

**Submission  
No 34**

**INQUIRY INTO THE PROVISION OF DRUG  
REHABILITATION SERVICES IN REGIONAL, RURAL AND  
REMOTE NEW SOUTH WALES**

**Organisation:** NSW Government

**Date received:** 17 January 2018

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# NSW Government submission to the Inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales

## Introduction

This NSW Government submission to the Inquiry into the provision of drug rehabilitation services in regional, rural and remote NSW contains information from NSW Health, Family and Community Services, the Department of Justice, NSW Police and the Department of Premier and Cabinet. This submission responds to each of the Inquiry's terms of reference as follows:

<b>Inquiry terms of reference</b>	<b>Submission section</b>
1. The range and types of services including the number of treatment beds currently available	A
2. Specific details regarding rehabilitation services for those with amphetamine and methamphetamine addictions	B
3. The qualification to receive funding as well as the funding arrangements for services be they public, not-for-profit, for profit or on any other basis	C
4. Registration and accreditation process required for rehabilitation services to be established	D
5. The cost to patients/clients, including fee structures provided to families, for accessing rehabilitation services	E
6. The waiting lists and waiting times for gaining entry into services	F
7. Any pre-entry conditions for gaining access to rehabilitation services	G
8. Investigate the evidence regarding the efficacy and impacts of mandatory detoxification programs for those who self-harm or are subject to an Apprehended Violence Order (AVO)	H
9. The gaps and shortages in the provision of services including geographical, resources and funding	I.1
10. Issues relating to the provision of appropriately qualified health professionals to fill positions in rehabilitation services	I.3
11. Evidence of rehabilitation services that have had both successful and unsuccessful outcomes, including what characteristics constitute a successful outcome and how reliable is the data collection and reporting mechanisms currently in place	J
12. Current and potential threats to existing rehabilitation services	I.2
13. Potential and innovative rehabilitation services and initiatives including naltrexone	K
14. Any other related matters	Context

## Context

### Introduction

People may experience a range of problems related to alcohol or other drug (AOD) use throughout their lives. Problems can include social problems related to relationships, work, housing, parenting or legal problems; physical health problems including injuries, infections, organ damage, and overdose; as well as mental health issues. These problems can range in severity from mild to severe and may affect individuals, their family and friends or others in the community. When people become dependent on drugs or alcohol, they can be unable to reduce or stop using when they need to.

Problems related to substance use may lead people to seek AOD treatment. Treatment can be provided in primary care, acute care and specialist AOD treatment settings. It is important that people seeking treatment know the options that are available to them, and how to access treatment. The NSW Government supports a wide range of public and community-based services for individuals that need assistance for their AOD related problems.

In considering treatment options, it is important to recognise the chronic nature of AOD dependence and the need to tailor care to the person's circumstances. Many people with AOD-related problems may have a range of other complex and chronic conditions, including mental health issues and cognitive impairment.

These issues may make it difficult for people to access or engage with primary health or specialist treatment services.

Further, intergenerational patterns of substance use and related problems including poverty, unemployment, domestic and family violence and other social problems create challenges in delivering effective, comprehensive treatment and in supporting the overall rehabilitation of people with alcohol and other drug dependence.

A range of health and social outcomes can be improved by earlier recognition of AOD issues along with access to more assertive care and follow up. That is why it is important that intervention commences at the client's first point of access to the health care system and that there are strong partnerships across health services, including with primary health care and non-government organisations (NGOs), for people who need assistance.

### Prevalence and harms of substance use

Alcohol and other drug use nationwide and within NSW continues to be below the high rates experienced in the 1990s. The National Drug Strategy Household Survey 2016 data for NSW indicates:<sup>1</sup>

- The rate of daily drinking in NSW declined to 6.3 per cent, similar to the national average.
- The proportion of people in NSW aged 14 years and over who exceeded the lifetime risk level for alcohol (more than 2 drinks per day) was unchanged (16.7 per cent).
- The recent use of any illicit drug increased slightly in NSW from 14.2 to 14.7 per cent, but is lower than the national rate of 15.6 per cent in 2016.
- Rates of illicit drug use in NSW are around the national average. However, NSW has the lowest rate of meth/amphetamine use and the highest rate for cocaine.
- The NSW rate of methamphetamine use in the last 12 months declined significantly (from 1.4 per cent in 2013 to 0.7 per cent in 2016), while the NSW rate of cocaine use in the last 12 months increased non-significantly (from 2.7 to 3.4 per cent).

It is important to recognise that the problematic use of alcohol and prescription medications (such as benzodiazepines, oxycodone and codeine) is a major concern and an important focus of AOD treatment. The burden of harm associated with the misuse of alcohol and

prescription drugs far outweighs the burden of harm from all other illicit substances.<sup>2</sup> Further, drug users commonly misuse multiple drugs together with alcohol. Excessive consumption of alcohol remains a major cause of health and social harm.<sup>3</sup>

In relation to directly drug induced deaths, after excluding alcohol, benzodiazepines were the most common substance present in drug induced deaths in Australia in 2016, being identified in 663 deaths (36.7 per cent; Table 1). Benzodiazepines are associated with both accidental and intentional overdoses and were the most common drug in both unintentional and suicidal drug deaths in 2016.

The majority of drug induced deaths in 2016 were due to acute accidental overdoses (71.3 per cent), followed by suicidal overdoses (22.7 per cent). Other types of drug deaths, including addictions and chronic complications of drug abuse accounted for the remaining 6.0 per cent. Over half (59.0 per cent) of all acute drug deaths had two or more substances identified on the toxicology report at death. Single capture of narcotics (where only one drug in the body system is reported), which includes illicit and prescription opioids as well as substances such as cocaine were more common in accidental drug deaths. Single capture of sedative and psychostimulant use, which includes benzodiazepines, antidepressants and amphetamines were more common in intentional selfharm drug deaths.

There has been a decrease in deaths from prescription opiates (painkillers) such as oxycodone, morphine and codeine since 1999, however, they remain present in over 30 per cent of drug induced deaths in 2016. Similar to benzodiazepines, they are common in both accidental and intentional drug induced deaths.

Psychostimulants such as methamphetamine were ranked third most common cause of drug induced deaths in Australia in 2016, closely followed by heroin (20.1 and 20.0 per cent respectively; Table 1).

**Table 1. Number of drug induced deaths by drug type (excluding alcohol), Australia, 1999 and 2016**

		Year					
		1999		2016			
Cause of death and ICD-10 drug code	Common terms assigned to ICD-10 category of drug	Number of deaths	Rank	Number of deaths	Rank	Proportion	Median age (years)
<b>Total drug induced deaths</b>		<b>1,740</b>	<b>n/a</b>	<b>1,808</b>	<b>n/a</b>	<b>n/a</b>	<b>45.3</b>
Benzodiazepines (T424)	Alprazolam, Diazepam, Oxazepam, Clonazepam, Temazepam, Oxazepam	503	2	663	1	36.7	44.6
Other opioids (T402)	Oxycodone, Codeine	678	1	550	2	30.4	46.0
Psychostimulants with abuse potential (T436)	Amphetamine, Ecstasy, MDA, MDMA, Speed, Methamphetamine, Ice, Caffeine	76	11	363	3	20.1	39.4
Heroin (T401)	Heroin, 6/3-Monoacetylmorphine	441	3	361	4	20.0	41.2
Other and unspecified antidepressants (T432)	Sertraline, Citalopram, Venlafaxine, Fluoxetine, Mirtazepine, Fluvoxamine, Paroxetine, Duloxetine,	124	9	276	5	15.3	48.1

