Reform Agenda for Alcohol and Drug Services in Tasmania

Consultation Draft

27 August 2018

Mental Health, Alcohol and Drug Directorate

Department of Health

Tasmanian Government

Reform Agenda for Alcohol and Drug Services in Tasmania

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Definition of terms

Alcohol and Other Drugs (AOD) Alcohol, Tobacco and Other Drugs (ATOD)	In this paper the acronym AOD is mainly used, but it is acknowledged the terms and acronyms (AOD and ATOD) can be used interchangeably, and whichever is used, it is accepted to include alcohol, tobacco and all other drugs, both licit and illicit.
Carer (Department of Premier and Cabinet, 2016)	A carer is a person who provides, in a non-contractual and unpaid capacity, ongoing care or assistance to another person who, because of a disability, aging conditions such as frailty, mental illness, chronic illness or pain, requires assistance with everyday tasks. A person is not a carer a) simply because they are the spouse, parent, guardian or relative of a person who requires care; or b) if the person provides the care or assistance as a volunteer for a voluntary organisation.
Client/Consumer (and patient)	A client or consumer or patient is a person who uses, has used or may use any service or program to address their alcohol, tobacco and/or other drugs use. It is accepted the terms can be used interchangeably, although client/consumer is mainly used in this paper.
Drug and Alcohol Service Planning Model [DASP]	The Drug and Alcohol Service Planning Model (DASP) for Australia (formerly the Drug and Alcohol Clinical Care and Prevention Model 2013 [DA-CCP]) estimator tool was used to calculate the type and quantity of services needed for the projected Tasmanian population. This demand modelling process involves the application of statistical methods, epidemiological data, evidence based practice and stakeholder expertise to estimate the type and quantity of services needed based on population size and features (e.g. age groups).
Harm minimisation	The concept of harm minimisation (or minimising the harms from AODs use) has underpinned Australia and Tasmania's approach to AOD use since 1985. Harm minimisation does not condone AOD use. It is a philosophical and practical approach defined by a combination of the three overarching policy approaches of supply reduction, demand reduction and harm reduction. It includes a wide range of treatment approaches including abstinence-oriented strategies.
PPEI (Promotion, Prevention and Early Intervention) (ATOD PPEI Framework 2013)	The terms promotion, prevention and early intervention often overlap. Generally in the context of AOD use issues, the focus is on prevention and early intervention to prevent uptake and reduce the harms associated with AOD use, as well as a focus on the reduction of harms associated with AOD use. Promotion (or health promotion) includes the promotion of wellbeing and involves actions to create conditions and environments that support health and wellbeing and allows people to adopt and maintain healthy lifestyles. In the context of AOD treatment, health promotion can also include providing information and advice to a person to minimise the harms from AOD use.

	Prevention initiatives include measures that focus on reducing risk factors and enhancing protective factors, to prevent or delay the onset of AOD use and reduce the associated harms. Prevention activities or responses can be classified as: universal, where they apply to an entire population, e.g. mass media campaigns and school-based AOD education programs (also health promotion activities); selective, where they target groups with elevated risk e.g. young people; and indicated where they target individuals. Early (or brief) interventions can have some overlap with indicated prevention but also include earlier treatment based on screening and assessment to identify people at an early stage of potentially harmful AOD use. Brief interventions often consist of informal counselling and providing information on the types of harms and risks associated with AOD use (which can also be a health promotion initiative).
Service System	The Alcohol and Other Drugs service system is made up of a range of service providers across government, non-government, and the private sector, and delivered in a range of settings, including public and private hospitals, primary care settings by general practitioners, pharmacies, and government and non-government specialised AOD services.
Severity of need	Severity of need refers to the level of distress and impairment experienced, not just the level of drug use.
Stepped care *Source: Department of Health, 2016*	Stepped care is defined by the Department of Health as: '*an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs. Within a stepped care approach, an individual will be supported to transition up to higher intensity services or transition down to lower intensity services as their needs change.*' It also notes that stepped care is a different concept from 'step up/step down' services.
Stigma and discrimination *Source: Lancaster, Seear & Ritter, 2017*	Stigma is labelling and stereotyping of difference, at both an individual and structural societal level, that leads to status loss (including exclusion, rejection and discrimination. Discrimination is the lived effects of stigma – the negative material and social outcomes that arise from experiences of stigma. Both stigma and discrimination rely on societal structures and systems that facilitate and create the conditions for their operation (for example unequal power is one such condition).

Primary Health Tasmania (PHT) has also developed a Glossary of terms that provides definitions of a number of the key terms used in PHT's AOD commissioning documents and discussion available here or visit www.primaryhealthtas.com.au and search for 'Glossary of Terms'.

Introduction

The Reform Agenda for Alcohol and Drug Services in Tasmania (Reform Agenda) has been informed by a range of reviews, most notably the 2017 work of Siggins Miller Consultants (Siggins Miller). Siggins Miller were engaged in 2017 to undertake an independent analysis of the current alcohol and other drug (AOD) service system following on from a 2014 review of drug use and service responses in North West Tasmania.

The Final Report was released on 2 May 2018 and is available on the Alcohol and Drug Services website by clicking here.

In 2016 Primary Health Tasmania (PHT) developed the Commissioning Intentions Document (Primary Health Tasmania, 2016), as part of its Federal funding commissioning. As part of the needs assessment and design stages, PHT undertook extensive consultation, a comprehensive needs assessment and a review of AOD service models.

These key pieces of work follow on from a 2013 internal review of the implementation of the Alcohol, Tobacco and Other Drug Services Future Service Directions Plan 2008/09 to 2012/13 (FSD) and a 2014 Tasmanian Audit Office compliance audit of the FSD.

Whilst those pieces of work identified the individual service elements that should exist are present in Tasmanian AOD services and that most individual treatment services and programs generally meet expectations, they also highlighted that the current service system providing services for people with AOD use issues has become difficult to navigate, confusing (for client/consumers and providers), and disjointed.

The main challenges facing the AOD treatment service system in Tasmania, as identified by both clients/consumers and providers during consultations undertaken by Siggins Miller, are:

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

This Reform Agenda recognises Tasmania's AOD system is complex and involves many stakeholders and providers, including specialist government and non-government AOD services, and primary health care including GPs and private providers.

The Reform Agenda also recognises that AOD services are only one part of a larger interdependent system of AOD and other health and welfare services and that Tasmanians may interact with multiple services over time. Tasmanians may also simultaneously seek treatment from more than one service or provider. The AOD service system overlaps with many services and sectors such as mental health services, disability services, acute services, emergency services, children and youth services, housing, justice, education and employment providers.

It also acknowledges that Tasmania has a relatively dispersed population, with more than half of the population living outside the capital city, making it one of the most regionally dispersed of any state or territory.

The Reform Agenda focuses on the client/consumer journey through the system, whilst acknowledging the importance of whole of population health promotion and prevention activities and prevention and early intervention as core components of AOD treatment.

This Reform Agenda is the new plan to guide the planning, funding and delivery of public-funded AOD services in Tasmania, and will assist the Tasmanian Department of Health (DoH), the Tasmanian Health Service (THS) and PHT in the commissioning, funding and delivery of AOD services in the future.

Siggins Miller suggests a focus on multi sector work, with a primary focus on the following:

- Partnership between government and non-government services
- Consumer representation
- Management of wait-times
- Continuity of care
- Integrated care pathways
- Support for GPs

Acknowledgements

The Mental Health, Alcohol and Drug Directorate (Directorate) of DoH acknowledges the many client/consumers, individual clinicians and groups, and service providers who took part in the various consultations to help inform the Reform Agenda.

Invitation to make a submission

Feedback to this Consultation Draft is invited from stakeholders including but not limited to government and non-government service providers, clients/consumers and their families and significant others, primary health care providers and General Practitioners, professional bodies and other health and community service providers.

Have your say!

The key dates and options in relation to this consultation process are:

- The Consultation Draft has been released and is available online on the Alcohol and Drug Services website here
- Stakeholders are invited to complete the Consultation Draft questions using the online survey on the website. It is not necessary to answer every question or address every issue.
- Alternatively, a written response to the questions or written submissions can be sent to the Directorate marked for the attention of Sylvia Engels, with ***Submission to the draft AOD Reform Agenda*** in the subject line to:

  Email: director.mhadd@health.tas.gov.au
  Mail: Mental Health, Alcohol and Drug Directorate
  GPO Box 125 HOBART 7001

- Stakeholders may also raise any other specific matters, either in their written submission or by contacting Sylvia Engels at the Directorate on 61660771 or email to sylvia.engels@health.tas.gov.au
- Clients/consumers can also contact the ATDC on 62315002 or Ruth Rowlands of Advocacy Tasmania on 1800 005 131 or r.rowlands@advocacytasmania.org.au if they would like assistance with hard copies of any of the documents, or with completing the survey or questionnaire or putting in a written submission.

Closing date:

The closing date for submissions and comments is **5.00 pm on 26 October 2018**. Submissions will not be made public.

