Lung cancer
5	Chronic obstructive pulmonary disease	Chronic obstructive pulmonary disease	Chronic obstructive pulmonary disease	Diabetes	Suicide
6	Colorectal cancer	Colorectal cancer	Colorectal cancer	Cerebrovascular disease	Cerebrovascular disease
7	Diabetes	Diabetes	Diabetes	Colorectal cancer	Land transport accidents
8	Influenza and pneumonia	Heart failure	Heart failure	Suicide	Dementia & Alzheimer disease
9	Heart failure	Prostate cancer	Prostate cancer	Land transport accidents	Colorectal cancer
10	Prostate cancer	Influenza and pneumonia	Suicide	Liver disease	Cancer of unknown primary site

Rate ratio compared to Australia

<= 1.0	1.1–1.24	1.25–1.49	1.5–1.9	2.0–2.9	3.0–4.0

Notes

1. Rates are age-standardised to the 2001 Australian standard population.
2. Leading causes of death are listed in order of number of deaths in each remoteness area from 2013–2017.
3. Boxes are coloured based on the rate ratio comparing each region to Australia overall.

Source: AIHW 2019d.

For more information see: Mortality Over Regions and Time (MORT) books.

Life expectancy

Estimates of life expectancy at birth represent the average number of years that a newborn baby can expect to live, assuming current age-specific death rates are experienced through their lifetime.

In 2015–2017, life expectancy at birth varied with remoteness and sex. Within each remoteness area, females had a higher life expectancy than males. For both sexes, life expectancy decreased as remoteness increased (Table 2) (ABS 2018).

Table 2: Life expectancy at birth, 2015–2017

	Major Cities	**Inner and outer regional**	**Remote and very remote**
Males	81 years	79 years	76 years
Females	84 years	83 years	80 years

Source: ABS 2018.

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Access to health care

People living in *Remote* and *Very remote* areas generally have poorer access to health services than people in regional areas and *Major cities*. They also have lower rates of bowel, breast and cervical cancer screening and higher rates of potentially preventable hospitalisations (AIHW 2018a, 2018b, 2019a, 2019b).

People living in remote areas of Australia may need to travel long distances or relocate to attend health services or receive specialised treatment. For example, based on combined data for 2005–2010, 57% of people with end-stage kidney disease who lived in *Very remote* areas at the start of their treatment moved to less remote areas within 1 year (AIHW 2013).

Primary health care

Primary health care is the entry level to the health system. As such, it is usually a person's first encounter with the system. It includes a broad range of activities and services, from health promotion and prevention, to treatment and management of acute and chronic conditions (AIHW 2016).

The way people in rural and remote areas access primary health care often differs to those in metropolitan areas. For example, facilities are generally smaller, have less infrastructure and provide a broader range of services to a more widely distributed population. Rural and remote populations also rely more on general practitioners (GPs) to provide health care services, due to less availability of local specialist services (Department of Health 2016).

Medicare claims data from 2017–18 shows that the number of non-hospital non-referred attendances per capita were less in *Outer regional* (6.0 per capita) and *Remote* and *Very remote* areas (4.9 and 3.6 per capita respectively), compared with *Major cities* (6.3 per capita). Bulk billing rates were highest in *Very remote* areas and *Major cities*; rates were slightly lower but similar in *regional areas* (Department of Health 2018) (Table 1).

Table 1: Medicare statistics, non-hospital non-referred attendances, excluding practice nurse items, by area of remoteness, 2017–18[(a)(b)(c)(d)]

	Major cities	Inner regional	Outer regional	Remote	Very remote
Number of services	112,015,315	27,742,916	12,273,644	1,431,221	731,445
Number of services per capita[(e)]	6.3	6.3	6.0	4.9	3.6
Bulk billing rate[(f)(g)]	87%	84%	85%	85%	89%
Average out of pocket cost for non-bulk billed services[(h)]	$38.37	$34.73	$35.72	$39.44	$40.59

Source: Department of Health Annual Medicare Statistics 2018.

Notes

a. Financial Year is determined by the date the claim for service was processed by the Department of Human Services, not the date the service was rendered.
b. Medicare services refer to services funded through the Medicare Benefits Schedule (MBS).
c. Remoteness area is determined by the patient's Medicare enrolment postcode as at the date their claim was processed.
d. Numbers are based on out of hospital data.
e. Number of services per capita is derived from the total Estimated Resident Population for financial years based on ABS catalogue 3218.0 Regional Population Growth, Australia, table 1 Estimated Residential Population, Remoteness Areas, Australia, released March each year. ERP used are based on June quarter population. However, there are people in the population who are not eligible for Medicare therefore this number is an estimate.
f. Bulk billing is reported on a year-to-date (YTD) basis over the course of the financial year. The bulk billing rates are rounded to whole numbers for reporting purposes.
g. Bulk Billing Rate represents the percentage of services bulk billed.
h. Average Patient Contribution Per Service is for patient billed services rendered out of hospital. The number of services is the total number of non-hospital, non-referred attendances, excluding practice nurse items, that were bulk billed or patient billed.