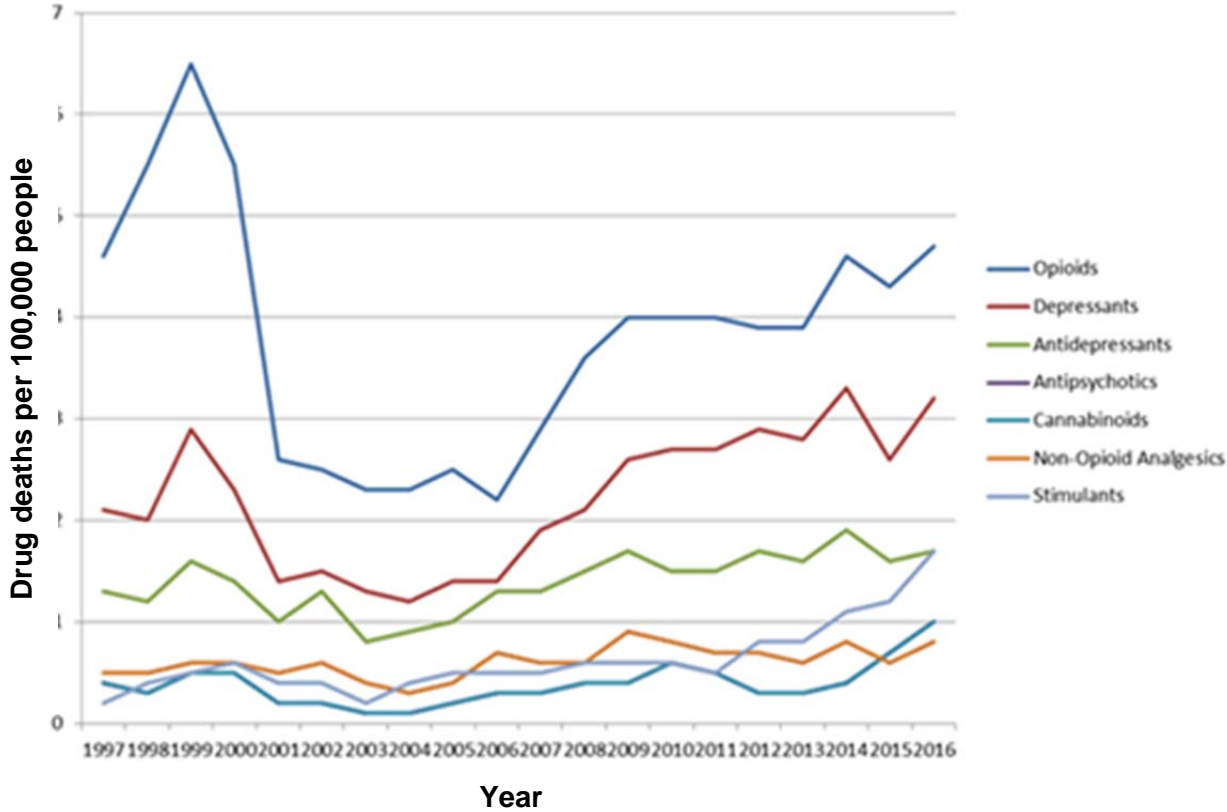
Bupropion							
Other synthetic narcotics (T404)	Fentanyl, Tramadol, Pethidine	68	12	234	<b>6</b>	12.9	41.3
Alcohol, unspecified* (T519)	Alcohol	252	4	222	<b>7</b>	12.3	47.4
Other and unspecified antipsychotics and neuroleptics (T435)	Quetiapine, Olanzapine, Antipsychotic, Risperidone	28	17	220	<b>8</b>	12.2	45.2
Methadone (T403)	Methadone	131	7	208	<b>9</b>	11.5	43.2
4-Aminophenol derivatives (T391)	Paracetamol	110	10	170	<b>10</b>	9.4	50.5

Source: Australian Bureau of Statistics 2017, 3303.0 - *Causes of Death, Australia, 2016*<sup>2</sup>

**\*Deaths directly attributable to alcohol were excluded from this analysis.** Even so, alcohol was still ranked the seventh most common substance present in drug induced deaths. All of these deaths involving alcohol were due to a multiple drug overdose.

When examined by drug class, opioids and depressants such as benzodiazepines are together responsible for the majority of directly drug-induced deaths in Australia (excluding alcohol), and this has been the case for the last 20 years. Stimulants such as methamphetamine have caused a rapid increase in the number of drug induced deaths since around 2011, but the number of deaths is still well below that caused by opioids and benzodiazepines (Figure 1).

Figure 1. Drug-induced deaths by drug class (excluding alcohol), Australia 1997-2016

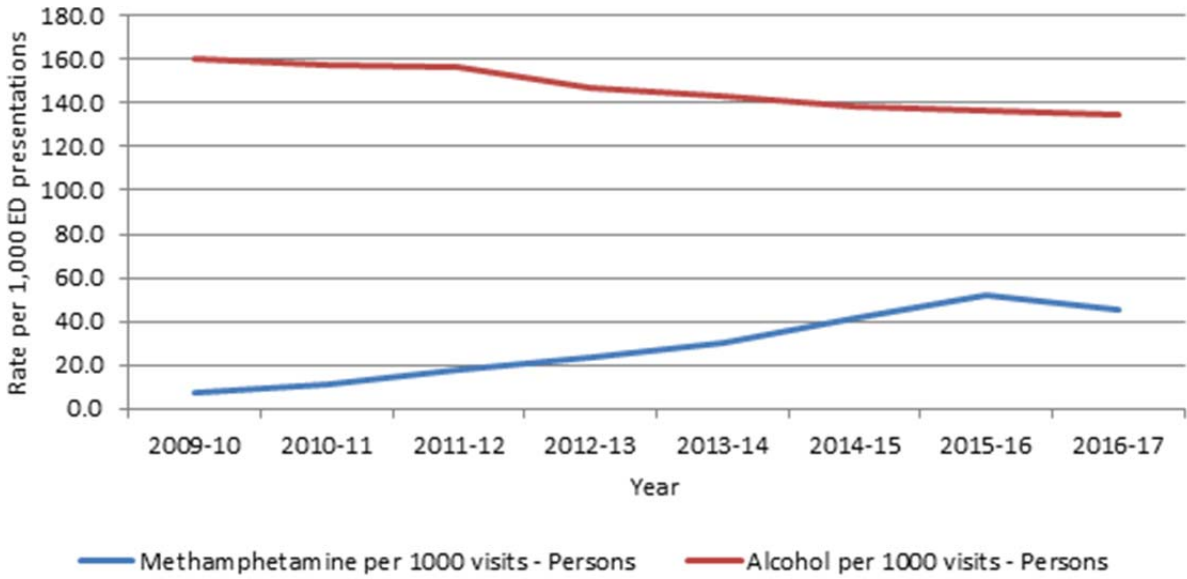


Source: Australian Bureau of Statistics 2017, 3303.0 - Causes of Death, Australia, 2016<sup>2</sup>

Although the number of people that use methamphetamine in NSW is falling, there has been an increase in harms associated with amphetamine use since around 2009-10. This is most likely related to increased purity, frequency of use, form of drug used (e.g. crystalline methamphetamine or “ice”) and the way it is used.

The most recent NSW emergency department data indicates that emergency department presentations for methamphetamine may be stabilising. This trend was found across all regions in NSW. It is important to note that alcohol-related emergency department presentations continue to far outnumber methamphetamine presentations, but alcohol-related presentations have been falling since 2009-10 (Figure 2).

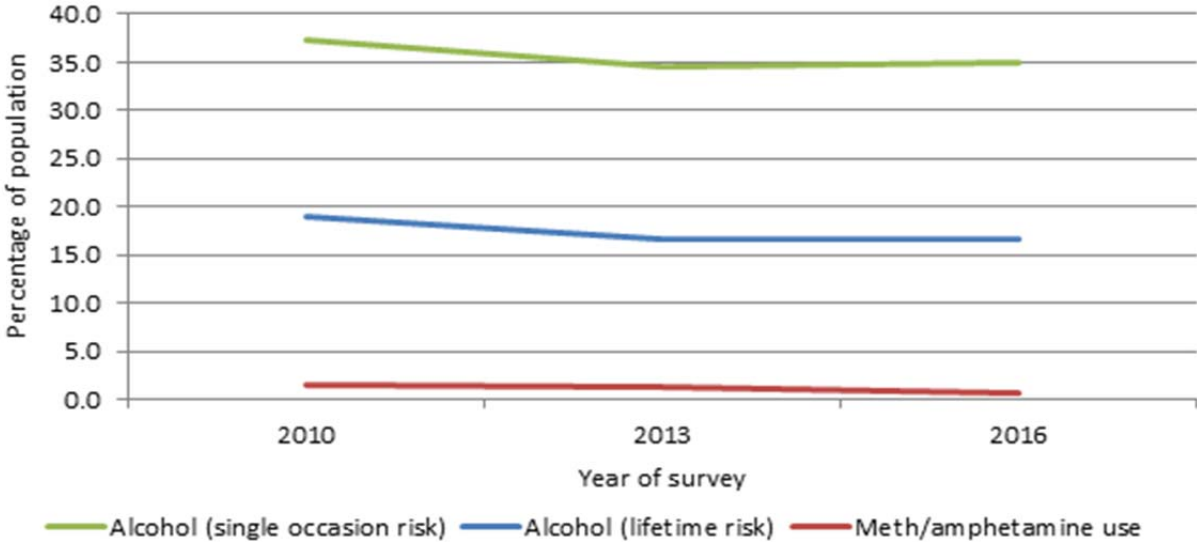
Figure 2. Rate of methamphetamine and alcohol-related emergency department presentations in NSW, 2009 to 2017



Source: Rapid Emergency Department Data for Surveillance, Centre for Epidemiology and Evidence, NSW Ministry of Health<sup>4</sup>

When considering the potential community need for treatment of alcohol and drug issues, it is important to recognise that there are many more people in the community with the potential to need treatment for alcohol than methamphetamines, for example (Figure 3).