Targeted consultation forums with a number of stakeholders including with clients/consumers will also occur.

New directions for services that provide alcohol and other drug programs and treatments

The current AOD service system is complex and fragmented and can prevent people with AOD issues from easily accessing treatment. People with AOD use issues tell us they find it difficult to access the right service(s) for them, in the right place(s) and at the right time. The current system is unsustainable from a health, social, economic and financial perspective.

If the system is not changed, the issues raised consistently over the years through the work undertaken by Siggins Miller and PHT and the earlier work under the North West Review and the FSD Reviews will not be addressed in a systematic way.

This Reform Agenda focuses on the client/consumer journey through the system, whilst acknowledging the importance of also maintaining a focus on population level health promotion and the social determinants of health.

The Reform Agenda identifies eight reform directions and the actions that will be undertaken to better support the client's/consumer's journey through the service system.

The objectives of the Reform Agenda are to:

- Deliver a seamless and integrated AOD service system along a continuum that provides a stepped care approach from promotion and prevention through to relapse prevention
- Provide a range of support and treatment options for client/consumers and carers
- Better integrate all treatment service system components to achieve better outcomes for all client/consumers
- Reduce duplication
- Better integrate AOD government and non-government treatment services
- Better integrate AOD services with non-AOD services

QUESTION

1. *What do you think about these objectives? Do you have any other suggestions?*

The reform directions and actions will be implemented over the next 10 years to meet the above objectives, in line with the aim and principles detailed below.

Aim

To ensure Tasmanians affected by alcohol, tobacco and other drug use have access to appropriate, timely, effective and quality alcohol, tobacco and other drug services, supports and treatments based on contemporary, evidence informed best practice, and delivered by a highly skilled workforce.

Principles

The delivery of AOD services in Tasmania is guided and informed by the principles below, which should underpin all aspects of service delivery.

All Tasmanian AOD services and programs will:

- be client/consumer focussed and person-centred, and thus be accessible, integrated and holistic, responsive to diversity, provide continuity of care, and be inclusive of the lived experience of clients/consumers and their families and significant others;
- reflect the complex, relapsing nature of substance use;
- operate within a harm minimisation framework;
- recognise the vulnerability of clients/consumers and their rights to access services that support achievement of optimum health and wellbeing without fear of stigmatisation or discrimination;
- be evidence-informed and in line with contemporary best practice;
- reflect that clients/consumers are part of the service system and may cycle through various programs and services;
- be integrated and delivered in partnership within the AOD service system and also with other sections of the health and human services system and other service sectors as appropriate;
- be underpinned by common approaches to assessment, referral, counselling, care coordination and case management;
- be inclusive of a range of treatment modalities, interventions, programs and services delivered along a continuum;
- be provided by a suitably knowledgeable, qualified, skilled and flexible workforce;
- be committed to continuous quality improvement; and
- be designed for sustainability and demonstrate value for money.

QUESTION

2. *What do you think about these principles? Would you add, remove or change any?*

Reform Directions

The reform directions take into consideration the main challenges identified through the work of both Siggins Miller and PHT, through previous reform processes, and as identified by both clients/consumers and providers.

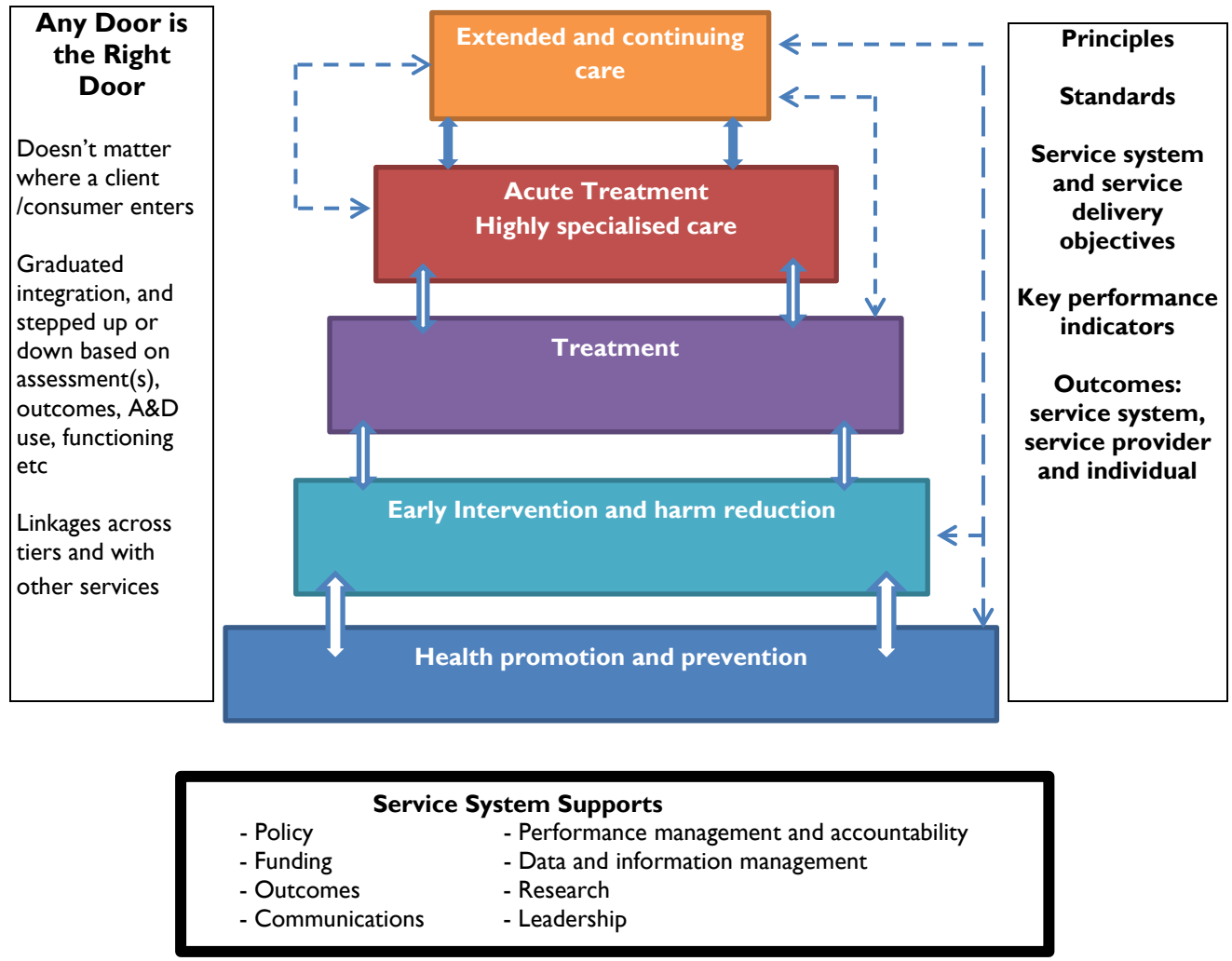
Those key pieces of work undertaken in Tasmania over the last few years have highlighted that the current service system providing services for people with AOD use issues has become difficult to navigate, confusing (for client/consumers and providers), and disjointed.

The reform directions also take into consideration the need for reform within the treatment system to ensure it is client/consumer-focused rather than provider or institution focused, with a cross and multi-sector focus, i.e. clients as clients of the system, not as

clients of any particular organisation/agency/service.

The reform directions are underpinned by the premise that clients/consumers will receive services along a continuum using a stepped care approach as depicted in the diagram below.

Continuum of care model



Adapted from Rush, 2010.

This is not a linear model and it should not matter where or when an individual enters the system. It is also worth mentioning that the role of the GP is critical, as they are often the first point of contact as demonstrated by the data.

This tiered continuum of care model also aligns well with a stepped care, or integrated care approach to the delivery of AOD services, where treatment is matched to the individual's needs.

QUESTIONS

3. *The model seeks to provide a stepped care approach along a continuum as defined earlier. What is your understanding of stepped care?*
4. *What are some of the opportunities and challenges associated with putting this model in place in Tasmania?*

5. *From the perspective of your service/organisation or from your perspective as a client/consumer where do you see the service(s) you provide or use fitting in this model? What, if any, changes do you think need to be made to those service(s)?*

In addition, there were a number of recommendations made in respect to the delivery of inpatient withdrawal and residential rehabilitation services in Tasmania, which have been incorporated in the reform directions.

The reform directions are inextricably linked and are not intended to be presented in any order of priority. Similarly, the actions under each reform direction are not presented in any particular order, although it is recognised some actions will be actioned earlier than others.

A key component of the reform directions is to work closely with key targeted stakeholders to support the implementation of the reform directions.

Reform direction 1: An integrated service system

Rationale:

From the literature on the effectiveness of treatment modalities, the message is clear that because of the chronic, relapsing nature of substance use issues, single episodes of treatment (regardless of the drug of use, type of treatment or individual or contextual factors) are unlikely to be effective or produce longer term improved outcomes. Completion of treatment and assistance by ongoing contact, care and support are required to maintain gains from treatment and reduce risk of relapse.