Survey of Health Care: Patient experiences

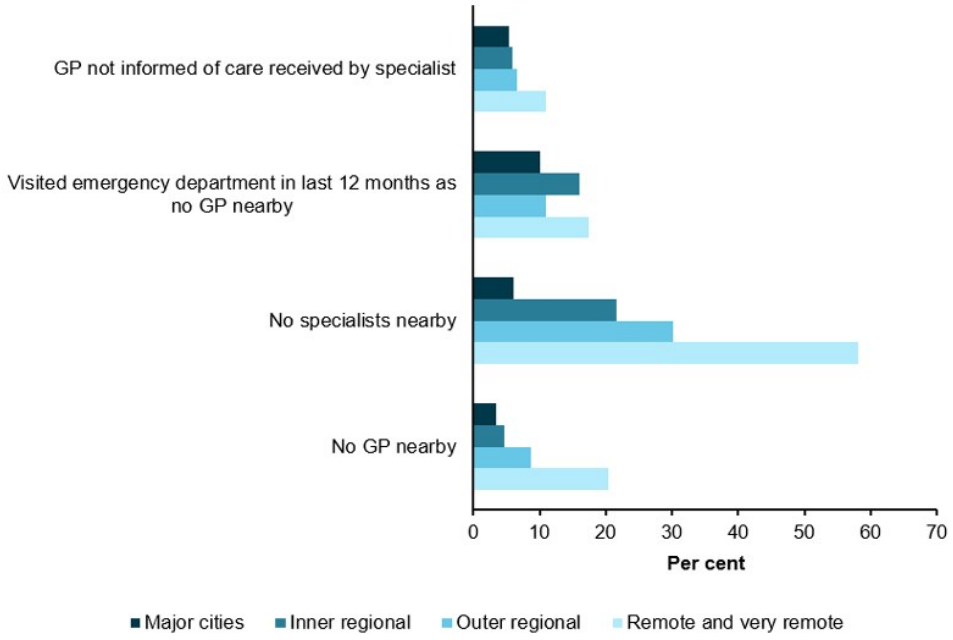
Based on self-reported data from the Australian Bureau of Statistics Survey of Health Care, in 2016, Australians aged 45 and over living in regional and *Remote* and *Very remote* areas were more likely than those living in *Major cities* to report barriers to receiving health care. When compared to *Major cities*, the rate of people reporting not having a GP nearby as a barrier to seeing one was:

- 2.5 times as high for *Outer regional* areas
- 6 times as high for *Remote and very remote* areas.

The proportion of people reporting not having a specialist nearby as a barrier to seeing one increased from:

- 6.0% in *Major cities* to
- 22% in *Inner regional* areas to
- 30% in *Outer regional* areas and
- 58% in *Remote and very remote* areas (Figure 1) (AIHW 2018c).

Figure 1: Patient experiences in adults aged 45 and over, by remoteness, 2016



Source: AIHW 2018c.

For more information see: Survey of Health Care: selected findings for rural and remote Australians.

Health workforce

Health workforce is measured by the number of full-time equivalent (FTE) health professionals in an area divided by the estimated resident population of the area.

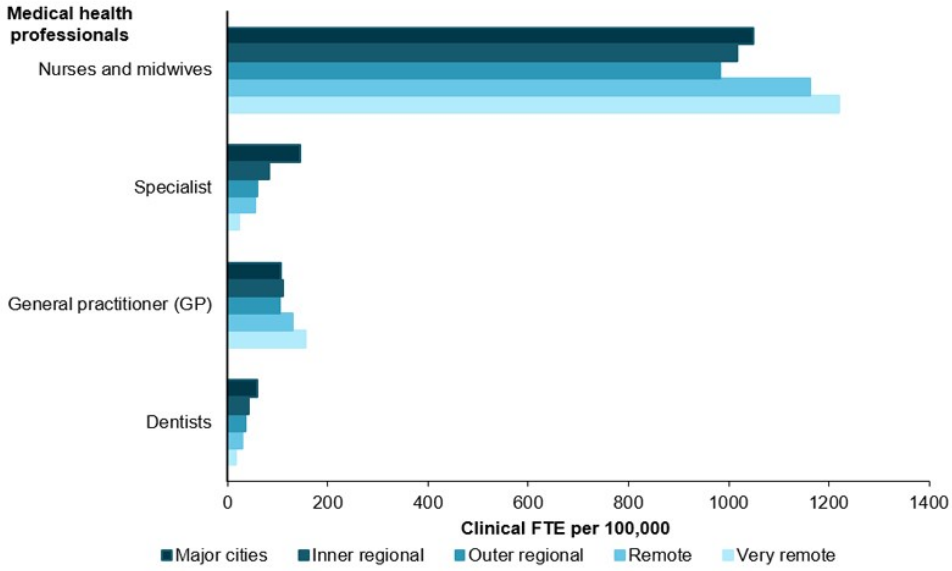
Australians living in *Remote* and *Very remote* areas experience health workforce shortages, despite having a greater need for medical services and practitioners with a broader scope of practice (AMA 2017). Data from the National Health Workforce Dataset show that the total clinical FTE for health professionals per 100,000 population generally decreased as remoteness increased. In 2017, the rate of allied health professionals, dentists and pharmacists was lower in regional areas and lowest in *Remote* and *Very remote* areas compared with *Major cities* (figures 2 and 3).

The rate of specialists also substantially declined with increasing remoteness from 145 per 100,000 population in *Major cities* to 22 per 100,000 population *Very remote* areas.

The clinical FTE rate for nurses and midwives was highest out of all health professionals. The rate declined from 1050 per 100,000 in *Major cities* to 1018 in *Inner regional* and 983 in *Outer regional* areas. However, the rate increased in *Remote* (1163) and *Very remote* areas (1221) (Department of Health 2019) (Figure 2).

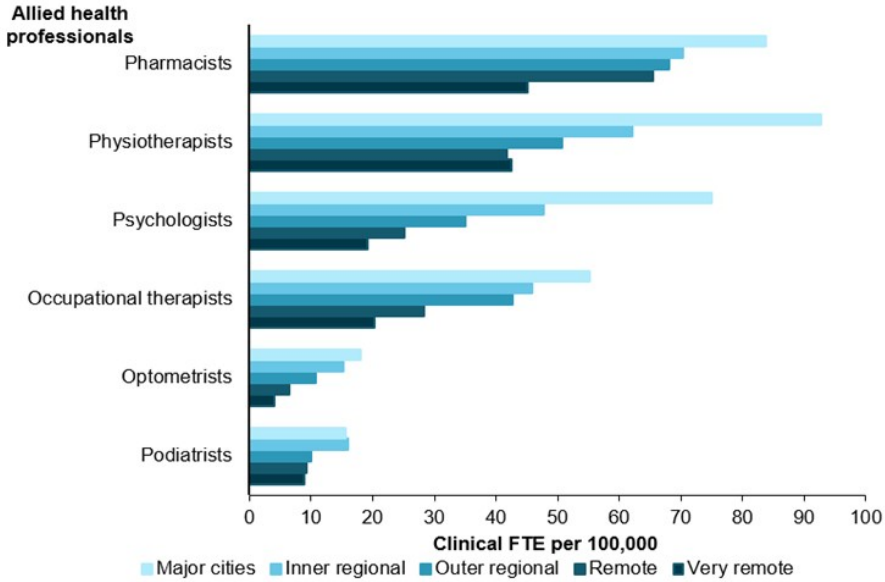
GP supply was also unequally distributed as remoteness increased. Data indicate that the rate of GPs in 2017 increased with remoteness, however, care should be taken in interpreting the data as work arrangements in these areas have the potential to be more complicated (NRHA 2017). For example, there may be poor differentiation between general practice for on-call hours, activity for procedures and hospital work for GPs working in rural and remote areas (Walters et al. 2017).

