Investment in the alcohol and other drugs sector in Tasmania

Final Report

Tasmanian Government

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An Australian Government Initiative

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360edge.

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About 360Edge

We are a leading Australian health consultancy, specialising in the alcohol and other drug, and allied, sectors. We provide a full suite of advisory services to help organisations accelerate change. We work with leading international organisations, governments and not for profit agencies across Australia and internationally.

Our vision is for a thriving community that provides the best policy and practice responses right across the spectrum of alcohol and other drug use. Our mission is to ensure governments and services have the tools they need to respond effectively and efficiently to people who use alcohol and other drugs to reduce harms.

We are driven to make a positive impact in the world and strongly believe in social justice and human rights, and it drives all of our work. We believe that everyone has the right to the opportunities and privileges that society has to offer. Our values of excellence, transparency and integrity are at the core of everything we do. We live these values within the team and with our customers and collaborators.

Our team of experienced 'pracademics' take a 360 approach to viewing situations from multiple perspectives. We collaboratively and holistically work with our clients at every stage, wherever they are in the cycle of change, to achieve their goals.

Acknowledgements

We would like to thank Primary Health Tasmania, the Department of Health Tasmania, the Australian Government Department of Health and Aged Care, and the National Indigenous Australians Agency for their substantial efforts in the data collection process.

Our thanks to the members of the Project Reference Group for their time and advice throughout the project, including Alison Lai and Dr Jackie Hallam from the Alcohol, Tobacco and other Drugs Council; Jodie Jones and Tania Holland from Primary Health Tasmania; and Corrina Smith and Darren Turner from the Department of Health Tasmania.

Special thanks to those from alcohol and other drug treatment service provider organisations and to the lived experience stakeholders for their time and significant contribution to the consultation process.

Our thanks also to Dr Steven Bothwell, Consultant at 360Edge, for assistance with early work and the first drafts of this report.

In the spirit of reconciliation, we acknowledge the traditional custodians of country throughout Australia and their connection to land, sea and community. We pay our deep respects to elders past and present.

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Executive summary

Background

In response to a 2015 review of alcohol and drug use and service responses in north west Tasmania, the Tasmanian Government engaged consultants Siggins Miller to conduct a treatment system review. In August 2017, the Tasmanian Government released the A Single Tasmanian Alcohol and Other Drug Service System Framework – Final Report (the Siggins Miller Report) which identified key actions for sector reform. The report used available data from 2015-2016.

The report guided the development of the Reform Agenda for the Alcohol and Other Drugs Sector in Tasmania, released in 2020.

In 2022, Primary Health Tasmania and the Department of Health Tasmania engaged 360Edge to update the 2017 report to inform the ongoing reforms.

This update will support the Tasmanian alcohol and other drug reform agenda, inform the commissioning of services by Primary Health Tasmania in July 2023 and support the review of Department of Health Tasmania funding agreements in July 2025.

We looked at 3 key areas:

- Funding investment
- Treatment demand and costs of meeting the demand
- Experiences of service users and service providers

Investment modelling

Updating 2017 investment modelling

The 2017 estimates have been used as the baseline for the updated estimates.

As we progressed with this work, we identified the need for the 2017 estimates to be adjusted down by a net $5.5m (from $40.4m to $34.9m) to reflect more accurate spending.

Individual adjustments included:

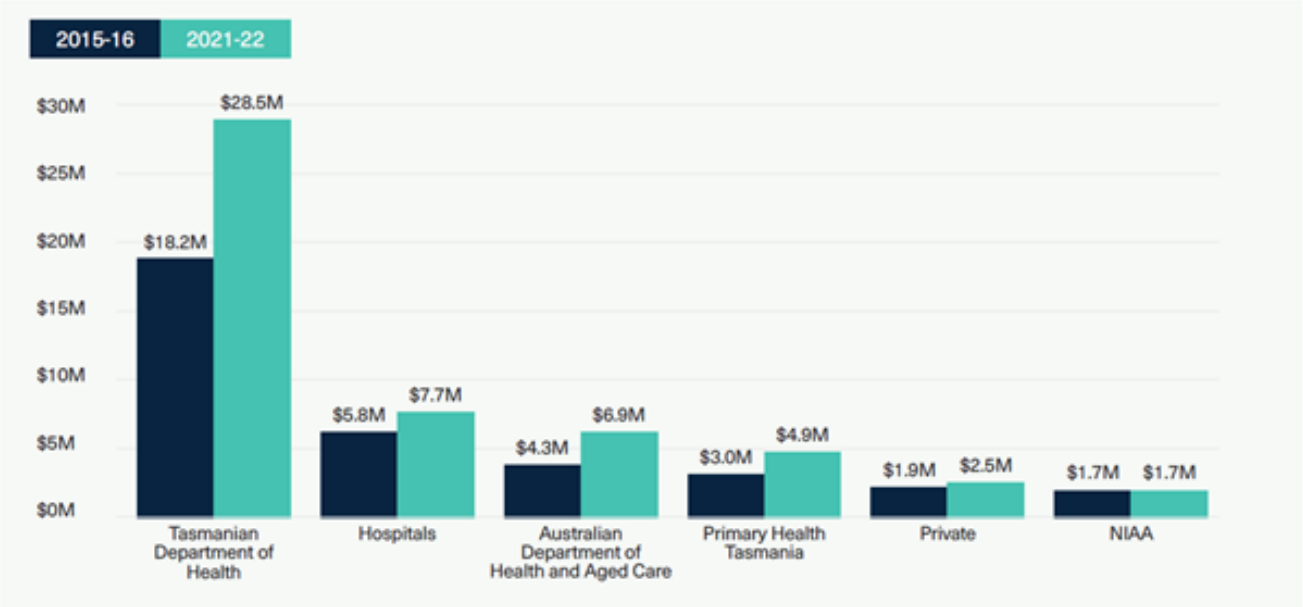
- Adjust down private hospital investment by $3.5m
- Adjust down state government investment by $3.4m
- Adjust up pharmacotherapy dispensing fees by $0.9m
- Adjust up investment in diagnostic tests by $0.6m

Investment estimates

We looked at the amount that is invested in alcohol and other drug services across government, non-government and private sector services. The updated estimate of recurrent investment in alcohol and other treatment by the key funding sources in Tasmania in 2021-2022 is $52.2m across the key treatment types (Figure 1).

There was an overall increase of $17.3m in investment from $34.9m in 2015-2016 to $52.2m in 2021-2022. The largest funding increase was from the Department of Health Tasmania of $10.3m, made up of $3.6m for residential rehabilitation services, $3.3m for government Alcohol and Drug Services (ADS), $1.2m for the inpatient withdrawal unit and the remaining $2.2m for other new investments and funding indexation.

Figure 1: Estimated current investment in alcohol and other drug treatment in Tasmania in FY22



The Australian Department of Health and Aged Care increased the total amount of funding by $2.6m including: $1.0m in residential rehabilitation services; Pharmaceutical Benefits Scheme costs increased by $1.0m mainly relating to the PBS Opiate Dependence Treatment Program; and $0.7m of increased investment in Medicare benefits relating to General Practitioners and allied health through the Better Access initiative. Funding from the National Ice Action Strategy bolstered Primary Health Tasmania funding by $1.9M.

The investment estimates do not include any reform investment budgeted but not spent during the 2021-22 financial year.

Treatment demand estimates

To generate estimates for treatment demand in the financial year 2021-22, we started with the demand figures presented in the 2017 report. The cost estimate associated with meeting treatment demand in 2017 was $46.3m. The updated cost of meeting treatment demand across non-residential, withdrawal, residential and prescription medicine and diagnostic tests is $60.2m. This represents an increase of $13.9m from 2017.

Growth in demand for treatment estimates are related to a population increase of 7.1% (37,000), indexation costs of 16.5% ($8.6m) and increases and adjustments in severity levels for amphetamine and opioid treatment populations groups adds $2.1m.

The quality of treatment for alcohol and other drug services in Tasmania was rated highly.

Sector experience of service users and service providers

Our service user and provider consultations identified similar themes to the 2017 findings.

The quality of treatment for alcohol and other drug services in Tasmania was rated highly. The key strengths identified were:

- The sector is open to new and innovative ways of working
- A strongly committed and passionate workforce
- The important role of the peak body Alcohol, Tobacco and other Drugs Council Tasmania (ATDC) in supporting and strengthening the community sector, providing leadership, advocacy and relationship building

Identified key service shortfalls:

- Access to residential rehabilitation in the north west of Tasmania
- Access to withdrawal services outside of the Southern Region
- Access to pharmacotherapy treatment
- Availability of online information about alcohol and other drug treatment services
- Availability of services for specific populations (eg. women, young people, families and people living in rural areas)
- Availability of culturally responsive services
- Services and support for people coming out of prison
- Collaboration with related services such as mental health, justice and housing services

Comparing investment and treatment demand

To compare investment and demand, we adjusted investment down by $4.2m to $48.0m to ensure both estimates covered the same range of treatment types.

An additional $12.2m of investment or a 25% increase in investment, is needed to meet treatment demand costs of $60.2m.

