REFORM AGENDA FOR THE ALCOHOL AND OTHER DRUGS SECTOR IN TASMANIA

NOVEMBER 2020

MENTAL HEALTH, ALCOHOL AND DRUG DIRECTORATE
DEPARTMENT OF HEALTH

Tasmanian Government

Reform Agenda for the Alcohol and Other Drugs Sector in Tasmania

For further information please contact:

Mental Health, Alcohol and Drug Directorate
Department of Health
GPO Box 125
Hobart Tasmania 7001
Telephone: + 61 3 6166 0774

Email: director.mhadd@health.tas.gov.au
Website: http://www.dhhs.tas.gov.au

www.dhhs.tas.gov.au/mentalhealth/alcohol_and_drug/reform_agenda_for_ads

Acknowledgements

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

The Directorate also acknowledges the work of the AOD Reform Agenda Drafting Working Group comprising membership from the Directorate and Government Relations and Strategic Policy of the Department of Health, Alcohol and Drug Services of the Tasmanian Health Service, Primary Health Tasmania and the Alcohol, Tobacco and Other Drugs Council Tasmania.

TABLE OF CONTENTS

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MESSAGE FROM THE MINISTER

The Tasmanian Government is committed to reducing the harms associated with the use of alcohol, tobacco and other drugs.

Since coming to Government, we reviewed the use of alcohol, tobacco and other drugs particularly in the North West which led to the engagement of Siggins Miller Consultants who undertook an independent analysis of the current AOD service system, with its final report being released in 2018. Those reviews have helped inform this Reform Agenda for the Alcohol and Other Drugs Sector in Tasmania (Reform Agenda).

We have also invested more into alcohol and other drug services in Tasmania than ever before. This included additional funding to establish a new 12-bed residential rehabilitation facility in Ulverstone managed by the Salvation Army Tasmania; and 31 additional residential rehabilitation beds across the State.

However, more than ever as we come to terms with the impact of the global pandemic Coronavirus, we recognise that more needs to be done to ensure access to appropriate, timely, effective and quality alcohol, tobacco and other drug services, supports and treatments. This should be regardless of whether that is through General Practitioners, through our public or private hospitals or through our specialist government and non-government alcohol and drug services.

Through the Reform Agenda we have developed the framework that aims to do just that - working toward a better integrated and coordinated service system from brief interventions through to acute service responses.

The Reform Agenda establishes a 10-year vision. It includes actions that are identified to start in the first few years from 2021-2022; and actions to be undertaken from 2023 onwards, including ongoing monitoring and evaluation.

The Government has committed $4.9 million over two years to commence the implementation of the Reform Agenda.

One of the first jobs under the oversight of the Mental Health, Alcohol and Drug Directorate of the Department of Health will be the development of an Implementation Plan based on the prioritisation of the actions in the Reform Agenda and the priority projects funded by the Government in the 2020-21 budget. There is an expectation that this will also work closely with the Tasmanian Mental Health Reform Program.

I would like to acknowledge and thank the many consumers of services, family and carers and service providers who engaged initially with Siggins Miller Consultants in their review work and with the Mental Health, Alcohol and Drug Directorate in providing input and feedback to the drafting of the Reform Agenda. That feedback was invaluable in finalising this Reform Agenda. Ongoing engagement and feedback in developing the Implementation Plan and in actual implementation will be equally important.

I look forward to working closely with the alcohol and other drug sector and Tasmanians in need to increase awareness of alcohol and other drug use issues, to reduce stigma and to ensure responsive services.

Jeremy Rockliff MP

Minister for Mental Health and Wellbeing

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OVERVIEW

The aim of the Reform Agenda for the Alcohol and other Drugs Sector in Tasmania (Reform Agenda) is to ensure Tasmanians affected by alcohol, tobacco and other drugs 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.

The objectives are to:

- Better integrate all treatment service system components to achieve better outcomes for all clients/consumers;
- Deliver a seamless, easy to navigate, effective and integrated alcohol and other drug (AOD) service system;
- Provide a range of support and treatment options for client/consumers and their families/carers and significant others;
- Enhance and ensure integration of government and non-government AOD specialist services; and
- Enhance and ensure integration of AOD specialist services with non-AOD-specialist services, especially primary health care where appropriate and possible

Integration in the context of the Reform Agenda is defined as better coordination, collaboration and communication between the components of the current service system. It refers to continuity and coordination of care across a continuum including stepped care, and the adoption of a client/consumer centred approach. This may evolve as the Reform Agenda, the Reform Directions, and the key actions are implemented.

A phased approach to implementation will be taken over the next ten years. Considerable work is identified to be actioned in the initial five to six years, but a ten-year timeframe allows for sequencing and any time delays that may occur, as well as a period of monitoring after implementation.

Implementation will build on the key strengths of the current government and non-government specialist AOD sector and work already underway, to build a more integrated and responsive system that better meets the needs of clients/consumers and their families and significant others.

Review work undertaken over the past two years identified that the individual service elements that should exist in Tasmanian government and non-government AOD specialist services are present, and individual treatment services and programs generally meet expectations. However, the reviews also highlighted that the current AOD service system has become difficult to navigate, confusing (for client/consumers and providers), and disjointed.

The Reform Agenda recognises the often-complex nature of AOD use and the range of co-occurring health, social and economic issues people with a severe AOD use issue may experience (see Appendix 1).

The intent of the Reform Agenda is to transform the current service system to an integrated system where clients/consumers receive services along a continuum of care based on their level of need. It identifies eight (8) Reform Directions each of which have a number of key actions.

The eight (8) Reform Directions are:

Reform Direction 1: A client/consumer-centred approach across the service system

Reform Direction 2: An integrated service system

Reform Direction 3: Developing service specifications and program guidelines

Reform Direction 4: Responding to specific population groups

Reform Direction 5: Maintaining a focus on promotion, prevention and early intervention

Reform Direction 6: Reducing stigma and discrimination

Reform Direction 7: Improving quality and safety

Reform Direction 8: Supporting and developing the workforce

An Implementation Steering Committee will be established. Its first task will be to agree on an Implementation Plan based on the prioritisation of the identified actions. The development of the Implementation Plan will also consider the processes required for implementation as well as areas of responsibility. It will also identify where reconfiguration of existing services may result in better integration and continuum of care for clients/consumers, and where additional funding and staffing resources may be required to better meet the needs of the Tasmanian community.

BACKGROUND

The Reform Agenda has been informed by a range of reviews, most notably the 2017 work of Siggins Miller Consultants (Siggins Miller). Following a 2014 review of drug use and service responses in North West Tasmania Siggins Miller was engaged in 2017 to undertake an independent analysis of the current AOD service system.

The Final Report (Siggins Miller 2017) was released on 2 May 2018 and is available on the Alcohol and Drug Services website by clicking here.

In 2016 Primary Health Tasmania developed the Commissioning Intentions Document (Primary Health Tasmania, 2016), as part of its Federal funding commissioning. To inform its development, Primary Health Tasmania 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 Agenda Plan 2008/09 to 2012/13 (FSD) and a 2014 Tasmanian Audit Office compliance audit of the FSD.

Those pieces of work identified the individual service elements that should exist are present and that individual treatment services and programs generally meet expectations. However, they also highlighted that the current service system 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 client/consumer-friendly and 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 North West regions, as well as travel required between different services; and
- a lack of integration and communication between different services, including perceived lack of communication between government and non-government services.

A consultation draft of the Reform Agenda for Alcohol and Drug Services in Tasmania was released in

September 2018. Targeted consultations were also held in October and November 2018. Feedback through those processes has been considered in finalisation of this Reform Agenda, the Reform Directions and their prioritisation.

PURPOSE OF THIS DOCUMENT

The purpose of the Reform Agenda is to provide the overarching framework of Reform Directions and activities that will be undertaken in a phased approach to deliver the right mix and level of services to meet the needs of Tasmanians. Its intent is to transform the current service system to an integrated system where clients/consumers receive services that are appropriate to their level of need at time and place of presentation.

The Reform Agenda together with its Implementation Plan will also be used to guide the future planning, funding and delivery of public-funded AOD services, and to assist the Tasmanian Department of Health, the Tasmanian Health Service and Primary Health Tasmania in the commissioning, funding and delivery of AOD services in Tasmania.