Figure 2: Employed medical health professionals, clinical full-time equivalent rate, by remoteness area, 2017



Source: Department of Health 2019; Table S6.

Figure 3: Employed allied health professionals, clinical full-time equivalent rate, by remoteness area, 2017



Source: Department of Health 2019; Table S6.

For more information and data see: supplementary tables.

Hospitalisations

In 2017–18, people living in *Very Remote* areas were hospitalised at almost twice the rate as those living in *Major cities* and 1.3 times in *Remote* areas. There was no difference in rate of hospitalisations for regional areas compared with *Major cities*.

People in *Major cities* had higher rates of rehabilitation care compared to people living in other remoteness areas (19 hospitalisations per 1,000 population compared with 11 for *Inner regional* areas, 6.9 for *Outer regional* areas, 6.2 for *Remote* areas and 5.1 for *Very remote* areas). In part, this may reflect the distribution of private hospitals across remoteness areas, as private hospitals accounted for 80% of rehabilitation care separations (AIHW 2019a). For more details on hospitalisations see glossary.

Potentially preventable hospitalisations

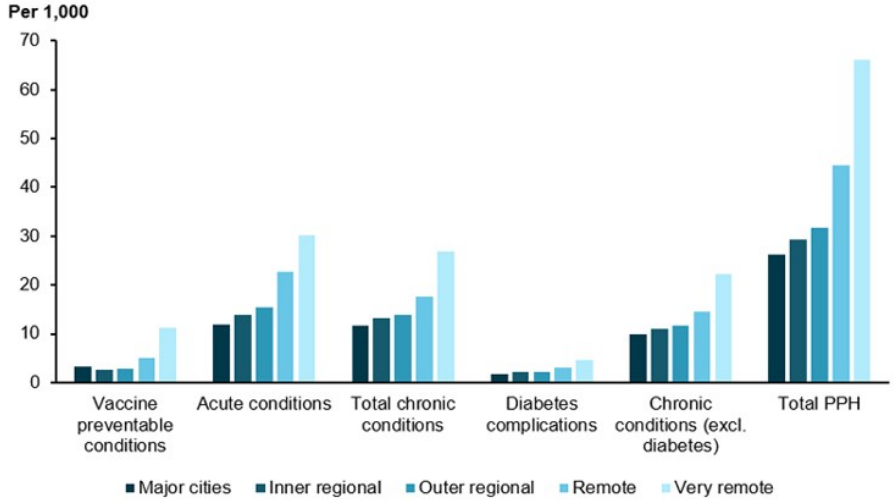
Potentially preventable hospitalisations (PPH) are conditions where hospitalisation could have potentially been prevented through the provision of appropriate individualised preventative health interventions and early disease management, usually delivered in primary care and community-based settings.

In 2017–18, the PPH rate increased with increasing remoteness. When compared with *Major cities,* the rate for those in *Very remote* areas was 2.5 times as high and in *Remote* areas was 1.7 times as high. For regional areas the PPH rates were slightly higher than for *Major cities* (Figure 4) (AIHW 2019a).

For more information see: Admitted patient care 2017–18: Australian hospital statistics.

For more in depth data see: Potentially preventable hospitalisations in Australia by small geographic areas.

Figure 4: Hospitalisations per 1,000 population for selected potentially preventable hospitalisations, by area of remoteness, 2017–18



Note: Hospitalisation rates are directly age-standardised using populations by remoteness areas, which do not include persons with unknown migratory area of usual residence.

Source: AIHW 2019a; Table S7.

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Technical notes

Rural and remote classification

The term 'rural and remote' encompasses all areas outside Australia's *Major cities.* Using the Australian Standard Geographical Classification System, these areas are classified as *Inner regional, Outer regional, Remote* or *Very remote.*

For more information, see the Australian Standard Geographical Classification System.

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Rural and remote classification

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For more information, see the Australian Standard Geographical Classification System.

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Technical notes

Australian Bureau of Statistics National Health Survey

This web report uses results from the Australian Bureau of Statistics (ABS) National Health Survey (NHS) 2017–18, collected between July 2017 and June 2018.

The survey is the most recent in a series of Australia-wide health surveys conducted by the ABS. It was designed to collect a range of information about the health of Australians, including:

- prevalence of long-term health conditions
- health risk factors such as smoking, overweight and obesity, alcohol consumption and physical activity
- use of health services such as consultations with health practitioners and actions people have recently taken for their health
- demographic and socioeconomic characteristics.

The 2017–18 NHS collected data on children and adults living in private dwellings. It excluded those living in non-private dwellings, *Very remote* areas and discrete Aboriginal and Torres Strait Islander communities.

For more information, see ABS National Health Survey: First Results, 2017–18.

It can be difficult to assess the implications of remoteness for health due to:

- interactions between remoteness, low socioeconomic position and the higher proportion of Indigenous Australians in many of these areas compared with *Major cities*.
- variability in the distribution of disadvantage and of Indigenous Australians across all areas—for example, levels of disadvantage on the fringe of *Major cities* can be more akin to those in rural and remote areas than to inner-city areas.
- gaps in the availability and coverage of health data in rural and remote areas, and in information available at local area level.

It is also difficult to measure if there is adequate supply of medical services because of the influence of factors such as:

- varying health-seeking behaviours
- professional scope of practice
- health system efficiency across remoteness areas.

