LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON THE DRUGS OF DEPENDENCE (PERSONAL USE) AMENDMENT BILL 2021
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Submission Cover Sheet

Inquiry into the Drugs of Dependence (Personal Use) Amendment Bill 2021

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Statement of Recognition

The Salvation Army acknowledges the Traditional Custodians of the lands and waters throughout Australia. We pay our respect to Elders, past, present and emerging, acknowledging their continuing relationship to this land and the ongoing living cultures of Aboriginal and Torres Strait Islander peoples across Australia.

About The Salvation Army

The Salvation Army is an international Christian movement with a presence in 128 countries. Operating in Australia since 1880, The Salvation Army is one of the largest providers of social services and programs for people experiencing hardship, injustice and social exclusion.

The Salvation Army Australia has a national operating budget of over $700 million and provides more than 1,000 social programs and activities through networks of social support services, community centres and churches across the country. Programs include:

- Financial inclusion, including emergency relief
- Homelessness services
- Youth services
- Family and domestic violence services
- Alcohol, drugs and other addictions
- Chaplaincy
- Emergency and disaster response
- Aged care
- Employment services

As a mission-driven organisation, The Salvation Army seeks to reduce social disadvantage and create a fair and harmonious society through holistic and person-centred approaches that reflect our mission to share the love of Jesus by:

- Caring for people
- Creating faith pathways
- Building healthy communities
- Working for justice

We commit ourselves in prayer and practice to this land of Australia and its people, seeking reconciliation, unity and equity.

Further Information

The Salvation Army would welcome the opportunity to discuss the content of this submission should any further information be of assistance. Further information can be sought from Major Paul Hateley, National Head of Government Relations, at government.relations@salvationarmy.org.au or on [redacted]

Introduction

The Salvation Army thanks the Government of the Australian Capital Territory for the opportunity to share our service delivery experience through this submission to the Inquiry into the Drugs of Dependence (Personal Use) Amendment Bill 2021.

The Salvation Army is an international Christian movement with a strong presence in Australia. Our vision is to confront hardship and injustice by living, loving and fighting alongside others to transform Australia one life at a time, with the love of Jesus. As part of achieving that vision we provide services to address substance use disorders across Australia. Our Alcohol and Other Drug (AOD) services are dedicated to creating a platform and pathways for people to build their lives in ways that are meaningful and purposeful. A core part of our services is focused on encouraging physical, emotional, mental, social, and spiritual health.

In the response that follows, we bring together the experience of our highly qualified alcohol and drug (AOD) services staff and managers who provide services across Australia and the voice of people who use our services. In particular, the evidence we put forward to the Committee has been informed by an extensive review of theory and practice evidence from both Australia and elsewhere, to provide a sound resource for AOD service redevelopment.

The Salvation Army will limit the scope of our input specifically to matters for which we feel qualified to speak at this time, namely Terms of Reference item 'e)', which seeks input on issues specific to the drug treatment and intervention sector, including models known to best suit people's needs. In so doing, we will assert the features of an effective stepped care treatment system in the hope that the opportunity for sector reform is seized.

This submission is in three main parts:

- Paradigms of best practice
- Recovery
- A stepped care approach

The Salvation Army's Alcohol and other drugs (AOD) services

The Salvation Army (TSA) is one of Australia's leading community service providers with a long and recognised history of providing alcohol and other drug services across the country. Over the last 135 years, TSA has consistently demonstrated the ability to work effectively with a diverse range of individuals, including forensic clients who are socially and economically disadvantaged and, as a result, marginalised within the community. Government and their departments partner with TSA because of our expertise, governance oversight and commitment to deliver on outcomes that improve the lives of Australians.

Nationally, TSA AOD Services include: Intake and Assessment, Counselling, Forensic Counselling, Care and Recovery Coordination, Residential Withdrawal, Home Based Withdrawal, Case Management, Harm Reduction Programs, Needle Syringe Programs, Day Rehabilitation Programs, Residential Rehabilitation and Aftercare. Services are delivered to a diverse client group including those from CALD backgrounds, LGBTIQ people, Aboriginal and Torres Strait Islander people, youth and families and forensic clients.

TSA have held ongoing funding contracts to deliver AOD services for many decades across all Australian states and territories. Current AOD funding contracts of various terms operate between TSA and the State and Territory Governments, the Commonwealth Government, Primary Health Networks and local Health Districts. Inclusive of approximately $14 million in public donations and fundraising efforts (Salvation Army funding) our current AOD Budget is in excess of $70 million across the country.

Best practice paradigms

The needs of local populations are extensive and our health and social care budgets finite. Therefore, it is incumbent on governments and organisations like The Salvation Army to ensure that precious resources are used wisely and that we invest in interventions that the evidence tells us will make a difference.

In considering some of the novel approaches to enhance the provision of AOD treatment systems and ensure greater access, better outcomes, better cost effectiveness and reduced barriers to access, The Salvation Army has identified the following initiatives and service delivery characteristics that should be considered in service redesign.

Pathways - AOD services couched within the wider health and welfare service system

An effective and accessible AOD treatment system must be couched within the wider welfare system to create pathways and services to better engage, maintain and exit people from treatment. Better outcomes are achieved when the system works together as a whole with pathways into and out of housing, education, training, employment, GP networks, prisons, mental health etc. The AOD sector has the potential to create a significant ripple effect in terms of protecting other more costly services by working with clients in a truly strengths based and holistic way.

Better engagement of people, at the right time and place with a service offering that is both attractive and flexible, requires a shift in the way services are delivered and integrated in wider public health systems, and a shift in the way they engage in their local communities.