Scope

The focus of the Reform Agenda and the Reform Directions is on the client/consumer journey through the system from screening and brief interventions to relapse prevention and recovery. It also acknowledges the importance of whole of population health promotion and prevention activities as integral to preventing and/or delaying the start of AOD use.

It identifies and describes the range of treatments and associated interventions that make up the AOD treatment service system including those provided through specialist government and non-government AOD services, primary health care including General Practitioners (GPs) and private sector providers, in the context of national and state strategic policy initiatives and priorities.

The Reform Agenda and the Implementation Plan will provide:

- a better understanding of what constitutes AOD treatment services in Tasmania for the Department of Health, Tasmanian Health Service, Primary Health Tasmania, specialist government and non-government AOD services, clients/consumers and their families/carers and significant others;
- a framework to provide clarity for clients/consumers and their families and significant others on where and how to access services;
- the framework to facilitate role clarity, planning and purchasing of government funded AOD services in Tasmania;
- an understanding for the broader Tasmanian community of what is or is not AOD treatment and what can be expected of specialist government and non-government AOD services and primary health services;
- a framework to better inform coordination between the AOD treatment service system and other overlapping services and sectors such as mental health services, disability services, acute services, emergency services, children and youth services, housing, justice, education and employment providers;
- a framework to facilitate better communication between services providers and improve coordination and integration between the different components of the service system; and
- a priority action plan

The current service system

The Reform Agenda recognises that Tasmania's AOD service system is complex and involves many stakeholders and providers. This includes specialist government and non-government AOD services, primary health care including GPs and private sector providers. At the same time, the specialist government and non-government AOD service sector in Tasmania is small with many competing demands.

It is also one small part of a larger health system including such services as hospital and acute services, mental health services, disability services, emergency services, and children and youth services, as well as housing, justice, education and employment providers, but there is currently little to no coordination between services.

The Reform Agenda 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.

CONTEXT

The impacts of alcohol and other drugs use in Tasmania

The use of alcohol, tobacco and other drugs, including illicit drugs and misuse of 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 other social and economic harms arising from the costs to health, hospitals, law enforcement and justice systems, decreased productivity, reinforcement of marginalisation and disadvantage, family and domestic violence and child safety issues.

Other conditions often co-occur with AOD use and can impact availability of and access to services and treatment outcomes. Co-occurring conditions include, but are not limited to mental health disorders, physical health conditions (for example cirrhosis, hepatitis, heart disease, diabetes), chronic pain, intellectual and learning disabilities and/or cognitive impairment. Appendix 1 provides a summary of some co-occurring conditions and issues.

It is well known and acknowledged that only a small proportion of people who experience an AOD related problem will seek or access 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).

It is estimated that in Tasmania, 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). There are also self-help organisations such as Alcoholics Anonymous and Narcotics Anonymous.

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 currently receiving some form of AOD treatment in any one year (Siggins Miller, 2017).

In 2018-19 (AIHW, 2020) the National Minimum Data Set (a requirement of any publicly funded AOD treatment service) reported a total of 3 856 closed episodes of treatment were provided to 2 791 unique individuals by the Tasmanian government and non-government specialist AOD providers.

This demonstrates that the bulk of AOD treatments in Tasmania are provided through non-AOD specialist services.

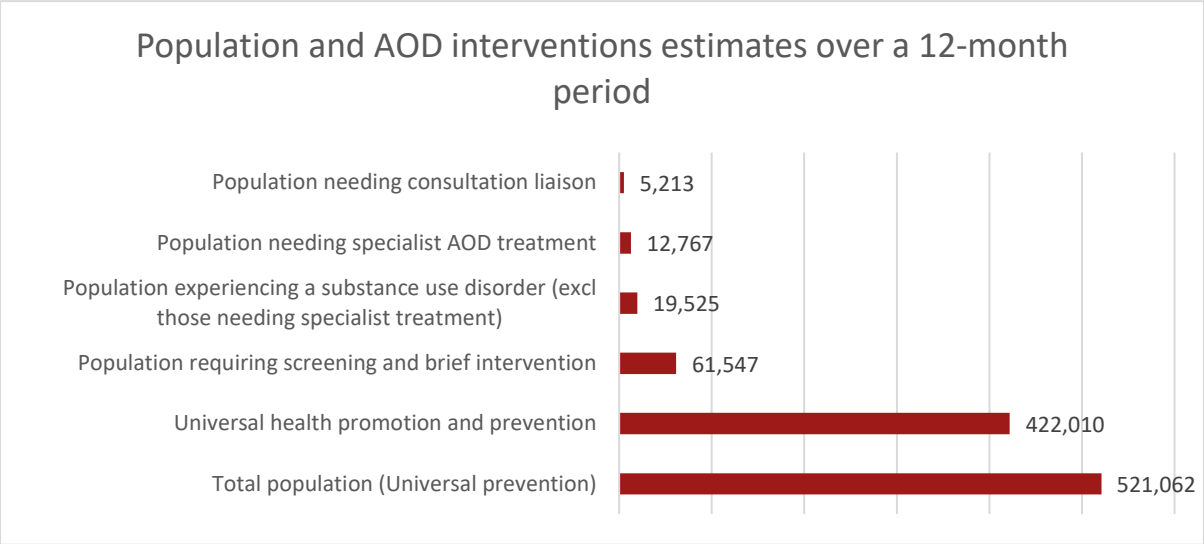
The national Drug and Alcohol Service Planning Model (DASP-M)[1] was used to calculate the type and quantity of services needed for the current and projected Tasmanian population. It found:

- Based on the estimated total population of Tasmania for year 2019, the proportion of the population who would experience an AOD use disorder over a 12-month period was estimated to be 6.2 per cent of the total population (estimated to be 32 292 individuals).
- Of those, 12 767 would require some form of treatment.
- DASP-M also estimated that a further 61 547 people (11.8 per cent of the population) should

[1] It is noted DASP-M is a population need estimation tool for planning purposes and is not a demand or funding model tool.

receive a screening and brief intervention[2].

- It also estimates that 5 213 people should be receiving a specialist consultation liaison service.



These estimates suggest there is a significant number of Tasmanians who may need some form of AOD treatment who for a variety of reasons are not currently receiving treatment.

[2] A screening and brief intervention (and referral to treatment) (SBIRT) can take place in a variety of settings, e.g. in hospital emergency departments and by GPs. Screening and brief interventions focus on the large number of people who may use AODs in a harmful way but may be unaware of the potential risks. A brief intervention may consist of 1 or more brief sessions focussed on education, raising awareness and insight of those harms and risks and enhancing motivation to behavioural change. A referral to treatment can be made if required.

NATIONAL AND STATE STRATEGIC POLICY CONTEXT

National Drug Strategy

The current National Drug Strategy 2017-2026 (NDS) is the Australian Government's overarching policy framework to inform responses to drug issues. It includes recognition of 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' capacity to respond to alcohol, tobacco and other drug issues.

Several sub-strategies sit under or are linked to the NDS:

- National Ice Action Strategy 2015
- National Quality Framework for Drug and Alcohol Treatment Services 2018
- National Framework for Alcohol, Tobacco and Other Drug Treatment 2019-2029
- National Alcohol Strategy 2019-2026
- National Fetal Alcohol Spectrum Disorder Strategic Action Plan 2018-2028
- 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 (under review)

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

In addition, there are also several linked strategies that impact the delivery of AOD interventions and treatment, including but not limited to:

- The Eighth National HIV Strategy 2018-2022
- The Fifth National Hepatitis C Strategy 2018-2022
- The Fifth National Mental Health and Suicide Prevention Plan 2018
- National Cultural Respect Framework

Tasmanian Drug Strategy

The Tasmanian Drug Strategy 2013-2018 (TDS) is Tasmania's overarching response to the use of alcohol, tobacco and other drugs. A new TDS 2021-2027 is currently being developed.