Data quality statement

For more information on the ABS 2017–18 National Health Survey see:

ABS cat. no. 4324.0.55.001 - Microdata: National Health Survey, 2017–18

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Further information

For more information on other data sources used in the report see the following:

Cancer

Deaths

Burden of disease

Health Workforce data

Coordination of health care

Hospitals

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Technical notes

Medicare Benefits Schedule 2017–18

Data for the report were sourced from the Medicare Benefits Schedule (MBS) claims data, which are administered by the Australian Government Department of Health. The claims data are derived from administrative information on services that qualify for a Medicare benefit under the Health Insurance Act 1973 and for which a claim has been processed by the Department of Human Services. Data are reported for claims processed between 1 July 2017 and 30 June 2018.

Scope and coverage

Under MBS arrangements, Medicare claims can be made by persons who reside permanently in Australia. This includes New Zealand citizens and holders of permanent residence visas. Applicants for permanent residence may also be eligible depending on circumstances. In addition, persons from countries with which Australia has reciprocal health care agreements might also be entitled to benefits under MBS arrangements.

It is important to note that some Australian residents may obtain medical services through other arrangements. This includes services that were fully or partially subsidised by the Department of Veterans' Affairs, compensation arrangements, or through other publicly funded programs including jurisdictional salaried GP services provided in remote outreach clinics. Some areas have a higher proportion of services that are not Medicare funded than other areas and this may affect comparability.

Out-of-pocket costs

Out-of-pocket costs for services to private in-patients and for privately insured episodes of hospital substitute treatment are not included, since data on supplementary benefits paid by private health benefits organisations are not available through the Medicare claims system. The out-of-pocket costs associated with services included in this report cannot be further subsidised under other insurance schemes.

Statistics in this report do not include persons who did not claim on Medicare, either because they did not have Medicare eligible services, or because they did not claim for Medicare eligible services. The report does not include costs related to pharmaceuticals, either purchased privately or subsidised by the Pharmaceutical Benefits Scheme.

Where patients have claimed on Medicare before paying the treating practitioner and have not subsequently produced proof to Medicare of the fee paid, the amount is included in the 'out-of pocket' costs.

For more detailed information on the MBS services and item types, see the Australian Government Department of Health MBS Online website.

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Data

- Data tables: Rural and remote health supplementary tables
  Download XLSX 67Kb

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29 July 2020

The Hon Jeremy Rockliff
Minister for Mental Health and Wellbeing
10th Floor Executive Building
15 Murray Street Hobart Tasmania 7000

Email: jeremy.rockliff@parliament.tas.gov.au

Dear Minister,

COVID-19 Recovery Priorities for the Tasmanian Alcohol, Tobacco and other Drugs Sector

At our meeting on Wednesday, 17 June 2020 we spoke in detail about how the Tasmanian alcohol, tobacco and other drugs sector has been responding to the challenges of the COVID-19 pandemic.

During this discussion I expressed gratitude for your leadership and that of the Tasmanian Government to assist our members to respond to the pandemic. This includes the injection of funds into our sector for pharmacotherapy treatment, technology and sector capacity building initiatives.

At this time, I also highlighted that we were working to identify the priority actions that would assist our sector to continue delivering programs and services, alongside preparing for an anticipated increase in demand due to COVID-19.

I am pleased to be able to present this information to you, outlined in the attached report '*ATOD Sector COVID-19 Recovery Priorities*'.

Prepared in consultation with our members delivering specialised alcohol, tobacco and other drug programs and services, the report identifies four key areas of concern:

- Increased drug use during COVID-19
- Investment to boost treatment programs and services to respond to COVID-19
- A lack of data / information to inform COVID-19 responses
- Inclusion of the ATOD sector in broader COVID-19 responses and consultations

To address these concerns, 13 priority actions are recommended. Careful consideration has been taken to present actions that are both appropriate and achievable within the current financial and operational landscape. In particular, attention has been given to identify actions that do not necessarily require extensive financial investment, or that can leverage or expand upon existing partnerships or government processes and priorities.

The Mental Health, Alcohol and Drug Directorate and Primary Health Tasmania have been kept informed of this work and have also been provided a copy of this report.

Minister, we believe the report provides the Tasmanian Government with sensible and achievable recommendations and we are seeking an opportunity to discuss them with you at your earliest convenience.

In the meantime, it is the intention of the ATDC to update our Budget Priority Statement submitted for the 2020-21 State Budget to reflect the priority actions outlined in this report. We will submit this information direct to the Department of Treasury by the required deadline.

Additionally, we will also submit the report to the secretariat of the Premier's Economic and Social Recovery Advisory Council (PESRAC), noting that our report references a range of recommendations outlined in the PESRAC Interim Report. Unfortunately the ATDC was not invited by PESRAC to directly contribute to their first round of consultations, but we have taken the opportunity in this report to identify recommendations in the PESRAC Interim Report that are relevant to the Tasmanian alcohol, tobacco and other drugs sector. We understand that consultations have closed and that a second round of PESRAC consultations will occur at some point in the future, but nonetheless will provide a copy to their office for their reference.

Thank you again Minister. I look forward to hearing from your office, and I can be contacted via email at ceo@atdc.org.au[redacted].

With kindest regards,

Alison Lai
Chief Executive Officer

cc: Michael Voumard, ATDC Chairperson

Jeremy Harbottle, General Manager – Mental Health, Alcohol and Drug Directorate

ATOD Sector COVID-19 Recovery Priorities.

July 2020

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Alcohol, Tobacco and other Drugs Sector COVID-19 Recovery Priorities

Introduction

This Report outlines the COVID-19 recovery priorities for the Tasmanian alcohol, tobacco and other drugs (ATOD) sector.

The concerns and priority actions outlined have been identified through consultation with community service organisations delivering specialist ATOD programs and services across Tasmania. It also builds on the information presented in the ATDC's report *'Determining the impact of the COVID-19 pandemic on the community organisations that provide alcohol and other drug services in Tasmania'* developed in June 2020.