> *"Good treatment planning for alcohol services should make brief treatment widely available. Such treatments are least restrictive and low cost. To conserve resources, our healthcare system should capitalize on minimum necessary levels of care. An efficient system would also develop effective linkages between services, so services are not unnecessarily duplicated within a community. In summary, appropriate non-intensive treatments should be the initial treatment in most cases. However, consistent with stepped care principles, treatment decisions should always be individualized".* [1]

Robust treatment pathways must be established to create seamless movement through the treatment system. A participant of services should have access to a wide variety of resources and services through the treating AOD agency. Management of client issues should be a task

[1] Sobel & Sobel (2000) *Stepped care for alcohol problems: An efficient method for planning and delivering clinical services*

collectively undertaken by public health and social sector services working in collaboration with each other and the participant to achieve that clients' individual definition of what it is to recover.

> *"Crucial to this approach is the inclusion of multiple service providers who reflect the complex needs of clients, and are able to deliver the right care, to the right person, at the right time."*[2]

Evidence-based practice

It is important that those interventions that are delivered are evidence based and effective. There is a wide body of knowledge available that describes the efficacy or otherwise of different treatment interventions. Because different things work for different people, participant choice is critical, where wide-ranging options for evidence-based interventions, along with community supports and the co-production of services is vital.

Integrating service into community and community into service creates an environment in which stigma can be addressed, increasing accesses to services, and forging greater tolerance and understanding in the community. The earlier we can intervene with someone experiencing AOD related harm, the less of a burden they will present on wider health, social care and criminal justice systems further down the track.

Co-production

People need to take ownership of their treatment journey. Co-production can be described as the process by which the responsibility for producing a particular health or social care outcome (such as sustained long-term recovery in the community) is divided between the service, service-user, and all stakeholders involved in an individual's recovery journey.

[2] Marel et al (2016), *Guidelines on the management of Co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*

> *"Recovery is a continuum process and experience through which individuals, families, and communities utilize internal and external resources to address drug dependence and substance abuse problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive and meaningful life"*[3]

For services to be effective people must be engaged in them, feel some ownership and agency over the processes that affect them (co-produce); they must be evidence-based, accessible and flexible. Resources and skills made available to people must enable a transition from a culture of addiction into a culture of recovery.

Classic theories of change

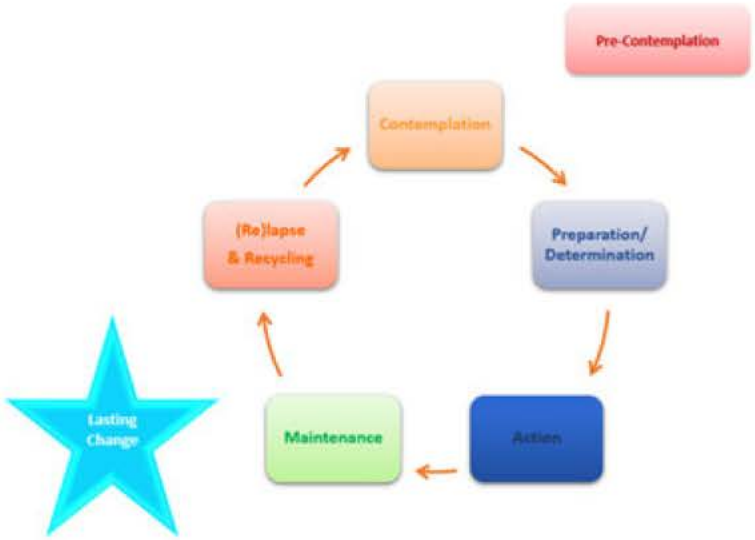
In order for people to be in a position to do the transformative work in addressing their problematic AOD use, they must be able to engage in the treatment on offer. This requires some stability. Basic needs must be met such as housing, access to food and security. Maslow's hierarchy of needs describes this.

Maslow; A (1943), T*heory of Human Motivation*

Furthermore, it is important to recognise that problematic AOD use is a chronic, lapsing condition. As described by Prochaska and DiClemente's stages of change model, in order for services to be able to engage with people at all stages, services must be able to provide a wide variety of

[3] White, W; An Integrated Model of Recovery-Oriented Behavioral Health Care. Philadelphia: Department of Behavioral Health, City Philadelphia. 2007

interventions that are suitable to the person's individual needs at a given time and place in their treatment journey. They must also be sufficiently flexible to accommodate changes in circumstance, for better or worse, within that journey.



Prochaska and DiClemente (1983 and 1992)

Asset Based Community Development

Historically, many AOD treatment programs have relegated many people to the margins of society. By contrast, the Asset Based Community Development model (ABCD), focuses on inclusion, ABCD offering an interdependence/collective control that welcomes those on the edge of society.

The five core principles of (ABCD):

1. Asset-Based
2. Place-Based
3. Relational
4. Working inclusively
5. Citizen-led

Services will move away from the treatment of a substance misuse problem in isolation to a whole of person approach based on life skills, empowerment and self-direction. Services will adopt a model of service-based recovery communities, that spill out into the wider community and become a place to inspire people to achieve their potential, take up active citizenship, creating a 'contagion effect' that pulls in others.

Work needs to take place to create an environment in which people can give something back to their own community, build experience, new skills and a sense of self-worth. Individuals will then form relationships based not on their shared deficits but on their assets and improved self-worth.

This approach allows people to move away from being defined by their deficits or the services that they receive to a positive focus on their potential and what they have to offer society. In the long term, self-directed support and a life of connectedness will come from access to positive and welcoming social networks - people being connected, not to a program but to each other. Services will enable people to connect to their passions and in doing so creating relationships with others based on reciprocity and mutual support.[4]

Case study – Mark's* story

Mark* has been through the residential program twice, the last time in 2015 and he remained sober for 2.5 years after this. After his mother died Mark began drinking again.