A number of sub-strategies sit under the TDS:

- Tasmanian Alcohol Action Framework (extended to 2019)
- 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 date 2013

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

There are other Tasmanian strategic policies and initiatives that link to or influence the AOD sector, including but not limited to:

- Rethink Mental Health: Better Mental Health and Wellbeing: *A long-term plan for mental*

health in Tasmania 2015-2025

- The Mental Health Integration Taskforce Report 2019 and Government Response
- The Tasmanian Mental Health Reform Program
- Tasmanian Suicide Prevention Strategy (2016-2020); Youth Suicide Prevention Plan for Tasmania; and Suicide Prevention Workforce Development and Training Plan for Tasmania
- Youth at Risk Strategy 2017
- Tasmanian Child and Youth Wellbeing Framework 2017
- Healthy Tasmania Five Year Strategic Plan 2017
- Breaking the Cycle – a Safer Community: Strategies for Improving Throughcare for Offenders 2016-2020

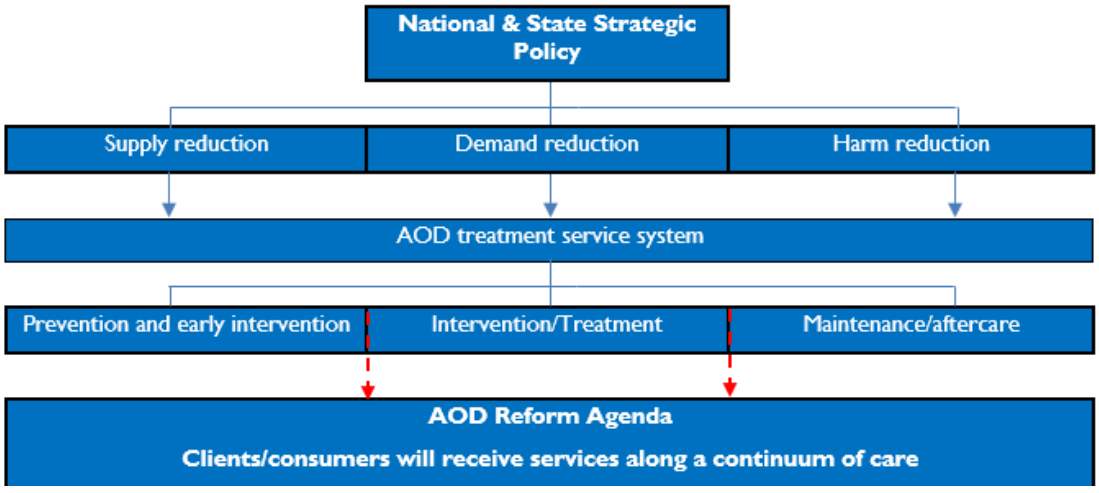
Supply, demand and harm reduction

Both the NDS and TDS support harm minimisation as their underlying concept. Harm minimisation is supported by actions under the three pillars of supply, demand and harm reduction:

- Supply reduction strategies aim to restrict availability and access to AODs to prevent or reduce AOD problems occurring, e.g. controlling and regulating the supply of and access to alcohol through liquor licensing laws and regulations, and the scheduling of licit and illicit drugs and pharmaceuticals.
- Demand reduction strategies aim to prevent uptake, delay onset of use or reduce consumption through prevention, early intervention and treatment measures, e.g. price and taxation levers on tobacco and alcohol, social marketing campaigns, assessment and brief interventions, the range of community-based treatment services, family support programs, post treatment support programs, and diversion programs.
- Harm reduction strategies aim to minimise the health, economic and social impacts of AOD use. They encourage lower risk behaviours and reduce preventable risk factors, e.g. Naloxone availability, sobering up facilities, Random Breath Testing, diversion from criminal justice system to treatment services, Hep B vaccination, and Needle Syringe Programs.

Alcohol and other drug interventions and treatment fall within the pillars of demand reduction and harm reduction. The Reform Agenda supports the harm reduction and demand reduction pillars of the NDS and TDS.

Figure 1: Strategic context of AOD treatment and the Reform Agenda



WHAT ARE AOD INTERVENTIONS AND TREATMENT?

There are many different settings where an AOD intervention or treatment occurs, including:

- at a general practice clinic or GP surgery;
- in a public or private hospital;
- through the internet (online) or over the telephone, or with videoconferencing;
- at home;
- at community pharmacies;
- in public places, e.g. community health centres, Neighbourhood Houses ('outreach');
- in correctional settings (at drug courts, or in prison);
- in a private facility;
- in services established for specific populations, such as Aboriginal Community Controlled Health Organisations; and
- in a dedicated specialist AOD treatment service, both inpatient and outpatient, e.g. inpatient withdrawal unit or residential rehabilitation service, or community-based non-residential services.

It should not matter where or when an individual enters the system. Evidence informed drug treatment services include screening, assessment, opportunistic and brief interventions for individuals at risk of harm, and assessment with tailored, intensive treatment and after care/relapse prevention and recovery tailored to individual need. Generally, levels of service and types of treatment that can be delivered in different settings along a continuum of care which includes stepped care.

In a stepped care approach, the style and content of treatment is matched to the intervention intensity that most suits the current needs of the client. This is dynamic and will be based on many factors including clinician assessment, client/consumer identified goals and needs, and evidence of effectiveness. An individual does not generally have to start at the lowest, least intensive level of intervention to progress to the next 'step'. Rather, they enter the system and have their service level aligned to their individual requirements.

In addition, the differing needs of some population groups identified at greater risk of experiencing AOD related harm or with specific needs also require consideration. These include children and young people including those children of parents who have experienced AOD-related harm, Aboriginal and Torres Strait Islander people, women, elderly people, people from culturally and linguistically diverse (CALD) backgrounds, LGBTQI, people in or leaving the justice system, and people who are homeless or at risk of homelessness.

REFORM DIRECTIONS FOR SERVICES THAT PROVIDE ALCOHOL AND OTHER DRUG PROGRAMS AND TREATMENTS

The identified Reform Directions are underpinned by the premise that clients/consumers will receive appropriate services along a continuum based on their individual needs which can vary across time.

As noted earlier, the majority of AOD treatment episodes are provided through non AOD-specialist services, particularly through GPs and public and private hospitals, as well as through other health and social welfare services. As such, they are a vital component of the AOD treatment service system and close collaboration with those other services is an important factor in determining new directions for the government and non-government AOD specialist services.

The new directions for AOD services and the Reform Directions below are mainly directed at the government and non-government AOD specialist services. The following specific types of support and treatment are required to be provided within a continuum of care.

- Withdrawal management – inpatient, ambulatory/home based, and community residential
- Residential rehabilitation – short term, long term and day programs
- Relapse prevention, recovery and maintenance
- Opioid Substitution Treatment
- Psychosocial interventions/counselling supports
- Care coordination/case management – either in combination or as stand-alone services
- Consultation Liaison
- Family support
- Brief Interventions
- Harm reduction programs, eg Needle and Syringe programs, and as component of all treatment provision

Our aim

The aim of the Reform Agenda is to ensure Tasmanians affected by alcohol, tobacco and other drugs 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.

Our objectives

The objectives of the Reform Agenda are to:

- Better integrate all treatment service system components to achieve better outcomes for all clients/consumers;
- Deliver a seamless, easy to navigate, effective and integrated AOD service system;
- Provide a range of support and treatment options for client/consumers and their families/carers and significant others;

- Enhance and ensure integration of government and non-government AOD specialist services; and
- Enhance and ensure integration of AOD specialist services with non-AOD-specialist services, especially primary health care where appropriate and possible

Our 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:

- operate within a harm minimisation framework of supply, demand and harm reduction;
- be evidence-informed and in line with contemporary best practice;
- be client/consumer focused and person-centred, and therefore 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 chronic relapsing and remitting nature of AOD use for people with complex issues and/or severe substance use issues;
- 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;
- 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 with other sections of the health and human services system and other service sectors as appropriate;
- be underpinned by common approaches to assessment, referral, 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 workforce with the necessary capacity, skills, knowledge, qualifications and experience to respond to the diverse needs of the client/consumer group;
- be committed to continuous quality improvement; and
- be designed for sustainability and demonstrate the most effective combination of cost and quality to meet client/consumer needs (value for money).

