Inquiry into Growing the Suburbs: Infrastructure and Business Development in Outer Suburban Melbourne

VAADA Vision

A Victorian community in which the harms associated with drug use are reduced and general health and wellbeing is promoted.

VAADA Objectives

To provide leadership, representation, advocacy and information to the alcohol and other drug and related sectors.
The Victorian Alcohol and Drug Association

The Victorian Alcohol and Drug Association (VAADA) is the peak body for alcohol and other drug (AOD) services in Victoria. We provide advocacy, leadership, information and representation on AOD issues both within and beyond the AOD sector.

As a state-wide peak organisation, VAADA has a broad constituency. Our membership and stakeholders include ‘drug specific’ organisations, consumer advocacy organisations, hospitals, community health centres, primary health organisations, disability services, religious services, general youth services, local government and others, as well as interested individuals.

VAADA’s Board is elected from the membership and comprises a range of expertise in the provision and management of alcohol and other drug services and related services.

As a peak organisation, VAADA’s purpose is to ensure that the issues for both people experiencing the harms associated with alcohol and other drug use, and the organisations that support them, are well represented in policy, program development, and public discussion.

VAADA has consulted with a select group of AOD managers and service providers regarding the challenges facing both the community and AOD treatment sector in contending with the rapidly expanding population in growth corridors and other regions of Melbourne. VAADA would like to thank those individuals who have given their time to provide information and insight for this submission.

Introduction

VAADA welcomes the opportunity to address the important issues surrounding infrastructure needs in the growth areas in outer suburban Melbourne. VAADA has consulted with a number of our member organisations and, combined with the concerning data highlighting the rapid growth experienced in a number of regions, is of the view that both the community and subsequently the AOD sector are facing a looming crisis caused by significant limitations on AOD service resourcing in these regions.

Although VAADA commends the 2010/11 Victorian government budget which outlined the allocation of $14M to the fringe areas of Casey, Hume, Whittlesea, Melton and Wyndham for increased AOD treatment service capacity (Victorian Auditor-General 2011:11) (hereafter VAGO), more must be done. The Growth Areas Authority (2011:6) indicates that Melbourne’s population is set to grow by two million over the next 30 – 40 years, which, if a comprehensive and strategic health plan is not adopted with costing, will create an untenable level of strain and have atrophic impact on the sustainability of the AOD treatment sector and the community as a whole. Of more immediate concern is the lack of appropriate infrastructure supporting the $14M allocation for AOD treatment services. AOD service providers have indicated that whilst they have funding to employ AOD workers it has not provided for many basic necessities such as office space and other capital works. Further, there is a lack of suitable premises for AOD treatment and other related health and welfare services available for lease within these regions.
Failure to appropriately resource AOD treatment services has a run-off effect on other service systems, with AOD related harms costing Victoria $14B per annum (VAGO 2011:vii) compared to the allocation of $135.7M to the AOD prevention and treatment activities.

The content of this submission is underpinned by the need to develop strategies to reduce AOD related harms and bring down the cost of these harms to the community. VAADA believes that the allocation of appropriate resources to counter the challenges of population growth is necessary and must occur in a systemic and strategic manner with a view to maximising the long term health of Victorians.

This submission has been developed with general reference to the Terms of Reference (TOR) with emphasis on (a), (b) and (c) as they relate to the provision of AOD treatment.

This submission will provide some examples of gaps in service caused by under-resourcing of AOD services in these growth regions where there are existing vulnerabilities in the population and will highlight areas where further resourcing is required.

Areas of rapid population growth

The discussion in this submission is centred on Melbourne’s growth corridors which are experiencing unprecedented population growth. VAADA believes that there is now a window of opportunity to cement positive health outcomes within these communities which currently experience a number of vulnerabilities creating a heightened risk of harms associated with AOD misuse. For instance, many of these regions endure high levels of unemployment, family breakdown, limited English fluency and literacy, low education and high levels of crime.