Mark was working part-time and wanted to continue to work, so he chose to do The Salvation Army's AOD day program, which meant he could live at home and still attend work whilst engaging in the program. Mark successfully completed the program in August 2019 and joined the aftercare program.

"When I did the program the last time there wasn't such a good aftercare program. You were just expected to go home and get on with it - which I did, until something serious happened in my life. The support of the aftercare program has been a big part of my recovery this time. I feel more connected and engaged and ready to give back."

Despite appearing to be managing well, engaging with the program, receiving psychological counseling, and continuing in his part-time job, Mark was still struggling with his mental health. Mark stated that in November of 2019, he began feeling suicidal. Mark presented to the support group one day with the intent to say goodbye. The aftercare worker realised something was wrong and immediately called an ambulance and the CATT team. Mark was admitted to hospital and spent 2 weeks under psychiatric care. On his return to the group, Mark was greeted with hugs and tears from his peers. Mark stated this had a huge impact on how he felt about himself. "I felt like I mattered and was part of the group." Mark said, "without aftercare I don't think I'd be here today."

Mark was 12 months sober in June 2020.

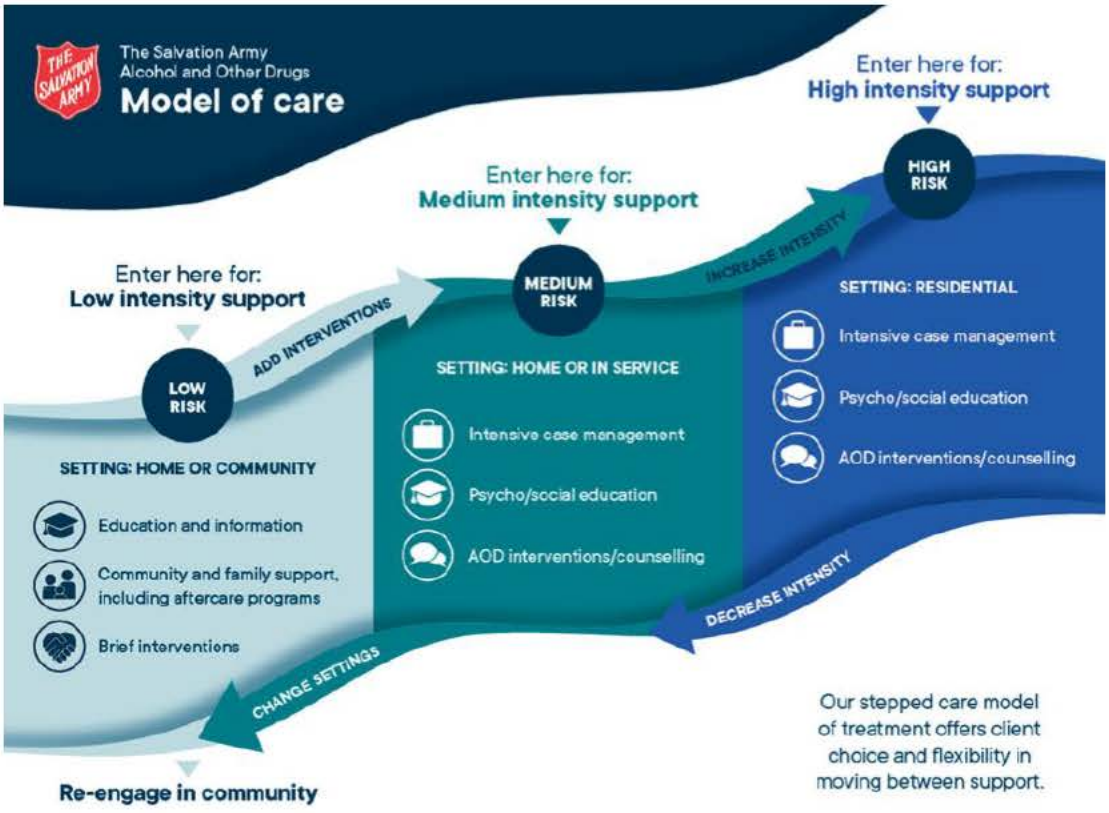
** Name has been changed*

[4] Nurture Development (2017) https://www.nurturedevelopment.org/blog/asset-based-community-development-5-core-principles/

Recovery

Recovery from problematic substance use is a unique and individual experience, and while there may be common themes and experiences, no two people's recovery journeys will be the same. This highlights the importance of developing diverse, localised recovery pathways that reflect the needs and resources of the local community.

In practice at the Salvation Army our national model looks like this.



This model is then localised to fit with what is happening in individual communities so as to play to their strengths and ensure that needs are met flexibly and effectively. We are currently in the process of rolling this model out nationally, however it has been effectively used over the last few years across our services in Tasmania, the outcomes of which are detailed on pages 25 and 26 of this submission.

