

A single Tasmanian alcohol and other drugs (AOD) service system framework

Final Report

August 2017



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Overarching main messages

Based on findings and discussions over the course of this project, we provide the following overarching main messages for the Department of Health and Human Services (DHHS) to consider in developing a single AOD Service System Framework for Tasmania:

1. There is strong support across all stakeholders in the AOD sector for system-level and service-type-specific reform and innovation outlined in this report. The change management agenda to implement these reforms is significant, will need the ongoing effort and contribution of all parts of the service system, and be resourced appropriately to implement the necessary change activities.
2. The complexity of the change process, the determinants of access to services, consumers' engagement with services, and the capacity to meet the broad social, employment, and education needs of consumers that are significant parts of their recovery requires a joined-up evidence-based approach to change. We suggest that the collective impact framework outlined in this report be used to guide this change process.
3. Tasmania has a major resource in the depth and commitment of its policy and clinical leadership. This resource needs to be harnessed and well-supported in the change process.
4. There are a number of system-wide issues addressed in this report, such as the need for joined up electronic health records; preparing the system for the national rollout of the My Health Record system; the extended use of telehealth for consultations to improve access for people in remote settings or for service providers to access secondary consultations; and remote monitoring of patients in ambulatory settings.
5. The bulk of Tasmanian AOD services appear to be evidence-based. There are some places where this review was unable to establish the evidence base of some services due to a lack of documentation, and recommendations have been made to address this.

Introduction

The Alcohol and Other Drug (AOD) Service System Framework project is a key initiative which supports three of the recommendations arising from the Review of Drug Use and Service Responses in North West Tasmania (NW Review), and is supported by additional funding of \$4.8 million over four years which was announced in May 2015. The DHHS through the Mental Health, Alcohol and Drug Directorate (Directorate) engaged Siggins Miller Consultants to undertake a range of activities and deliver a suite of working papers and reports that culminate in this Final Report which clearly articulates options and recommendations to enable the DHHS, working closely with other service funders and providers within the state of Tasmania, to develop a single AOD Service System Framework for Tasmania. This final report is intended to assist the Tasmanian DHHS and other service funders and providers in identifying options and recommendations to develop a single AOD service system framework for Tasmania.

This final report includes the key findings from each of the commissioned deliverables: the Mapping Paper; Literature Review; Client Pathway; Needs and Gap Analysis; Residential Rehabilitation; and the Withdrawal Management reports, as they relate to:

- a. Options and recommendations of how the current Tasmanian AOD service system can be changed or reconfigured to improve client service delivery and cost effectiveness, and service sector efficiency, including opportunities for collaboration/integration within the AOD sector and more broadly where relevant and possible.
- b. Options and recommendations of what is needed in the medium and longer term to achieve a recommended single AOD service system framework, including where any new investment or resources are best prioritised.

Methodology

This report integrates findings of the following deliverables provided to the DHHS throughout the course of this project¹:

1. Literature Review
2. Mapping Working Paper
3. Need and Gap Analysis Working Paper
4. Client Pathways Paper
5. Residential Rehabilitation Report
6. Withdrawal Management Report

Detailed methodologies of these deliverables are outlined in the corresponding reports. A brief description of the methodology of the overall project is outlined below.

Literature review

An overarching literature review of recent research, reports, and evaluations to determine components of an effective and efficient contemporary best practice and evidence-informed AOD treatment system for Tasmania including a focus on stepped care modelling as appropriate was conducted. This literature review was conducted by accessing bibliographic databases that index the academic literature and networked library catalogues for print monographs and related material. All Australian material of direct relevance, as well as a selection of relevant overseas material, in particular peer reviewed systematic

¹ The deliverable "Communications and Project Plan" sets out methodology for each of the project deliverables and does not contain findings per se. Thus, it is excluded from this final report.



reviews of treatment effectiveness, was considered. Reference lists of relevant articles, and other recent major reviews commissioned in the sector, were used to identify potential studies for inclusion. In addition, a search of grey literature using web tools such as Google Scholar and Scopus was conducted.

The residential rehabilitation report expanded on the contemporary best practice and evidence-based residential options contained in the Literature Review, with international and local evidence of what contributes to effective treatment outcomes from drug and alcohol residential rehabilitation treatment services; as well as contemporary clinical practice guidelines and best practice models in regard to residential rehabilitation services as appropriate for Tasmania.

Similarly, the withdrawal management report expanded on the withdrawal management findings contained in the Literature Review, with international and local evidence of withdrawal management models; as well as contemporary clinical practice guidelines in regard to residential rehabilitation services as appropriate for Tasmania.

Stakeholder consultations

Initial Consultations: Regional consultation workshops and consumer and carers focus groups

Initial consultations, in the form of Consumers and Carers Focus Groups and Service Providers Regional Consultation Workshops were conducted over the period of 6 March to 8 March 2017. These workshops and focus groups were conducted in Launceston, Ulverstone and Hobart. A total of 49 service providers and 25 consumers and carers took part in these workshops. Their views on service gap, service integration, accessibility and flexibility of AOD services and the AOD service system were summarised in the Client Pathways Paper.

Targeted Consultations: Interviews with service providers and consumers

Individual and group interviews were conducted with AOD service providers and consumers in Tasmania from 1-19 May 2017. The interviews provided an opportunity for service providers to discuss their perceptions of services and the service system, current service provision arrangements and future needs.