The growth corridors mentioned above will experience a massive population increase with:

- The Cardinia Shire to more than double its current population over the next 20 years from 76,335 in 2011 to 155,619 in 2031 (.id 2011);
- The Melton Shire to experience an increase of almost 110 per cent from 108,840 in 2011 to 226,704 in 2031 (.id 2011a);
- The Whittlesea Shire to experience an increase of over 80 per cent from 162,067 in 2011 to 295,440 in 2031 (.id 2011b);
- The City of Wyndham to experience an increase of almost 95 per cent from 172,106 in 2011 to 334,678 in 2031 (.id 2011c); and
- The City of Hume to experience an increase of approximately 60 per cent from 175,002 in 2011 to 280,668 in 2031 (.id 2011d).

The initial resourcing provided by government to these areas is a good start, however further planning, resourcing and action is required in these areas.
Key challenges

The following points, which summarised the key challenges to the AOD sector regarding population growth, were relayed to us by AOD treatment sector representatives working within Melbourne’s growth corridors:

1. There is a need to ensure that a robust population health plan is developed with a view to ensuring that it goes beyond quantity to include composition, covering specific demographic information such as age, gender, CALD background, employment, health and a range of other areas which contribute to vulnerability;
2. A population health plan must be appropriately costed and should account for the various nuances evident in specific populations;
3. AOD service need must be costed and resources allocated for bolstering AOD service provision in response to burgeoning need;
4. Infrastructure costs must be included in all resourcing, such as capital works. AOD service providers have noted the absence of infrastructure resourcing and availability within the current funding arrangements in growth corridors. The government should provide for the long term and fund the development of appropriate premises to house AOD treatment services. Limitations on infrastructure have significant impacts on positive health outcomes and has been highlighted as a core challenge in growth corridors;
5. A well-resourced AOD treatment sector can contribute to early intervention initiatives which will reduce the overall burden on other health and welfare sectors and enhance positive health outcomes for the community;
6. Inaction on the challenges emerging from populations booms in growth corridors will result in lost preventative and early intervention opportunities and will contribute to the perpetuation of intergenerational harms associated with AOD as well as a range of other related areas of disadvantage;
7. The tendering process creates burdensome logistical challenges amounting to the successful tenderer having approximately one month to locate and furnish appropriate office space; and
8. Internet and telephone services often do not function at an optimal level, with ‘slow periods’ occurring throughout the day with obvious impacts on the functionality of AOD (and other) treatment services.

South Eastern regions (Casey Cardinia)

Lack of addiction medicine specialists

As noted above, it is predicted that the Cardinia Shire will more than double its current population over the next 20 years. This will create a significant burden on the AOD treatment services within that region and will have a pronounced adverse run off into other service sectors. AOD service providers have expressed concern that there is currently no consultation or addiction medicine unit within Casey Hospital despite there being such services available at other hospitals within the South East Region of Melbourne. This is of grave concern as, given that VAGO indicated that there are 77,000 Victorians hospitalised for AOD related harms annually (VAGO 2011:vii), it is likely that this
service deficit is reducing positive health outcomes and creating an additional (potentially preventable) burden on health services. The availability of consultation and addiction medicine support at Casey Hospital (as well as many other areas) would have potential to reduce the length of stay within the hospital system, resulting in better health outcomes and a cost saving to government.

**Limited Infrastructure**

It should be noted that there is a range of services and evidence informed options and interventions available for community members with AOD dependence issues that can be undertaken which can prevent the more drastic intervention of hospital admission. AOD service providers were concerned that more popular and visible services are prioritised in growth corridors such as hospitals and schools whilst those whilst other less prominent health and welfare services are provided with limited funding and often work within substandard offices. One southern region AOD provider indicated that they experienced significant difficulties obtaining appropriate office space. They further remarked that it can be difficult to find services with existing infrastructure who have capacity to accommodate AOD services with the result being the need to utilise premises which were designed as private residence.