To meet treatment demand, investment in withdrawal needs to increase by 50%, investment in non-residential and residential rehabilitation needs to increase by 20-30%, and significantly more investment is required in pharmacotherapy.

Since 2017, the proportional gap between demand and investment has reduced from 50% to 25%.

The gaps between investment and demand align with shortfalls identified by consultation feedback from service users and providers. These include a need for:

- Additional investment in withdrawal services in locations outside of Hobart
- Additional investment in residential rehabilitation, particularly in the in the north west of Tasmania
- Additional access to pharmacotherapy

Introduction

About the project

The Tasmanian Alcohol, Tobacco, and other Drug Sector is undergoing significant reform, guided by the *Reform Agenda for the Alcohol and Other Drugs Sector in Tasmania (2020)*.

The aim is to ensure Tasmanians affected by alcohol, tobacco and other drug use have access to appropriate, timely, effective and quality services.

In 2017, Siggins Miller was commissioned by the Department of Health Tasmania to conduct an independent analysis of the alcohol and other drug service system and build the foundation for Tasmanian alcohol and other drug sector reform.

The alcohol and other drug sector landscape has changed in the 5 years since the 2017 sector mapping work was commissioned. The COVID-19 pandemic impacted upon and increased demand for services across the alcohol and other drug sector. Therefore, the original work needed to be updated to ensure that up to date data is used to inform planning and the reform agenda.

This mapping work supports the objectives of the Tasmanian Reform Agenda including action 3.3 of the Reform Direction 3: *'Map and reconfigure current funded services as required to align with the Service Delivery Framework'*.

Primary Health Tasmania and the Department of Health Tasmania as equal project partners commissioned 360Edge to review and update 3 sections of the 2017 mapping work. This updated work will inform the commissioning of services by Primary Health Tasmania in 2023 and the review of Department of Health Tasmania funding agreements in July 2025..

About this report

This report presents the updated findings of the funding investment mapping, treatment demand analysis and sector experiences for service users and service providers.

The aim is to ensure Tasmanians affected by alcohol, tobacco and other drug use have access to appropriate, timely, effective and quality services.

Approach

Overview

The key data sources used to update the investment and treatment demand modelling included current funding investment and the 2017 report. Funding and demand data was provided by the Department of Health Tasmania Alcohol and Drug Services and Primary Health Tasmania and through the Alcohol and Drug Treatment Services National Minimum Dataset.

We developed a common structure to collate the data (data structure) to ensure that the final version of the dataset was fit for purpose for modelling investment and treatment demand estimates. The data structure was reviewed and approved by the funding bodies as accurately representing the data.

We used the 2017 work as a reference source to review and assess the current sector landscape to update key data components. Across the 3 focus areas of this work: 1. investment mapping, 2. treatment demand estimates and 3. service user and service provider experiences, we used a mix of data collection methods including financial modelling, literature review and consultation with key stakeholders.

Figure 2: Three sector mapping elements

Sector Investment mapping

Review previous mapping work

Access and review federal and state funding data

Confirm data structure, collate data and map investment

Treatment demand estimates

Review and assess previous need and demand work

Review published literature

Update previous work as required

Sector experience

Explore service user and service provider experience with sector

Review documented service users and service pathways

Recruit service users and service providers

Undertake consultations and write up findings

Investment mapping

We reviewed current funding stream data across the major funding sources, including both state and federal funding and private funding where there was available data.

Treatment demand modelling

The 2017 mapping work used the Drug and Alcohol Services Planning Model (DASPM) to undertake alcohol and other drug treatment demand analysis. We did not have access to the DASPM for this project. Therefore, we used the 2017 report as the basis for developing a model to produce an updated demand estimate.

This model used data on population, prevalence of alcohol and other drug use disorders, severity of alcohol and other drug use disorders and the proportion of people seeking treatment.

Stakeholder identification

We worked with Primary Health Tasmania and the Department of Health Tasmania to identify key stakeholders (service providers and service users) to participate in the sector mapping process.

We held consultations with service users and service providers across Tasmania to capture insights about their experiences engaging with the sector. We asked consultation participants to identify gaps in the Tasmanian alcohol and other drug service system. Consultation questions were designed to capture insights about the capacity of the service system to meet treatment needs, to identify service strengths and gaps and to explore service access barriers.

We held 6 consultations in 3 locations (Hobart, Launceston and Ulverstone). In each location, we held 1 consultation with service providers and 1 with service users. We undertook 1 service user consultation via phone. We also held a consultation with the Alcohol and Drug Services Clinical Specialist Group.

Service providers were engaged through communication with Primary Health Tasmania, the Department of Health Tasmania and the peak body, Alcohol, Tobacco and other Drugs Council Tasmania. Service users were engaged with the help of ATDC and were given a $50 voucher to thank them for their participation in the consultations.

Data assumptions and limitations

This project will significantly improve the understanding and accuracy of estimating investment and demand for alcohol and other drug treatment in Tasmania. But, like all modelling, there are some assumptions and limitations related to undertaking quantitative analysis that should be considered when interpreting the results of the modelling.

Treatment demand modelling

The 2017 mapping work used the Drug and Alcohol Services Planning Model (DASPM) to do the demand analysis. The DASPM was developed by the Drug Policy Modelling Program for the NSW Ministry of Health as a framework for service planning.

The DASPM is a proprietary product, and we did not have access to it for this project. We tested and updated the underlying assumptions including population, prevalence and severity data, to calculate the proportion of people seeking treatment in Tasmania.

We note that the DASPM used in the 2017 report did not include all components of a contemporary alcohol and other drug system. Services out of scope in the previous work include harm reduction, correctional services such as diversion programs and prison programs, comorbidity services, self help and peer based programs and prevention and health promotion activities.

The previous work also did not include an increase in funding for services for Aboriginal and Torres Strait Islander people. We used the 2014 DASPM adapted for Aboriginal and Torres Strait Islander people to estimate an uplift of 27%, noting that the model is a planning tool, and like all modelling approaches is informed by assumptions and generalisations. The 2017 report also noted that treatment demand

estimates could be reduced by 25% to avoid overestimates for polysubstance use.

Taken together, these 2 adjustments effectively cancel each other out (leaving only a 2% difference), so the raw demand estimate for the updated work did not need to be revised.

A review of a tailored demand modelling solution for Tasmania is a possible future area of focus.

Withdrawal demand

In assessing withdrawal investment, we were not always able to separate withdrawal from other service types. This included inpatient withdrawal management in a private hospital bed and the proportion of withdrawal services at the Bridge South facility and at Serenity House.

Inpatient investment and demand

The 2017 report noted that 'Inpatient identified in the DASPM is for withdrawal management in a hospital bed'. However, the investment data for public hospitals indicates that more than just withdrawal services are provided.

Therefore, we have included an upper range investment estimate that captures public hospital services that are not withdrawal, in addition to all private hospital investment as we did not have the data available to split out the non-withdrawal component.

We have also included all private hospital investment in an upper range of investment data. This small number reflects access barriers for over half the population who do not have private health insurance, possibly due to cost challenges, and it is unclear from the 2017 report whether this investment has a corresponding demand estimate in the DASPM.

We recommend exploring how data for withdrawal and inpatient investment is reported and modelled. This will assist with future investment decisions.

Reform investment

The investment estimate in the report is based on the 2021-22 financial year and does not include any reform investment that was budgeted for but not spent during the year.

Medication assisted treatment

There are two components to understanding the investment and demand for medication assisted treatment. The first component is prescription medicine and the second is labour and related resources to support prescribing and dispensing.

There is a gap between demand estimates for prescription medicine and current investment, we suggest that demand modelling and investment continues to be an ongoing focus area.

The 'ambulatory' category

The treatment demand estimates in 2017 used a treatment type category called 'ambulatory'.

Our investment estimate is based on a more defined treatment type taxonomy, so in order to compare demand to investment we have grouped the investment of the following treatment types to compare to 'ambulatory':

- Psychosocial
- Non residential
- Low threshold
- Primary care
- Medication assisted treatment

A nationally consistent taxonomy for alcohol and other drug treatment types is a suggested future area of focus for the Australian alcohol and other drug sector.

Reporting

The results of the mapping and modelling work are detailed in this report. Additionally, we developed a range of interactive maps of treatment service investment and associated data sets which have been made available to Primary Health Tasmania and the Department of Health Tasmania to complement the key findings presented in this final report.

Investment mapping findings

In Tasmania, alcohol and other drug treatment is funded by a variety of sources and delivered in a range of settings. This includes the services delivered by state based Alcohol and Drug Services, government funded non-government organisations, the Medicare Benefits Scheme, the Pharmaceutical Benefits Scheme, public and private hospital treatment costs and individual contributions toward treatment.

We reviewed existing funding streams across the main funding sources, including both State and Commonwealth funding and where possible private sector investment, including withdrawal, private psychiatric hospitals and pharmacotherapy.

Developing a common taxonomy

Our data structure included a common taxonomy to classify treatment types and geographic locations in recognition of the absence of consistent treatment categories and descriptors across the alcohol and other drug sector. We adjusted the 2017 category structure and updated the taxonomies to ensure the data could be presented in a more complete form.