The journey so far

The COVID-19 pandemic had a large impact on community organisations providing ATOD services in Tasmania. Despite these challenges, organisations proved themselves to be agile, client focused and able to enact changes to service delivery and business practices quickly and effectively. This included quickly transitioning their services to telehealth and online platforms, and implementing physical distancing to ensure treatment continued.

While this agility and the expertise of the sector was a key strength, the absence of reporting systems and processes meant they operated, and continue to operate with, limited data or information informing current or emerging areas of need. A lack of data and information, particularly in relation to illicit drugs, is a long-standing issue for the Tasmanian ATOD sector, which was further exacerbated by COVID-19. Similarly, the prevailing absence of the lived experience viewpoint in the Tasmanian ATOD sector was also highlighted during this time.

To assist, the Federal and State Governments invested approximately $740,000 to support Tasmanian ATOD sector organisations. Approximately $590,000 of these funds were provided by the Tasmanian Government for pharmacotherapy treatment, technology and sector capacity building initiatives[1]. Additionally, through the Tasmanian Government's $4 million response package for the mental health sector, additional support was provided to Tasmanians presenting with ATOD concerns to these services. This included the expansion of the Tasmanian Lifeline Service and additional support to Rural Alive and Well.

As Tasmanian specialist ATOD community organisations transition to a post COVID-19 service environment, most have returned to delivering services and programs face-to-face, while retaining telehealth and online services as complementary service options. Focusing on what lays ahead, their four key concerns are:

- Increased drug use during COVID-19
- Investment to boost treatment programs and services to respond to COVID-19
- A lack of data / information to inform COVID-19 responses
- Inclusion of the ATOD sector in broader COVID-19 responses and consultations

Given the wide-ranging impact substance use has in Tasmania, ensuring we are well-placed to respond to these concerns will be critical to address well-being as a key measure of our COVID-19 recovery success.

To strengthen the sector's ability to respond to these concerns and the anticipated 'service-bubble' that will occur in the coming months, a range of priority actions have been identified.

These priority actions are summarised in Table One (over-page).

[1] Includes approx. $191,000 awarded to ATOD organisations through the Community Managed Mental Health and Alcohol and Drug Sector COVID-19 Technology Fund

Table One: Alcohol, Tobacco and other Drugs Sector COVID-19 Priority Concerns	
Priority Concern #1 – Increased drug usage during COVID-19. Tasmanian ATOD service providers are concerned about the increased use of drugs during COVID-19 (drinking, smoking and the use of illicit substances). Alongside reports of increased referrals for support from new cohorts (e.g. employed 'middle-class' Tasmanians), there are reports of drug substitution (e.g. alcohol in the absence of illicit substances) and serious concerns regarding an anticipated spike in substance use following the cessation of existing COVID-19 financial initiatives (e.g. JobKeeper, JobSeeker and anti-eviction legislation).	
Priority Action 1.1	Immediate investment into the transition of existing face-to-face drug education and awareness programs to a digital service delivery model
Priority Action 1.2	Continued investment into a COVID-19 community public health campaign for the next 12 months
Priority Action 1.3	Immediate initiation of protocols requiring all Tasmanian Government health care professionals to ask patients if they smoke, and if they do, provide an opt-out referral to the Quitline
Priority Concern #2 - Investment to boost treatment and programs to respond to COVID-19. The Tasmanian ATOD sector has required additional investment for a number of years and COVID-19 has exacerbated existing treatment gaps. Alongside concern regarding increased drug usage, there is a critical need to bolster treatment services at this time to ensure continuity of services (including the retention of targeted treatment initiatives introduced during COVID-19).	
Priority Action 2.1	Confirmation of continuity of funding for existing AOD treatment services with funding agreements expiring at 31 December 2020
Priority Action 2.2	Allocation of funding to an *AOD Treatment COVID-19 Recovery Fund* specifically to implement initiatives to address emerging treatment needs & existing treatment gaps being exacerbated by COVID-19
Priority Action 2.3	Active leadership from the Tasmanian Government, collaborating with all Tasmanian elected representatives to lobby the Australian Government to ensure the continuation of Equal Remuneration Order payments for impacted community sector organisations
Priority Action 2.4	Prioritisation of the necessary feasibility work to identify alternative and / or additional approaches to withdrawal treatment to address the reduced capacity of the Inpatient Withdrawal Unit in Hobart
Priority Action 2.5	Continued access to free Naloxone across Tasmania's needle and syringe program outlets, and the expansion of this program to Tasmanians on the waiting list to access the Tasmanian Government's pharmacotherapy treatment program, and those exiting the Tasmanian Prison Service over the next 12 months
Priority Action 2.6	Immediate review of the waiting lists for Tasmanians seeking to access the Tasmanian Government's pharmacotherapy treatment program & continuation of the depot buprenorphine trial currently underway
Priority Concern #3 – A lack of data / information to inform COVID-19 responses. Tasmanian ATOD service providers have stressed the importance of improving access to information and data. This is a long-standing issue that has been exacerbated during the COVID-19 response and recovery processes. It's a critical issue that needs urgent attention to ensure that the ATOD sector can strengthen how it monitors drug usage and treatment trends.	
Priority Action 3.1	Confirm commitment to investment in a consumer representative service for the Tasmanian ATOD Sector to ensure the lived experience is included in existing and future responses
Priority Action 3.2	Convening of an illicit drug working group to share intelligence and information on the supply and use of illicit drugs to inform treatment, prevention and harm reduction strategies
Priority Action 3.3	Provide access to existing ATOD data-sets to monitor treatment episodes and population trends
Priority Concern #4 - Inclusion of ATODs sector into broader COVID-19 responses and consultations. There are a range of existing Tasmanian Government COVID-19 recovery initiatives underway to assist the community sector and other industries. The inclusion of the ATOD sector into these initiatives will assist to broaden the impact of these programs and assist the Tasmanian ATOD sector's recovery efforts.	
Priority Action 4.1	Targeted inclusion of ATOD feedback into the development and implementation of community economic and social COVID-19 recovery initiatives

Priority Concern #1: Increased drug usage during COVID-19

Tasmanian ATOD service providers have reported increased concern regarding the increased use of drugs during COVID-19.