Figure 3. High risk alcohol consumption and methamphetamine use, NSW, 2010 to 2016



Source: Australian Institute of Health and Welfare 2017, *National Drug Strategy Household Survey key findings*<sup>1</sup>

Notes: Single occasion risk is defined as more than four standard drinks on one occasion in the last 12 months. Lifetime risk is defined as more than two standard drinks per day in the last 12 months

In 2015-16, over 30 per cent of service episodes for specialist alcohol and other drug services in NSW were for alcohol as the principal drug of concern in NSW. Amphetamine-type substances accounted for 24 per cent of service episodes and cannabis 14 per cent.<sup>5</sup>

## **Policy context**

The NSW Government's response to AOD-related harm is in the context of Australia's long-standing commitment to harm minimisation. This approach recognises that drug use occurs across a continuum, from occasional to heavy use, and that a range of harms are associated with different types and patterns of drug use. Therefore, the response to these harms requires a flexible, tailored approach.

The three pillars of harm minimisation are demand reduction, supply reduction and harm reduction. At the population level, strategies to minimise alcohol and other drug harms should be coordinated and balanced across these three pillars.

In 2017-18 the NSW Government committed \$208 million to AOD-related health services, which includes enhancement from the \$75 million Drug Package announced in 2016. The NSW government is committed to ensuring that there is range of accessible drug and alcohol treatment services available in the community and that these services meet the needs of individuals. This includes establishing clear referral pathways to specialist services from hospitals and primary health services.

Family and Community Services (FACS) is leading the development of a new whole-of-government strategy on homelessness that provides a long-term plan to prevent and reduce homelessness. The NSW Homelessness Strategy has been informed by wide consultation with government and non-government agencies, including the drug and alcohol sector. The Strategy will provide the framework for new investment in services that address the key risk factors of homelessness, one of which is alcohol and other drug dependence.

## **What are drug rehabilitation services?**

Within this submission, the term 'drug rehabilitation' refers to a range of drug treatments, including withdrawal management ('detoxification') in inpatient and ambulatory settings, drug counselling, medication-assisted treatment, opioid treatment, hospital-based drug and alcohol consultation services, intensive outpatient programs, outreach services, and residential rehabilitation treatment programs. The reason for this is that there is no one size fits all approach to AOD treatment.

A person's AOD treatment needs will vary depending on the severity of addiction and where they are on their treatment journey, with some treatment types provided together. Some people may only require counselling, some may need withdrawal management followed by counselling or residential rehabilitation, while for others medication-assisted treatment (e.g. anti-craving treatment such as Antabuse or naltrexone for alcohol dependence) may be required. Withdrawal may be managed in the community, or in a hospital (inpatient) setting for more clinically risky issues e.g. for a person at risk of alcohol withdrawal seizures.

Typically, residential rehabilitation treatment models aim to assist clients in moving to a stage in which they are drug or alcohol free, through addressing underlying issues in the clients' lives. Most residential services require clients to have already fully withdrawn from substances before admission and to be drug-free throughout their stay, although a small number of services are now accepting clients who can undergo withdrawal management in the service and/or who can be provided methadone maintenance therapy for opioid dependence.<sup>6</sup>

Residential rehabilitation should be reserved for people who have severe and complex drug and alcohol problems that require intensive treatment and support. The majority of people who need treatment for AOD use problems would be best served by treatment in the community, ideally their local community. This may include one-on-one or group psychosocial counselling (such as cognitive behaviour therapy), day rehabilitation programs and outreach services. These services provide treatment for those who are unable to commit to an intensive residential stay of between six weeks and six months, for reasons such as



family and community connections and work commitments and the need for stable accommodation.

### **Scope of this submission**

It is important to note that the drug rehabilitation services referred to in this submission are those for which service provision was funded wholly or in part by the NSW Government, from NSW Health and/or the other agencies that provided contributions to this submission. These services include NSW government owned and operated hospitals and community clinics, NGO run services and Aboriginal community controlled health organisations and services.

Private or Commonwealth funded services (including those funded through Primary Health Networks) are outside the scope of this submission.

## A. The range and types of drug rehabilitation services in regional, rural and remote NSW

NSW public sector drug rehabilitation services and NSW Government-funded NGO drug rehabilitation services are primarily delivered via the Health and Human Services, and Justice clusters.

### NSW Health drug rehabilitation programs

NSW Health delivers a comprehensive range of evidence based AOD prevention, education and treatment services state-wide through the local health districts and specialist health networks, and non-government organisations. The range and types of rehabilitation services are designed to meet a variety of treatment needs. Services include:

- Case management
- Psychosocial counselling (one to one and group work)
- Opioid treatment (methadone, buprenorphine)
- Care coordination
- Inpatient withdrawal management
- Day program rehabilitation treatment
- Residential withdrawal management
- Residential rehabilitation.

**Table 2. Number of clients treated by NSW-funded alcohol and other drug services, by main service provided and local health district (LHD) region, NSW, 2016-17**

Main service provided	Metropolitan LHDs	Regional LHDs	Total (n)	Total (%)
Counselling	6,302	5,582	11,884	26.4
Maintenance pharmacotherapy (opioid)*	5,031	3,894	8,925	19.8
Consultation activities	3,078	3,730	6,808	15.1
Assessment only	2,277	2,456	4,733	10.5
Residential withdrawal management	3,009	1,261	4,270	9.5
Support and case management only	1,815	2,162	3,977	8.8
Residential rehabilitation activities	1,297	933	2,230	4.9
Ambulatory withdrawal management	533	595	1,128	2.5
Ambulatory rehabilitation (day programs)	229	312	541	1.2
Involuntary drug and alcohol treatment	46	71	117	0.3
Maintenance pharmacotherapy (non-opioid)	29	34	63	0.1
Other	401	22	423	0.9
<b>Total number of clients</b>	<b>24,047</b>	<b>21,052</b>	<b>45,099</b>	<b>100</b>

Source: NSW Alcohol and Other Drug Treatment Services - Minimum Data Set, extracted 21 November 2017. <sup>7</sup>

Notes: Numbers of clients on opioid maintenance pharmacotherapy as reported through the NSW Alcohol and other drug treatment service minimum data sets is an undercount. More complete information is available through the National Opioid Pharmacotherapy Statistics (NOPSAD) 2016. <sup>8</sup>

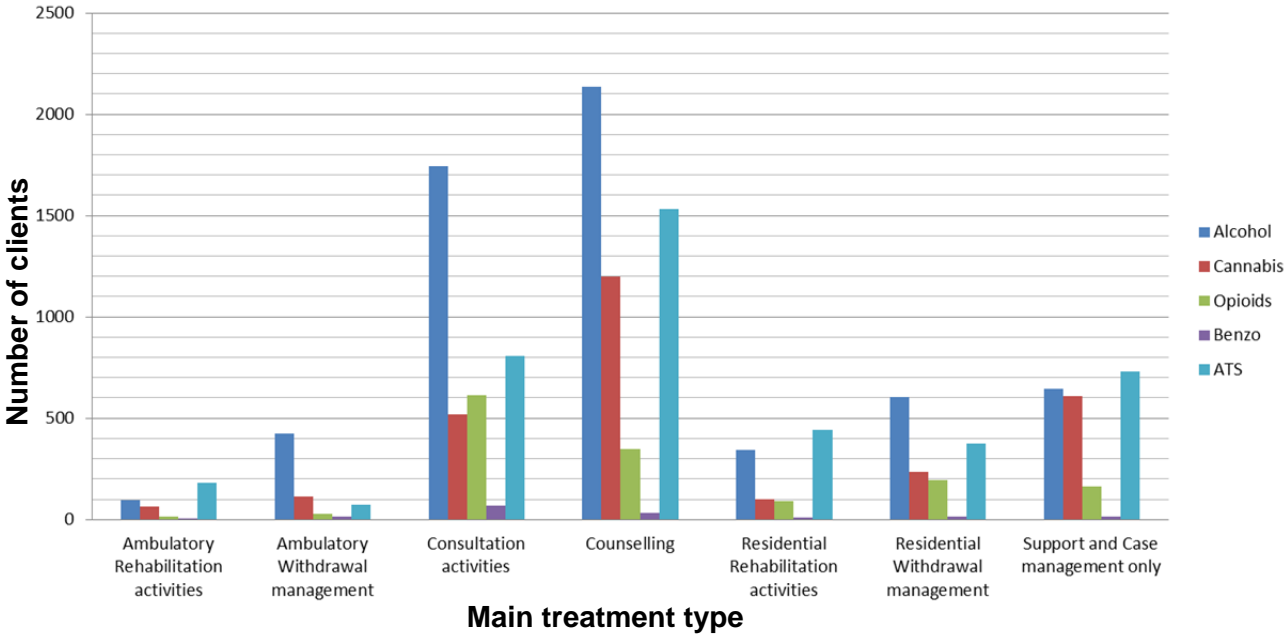
Metropolitan local health districts include Sydney, Northern Sydney, South Eastern Sydney, South Western Sydney, Western Sydney, Central Coast, Nepean Blue Mountains and St Vincent's Hospital Network. Regional local health districts include Illawarra Shoalhaven, Hunter New England, Mid North Coast, Murrumbidgee, Northern NSW, Southern NSW, Western NSW, and Far West. Includes all closed main services for July 2016 to June 2017 except for maintenance pharmacotherapy (opioid), which includes all open services. Northern NSW Local Health District data is from July 2016 – December 2016 only. St Vincent's Hospital residential withdrawal data is excluded. Services to secondary clients (such as family members) are excluded.