Disturbingly, AOD service providers have indicated that there has been a reluctance by some community services to co-locate with AOD treatment services due to adverse perceptions of AOD clients. This is contrary to the rhetoric regarding the need to break down silos and that service users are presenting with a range of complex interweaving issues which cannot be addressed solely by a single service sector. VAADA recently prepared a submission for the *Whole of Victorian Government Alcohol and other Drug Strategy* which emphasised the benefits of well-resourced collaborative activities between service sectors where such activity would elucidate discernible benefits for health and welfare sector service users.

Infrastructure limitations are further augmented by the composition of the population in the outer South East region of Melbourne (and also in many of the other growth corridors) with these regions being described as sleeper suburbs, whereby many of those local residents in need of AOD treatment work externally to the region and can only attend evening treatment programs. The scarcity of office space is exacerbated when the additional burden of security and other OH&S concerns are considered in light of the need for running after hours treatment programs and group and individual treatment.

**OH&S**

Other challenges emerging from infrastructure issues again related to OH&S as well as good clinical practice and duty of care is the forced necessity of running youth and adult AOD treatment services from the same venue and the subsequent issues inherent in mixing these two populations. AOD treatment services must be provided with the resources to ensure that young people are not inadvertently provided with the opportunity to mix with older service users.
Impact of travel

Another significant limitation outlined by AOD service providers is the difficulties in travelling for both workers and clients. Scarce public transport infrastructure creates significant limitations in service access with an adverse impact on positive outcomes and service user retention. Also, given that many of the residents work within other regions it is optimal to ensure that AOD treatment services have capacity to safely undertake after hours programmatic activity.

North, north western and western regions (Hume, Melton, Whittlesea and Wyndham)

Many of the challenges in the south east are evident in the north, north western and western regions of Victoria. Infrastructure issues create the most debilitating restrictions on services and continues to undermine the efficacy of the government’s significant $14M allocation of funding for AOD treatment services in growth corridors.

Disturbingly, AOD service providers have indicating that service provision at Craigieburn is nearing crisis with the pending increase in population from approximately 20,000 residents to 55,000 over the next decade. The AOD services in that region have not been provided with any affirmation of the impact of this population explosion on service provision. AOD service providers noted that there is a ‘ferocity of activity’ in this and other neighbouring regions, amounting to the rapid construction of residential property and some business but with only limited public amenity and health based service development.

AOD service providers have expressed concern that the rapid development of residential property combined with the scarce availability of appropriate premises for health and welfare services will result in a bottle neck occurring at service entry, creating a significant disincentive for a range of health services, including AOD treatment and perpetuating disadvantage as well as reducing the overall health in Victoria.

AOD services have cited significant challenges in obtaining premises for treatment services, with some co-locating and others working in abysmal premises with significant maintenance difficulties such as, unbelievably, the lack of a functioning toilet.

Composition of population

AOD service providers have remarked that there is no population health plan or strategy providing guidance and direction for health and welfare service providers in working with the broad and further expanding range of culturally and linguistically diverse (CALD) populations emerging in these regions. The VAGO report (2011:22) noted that these populations are under-represented in treatment and VAADA (2009:13-15) has also noted that there is a dearth of research and information in this area. Anecdotal evidence from AOD service providers reveals that many CALD
populations will deal with AOD issues in a manner which is not consistent with obtaining treatment and may be less likely to take heed or have awareness of harm reduction strategies. This may be due to issues relating to AOD being ‘taboo’ as well as low participation rates in research (Browne 2010:2).

There are a range of recommendations and comments highlighted by both VAADA and VAGO in relation to the challenges facing the AOD sector arising from emerging CALD communities which are appropriate for this inquiry (given the high proportion of CALD communities emerging in the growth corridors) and should be considered. These include the development of a research agenda to overcome gaps in knowledge regarding CALD and Aboriginal and Torres Strait Islander communities, enhance cultural competency throughout the AOD treatment workforce and fund a body similar to the NSW Drug and Alcohol Multicultural Education Centre (VAADA 2009:6).