This suggests investment in services, programs or approaches that do not include or link with proactive follow up and after care is likely to achieve suboptimum outcomes. Additionally, continuity of care planning and aftercare support are critical components to sustaining effective treatment outcomes.

As identified by the work of Siggins Miller, there was agreement between both clients/consumers and service providers that there is a need for improved integration and communication between service providers, particularly between government and non-government services.

Integration with housing, employment, and the criminal and justice system were also identified as in need of improvement, as was integration with mental health services, particularly for consumers with mental health issues who are not eligible for public specialised mental health services.

Through the work of Siggins Miller and PHT, client/consumers and providers thought there was a need for better integration:

- between withdrawal management and residential rehabilitation (and other AOD services);
- between AOD service providers more generally, particularly between government and non-government services, made worse by lack of information sharing;
- with mental health services particularly for client/consumers with mental health issues but not eligible for Public Mental Health Services; and
- with housing, employment and justice. Integration with the criminal justice system was discussed in the context of AOD services offered in prison; legal aid offered to

client/consumers of AOD services, typically in the context of child safety; and AOD services for people released from prison.

Reform Goals:

- To improve the client/consumer journey
- To improve the integration between and within state and federal funded government and non-government AOD service providers and programs, and with primary health care, clinical and non-clinical services and private providers
- To embed a continuum of care model using a stepped care approach into all aspects of clinical practice across government and non-government AOD services, prioritised upon highest level of assessed clinical need and risk
- To improve access to a range of evidence-informed specialist AOD treatment services
- To prioritise access, and level and intensity of ongoing care based on assessment, severity of need, and individual clients responses and outcomes

Key Actions:

1.1 Define the required components, appropriate roles and scope of the specialist public ADS, the community sector AOD services, primary health care and the private sector within an integrated service system and using a continuum of care model

1.2 Reconfigure current services and funding arrangements as required to align with and match the above components and roles

1.3 Identify linkages across funding and service provision to clearly identify gaps and duplications across all services

1.4 Work with Primary Health Tasmania to develop a co-commissioning framework for AOD services in Tasmania

1.5 Support the implementation of the Rethink Mental Health reform agenda to strengthen support for people with co-occurring AOD and mental health issues

Reform direction 2: Developing service specifications and program guidelines

Rationale:

This reform direction is strongly linked to reform direction 1, but as stated earlier, all of the reform directions are inextricably linked, and as such many of the goals and actions are mutually reliant. It is important that all clients/consumers receive consistent and evidence informed treatment services based on their needs, within an integrated service system.

Clients/consumers identified:

- Need for more aftercare services particularly following acute episodes, and post rehabilitation;
- Need for greater support for those on a 'wait' list, or a step-down service;
- Lack of outpatient treatment;
- Lack of appropriate treatment options following detoxification including housing options;

- Need for more responsiveness and flexibility of AOD services, i.e. opening hours, treatment duration; and
- Need for greater client/consumer representation at both individual planning and higher levels.

Siggins Miller recommends a model for rehabilitation treatment in Tasmania incorporating both short and longer-term stays and day programs, incorporating a step-up/step-down program to bridge ambulatory services and inpatient/residential services.

It also recommends a review of the operations of the Inpatient Withdrawal Management Unit against contemporary benchmarks with a view to achieving an integrated approach that includes developing a model of care for withdrawal management services in Tasmania.

It also notes the need to work out seamless client pathways from withdrawal management to other services, and mutually agreed processes and protocols to support those client pathways.

Analysis by Siggins Miller also shows there is scope for reconfiguration of existing and future resources to better focus on people with severe and complex problems and to ensure balanced investment across the treatment types, as defined in the Drug and Alcohol Service Planning model (DASP).

Reform Goals:

- To ensure all clients/consumers receive seamless, consistent and evidence-informed treatment services along a continuum and stepped up or down based on their particular needs
- To increase the effectiveness of treatment and improve treatment outcomes across the range of specialist AOD treatment services
- To ensure all government funded providers of AOD services align with, are aware of and implement services and programs consistent with agreed treatment service specifications and guidelines

Key Actions:

2.1 Develop a series of AOD treatment service specifications and program guidelines, all incorporating aftercare and relapse prevention, including:

a) A Residential Rehabilitation Treatment Model incorporating both short and longer-term stays, and day programs for rehabilitation treatment in Tasmania

b) A Withdrawal Management Model of Care incorporating medically-supervised inpatient withdrawal and ambulatory community or home-based withdrawal services

c) Care coordination/case management framework

d) Youth services – see also Reform Direction 5

2.2 Reconfigure current funded services as required to align with and match treatment service specifications and program guidelines (and consistent with reform direction1.2)

2.3 Develop a suite of common assessment, admission, referral and discharge forms for consistent use across all AOD services

Reform direction 3: A client/consumer-centred approach across the service system

Rationale:

Clients/consumers with AOD use issues often present with complex life problems.

Consumers identified difficulties in accessing specialised AOD treatment services, and cited several challenges including:

1) a lack of consistent information on how to identify and access appropriate services, particularly a lack of information from their GPs about the different types of specialist AOD treatment services that they could access;
2) long wait-times, and sometimes restrictive criteria, to access services, particularly withdrawal management and residential rehabilitation services; and
3) lengthy distances to travel between different services.

With regard to the responsiveness and flexibility of AOD services and the AOD service system, clients/consumers indicated they would like greater flexibility in opening hours of services and in extending treatment duration. Clients/consumers across all three focus groups indicated that the Tasmanian pharmacotherapy program lacked flexibility, with consumers providing examples on how it impacts on their health and social needs.

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

Siggins Miller suggested adopting a model of client/consumer representation similar to that used by the mental health sector in Tasmania to support AOD consumers.

Reform Goals:

- To embed a client/consumer-focussed approach rather than a provider or organisational focus
- Increase the capacity of AOD clients/consumers to have a say in their own treatment
- Increase the capacity of AOD clients/consumers and carers to have a say in the planning, implementation, delivery and evaluation of AOD services in Tasmania

Key Actions:

3.1 Develop and implement a Client/Consumer Participation Framework

3.2 Increase advocacy for people with AOD use issues

3.3 Provide information, support and training to increase client/consumer understanding of the service system and to increase their confidence to provide meaningful input on ways to improve individual service delivery and the service system

Reform direction 4: Improving quality and safety

Rationale:

According to the World Health Organization, *Standards* provide rules or minimum requirements for clinical practice – generally accepted principles of patient management in the healthcare system that should always be followed (UNODC/WHO, 2016).

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) considers standards and quality standards as '*principles and sets of rules based on evidence, used to provide clear and measurable statements related to content issues, to processes, or to structural aspects of quality assurance*.'

It is noted a National Quality Framework for Alcohol and Drug Services is being developed, and it is expected it will include a set of quality standards that will apply to all alcohol and other drug treatment providers in Australia, including services that provide early intervention and continuing care and recovery (where relevant).

The project will explore standards that are consistent with the contemporary quality evidence. This includes standards for the quality of service delivery, workforce capabilities, and cross agency collaboration, and monitoring and evaluation of treatment outcomes and effectiveness. There will be an expectation that all states and territories will implement the standards.

Reform Goals:

- To embed a culture of continuous quality improvement across all AOD services
- To ensure quality health outcomes for all client/consumers of AOD services

Key Actions:

4.1 Ensure all government and non-government AOD services commence implementation of the National Quality Framework for Drug and Alcohol Treatment Services (NQF) when finalised and endorsed

4.2 Establish a monitoring and reporting process for the NQF

4.3 Work with private providers to implement the NQF

Reform direction 5: Responding to specific population groups

Rationale:

It is acknowledged that some priority groups are not inherently more at risk of AOD misuse, but rather that they may experience greater rates of discrimination, isolation and other forms of social exclusion that can impact on AOD use. As identified by Siggins Miller and the literature, these may include: children and young people; Aboriginal and Torres Strait Islander Australians; women; elderly people; people from culturally and linguistically diverse (CALD) backgrounds; lesbian, gay, bisexual, transgender, queer or questioning and intersex people (LGBTQI); and people in or leaving the justice system.