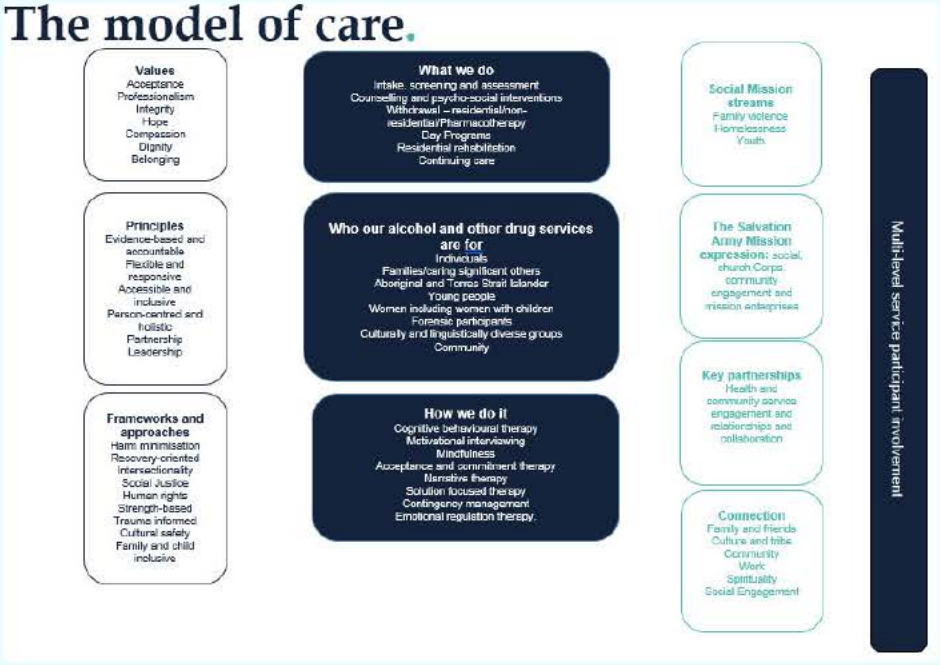
The Salvation Army's Model of Care

Our alcohol and other drug services are dedicated to creating a platform and pathways for people to build their lives in ways that are meaningful and purposeful. Harm reduction is the overarching framework of our alcohol and other drug services. Our primary purpose is to prevent and reduce harm for both individuals and the wider community and to support the reduction and cessation of use.

While addressing problematic substance use is key, we want people to have a sense of belonging to their families, friends and communities. Our core belief is that all people are worthy and deserving of love, respect and dignity.

The Salvation Army's Model of Care ensures a consistent, evidence-based model of care that aligns with current best practice, state and national alcohol and other drug policy frameworks and directions and The Salvation Army's philosophy and values. It provides an opportunity for our services to better align with the model and to develop pathways to address gaps and to identify opportunities for new directions and practice change.

Using a stepped care approach, we match people with a treatment that is right for them. We operate a number of programs designed for specific populations including young people, indigenous people, women including those with children and culturally and linguistically diverse groups.



Recovery Capital

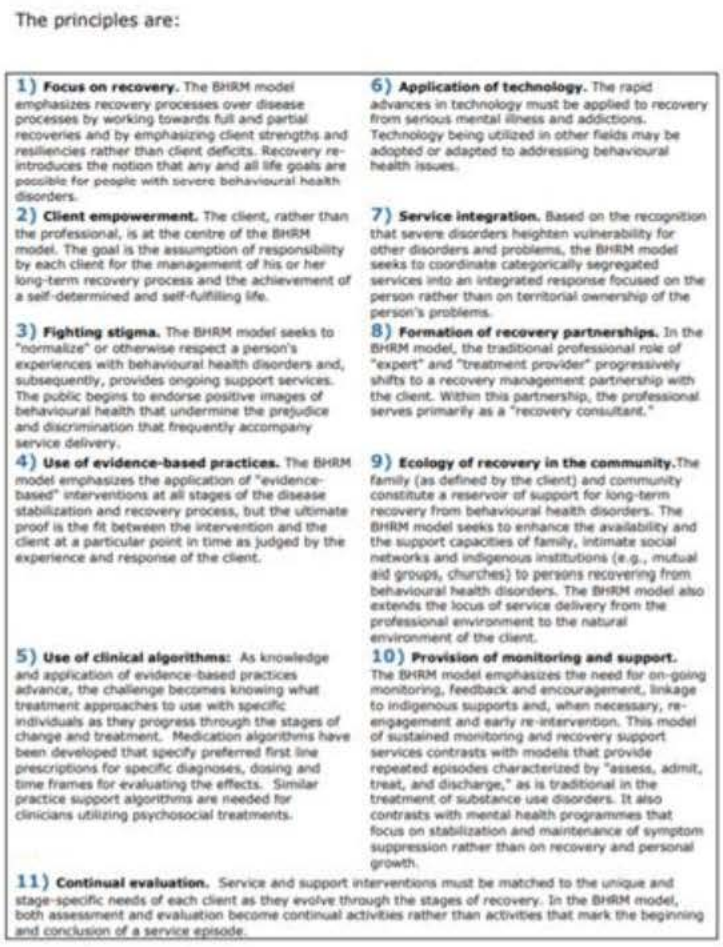
> *"Recovery capital is the sum of personal and social resources at one's disposal for addressing drug dependence and, chiefly, bolstering one's capacity and opportunities for recovery"*[5]

Simply put, the more access to things that are valuable to people (experience, sports/social clubs, fun, social networks, family, jobs, health, education etc.), the greater the likelihood of them achieving sustained recovery.

Bamber S (2010), *The Art of life Itself*

[5] Cloud, W. and Granfield, R (2001), *Natural recovery from substance dependency: Lessons for treatment providers*

The United Nations Office on Drugs and Crime (UNODC) describes recovery capital as part of a behavioural health recovery management approach, within which there are eleven principles of behavioural health recovery management.[6]



The principles are:

1) **Focus on recovery.** The BHRM model emphasizes recovery processes over disease processes by working towards full and partial recoveries and by emphasizing client strengths and resiliencies rather than client deficits. Recovery re-introduces the notion that any and all life goals are possible for people with severe behavioural health disorders.

2) **Client empowerment.** The client, rather than the professional, is at the centre of the BHRM model. The goal is the assumption of responsibility by each client for the management of his or her long-term recovery process and the achievement of a self-determined and self-fulfilling life.

3) **Fighting stigma.** The BHRM model seeks to "normalize" or otherwise respect a person's experiences with behavioural health disorders and, subsequently, provides ongoing support services. The public begins to endorse positive images of behavioural health that undermine the prejudice and discrimination that frequently accompany service delivery.