**Early intervention – lost opportunities**

Limited access to AOD treatment services and other health and welfare services will reduce the overall health of vulnerable communities living in growth corridors. Essentially, early intervention measures must be built into the service delivery framework at the incipient stages in developing growth corridors. Early intervention can consist of brief interventions, strategic interventions at opportune times in people’s lives (ie, aged based interventions at various stages at school, or when having started a family) and the targeting of services to those who may have already had interaction with the AOD service sector or have manifested other health, welfare or justice related issues. Such interventions can consist of counselling, education, self-help programs or pharmacological treatments (Rowland 2006:6).

A strong population health planning strategy would, through evidence informed means of predicting future population growth and composition, enable early intervention programs to be better targeted and responding to the needs of the community as needs arise. This would assist in preventing a significant amount of harm to the community through a reduction in need for tertiary health services and would also equate to a long term cost saving for the government.

Under resourced AOD treatment services and a fragmented prevention based response bereft of an evidence-informed population health forecasting plan will result in missed opportunities for early intervention and prevention, thereby embedding a range of harms evident in the populations inhabiting Melbourne’s growth corridors.

**Impact of travel**

Similar challenges are evident in these regions as in the South East. However, compounding these issues are the limited array of services available, resulting in, for instance, clients requiring residential rehabilitation having to travel longer distances resulting in limitations to service access. Clearly, growth corridors, with booming population growth, must have a range of services which is equitable with that of other areas in Victoria.
Lotterywest

Our sibling AOD peak, Western Australian Alcohol and other Drug Network Agencies (WANADA) has provided insightful commentary on Lotterywest, from which profits are ploughed into community services. The funding can provide for capital works and other ‘one off’ resource needs. This model should be explored more thoroughly, especially as Victoria has a much larger gambling industry than Western Australia and thus a greater scope for programmatic development. Further, as poker machines are ‘concentrated in municipalities that have a lower than average socio-economic status’, (Doughney 2002:134) it is appropriate that those regions should benefit with the range of services which address the wide array of problems arising from problem gambling; it should be noted that Melbourne’s growth corridors generally experience lower than average socio-economic status. It is instructive to consider the approach taken by Lotterywest in Western Australia which applies profits into building infrastructure in those communities. Some of the profit in Victoria from gambling could be developed into building infrastructure development in growth corridors.

Conclusion

Currently, the AOD treatment system lacks the systemic infrastructure to forecast future AOD treatment need. This translates into an ad hoc methodology of resource allocation and management resulting in a high risk of widening gaps in service delivery to vulnerable Victorians. The VAGO report (2011:19) remarks that DH has not maintained a ‘population-based approach’ in resourcing and allocating AOD treatment services. A population health forecasting system must be instated to direct AOD treatment resource allocation and should be tied into the provision of other associated health services.
Recommendations

The recommendations contained herein provide a framework for ensuring that the growth corridors of Melbourne have an adequate level of AOD treatment services and that these services are accessible to all community members.

1. Engage in population based health planning and forecasting for Victoria which has:
   a. Capacity to ascertain not only the forecasted growth of the population in these regions but also the composition of the population, including, but not limited to age, gender, employment status, country of origin, English as a first language and various health indicators;
   b. Funding attached which can be allocated to the development of appropriate services;
   c. Capacity to provide for the development of appropriate premises for AOD treatment services;
2. All population health planning and forecasting is evidence informed;
3. Resultant data from population health planning and forecasting activity is regularly released publicly (at least annually);
4. This data is used to inform the development of evidence informed local prevention and early intervention activities to reduce the likelihood of embedded harmful practices emerging in growth corridors;
5. Service users should have access to AOD services at times which are convenient to them (which may include evenings);
6. Undertake a review to ascertain the value of implementing a model of capital works resourcing similar to the Lotterywest model in Western Australia to assist with the provision of infrastructure to community services in these growth corridors.
References

.id 2011, Population forecasts Cardinia, [online] accessed 9 November

.id 2011a, Population forecasts Melton, [online] accessed 9 November

.id 2011b, Population forecasts Whittlesea, [online] accessed 9 November

.id 2011c, Population forecasts Wyndham, [online] accessed 9 November

.id 2011d, Population forecasts Hume, [online] accessed 9 November