AOD service providers who were invited to participate in individual and group interviews are listed in Table 1. In total, 28 (individual and group) interviews were conducted. In addition, 45 stakeholders were invited to submit a written submission. Of those, 3 organisations submitted written submissions to this review.

Table 1: Stakeholder interviews and written submissions - targeted consultations

Sectors	Stakeholders		
Rehabilitation service providers	Launceston City Mission (Individual interview: 2 participants)	The Salvation Army (Individual interview)	
CSOs	Group interview: 13 agencies invited, 5 agencies participated, 1 agency opted for written submission		
Indigenous health service providers	Circular Head Aboriginal Corporation (Individual interview)	Tasmanian Aboriginal Centre (Individual interview)	
Primary health service providers	Primary Health Tasmania (Individual interview)	2 interviews: GPs (Individual interview)	Pharmacy Guild (Individual interview)
Peak organisations	Alcohol, Tobacco and other Drugs Council Tasmania Inc (Individual interview: 3 participants)	Advocacy Tasmania (Individual interview)	
Alcohol and Drug service providers	6 Individual interviews: including area manager, pharmacist, Specialist medical practitioners, and staff specialist of the Inpatient Withdrawal Unit	Group interview: 17 invited, 6 participated	
Midwives	Group interview: 3 invited, 2 participated		
Mental Health Services	3 Individual interviews: including Mental Health Services project manager, Correctional Primary Health Services,	Group interview: 18 invited, 1 participated.	
Child and youth services	Group interview: 12 invited, 1 participated, 1 written submission		
Consumers	Group interview: 3 invited, 1 participated		
Justice related services	Group interview: 10 invited, 1 written submission		
Public Health Services	Group interview: 5 invited, 1 participated		
Other	University of Tasmania (Individual interview)		
Additional written submissions	3 written submissions: provided by Clarence Community Health Wellbeing Advisory Committee, Department of Education, and Bethlehem House		

Note: Consumers were recruited through the consumer and carer focus groups conducted as part of the initial consultation for this project. They represent the Tasmanian Users Health and Support League (TUHSL), a volunteer run organisation representing the needs of AOD consumers. Opportunities were provided to Velocity Transformations to take part in both group and individual interviews. This invitation was declined due to an unforeseen change of management of the organisation. They provided materials to assist in the review following the close of stakeholder consultation period.

In brief, discussions with service providers and consumers covered the following domains:

- Service demand
- Screening of AOD user (if appropriate)
- Service integration with other AOD services and non-AOD services (e.g. for clients' mental health, physical health, and other needs)
- Views specific to withdrawal management services and residential rehabilitation services
- Other comments and feedback

The Drug and Alcohol Service Planning (DASP) Model

The Drug and Alcohol Service Planning (DASP) Model for Australia is a planning tool that aims to assist health planners to meet the needs of people with alcohol and other drug (AOD) problems, and was used to provide benchmark estimates of the resources needed to deliver the range of AOD services required for Tasmania. The architecture of the tool, including its background, model parameters and limitations, are outlined in Appendix 1 of the Need and Gap Analysis Working Paper.

Data on current service provision

As detailed in the Mapping Working Paper and the Need and Gap Analysis Working Paper, a range of administrative data sources were used to profile current AOD service provision and utilisation in Tasmania, across all treatment settings.

The DHHS Health Information Unit also provided hospital separations data, the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS), and Needle and Syringe Program data for the year 2015 – 16 to facilitate the review of AOD treatment services provided in these settings.

For information on residential rehabilitation and withdrawal management treatment approaches, service providers were approached to provide information on their current service delivery and models of care to inform the corresponding reports. Where necessary, additional information was sourced through individual organisations' webpages. Feedback from service providers through individual and group interviews were also used to inform our findings.

Limitations of DASP modelling and data in the Tasmanian context

In terms of other service elements (e.g. after-care), the information available does not allow for analysis of current allocations and activities against the service elements and care packages identified in the DASP. For example, it is impossible to discern the proportion of resources that went to psychosocial interventions, screening and brief intervention, or case management for clients receiving pharmacotherapy. Likewise, for services delivered by the NGO grants, there is no ability to accurately distinguish the proportion of funding allocated to the different service activities undertaken by an organisation, nor was that in scope for this project. As such, the DASP projections should be conceptualised as a guide for proportional investment of future funding and for identification of the profile of outputs required.

Available information also does not allow analysis of current FTEs in Tasmania across all service settings, or how many are providing services to different age groups or across the severity categories.