4) **Use of evidence-based practices.** The BHRM model emphasizes the application of "evidence-based" interventions at all stages of the disease stabilization and recovery process, but the ultimate proof is the fit between the intervention and the client at a particular point in time as judged by the experience and response of the client.

5) **Use of clinical algorithms:** As knowledge and application of evidence-based practices advance, the challenge becomes knowing what treatment approaches to use with specific individuals as they progress through the stages of change and treatment. Medication algorithms have been developed that specify preferred first line prescriptions for specific diagnoses, dosing and time frames for evaluating the effects. Similar practice support algorithms are needed for clinicians utilizing psychosocial treatments.

6) **Application of technology.** The rapid advances in technology must be applied to recovery from serious mental illness and addictions. Technology being utilized in other fields may be adopted or adapted to addressing behavioural health issues.

7) **Service integration.** Based on the recognition that severe disorders heighten vulnerability for other disorders and problems, the BHRM model seeks to coordinate categorically segregated services into an integrated response focused on the person rather than on territorial ownership of the person's problems.

8) **Formation of recovery partnerships.** In the BHRM model, the traditional professional role of "expert" and "treatment provider" progressively shifts to a recovery management partnership with the client. Within this partnership, the professional serves primarily as a "recovery consultant."

9) **Ecology of recovery in the community.** The family (as defined by the client) and community constitute a reservoir of support for long-term recovery from behavioural health disorders. The BHRM model seeks to enhance the availability and the support capacities of family, intimate social networks and indigenous institutions (e.g., mutual aid groups, churches) to persons recovering from behavioural health disorders. The BHRM model also extends the locus of service delivery from the professional environment to the natural environment of the client.

10) **Provision of monitoring and support.** The BHRM model emphasizes the need for on-going monitoring, feedback and encouragement, linkage to indigenous supports and, when necessary, re-engagement and early re-intervention. This model of sustained monitoring and recovery support services contrasts with models that provide repeated episodes characterized by "assess, admit, treat, and discharge," as is traditional in the treatment of substance use disorders. It also contrasts with mental health programmes that focus on stabilization and maintenance of symptom suppression rather than on recovery and personal growth.

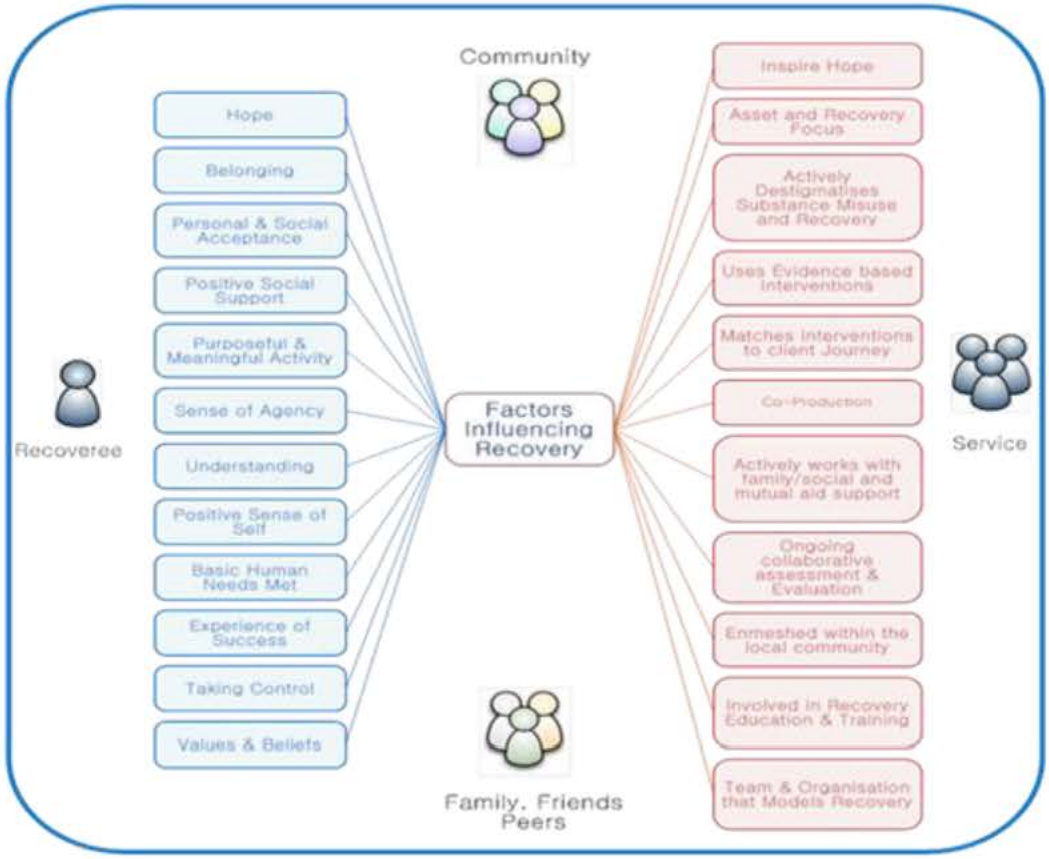
11) **Continual evaluation.** Service and support interventions must be matched to the unique and stage-specific needs of each client as they evolve through the stages of recovery. In the BHRM model, both assessment and evaluation become continual activities rather than activities that mark the beginning and conclusion of a service episode.

United Nation Office of Drugs and Crime (UNODC) (2008), *Sustained Recovery Management Good Practice*

The principles share elements contained in disease management approaches for other chronic diseases such as diabetes, hypertension, and chronic asthma. They include the use of evidence-based medicine, clinical guidelines, patient education and empowerment, and ongoing monitoring and support. Further, the sustained recovery management approach goes beyond these common factors of disease management by including the community in recovery support and by placing greater emphasis on individual empowerment and peer supports.[7]

At a service level, the diagram below describes the significant number of factors that influence recovery.