Of all clients provided specialist drug and alcohol services, 47 per cent of clients were treated in regional local health districts (Table 2).

There were no substantial differences in the principal drug of concern for clients presenting in rural and regional NSW compared to metropolitan areas.

Alcohol was the principal drug of concern for the bulk of counselling activities, consultation activities, ambulatory and residential withdrawal management, residential rehabilitation and ambulatory rehabilitation activities (day treatment programs) for clients treated in regional NSW local health districts (Figure 4).

**Figure 4. Number of clients provided alcohol and other drug treatment, by principal drug of concern and main treatment type, regional local health districts, NSW, 2016-17**



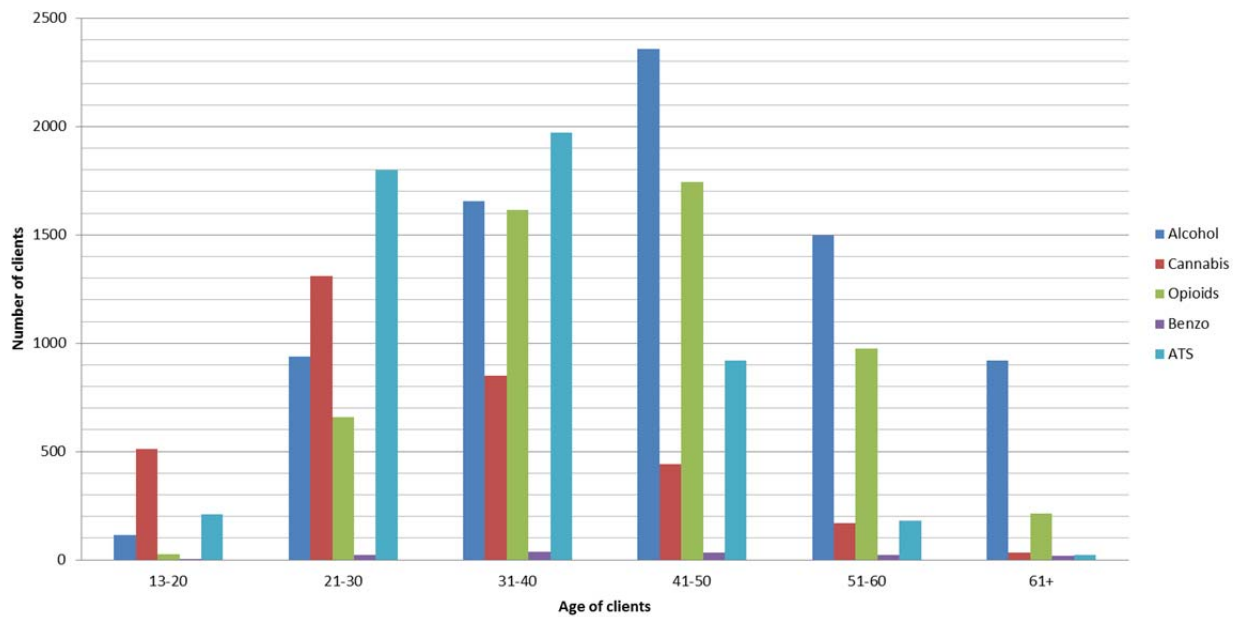
Source: NSW Alcohol and Other Drug Treatment Services - Minimum Data Set. Extracted 21 November 2017. NSW Ministry of Health <sup>7</sup>

Alcohol was the most common principal drug of concern for people aged 41 years and over, and was also a significant issue for people aged 31-40 years. Amphetamine-type substances (ATS) were the most common principal drug of concern in people aged 21 to 30 years, and cannabis was the principal drug of concern for young people (aged 13 to 20 years). Opioids were a drug of concern in many people aged 31-60 years (Figure 5).

Apart from the slightly older age profile for people with opioids as their principal drug of concern in regional areas, the pattern of drug use by age is very similar between metropolitan and regional local health districts in NSW (Figures 5 and 6).

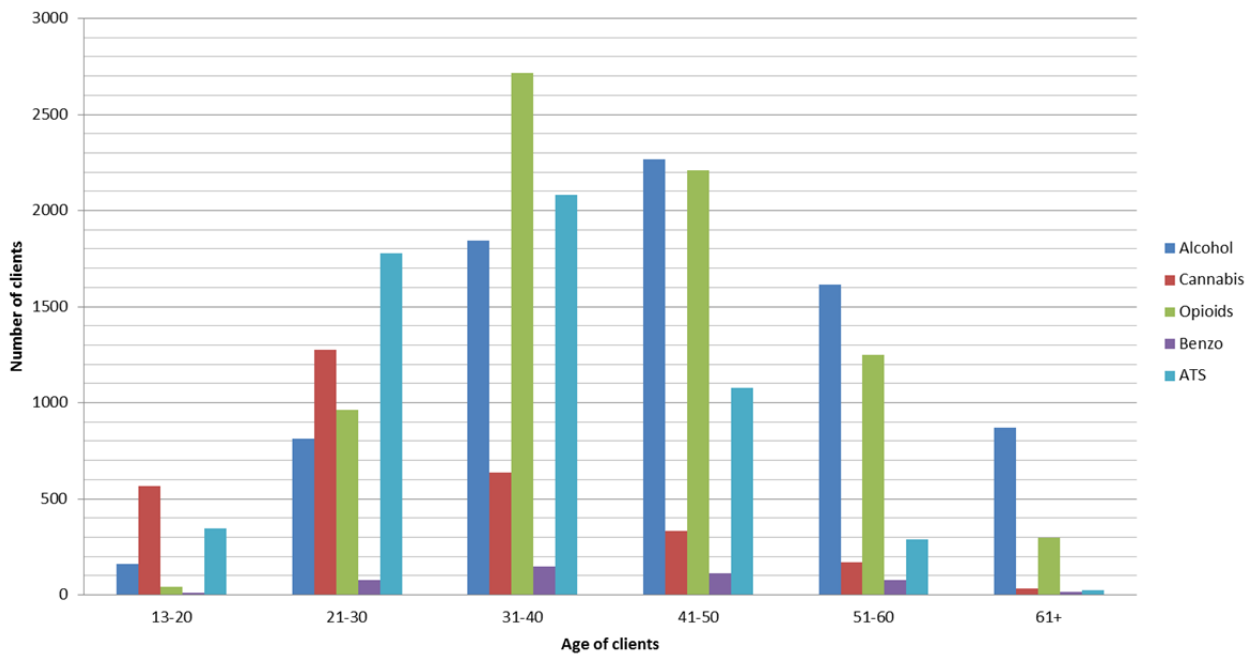
It is important to note that the number of clients receiving opioid maintenance pharmacotherapy is undercounted through the NSW Alcohol and Other Drug Treatment Services Minimum Data Set. More complete information is available from the National Opioid Pharmacotherapy Statistics (NOPSAD), which in 2016 reported that in NSW 14,525 people received methadone treatment, and another 5,532 received buprenorphine-naloxone treatment – a total of 20,057 people on opioid treatment in NSW.<sup>9</sup>

**Figure 5. Principal drug of concern, by age, regional local health districts, NSW, 2016-17**



Source: NSW Alcohol and Other Drug Treatment Services - Minimum Data Set. Extraction as at 21 November 2017. NSW Ministry of Health <sup>7</sup>

**Figure 6. Principal drug of concern by age, metropolitan local health districts, NSW, 2016-17**



Source: NSW Alcohol and Other Drug Treatment Services - Minimum Data Set. Extraction as at 21 November 2017. NSW Ministry of Health <sup>7</sup>

It is important to note that people with substance use issues are also identified and managed in a range of other health service settings including emergency departments, mental health services, sexual health services and antenatal services.

Primary care clinicians also treat people with substance use problems. General practitioners are the first health system contact for many people with mild to moderate drug and alcohol problems. General practitioners can assist people to undertake withdrawal at home and treat people with opiate dependence using opiate substitution treatment.