Options and recommendations

The following sections outline the:

- Key estimates based on the modelling undertaken through this process and the findings from the Mapping Working Paper

- Options for Investment and Resources
- Overarching system wide options and recommendations based on background papers and reports commissioned as part of this review process
- Findings, and options and recommendations specific to Residential Rehabilitation
- Findings, and options and recommendation to Withdrawal Management

Key estimates based on the modelling undertaken through this process and the findings from the Mapping Working Paper

Modelling approach:

- As there are no nationally established conversion rates, the methodology developed by Chalmers et al. (2016)² in estimating national AOD service utilisation has been followed. This entails completion of a series of four steps in converting the estimates of treatment utilisation:
 1. Convert treatment service episodes to an estimated number of treatment service recipients within each dataset;
 2. Adjust for double counting of treatment recipients across agencies providing treatment service data within each dataset;
 3. Convert treatment recipient count to an annual figure (only applies to NOPSAD); and
 4. Adjust for double counting of treatment service recipients across multiple datasets.
- In total, 61,321 AOD treatment episodes/sessions are delivered across all treatment settings, which represents between 8,948 and 12,545 people who will receive some form of AOD treatment in any one year (when factoring in access to more than one treatment setting).
- This equates to between 5,759 and 6,550 unique individuals receiving AOD treatment over one year, across the mild, moderate and severe populations, and across all treatment settings.
- The number of individuals in Tasmania who will experience a substance use disorder over one year³ is modelled as 32,292, of which 12,767 will need some form of treatment.
- This suggests that at a minimum, between 6,217 and 7,008 unique individuals in Tasmania are currently not accessing or receiving AOD treatment.
- A further 5,213 people will need consultation liaison services and 61,547 people will require screening and brief intervention only.
- The total DASP modelled cost of providing treatment services is \$46.31 million per annum, which would provide 287.41 FTE staff working in hospitals and the community, and 149 beds for residential rehabilitant and withdrawal management treatment.
- Current expenditure includes a range of State Government funded AOD services that are not included in the DASP modelling:
 - \$3.17 million for harm reduction and related activities
 - \$4.2 million for Program and Service Development (part thereof)

² Chalmers, J., Ritter, A., & Berends, L. (2016). Estimating met demand for alcohol and other drug treatment in Australia. *Addiction*, 111, 2041-2049.

³ *ibid.*

- \$406,533 for diversion-related activities
- The Commonwealth Government also provides \$1.7 million for A&TSI specific AOD treatment services, also not included in the DASP modelling.
- The DASP modelling suggests 125 beds (or places) are needed to provide residential rehabilitation services, and 23 beds to provide withdrawal management in inpatient and detoxification in dormitory settings. All beds modelled are for the severe population.
- The model estimates that for the 12-17 age groups, only 3 beds in total are required for residential rehabilitation and withdrawal management treatment services.
- Tasmania presently has a total 68 beds across the State – 58 residential rehabilitation beds (funded through a mix of state, Commonwealth and CSO funding) and 10 inpatient clinical treatment (the Inpatient Withdrawal Unit). There are also an unknown number of private hospital beds used to provide withdrawal management services.
- There are also 6 Places of Safety and Sobering Up Beds, which is not modelled in the DASP model.

Gaps Identified:

- Current expenditure across all treatment settings is approximately \$40.43 million per annum, and DASP modelling indicated a need for \$46.31 million per annum is required. This suggests a funding shortfall of around \$5.88 million per annum across all treatment settings.
- Due to certain AOD treatment services not being modelled by DASP (i.e. harm reduction activities, program and service development, etc.), as well as the \$1.7 million in funding provided by the Commonwealth for A&TSI treatment services not being modelled by DASP, this suggests a far greater funding shortfall across all treatment settings.
- Comparing DASP modelling and currently available beds for the severe population suggests an undersupply of residential rehabilitation beds (Table 2). It also suggests that combined inpatient clinical treatment beds and detoxification (withdrawal management) beds numbers in Tasmania may be appropriate, when taking into account the state Inpatient Withdrawal Unit, and those provided within the private hospitals system.

Table 2: Comparison of DASP estimated resources (beds) and current service utilisation.

Data sources	Inpatient**	Detoxification***	Residential rehabilitation	Total
DASP estimates: All treatment populations*	4	19	125	149
Mapping working paper: current service utilisation	10*		54-58	NA

Note: All beds are for the severe population.

Due to rounding, some numbers may not add exactly to the totals.

*Dedicated inpatient beds in the ADS Inpatient Withdrawal Unit.

**Inpatient identified in DASP are for withdrawal management in a hospital bed.

*** Detoxification beds identified in DASP are for withdrawal management in residential – dorm setting.

- The DASP modelling estimates that the total number of FTEs required over a 12-month period to provide treatment services to all people who will experience a substance use disorder is 287.41, across all treatment settings. It is not possible to estimate the total number of FTEs currently providing services.

Overall, our analysis shows that there is scope for reconfiguration of existing and future resources to better focus on people with severe and complex problems and to ensure balanced investment across the treatment types, defined in the DASP framework.

Options for Investment and Resources

Comparison across treatment settings is challenged by the variety of ways in which treatment provision is recorded. Nonetheless, using the methodology of a recent evaluation of national AOD service utilisation⁴, the following findings were noted for the AOD service provision and utilisation in Tasmania:

- The overall expenditure for AOD treatment services in Tasmania for 2015-16 was \$40.43 million. The Tasmanian state government contributed an estimated 56.2% of total funding for AOD treatment services, whereas the Commonwealth contributed 22.9%, with the remaining 21.0% of funding originated from private sources (e.g. private hospital admissions, GP co-payments etc).
- In any one year, at least 61,321 AOD treatment episodes/sessions are provided across all treatment settings including both the government and non-government specialist AOD sectors, 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.
- Consistent with evaluation of national AOD service utilisation, the largest proportion of AOD treatment sessions/episodes are provided through GP consultations (35.2%). Based on national-equivalent estimates, our analysis shows that in general, approximately 2% of national AOD treatment services occur in Tasmania.
- Geographic mapping of services shows that services are typically located in Hobart and Glenorchy in the southern region, Launceston in the northern region, and Devonport, Ulverstone and Burnie in the northwest region of Tasmania.
- Geographic mapping of service utilization data (AODTS-NMDS 2015-16) shows relatively consistent patterns of drug types and treatment types across South, North and Northwest regions in Tasmania.
- Whilst there is only one DHHS-funded stand-alone medically supervised inpatient withdrawal unit in the South, data shows withdrawal management services are also undertaken within public and private hospitals across Tasmania.