This concern relates to drinking, smoking and the use of illicit substances. Alongside reports of increased referrals for support from new cohorts (e.g. employed 'middle-class' Tasmanians), there are reports of drug substitution (e.g. alcohol in the absence of illicit substances) and serious concerns about a spike in substance use following the impending cessation of existing COVID-19 financial initiatives (e.g. JobKeeper, JobSeeker and anti-eviction laws).

It was acknowledged in the Tasmanian Government's PESRAC Interim Report, that mental health issues will continue to increase due to the compounding effects associated with COVID-19. The same is anticipated with respect to alcohol consumption, which this report acknowledges is associated with increased mental ill health. While it is highly recognised that alcohol consumption has increased, the Tasmanian ATOD sector also urges the Tasmanian Government not to overlook the harm caused from an increased use of illicit drugs, prescription medication and smoking during this time.

Strong preventative messaging and responses will be critical to address these concerns, with three priority actions outlined in Table 2 below.

Table 2: Priority Concern #1: Increased drug usage during COVID-19

Priority Action	Rationale	Lead Agency	Investment
Priority Action 1.1 Immediate investment into the transition of existing face-to-face drug education and awareness programs	There is currently an absence of program delivery across the State. Priority to ensure existing programs can be delivered, and to ensure continuity of education programs	Drug Education Network	$80,000
Priority Action 1.2 Continued investment into a COVID-19 community public health campaign for the next 12 months	A priority to ensure action is undertaken to raise awareness of substance use, and where to find support	Drug Education Network & Alcohol and Drug Foundation	$100,000
Priority Action 1.3 Immediate initiation of protocols requiring all Tasmanian Government health care professionals to ask patients if they smoke, and if they do provide an opt-out referral to the Quitline	Tasmanians who smoke are high-risk for COVID-19 complications and an opt-out referral process should be mandated	Department of Health & Cancer Council Tasmania	Nil

Priority Concern #2: Investment to boost treatment and programs

The Tasmanian ATOD sector has required additional investment for a number of years and COVID-19 has exacerbated existing treatment gaps.

Alongside concern regarding increased drug usage, there is a critical need to bolster treatment services at this time to ensure continuity of services (including the retention of targeted treatment initiatives introduced during COVID-19).

The Tasmanian Government's PESRAC Interim Report's recommendation to modify contracts with community sector providers to ensure longer-term funding certainty, and employment tenure for staff (Recommendation #12 and #13) is welcomed by the ATOD sector.

Providing this funding certainty and flexibility is crucial, and it must be accompanied by an additional boost in funding. There is currently a minimum of $1 million in additional treatment and service funds required by the sector to respond to the impact of COVID-19 across all treatment types, and in all regions of the island. A list of these funding requirements is outlined in Attachment A, and the ATDC recommends that the Tasmanian Government establish a Recovery Fund specifically for the Tasmanian ATOD sector, to be administered by the ATDC in the same manner as the *COVID-19 Sector Capacity Building Funds*.

The priority actions are summarised in Table 4 below.

Table 4: Priority Concern #2: Investment to boost treatment and programs

Priority Action	Rationale	Lead Agency	Investment
Priority Action 2.1 Confirmation of continuity of funding for existing AOD treatment services with funding agreements expiring at 31 December 2020	These organisations include, but may not be limited to Pathways Tasmania, Holyoake, the ADF and the ATDC. Ensuring the continuity of these funding agreements will ensure that there is no impact to the community.	Department of Health	Various
Priority Action 2.2 Allocation of funding to an *AOD Treatment COVID-19 Recovery Fund* specifically to implement initiatives to address emerging treatment needs & existing treatment gaps being exacerbated by COVID-19	During consultation with Members, the ATDC identified a minimum of $1 million dollars in treatment and service requests to respond to the impact of COVID-19. The ATDC recommends that the Tasmanian Government establish a Recovery Fund specifically to assist Tasmanian ATOD organisations to develop place-based COVID-19 program responses.	Department of Health (administered by the ATDC)	$1 million
Priority Action 2.3 Active leadership from the Tasmanian Government, collaborating with all Tasmanian elected representatives to lobby the Australian Government to ensure the continuation of Equal Remuneration Order payments for impacted community sector organisations	The impending cessation of the Australian Government's Equal Remuneration Order will impact Tasmanian ATOD community sector organisations. The cessation of this funding will result in reduced services, and loss of employment. Actions to avoid this outcome will be critical.	Department of Health & Department of Premier and Cabinet	Nil

Priority Action 2.4 Prioritisation of the necessary feasibility work to identify alternative and / or additional approaches to withdrawal treatment to address the reduced capacity of the Inpatient Withdrawal Unit in Hobart	Prior to COVID-19 there were existing concerns that Tasmania's reliance on a 9 bed inpatient withdrawal unit located in Hobart was insufficient to address the demand for the number of residential rehabilitation beds across the island. Given that COVID-19 has seen the number of these beds reduce to 6, these concerns are now critical. Inaccessibility to withdrawal services leads to blockages in treatment pathways, stopping patients from progressing through to residential rehabilitation services. The Launceston City Mission is currently considering how to establish an onsite medically supervised withdrawal service, and a feasibility study to review this option and others should be prioritized urgently.	Department of Health, Alcohol and Drug Service & community residential rehabilitation treatment providers	Nil
Priority Action 2.5 Continued access to free Naloxone across Tasmania's needle and syringe program outlets, and the expansion of this program to Tasmanians on the waiting list to access the Tasmanian Government's pharmacotherapy treatment program, and those exiting the Tasmanian Prison Service over the next 12 months	Ensuring ongoing access to the anti-overdose medication naloxone will save lives. Due to the extensive waiting lists to access the Tasmanian Government's pharmacotherapy program, Tasmanians who are turned away from this treatment must also be included, as should any individuals exiting the Tasmanian Prison Service – particularly in the knowledge of reported illicit drug shortages.	Department of Health	$30,000
Priority Action 2.6 Immediate review of the waiting lists for Tasmanians seeking to access the Tasmanian Government's pharmacotherapy treatment program & continuation of the depot buprenorphine trial currently underway	Prior to COVID-19, there was a waiting list of approximately 75 Tasmanians waiting to access the pharmacotherapy program administered by the Alcohol and Drug Services. This needs to be addressed as a priority to limit the risk of harm from illicit drug use or substitution.	Department of Health	Unknown

Priority Concern #3: A lack of data / information to inform COVID-19 responses

Tasmanian ATOD service providers have stressed the importance of improving access to information and data.