REFORM DIRECTIONS

The Reform Directions take into consideration the main challenges identified through the work of both Siggins Miller and Primary Health Tasmania, through previous reform processes and through consultations undertaken on the draft Reform Agenda.

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 that some have been identified to be actioned earlier than others.

A key component of the Reform Agenda is to work closely with key stakeholders to support its implementation, the Reform Directions and identified actions.

Reform Direction 1: A client/consumer-centred approach across the service system

Rationale:

Clients/consumers often present with complex life issues.

During consultations, clients/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 particularly for relapse prevention. 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.

Working more closely with family and significant others was also a recurring theme with some clients/consumers, including increasing AOD health literacy for clients/consumers and their family and significant others.

Reform Goals:

- Embed a client/consumer-focused approach rather than a provider or organisational focus
- Increase the AOD health and treatment literacy of the client/consumer and their family/carer/significant other
- Increase the capacity of AOD clients/consumers to have a say in their own treatment within the parameters of clinically safe and evidence-informed treatment as defined with the service specifications and program guidelines to be developed under Reform Direction 3
- Increase the capacity of AOD clients/consumers and family/carers to have a say in the planning, implementation, delivery and evaluation of AOD services in Tasmania
- Ensure client/consumer meaningful input into service design

Key Actions:

1.1 Establish a funded AOD consumer organisation in Tasmania

1.2 Develop and implement a client/consumer participation framework for Tasmania

1.3 Increase advocacy support for people affected by AOD use issues

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

1.5 Establish a client/consumer input process into the work to be undertaken under Reform Directions 2 and 3

Support for an AOD consumer representative body

The Tasmanian Government's 2020-21 budget has provided $124 000 in year 2 to support an AOD Consumer representative body through the Alcohol, Tobacco and Other Drug Council Tasmania (ATDC).

This investment will allow for a Project Officer position to support AOD consumer representation across Tasmania in 2021-22 and enable ongoing development of a consumer representative network across Tasmania. The aim will be to build capacity amongst consumers and the consumer networks including training; and ensure more developmental work and policies and guidelines to support a stand-alone sustainable consumer representative organisation in the future.

The ATDC finalised the Options Paper - *How do we add the missing piece? An ATOD Consumer Representative Organisation for Tasmania* in August 2019. It provides a summary of four possible options for the establishment of a Tasmanian consumer representative organisation, outlining the benefits, limitations, general considerations and rationale for each and the preferred approach.

The intention of this project is that within three years, a sustainable, funded and valued consumer representation organisation will exist for the AOD sector in Tasmania that can provide systemic representation of people with lived experience. In doing this, the quality and outcomes of services will be enhanced for clients/consumers and service providers as will the health and human rights of clients/consumers.

This project has built on moves in recent years to shift to a model of consumer engagement and representation for the AOD sector that will help inform treatment provision, provide input at an organisation level on how services are delivered, and provide advice to sector strategic policy provision. This project will help address the difficulties reported by consumers in navigating the service system as well as better support and advocacy when receiving services. It will also help reduce the stigma and discrimination that can be experienced when accessing services, for example by providing information and training from people with lived experience.

Reform Direction 2: An integrated service system

Rationale:

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

From the literature on the effectiveness of treatment modalities it is clear that 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 for clients/consumers with complex issues or severe substance use issues. Completion of treatment and assistance by ongoing contact, care and support are required to maintain gains from treatment and reduce risk of relapse.

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 AOD specialist services.

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

- between withdrawal management and residential rehabilitation (and other AOD services);
- 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 a non-diagnosed mental health illness and 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 in and being released from prison.

Integration in the context of the Reform Agenda is defined as better coordination, collaboration and communication between the components of the current service system. It refers to continuity and coordination of care along a continuum including stepped care, and the adoption of a client/consumer centred approach.

Reform Goals:

- Improve the client/consumer journey
- Improve the integration and collaboration 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
- Embed a continuum of care model including stepped care approaches into all aspects of clinical practice across government and non-government AOD services, prioritised upon highest level of assessed clinical need and risk
- Improve access to a range of evidence-informed specialist AOD treatment services
- Prioritise access, and level and intensity of ongoing care based on assessment, severity of need, and individual client responses and outcomes

- Work towards a system of fully integrated AOD care and support across Tasmania

Case Study: PHT Health Pathways

Tasmanian HealthPathways (THP) is an online portal designed to be used by general practice at the point of care. It aims to guide best-practice assessment and management of common medical conditions, including how to refer patients to local specialists and services in the most timely and efficient way.

THP commenced in October 2013 as part of a dynamic collaboration between the then Tasmania Medicare Local (now Primary Health Tasmania), the three Tasmanian Health Organisations (now Tasmanian Health Service) and Department of Health and Human Services (now Department of Health).

THP is based on the HealthPathways approach developed by the Canterbury District Health Board of New Zealand, which is now being successfully used in 43 Primary Health Networks and District Health Boards in New Zealand, Australia and the United Kingdom.

Primary Health Tasmania, in collaboration with Tasmanian health professionals (GPs, hospital specialists, nurses and allied health professionals) develop the Pathways, ensuring they suit the local setting and meet local needs.

Key Actions:

2.1 Define the required components, appropriate roles and scope of the specialist public Alcohol and Drug Service, the community sector AOD services, primary health care and the private sector within an integrated service system and using a continuum of care model consistent with the work under 3.1

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

2.3 Map and reconfigure current services and funding arrangements as required to align with and match 2.1 and 2.2 above and 3.1 below

2.4 Develop a co-commissioning framework for AOD services in Tasmania

2.5 Work within Statewide Mental Health Services and with the AOD and Mental Health (MH) service sectors to ensure the needs of clients/consumers with MH and AOD comorbidity are fully considered and addressed under the Reform Agenda and the Tasmanian Mental Health Reform Program, for example new programs and development of Models of Care will include clients/consumers with dual diagnosis and will include specific AOD/MH dual diagnosis positions where relevant

Detox@Home

The Tasmanian Government's 2020-21 budget has provided $1.8 million over two (2) years for a trial of a new Detox in the Home program.

The Detox@Home program will be trialled in the south initially and complement the existing medically supervised inpatient withdrawal management service and the ambulatory withdrawal service operated by the Salvation Army. It will provide supervised withdrawal management support services for people in their home and will operate as a 'virtual unit' of the Inpatient Withdrawal Management Unit.

Reform Direction 3: Developing service specifications and program guidelines

Rationale:

This Reform Direction is strongly linked to Reform Direction 2. 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:

- the need for more aftercare services particularly following acute episodes, and post rehabilitation;
- the need for greater support for those on a 'wait' list, or a step-down service;
- lack of outpatient treatment options;
- lack of appropriate options following detoxification including safe and secure housing options;
- the need for more responsiveness and flexibility of AOD services, i.e. opening hours, treatment duration; and
- the 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 noted the need to establish seamless client/consumer pathways from withdrawal management to other services, and mutually agreed processes and protocols to support those client pathways, as part of a fully integrated system. It should be noted that withdrawal management is not a form of treatment or rehabilitation but part of a client/consumer's preparation for ongoing treatment.

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-M).

Reform Goals:

- Ensure all clients/consumers receive seamless, consistent and evidence-informed treatment services based on their individual needs
- Increase the effectiveness of treatment and improve treatment outcomes across the range of specialist AOD treatment services
- 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:

3.1 Develop an overarching Service Delivery Framework for Tasmania that describes AOD treatment and provides the overarching specifications for all funded government and non-government specialist AOD service providers

3.2 Develop a series of Treatment Models and Guidelines documents including treatment service specifications and program guidelines, all incorporating aftercare and relapse prevention, for:

a) Residential Rehabilitation incorporating both short and longer-term stays, and day programs;

b) Withdrawal Management incorporating medically supervised inpatient withdrawal, community residential and home-based withdrawal services;

c) Care coordination and case management;

d) Screening, Brief Intervention and Referral to Treatment; and

e) Opioid Pharmacotherapy Program,

3.2 Map and reconfigure current funded services as required to align with the Service Delivery Framework consistent with Reform Direction 3.1, and with Reform Directions 2.1, 2.2 and 2.3

3.3 Develop a suite of agreed objectives, key performance indicators and client/consumer and service outcomes for each treatment type

3.4 Develop a suite of common assessment, admission, referral and discharge forms for consistent use across all AOD services, and ensure all clinical staff in both government and non-government AOD services are provided with the necessary training and education in the use of those forms - linked to workforce development Reform Direction 8

3.5 Develop a protocol for the sharing of information including for e-Health technologies

Case study: PART Panel

The Partnership in Alcohol and Other Drugs Residential Treatment (PART) Panel was convened by the Alcohol and Drug Service (Tasmanian Health Service) with The Salvation Army and City Mission to establish a process to work in a consistent and shared care framework, and to maximise treatment opportunities.