Overarching system wide options and recommendations

The following part describes the overarching system wide options and recommendations based on the background papers and reports that were commissioned as part of this review. It includes options and recommendations that are relevant to

(1) the system change and reconfiguration to improve client service delivery and service efficiency, including opportunities for collaboration/integration within the AOD sector and more broadly where relevant and possible; and

(2) what is needed in the medium and longer term to achieve a recommended single AOD service system framework, including where any new investment or resources are best

⁴ Chalmers, J, Ritter, A., & Berends, L. (2016). Estimating met demand for alcohol and other drug treatment in Australia. *Addiction*, 11, 2041-2049.



prioritised. Following the system wide recommendations and options we present the recommendations and options relevant to residential rehabilitation and withdrawal management.

Triangulating the data from all sources used and developed in this review, as outlined in the methodology section above, we provide the following observations, options and recommendations:

- The elements of the Tasmanian AOD system covers all appropriate and evidence based treatment types.
- The main challenges facing the AOD treatment service system in Tasmania that were identified by both consumers and providers during consultations are as follow:
 - A lack of consistent information on how to identify and access appropriate services.
 - Perceived long wait-times and sometimes restrictive criteria to access services, particularly withdrawal management and residential rehabilitation services.
 - Lengthy distances to travel to services, particularly for consumers from North and Northwest regions, as well as travel required between different services.
 - Lack of integration and communication between different services, including perceived lack of communication between government and non-government services.
- As noted in the Client Pathways Paper, consumer's experience the implementation of pharmacotherapy services as too restrictive and not conducive to longer term rehabilitation outcomes. We note that the ADS is undertaking a review of the Tasmanian Opioid Pharmacotherapy Program, Policy and Clinical Practice Standards (TOPP) in the context of the Tasmanian epidemiology and opioid use, to identify barriers (internal and external) and consider alignment with best practice guidelines of other Australian jurisdictions.

Reports from consumers who accessed GP services after developing substance use problems, prior to engaging with specialised AOD treatment reported the interaction with the GP was not beneficial to their recovery from substance use. In line with these reports, service providers at the Regional Consultation workshops identified a need to enhance support to GPs to allow for their increased capacity to deliver AOD treatment services.

Many consumers reported long wait times to access withdrawal management and residential rehabilitation services. Additionally, the wait-time identified by participants in the Launceston and Ulverstone focus groups was notably longer (reportedly over 10-week wait-times) than that reported by the Hobart focus group. Further input by consumers highlighted the need for more aftercare services, particularly following acute episodes of substance use.

There was agreement between both consumers and service providers that there is a need for improved integration and communication between service providers, particularly between government and non-government services. Integration with housing, employment, and the criminal and justice system were also identified as in need of improvement. Integration with mental health services was identified to be a key challenge across all consumers' focus groups and regional consultation workshops, particularly for consumers with mental health issues who are not eligible for public specialised mental health services.

With regard to the responsiveness and flexibility of AOD services and the AOD service system, consumers indicated that they would like to have greater flexibility in opening hours of services and in extending treatment duration. Consumers across all three focus groups indicated that the Tasmanian

pharmacotherapy program lacked flexibility, with consumers providing examples on how it impacts on their health and social needs.

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

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

On this basis, we recommend the following:

- There is a need for reform within the treatment system to ensure that it is client-focused, rather than provider or institution focused, with services to be designed around client convenience, access and providing support to seek help as close as possible to where they live. This would align the AOD service system with directions and reforms in treatment and support of other equally intractable chronic diseases elsewhere in the broader health system. We suggest that, due to needs of consumers crossing sectoral boundaries across portfolios and across government, non-government and private sector service providers, the system reforms to address the identified problems be guided by the methodology developed within Stanford University, known as A Collective Impact framework. Collective impact occurs when a group of multi-sector stakeholders '*commit to a common agenda for solving a complex social problem... Their actions are supported by a shared measurement system, mutually reinforcing activities, and ongoing communication, and are staffed by an independent backbone organisation.*'⁵ The collective impact framework identifies five conditions of collective success:
 - *Common agenda*: All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it though agreed upon actions.
 - *Shared measurement*: Collecting data and measuring results consistently across all participants ensures efforts remain aligned and participants hold each other accountable.
 - *Mutually reinforcing activities*: Participant activities must be differentiated while still being coordinated through a mutually reinforcing plan of action.
 - *Continuous communication*: Consistent and open communication is needed across the many players to build trust, assure mutual objectives, and create common motivation.
 - *Backbone support*: Creating and managing collective impact requires a separate organisation(s) with staff and a specific set of skills to service as the backbone for the entire initiative and coordinate participating organisations and agencies. In the Tasmanian context, we suggest an AOD specialist clinician/nurse practitioner who supports system design, an organisational change management specialist to implement change activities, and a data analyst to support shared measurement activities.