Factors that may contribute to this increased risk include that they may:

- experience prejudice and stigmatisation based on beliefs that these groups are the only ones with drug problems
- be offered inappropriate interventions
- lack information and education that effectively communicates drug use risks
- feel disengaged from the service system
- have had negative experiences with culturally insensitive and unsafe services
- have had difficulty seeking help and/or navigating the service system

Reform Goals:

- To ensure population groups identified at higher risk of AOD-related harm can access appropriate treatment and support when and where they need it
- To ensure all AOD service providers provide appropriate evidence-informed, culturally aware and respectful services to address the needs of any identified specific population group
- To better integrate with other non-AOD specialist services such as prison services, children and youth services, homelessness services and education

Key Actions:

5.1 Work with the youth sector to review, develop and implement a Youth Framework for the AOD sector

5.2 Consider the specific needs of young people, women and people with children as part of the development of the Residential Rehabilitation Model for Tasmania

5.3 As part of Reform Directions 1 and 2, work closely with Correctional Primary Health Services and the Department of Justice to better support people in or leaving the justice system

5.4 Review current investment to consider the needs of other specific population groups including but not limited to older people, Aboriginal people, CALD including humanitarian entrants, and LGBTQI

Reform direction 6: Maintain a focus on promotion, prevention and early intervention

Rationale:

A 2009-cost benefit analysis showed a return of $18 for every dollar spent on drug prevention programs (US Department of Health and Human Services, 2009), which is likely to be an underestimate. There is limited research to date specific to Australia, but a 2009 project and report (National Centre in HIV Epidemiology and Clinical Research (2009) on the net population benefits of needle and syringe programs found for every $1 invested in AOD treatment, society gains $7.

Everybody's Business, A Strategic Framework for Implementing Promotion, Prevention and Early Intervention Approaches in Averting Alcohol, Tobacco and Other Drugs Use (ATOD PPEI Framework) was developed in 2013 to provide a focus on the social and structural determinants of health that influence ATOD use.

Interventions to reduce AOD related harm can be broadly categorised as promotion and prevention activities and drug treatment services, but many of the government and non-government specialist service providers include health promotion and prevention, harm reduction and brief interventions as part of the services they deliver and in the context of other treatments and programs.

Whilst the primary focus of this Reform Agenda is on the treatment service system, health promotion and prevention, and brief interventions and harm reduction are key aspects of the continuum of care model underpinning this Reform Agenda.

Reform Goals:

- Maintain an equal focus on population level health promotion and the social determinants of health
- Maintain an equal focus on promotion, prevention and early intervention activities and actions to prevent or alleviate the harms from AOD use
- Improve AOD assessment and the provision of brief interventions and early referrals across a range of settings
- Build capacity to implement a range of evidence-informed PPEI activities
- Build the capacity across all government and non-government AOD service providers to implement evidence-informed health promotion and prevention, and brief intervention and harm reduction activities

Key Actions:

6.1 Review the current ATOD PPEI Framework and Implementation Plan

6.2 Support communities and community sector organisations to deliver evidence-informed AOD health promotion and prevention initiatives, including tapping into current and new social marketing/awareness/education campaigns

6.3 Provide support to improve GP capability for AOD assessment and the provision of brief interventions

6.4 Work with other primary health care providers and hospitals to support the provision of appropriate PPEI activities

Reform direction 7: Supporting and developing the workforce

Rationale:

The AOD workforce includes workers whose primary role involves reducing AOD-related harm as well as those whose primary work focus is on other issues but, nevertheless, play an important role in reducing AOD harm (National Alcohol and other Drug Workforce Development Strategy 2015-2018).

Workforce development (WFD) in the AOD field aims to build the capacity of organisations and individuals to prevent and respond to AOD-related problems and to promote evidence-based practice. It goes beyond the provision of education and training to include issues such as recruitment and retention, workforce planning, professional and career development and worker wellbeing. As such, WFD can be defined as:

> *…a multi-faceted approach which addresses the range of factors impacting on the ability of the workforce to function with maximum effectiveness in responding to alcohol and other drug-related problems. Workforce development should have a systems focus. Unlike traditional approaches, this is broad and comprehensive, targeting individual, organisational and structural factors, rather than just addressing education and training of individual mainstream workers (Roche, 2002a).*

Tasmania has long experienced difficulties in recruiting and retaining a suitably qualified and skilled AOD workforce, for a variety of reasons which may include:

- Stigma and discrimination associated with working within the AOD sector;
- Lack of specialists with AOD skills, knowledge and experience;

- Employment of qualified staff, e.g. allied health, medical, nursing who come with qualifications but not necessarily with practical AOD experience or skills; and
- Lack of mentoring opportunities and difficulties in accessing clinical supervision

There are also a range of emerging issues which have ongoing significant impacts for the AOD workforce, including:

- Ageing workforce;
- Ageing client group;
- New substances;
- New evidence, research and treatments/interventions;
- Increased consumer engagement;
- AOD use occurring at earlier ages; and
- Multiple comorbidities.

Reform Goal:

- Develop the workforce to support the implementation of the Reform Agenda
- To have a highly skilled and appropriately qualified workforce working across all government and non-government AOD programs and services

Key Actions:

7.1 Determine minimum staffing key competencies and requirements across all government and non-government AOD programs and services

7.2 Develop a Tasmanian AOD Workforce Development Strategy for government and non-government AOD services

7.3 Support primary health care through education and training, including in PPEI activities

Reform direction 8: Reducing stigma and discrimination

Rationale:

It is well documented that individuals and significant others affected by AOD use problems experience considerable levels of stigma.

The World Health Organization states that illicit drug dependence is the most stigmatised health condition in the world; and dependence on alcohol is ranked as the fourth most stigmatised condition.

Stigma and discrimination have wide ranging impacts on the health and well-being of people affected by AOD use. This includes social and economic participation and willingness to access treatment and support, both AOD specialist treatment and general health care. It can also impact the effectiveness of screening and early and brief interventions.

The reasons behind AOD use are complex, however individual 'blame' and 'shame' for the problems associated with AOD use often lays at the heart of this stigma. Media representation is often simplistic or sensationalistic, linking AOD use to crime and other negative social aspects, and perpetuating a fearful and moralistic view.

In the work undertaken by Siggins Miller, clients/consumers suggested the need for more community education in order to reduce the stigma of substance use and improve knowledge of substance use disorders and treatment options, and how better understanding would also help with the recovery process. Service providers also discussed the implications of negative media portrayal of drug use on their services.

Ethical treatment and patients' rights principles include the need to ensure staff are properly training in full compliance with ethical standards and human rights principles and demonstrate respectful, non-stigmatising and non-discriminatory attitudes toward service users (UNODC/WHO, 2016).

Reform Goal:

- Reduce the stigma associated with AOD use issues and treatment

Key Actions:

8.1 Work closely with clients/consumers, carers and service providers and through the development of the Tasmanian AOD Workforce Development Strategy to embed respectful, non-stigmatising and non-discriminatory attitudes across all providers of AOD services and programs

8.2 Strengthen relationships with local media to increase accuracy of reporting of AOD issues in Tasmania, e.g. use AOD Media Watch

8.3 Develop and actively promote a position statement that aims to reduce the stigma and discrimination associated with AOD use issues and treatment

8.4 Increase AOD health policy literacy by providing more community information on AOD use disorders and treatment options

QUESTIONS

6. *Do you have any comments on these reform directions and the associated goals and actions? Is there anything else would you like to see under the Reform Directions, and if so why.*
7. *Has anything changed recently that also needs to be considered?*

Implementation and monitoring

This Reform Agenda has been informed by the work undertaken by Siggins Miller and PHT and the earlier work under the North West Review and the reviews of Future Service Directions. It has also been informed by the input provided by a wide range of stakeholders across government and non-government including clients/consumers, individual clinicians and groups, and service providers. It is important that key groups have an ongoing role in implementation and monitoring.

In discussion on the concepts and effectiveness of 'treatment' the literature review found that 'effectiveness' of AOD care has two elements – local service system effectiveness and the effectiveness of treatment modalities. Both elements will be monitored through implementation of the Reform Agenda.

To ensure the Reform Agenda and the reform directions remain relevant, the Reform Agenda and reform directions will be re-visited at the half-way point, and changed if necessary.

Reform requires a commitment to change. It also requires support at every level and time to implement, as well as a shared understanding and agreement on the way forward. One of the first tasks will be to identify the resources required to support implementation of the Reform Agenda.

Implementation Goals:

- Meet the objectives to:
    - Deliver a seamless and integrated AOD service system along a continuum that provides a stepped care approach from promotion and prevention through to relapse prevention
    - Provide a range of support and treatment options for client/consumers and carers
    - Better integrate all treatment service system components to achieve better outcomes for all clients/consumers
    - Reduce duplication
    - Better integrate AOD government and non-government treatment services
    - Better integrate AOD services with non-AOD services
- Ensure progress in implementation of the Reform Agenda and the reform directions is regularly monitored and evaluated
- Monitor the aim of the Reform Agenda

Key Actions:

1. Identify resources to support implementation of this Reform Agenda
2. Establish a governance structure, and monitoring and reporting process for implementation of the Reform Agenda
3. Develop and implement a Communications Strategy for the implementation of the Reform Agenda
4. Develop a suite of agreed objectives, KPIs, and outcomes for each treatment type (also as part of Reform Directions 1 and 2)
5. Develop a data collection, collation, reporting and sharing of information protocol for use across all government and non-government AOD service providers, and with other linked agencies/organisations, e.g. mental health, hospitals
6. Identify a suitable clinical information management system to meet data system requirements for use across the Tasmanian government and non-government specialist AOD sector

Putting the Reform Agenda into action

Consistent with the Implementation section, a governance model will be established to monitor and report against implementation of this Reform Agenda.