There are many people seeking treatment with complex needs and there is limited service capacity and availability. This is especially true within the residential treatment arena, with limited beds available and demand exceeding capacity. There is an AOD residential treatment facility located in each major region of Tasmanian (i.e. North, North West and South).

For a person seeking treatment or for a service/GP/hospital/family referring someone for treatment the pathway can be unclear. This was supported in the Siggins Miller review of the ATOD sector.

There was no mechanism to bring together the government services and the CSOs providing AOD residential rehabilitation treatment for regular collaboration and coordination of client care, especially considering the increasing complexity of people presenting for AOD treatment.

The PART panel provides a clear referral and admission pathway for consumers to receive timely and appropriate treatment.

Reform Direction 4: Responding to specific population groups

Rationale:

It is acknowledged that some priority groups are not inherently more at risk of AOD use, but rather that they may experience greater rates of trauma, 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 including children of parents who use AODs; Aboriginal and Torres Strait Islander people; women; elderly people; people from culturally and linguistically diverse (CALD) backgrounds; LGBTQI+ people; and people in or leaving the justice system. This also includes those experiencing or at risk of homelessness.

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 AOD problems.
- be offered inappropriate interventions.
- lack information and education that effectively communicates AOD use risks and harms.
- 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.
- have experienced significant trauma.

Reform Goals:

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

Key Actions:

4.1 Work with the youth sector to review, develop and implement a Youth Framework for the AOD sector including treatment service specifications and program guidelines and specific consideration of a developmentally appropriate approach for young people with co-occurring issues

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

4.3 As part of Reform Directions 2 and 3, work closely with Correctional Primary Health Services and the Department of Justice to better support people in or leaving the justice system

4.4 Consider the needs of other specific population groups including but not limited to older people, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse (CALD) backgrounds including humanitarian entrants, and LGBTIQ+ people

4.5 Support the implementation of the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016–2026* across the AOD sector in Tasmania.

AOD Homeless Consultation and Liaison

The Tasmanian Government's 2020-21 budget has provided $383 000 over two (2) years for a trial of an alcohol and other drug homeless consultation and liaison project.

This will complement the existing Mental Health Homelessness Outreach Support Team (MHHOST) which started in September 2020.

The trial program will use a consultation liaison outreach model of service delivery to support clients who have alcohol and other drug use and mental health issues that significantly impact their ability to retain or transition into stable housing.

Reform Direction 5: Maintain a focus on promotion, prevention and early intervention

Rationale:

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 as a sub-strategy of the Tasmanian Drug Strategy to provide a focus on the social and structural determinants of health that influence AOD use. Recognising the largely whole of population focus of the ATOD PPEI Framework, an AOD sector Implementation Plan was developed in 2015, to identify goals and activities that the AOD sector in Tasmania could undertake.

Addressing the social, socio-economic and structural determinants of health and the protective and risk factors that influence AOD use in Tasmania sits outside the sphere of AOD treatment services.

However, preventing and reducing AOD-related harm are important components of an integrated service system, e.g. Needle and Syringe programs, places of safety (for sobering up), information and support to families. These types of interventions aim to reduce harms, provide information and support and refer people into treatment when required.

In the context of the Reform Agenda and the AOD service system, the focus is on prevention and early intervention and harm reduction activities and interventions as part of a continuum of care.

Reform Goals:

- Maintain a focus on population level health promotion and the social and health determinants of AOD use (primary prevention)
- Ensure continuation of interventions to reduce the harms from AOD use
- Improve AOD health and AOD policy literacy across the community and among other service providers and primary health services, linked to reducing stigma and discrimination under Reform Direction 6
- Improve AOD screening, assessment and the provision of brief interventions and early referrals across a range of settings

Key Actions:

5.1 Convene a Working Group to review the current ATOD PPEI Framework and Implementation Plan in the context of development of a new Tasmanian Drug Strategy

5.2 Develop a GP training program in Screening, Brief Intervention and Referral to Treatment (SBIRT) linked to Key Action 3.1 d)

Drug and Alcohol ED Brief Intervention Team (DABIT)

The Tasmanian Government's 2020-21 budget has provided $520 000 over two (2) years for a trial of a specialised brief intervention team within a hospital setting.

The DABIT will work closely with hospital Emergency Department staff, and the existing Alcohol and Drug Services Consultation and Liaison teams to support emergency department staff with patients who present under the influence of alcohol and/or other drugs.

It will provide specialist advice and interventions to staff and provide patients with both harm reduction strategies and advice and referrals to alcohol and drug treatment options.

Reform Direction 6: 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 (WHO) 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, due in part to a reluctance to self-report.

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 to reduce the stigma of AOD use and improve knowledge of AOD 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 trained 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
- Increase AOD policy and AOD treatment health literacy amongst other service providers, primary health services and the Tasmanian community

Key Actions:

6.1 Work closely with clients/consumers, carers and service providers and through the development of the Tasmanian AOD Workforce Development Strategy under Reform

Direction 8 to embed respectful, non-stigmatising and non-discriminatory attitudes across all providers of AOD services and programs

6.2 Strengthen relationships with local media to increase accuracy of reporting of AOD issues in Tasmania

6.3 Develop and actively promote a range of activities including for example a position statement and campaigns to reduce the stigma and discrimination associated with AOD use issues and treatment

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

Reform Direction 7: 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*.'

The National Quality Framework for Drug and Alcohol Treatment Services (NQF) (Commonwealth of Australia, 2018) was endorsed in 2018. It noted the lack of a consistent approach to minimum quality standards and continuous quality improvement in the AOD treatment sector. The NQF requires all organisations providing AOD services including services that provide early intervention and continuing care and recovery (where relevant) to be accredited with at least one accreditation standard determined to be acceptable, within a transitional period of three years.

There is an expectation that all states and territories will implement the NQF accreditation standards.

Reform Goals:

- Embed a culture of continuous quality improvement across all AOD services
- Ensure quality health outcomes for all client/consumers of AOD services
- Ensure all AOD services adhere to an agreed accreditation standard within the required three-year transition period
- Work to ensure only quality assured and accredited organisations are eligible for Tasmanian Government funding

Key Actions:

7.1 Set up a process to map existing government funded AOD services against the agreed NQF accreditation standards

7.2 Establish a monitoring and reporting process for the NQF

7.3 Work with private providers to implement the NQF

Reform Direction 8: Supporting and developing the workforce

Rationale:

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;
- salary and remuneration;
- 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 and emerging 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
- Positively promote the AOD sector and its workforce, linked to reducing stigma and discrimination under Reform Direction 6

Key Actions:

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

8.2 Develop a Tasmanian AOD Workforce Development Strategy for government and non-government AOD specialist services including a focus on strategies to address recruitment and retention issues

8.3 Support primary health care through education and training - linked to Key Actions 3.1d) and 5.2

Additional Fulltime Equivalent staffing for the Alcohol and Drug Service

$1.7 million has initially been provided over two (2) years in the 2020-21 state budget to support up to ten (10) additional Allied Health Professional clinical staff for the Alcohol and Drug Service statewide.

IMPLEMENTATION, MONITORING AND EVALUATION

This is an ambitious document. Many of the actions under the Reform Directions rely on other actions. Full implementation will take time and a commitment to change and collaborative action, as well as support at every level and a shared understanding and agreement on the way forward. It is important that key groups who were involved in the work undertaken to date and in consultations have an ongoing role in implementation, monitoring and evaluation.

The success of this Reform Agenda can be monitored by how it is meeting the aim to ensure Tasmanians affected by alcohol, tobacco and other drugs 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.