The focus of this multi sector work, in the first instance, should focus on the following:

- **Partnership between government and non-government services**: Relationships between government and non-government services have been identified as an area of focus by both service providers and consumers. Other jurisdictions (e.g. Victoria, NSW and QLD) have

⁵ Hanley brown, F; Kania; J; Kramer, M. Channelling Change: Making Collective Impact Work, Stanford Social Innovation Review, 26 Jan 2012.



established sub-acute bed-based mental health services administered by state or territory mental health services or non-government agencies, but generally staffed by a mixture of clinical and non-clinical staff and most commonly located in the community, or a mix of hospital and community based facilities. An example of this service type is the Victorian Prevention and Recovery Care (PARC) service⁶. This partnership model may be considered in the Tasmanian context to provide a transitional bed-based treatment service to AOD consumers with high needs which is less intensive than acute inpatient treatment but more so than traditional community based AOD treatment services. The 6 Places of Safety/Sobering Up Beds may be considered as multi-purpose facilities for this partnership.

- **Consumer representation:** We suggest adopting the model of consumer representation used by the mental health sector in Tasmania to support AOD consumers, and provide consumers with support and training to increase their understanding of the AOD service system and confidence in their abilities to provide meaningful input on ways to improve the AOD system.
- **Management of wait-times:** When necessary actively manage waiting times, through e health support to monitor health status and prioritise those deteriorating.
- **Continuity of care:** Support for clients to improve continuity of care, including supporting clients' transfer from one treatment to another, engage clients while they wait for treatment (e.g. motivation interviewing, improve linkages between treatment elements to improve service integration).
- **Integrated care pathways:** Develop clearly articulated integrated care pathways, provided to service providers and clients developed in partnership with consumers.
- **Support for GPs:** Greater support for GPs not only in their role in OST but withdrawal and ongoing treatment in primary health settings.

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

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

Findings, and options and recommendations specific to Residential Rehabilitation

Findings

Informed by international and Australian peer-reviewed literature and clinical guidelines, this report analysed current residential rehabilitation services in Tasmania against contemporary benchmarks and service providers' feedback to identify potential areas of improvement.

⁶ Adult prevention and recovery care (PARC) services framework and operational guidelines, (2010). Mental Health, Drugs and Regions Division, Victorian Government, DHHS of Health, Melbourne, Victoria.

Three rehabilitation models were identified: 1) long term residential care (defined as 24-hour care for a minimum of 60 days); 2) short-term residential care (generally defined as less than one-month of treatment); 3) and non-residential (day program) care.

Generally, for residential or outpatient treatment participation, 90 days or less is of limited effectiveness. The evaluation literature suggests that short term residential treatments may not be effective unless they incorporate a progression to structured options such as supervised half-way house accommodation or daily/weekly participation in non-residential programs. The evidence on the effectiveness of short term residential rehabilitation treatment is in its early stages. Non-residential rehabilitation treatment options may be more viable for clients who have supportive environment and/ or are on a waiting list for a residential treatment bed and need help and support while they wait.

In Tasmania, services are provided by three organisations in four locations, with up to 58 beds available for AOD residential rehabilitation. There are also six beds available in Places of Safety and Sobering Up facilities providing overnight or very short term stay across Tasmania. One of which (Serenity House) has been multi-purposed by Launceston City Mission and The Salvation Army to provide short-stay (i.e. 2-week) for clients, with assessments and psychosocial support prior to entering longer-term residential treatment. Based on 2015-16 data, despite having a relatively small proportion of residential rehabilitation beds (21%, 12 beds), the Northwest region recorded most of the rehabilitation treatment episodes (42.3%; 220 episodes), noting however that the majority of rehabilitation episodes were provided in outreach settings.

By examining international and Australian examples of evidence-based treatment guidelines and principles, together with the peer reviewed literature, this paper identified the elements of best practice against which to assess the current service delivery in Tasmania. The emerging key themes from the evidence base as reflected in the service provider feedback included:

- A shortage of residential rehabilitation beds available in Tasmania, and a lack of appropriate services for youth and women with children who require residential rehabilitation for substance use issues.
- A lack of coordinated admission processes and a pathway from withdrawal management to residential rehabilitation.
- A lack of clarity about treatment models and structured aftercare for some services.

Based on the available evidence from the three organisations (Launceston City Mission, The Salvation Army and Velocity Transformations/ Pathways Tasmania) there are varying degrees of alignment with the elements of best practice in residential rehabilitation services. This evidence, together with the Drug and Alcohol Service Planning (DASP) modelling of demand for residential rehabilitation beds results in the following conclusions:

Key areas of service gap/ need identified by this review:

- There is evidence to support an increase in the capacity of residential rehabilitation services in Tasmania;
- There is evidence of potential unmet demand for residential rehabilitation services for youth in Tasmania. The quantum of service that would be required to satisfy this demand is not sufficient to warrant a standalone residential facility. Services could explore the feasibility of extending current intake criteria and to adopt a more flexible approach to program delivery to provide residential rehabilitation services appropriate for youth. Services could also consider forming partnerships with other service providers (e.g. Housing Connect and women's shelters) to

provide in-reach and/or e-health services for young people that require residential rehabilitation treatment;

- There may be a need to explore the feasibility of providing women with children rehabilitation services in residential settings. This may include a small amount of infrastructure work to fit-out current facilities for them to be suitable for children (e.g. converting one existing unit to be able to cater for women with children on a flexible basis). Alternatively, or as well, the system could consider how to form partnerships with other human service providers that cater to women with children such as shelters to provide in-reach and/ or e-health based services for women with children in those other settings.