The Justice Health and Forensic Mental Health Network (Justice Health) provides health care to people in the adult correctional environment and in courts and police cells, to juvenile detainees and to those within the forensic mental health system in the community. Justice Health provides risk assessment, blood borne virus prevention and treatment services, management of intoxication and withdrawal, counselling and opioid treatment for clients. As well as post release support programs, the Connections Program has staff based at each rural and metropolitan cluster of correctional centres across NSW. The Connections Program aims to improve the continuity of care for clients with drug and alcohol problems who are being released into the community.

All Connection Program participants have a comprehensive assessment and release plan developed prior to release. Participants are then assertively followed up in the community for a period of four weeks to assist with community integration. In 2016-17, 772 released patients were followed up in the community with 318 of those from a regional area.

### **Court diversion programs**

NSW has the largest suite of evidence-based diversion programs in Australia, with a combination of police and court-based programs operating within an interagency approach. Programs divert illicit drug users, and more recently alcohol users, from the adult criminal justice system into treatment to improve health and social outcomes and reduce re-offending.<sup>9</sup> Diversion programs are well established in NSW and have been evaluated favourably (see section J.1 for evidence of effectiveness).

The Magistrates Early Referral Into Treatment (MERIT) Program is a voluntary pre-plea program for adult defendants that aims to intervene in the cycle of drug use and crime by providing an intensive three-month case management program that addresses the health and social welfare issues considered to be instrumental in bringing defendants into contact with the criminal justice system. Progress in the MERIT program is taken into consideration upon sentencing.

The MERIT program currently operates in 62 of the 150 NSW local courts. Of the 62 MERIT courts, 37 are in regional, rural or remote NSW. MERIT Alcohol is a derivative of the MERIT program for offenders with alcohol use issues. MERIT Alcohol operates in seven local courts, all of which are in rural or regional areas: Bathurst, Broken Hill, Coffs Harbour, Dubbo, Orange, Wellington and Wilcannia.

In 2015, 33 per cent of MERIT program participants were from regional NSW. Cannabis and stimulants are the highest principal drug of concern for MERIT clients in rural and regional NSW, followed by alcohol (Table 3). As there are only seven courts that accept clients with a principal concern of alcohol, people with alcohol as their principal substance issue are unable to access the MERIT program in many areas. However, local health districts offer alcohol treatment services as part of their normal drug and alcohol services.

The NSW Drug Court was established by the *NSW Drug Court Act 1998* and Drug Court Regulation 1998 and has been operating since February 1999. The Drug Court aims to help adult offenders who have serious drug problems break the drug-crime cycle by providing a highly supervised and intensive program of treatment and rehabilitation involving the health sector and criminal justice system. The Drug Court is primarily a metropolitan based program and operates from three locations in Sydney, Parramatta as well as within the Hunter region.

**Table 3. Proportion of client with a principal drug of concern within the Magistrates Early Release into Treatment (MERIT) Program, by Program location, NSW, 2015**

Principal drug of concern	Sydney	Non-Sydney metropolitan	Regional
Cannabis	29.2%	37.4%	41.5%
Stimulants	54.0%	55.3%	38.9%
Alcohol	0.0%	0.0%	14.5%
Opiates	13.8%	5.4%	4.1%
Sedatives/anaesthetics	2.8%	1.7%	1.0%
Other drug	0.2%	0.2%	0.0%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Source: NSW Ministry of Health. MERIT Program Annual Report 2015<sup>10</sup>

### Programs delivered by Corrective Services NSW

Programs that are delivered by Corrective Services NSW are not specific to drug type. Programs are strongly grounded in the evidence around 'what works' in correctional programming.

In the 12 month period from October 2016 to September 2017, Corrective Services NSW (CSNSW) staff delivered 162 addiction programs in regional NSW, both within correctional centres and in the community. For these programs, 2,266 offenders participated and 23,484 sessions were recorded, with an average of 10.4 sessions per individual participant.

Within correctional centres the EQUIPS (Explore, Question, Understand, Investigate, Practice, Succeed) Addiction Program is designed to address the addictive behaviour of medium to high risk offenders and to provide participants with a pathway to support services for addictive behaviours. EQUIPS includes a foundation program (general offending), as well as three offence-specific programs addressing aggression, domestic abuse and addiction, depending on the needs of the participating offender. For this Program, 20 two hour sessions are delivered to participants. From October 2016 to September 2017, 93 programs were delivered to 1,549 offenders across 20 regional centres.

The Health Survival intervention promotes a safe and healthy environment within correctional centres. The program recognises that people in custody are at high risk of blood borne communicable diseases such as hepatitis B, hepatitis C and HIV/AIDS due to high rates of unsafe injecting practices and other risky behaviours. All inmates housed in NSW correctional centres are scheduled to attend a facilitated Health Survival Tips session at least once every twelve months and complete an associated knowledge assessment. In this reporting period, almost 6,000 inmates attended a Health Survival session in the north and south regions.

At Community Offender Services locations, 69 addiction programs were delivered to 717 offenders. At these regional locations, 5,321 sessions were recorded with an average of 7.4 sessions per individual.

The Practice Guide for Intervention (PGI) tool is provided to assist Community Corrections Officers deliver interventions to all medium and above risk offenders being supervised in the community. It provides intervention exercises that can be used during routine supervision contacts. This is a significant benefit for regional and rural towns, where identifying sufficient numbers of offenders to run groups is more challenging. PGI is designed to be used for all offender types, working on issues common across many offending behaviours such as environmental or interpersonal risk factors and antisocial attitudes. Many of these factors are

relevant to AOD use. However, some PGI modules are targeted more directly at substance abuse. Modules with a stronger AOD focus were used for 16 per cent of offenders during October, with 69 per cent having one of these modules incorporated into the plan for the offender's overall supervision.

Data for all non-Sydney metropolitan locations from October 2017 indicate that 91 per cent of all offenders who were medium risk and above had a PGI session. Of 42 offices, 41 had used PGI for over 80 per cent of their medium risk offenders.

The priority for offenders under a community order is on the EQUIPS Foundation and EQUIPS Domestic Abuse programs, which have a strong focus on offence mapping and on identifying the various triggers which led to the offences for which the offender was convicted. Community Offender Services staff refer offenders who require addiction interventions to broader community-based and health services.

### **Programs delivered by the Department of Justice**

Juvenile Justice provides Rural Residential AOD Rehabilitation Services (the Rehabs) at Coffs Harbour and Dubbo. The Rehabs offer an intensive AOD program in a residential setting to assist young people to address their AOD use connected with their offending behaviour. The Rehabs are provided for Juvenile Justice clients only and do not provide detoxification services. The Rehabs provide a stable and secure environment where young people are assisted to address anti-social and risk-taking behaviours while strengthening interpersonal skills and targets:

- young people 13 to 18 years old who have a history of significant AOD use that contributes to their offending behaviour
- young people who have a dual diagnosis, as well as young people on methadone, buprenorphine and/or other medically supervised medications.

Each of the Rehabs has eight beds and caters for both male and female young people. It is a 12-week residential service with a maximum stay of 4 months followed by 12 weeks aftercare support. During their residency, young people are required to participate in X-Roads which is an offence focussed, interactive, cognitive-behavioural model of intervention designed for young people assessed as having significant substance use issues. The program was developed by Juvenile Justice for use with young people who are on community based court orders and in custody.