The importance of prioritising work, including shared data capability was a priority action identified in the Tasmanian Government's PESRAC Interim Report (Recommendation #50).

The lack of shared data and information in the Tasmanian ATOD sector is a long-standing issue that has been exacerbated during the COVID-19 response and recovery processes for both data and information, and the absence of a consumer perspective into service design and delivery. This is a critical issue that needs urgent attention to ensure that the ATOD sector can strengthen how it monitors drug usage and treatment trends emerging due to COVID-19. The sector, through the work already undertaken by the ATDC and key partners, is well-placed to implement a range of initiatives quickly. These priority actions are outlined in Table 3 below.

Table 3: Priority Concern #3: A lack of data / information to inform COVID-19 responses

Priority Action	Rationale	Lead Agency	Investment
Priority Action 3.1 Confirm commitment to investment in a consumer representative service for the Tasmanian ATOD Sector to ensure the lived experience is included in existing and future responses	Ensuring the inclusion of the lived experience into COVID-19 response and recovery initiatives remains a priority. While the ATDC worked hard to ensure it was included where possible, it was significantly absent during this time. **The minimum funding requested from the 2020-21 State Budget.*	ATDC	$250,000 minimum*
Priority Action 3.2 Convening of an illicit drug working group to share intelligence and information on the supply and use of illicit drugs to inform treatment, prevention and harm reduction strategies	A key area of concern has been the lack of a coordinated approach attempting to understand the impact COVID-19 has had on those Tasmanians who use illicit substances. In the absence of this information, any responses will be hampered by a reliance on anecdotal information. ** Alongside partner organisations e.g. UTAS & relevant government agencies.	Department of Health & ATDC **	Nil
Priority Action 3.3 Provide access to existing ATOD data-sets to monitor treatment episodes and population trends	The ATDC is seeking access to the Department of Health's AOD National Minimum Data Set information. This is a pre-existing request to enable the ATDC to monitor trends in treatment episodes. They are also calling on the government to urgently fast-track access to Tasmanian Government ATOD data sets (e.g. ambulance, hospital, police and public treatment). This work has already been identified as necessary to support the Tasmanian Drug Strategy and the Tasmanian AOD Reform Agenda – and should be expedited. ****The funding requested from the 2020-21 State Budget. Primary Health Tasmania has also committed funding towards a joint data-sharing project.* The DEN and the ADF are both seeking access to the Student Health and Wellbeing Survey results at a local municipality level.	Department of Health, ATDC & UTAS	$50,000***

Priority Concern #4: Inclusion of ATOD sector into broader COVID-19 responses and consultations

There are a range of existing Tasmanian Government COVID-19 recovery initiatives underway to assist the community sector and other industries. The inclusion of the ATOD sector into these initiatives, and discussions of future initiatives is critical.

It's important to note that while the recent PESRAC Interim Report was developed in consultation with government agencies, and peak bodies, the ATDC was not approached to provide comment. The ATDC were able to provide comment via the Alcohol and Drug Services, and TasCOSS submissions but was concerned at the omission of the ATOD sector as a key consultation partner, particularly given the significant social impact of substance use during COVID-19, particularly alcohol consumption.

During the COVID-19 response, the ATDC experienced challenges engaging with the Tasmanian Department of Health resulting in delayed communications and missed opportunities to share information and work collaboratively. The ATDC is seeking, and is ready to work with the Department of Health to avoid a repeat of this situation if a second-wave of COVID-19 was to occur.

In the meantime, there is a range of additional recommendations within the PESRAC Interim Report, not already noted in this Report that can also provide benefit to ATOD community sector organisations and broaden the impact of these recovery efforts.

These recommendations are outlined in Table 5 below.

Table 5: Priority Concern #4: Inclusion of ATOD sector into broader COVID-19 responses and consultations

Priority Action	Rationale	Lead Agency	Investment
Priority Action 4.1 Targeted inclusion of ATOD feedback into the development and implementation of community economic and social COVID-19 recovery initiatives, including future PESRAC consultations	Ongoing prioritisation of AOD services into Tasmanian Government mental health and homelessness recovery initiatives, and the following PESRAC Interim Report recommendations: #16 – The ATOD sector seeks the inclusion of the AOD Certificate IV and the AOD Peer Worker Certificate IV #52 – The ATOD sector has shovel ready capital projects in Circular Head (CHAC) and Northern Tasmania (Launceston City Mission) #54 – Refer Priority Action 3.3. #57 – The ATOD sector welcomes the opportunity to be included in this review #58 – the ATOD sector seeks the opportunity to be included in this work. Refer Priority Action 3.2 #61 – the ATOD sector welcomes the opportunity for this screening tool to be expanded to include alcohol and other drugs	Varied. The ATDC is available to provide input and feedback into any recovery initiatives	Nil

Attachment A – Summary of Member Responses

ATDC members delivering specialist ATOD services were asked to comment on:

- If they had any capital infrastructure projects that may increase service capacity
- If they were going to need additional funding assistance to cover ongoing telehealth or cleaning/PPE costs
- Main concerns for their COVID-19 response and recovery efforts
- What assistance they would be seeking from the Tasmanian Government to assist with their COVID-19 recovery