It can also be monitored by how well it is meeting the objectives to:

- Better integrate all treatment service system components to achieve better outcomes for all clients/consumers;
- Deliver a seamless, easy to navigate, effective and integrated alcohol and other drug (AOD) service system;
- Provide a range of support and treatment options for client/consumers and their families/carers and significant others;
- Enhance and ensure integration of government and non-government AOD specialist services; and
- Enhance and ensure integration of AOD specialist services with non-AOD-specialist services, especially primary health care where appropriate and possible

To ensure the Reform Agenda remains relevant, the Reform Directions and progress against the actions will be re-visited at the half-way point and changed where indicated.

The first task, to be led by the Mental Health, Alcohol and Drug Directorate will be to develop an Implementation Plan for the first two (2) years, and to convene a project Implementation Steering Committee. One of its first tasks will be to agree an Implementation Plan over the ten (10) years of the Reform Agenda. It will be required to:

1. develop an Implementation Plan including identifying the resources and areas of responsibility needed to support implementation.
2. establish a 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. convene working groups as deemed necessary.
5. identify a suitable clinical information management system to meet data system requirements for use across the Tasmanian government and non-government specialist AOD sector.
6. 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.

7. undertake a mid-term review of the Reform Agenda

Monitoring and evaluation also needs to include an ongoing emphasis on building the evidence base around the health and social determinants of AOD use and harm, and AOD treatment. This should include continuing to:

i. estimate population-level AOD use and harms trends.

ii. identify the services/interventions required to most optimally meet those population trends.

iii. map the optimal services/interventions to a framework of services.

iv. estimate the resources and costs to deliver the required interventions to meet the identified population needs, and setting resource targets.

TAKING ACTION AND GOVERNANCE

It will be important to establish a governance framework for the implementation of the Reform Agenda. There is an expectation that the implementation governance of the Reform Agenda will work closely with implementation of the Tasmanian Mental Health Reform Program, through Statewide Mental Health Services.

The Mental Health, Alcohol and Drug Directorate of the Department of Health will have ultimate responsibility and accountability for implementation of the Reform Agenda. The Deputy Secretary, Community Mental Health and Wellbeing is the implementation project sponsor and will report to the Minister for Health and Wellbeing and to the Secretary of the Department of Health.

Consistent with the implementation, monitoring and evaluation section, a project Implementation Steering Committee will be established. Its first task will be to agree to an Implementation Plan based on the prioritisation of actions indicated below. The Implementation Plan will also incorporate and report on the initial projects and programs supported through the state Government's 2020-2021 budget.

The Steering Committee will receive input from an Implementation Sector Advisory Group. The existing AOD Treatment Expert Advisory Group will be reviewed to take on that role. The Interagency Drug Policy Committee will be one of the project Reference Groups. Other advisory and working groups can be convened or external consultants/expert advisors recruited for discrete pieces of work as identified and approved.

The following table summarises the key actions under each of the Reform Directions and provides a suggested timeframe.

Actions have been prioritised based on information provided through the work undertaken by Siggins Miller, from feedback provided through consultation on the draft Reform Agenda, through the expertise and input of members of the Drafting Working Group and advice and direction provided by the Advisory Group.

Actions 2021-2022
Recruit to project management team positions
Recruit to Alcohol and Drug Service positions
Establish the Detox@Home program
Establish the AOD Homeless Consultation and Liaison Program (complementary to MHHOST)
Establish the Drug and Alcohol Brief Intervention Team (DABIT)
Reform Direction 1: A client/consumer-centred approach across the service system
1.1 Establish a funded AOD Consumer Organisation in Tasmania
1.2 Develop and implement a Client/Consumer Participation Framework for Tasmania
1.3 Increase advocacy support for people with AOD use issues
1.5 Establish a client/consumer input process into the work to be undertaken under Reform Directions 2 and 3

Reform Direction 2: An integrated service system
2.1 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, consistent with the work under 3.1
2.5 Work within Statewide Mental Health Services and with the AOD and Mental Health (MH) service sectors to ensure the needs of clients/consumers with MH and AOD comorbidity are fully considered and addressed under the Reform Agenda and the Tasmanian Mental Health Reform Program, for example new programs and development of Models of Care will include clients/consumers with dual diagnosis and will include specific AOD/MH dual diagnosis positions where relevant
Reform Direction 3: Developing service specifications and program guidelines
3.1 Develop an overarching Service Delivery Framework for Tasmania that describes AOD treatment and provides the overarching specifications for all funded government and non-government specialist AOD service providers
3.1 a) Develop a Residential Rehabilitation Treatment Model and Guidelines for Tasmania
3.1 b) Develop a Withdrawal Management Treatment Model and Guidelines
3.3 Develop a suite of agreed objectives, key performance indicators, and client/consumer and service outcomes for each treatment type
Reform Direction 4: Responding to specific population groups
4.5 Support implementation of the Cultural Respect Framework across the AOD sector in Tasmania
Reform Direction 5: Maintain a focus on promotion, prevention and early intervention
5.1 Convene a working group to review the current Framework and Implementation Plan in the context of development of a new Tasmanian Drug Strategy
Reform Direction 6: Reducing stigma and discrimination
6.2 Strengthen relationships with local media to increase accuracy of reporting of AOD issues in Tasmania
6.3 Develop and actively promote a position statement that aims to reduce the stigma and discrimination associated with AOD use issues and treatment
6.4 Increase AOD health and AOD health policy literacy by providing more community information on AOD use disorders and treatment options
Reform Direction 7: Improving quality and safety
7.1 Set up a process to map existing government funded AOD services against the agreed NQF accreditation standards
7.2 Establish a monitoring and reporting process for the NQF

Implementation, monitoring and evaluation
1 Develop an Implementation Plan
2 Establish a monitoring and reporting process
3 Develop and implement a Communications Strategy
4 Convene Working Groups
6 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. with mental health services, hospitals
Actions 2023-2026
Reform Direction 1: A client/consumer-centred approach across the service system
1.4 Provide information, support and training to increase client/consumer AOD health and treatment literacy and understanding of the service system to increase their confidence to provide meaningful input on ways to improve individual service delivery and the service system
Reform Direction 2: An integrated service system
2.2 Identity linkages across funding and service provision to clearly identify gaps and duplications across services
2.3 Map and reconfigure current services and funding arrangements as required to align with and match 2.1, 2.2 and 3.1
2.4 Develop a co-commissioning framework for AOD services in Tasmania
Reform Direction 3: Developing service specifications and program guidelines
3.1 c) Develop a care coordination/case management framework
3.1 d) Develop a Screening, Brief Intervention and Referral to Treatment (SBIRT) Framework
3.1 e) Develop an Opioid Pharmacotherapy Program Model of Care
3.1 f) Incorporate service specifications and programs guidelines as part of the development of the Youth Framework under Reform Direction 4
3.2 Map and reconfigure current funded services as required to align with the Service Delivery Framework consistent with Reform Direction 3.1, and with Reform Directions 2.1, 2.2 and 2.3)
3.4 Develop a suite of common assessment, admission, referral and discharge forms, and linked to reform direction 8, ensure all clinical staff in both government and non-government AOD services are provided with the necessary training and education in the use of those forms, linked to Workforce Development Reform Direction 8
3.5 Develop a protocol for the sharing of information including for e-Health technologies

Reform Direction 4: Responding to specific population groups
4.1 Work with the youth sector to review, develop and implement a Youth Framework for the AOD sector including treatment service specifications and program guidelines and specific consideration of a developmentally appropriate approach for young people with co-occurring issues
4.2 Consider the specific needs of young people, women and people with children in development of the Residential Rehabilitation Treatment Model and Guidelines
4.3 As part of reform directions 2 and 3, work closely with Correctional Primary Health Services and the Department of Justice to better support people in or leaving the justice system
4.4 Review the 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 LGBTIQ
Reform Direction 5: Maintain a focus on promotion, prevention and early intervention
5.2 Develop a GP training program in Screening, Brief Intervention and Referral to Treatment (SBIRT) Framework
Reform Direction 6: Reducing stigma and discrimination
6.1 Work closely with clients/consumers, carers and service providers and through the development of the AOD Workforce Development Strategy to embed respectful, non-stigmatising and non-discriminatory attitudes across all providers or AOD services and programs
Reform Direction 7: Improving quality and safety
7.3 Work with private providers to implement the NQF
Reform Direction 8: Supporting and developing the workforce
8.1 Determine minimum staffing key competencies and requirements across all government and non-government specialist AOD programs and services
8.2 Develop a Tasmanian AOD Workforce Development Strategy for government and non-government AOD specialist services including a focus on strategies to address recruitment and retention issues
8.3 Support primary health care through education and training, including in PPEI activities, linked to Key Action 5.2
Implementation and monitoring
5 Identify a suitable Clinical Information System
7 Undertake a mid-term review
Actions beyond 2027
Implementation and monitoring - ongoing