There are a number of key actions identified under the reform directions, and many are relevant across a number of the reform directions. The table below summarises the reform directions and actions.

Reform Directions and Actions – summary table

Reform Direction 1: An integrated service system	
1.1	Define the required components, appropriate roles and scope of the specialist public ADS, the community sector AOD services, primary health care and the private sector within an integrated service system and using a continuum of care model
1.2	Reconfigure current services and funding arrangements as required to align with and match the above components and roles
1.3	Identify linkages across funding and service provision to clearly identify gaps and duplications across all services
1.4	Work with Primary Health Tasmania to develop a co-commissioning framework for AOD services in Tasmania
1.5	Support the implementation of the Rethink Mental Health reform agenda to strengthen support for people with co-occurring AOD and mental health issues
Reform Direction 2: Developing service specifications and program guidelines	
2.1	Develop a series of AOD treatment service specifications and program guidelines, all incorporating aftercare and relapse prevention, including: a) A Residential Rehabilitation Treatment Model incorporating both short and longer-term stays, and day programs for rehabilitation treatment in Tasmania b) A Withdrawal Management Model of Care incorporating medically-supervised inpatient withdrawal and ambulatory community or home-based withdrawal services c) Care coordination/case management framework d) Youth services – see also Reform Direction 5
2.2	Reconfigure current funded services as required to align with and match treatment service specifications and program guidelines (and consistent with reform direction 1.2)
2.3	Develop a suite of common assessment, admission, referral and discharge forms for consistent use across all AOD services

Reform direction 3: A client/consumer-centered approach across the service system	
3.1	Develop and implement a Client/Consumer Participation Framework
3.2	Increase advocacy for people with AOD use issues
3.3	Provide information, support and training to increase client/consumer understanding of the service system and to increase their confidence to provide meaningful input on ways to improve individual service delivery and the service system
Reform direction 4: Improving quality and safety	
4.1	Ensure all government and non-government AOD services commence implementation of the National Quality Framework for Drug and Alcohol Treatment Services (NQF) when finalised and endorsed
4.2	Establish a monitoring and reporting process for the NQF
4.3	Work with private providers to implement the NQF
Reform direction 5: Responding to specific population groups	
5.1	Work with the youth sector to review, develop and implement a Youth Framework for the AOD sector
5.2	Consider the specific needs of young people, women and people with children as part of the development of the Residential Rehabilitation Model for Tasmania
5.3	As part of reform directions 1 and 2, work closely with Correctional Primary Health Services and the Department of Justice to better support people in or leaving the justice system
5.4	Review current investment to consider the needs of other specific population groups including but not limited to older people, Aboriginal people, CALD including humanitarian entrants, and LGBTQI
Reform direction 6: Maintain a focus on promotion, prevention and early intervention	
6.1	Review the current ATOD PPEI Framework and Implementation Plan
6.2	Support communities and community sector organisations to deliver evidence-informed AOD health promotion and prevention initiatives, including tapping into current and new social marketing/awareness/education campaigns
6.3	Provide support to improve GP capability for AOD assessment and the provision of brief interventions
6.4	Work with other primary health care providers and hospitals to support the

	provision of appropriate PPEI activities
Reform direction 7: Supporting and developing the workforce	
7.1	Determine minimum staffing key competencies and requirements across all government and non-government AOD programs and services
7.2	Develop a Tasmanian AOD Workforce Development Strategy for government and non-government AOD services
7.3	Support primary health care through education and training, including in PPEI activities
Reform direction 8: Reducing stigma and discrimination	
8.1	Work closely with clients/consumers, carers and service providers and through the development of the Tasmanian AOD Workforce Development Strategy to embed respectful, non-stigmatising and non-discriminatory attitudes across all providers of AOD services and programs
8.2	Strengthen relationships with local media to increase accuracy of reporting of AOD issues in Tasmania, e.g. use AOD Media Watch
8.3	Develop and actively promote a position statement that aims to reduce the stigma and discrimination associated with AOD use issues and treatment
8.4	Increase AOD health policy literacy by providing more community information on AOD use disorders and treatment options
Implementation and monitoring	
1	Identify resources to support implementation of this Reform Agenda
2	Establish a governance structure, and monitoring and reporting process for implementation of the Reform Agenda
3	Develop and implement a Communications Strategy for the implementation of the Reform Agenda
4	Develop a suite of agreed objectives, KPIs, and outcomes for each treatment type (also as part of reform directions 1 and 2)
5	Develop a data collection, collation, reporting and sharing of information protocol for use across all government and non-government AOD service providers, and with other linked agencies/organisations, e.g. mental health, hospitals
6	Identify a suitable clinical information management system to meet data system requirements for use across the Tasmanian government and non-government specialist AOD sector

This is an ambitious Reform Agenda and additional resources have not to date been identified or provided to support its implementation. Some of the actions rely on other actions to either start at the same time or be completed. Full implementation will take time, and a commitment to both change and collaborative action.

Questions

8. *From the perspective of your service/organisation or from your perspective as a client/consumer what do you see as the risks and challenges in implementing the Reform Agenda and these reform directions and actions?*
9. *From the perspective of your service/organisation or from your perspective as a client/consumer what do you consider the opportunities in implementing the Reform Agenda and these reform directions and actions?*
10. *Can you please indicate which of the specific actions you consider to be priorities (list up to 5 actions), and explain why.*

Your feedback will help inform one of the first pieces of work to be undertaken following the endorsement of the Reform Agenda, being prioritising the actions and considering the governance and resources needed to support each action.

Background

The following sections provide the background and context that has informed this Reform Agenda and the reform directions.

The development of the Reform Agenda has been informed by the work of Siggins Miller Consultants (Siggins Miller), who were engaged to undertake an independent analysis of the current AOD service system.

The Final Report was released on 2 May 2018 and is available from the Alcohol and Drug Services website Siggins Miller Final Report

Overall, analysis by Siggins Miller shows that there is scope for reconfiguration of existing and future resources to better focus on people with severe and complex problems and to ensure balanced investment across the treatment types, as defined in the Drug and Alcohol Service Planning model (DASP)[1].

Siggins Miller noted the main challenges facing the specialist AOD treatment sector in Tasmania, identified by both client/consumers and provider are:

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

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

Client/consumers and providers thought there was a need for better integration:

- between withdrawal management and residential rehabilitation (and other AOD services);
- between AOD service providers more generally, particularly between government and non-government services made worse by lack of information sharing;
- with mental health services particularly for clients/consumers with mental health issues but not eligible for Public Mental Health Services; and
- with housing, employment and justice. Integration with the criminal justice system was discussed in the context of AOD services offered in prison; legal aid offered to

[1] The Drug and Alcohol Service Planning Model (DASP) for Australia (formerly the Drug and Alcohol Clinical Care and Prevention Model 2013 [DA-CCP]) estimator tool was used to calculate the type and quantity of services needed for the projected Tasmanian population. This demand modelling process involves the application of statistical methods, epidemiological data, evidence based practice and stakeholder expertise to estimate the type and quantity of services needed based on population size and features (e.g. age groups).

client/consumers of AOD services, typically in the context of child safety; and AOD services for people released from prison.

Client/consumers also identified:

- Need for more aftercare services particularly following acute episodes, and post rehabilitation;
- Need for greater support for those on a 'wait' list, or a step-down service;
- Lack of outpatient treatment;
- Lack of appropriate treatment options following detoxification including housing options;
- Need for more responsiveness and flexibility of AOD services, i.e. opening hours, treatment duration; and
- Need for greater client/consumer representation at both individual planning and higher levels.

Siggins Miller recommended that there is a need for reform within the treatment system to ensure that it is client-focused, rather than provider or institution focused, with services to be designed around client convenience, access and providing support to seek help as close as possible to where clients live. This would align the AOD service system with directions and reforms in treatment and support of other equally intractable chronic diseases elsewhere in the broader health system.

It suggested a focus on multi-sector work, with a focus in the first instance on:

- Partnership between government and non-government services;
- Client/consumer representation;
- Management of wait-times;
- Continuity of care;
- Integrated care pathways; and
- Support for GPs

Siggins Miller also provided some overarching main messages for consideration in developing the Reform Agenda:

1. There is strong support across all stakeholders in the AOD sector for system-level and service-type-specific reform. The change management agenda to implement these reforms is significant, will need the ongoing effort and contribution of all parts of the service system, and be resourced appropriately to implement the necessary change activities.
2. The complexity of the change process, the determinants of access to services, client/consumers' engagement with services, and the capacity to meet the broad social, employment, and education needs of client/consumers that are significant parts of their recovery requires a joined-up evidence-based approach to change.