The final version of the taxonomy included the following treatment types and sub types:

- Harm reduction
- Low threshold
  - Information and assessment
  - Brief intervention
  - Education and prevention
- Withdrawal
  - Outpatient withdrawal
  - Home based withdrawal
  - Inpatient hospital/medicated withdrawal
  - Inpatient non medicated withdrawal
- Psychosocial
  - Outpatient counselling (1:1)
  - Case management
  - Outreach
  - Group programs

- Medication assisted treatment
- Non residential[1]
- Residential treatment
- Inpatient treatment (non withdrawal)
- Other
    - Diversion/therapeutic jurisprudence
    - Peer navigation
    - Peer support groups
    - Specialist dual diagnosis services
    - Family services
    - Capacity building
    - Lived experience advocacy

Investment in government alcohol and drug services is an example of multiple treatment types being clustered in a single investment amount. There are also some commissioned service categories that include multiple treatment types. The category non residential was created to capture these types of investment. The category may include counselling services, direct treatment, comorbidity, social and emotional wellbeing, crisis management, day rehabilitation and aftercare. For a detailed version of the taxonomy see Appendix 1.

Investment findings

Investment in alcohol and other drug treatment across Tasmania by major funders in 2021-2022 was $52.2m. This represents an increase of $17.3m or a 50% increase in investment since 2015-2016 ($34.9m) (Table 1).

During the period 2016-2022, there was new investment that contributed to the increase. This included the National Ice Action Strategy funding of $1.9m, which was considered in 2017 but the full investment amount had not yet been finalised. There was also $4.4m of new investment in residential rehabilitation from multiple funders.

Approximately $1.8m of the $6.7m of 2021-2022 funding from Primary Health Tasmania is described as surplus funding from previous years. This is non-recurrent funding and therefore excluded from the updated investment totals and in comparisons with treatment demand.

Since the 2015-2016 estimates, there have been some significant changes in allocation of responsibility for Commonwealth funding, including the introduction of Primary Health Networks and the National Indigenous Australian Agency (NIAA). The Commonwealth Department of Health and Aged Care also continued to invest directly.

We updated the method for calculating the 2015-16 private hospital investment which resulted in a reduction of the previous amount by $3.5m. We also updated the 2017 estimates to exclude duplicated investment estimates (program and service development unit) of $3.4m. Partially offsetting these decreasing adjustments were the inclusion of additional pathology costs ($0.6m) and pharmacotherapy dispensing fees ($0.9m). The overall net downward adjustment was $5.5m (from $40.4m to $34.9m). Table 1 provides a summary of investment mapping estimates comparisons for 2015-16 and 2021-22.

[1] Non residential treatment categorises investment covering multiple treatment types in non residential settings where data are not available to disaggregate the investment into separate categories.

Table 1: Summary of 2015-16 and 2021-22 mapping findings

Funder	Funding stream	2015-16	2020-21
Australian Department of Health and Aged Care	Primary Health Tasmania [1]	$2,952,710	$4,933,957
	NIAA [2]	$1,705,439	$1,711,466
	Department of Health and Aged Care	$152,629	$1,134,231
	Primary Health (Medicare Benefits Scheme)	$1,247,627	$1,386,203
	Pharmaceutical Benefits Scheme	$1,208,632	$2,249,531
	Diagnostic tests	$599,150*	$572,883
	Addiction specialist alcohol and other drug items (MBS)	N/A	$25,456
	Better Access & ATAPS	$1,134,226*	$1,487,950
	Total	**$9,000,683**	**$13,501,677**
Department of Health Tasmania	Government alcohol and other drug services	$7,791,332*	$11,045,510
	IPWU and withdrawal at other public hospitals	$2,509,923*	$3,755,312
	Community alcohol and other drug services	$7,890,892*	$13,747,384
	Total	**$18,192,147**	**$28,548,206**
Hospitals (Commonwealth, state and individual funding)	Public hospital alcohol and other drug treatment costs	$2,279,099*	$3,682,636
	Private hospital alcohol and other drug treatment costs	$3,551,816*	$3,974,631
	Total	**$5,830,915**	**$7,657,267**
Individual contributions	GP co-payments	$257,924	$387,454
	Pharmacotherapy dispensing fees	$1,211,800*	$1,300,834
	Residential rehabilitation	$444,688*	$820,519
	Total	**$1,914,412**	**$2,508,807**
	TOTAL ALL INVESTMENT	**$34,938,157**	**$52,215,957**

*Corrected value differs from original Siggins Miller 2017 report

[1] Categorised as Commonwealth Department of Health alcohol and other drug treatment grants in 2017

[2] Categorised as Commonwealth Prime Minister and Cabinet alcohol and other drug treatment grants in 2017

Detailed investment data

Primary Health Tasmania

In 2015-2016, community alcohol and other drug services received funding from two major Commonwealth grant programs. The Non Government Organisation Treatment Grants Program (NGOTGP) and the Substance Misuse Service Delivery Grants Fund (SMSDGF) were administered by the Australian Department of Health and Aged Care.

The NGOTGP and the SMSDGF were transitioned to 'Core Operational' funding in 2019 and continue to be distributed to community alcohol and other drug services along with National Ice Action Strategy (NIAS) funding. Both Core Operational and NIAS funding are managed by the Primary Health Networks (PHN).

Primary Health Tasmania funded community based alcohol and other drug services a total of $6,661,257 in 2021-2022 through Core Operation and NIAS funding, as well as through direct grants. Unspent previous year funds (underspends) go into funding direct one off grants for capacity building and sector innovation.

To account for the funding underspends in annual investment totals, we reviewed the total amount of alcohol and other drug funding provided by the Commonwealth Department of Health and Aged Care minus Primary Health Tasmania operational costs. The available funding Primary Health Tasmania had to invest in the sector in 2021-22 was estimated at $4.9m (Table 2).

Table 2: Estimated recurrent funding from Primary Health Tasmania

Funding stream	2021-22	Operational cost (6%)	Net investment
Core and Operational Funding	$3,123,642	($187,419)	$2,936,223
NIAS Operational and Mainstream Funding	$1,269,978	($76,199)	$1,193,779
NIAS Aboriginal and Torres Strait Islander People Funding	$627,836	($37,670)	$590,166
Drug and Alcohol Treatment Services Maintenance	$227,434	($13,646)	$213,788
TOTAL	**$5,248,890**	**($314,933)**	**$4,933,957**

National Indigenous Australians Agency

In 2017 the Commonwealth Department of Prime Minister and Cabinet invested directly in Aboriginal and Torres Strait Islander alcohol and other drug services. This funding is now distributed through the National Indigenous Australians Agency (NIAA).

In 2021-2022, NIAA investment in alcohol and other drugs services for Aboriginal community controlled organisations (ACCOs) totalled $1,711,466, representing an increase of $6,027 from 2017.

Australian Government Department of Health and Aged Care

Direct grants to community alcohol and other drug services in Tasmania

The Australian Department of Health and Aged Care currently provides $1,134,231 per annum, representing a significant increase from a total of $152,629 of funding provided in 2017.

Primary care services through Medicare

We estimate $1,386,203 is spent on services delivered by General Practitioners through the Medicare Benefits Schedule (MBS), an increase of 11% from 2017 estimates.[2]

We have used the calculation method applied in 2017 to estimate the value of alcohol and other drug treatment in general practice settings.[1]

Pharmaceutical Benefits Scheme – medications

The total PBS government expenditure for 2020-2021 was $13.8 billion across Australia.[2] If we assume If we assume non-medication-assisted treatment for opioid dependence (MATOD) alcohol and other drug expenditure on prescriptions remained at approximately 0.3% then PBS alcohol and other drug expenditure is $41,400,000 (excluding MATOD).

A pro rata population conversion was used for the Tasmanian population estimate. In 2020-2021, the Australian population was estimated to be 25,766,605 and the Tasmanian population 558,000.[4]

Tasmania accounts for 2.17% of the Australian population. Applying this ratio to the estimated non MATOD alcohol and other drug expenditure across Australia results in an additional spend of approximately $898,380 in PBS medications for alcohol and other drug treatment other than MATOD.

Calculating PBS expenditure on alcohol and other drug prescriptions in Tasmania

In 2020-2021, the Opiate Dependence Treatment Program received $90,681,291 of PBS funding, up from $70,649,486 in the previous 12 months.[2]

The National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) reported that in a 2021 snapshot, Tasmania accounted for 1.49% of MATOD clients out of a total of 47,563 nationally.[3] We applied this ratio to national Opiate Dependence Treatment Program expenditure ($90,681,291) to compare Tasmanian MATOD investment, resulting in an approximate estimate of $1,351,151.

The combined spend on PBS medications used in the treatment of alcohol and other drug use in Tasmania in 2020-2021 is estimated at $2,249,531.

Pathology services funded through Medicare

To estimate alcohol and other drug pathology costs we used the methods described in Ritter et al. 2015.[1] The common pathology tests are full blood examination, liver function test and urea, electrolytes and creatine. The average cost per test to Medicare is $14.75 (which is the 85% benefit rate).