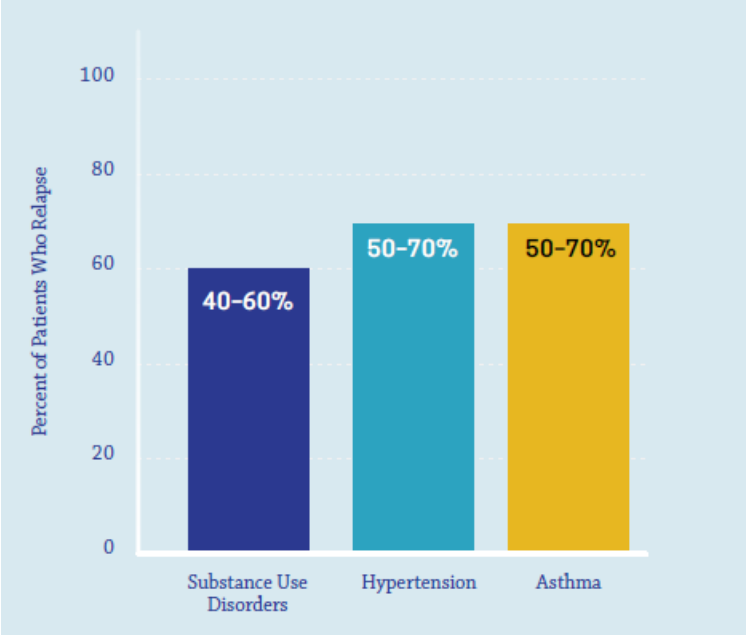
APPENDIX 1

The nature of substance use

Substance use disorder is now the preferred term for a person with an addiction or dependence and is used in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V, 2013), combining substance abuse and substance dependence into a single disorder measured on a continuum from mild to severe. Defining an addiction as a substance use disorder is a more inclusive way of identifying people who need help.

Substance dependence is a diagnosis in the revised ICD 11 that refers to a pattern of drug-taking behaviours and compulsive drug use despite evidence of physical, psychological, or social harm. To meet the ICD 11 diagnostic criteria for substance dependence, an individual must have two or more of the following features: impaired control over substance use; substance use becoming an increasing priority such that it takes precedence over other interests or enjoyment; and physiologic features indicative of neuro-adaptation to the substance, such as tolerance, withdrawal or use of the substance to prevent and alleviate withdrawal.

As identified by the modelling undertaking by Siggins Miller, a relatively small percentage of the population will need specialist AOD treatment or interventions. For people with a severe substance use disorder, who may or may not also have other co-occurring conditions and issues, the nature of that substance use is recognised as a relapsing and remitting condition. Relapse rates, i.e. how often symptoms recur, are similar to relapse rates for other illnesses such as diabetes, hypertension and asthma.



Source: JAMA, 284:1689-1695, 2000

Relapse rates for people treated for substance use disorders are compared with those for people treated for high blood pressure and asthma. Relapse is common and similar across these illnesses. Therefore, substance use disorders should be treated like any other chronic illness. Relapse serves as a sign for resumed, modified, or new treatment.

There are many social, socio-economic, cultural and environmental conditions, and risk and protective factors that influence AOD use. Those risk and protective factors (shown below) are shared across multiple issues, such as mental health and wellbeing, child maltreatment, domestic

and family violence, bullying, discrimination, poor quality diet, physical inactivity, loneliness, and the social determinants of health (e.g. education, employment, housing).

Domain	Risk factors	Protective factors
Individual	Genetic disposition Personality disorder Depression and suicidal behaviour	Good coping skills Self-efficacy Risk perception Optimism Health-related behaviour General health behaviour
Family	Family disruption and dependence problems Social deprivation Victim of child abuse	Assistance to attend and maintain treatment Social support Knowledge of individual's history
Friends	Peer culture Cultural norms, attitudes	Ability to resist peer pressure Social integration Positive life events
Education/ employment	Poor performance at school Occupational stressors	Social integration Income
Community/ environmental	Drug availability Poverty Drug policies Discrimination Inequality	Situational control Social capital Social change

Source: WHO, 2004 and Blum and Blum, 2009

Co-occurring conditions and issues (comorbidities)

Other conditions that are often found to co-occur with AOD use include anxiety, depression, post-traumatic stress or bipolar disorder, physical health conditions (e.g., cirrhosis, hepatitis, heart disease, diabetes), chronic pain, intellectual and learning disabilities and cognitive impairment. Issues associated with AOD use include financial, (un)employment, legal and family and relationship problems, and risk-taking behaviours including impaired driving and sexual risk-taking.

Substance use disorders and mental illness are associated with increased rates of cardiovascular disease and cancer, and average life expectancy is 20–30 years shorter among people with those disorders (NSW Ministry of Health 2015).

Estimates (Marel et al, 2016) indicate that 35 per cent of individuals with a substance use disorder (31 per cent of men and 44 per cent of women) have at least one co-occurring affective or anxiety disorders. Studies that have undertaken comprehensive assessments of mental health disorders indicate that between 50–76 per cent of Australian clients meet diagnostic criteria for at least one comorbid mental disorder. At least one in three have multiple comorbidities.

Suicide has been described as the hidden issue of AOD use and the dimension of the problems is such that one-third of those who enter AOD treatment will have attempted suicide over their lifetime and one in ten will have done so within the previous twelve months (Darke, 2009).

The over prescribing of opioids for chronic non-cancer pain poses serious risks, including overdose and addiction. Currently in Australia, there are more deaths associated with prescription opioids than heroin, cocaine, or other illicit drugs. In 2017-18, 823 Australians are believed to have lost their lives because of prescription opioid misuse (AIHW, 2018a). High rates of generalised anxiety disorder, post-traumatic stress disorder and substance misuse are reported in people with chronic pain (Deloitte, 2019). Episodes of acute pain may negatively impact upon long-term retention in both AOD treatment programs and pain management programs and better acute pain control may

improve such retention.

Prison entrants are four times as likely as people in the general population to report illicit drug use (including use of illegal drugs and non-medical prescription medication and volatile substances), with almost two-thirds (65 per cent) having used an illicit drug in the previous year (AIHW, 2019). Substance use is also an ongoing risk factor for recidivism and requires a degree of aftercare and post-release support due to risk of overdose, continued use and returning to the same social environment. AOD use problems can often be made worse because of the imprisonment.

There is a strong link between substance use and homelessness. Between 2012-13 and 2016-17 almost one in ten people presenting to homelessness services reported having problematic AOD use issue. Around 6 per cent of clients of homelessness services in 2016-17 reported AOD use as the main reason for seeking assistance (AIHW, 2018b).

Alcohol is involved in approximately half of domestic and family violence incidents reported to police (Miller et al, 2016). When considering incidents not reported, alcohol involvement is likely to be higher. The Victorian Royal Commission into Family Violence heard that between 50 per cent and 90 per cent of women accessing mental health services and AOD services had been victims of child abuse or domestic violence (State of Victoria, 2016).

Knowledge regarding substance use and substance use disorder in individuals with mild to borderline intellectual disabilities has increased over the last decade but is still limited. Research out of the USA suggests that people with physical disabilities experience substance use disorders at two to four times the rate of the general population (Chapman and Wu, 2012). Conversely, people with addictions are more likely to become disabled, either through accidental injury or through long-term side effects of substance use.