### **Programs delivered by Family and Community Services**

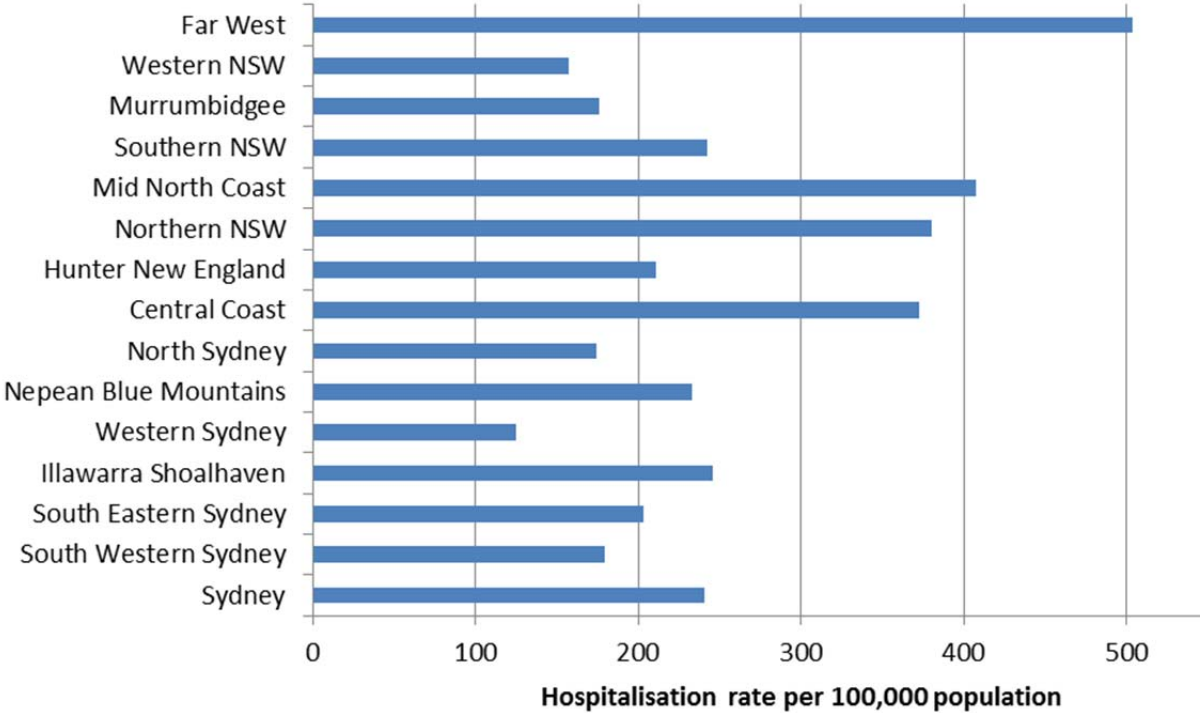
Across Australia, the majority of clients receiving specialist homelessness services and AOD services are members of one or more other vulnerable groups, and often move frequently in and out of support with each crisis.<sup>11</sup> Clients receiving both specialist homelessness and AOD services had more days of support in total than other specialist homelessness service clients but were likely to have more frequent episodes of homelessness support and receive fewer nights of accommodation. This suggests that there was difficulty in housing clients with alcohol and other substance issues.

In 2015-16, almost 70,000 people accessed specialist homelessness services in NSW. Of these more than 10 per cent reported AOD misuse.<sup>12</sup> As a result, rough sleepers have multiple interactions with the health system and other government services, and often require frequent crisis intervention.

**The number of treatment beds currently available**

In 2016-17, 5,398 clients received an inpatient or residential withdrawal management treatment episode in NSW. Of these clients, 34 per cent were from rural or regional NSW.<sup>7</sup>

**Figure 5. Rate of hospitalisation for withdrawal or detoxification from alcohol and other substances by client’s local health district of residence, NSW, July 2015 to June 2016**



Source: Combined Admitted Patient Epidemiology Data, NSW Ministry of Health <sup>13</sup>

Note that Far West Local Health District has small numbers of patients.

NSW Government funded residential rehabilitation services managed 2,230 clients in 2016-17, with 933 (42 per cent) of these clients treated in regional LHDs (Table 2).

Funding agreements between NSW Health and residential rehabilitation services describe contributions to the service provider’s delivery of AOD services. Funding is not generally allocated on a ‘per bed’ basis. Residential rehabilitation services are delivered almost exclusively by NGOs, customised in accordance with client needs.

It is difficult to quantify the exact number of NSW Government funded residential treatment beds available across NSW, as funding is from a variety of sources, which may include the NSW Government, the Commonwealth, philanthropic donations or client contributions.



## **B. Rehabilitation services for those with amphetamine and methamphetamine addictions**

Although the number of people that use methamphetamine in NSW is falling, there is evidence of an increase in harms associated with methamphetamine use since around 2010 (Figures 1 and 2). The literature is limited in the number of well-conducted, controlled studies, however the available evidence suggests that structured psychological interventions such as outpatient cognitive behaviour therapy (CBT) is best practice for amphetamine type stimulant users in Australia.<sup>14</sup>

Withdrawal management may be required for some people with chronic amphetamine use, and can be undertaken in an outpatient, inpatient, residential or ambulatory setting (such as a general practitioner monitoring a person undertaking withdrawal within their own home). While physical withdrawal of stimulants can be quick, the psychological effect of withdrawal may be longer than other drug types - up to around three weeks for amphetamine use.<sup>15</sup>

Substitution therapies aim to replace harmful drug use with safer modes to allow clients to stabilise on a dose that prevents withdrawal whilst reducing illicit drug-related harm. In NSW a trial of dexamphetamine in conjunction with psychosocial interventions found benefit in reducing withdrawal symptoms and increasing abstinence rates.<sup>16</sup> However, further research is required to prove the long-term effects and efficacy of dexamphetamine as a treatment.

People with amphetamine use problems may also require acute mental health treatment and emergency management. Mental health complications from amphetamine use include psychosis, depression (including self-harm) and anxiety. These complications may require inpatient admission followed by intensive outpatient treatment.

All NSW Health AOD services are able to respond to people who present with amphetamine (including methamphetamine) related issues, along with any other presenting AOD issue. The delivery of high quality and effective treatment services in NSW is based on evidence-informed clinical practice. This includes establishing clear referral pathways to specialist services from hospitals and primary health services. The majority of these services are non-acute and are usually only required by patients for the short to medium term. However NSW Health does run a specialist program called the Stimulant Treatment Program, which provides clinical support to improve the health and social outcomes of people who use amphetamines. This includes supporting those with comorbid mental health issues through the provision of psychosocial support services such as counselling and relapse prevention.

In 2015-16, the NSW Government invested an additional \$11 million over four years into new services to treat and support people who use crystalline methamphetamine. Included in this investment was:

- \$7 million to fund new stimulant treatment services in the Illawarra Shoalhaven, Mid North Coast, Northern NSW and Western Sydney Local Health Districts. Existing Stimulant Treatment Programs at St Vincent's Hospital in Darlinghurst and Hunter New England Local Health District have also been enhanced as part of the investment.
- \$4 million to fund new non-government treatment services to tackle crystalline methamphetamine use in rural and regional NSW. Services have been implemented in three locations across the state: Directions ACT, in partnership with the Ted Noffs Foundation, are delivering services in Southern NSW (Goulburn and surrounds) and Murrumbidgee (Wagga Wagga, Griffith and surrounds) Local Health Districts. The Lyndon Community is delivering services in Western NSW Local Health District (Dubbo, Wellington and surrounds). Since the program commenced in early 2016 to end of October 2017, 542 people have been assisted through these services.

Non-government residential rehabilitation services provide treatment for people with amphetamine dependence although most require withdrawal to be complete before admission.

As part of the 2015 “Ice Election Commitment” the Government also committed to other health system and treatment related measures, which have all been implemented:

- building the capacity of the health system to respond to methamphetamine;
- educating the community on the dangers of methamphetamine use; and
- mandatory state-wide recording of pseudoephedrine sales in pharmacies.

## **C. Funding of NSW drug rehabilitation services**

The response to Section C relates to provision of NSW Government funding to the non-government sector.

### **Qualification to receive funding**

NSW Health generally undertakes a market testing process to select service providers based on a response to a set of tender criteria. Key principles for allocating funding include ensuring value for money, sustainability and fairness. Prospective service providers must be able to demonstrate that they have the capacity to deliver services effectively at a competitive price. AOD treatment services require various levels of funding dependent upon their client group and level of intensity of treatment required.

The NSW Ministry of Health's funding criteria for non-government organisations are set out in the NGO Operational Guidelines.<sup>17</sup> Funding agreements may be reviewed annually, or up to every three years, taking into account the level of compliance with the Guidelines and the contractual agreement, including achievement of key performance indicators.

### **Funding arrangements for services**

NSW Health provides funding to non-government services under contract (funding agreement) with payments linked to achievement of key milestones and key performance indicators. The contracts are managed through regular service and performance reviews to ensure the terms of the contract are being met.

## **D. Registration and accreditation of services**

### **Processes for establishment of rehabilitation services in New South Wales**

NSW Health-funded organisations that provide AOD rehabilitation services are required to maintain accreditation or be actively working to attain accreditation against appropriate health care and/or community service standards, such as the National Safety and Quality Health Service (NSQHS) Standards.

Licensing of opioid treatment program (OTP) clinics occurs in accordance with the Poisons and Therapeutic Goods Regulation 2008. Licensing conditions for all private opioid treatment program OTP clinics requires them to achieve and maintain accreditation from a quality assurance organisation. Licensing of other types of drug and alcohol services is not currently required.

Privately-run drug and alcohol rehabilitation services providing clinical interventions can be accredited against the same service standards as non-government services, however this is not mandated within NSW or nationally. The Ministerial Drug and Alcohol Forum approved in principle in November 2017 the development of a National Quality Framework for Drug and Alcohol Treatment Services,

### **D.1. Organisational accreditation**

Accreditation is based on recognition from an independent third party that a service or program meets the requirements of defined criteria or standards. Accreditation for an NGO AOD service can be obtained through generic accreditation and quality frameworks by a certified entity or through more specialised accreditation schemes.