	Capital Projects	Telehealth costs	Cleaning / PPE costs	Main Concerns	Assistance Sought
1. Advocacy Tasmania	No support required at this time				
2. ADF	No	No	No	- Lack of focus or funding on prevention and early intervention - Sporting clubs will seek to focus on alcohol sales to boost lost revenue	1. Commitment to ongoing funding of Good Sports Program ($430Kpa) 2. Access to the DoE student wellbeing survey 3. Ongoing investment into public health campaigns
3. Anglicare Tasmania	No	No	No	- Increased substance use - Lack of data to aid responses - Staff wellbeing - Staff safety	1. $150K for 1.5 FTE (0.5 FTE in each region) to respond flexibly to managing assessments, referrals and support
4. Bethlehem House	No*	Uncertain*	Uncertain*	- Lack of AOD services for residents	1. $100K to immediately support the AOD service provision to existing BH residents. Despite increase in residents, there has been no increase in funding for services. *Major infrastructure development already well-progressed and currently determining impact of COVID-19 on costs. Currently negotiating new funding agreement with Communities Tasmania where any increase would be incorporated.
5. CHAC	Yes	No	No	- Increased substance use - Anticipated increase in service demand and not enough staff to assist - Comorbidity increase and lack of emergency crisis support and accommodation in region	1. $300K approx. to extend their existing health centre to increase their consulting room space to respond to the physical distancing requirements of COVID19 and also upgrade their facility for the future. 2. $100K approx. for a resource to provide crisis support to those in the region in need

6. DEN	No	No	No	- Ensuring that people/staff are not missing out on receiving information, resources or support - The ongoing siloed approach to addressing MH and AOD, particularly in the prevention space - Rhetoric that the existing COVID-19 stimulus payments should be reduced, due to people using the extra funds to pay for more drugs	1. Seed funding to help them expedite the development of online resources ($80,000) 2. Tasmania Police to provide information to the ATOD sector regarding their knowledge of illicit drug matters to help inform preparation and response planning
7. LCM (Serenity House & Missiondale)	Yes	No	No	- Poor communication with ADS - Reduced capacity at IPWU slowing admissions and increasing waiting lists - Pace of ADS/IPWU protocol implementation	1. $150K for on-site development of Missiondale (consulting rooms) 2. Clarification / authorization to deliver on-site medically supervised detox. 3. TasTAFE to provide Certificate IV in AOD at no cost
8. The Hobart Clinic	No*	No	No	- Working with medical staff to find balance between telehealth and hospital admissions	*No requests. THC has a major infrastructure project currently planned
9. Holyoake	No	Yes	Yes	- Impact of COVID19 on young Tasmanians - Reported demand in schools for counselling sessions	1. $100K to fund a full-time counsellor for 12 months to respond to the demand from schools. Anticipate that this resource would provide services to at least 500 students in southern Tasmania. This would be a modest ask for the benefits that would be delivered. 2. $150K (ongoing) to increase their services in the prison and community corrections. This is an existing budget request because their services are unable to fulfil the existing demand.
10. The Link	No	No	No	- How to re-engage young people who have been negatively impacted - Increase in comorbidity presentations	1. $100K for a 6-12 month resource to focus on re-engaging young people and to co-design the 'new normal' service for the future
11. Pathways Tasmania	No	No	No	- Ensuring appropriate activities for residents if a second wave occurs	1. $460K to fund the employment of house supervisors for both their male and female programs ($230K per program). Currently a role that is undertaken by volunteers. This is an existing request that government is already aware of.

12. Salvation Army	No*	No	No	- Anticipated increase in demand - Returning past residents who have relapsed due to lack of secure accommodation during COVID19 - IPWU and reduction in bed numbers slowing down admission	1. $100K per annum for a counsellor/ psychologist to review and maintain the online service model (see points above) 2. $100K per annum to continue the Matrix Program, and to transition it to a portable model that could be delivered offsite. An internal evaluation has been undertaken, demonstrating that it is a cost effective treatment model (60 people over 12 months through this program versus approx. $80K per residential bed). *Multiple infrastructure projects underway through TSA's community programs
SETAC – feedback pending					
13. TAC	No	N/A*	N/A*	- Not having a 'line of sight' about what is happening behind doors for their community members - An increase in drug usage (linked to govt payments) - Lack of illicit drug supply, and that people are substituting and the quality of what is out there at the moment is not very good	- No particular key request but concerned about what will happen later this year when the JobKeeper and other financial assistance packages cease and how best to respond / plan for the impact of this. *They will be monitoring this. Unclear what the ongoing costs / admin impact might be.
14. QUIT Tasmania	No	No	No	- The continuing high smoking rates, and the reality that people are continuing to smoke despite the risks of COVID-19	1. A COVID-19 directive from the Tasmanian Government instructing all Tasmanian Government health workers to refer current smokers to the Quitline using an opt-out approach.
15. YFCC	No	No	No	- Increased substance use aggravated by COVID19 - Increased comorbidity presentations - Maintaining physical distancing requirements in existing buildings	1. $30K for a six month trial to bring a psychiatrist to the region. There is an existing business case in place for a six month trial to address issues with prescribing medicines, with getting into a GP at the moment 'almost impossible'. 2. $152K (for two years) for an early intervention/prevention initiative that has benefits for AOD/MH/FDV and homelessness.

Who are we?

The Alcohol, Tobacco and other Drugs Council is the peak body representing and supporting community organisations, and the people they assist, to reduce alcohol, tobacco and other drug related harm for all Tasmanians. Our vision is a Tasmania without alcohol, tobacco or other drug related harm or discrimination.

Problematic use of alcohol, tobacco and other drugs continues to be a major cause of harm in Tasmania, and is a significant driver of preventable death, disease and illness, psychological distress, unemployment, homelessness, police arrests and prison sentences.

As an independent not-for-profit organisation, the ATDC represents a broad range of alcohol, tobacco and other drug organisations. These organisations provide information and awareness, prevention and early intervention, harm-reduction and specialised treatment and recovery services and programs.

Working with all levels of government and the community, the ATDC plays a vital role in leading, collaborating and advocating for increased investment into treatment services, and population based initiatives that reduce the harms associated with problematic substance use across Tasmania.

The ATDC supports the sector by delivering training, networking and information sharing opportunities, as well as undertaking policy and advocacy projects with, and on behalf of our members. At all times our work is underpinned by a commitment to evidence-based practices and policies, consumer participation, harm reduction, and partnerships and collaboration.