Options and recommendations for system reconfiguration, cost effectiveness, efficiency and collaboration and integration

Drawing on the evidence from all sources, we suggest the following improvements:

1. There was no suitable information available to the review on one service provider, Velocity Transformations and therefore, no judgement can be made about the alignment of its model of care with the evidence base. We recommend it be independently reviewed in the short term.
2. Develop a more standardised and coordinated approach to admit clients to residential rehabilitation treatment and improve the continuum of care. This would better ensure that places go to the people in most need and more efficiently utilise resources currently available. Integrated care pathways, based on the UK NHS, from initial assessment to short stay or long stay residential rehabilitation program are suggested as appropriate models (see Figures 2 & 3; Chapter 7 of the Residential Rehabilitation Report).
3. Examine the structure and feasibility of short-term residential treatment models and the possibility of using Places of Safety and Sobering-up beds as multi-purpose facilities to provide flexible short term residential treatment.
4. Consider the option of providing residential step-up/step-down treatment, along the lines of Mental Health models, which provide a less structured treatment approach compared to short term residential rehabilitation treatment.
5. Treatment methods used in the program should be clearly identified and available to clients and stakeholders. Consequences of negative behaviours also need to be clearly identified for clients but handled in a way that keeps the client engaged with the service or with some part of the treatment service system.
6. From the information available, treatments provided at two rehabilitation services appear to be evidence based, using appropriate treatment methods aligned with contemporary best practice guidelines. Further review of the treatment provided by the third service, including its assessment and discharge procedures, and its length of stay, is recommended.
7. Services should ensure that language used to describe their treatment demonstrates respect for clients' choice.
8. Organisations differ in their approaches to manage waiting lists. While clients with moderate substance use dependency may also benefit from residential treatment, best practice guidelines state that people with more severe substance use dependence and/or complex issues should be the target population for this type of treatment. As such, residential rehabilitation treatment should be prioritised for people with more severe and/or complex issues.

9. Examine the structure and processes of enrolling clients into residential rehabilitation services, focusing on identifying ways to minimise waiting times and, where they are unavoidable, ensuring support is provided in the interim. Provide assertive outreach to engage people as soon as places become available. Services should consider the use of e-health technologies to provide support and monitor clients' progress while they wait, and then as necessary prioritise entry to those that rapidly deteriorate or whose circumstances change significantly putting their health at risk.
10. Consider using standardised assessment tools to track clients' progress and assist with service evaluation, benchmarking and reporting at the state-wide level. For example, extend the use of the Alcohol and Drug Outcome Star and the Mental Health Outcome Star to track and report clients' progress in all three organisations.
11. Ensure adoption of the Quality Assurance Framework developed at the national level in all services in Tasmania.
12. Further review approaches to transition and aftercare to ensure clients who complete rehabilitation treatments are provided structured continuing care to support maintenance of treatment gains as they re-enter the community making maximum use of e-health options where appropriate and possible.
13. Review the rehabilitation service provider workforce's qualifications to ensure that all staff have appropriate training in AOD issues.
14. Set funding at levels that will allow for appointment of suitably qualified staff, ensuring a career path and providing strong support and supervision.
15. Develop strategies to link drug treatment services and other services that are critical to clients' quality of life and to clients' recovery. Suggestions are included in the Residential Rehabilitation Report.
16. Consider better ways to manage co-existing problems (e.g. mental and physical health). Detailed suggestions are included in the Residential Rehabilitation Report.

Options and recommendations for medium and longer-term activities

Based on the findings of this review, we developed and recommend a model of a service framework incorporating both short and longer-term stays, and day programs for rehabilitation treatment in Tasmania (Figure 1). In addition to the service elements identified in this model, an integrated AOD service system that provides a continuum of care should provide a step-up/step-down program to bridge ambulatory services and inpatient/residential services.