[2] An estimation method needs to be developed to compensate for the lack of MBS items numbers directly related to the provision of alcohol and other drug support/treatment provided in general practice settings.

Applying $14.75 to an estimated 9,338 pathology tests in Tasmania in 2020-21, equates to $137,740 in Medicare costs.

Pathology tests for opioid pharmacotherapy include urine drug screen tests.[3] We estimate the total cost of Medicare rebated pathology as $435,143.

In 2021-22 total pathology costs are estimated to be $572,883. To increase the future accuracy of the estimate there needs to be further detailed analysis.

Addiction Medicine Specialists through Medicare

In November 2016, 15 items were introduced into the MBS for Addiction Medicine to support specialists to provide care (items 6018-6042). No specific Addiction Medicine MBS items were introduced for use in general practice.

We used 'Medicare Item Reports' to assess MBS expenditure on Addiction Medicine items for the 2020-2021 financial year. Total Addiction Medicine benefits across Tasmania were $25,456.

The 2020-2021 period was used because of the change in telehealth MBS items on 1 January 2022 that removed telehealth items 6025 and 6026. The change noted that the broader MBS items relating to consultant physician telehealth services include Addiction Medicine, thus making identifying the claims specific to Addiction Medicine specialists from 1 January 2022 problematic.

Allied health services

Better Access is a mental health program funded through the Medicare Benefits Scheme. Treatment to a mental health specialist is accessed through referral obtained through a General Practitioner. People who use alcohol and other drugs are eligible under this scheme and can access up to 10 individual sessions per calendar year.

We used 'Medicare Items Reports' to collate reporting data on Better Access program funding provided in 2021-2022 (Table 3). The total cost of all non GP Better Access items in Tasmania was $16,090,466.

Figures derived from the Better Access evaluation 2009 estimated that 8% of clients seeing a Clinical Psychologist or a Registered Psychologist through Better Access were receiving services for alcohol and other drug use. Applying this ratio to the 2021-2022 figures results in an estimation of Better Access costs of $1,287,237 that were spent on providing specialist support services to people with alcohol and other drug use concerns across Tasmania.[4]

Table 3: Cost of non GP Better Access in Tasmania

Services	Tasmania (2021-22)
Consultant Psychiatry	$1,380,796
Psychological Therapy Services	$9,568,855
Focused Psychological Strategies	$5,140,815
TOTAL	**$16,090,466**
8% relating to alcohol and other drugs	$1,287,237

[3] With pharmacotherapy dispensed to 587 clients on a pharmacy snapshot day, with each client able to receive 21 tests per annum under Medicare at a cost of $35.30 per test. Noting that Ritter et al. 20151 assess 21 tests per annum to likely be an overestimate. Over time there has been a reduction in the use of urine drug screen tests which would increase the likelihood that the costs are an overestimate. However, Ritter et al. 20151 also noted that the total pathology costs estimated is likely to represent only a proportion of the real pathology costs for alcohol and other drug treatment across all settings and service user groups.

[4] We sought updated figures from the current Better Access evaluation team but were advised that the current evaluation was underway.

Hospitals

Estimated investment in hospital alcohol and other drug treatment in 2021-2022, excluding the inpatient withdrawal unit, is $7,657,267. This is a 31% increase from the adjusted 2015-2016 estimate.

We amended the 2017 calculations to address the previously identified issues and limitations resulting in more accurate estimates of hospital investment in alcohol and other drug treatment.

Public hospitals

Estimated investment in alcohol and other treatment in public hospitals in 2021-22, excluding the inpatient withdrawal unit, is $3,682,636. This represents an increase of 62% from the adjusted 2015-16 estimate.

We adjusted public hospital estimates upward to account for assumptions used in 2017 that underestimated the average length of stay and activity growth rates in Tasmanian public hospitals.

Our 2021-22 estimate is based on the national price for public hospital episodes, excluding those in the inpatient withdrawal unit, with a principal diagnosis relating to alcohol and other drugs. National Weighted Activity Unit (NWAU) data for these episodes was provided by the Department of Health Tasmania.

Private hospitals

Estimated investment in alcohol and other drug treatment in private hospitals in 2021-22 is $3,974,631. This is $3,081,206 less than 2017 estimates ($7.1m) and did not include the significantly higher proportion of same day alcohol and other drugs treatment episodes in private hospitals relative to public hospitals.

In relation to the 2017 report overestimate, the two key steps in the method used in the 2017 report to estimate private hospital investment were:

1. Turning the private hospital separations into National Weight Activity Units
2. Applying the National Efficient Price to the total National Weight Activity Units

The key assumptions behind this approach are that private hospital casemix is the same as public hospitals and that private hospitals incur the same costs as public hospitals on average. This approach significantly overstates the investment.

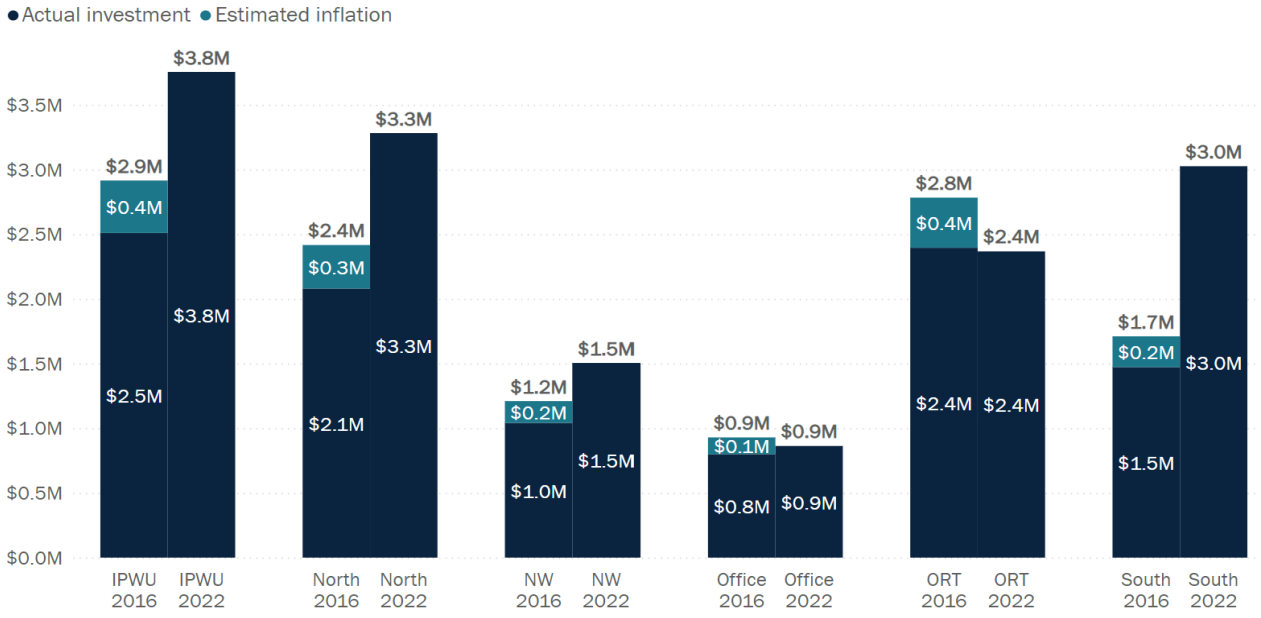
Private hospital funding for a day of care is lower than the public hospital estimate of $1.3k (which is similar for both a same day episode and an overnight episode. The average cost for same day treatment in a private hospital was $297 in 2015-16, and for an overnight episode was $679.

Our 2021-22 estimate is based on data from the Private Hospital Data Bureau 2020-21 annual report.

Department of Health Tasmania

The Department of Health Tasmania provided data on their investment in alcohol and other drug treatment across community organisations and government organisations. A total of $28,548,206 in funding was allocated through the Department of Health Tasmania in 2021-2022. Government alcohol and other drug services received $14,800,822 (Figure 3) and community organisations received a total of $13,747,384 in funding.

Figure 3: Department of Health Tasmania investments in government Alcohol and Drug Services in FY16 and FY22 (estimated inflation based on ABS data)



Individual contributions

GP co-payments

Using the method applied in 2017[1], we estimated the total number of alcohol and other drug GP presentations in Tasmania in 2020-21 to be 28,997.

For those without a health care card, the average out of pocket cost for GP visits in 2021-22 was applied, which is $40.28.[6] The estimate of GP co-payments for alcohol and other drug presentations across Tasmania is $387,454. (Table 4).

Table 4: GP co-payments by presentation

Presentation	% of all GP encounters	2020-21 estimate	% health care card holders	Number of non-health care card holders	Out of pocket cost
Alcohol use disorder	0.41%	13,510	55.4%	6,026	$242,727
Non-medicinal drug use disorder (non-opioid)	0.23%	7,579	73.9%	1,978	$79,674
Opioid use	0.06%	1,977	73.5%	524	$21,107
Medicinal drug use disorder (non-opioid substitute prescribed)	0.18%	5,931	81.6%	1,091	$43,946
TOTAL	-	-	-	-	**$387,454**

Pharmacotherapy dispensing fees

Several overarching assumptions were used to estimate costs associated with pharmacotherapy dispensing fees in Tasmania.