[6] United Nation Office of Drugs and Crime (UNODC) (2008), *Sustained Recovery Management Good Practice*
[7] United Nation Office of Drugs and Crime (UNODC) (2008), *Sustained Recovery Management Good Practice*



Miller et al. simply put to us that "To attract, engage and retain people more successfully with addiction-related problems, addiction services and the interventions they use need to be more welcoming, attractive and focused broadly towards their clients' actual needs".[8]

[8] Miller, P. G., & Miller, W. R (2009), *What should we be aiming for in the treatment of addiction?*

Case study – Debbie's* story

Debbie is a single mum of 3 small children. Years of family violence and a history of childhood trauma has taken its toll on Debbie. "I started using drugs when I was about 13 to help me deal with the trauma in my past life, but things really got out of hand when I met my partner. He used ice on a regular basis and introduced it to me. When he was using, he would get violent towards me and the kids and eventually Child Protection (CP) intervened and took my kids away."

Debbie came to The Salvation Army's AOD program for help, desperate to get away from the violence and to get her kids back. "The program has been wonderful for me, I was such a mess, I couldn't focus on anything other than my problems, I really could not have done an intensive structured program like residential treatment at that time. They linked me to their parenting program, which worked with me to help me fulfil the CP requirements and helped me with supervised child access meetings. The Salvation Army found an apartment for me where I was safe from my partner and I could easily access both the parenting program and the AOD program."

"The AOD program offered me a day program which was flexible and meant that I could attend groups and meetings at times that suited me. This meant I could also continue to work with the parenting programs, CP and my psychologist while still doing the program."

With the support of the local Salvation Army programs and the chaplain located at the AOD program, Debbie thrived, and CP eventually approved overnight stays for her children. "I needed to keep working in the program, but my kids were my priority. The AOD day program provided me with the flexibility and support I needed to get my life back together, to focus on my kids.' When asked about the most valuable parts of the program, Debbie replied "the community support is phenomenal, we all go through the recovery together. The program has helped me be accountable for what I do and to move forward and get better. But the key was having structure in my life, having a place where I could go and get support when I needed it. The program helped me develop routine and structure which I've learned is really important for kids."

Debbie has completed the day program and is engaging in the aftercare program 3 days per week. She also meets with the chaplain weekly for coffee and support. CP have increased her unsupervised access and she is hoping to regain full custody of her children in the next few months.

** Name has been changed*

A stepped care approach

Informed by our extensive practice experience and opportunities for service development and review, The Salvation Army has found that stepped care offers a flexible way in which to deliver services that can meet a wide variety of need at point of access. It enables better and more sustainable outcomes for communities that are significantly more cost effective for providers and funders alike. This in turn creates an environment where greater access to treatment is enabled, allowing for better engagement of more people and over-all increases in public health and criminal justice outcomes. Most significantly, the approach offers rapid and sustained access to treatment services for those who need them, increasing the systems' capacity in terms of throughput, but also increasing successful outcomes for those with whom we engage.

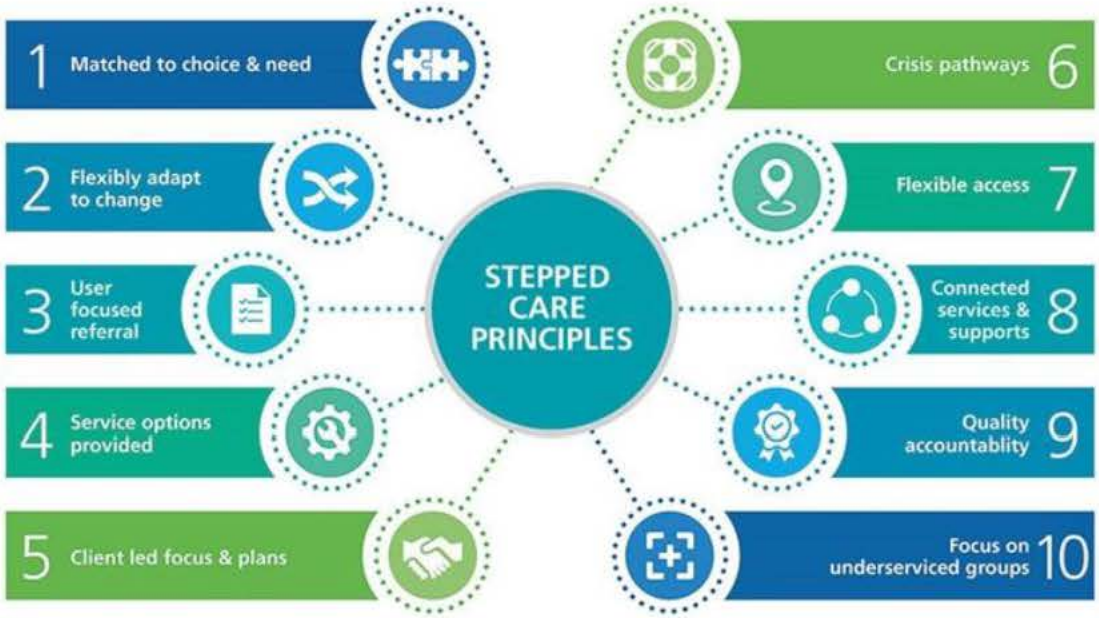
The need and efficacy for a stepped care approach in AOD treatment systems are recognised globally and in jurisdictions around Australia as demonstrated through the following quotes:

- "Stepped care treatment models offer an alternative way to manage existing treatment resources more efficiently (e.g. time) and are flexibly able to incorporate new evidence directly into practice as it comes available. Stepped care approaches to treatment have been tested in several different settings, including depression, anxiety, alcohol problems, smoking, heroin dependency and recently for people experiencing mental health and substance use co-morbidity".[9]
- "The department supports a stepped care approach…."[10]
- "Stepped Care is a central platform to guide PHNs in their role in planning, commissioning and coordinating primary mental healthcare services".[11]
- "People who use methamphetamine may present a complex array of needs. The stepped care model can encompass a range of treatment and prevention methods that can be tailored to meet the specific needs of the client at that particular time. Focusing the interventions and treatment on the needs of the clients can improve client engagement and retention".[12]
- "Stepped care is seen as essential to improving service integration and navigation through the system and to optimising the use of available resources".[13]

[9]NSW Health Drug and Alcohol Psychosocial intervention (2008) *Professional Practice Guidelines* pg.15. 2008)
[10] Victorian Government, Department of Health and Human Services (2018), *Alcohol and other drug program guidelines*
[11] Australian Government, Department of Health (2019), *PHN Primary Mental Health Care Flexible Funding Pool Programme Guidance*
[12] F Kay-Lambkin (2008), *The stepped care model: a useful intervention strategy for people who use methamphetamine – Fact Sheet* https://cracksintheice.org.au/doc/stepped-care-model.pdf. 2008
[13] Australian Government, Department of the Prime Minister (2017)

- "Stepped care models aim at matching treatment intensity to defined patient characteristics in a systematic way, thereby avoiding misplacements and making best use of available treatment resources at the same time. In principle, treatment planning for new patients starts with the least intensive care, progressing to more intensive regimes for non-responders. Such models have been introduced in psychiatry and in other medical fields".[14]

The basic tenants of a stepped care approach are described below:



Central and Eastern Sydney PHN (2019)

In practice, this approach provides staged and flexible access to wide-ranging services designed to meet and work with presenting need. People can move up and down in intensity and select the content of their treatment from a menu of options, allowing a strengths-based approach to holistic treatment provision. Participants build their own treatment packages to suit their specific needs. This affords a different sort of relationship between the service provider and the service consumer. Emphasis is placed on supporting the individual to achieve recovery, whatever that means to them. Gone are the days of services assessing people to see if they meet the threshold of service entry. Service will no longer assess for access, rather they will assess for presenting need and collaboratively develop treatment packages in concert with the participant to facilitate appropriate access to the treatment system.

[14] Uchtenhagen A. (2021), *Stepped Care Models in Addiction Treatment*

Treatment stages – experience from the United Kingdom

The United Kingdom's models of care (2006) describes the components of a basic tiered/stepped approach to treatment and what each stage should contain.

Tier 1 drug interventions:

- Drug treatment screening and assessment
- Referral to specialised drug treatment
- Drug advice and information
- Partnership or shared care - working with specialised drug treatment services to provide specific interventions

Tier 2 interventions that should be commissioned in each local area include:

- Triage assessment and referral for structured drug treatment
- Drug interventions which attract and motivate drug users into local treatment systems, including engagement with priority groups, such as pregnant women, offenders and stimulant users
- Interventions to reduce harm and risk due to BBVs and other infections for active drug users, including dedicated needle exchanges and the support and co-ordination of pharmacy-based needle exchanges
- Interventions to minimise the risk of overdose and diversion of prescribed drugs
- Brief psychosocial interventions for drug and alcohol use (including for stimulants and cannabis problems if it does not require structured treatment)
- Brief interventions for specific target groups including high-risk and other priority groups
- Drug-related support for clients seeking abstinence
- Drug-related aftercare support for those who have left care, including planned, structured treatment
- Liaison and support for generic providers of Tier 1 interventions
- Outreach services to engage clients into treatment and to re-engage people who have dropped out of treatment
- A range of the above interventions for drug-misusing offenders.

Tier 3 interventions that should be commissioned in each local area include:

- Comprehensive drug misuse assessment
- Care planning, co-ordination and review for all in structured treatment, often with regular case work sessions as standard practice
- Community care assessment and case management for drug misusers
- Harm reduction activities as integral to care-planned treatment
- A range of prescribing interventions
- A range of structured, evidence-based psychosocial interventions to assist individuals to make changes in drug and alcohol using behaviour

- Structured day programs and care-planned day care (e.g. interventions targeting specific groups)
- Liaison services for acute medical and psychiatric health services (e.g. pregnancy, mental health and hepatitis services)
- Liaison services for social care services (e.g. child protection and community care teams, housing, homelessness)
- A range of the above interventions for drug-using offenders.

Tier 4 interventions that should be commissioned to meet local area needs include:

- Inpatient specialist drug and alcohol assessment, stabilisation, and detoxification/assisted withdrawal services
- A range of drug and alcohol residential rehabilitation units to suit the needs of different service users
- A range of drug halfway houses or supportive accommodation for drug misusers
- Residential drug and alcohol crisis intervention units (in larger urban areas)
- Inpatient detoxification/assisted withdrawal provision, directly attached to residential rehabilitation units for suitable individuals
- Provision for special groups for which a need is identified (e.g. for drug-using pregnant women, drug users with liver problems, drugs users with severe and enduring mental illness). These interventions may require joint initiatives between specialised drug services and other specialist inpatient units
- A range of the above interventions for drug-misusing offenders.

The UK systems has evolved on from models of care in the way that services in the four tiers are defined. They employ a "phased and layered' approach to treatment across four stages of treatment; assessment, engagement, behaviour change, and early recovery. Services are commissioned to deliver across all four elements with seamless pathways allowing people to move between phases as their treatment need requires. The layers describe standard and enhanced care depending upon the individual circumstances to enable a sliding scale of intensity and intervention at each stage.[15]

[15] UK Department of Health (2017) *Clinical Guidelines on Drug Misuse and Dependence Update 2017*

Case study – Carl's* story

Carl is 38 years old, has spent over 6 years in prison, is homeless and has a diagnosis of depression, ADHD and symptoms indicative of PTSD. Carl's substance use included ice, benzodiazepines, alcohol and cannabis.