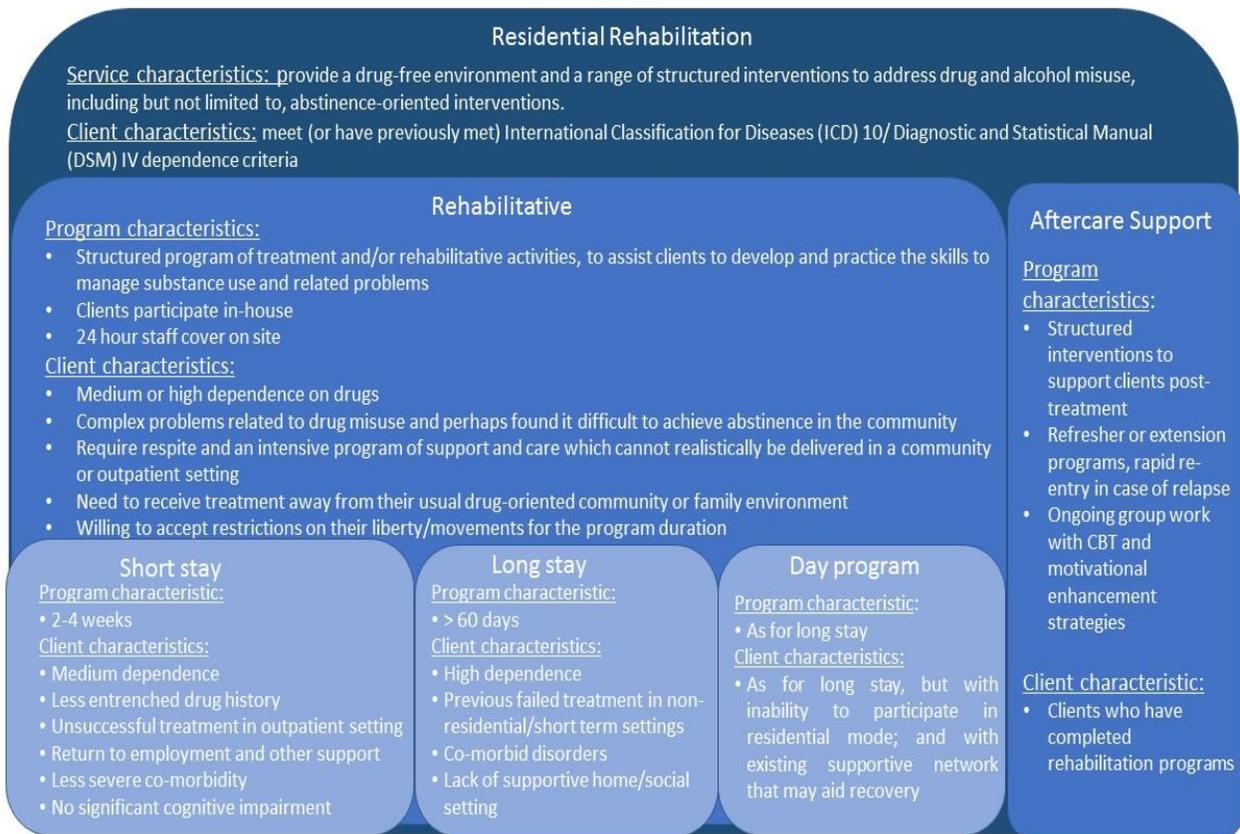


Figure 1: Draft Framework for rehabilitation treatment in Tasmania

Findings, and options and recommendation to Withdrawal Management

Findings

Informed by international and Australian peer-reviewed literature and clinical guidelines, this report analysed current withdrawal management services in Tasmania against contemporary benchmarks and service providers' feedback to identify potential areas of improvement.

Four withdrawal management models were identified: 1) ambulatory home-based withdrawal management; 2) community residential withdrawal management (with or without medical supervision); 3) inpatient withdrawal management; and 4) rural and regional withdrawal management.

Contemporary best practice guidelines highlight that ambulatory withdrawal management should be considered the first option, as it is the least restrictive option for the patient. Patients should only be referred to hospital when withdrawal may be complicated by its severity or other medical or psychiatric problems, or when no other suitable option is available, noting that the suitability of ambulatory withdrawal management services differs by drug type and complexity of presentations, and they are unsuitable for those individuals who do not have a home environment that is conducive to withdrawal management.

In Tasmania, withdrawal management services are mainly provided by the single Inpatient Withdrawal Management Unit in Hobart, with limited capacity of ambulatory home-based withdrawal management provided by The Salvation Army. Hospital separations data also shows a significant proportion of

inpatient withdrawal management occurred in public and private hospitals throughout Tasmania. Recently, the Launceston City Mission and The Salvation Army has formed a partnership to provide withdrawal management (without medical supervision) for clients with less complex presentations at the Sobering up/Places of Safety Beds at Serenity House.

Table 3 below presents a high-level summary of the resources (clinical FTEs and beds) modelled to provide ambulatory and inpatient withdrawal management in Tasmania.

Table 3: High level summary of clinical staff and bed estimates for withdrawal management modelled in the DASP model

Settings	Clinical staff FTEs		Beds	
	Clinical Staff FTEs	Clinical Staff FTE cost \$mill	Beds	Bed overheads cost \$mill
Ambulatory				
Ambulatory - standard	4.3	0.6	-	-
Ambulatory – complex (addition)	0.4	0.0	-	-
Detoxification				
Detox	6.8	1.0	19.3	1.3
Detox-caretaker	4.3	0.5	-	-
Inpatient				
Inpatient	9.8	5.6	4.5	0.3

Note: Caretaker Clinical Staff are a small additional component of Clinical staffing FTE resources and costs, in residential rehabilitation and withdrawal (residential – dorm) bed settings. Within withdrawal management context, caretaker clinical staff are modelled based on NAH category.

Comparisons between current service provisions against the DASP modelling of demand for withdrawal management services shows resources (clinical staff FTEs and beds) for inpatient withdrawal management approximates that modelled in the DASP, noting a lack of information on resources available for inpatient withdrawal management in private hospitals. Our comparison shows a significant gap of separations needed for inpatient withdrawal management. Clinical staff FTEs available for ambulatory home-based withdrawal management was not available; however, documentation available points to a significant gap. This interpretation is also consistent with stakeholders’ views provided in individual and group interviews. Resources budgeted to provide consultation liaison (CL) services for withdrawal management approximate that modelled by the DASP.