These assumptions are based on an average dispensing fee for methadone and buprenorphine at $6.07 per day.[7] No dispensing fee is paid by people accessing pharmacotherapy through public clinics and prisons. A total of 587 people accessed pharmacotherapy from a pharmacy.[3] The number of clients accessing pharmacotherapy in private clinics (snapshot 2020 data) was negligible.

The estimated client dispensing fee contributions in Tasmania for 2021-22 is $1,300,834.

Residential rehabilitation

The estimated average length of stay in residential rehabilitation in 2017 was 53.5 days, (estimates drawn from data provided by Salvation Army Tasmania). Per bed day service user contributions were previously reported to be approximately 75-80% of Centrelink benefits. The 2017 estimates were based on the assumption that the main Centrelink benefit for people entering residential rehabilitation was NewStart. This type of benefit was discontinued in early 2020 and replaced by Jobseeker. As at 20 September 2022, the maximum Jobseeker payment for a single person with no children was $668.40 per fortnight.

This estimates the per day contribution of someone in residential rehabilitation at $37.00. The average length of stay is 53.5 days, and the average number of closed treatment episodes in Tasmania in 2020-2021 was 829. This equates to an approximate total number of bed days in Tasmania for 2020-2021 of 44,352.

Applying the same model that was used in 2017, we have estimated total client contributions while in residential rehabilitation as $820,519.

Treatment demand estimates

Method

The treatment demand analysis estimates the levels of demand for alcohol and other drug treatment services across Tasmania. To update the estimates, we used a similar method that was applied in 2017, which relied on the DASPM to calculate treatment resource estimates in Tasmania.

The DASPM estimates the resources needed to treat an average population that would normally be funded by state or federal governments, including services delivered by community service organisations. It calculates estimates based on treatment populations and the required resources needed to meet the treatment demand across 5 drug types: Alcohol, benzodiazepine, cannabis, amphetamines, and opioids. Other drug types such as inhalants, synthetic cannabinoids, polydrug use, steroids and tobacco are out of scope for this model.

Services considered out of scope for the DASPM include adjacent services such as housing and homelessness services, welfare support services, correctional services such as diversion programs and prison programs, comorbidity services, supported accommodation, self help and peer based programs and prevention and promotion activities.

Services specifically for Aboriginal and Torres Strait Islander people were not included in the original DASPM, but an adapted model was developed in 2014 that includes estimates about resources requirements for Aboriginal and Torres Strait Islander services.

We were able to extract the key assumptions that drive the DASPM based on the data presented in the 2017 report.

There are four key elements to estimating costs associated with treatment demand (Figure 4):

1. Population
2. Prevalence of substance use disorder
3. Severity of substance use disorder
4. Treatment population by severity

Figure 4: Treatment demand modelling method

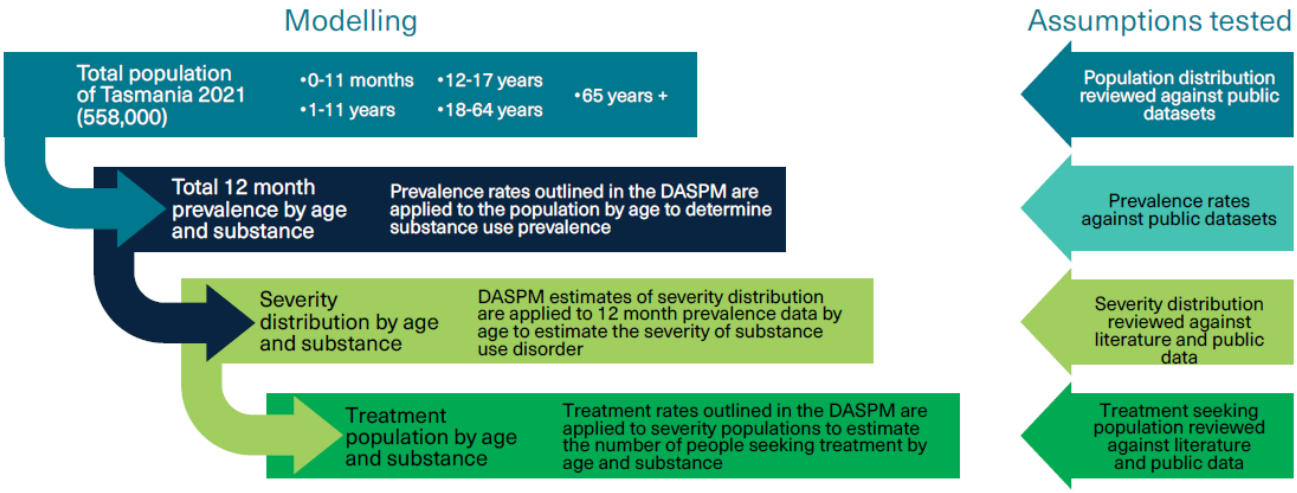


Table 5: National Drug Strategy Household Survey prevalence of drug use 2013 and 2019

Drug type	Population use in last 12 months (2013)		Population use in last 12 months (2019)[a]	
	Tasmania	Australia	Tasmania	Australia
Alcohol (recent use)	83.2%	78.2%	83.2%	76.6%
Cannabis	11.8%	10.2%	12.6%	11.6%
Meth/amphetamines	3.0%*	2.1%	0.6%**	1.3%
Heroin	-	0.1%	0.1%**	<0.1%*
Any illicit (excluding pharmaceuticals)	**13.3%**	**12.0%**	**14.0%**	**14.1%**
Pharmaceuticals (illicit use)	**4.3%**	**4.7%**	**4.5%**	**4.2%**

*Estimate has a relative standard error of 25-50% and should be used with caution. **Estimate has a relative standard error >50% and is considered too unreliable for general use. Replicated from the Australian Institute of Health and Welfare. [a]National Drug Strategy Household Survey detailed report 2013 and 2019.

Benchmarks for service provision 2020-21

We reviewed published literature and public datasets to test the assumptions made in the original DASPM and in estimates outlined in the 2017 report. We updated these assumptions to reflect 2020-2021 prevalence and treatment populations.

The key updates between the assumptions used in the 2017 report and those used in our model were:

1. Population: Tasmanian population increased from 521,062 to 558,000
2. Prevalence: No change
3. Severity Distribution: Severity distribution for amphetamines was updated from 0% mild, 10% moderate and 90% severe to 30% mild, 40% moderate and 30% severe [5]
4. Treatment population:
   a. Treatment population for amphetamines was updated from 0% mild, 50% moderate, 35% severe to 50% mild, 50% moderate, and 100% severe
   b. Treatment population for severe opioid use disorder was updated from 90% to 100%

Population

Between 2017 and 2021, the population of Tasmania increased by 36,938. The population age distribution remains the same, with the median age of 42 years in both 2017 and 2021.[9]

Prevalence

We compared prevalence of drug use reported by the National Drug Strategy Household Survey in 2013 when the original DASPM was developed with prevalence reported in 2019 (the most current dataset available) to test the prevalence assumptions outlined in the original DASPM. Prevalence rates for drug use included in the DASPM are presented in Table 5 and prevalence rates from all drugs reported in the National Drug Strategy Household Survey are presented in Appendix 2.

Prevalence rates in Tasmania for alcohol, cannabis, heroin and illicit use of pharmaceuticals remained similar between 2013 and 2019. There was a 2.4% decrease in reported prevalence of amphetamines, noting that this estimate also had a large margin of error. So, we did not change our assumption of prevalence of amphetamine use.

[5] Mellor and Ritter(10) noted that the original DASPM model parameters for amphetamines were not realistic. They adjusted the severity distribution for amphetamines when applying the DASPM model to NSW to 30% mild, 40% moderate, and 11% severe. We have applied the same adjustment to our model.

Severity distribution

Mellor and Ritter noted that the original DASPM model parameters for amphetamines were not realistic.[10] They adjusted the severity distribution for amphetamines when applying the DASPM model to NSW to 30% mild, 40% moderate, and 11% severe. We have applied the same adjustment to our model.

Treatment population

In consultation with an expert reference group, Mellor and Ritter identified that the treatment population estimates for rates of amphetamines and illicit opiate use in the original DASPM were likely outdated.[10]

We used updated treatment rates for amphetamines and illicit opiate use estimates which align with interpretations of the expert reference group and with data on drug related harms. Our estimates on rates of use and assumptions about treatment seeking distributions are outlined in Table 6.

Summary of demand analysis

We estimate the cost of meeting the treatment demand in Tasmania is $60.2 million (Table 7). This includes 158 beds at an occupancy rate of 76% for residential and 87% for withdrawal. Most of this resource cost relates to treatment for people categorised in the severe population.

This cost is based on a modelling equation that assumes that out of 34,582 people who are likely to experience a substance use disorder in a 12-month period, a total of 14,473 people will require treatment; 6,336 people were categorised as severe based on the severity estimates outlined in Table 6 below.