3. Tasmania has a major resource in the depth and commitment of its policy and clinical leadership. This resource needs to be harnessed and well-supported in the change process.
4. There are a number of system-wide issues addressed in this report, such as the need for joined up electronic health records; preparing the system for the national rollout of the My Health Record system; the extended use of telehealth for consultations to improve access for people in remote settings or for service providers to access secondary consultations; and remote monitoring of patients in ambulatory settings.
5. The bulk of Tasmanian AOD services appear to be evidence-based. There are some places where the review was unable to establish the evidence base of some services due to a lack of documentation.

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

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

As part of its role as the commissioning agency for the Australian Government-funded AOD services, in 2016 PHT developed the Commissioning Intentions Document (Primary Health Tasmania, 2016). As part of its needs assessment and design stages, it undertook extensive consultation, comprehensive needs assessment and reviewed alcohol and drug service models.

It identified a number of key issues and themes:

- The need to enhance integration within the alcohol and other drug service system especially between government and community sector services.
- Significant waiting times for key alcohol and other drug interventions such as counselling, withdrawal management, residential rehabilitation and pharmacotherapy.
- Workforce and sector development needs including the capacity to deliver culturally safe services to Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, and lesbian, gay, bisexual, transgender and intersex (LGBTI) communities.
- The need for an evidence-based approach to assertive aftercare.
- Service access issues for particular population target groups such as young people, mothers and parents with accompanying children.
- The need for service coordination for clients with co-occurring alcohol and other drug issues and mental health problems.
- Expectations of client and family centred approaches in service provision.
- The benefits of client/consumer involvement in service planning, delivery and evaluation, including the need to fund Tasmania's drug user organisation.

- The value of using shared assessment tools across the sector.
- The need to improve data and information quality and enhance the reporting and evidence base for the sector.
- The value of prevention and health promotion activities.

Following a major review of the alcohol, tobacco and other drug treatment sector in 2007-08, the Future Service Directions Plan (FSD) 2008/09 – 2012/13 was released to guide service development (available at Alcohol and Drug Services Publications)

A number of key initiatives were identified to enhance treatment delivery responses across the ATOD sector. Both a 2013 internal review of the implementation of FSD and a 2014 Tasmanian Audit Office compliance audit of FSD identified a number of areas for further work, including:

- Development of a framework for delivery of evidence based psychosocial services and interventions;
- Improving access to residential rehabilitation services;
- Developing diversity in where and how withdrawal management services are provided;
- Continuing to grow consultation liaison services;
- Increasing access to services for rural and remote areas of the state;
- Expanding services for young people;
- Developing alternative aftercare support services;
- Developing a service framework to integrate alcohol and drug interventions with other government and non-government services; and
- Developing a model of outreach service provision and alternative ways to expand services across all regions.

In 2014 following claims of growing drug use in the North West region of Tasmania a review of drug use and service responses in the North West region was undertaken. The Final Report: *Review of drug use and service responses in the North West* (NW Review Report) can also be found at Alcohol and Drug Services Publications As noted in the NW Review Report, whilst it focussed largely on drug use issues and service delivery responses in the North West of Tasmania, the findings and recommendations address the current drug related issues in the North West and across the State more broadly.

The NW Review Report; the review of FSD; and the Tasmanian Audit Office Compliance Audit all identify similar ongoing issues within the Tasmanian AOD sector.

As noted in the NW Review Report:

> *'More recent consultations, as part of this review, have raised concerns over the current configuration of the service system with indications that some service types are not being fully utilised and there may be opportunities to consider alternative approaches to service delivery. Although the recent feedback was particularly focussed on service provision in the North West, it is likely that similar experiences are occurring in other regions of the State.'*
>
> And:

'It is evident that across Tasmania the delivery of specialist alcohol and drug treatment services continues to be extremely fragmented despite recent attempts for better collaboration and integration between services. There continues to be an opportunity to better integrate services to enable the service system to:

- *Provide comprehensive services across the continuum of care;*
- *Be patient focussed;*
- *Improve geographic location (and coverage);*
- *Standardise high quality care;*
- *Improve utilisation of clinical resources; and*
- *Improve governance and financial sustainability.*

Required elements of government and non-government treatment services in Tasmania

Ritter et al (2013) summarises the types of formal service settings where people may receive AOD treatment, and the types of treatments provided in those settings as:

- The AOD specialist system (withdrawal, counselling, residential rehabilitation and pharmacotherapy maintenance)
- General hospitals (withdrawal services and brief interventions)
- General practice (withdrawal, brief interventions, and pharmacotherapy maintenance treatment)
- Community health settings (counselling)
- Welfare services (counselling)
- Private psychologists (counselling)
- Private hospitals (withdrawal, residential rehabilitation and counselling)
- Private psychiatrists (withdrawal and counselling)

Service Requirements

In addition to the aim and principles identified earlier, this Reform Agenda identifies the service requirements for all Tasmanian government and non-government AOD services and programs, linked to a tiered continuum of care model of service delivery using a stepped care approach.

The following specific types of treatment are required in Tasmania:

- Withdrawal management – inpatient, ambulatory/home based, and community residential
- Residential Rehabilitation – short term, long term and day programs
- Relapse prevention (after care) – possible combination of new specific services and attached to residential rehabilitation services

- Opioid Pharmacotherapy substitution
- Psychosocial interventions/counselling supports
- Care coordination/case management – either in combination or as stand-alone services
- Consultation Liaison
- Family support
- Brief Interventions
- Harm reduction, and as ongoing components of all treatment providers
- Health promotion and prevention

In addition, the differing needs of some population groups identified at greater risk of experiencing AOD related harm will be considered. These include children and young people, Aboriginal and Torres Strait Islander Australians, women, elderly people, people from culturally and linguistically diverse (CALD) backgrounds, lesbian, gay, bisexual, transgender, queer or questioning and intersex people (LGBTQI) and people in or leaving the justice system.

Continuum of Care model of service delivery

The identified reform directions are underpinned by the premise that clients/consumers will receive services along a continuum and stepped up or down based on their particular needs from time to time.

In a stepped care approach, treatment is matched to the intervention level that most suits current need based on a number of factors including assessment(s), AOD use, client/consumer identified goals and needs, and client and service outcomes. An individual does not generally have to start at the lowest, least intensive level of intervention in order to progress to the next 'step'. Rather, they enter the system and have their service level aligned to their requirements.

The basic philosophy of stepped care encompasses a model whereby clients *'who respond poorly to treatment are moved to greater intensities of care, while those who respond well receive less intensive services'*

Evidence informed drug treatment services include a number of interventions (screening, assessment, early (or brief) intervention, intensive treatment and after care/relapse prevention) tailored for individuals at risk of harm and treatment for those who are dependent on drugs or are recovering from dependence. Generally, levels of service and types of treatment that can be delivered in different settings along a continuum.

Interventions need to include a wide range of activities, initiatives and services, and a local system of AOD programs and services that includes community education and information, promotion, prevention and early intervention as well as treatment and support for individuals and families, and after care or relapse prevention.

From the literature of the effectiveness of treatment modalities, the message is clear that because of the chronic, relapsing nature of substance misuse or dependence, single episodes of treatment (regardless of the drug of use, type of treatment or individual or contextual factors) are unlikely to be effective or produce longer term improved outcomes; and that