An accredited NGO meets acceptable standards of service delivery, management, staffing and organisational development. The AOD sector does not have a formal, national agency accreditation process, but a number of organisational accreditation systems are available to be used for NGO AOD treatment services. These include<sup>18</sup>:

- The Australian Council on Healthcare Standards (ACHS) EQUiP5 (5th edition of the ACHS Evaluation and Quality Improvement Program)
- Quality Innovation Performance (QIP) or QICSA The QIC Health and Community Services Standards 6th edition were developed by the Quality Improvement Council (QIC)
- The Institute for Healthy Communities Australia (IHCA)
- Australian General Practice Accreditation Limited.

In addition to organisations that provide accreditation, a number of organisations specify the standards by which accreditation occurs. These include the International Organization for Standardization (ISO) and Joint Accreditation System of Australia and New Zealand (JAS-ANZ).<sup>18</sup>

Clinical guidelines and best practice standards for residential treatment include the Drug and Alcohol Treatment Guidelines for Residential Settings (NSW Department of Health, 2007) and Service Standards for Addiction Therapeutic Communities (The Royal College of Psychiatrists, 2006).<sup>18</sup>

As part of contractual agreements NSW Health funded non-government organisations providing AOD rehabilitation services are expected to maintain accreditation and engage in formal quality improvement processes.

Most non-government AOD services are members of the NSW Peak Body, the Network of Alcohol and Other Drugs Agencies (NADA).

Public sector AOD services are accredited as part of the general health services accreditation process.

## D.2. Worker and professional accreditation

Professional disciplines that work in the alcohol and other drug sector require registration with a relevant professional body. These individual professional registration bodies include:<sup>15</sup>

- The Australian Psychological Society
- The Royal Australian College of General Practitioners
- Pharmacy Board of Australia
- The Australian College of Nursing
- The Royal Australasian College of Physicians
- The Royal Australian and New Zealand College of Psychiatrists
- Australian Association of Social Workers (AASW).

The Australian Health Practitioner Regulation Agency (AHPRA) is the organisation responsible for the implementation of the National Registration and Accreditation Scheme across Australia.<sup>18</sup>

To-date there is no national minimum qualification requirement for non-professional alcohol and other drug specialist workers in NSW. In 2014 the Network of Alcohol and other Drug Agencies reported that 57 per cent of the surveyed drug and alcohol sector in NSW has tertiary qualifications. This includes 48.5 per cent of respondents with undergraduate or above level qualifications such as undergraduate social work, psychology, social sciences/social welfare and post-graduate qualifications in counselling, social health and Gestalt therapy.<sup>19</sup> It should be noted that these qualifications are not necessarily alcohol and other drug specific. Roles within drug and alcohol services can vary, depending on the services being provided, and workers are matched to the skill required of the role.

Some Australian jurisdictions (ACT and Victoria) currently specify a minimum qualification for these AOD specialist workers.

NGOs are responsible for ensuring that each staff member maintains his/her qualifications and registration. Access to medical and mental health practitioners needs to be demonstrated by the NGO.<sup>18</sup>

For residential treatment, the minimum staffing profile is 24 hour coverage (with a minimum of one overnight staff member). The *Non-Government Organisation Alcohol and Other Drug Treatment Service Specifications* suggest that a staffing profile for residential rehabilitation facilities include, at a minimum, alcohol and other drug case managers and alcohol and other drug clinicians.<sup>18</sup>

The different disciplinary backgrounds in a residential treatment program will reflect the program requirements and client needs. These disciplines may include physiotherapist, psychologist, social worker, nurse, peer support worker, and mental health clinician, as well as staff qualified to work with children and families.

The Australasian Professional Society on Alcohol and other Drugs (APSAD), is the peak multidisciplinary professional society in the drug and alcohol field in Australia. It holds an annual conference and runs training events in each state.

## **E. Cost of rehabilitation services**

### **E.1. Cost to clients and their families**

Public health services do not charge a fee for services. However, there may be costs for patients from regional and remote areas, for example the cost of travel if they need to access non-government drug rehabilitation services located in larger centres. This issue is particularly significant for people from remote areas. People who need to travel long distances for specialist medical treatment may be eligible for the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS).

For some people, the cost of residential rehabilitation means they need to give up their rental accommodation, as they can't afford both. A key barrier to people seeking treatment in residential rehabilitation may be the desire to maintain their existing stable housing arrangement. Public and community housing providers may require tenants to give up their tenancy if residential treatment is longer than six months and their property will be vacant during this time. In this case, alternative community-based treatment may be more suitable.

Patients on medication-assisted treatment for opioid dependence treated through a community pharmacy pay out-of-pocket costs directly to the pharmacist of \$25 to \$90 per week (depending on the location). This is not rebated by Medicare, and is cited as a principal reason for people discontinuing treatment prematurely with poor clinical outcomes. People who are treated at public sector services access treatment for free.

Private hospitals set their own fees and charges for inpatient and ambulatory services. Aboriginal community-controlled residential rehabilitation services may charge clients a co-payment. The level of co-payment may be affected by the funding the service receives from other agencies, such as the Aboriginal Hostels Limited.

There is currently no official industry-wide fee structuring consensus in NSW in the non-government sector. Client charges or fees for service in the non-government sector are usually determined by the type of funded service and the income and health insurance status of the individual (for example, receiving a government benefit or with private health insurance).

While non-government outreach services may be free, residential rehabilitation services usually charge fees. NGO residential treatment services may require a substantial proportion of welfare payments, for example, Newstart - the Disability Support Pension, to be paid to the service during the period of residential treatment. The cost of providing accommodation and 24 hour worker support is resource intensive in residential rehabilitation services. Clients may be asked to contribute between 60 to 80 per cent of their Centrelink benefits to cover food, treatment costs and lodging. Some services also charge an admission fee. Costs and fee structures vary for each service.

The presence of clients' children in residence results in a range of increased costs for services due to additional staffing requirements such as for child care.<sup>6</sup> However, these costs are not necessarily passed on to the clients and their families in the case of government-funded services. For example, Kamira Alcohol and Other Drugs Treatment Services, located on the NSW Central Coast, currently offers to accommodate children up to the age of eight with their mothers on-premises during residential rehabilitation. For this service, residents are charged a board and lodgings fee of 80 per cent of their social security payment. Kamira is funded by NSW Health, the Commonwealth Department of Health, the Department of Family and Community Services and by its own fundraising activities.

## **F. Waiting times for admission to NSW drug rehabilitation services**

### **Waiting list and wait times for NSW public sector services**

NSW local health districts have a centralised AOD telephone intake line, and incorporate systematic triaging based on clinical priority so that people with the highest need are identified and supported to access services in a timely way. The NSW Ministry of Health is currently developing systems to support routine reporting on the service intake and assessment process through the electronic medical record system for all NSW Health services. Consistent state-wide waitlist and waiting time information is not available at present.

Clients are prioritised entry to services based on a range of factors such as:

- Hospital and emergency department transfers
- Aboriginal status
- Pregnancy
- Engagement in court diversion programs
- Recently released from prison
- Domestic violence or child protection concerns
- Mental health issues.

There is variability in access and waiting times across services that may be dependent on treatment type, priority population or geographical location. For example Northern NSW Local Health District has reported on some waiting times for their AOD rehabilitation services:

- Less than two weeks' waiting time for the Inpatient Withdrawal Unit (Lismore Base Hospital)
- Around two to four week wait time to access the Opioid Treatment Program, dependent on medical officer availability and the number of patients they are able to prescribe for
- A one week waiting period for counselling services for high priority patients, 14 days for other patients
- A two week waiting period from client court referral to acceptance on the MERIT program
- Currently no waiting list for substance use in pregnancy services.

These waiting periods may vary considerably across LHDs in NSW.

A key priority of NSW Health is to improve early intervention and pathways into treatment. This might include ensuring brief intervention and support is provided if there is a wait for residential treatment, or referring on to another provider for treatment or support.

### **Waiting list and wait times for NSW funded non-government services**

Non-government services have varying processes in relation to wait lists. Some non-government services compile a waiting list comprised of all people contacting the service, without assessment or follow-up, which results in long wait lists. Other services assess client eligibility and suitability before adding people to their waitlist. Services may also limit numbers on their waitlist so they are able to provide daily or weekly support.

An issue that people may face in gaining admission to residential rehabilitation services is an expectation that they complete inpatient withdrawal management prior to admission. This is clinically not necessary for all patients, however is often required by residential rehabilitation providers. This can result in a challenge to co-ordinate timing between the withdrawal unit and the service.



As alcohol and other drug dependence is a chronic relapsing condition, some clients may experience a relapse during the period between completing withdrawal and admission to the residential service. This may further delay their admission to residential rehabilitation. Additionally, some services require a copy of a client's criminal record to check for violence-related offences prior to being considered for admission, resulting in a wait time that may range from days to months.