In addition to the total number of people estimated to need treatment, a further 5,580 people are estimated to need consultation and liaison services (this includes liaison to obstetrics, residential aged care and mental health, as well as consultation and liaison to general hospital beds where a person has primary or secondary drug and alcohol diagnosis), and a further 65,759 people are estimated to need screening and brief interventions for presentations at emergency departments.

Table 6: Example of service need and demand modelling assumptions 2021-2022 for the 18-64 year old population

Substance	Prevalence	Severity distribution			Treatment seeking distribution		
		Mild	Mod	Sev	Mild	Mod	Sev
Alcohol	6.35%	67%	22%	11%	30%	50%	100%
Amphetamines	0.51%	30%	40%	30%	50%	50%	100%
Benzodiazepine	0.51%	50%	30%	20%	20%	50%	100%
Cannabis	1.76%	67%	22%	11%	20%	50%	100%
Illicit opioids	0.65%	0%	0%	100%	0%	0%	100%

*Mild, moderate (Mod) and severe (Sev)

Table 7: The estimated demand for alcohol and other drug treatment services in Tasmania is $60.2m

Settings	Estimated demand
Non residential including psychosocial, low threshold, primary care, medication assisted treatment*	$30.0m
Withdrawal	$5.7m
Residential rehabilitation	$11.7m
Prescription medicine and diagnostic tests*	$12.8m
TOTAL	**$60.2m**

*We consider that these treatment types collectively correspond to the 'Ambulatory' category used in the 2017 report

Comparing investment and treatment demand

An additional $12.2m, or a 25% increase in investment, is needed to meet treatment demand costs of $60.2m (Table 8).

To meet treatment demand, investment in withdrawal needs to increase by 50%, investment in non residential and residential rehabilitation needs to increase by 20-30%, and significantly more investment is required in pharmacotherapy.

Since 2017, the proportional gap between demand and investment has reduced from 50% to 25%.

Table 8: Increase in investment required to meet treatment demand in 2021-22

Setting	Demand*	Investment*	Gap 2021-22	Gap 2015-16
Non residential including psychosocial, low threshold, primary care, medication assisted treatment	$30m	$24.8m	$5.2m (21%)	38%
Residential rehabilitation	$11.7m	$9m	$2.7m (30%)	133%
Withdrawal	$5.7m	$3.8m	$1.9m (50%)	76%
Prescription medicine and diagnostic tests	$12.8m	$2.8m	$10m (357%)	433%
TOTAL (lower range investment estimate)	**$60.2m**	**$40.4m**	**$19.8m (49%)**	**85%**
Public hospital non withdrawal and private hospital inpatient	^	$7.6m	($7.6m)	-
TOTAL (upper range investment estimate)	**$60.2m**	**$48m**	**$12.2m (25%)**	**50%**

*Excludes harm reduction, correctional services, telephone or web-based interventions, self-help and peer-based programs, services for mental health co-morbidity and prevention and promotion activities

^Unclear whether there is a corresponding estimate in the DASPM demand calculation for this investment

Sector experience: Service users and service providers

Overview

Mapping stakeholder (service users and service providers) experience of the Tasmanian alcohol and other drug treatment sector was a key component of the 2017 mapping work. The 2017 sector experience consultations identified service user priorities and these were used to inform the development of the Reform Agenda for the Alcohol and Other Drugs Sector in Tasmania.

Some priorities identified by service users included:

- A lack of consistent information on how to access alcohol and other drug services and a lack of information from GPs
- Long wait times and access barriers such as sometimes restrictive criteria to access services
- Lengthy distances to travel between services

The alcohol and other drug service sector landscape has changed significantly since the original 2017 work.

As outlined in this report there have been changes to and increases in levels of investment across the service system, including new investment for residential rehabilitation and the introduction of the Australian Government's National Ice Action Strategy funding.

The Tasmanian reform agenda was also released in 2020 and during this time the sector has had to respond to the impact and aftermath of COVID-19.

Consultation findings

The focus of the consultations was to provide an updated snapshot of the Tasmanian alcohol and other drug treatment sector in 2022. Consultation questions were designed to capture insights into the service system strengths, gaps and service improvement areas and to understand the barriers to accessing treatment.

Sector strengths

Service user and service provider consultation participants identified a number of Tasmanian alcohol and other drug sector strengths. These include:

- The sector is open to new and innovative ways of working
- The workforce is both passionate and strongly committed to delivering services
- The peak body, Alcohol Tobacco and other Drugs Council Tasmania (ATDC), plays a crucial role supporting and helping to strengthen the community sector, providing sector leadership, advocating to government for the sector and relationship building.

Areas for improvement

The consultations identified key areas for increased investment and improvement within the alcohol and other drug treatment sector and across the various treatment types.

Information and referral

There was limited awareness of available treatment types, including the promotion of the full range of alcohol and other drug services. Service information is primarily only available through hard copy brochures.

Online information about services is limited and described as fragmented. Navigating the system is challenging and creates 'cognitive hurdles' for people seeking information about services.

The most common referral pathways into treatment are via GPs, ADS and child protection services.

> **"I tried to look online to find out where I could go for treatment, but I couldn't figure it out. It's hard to find the information...it's even harder to focus when you're hungry or craving"**
>
> *Service user*

Withdrawal services

Service users described experiencing challenges to timely access to withdrawal services. They identified a withdrawal intake 'bottleneck' that delays admission into residential rehabilitation. The limited number of available beds in the ADS was identified as a key contributor to the bottleneck. Service users perceive that there is an underutilisation of withdrawal beds in the hospital system, particularly when there are 'no shows' and the bed remains empty.

People describe feeling distressed about the long wait lists of between 3 and 6 weeks to get admission into withdrawal services. This results in distress for people seeking withdrawal support. Consultation participants reported being advised to continue their use until a withdrawal bed becomes available.

There are no available beds in the north and north west region, with people having to travel to Hobart to access supported withdrawal services. Travelling long distances when experiencing withdrawal symptoms operates as a barrier to accessing public transport. Service users expressed concern about experiencing withdrawal symptoms and becoming agitated which can result in failure to complete the journey.

The availability of financial support for people travelling to access the Hobart-based ADS withdrawal facility is not widely known. Knowledge about this financial support is gained primarily through 'word of mouth' rather than systematically available.

Policies that restrict access to withdrawal services to once or twice in a 12-month period have resulted in people feeling disapproved of by staff when accessing the service multiple times.

There is a need for consistency in the delivery of withdrawal services across the state, regardless of where the service is being provided. The consultation participants disclosed examples of negative and traumatising experiences of people in the withdrawal services, for example some staff project negative attitudes and some people have experienced seizures while in care.

Access to GPs

Timely access to GPs was identified as an area of concern for consultation participants. The issues include:

- Long wait times for appointments
- Costs associated with seeing a GP
- GPs having poor understanding of alcohol and other drug issues and the full range of treatment options

There is limited access to bulk billing GPs, particularly in the north and north west regions. The cost of longer appointments for patients with complex needs acts as a barrier to seeking support from GPs. These barriers act as impediments to the broader specialist treatment system.

There is a lack of incentives offered to GPs in Tasmania to become pharmacotherapy prescribers, and there is a strict regime of

protocols to get prescribing accreditation in comparison to other states and territories. This has resulted in a shortfall in the number of GP prescribers in Tasmania. Prescribers also have large caseloads and often risk experiencing burnout.

Access to pharmacotherapy

As outlined above, access to pharmacotherapy is impacted by long wait lists for access to GP prescribers. Access to pharmacotherapy is also limited by the number of available dispensing outlets and dispensing fees. Note that this is being addressed by the ADS through the changes to Opioid Dependence Treatment introduced by the Australian Government in 2023.

Rural and remote outreach services

The outreach services are identified as an important service and treatment access point in the north and north west regions. However, available funding for outreach services is determined to be inadequate. Consultation participants reported that the shortfall in outreach funding is often 'topped up' through other funding sources, such as provider core funding.

People who make the decision to access more centralised services face challenges such as lengthy travel times on public transport.

Gender specific and family based treatment options

Service providers noted that some women-only services are available for women who have experienced domestic and family violence. However, women who do not meet this criteria can experience challenges in mixed gender treatment settings, particularly if they have trauma histories and/or other complexities such as child protection involvement.

> **I felt uncomfortable when dealing with child protective services while in a mixed facility without sufficient privacy**
>
> *Service user*

Stakeholders identified that there is a limited number of residential treatment options for women and children as well as families as a whole. Having limited access to children and support networks for people in withdrawal services and residential treatment settings is identified as a service engagement challenge and access barrier. Some consultation participants believe that involving family in their treatment would help to facilitate an increased understanding about their alcohol and other drug issues and promote better support.

> **Being able to see my child while in rehab would have strengthened my resolve**
>
> *Service user*

Youth services in the north

Limited access to youth specific services in Launceston and the North region was highlighted by consultation participants as a service gap.

Residential beds in the north and north west

Demand for residential beds in the north and north west currently exceeds supply for both short and long term treatment support. This means that some people seeking treatment have to travel to the South to access residential rehabilitation.