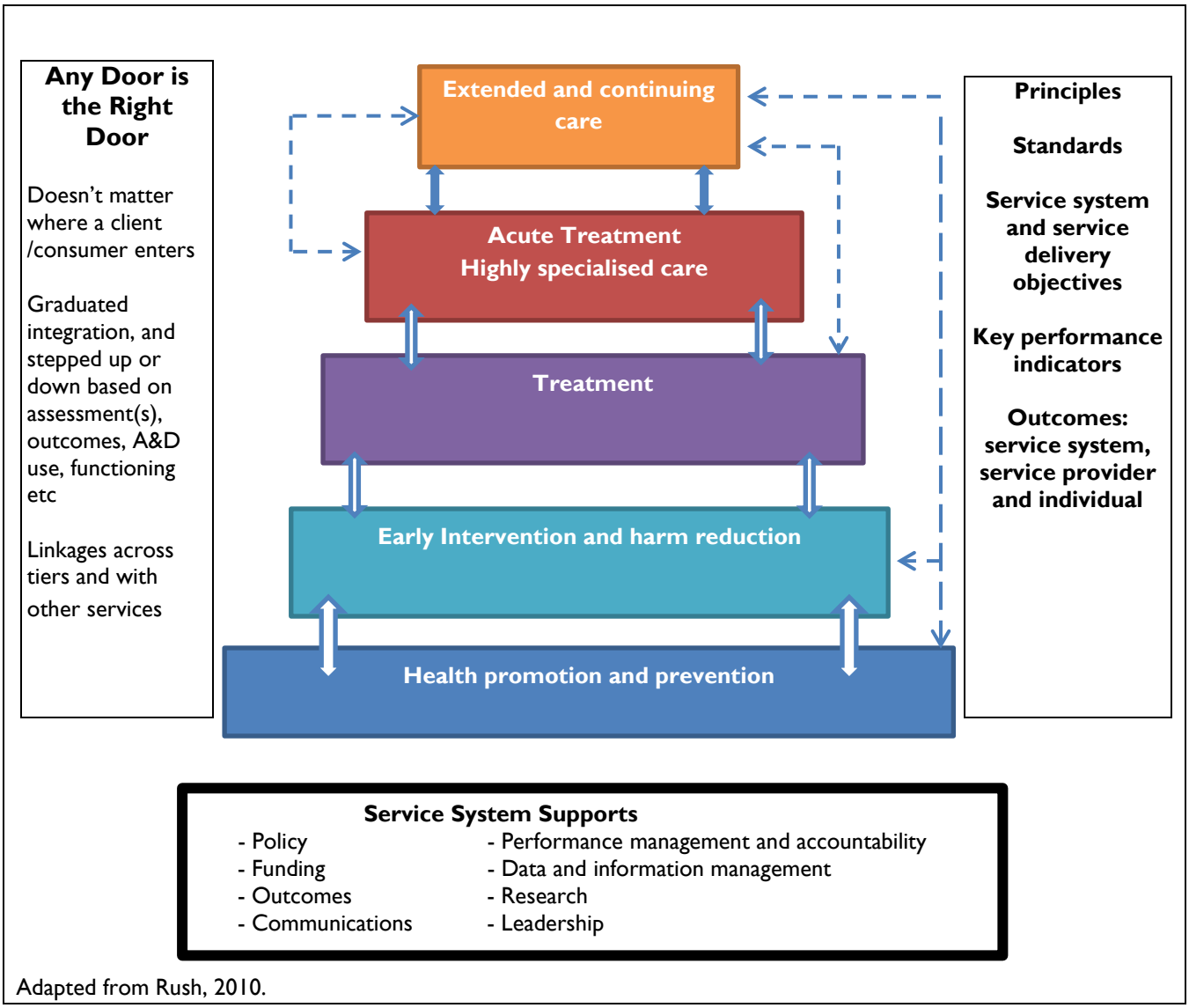
both completion of treatment and assistance by ongoing contact, care and support are required to maintain gains from treatment and reduce risk of relapse.

This suggests that investment in services, programs or approaches that do not include or link with proactive follow up and after care is likely to achieve suboptimum outcomes. Additionally, continuity of care planning and aftercare support are critical components to sustaining effective treatment outcomes.

Generally, in discussion on the concepts and effectiveness of 'treatment' the literature review found that 'effectiveness' of AOD care has two elements – local service system effectiveness and the effectiveness of treatment modalities.

A five tiered continuum of care model will be adopted to describe the drug use focus, types of interventions, the service settings, and workforce needs that are required in Tasmania, as depicted below. More information is provided in Appendix 1.

Continuum of care model



Adapted from Rush, 2010.

Setting the Scene

Strategic policy

The national and state strategic policy landscape comes from the overarching National Drug Strategy. The current National Drug Strategy 2017-2026 (NDS) is the Australian Government's overarching policy response to drug issues. It recognises the health, social and economic consequences of drug use on individuals, families and communities, and includes a number of priority areas for action to address these issues including improving service access, preventative measures, better collaboration between governments, and strengthening communities to respond to alcohol, tobacco and other drug issues.

A number of sub-strategies that provide direction and context for specific issues sit under the NDS:

- National Ice Action Strategy
- National Aboriginal Torres Strait Islander Peoples Drug Strategy 2014–2019
- National Alcohol and other Drug Workforce Development Strategy 2015–2018
- National Tobacco Strategy 2012–2018

The following strategies are also under development, with significant input from all state and territory governments:

- National Alcohol Strategy 2018-2026
- National Fetal Alcohol Spectrum Disorder Strategy 2018-2028
- National Quality Framework for Drug and Alcohol Treatment Services

More information on the NDS and sub-strategies can be found on the Australian Government Department of Health website Department of Health Ministerial Drug and Alcohol Forum

The Tasmanian Drug Strategy 2013-2018 (TDS) is Tasmania's overarching response to the use of alcohol, tobacco and other drugs, and similar to the NDS maintains the concept of harm minimisation as its underlying concept.

A number of sub-strategies sit under the TDS:

- Tasmanian Alcohol Action Framework (extended to 2018)
- Tasmanian Tobacco Control Plan 2017-2021
- Everybody's Business: A Plan for Implementing Promotion, Prevention and Early Intervention (PPEI), Approaches in Averting Alcohol, Tobacco and Other Drugs Use

More information on the TDS can be found on the Tasmanian Drug Strategy website Tasmanian Drug Strategy

In addition, there are a number of other linked strategic policies including but not limited to:

- *Healthy Tasmania Five Year Strategic Plan*
- *One State, One Health System, Better Outcomes*
- *Rethink Mental Health*
- *Tasmanian Child and Youth Wellbeing Framework*
- *Youth at Risk Strategy*
- *Safe Homes, Safe Families: Tasmania's Family Violence Action Plan 2015-2020*
- *Breaking the Cycle – A Safer Community: Strategies for Improving Throughcare for Offenders*

The impact of AOD use

The use of drugs, including alcohol, tobacco, illicit drugs and pharmaceuticals causes significant harms to individuals, families and the community. The health harms include increased risk of injuries and deaths, cancers, cardiovascular diseases, liver cirrhosis, mental health problems, and shortened life expectancy. It also includes economic harms arising from the costs to health, hospitals, law enforcement and justice systems, decreased productivity, associated criminal activity, reinforcement of marginalisation and disadvantage, domestic and family violence and child protection issues.

Alcohol and other drug problems are also associated with social and health determinants such as discrimination, unemployment, homelessness, poverty and family and domestic violence.

The table below summarises self-reported tobacco, alcohol and illicit drug use for Tasmania from the 2016 NDSHS, by Statistical Area Level (SAL).

	Smoking status			Alcohol risk						Illicit drug use
SAL	Daily	Ex-smoker[c]	Never smoked[d]	Abstainer /ex-drinkers[e]	Lifetime risk: Low risk[f]	Lifetime risk: Risky[g]	Single occasion: Low risk[h]	Single occasion: At least yearly but not monthly[i]	Single occasion: At least monthly[j]	Recent illicit[k]
Hobart (601)	11.7	25.1	58.8	15.5	64.2	20.3	39.3	18.0	27.2	19.2
L'ton and North East (602)	17.2	29.7	51.1	24.3	61.6	14.1	38.8	8.9	27.9	13.9
West and North West (604)	20.4	22.8	55.7	17.3	66.5	16.2	44.2	13.1	25.3	17.3

(c) Smoked at least 100 cigarettes (manufactured and/or roll-your-own) or the equivalent amount of tobacco in their life, and reported no longer smoking.
(d) Never smoked 100 cigarettes (manufactured and/or roll-your-own) or the equivalent amount of tobacco.
(e) Not consumed alcohol in the previous 12 months.
(f) On average, had no more than 2 standard drinks per day.
(g) On average, had more than 2 standard drinks per day.
(h) Never had more than 4 standard drinks on any occasion.
(i) Had more than 4 standard drinks at least once a year but not as often as monthly.
(j) Had more than 4 standard drinks at least once a month but not as often as weekly.
(k) Used at least 1 of 16 illicit drugs in 2016.

Current service provision across Tasmania

It is well known and acknowledged that only a small proportion of people who experience an AOD related problem will seek assistance, and that AOD service settings are only one part of a larger interdependent system of AOD and other health and welfare services accessed by people with AOD related problems (Lubman et al, 2014).

Tasmania's AOD system is complex and involves many stakeholders and providers, including specialist government and non-government AOD services, primary health care including GPs and private providers.

It was estimated that in Tasmania in any one year, at least 61 320 AOD treatment episodes/sessions are provided each year, noting different data sources and counting rules (Siggins Miller, 2017). These are provided across all treatment settings including government and non-government specialist AOD services, by GPs, in public and private hospitals, through private opioid pharmacotherapy providers, in government community and residential mental health services, and by psychiatrists and allied health professionals in the mental health sector (all treatment settings).