Fetal Alcohol Spectrum Disorder (FASD) is a diagnostic term for a range of physical, cognitive, behavioural and neurodevelopmental abnormalities, that result from an acquired brain injury caused by alcohol exposure before birth. It is a lifelong condition, often unrecognised and undiagnosed and entirely preventable by avoiding alcohol during pregnancy.

Australian and international guidelines advise that there is no safe level of prenatal alcohol exposure or exposure to alcohol while breastfeeding. Alcohol crosses the placenta and may irreparably damage the brain and other organs of the developing embryo and fetus.

It difficult to determine the prevalence of FASD in Australia due to lack of awareness of the full spectrum of FASD, lack of routine assessment and screening, lack of knowledge of diagnostic criteria, and lack of nationally consistent data collection and reporting. According to the National FASD Strategic Action Plan 2018 (Commonwealth of Australia), based on state and territory data, estimated likely rates of FASD range from 0.01 to 0.68 per 1 000 births. However, there are concerns these are likely to be underestimates due to lack of awareness and diagnoses, and that as many as 2 per cent of Australian babies may be born with some form of FASD.

Addressing some of these co-occurring conditions and issues are picked up in the Reform Directions and Key Actions. Some are outside the sphere of the AOD treatment services system, and some are being addressed through linked external processes. Examples include:

- Both this Reform Agenda and the Mental Health Reform Program include a commitment to review the relationships between Mental Health and Alcohol and Drug Services. There is also a commitment to suicide prevention reform.

- The Mental Health, Alcohol and Drug Directorate with support of the Drug Education Network is convening a FASD State Coordination Group to coordinate a Tasmanian response to the National Fetal Alcohol Spectrum Disorder Strategic Action Plan.

- A new Tasmanian Drug Strategy is being developed. Its focus will be on whole-of-government strategic approaches, e.g. a collaborative multi-agency approach to managing people in and leaving the criminal justice system.

APPENDIX 2

Glossary

Term	Description
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, including misuse of prescribed medicines.
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-M	The Drug and Alcohol Service Planning Model (DASP-M) 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.
Integration	Integration in the context of the AOD Reform Agenda is defined as better coordination, collaboration and communication between the components of the current service system. It refers to continuity and coordination of care including stepped care and the adoption of a client/consumer centred approach. This may evolve as the AOD Reform Agenda, the Reform Directions, and the key actions are implemented.
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 the level of drug use.

Term	Description
Specialist AOD sector	Refers to both government and non-government alcohol and other drugs treatment services whose core business is providing alcohol and other drugs treatment.
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 has also developed a Glossary of terms that provides definitions of a number of the key terms used in Primary Health Tasmania's AOD commissioning documents and discussion available here or visit www.primaryhealthtas.com.au and search for 'Glossary of Terms'.

REFERENCES

ACT Government. (2011). *ACT Prevention of Violence Against Women and Children Strategy 2011 – 2017*. Canberra: ACT Government. Accessed on 1 December 2017 at: http://www.communityservices.act.gov.au/__data/assets/pdf_file/0014/231341/ACT_Prevention_of_Violence_Against_Women_and_Children_Strategy_2011.pdf

Australian Institute of Health and Welfare (AIHW). (2020). Alcohol and other drugs treatment services in Australia: 2018-19. Drug treatment series no. 34. Cat. No. HSE 243. Canberra: AIHW

Australian Institute of Health and Welfare (AIHW). (2018a). Opioid harm in Australia and comparisons between Australia and Canada. Cat. no. HSE 210. Canberra: AIHW

Australian Institute of Health and Welfare (AIHW). (2018b). Alcohol, tobacco and other drugs in Australia. Cat. no. HSE 221. Canberra: AIHW

Australian Institute of Health and Welfare (AIHW) (2019). The health of Australia's prisoners 2018. Cat. no. PHE 246. Canberra: AIHW.

Blum & Blum (2009) Resilience in Adolescence in Santelli, DiClemente and Crosby Adolescent Health: Understanding and Preventing Risk Behaviors. San Francisco: Jossey Bass, 2009. 108.

Chapman SL, Wu LT. Substance abuse among individuals with intellectual disabilities. Res Dev Disabil. 2012;33:1147-56.

Commonwealth Department of Health (2016). PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance

Commonwealth of Australia (Department of Health) (2018). National Quality Framework for Drug and Alcohol Treatment Services. Canberra

Darke, S "Suicide: The hidden issue," in *Drug Use and Mental Health,* Melbourne, IP Communications, 2009, pp. 143-149.

Deloitte Access Economics (2019). The cost of pain in Australia. Report for Painaustralia

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2010). Best Practice Portal. Standards and guidelines for practices. http://www.emcdda.europa.eu/best-practice/standards/treatment

Kingsland, M., Wolfenden, L., Rowland, B., Gillham, K., Kennedy, V., Ramsden, R., Wiggers, J. (2013). Alcohol consumption and sport: a cross-sectional study of alcohol management practices associated with at-risk alcohol consumption at community football clubs. *BMC Public Health, 13*.

KPMG Health Economics Group (2013). Economic evaluation of the Good Sports Program Australian Drug Foundation. Update November 2013.

Lubman, D., Manning, V., Best, D., Berends, L., Mugavin, J., Lloyd, B., Lam, T., Garfield, J., Buykx, P., Matthews, S., Larner, A., Gao, C., Allsop, S., Room, R. (2014). *A study of patient pathways in alcohol and other drug treatment.* Fitzroy: Turning Point.

Marel C, Mills KL, Kingston R, Gournay K, Deady M, Kay-Lambkin F, Baker A, Teesson M (2016). Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition). Sydney, Australia: Centre of Research Excellence in Mental Health and Substance Use, National Drug and Alcohol

Miller P, Cox E, Costa B, Mayshak R, Walker A, Hyder S, et al. (2016). *Alcohol/Drug-Involved Family Violence in Australia (ADIVA)*. Research Centre, University of New South Wales. Canberra: National Drug Law Enforcement Research Fund (NDLERF).

National Centre in HIV Epidemiology and Clinical Research (2009). *Return on investment 2: Evaluating the cost-effectiveness of needle and syringe programs in Australia 2009*. The University of New South Wales, Sydney.

New South Wales (NSW) Ministry of Health (2015). Effective Models of Care for Comorbid Mental Illness and Illicit Substance Use, Evidence Check Review. North Sydney, NSW

Primary Health Tasmania (PHT), (2016). Drug Treatment Services: for the Tasmanian community including Aboriginal and Torres Strait Islander peoples, Commissioning Intentions Document Version 1.0. Primary Health Tasmania

Queensland, 2015. Queensland Alcohol and Other Drug Treatment Service Delivery Framework. Accessed online: https://insight.qld.edu.au/file/235/download

Ritter, A., Chalmers, J. & Sunderland, M. (2013) *Estimating need and demand for treatment – a background briefing*. Working Paper No 1 – Review of AOD prevention and treatment services. Sydney: Drug Policy Modelling Program, National Drug and Alcohol Research Centre (NDARC), UNSW

Rush, B. (2010). Tiered framework for planning substance use service delivery systems: Origins and key principles. Nordic Studies on Alcohol and Drugs, 27, 617-636.

State of Victoria. (2016). *Royal Commission into Family Violence: Report and recommendations, volume III. Parl Paper No 132 (2014–16).* Melbourne: Victorian Government.

Siggins Miller (2017). A single Tasmania Alcohol and other Drugs Service System Framework – Final Report. Available from Alcohol and Drug Services Publications

United Nations Office on Drugs and Crime (UNODC)/World Health Organisation (WHO) (2016). *International Standards for the Treatment of Drug Use Disorders*, *Draft for Field Testing*. https://www.unodc.org/documents/.../CND/.../ECN72016_CRP4_V1601463.pdf

World Health Organization (2004). Neuroscience of psychoactive substance use and dependence. Geneva: World Health Organization

Tasmanian Government

Department of Health

GPO Box 125

HOBART TAS 7000

Phone: (03) 61666074

Email: aodreform@health.tas.gov.au

Or director.mhadd@health.tas.gov.au

Visit: www.dhhs.tas.gov.au/mentalhealth/alcohol_and_drug/reform_agenda_for_ads