Carl has had a few attempts at residential treatment, his longest stint lasted just 4 days. Carl attributes this to a few reasons. "Being in prison changes you, you need to be the top dog, or you get beaten down. I guess my behaviour is a bit anti-social. I just can't cope with rules and being locked in. I don't like other people knowing my business and I have trouble getting on with people. I can't control my anger and I just snap."

When Carl re-engaged after being referred to The Salvation Army's AOD program by the local Salvation Army Corps Officer (church minister), he wasn't sure that he could do the program having had many unsuccessful attempts in the past.

"My worker was great - she helped me develop a program that suited me, I got to choose what my goals were and work on them. I got to keep working with the Corps and find a house. I just did one-on-one appointments for a while until I got used to the program, then I got referred to the AOD program psychologist who helped me do a plan to manage my mental health and my anger. When I was ready, I started doing a couple of groups a week to get used to being with other people. It's been hard but the community and the staff have been awesome. I feel that they 'get me' and that they don't judge me. If I don't come to a group someone always checks in and asks how I'm doing. When I started, I wasn't in a good way, but now I'm looking forward to tomorrow and feel positive about the future for the first time in years."

Carl described enjoying the outpatient style of treatment stating that "residential is just not me, a lot of people don't suit that program."

** Name has been changed*

Recommendations

- That the ACT redesign it's AOD Service System to align with the evidence base for the provision for a stepped care approach to AOD treatment
- That links with the broader primary health and community service system be implicit in the new service delivery model, creating shared accountability for outcomes
- That the ACT work with the AOD Sector to develop a funding model which supports the provision of a stepped care approach to AOD treatment
- That evaluation of the efficacy and efficiency of the new service system model be built into the funding model.

Summary

This submission brings together the theory and evidence from both at home and abroad to provide a sound resource for the redevelopment of the AOD treatment system in the ACT.

Informed by the concepts outlined (solid pathways, appropriate service provision at each stage, strong evidence base, co-production, asset-based community development, theories of change, a recovery management framework, participant involvement, strong links to public health and social support systems), the development of a stepped care system within AOD services in the ACT would:

- Make better use of resources already available in the community
- Eradicate or significantly reduce waiting lists
- Provide better, more sustained, more accessible and cost-effective outcomes for communities
- Recognise that residential treatment is not the answer for all
- Enable people to recover in-situ with better long-term outcomes
- See costs reduced and treatment numbers go up
- Provide greater flexibility in what we deliver
- Deliver effective treatment pathways that adapt to need
- Address the stigma associated with AOD use.

A stepped care system within AOD services would lead to improved treatment outcomes. Treatment and support would become more accessible for larger numbers of people in a cost-effective way. It would enable the coordination and orientation of services to deliver evidence-based practice that compliments the work of public health and criminal justice, working in concert to ensure sustained outcomes that improve overall public health and well-being across the community. This approach allows for the mobilisation of the concerned community, affording them the ability to positively affect their own lives and the lives of others while improving their own community.

Case Study – Characteristics of reorienting Salvation Army AOD services in Tasmania

Over the last few years, the Salvation Army has been using its Model of Care as the basis to deliver services in Tasmania. The intention is to reduce waiting times and cost, and to increase access to treatment through dropping barriers. Barriers can be wide-ranging and include travel, the need to care for children, employment, time taken to engage and stigma of attending (amongst others).

There are no waiting lists, clients are engaged at assessment, and through a collaborative triage process placed in appropriate treatment. Treatment is delivered in both a community and residential setting, offering a sliding scale of intensity depending upon need. Residential programs, which are more costly and time consuming are protected. Stays are shortened and community services are used to engage people for the length of time they require to achieve their recovery. Shorter, more intensive residential stays are provided, along with comprehensive community group-work programs, counselling, recovery planning, outreach, engagement services, care-coordination, risk management and access to education, training and employment and after care services.

Services are embedded in the local community and run from a variety of locations with flexible opening times, taking treatment to the areas and communities in which people live. This works to drop barriers to engagement, increase community stakeholder involvement, consumer participation and decrease dropouts. It enables services to engage people where they live and help them to get well in-situ, which in turn helps to create better outcomes that are maintained and sustainable in terms of cost effectiveness.

Most people who engage do not need residential services to succeed in achieving recovery. The statistics bear out the fact that treatment works well when it is localised and embedded in community. A wide variety of treatment options helps to prevent discharge from services, which in turn provides better public health and criminal justice outcomes.

Data indicators - AOD services Salvation Army Tasmania

- 37% of our total income pays for community-based services, with 92% of clients receiving community-based (non-residential) services in 2020/21. This equated to 821 individuals in community-based services and 71 in residential.
- In 2019/20, 87% of clients were engaged in community-based services (totaling 1148 individuals), while we saw 168 in a residential setting.
- Residential beds cost on average $70k per annum (based on actual cost and number of beds). Community-based clients cost on average $1310 per annum (based on actual cost and number of clients in 2019/20 (pre-covid)). This cost increased to $1832 in FY 20/21 due to COVID.
- Whilst the numbers of clients in community-based care are significantly higher than those in residential settings, the treatment outcomes are relatively consistent.
- It is worth noting that clients in residential treatment are not participating in community living and are not as influenced by external pressures as those in community settings.
- Improvements in psychological wellbeing were reported by 64% of community-based clients as opposed to 40 % in a residential setting. The WHOQAL (a quality of life indicator) was consistent at 60% improvement across both settings. Drop-out rates were slightly higher in community at 34% as opposed to 21% in a residential setting. The treatment goals achieved in both settings were comparable at around the 80% mark.