Access to aftercare

Aftercare programs take place between 9am and 5pm, which makes it difficult to look for work after exiting residential treatment.

Access to aftercare is also challenging for those with childcare responsibilities. One service user reported that she was unable to attend aftercare support because she had to prioritise looking after her child during program times.

There is limited access to housing for people completing residential treatment programs, particularly long stay programs.

Access to comorbidity support

People seeking access to mental health services are often referred to alcohol and other drug services to address their alcohol and other drug use before being able to commence mental health treatment. This often results in alcohol and other drug workers having to manage acute mental health issues.

Service users are sometimes being 'handballed' between alcohol and other drug and mental health services. Service users are frequently told to engage with a mental health service prior to engaging in treatment for alcohol and other drug use.

One service user described their experience of accessing different services over several years where their underlying trauma went undetected and unaddressed. Eventually, they travelled interstate to attend a service that they felt was better suited to meet their treatment needs.

> **I had bad experiences in some services in Tasmania, so I went to Sydney to find a service that was better suited to me – a service that was able to deal with both my drug use and my underlying trauma**
>
> *Service user*

Access to treatment for people exiting custodial settings

People exiting custodial settings were identified as a treatment population cohort with a range of unmet treatment needs. These include leaving a custodial setting with a limited supply of medication and no referral to continue treatment support including pharmacotherapy.

Crisis response

Consultation participants assess that both non government and government services have limited capacity to respond to people in high risk or crisis situations.

Barriers to treatment

The stakeholders identified the lack of available withdrawal and residential rehabilitation services as a barrier to treatment. Availability issues are compounded by long wait times and having to travel long distances to access services.

Other barriers included a lack of access to the full range of appropriate services, after hours access to services, issues related to social housing, stigma, cultural barriers and perceptions that the service system is punitive.

These consultation findings align with our investment and demand analyses, which estimated that there is a gap between service availability and demand for treatment.

Stigma

Stigma has been identified as a barrier to accessing and staying in treatment. There was a general consensus across stakeholder groups that GPs display a high level of discrimination toward people seeking support for alcohol and other drug use. As this is an important pathway into the service system, this presents major challenges for service users across the sector.

Service users also reported feeling traumatised by some of the attitudes displayed across the alcohol and other drug workforce after relapse. This stigma is experienced as disapproval about needing to attend a service multiple times.

Access to after hours support

Limited flexibility in service operating times acts as a barrier to treatment. The importance of providing support to people when they are 'treatment ready' was emphasised during our consultations.

> **I was actually told by a staff member 'this isn't a revolving door'**
>
> *Service user*

Housing

Housing was identified as a common barrier to treatment engagement and program completion. People living in public housing and admitted into residential rehabilitation can receive discounted rent for up to 3 months but loss of secure housing is a risk for long stay admissions.

People in private rentals or with mortgages can often be discouraged from accessing residential rehabilitation as they have to continue to pay their rent or mortgage as well as fees associated with their admission.

A lack of available affordable social housing for people exiting prison and treatment increases the risk of recidivism and relapse.

Access barriers for diverse populations

A lack of cultural sensitivity among alcohol and other drug workers is understood to be a barrier to entering treatment. Service providers believe that the current service system is primarily designed for a mainstream population.

The limited options for people seeking alcohol and other drug services outside of faith-based organisations is a barrier to accessing treatment for some people from diverse cultures and faiths and for people who identify as lesbian, gay, bisexual, transgender, intersex, queer/questioning, and/or asexual (LGBTIQA+).

Service users identified the limited availability of non-faith-based services as a service gap. Some participants disclosed that they have left services because of the 'strong faith-based components'.

Sector issues

Leadership role of funding bodies

There is an opportunity for funding bodies to take a leadership role in the sector, which would help facilitate a more cohesive and collaborative alcohol and other drug treatment service system. Funders are in a good position to embrace a leadership role because of their networks across alcohol and other drug and adjacent sectors.

For example, stakeholders identified the importance of developing more formal networking opportunities for alcohol and other drug and adjacent sectors. This would help to build a better understanding of available services, develop relationships, facilitate better collaboration and knowledge sharing, and enable the service system to better meet the needs of people in treatment.

Communication across the sector

Formalised and improved pathways for communication and collaboration between ADS, community service organisations, and primary care are needed. These services are currently perceived as siloed and not engaging in effective coordination and communication.

Information sharing

While confidentiality issues were recognised as an issue that limits information sharing, most service users emphasised a preference for a system that supported them to consent to information sharing with a selection of key service providers.

Driving innovation

Stakeholders characterised the Tasmanian alcohol and other drug sector as highly innovative and driven by a passionate workforce. Service providers believe that there is an opportunity to drive further innovation across the sector, noting the key enabler is having only one Primary Health Network for the whole of Tasmania.

> **"We only receive innovative funding for short periods of time. The amount of resources that go into these projects only for funding to be discontinued means it's often not worth it"**
>
> *Service provider*

Service providers are requesting more support from funding bodies to drive innovation. This could be supported by increasing opportunities

to evaluate service impacts and outcomes. This evidence could then be used as a basis for justifying and extending contract time frames.

Tailoring key performance indicators

Service providers across the regions emphasised the importance of having input into the development of key performance indicators for their funding contracts. There is a lot of diversity between services including in their operation models. Service providers felt that the current set KPIs used across the funding bodies do not correctly represent the full range of diverse service types and the way services are delivered.

Responding to complex care needs

Service providers report that people are presenting with increasingly complex treatment needs and that they are not resourced well enough to effectively respond. This is compounded by the cost of delivering services that has increased at a rate that exceeds annual funding indexation.

Service delivery frameworks and models of care

Reform Direction 3 of the Reform Agenda for the Alcohol and Other Drugs Sector in Tasmania aims to provide service delivery frameworks to ensure people across Tasmania have access to alcohol and other drug treatment of high quality that is consistent with contemporary best practice. The need for these frameworks was emphasised by both service providers and service users throughout the consultations.

Service users describe inconsistencies in the quality of available treatment across the service system.

Stakeholders identified the need to implement formal frameworks to help facilitate better collaboration in the alcohol and other drug and adjacent sectors, including the need for a central resource to support referral processes.

Workforce

The alcohol and other drug sector in Tasmania is described as having an ageing workforce that experiences challenges in recruiting and retaining skilled staff. Funding limitations is only one of the contributing factors. Service providers noted they are also competing for staff from the same small workforce pool.

Skills shortages contribute to recruitment challenges. Service providers reported that social work and allied health qualifications do not adequately train people to deliver alcohol and other drug services which results in people applying for roles that they aren't suitably qualified for.

Sector enhancement opportunities

The service system strengths can be strategically leveraged to develop a more collaborative approach to sector reform. This could include formalising collaborations and communication pathways across the government, non-government and primary care.

The consultation findings suggest that the sector would benefit from funding bodies taking on more of a leadership role in defining the direction of the sector. This could include driving increased opportunities for collaboration, developing treatment frameworks and improving links between alcohol and other drug service providers and relevant adjacent sectors such as mental health, justice and housing services.

Consultation participants noted that increased investment would enable the sector to develop and trial more innovative approaches to service delivery. Increased investment would also help expand service capacity and capabilities to deal with increasingly complex treatment presentations.

Service providers identified that the key performance indicators in service agreements don't always accurately reflect service delivery activities. Providers would like the opportunity to work with funding bodies to develop tailored key performance indicators that capture service activity and the resources required to achieve treatment outcomes for service users.

Information and referrals

Stakeholders identified an opportunity to develop a centralised service information resource. Most participants found out about services from other service users after they were already engaged in the alcohol and other drug service system.

More information could be available in General Practitioner consulting rooms, such as an information flyer with the number to the National Alcohol and Other Drug Hotline – ADIS (Alcohol Drug Information Service).

Improving information resources for parents and carers to support young people should also be a key area of focus. Parents and carers are often not sure where to access support within the sector.

Out of hours support

Stakeholders identified an opportunity to invest in 'out of hours' support provided by phone and/or face to face. It is believed out of hours support would help people to seek advice and information when they need it.

Withdrawal services

Some of the stakeholders suggested that there may be an opportunity to fund a community based service to provide withdrawal services supported by a clinical workforce.

Outreach services

The consultation participants identified the opportunity to increase investment in outreach support services as well as extending the funding contract period to build local community relationships that help to build trust and engagement levels.

Comorbidity services

Increased investment in comorbidity support services to establish a 'no wrong door' approach for people who are seeking support for both alcohol and other drug use and mental health concerns.

People exiting the justice system

There is an opportunity to establish case managers to support people who have alcohol and other drug treatment needs when they are exiting the criminal justice system.

Peer support

Stakeholders identified an opportunity to increase levels of peer support across the service system. Increasing the roles of peers would have a positive impact in terms of 'role modelling' and could also help people to navigate the service system.

Appendix 1: Taxonomy for alcohol and other drug treatment mapping

Developing a common taxonomy to describe alcohol and other drug treatment services is essential to enable correct comparison of funding between funders. We worked to develop a common taxonomy as part of the data structuring phase of this project. This involved reviewing the terminology for alcohol and other drug treatment types used in the original 2017 mapping report, and in internal Primary Health Tasmania and Department of Health Tasmania documents.