Comparisons between current service provisions against the DASP modelling of demand for withdrawal management services, taking into account feedback provided by service providers and consumers through targeted consultations, results in the following recommendations:

Options and recommendations for system reconfiguration, cost effectiveness, efficiency and collaboration and integration

Taking together the information from the literature review, client pathway consultations and the DASP modelling (based on the specific DRGs code for withdrawal management⁷) it would appear that the

⁷ The following DRGs are: V60A Alcohol Intoxication and Withdrawal with complications; V60B Alcohol Intoxication and Withdrawal without complications; and V61Z Drug Intoxication and Withdrawal

resources available for inpatient withdrawal management are adequate to meet the needs of the Tasmanian population. However, there is a question remaining about the data provided to this review. Comments received from the DHHS at the end of the review process about the coding practices of the hospital in relation to the client load of the In-Patient Withdrawal Unit (IPWU), where a proportion of the unit workload is coded to the following DRGs:

- V62Z Alcohol Use and Dependence
- V63Z Opioid Use and Dependence
- V64Z Other Drug Use and Dependence

This, therefore, leaves open the possibility that this unit is providing a mixture of inpatient withdrawal services and treatment services, or that there is a problem with the coding practices. This issue cannot be resolved within the timeframe or scope of this review. We recommend that the DHHS include a review of coding practices as part of the overall review of the IPWU.

- The review of the IPWU should focus on understanding the barriers to accessing the unit including opening hours for the admission of patients.
- The review will include bringing the sector together to work out the seamless client pathways from withdrawal management to other services and mutually agreed processes and protocols to support that client pathway. The review also needs to ensure that the client pathway does not need to meet the requirement that the consumer have a pre-determined post withdrawal destination as a condition of admission, but rather includes the determination of the clients' pathway post withdrawal management during the withdrawal period.
- The review should consider the benefits and/or disadvantages of transfer of the management and clinical governance of the IPWU to the Royal Hobart Hospital, based on: the need to improve access to medical and nursing staff on a 24/7 basis; to allow for more user-friendly operating hours and therefore potential to increase the capacity for training for general medical, nursing and allied health staff in addiction medicine management; opportunities for the training of specialist AOD medical and other staff; and the most cost-effective use of the existing highly specialist staff of the IPWU in the provision of supervision, training and consultation liaison services into the hospital and secondary consultation services to the broader treatment system.

Options and recommendations for medium and long-term activities

In addition, in relation to options and recommendation of what is needed in the medium and longer term to achieve an integrated approach to withdrawal management within a single AOD service system framework, we suggest that:

- **Model of care:** A model of care for withdrawal management services in Tasmania that clearly identifies treatment approaches for withdrawal management is required. This model of care should include the adoption of contemporary clinical guidelines such as those recently developed in Victoria, Queensland and New South Wales for all withdrawal management settings in Tasmania, including but not limited to inpatient and ambulatory home-based settings.
- **Withdrawal management in private hospital settings:** Reviewing the capacity of private hospitals to provide withdrawal management services in Tasmania, and whether it might be a cost-effective option for the public system to consider purchasing public admissions in private facilities rather than increasing public sector investment in infrastructure and staffing.

- **Ambulatory home-based withdrawal management:** Increasing the capacity for ambulatory withdrawal management services in Tasmania. Many service providers considered that the provision of ambulatory, home-based withdrawal management services would provide clients with less complex presentations with more treatment options to undergo withdrawal management. Existing resources of the Inpatient Withdrawal Unit (IPWU) may be used to support GPs and home-based withdrawal nurses in the delivery of ambulatory home-based withdrawal management.
- **Community residential withdrawal management:** Community residential withdrawal management (with or without medical supervision) has been identified as suitable for patients with less complex presentations, or those in need of a more stable care environment. Tasmania DHHS may want to consider the use of other Places of Safety/Sobering Up beds as multi-purpose facilities to provide community residential withdrawal management.
- **Inpatient withdrawal management in general hospital beds:** Due to resource limitations, the DHHS may also consider enhancing the capacity of hospitals and other clinical facilities to manage a small number of cases in areas outside of Hobart.
- **Youth:** Addressing the need for inpatient withdrawal management services appropriate for youth. DASP estimates for inpatient withdrawal management for youth indicated that there is not enough demand to warrant a stand-alone facility. Alternative options for youth inpatient withdrawal management should be considered.
- **Transition from withdrawal management:** Withdrawal services should meet with ongoing care and work out how to ensure smooth and timely transition from withdrawal to ongoing outpatient and inpatient care after withdrawal including identification and resolution of barriers.
- **Mersey Community Hospital:** We note the recent transfer of the Mersey Community Hospital back to the Tasmanian state government. The establishment of a level 4 service at the Mersey Community Hospital in the Northwest, as noted in the *Delivering Safe and Sustainable Services* White Paper, would allow the development of Addiction Medicine Services. The capacity of this service, as well as the opportunity to use general hospital beds in this facility for inpatient withdrawal management, should be considered in the development of withdrawal management services state-wide.