Estimated utilisation of AOD treatment services/episodes of care in Tasmania by all treatment settings over a year

Settings	Year of data	Tasmania	National equivalent	% of National
GP consultations – BEACH data set	2008-2013; 2015-2016	21,607 consultations	1,005,242 consultations	2.15%
Specialised AOD treatment services (own drug use) - AODTS NMDS 2015-16	2015-2016	3,585 episodes (2,768 clients)	NA	NA
Hospital admissions - NHMD – NMDS (both public and private)[2]	2015-16	2,268 separations	80,376 separations	2.82%
ED care (without subsequent admission) - NAPEDC NMDS	2014-15	799 episodes	47,916 episodes	1.67%
OST treatment - NOPSAD	2015	757 clients	48,522 clients	1.56%
Community Mental Health Care (Mental Health Services in Australia [MHSA]) - CMHC-NMDS	2014-15	907.3 service contacts	192,176 service contacts	0.47%
PM&C funded ATSI AOD services (OSR)				
Residential care	2014-15	49 client/consumers	2,236 client/consumers	2.15%
Sobering up, residential respite or short-term care	2014-15	124 client/consumers	5769 client/consumers	2.15%
Non-residential care	2014-15	429 client/consumers	19,938 client/consumers	2.15%
Needle and Syringe Programs	2015-16	19,303 interventions	NA	NA
Better Access - MHSA	2014-15	11,207 services	549,409 services	2.00%
ATAPS – ATAPS NBMDS	2014-15	286.6 sessions/ 58.3 client/consumers	2,736 client/consumers	2.10%
Total estimate consultations/episodes/sessions		**61,321**		

[2] The National Hospital Morbidity Database National Minimum Data Set (NHMD-NMDS) collects information on services in all public and private hospitals. This includes DRG codes for alcohol intoxication and withdrawal (with complications and without complications); drug intoxication and withdrawal; alcohol use and dependence; opioid use and dependence; other drug use and dependence; treatment for alcohol disorders (same day) and treatment for drug disorders (same day). The data is reported as separations, rather than individual clients, and double counting may occur if a given patient has multiple separations within the same year.

When factoring in both multiple sessions and access to more than one treatment setting by any one individual, it is estimated that in Tasmania between 5 759 and 6 550 unique individuals are receiving some form of AOD treatment in any one year (Siggins Miller, 2017).

In 2015-16 (AIHW, 2017b) a total of 3,840 closed episodes of treatment were provided to 2,936 unique individuals by specialist government and non-government AOD services, for own and others' drug use. Overall, this equates to 742 episodes per 100,000 of population for Tasmania, compared to the national rate of 863 per 100,000 - a gap of 121 episodes per 100,000, or approximately 600 episodes of care over a year (Siggins Miller, 2017).

Findings for 2016-17 (AIHW, 2018) indicate a total of 3,389 closed episodes of treatment were provided to 2,401 unique individuals in 2016-17.

Principal drugs of concern and main treatment type by closed episodes of treatment by proportion, 2015-16 and 2016-17

Principal drug	**2015-2016**	**2016-2017**
Alcohol	39 %	39 %
Cannabinoids	26 %	23 %
Amphetamines	22 %	22 %
Pharmaceutical Opioids	9 %	8%
Main treatment type		
Counselling	1,519 (42 %)	39 %
Assessment only	1,102 (30 %)	24 %
Rehabilitation	568 (16 %)	23 %
Information and education only	188 (5 %)	5 %
Others	208	

In 2016-17, the following specialist government and non-government organisations provided a range of treatment services.

Current State Government funded AOD services

- Advocacy Tasmania Inc
- Alcohol and Drug Foundation
- Alcohol and Drug Services, South
- Alcohol and Drug Services, North
- Alcohol and Drug Services, North West
- Alcohol, Tobacco and Other Drugs Council Tasmania
- Anglicare Tasmania
- Circular Head Aboriginal Corporation
- Drug Education Network
- Eastern Health Service (Turning Point)
- Holyoake
- Launceston City Mission
- Salvation Army
- The Link Youth Health Service
- Velocity Transformations (Pathways Tasmania)
- Youth, Family and Community Connections

In addition, the organisations below receive Federal funding through PHT:

- Anglicare Tasmania
- Youth, Family and Community Connections
- South East Tasmanian Aboriginal Corporation
- Drug Education Network
- Holyoake
- Salvation Army
- Advocacy Tasmania
- Hello Sunday Morning

Based on information provided by the Commonwealth Department of Prime Minister and Cabinet, three organisations in Tasmania received funding to deliver AOD treatment for Indigenous Australians for the year 2016-17:

- Tasmanian Aboriginal Centre
- Circular Head Aboriginal Corporation
- Cornerstone Youth Services

In the work undertaken by Siggins Miller, it was estimated that the total expenditure on AOD treatment services and activities in Tasmania per annum is around $40,426,964 (Siggins Miller, 2017) across all treatment settings.

Estimated AOD treatment investment in Tasmania per annum

	Funder type	Estimated amount	% of total	National %
Commonwealth AOD grants (Health)	CW	$3,105,339	7.7%	10.8%
Commonwealth AOD grants (PM&C)	CW	$1,705,439	4.2%	
State/territory AOD investment				41.2%
Community Sector Organisations	ST	$7,541,237	18.7%	
Government ADS services	ST	$13,555,632	33.5%	
Hospital admitted patients – public ABF	CW	$781,652	1.9%	15.0%
Hospital admitted patients – public ABF	ST	$1,359,862	3.4%	
Hospital admitted patients – public block grant	CW	$132,099	0.3%	
Hospital admitted patients – public block grant	ST	$229,817	0.6%	
Private hospitals – admitted patients, excluding DVA	private	$7,055,837	17.5%	10.8%
Medicare	CW	$1,247,627	3.1%	8.1%
Pharmaceutical Benefits Scheme	CW	$77,598	0.2%	
ATAPS- Allied Health Services	CW	$981,228	2.4%	2.6%
Better Access – Allied Health Services	CW	$1,208,632	3.0%	
Individual client contribution- rehabilitation	private	$888,241	2.2%	7.0%
GP co-payments	private	$257,924	0.6%	
Pharmacotherapy dispensing fees	private	$298,800	0.7%	
Total		**$40,426,964**	**100.0%**	**100%**

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Appendix 1: Integrated continuum of care tiered model

	Health Promotion and Prevention Focus is on prevention and early intervention to prevent uptake, and reduce the harms associated with AOD use	**Early Intervention and harm reduction** Focus in on the reduction of harms associated with AOD use	**Treatment** Focus is on access to a range of clinical and inpatient specialist services	**Acute Treatment** Focus is on a range of specialist services based on severity of distress and impairment and dependence	**Extended and continuing care (aftercare and relapse prevention)** Focus is on ongoing aftercare and relapse prevention for up to 12 months
Population and drug use focus	General population	• General population with a focus on 'at risk' individuals and groups • Problematic drug use • Families or significant others	• Problematic or dependent drug use • Families or significant others • Special needs groups, e.g. young people, Aboriginal, CALD	• The same as for treatment but with a focus on high complex health and social needs • Women and parents with children • Coexisting issues, e.g. mental health, disability, pain management • Criminal justice issues	• The same as for treatment and acute treatment
Types of services/ Interventions (examples)	• Universal health promotion • Brief Interventions – Information and education • Community and school-based information and education • Telephone and online self-help programs • Community programs,	• Needle and syringe programs (NSP) • Extended Brief Interventions • Diversion programs, e.g. Illicit Drug Diversion Initiative • Health promotion and prevention – community development, information and	• Care coordination • Case Management • Counselling • Withdrawal Management • Residential Rehabilitation • Opioid Pharmacotherapy Program, (OPP) • Assertive outreach	• The same as for treatment	• Care coordination • Case Management • Assertive outreach • OPP • Referral to other services

	Health Promotion and Prevention Focus is on prevention and early intervention to prevent uptake, and reduce the harms associated with AOD use	**Early Intervention and harm reduction** Focus in on the reduction of harms associated with AOD use	**Treatment** Focus is on access to a range of clinical and inpatient specialist services	**Acute Treatment** Focus is on a range of specialist services based on severity of distress and impairment and dependence	**Extended and continuing care (aftercare and relapse prevention)** Focus is on ongoing aftercare and relapse prevention for up to 12 months
	e.g. Good Sports • Laws and regulations on the sale and supply of AODs	education • Places of Safety and Street Teams (for public intoxication)			
Service settings (examples)	• Healthcare services, e.g. GPs, Hospitals • Community Health Centres including targeted services, e.g. Aboriginal health, youth health, mental health • Neighborhood Houses • Schools • Community events • Community Sporting Clubs	• The same as for Health Promotion • Some specialist AOD providers, e.g. for NSPs, places of safety, street teams • GPs	• Specialist government and non-government AOD services both inpatient and outpatient • Hospitals • Some GPs, e.g. OPP providers	• Specialist government and non-government AOD services both inpatient and outpatient	• The same as for treatment and acute treatment
Workforce needs	• Appropriate knowledge of AOD-use issues • Appropriate knowledge, training and qualifications to deliver information and education sessions	• The same as for Health Promotion • Some specialist AOD knowledge and skills	• Specialist AOD knowledge, training and qualifications including range of disciplines, e.g. addiction medicine specialists, social workers, psychologists, nurses	• The same as for treatment	• The same as for treatment and acute treatment

	Health Promotion and Prevention Focus is on prevention and early intervention to prevent uptake, and reduce the harms associated with AOD use	**Early Intervention and harm reduction** Focus in on the reduction of harms associated with AOD use	**Treatment** Focus is on access to a range of clinical and inpatient specialist services	**Acute Treatment** Focus is on a range of specialist services based on severity of distress and impairment and dependence	**Extended and continuing care (aftercare and relapse prevention)** Focus is on ongoing aftercare and relapse prevention for up to 12 months
			• AOD workers/ counsellors • Youth workers		