Table 9 shows the taxonomy we used to map alcohol and other drug investments during this project, compared with the terminology used in previous reports.

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Table 9: Comparison of alcohol and other drug taxonomy across funding reports

Taxonomy used for mapping alcohol and other drug investments	Siggins Miller 2017 taxonomy	Primary Health Tasmania NIAS and CORE funded treatment services taxonomy	Primary Health Tasmania alcohol and other drug commissioning taxonomy	Tasmania Department of Health alcohol and other drug treatment services taxonomy
Harm reduction				
• Places of safety and sobering up beds • Needle and syringe program	• Places of safety and sobering up beds • Needle and syringe programs	• Recovery services including brief intervention, harm minimisation, counselling, psychological therapies, case management and aftercare†	-	• Places of safety
Low threshold				
• Information • Assessment • Early intervention (including brief intervention)	• Prevention and promotion • Education • Early intervention • Assessment	• Referrals • Recovery services including brief intervention, harm minimisation, counselling, psychological therapies, case management and aftercare† • Mental health (dual diagnosis) assessment and treatment†	• Early intervention • Education	• Alcohol and other drug health promotion • Information
Withdrawal management				
• Outpatient withdrawal • Home based withdrawal • Inpatient hospital/ medicated withdrawal • Inpatient non medicated withdrawal	-	-	-	-

Taxonomy used for mapping alcohol and other drug investments	Siggins Miller 2017 taxonomy	Primary Health Tasmania NIAS and CORE funded treatment services taxonomy	Primary Health Tasmania alcohol and other drug commissioning taxonomy	Tasmania Department of Health alcohol and other drug treatment services taxonomy
Psychosocial				
• Case management • Outreach • Group programs	• Case management and case coordination	• Case management, care planning and coordination • Relapse prevention • Direct treatment (does not specific what direct treatment is provided) • Mental health (dual diagnosis) assessment and treatment† • Recovery services including brief intervention, harm minimisation, counselling, psychological therapies, case management and aftercare†	• Treatment (not specified) • Aboriginal alcohol and other drug treatment services (not specified)	• Alcohol and other drug treatment (not specified) • Alcohol and other drug treatment (youth) (not specified) • Care coordination services
Medication assisted treatment				
• Medication Assisted Treatment of Opioid Dependence • Pharmacotherapy for alcohol dependence	-	• Nicotine replacement therapy	-	-
Residential treatment				
-	• Rehabilitation (does not clarify if this refers to residential or day rehabilitation)	-	-	• Residential rehabilitation

Taxonomy used for mapping alcohol and other drug investments	Siggins Miller 2017 taxonomy	Primary Health Tasmania NIAS and CORE funded treatment services taxonomy	Primary Health Tasmania alcohol and other drug commissioning taxonomy	Tasmania Department of Health alcohol and other drug treatment services taxonomy
Non-residential treatment				
• Counselling services • Direct treatment • Comorbidity treatment and ATSI treatment • Crisis management • Day rehabilitation • Aftercare	-	• Recovery services including brief intervention, harm minimisation, counselling, psychological therapies, case management and aftercare† • Mental health (dual diagnosis) assessment and treatment†	-	-
Other				
• Diversion/ therapeutic jurisprudence • Peer navigation • Peer support groups • Specialist dual diagnosis services • Family • Sector/ organisational capacity building • Lived experience advocacy and engagement	• Diversion related activities • Sector wide activities (sector development) • Organisational capacity building	• Support groups • Pre and post residential rehabilitation support	• Stigma reduction • Service participant engagement • Lived experience • Innovation • Workforce development • Research/ evaluation	• Advocacy and service participant engagement • Family support • Peak body

† applies across more than one category of the proposed taxonomy

Appendix 2: Updated prevalence estimates for alcohol and other drug use

We compared prevalence rates for alcohol and other drug use in Australia in 2013, when the DASPM was developed and in 2019 (the latest available dataset of population prevalence from the National Drug Strategy Household Survey).

Between 2013 and 2019, total illicit drug use in the Tasmanian population increased from 13.3% to 14.0% (Table 10).

The DASPM provides an estimate for treatment demand across five different drugs including: alcohol, cannabis, amphetamines and illicit opioids and benzodiazepines. We compared prevalence of recent use of these drugs.

The key changes from 2016-2019 were:

- The prevalence of recent alcohol use in Tasmania was the same in 2019 as in 2013 at 83.2%. Weekly single occasion risky drinking decreased from 15.2% in 2013 to 13.8% in 2019. Lifetime risky drinking also decreased from 18.6% in 2013 to 16.6% in 2019 (Table 11)
- Prevalence of cannabis use in Tasmania increased from 11.8% in 2013 to 12.6% in 2019
- Prevalence of amphetamines use decreased from 3% in 2013 to 0.6% in 2019
- Response rates for the use of illicit opioids (heroin) were too low in 2013 to make an estimate of prevalence. Prevalence in 2019 was 0.1%
- Illicit use of tranquilisers/sleeping pills was used to estimate prevalence of benzodiazepine use, which decreased from 1.9% in 2013 to 1.3% in 2019

Prevalence of any alcohol and other drug use

Table 10: Percentage of population 14 years or over reporting substance use in the previous 12 months, by drug type and region, 2013 and 2019

Drug type	Population use in last 12 months (2013)		Population use in last 12 months (2019)[(a)]	
	Tasmania	Australia	Tasmania	Australia
Current smoker	18.4%	15.8%	14.1%	14.0%
Alcohol (recent use)	83.2%	78.2%	83.2%	76.6%
Cannabis	11.8%	10.2%	12.6%	11.6%
Ecstasy	2.9%*	2.5%	2.4%*	3.0%
Meth/amphetamines	3.0%*	2.1%	0.6%**	1.3%
Cocaine	1.2%**	2.1%	1.6%*	4.2%
Hallucinogens	1.1%*	1.3%	0.8%*	1.6%
Inhalants	1.7%*	0.8%	0.7%*	1.4%
Heroin	-	0.1%	0.1%**	<0.1%*
Ketamine	0.8%*	0.3%	0.3%**	0.9%
GHB	0.7%**	<0.1%*	-	0.1%*
Synthetic cannabinoids	0.9%*	1.2%	-	0.2%
New and emerging psychoactive substances	1.1%**	0.4%	-	0.1%*
Injected drugs	0.9%*	0.3%	0.2%**	0.3%
Any illicit (excluding pharmaceuticals)	13.3%	12.0%	14.0%	14.1%
Pharmaceuticals (illicit use)	4.3%	4.7%	4.5%	4.2%
Painkillers/analgesics	2.7%	3.3%	2.5%	2.7%
Tranquillisers/sleeping pills	1.9%*	1.6%	1.3%*	1.8%
Steroids	0.5%**	0.1%*	0.3%**	0.2%
Methadone or buprenorphine	0.3%**	0.2%	0.9%**	0.1%
Other opiates/opioids	0.5%**	0.4%	N/A	N/A
Illicit use of any drug	15.1%	15.0%	16.5%	16.4%
None of the above	14.2%	18.5%	14.3%	20.4%

Note: For tobacco and alcohol, recent/current use means daily, weekly and less than weekly smokers and drinkers. *Estimate has a relative standard error of 25-50% and should be used with caution. **Estimate has a relative standard error >50% and is considered too unreliable for general use. Replicated from the Australian Institute of Health and Welfare. [(a)]National Drug Strategy Household Survey detailed report 2013 and 2019.

Risky alcohol use

Table 11: Tasmanian estimates of alcohol consumed in the last 12 months

Drug type		Tasmanian population use in previous 12 months (%)					
		2013			2019[(a)]		
		Males	Females	Persons	Males	Females	Persons
Frequency of alcohol use							
Daily		7.2%	4.9%	6.0%	6.6%	3.8%	5.1%
Weekly		46.4%	32.2%	39.3%	43.2%	33.1%	38.1%
Monthly		18.3%	25.5%	21.9%	19.8%	26.0%	22.8%
Less often than monthly		14.4%	18.9%	16.6%	14.5%	19.9%	17.2%
Ex drinker		5.8%	8.0%	6.9%	10.4%	9.9%	10.4%
Never a full glass of alcohol		8.0%	10.5%	9.2%	*5.6%	7.3%	6.4%
Lifetime risk status							
Risky		28.2%	9.2%	18.6%	22.9%	10.5%	16.6%
Low risk		57.4%	71.3%	64.4%	60.8%	72.2%	66.4%
Abstainers		14.4%	19.5%	16.9%	16.3%	17.3%	17.0%
Single occasion risk status							
Risky	At least weekly	23.1%	7.5%	15.2%	19.5%	7.8%	13.8%
	At least monthly	18.4%	10.2%	14.3%	15.7%	9.9%	12.6%
	At least yearly	10.7%	11.8%	11.2%	11.7%	14.5%	13.1%
Low risk		33.4%	51.1%	42.4%	36.8%	50.6%	43.5%

[(a)] National Drug Strategy Household Survey 2019 [11]

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