Services that offer longer term programs, for example up to nine months, will have longer waiting times as they need current clients to be discharged from the program before a new client can commence treatment.

The number of drug rehabilitation services available to young people across NSW is limited and wait lists to access these services remain high. Young people in Out of Home Care (OOHC) and those exiting care are more likely to experience poorer health outcomes, including substance abuse issues, than their peers. Therefore, access to effective drug prevention and rehabilitation services is important for this cohort.

## **G. Pre-entry conditions for gaining access to rehabilitation services**

In general, AOD treatment services are accessible to any person seeking treatment relating their drug and/or alcohol use. All people seeking entry into AOD treatment programs need to be properly assessed for their treatment needs. An adequate, unbiased assessment should cover: client demographics, drug use behaviours, history and effects of use, previous treatment received, general health, mental health and current health concerns and associated co-morbidities.<sup>20</sup>

Access to specialist rehabilitation programs is based on a comprehensive clinical assessment of need. The target group for specialist AOD treatment is generally people who have not succeeded or are not likely to succeed in less intensive treatment settings such as outpatient counselling or day programs. Individuals with specific needs or complex conditions may require additional assessment and enhanced support.<sup>18</sup>

Equity of access for all clients is essential. For example, services may not exclude people based on past criminal charges, client characteristics (such as sexual preference or mental health issues) or client circumstances (such as homelessness).

Regarding residential rehabilitation services, the *NSW Health Drug and Alcohol Treatment Guidelines for Residential Settings* provide a high level guideline for pre-entry criteria for residential rehabilitation services to adhere to.<sup>20</sup> These guidelines are not prescriptive and services may design their own intake policy, complete with eligibility and exclusion criteria. NSW Health is increasing the focus on clinical quality and safety, which will include review of the *Guidelines*.

The majority of residential rehabilitation services will require the person to have completed withdrawal or to be “drug free” to commence treatment. Residential services typically require a commitment for the person to remain drug free during their residential stay, and will discharge clients if they suspect substance use. This can be a problem, as determination of drug use is not always able to occur objectively, and laboratory tests usually take at least several days and at times several weeks to confirm recent drug use. Toxicological tests are not available for all drugs.

There are some specialised residential services that are targeted to particular population groups (e.g. women with children, Aboriginal people, and young people), which therefore apply exclusion criteria for those outside these target populations.<sup>18</sup>

Certain criminal charges may exclude access to residential service treatment for the safety of other service participants (e.g. arson, violent offences, child sexual assault).

Some residential rehabilitation services have varying pre-entry conditions dependent on what service they provide. For example if a service provides treatment for people with a co-occurring mental health and alcohol and other drug issue, certain documentation may be required from the person’s mental health treatment provider.

Some services may permit entry to clients undergoing opioid substitution therapy. A number of rehabilitation services require a certificate of detoxification prior to admission. This can be done easily for alcohol but is more difficult for other substances such as cannabis.

## **H. Evidence regarding the efficacy and impacts of mandatory detoxification programs in NSW for those who self-harm or are subject to an Apprehended Violence Order**

AOD treatment in Australia is predominantly voluntary because addiction is a chronic disorder. Although people can be successfully managed through a period of drug withdrawal, this does not address the underlying disorder. The aim of treatment is to achieve sustained voluntary behaviour change in the individual and ensure that they have adequate skills and supports in their life to maintain successful recovery from drug dependence.

There are involuntary programs available that are provided as a last resort for people with severe substance use issues. Involuntary inpatient treatment is provided under the *NSW Drug and Alcohol Treatment Act 2007*. Access to the Involuntary Drug and Treatment Program (IDAT) requires screening and assessment, which is facilitated by a state-wide referral network of involuntary treatment liaison officers.

A comprehensive assessment of the patient's suitability for a dependency certificate is made by an accredited medical practitioner. Generally, patients considered suitable for involuntary treatment are those that: are likely to benefit from treatment but have refused, and have lost the capacity to make decisions about their substance use or their welfare. There also needs to be evidence that no other less restrictive means of managing the person's substance use is reasonably available.

Involuntary drug and alcohol treatment in NSW operates from two treatment sites, one in Northern Sydney Local Health District (four beds in a detoxification unit) and the other in Western NSW Local Health District (eight beds in a unit at Bloomfield Hospital in Orange).

The inpatient treatment component generally lasts for up to 28 days. There is an option to extend the treatment period for up to three months. The program has both inpatient and community based care components.

The effectiveness of involuntary treatment was informed by a trial that demonstrated positive clinical and psychosocial outcomes for patients during the involuntary period. Key findings were that involuntary treatment<sup>9</sup>:

- Provided the opportunity for medical conditions and physical health to be properly assessed and addressed and enabled patients to complete an extended period of abstinence that they would not be able to complete as voluntary patients.
- Improved social relationships, particularly with family, which was the most marked psychological change to patients over the first four week period.
- Led to a reduction in mental health symptoms such as depression.
- Led 80 per cent of involuntary patients to take up post-discharge voluntary aftercare.

Positive outcomes were maintained post-discharge for patients accessing aftercare:

- The majority of patients were observed by the aftercare service to have better general, mental and physical health than in the six months previous.
- It was identified by the aftercare service that the support most commonly provided to clients related to relapse prevention and medical treatment.

Other major findings included:

- The legislation, to the extent it has been tested, provided an overall appropriate legal structure for the services being provided.
- The interests of the dependent person were maintained as paramount.
- The program successfully engaged families and carers of those people admitted.
- The voluntary aftercare component of the trial was a successful and important part of the model of care.

However, the evaluation had significant limitations, including the lack of a comparison group. NSW Health has funded a university research group to investigate the effects of involuntary treatment compared to other treatment in NSW. This evaluation is underway.

## **I. Areas for consideration and improvement in provision of drug treatment services**

### **I.1. Areas of need for resourcing and funding**

Developmental vulnerability, poverty, marginalisation and social disadvantage and living in rural or remote areas have been identified as factors that exacerbate alcohol and other drug-related harm. These categories are not mutually exclusive.

Priority populations for AOD treatment may change as circumstances change; for example, as new drug-related harms and drug use patterns emerge. Policy and program responses should be tailored to meet these new challenges. A key feature of effective AOD treatment is that each person's alcohol and other drug needs are able to be met at their point of access across health and other systems. Streamlined access to treatment is especially important for vulnerable populations.

#### **Aboriginal populations**

Alcohol and drug related harm contributes to disparities in health and life expectancy between Aboriginal people and other Australians.<sup>21</sup> Dispossession and intergenerational trauma has significantly impacted on the health and wellbeing of Aboriginal people.<sup>22</sup>

In NSW, among Aboriginal people who do drink alcohol, a higher proportion drinks at levels that place their long-term health at risk.<sup>23</sup> While the majority of Aboriginal people in Australia do not use drugs, national surveys have consistently reported higher levels of 'recent' illicit drug use among Aboriginal people than among non-Aboriginal people.<sup>24</sup>

Aboriginal people represented 15 per cent of all clients in alcohol and other drug treatment services in 2014-15.<sup>25</sup>

Culture can influence Aboriginal people's decisions about seeking health care.<sup>22</sup> Culturally appropriate strategies are required to support effective health service delivery and better health outcomes. Aboriginal community controlled health services contribute to improving access for hard to reach sub-populations of Aboriginal people, including those with comorbid mental health and alcohol and drug issues.<sup>26</sup>

A key component of a culturally appropriate service for Aboriginal people is a service with an Aboriginal workforce. The Aboriginal drug and alcohol workforce in NSW has grown rapidly, but is still relatively small. There are no Aboriginal doctors specialising in addiction medicine in NSW, and few Aboriginal psychologists or nurses. Opportunities exist to encourage the development of this important workforce. Hunter New England Local Health District Drug and Alcohol Clinical Services are exceptional in having over 10 per cent of staff identifying as Aboriginal. The Aboriginal drug and alcohol workforce needs to continue to grow across NSW to assist mainstream services and Aboriginal community controlled organisations in assisting this population. Services also need to improve the cultural competency of non-Aboriginal health service staff to work with Aboriginal clients.

There are three key elements to consider to improve the provision of drug treatment services for Aboriginal people in NSW: accessibility in the sense of being culturally safe and appropriate for Aboriginal people; and being physically accessible, especially for those living in regional areas. Additionally, consideration needs to be made of the complexity of issues faced by Aboriginal clients which require longer duration of services, and at a higher intensity which may require family centred, rather than individually-focused treatment approaches

## People living in regional, rural and remote areas

The health challenges faced by people who live in rural and remote NSW are generally greater than for those living in major cities.<sup>27</sup> While there have been improvements in health care delivery, people living in rural and remote communities in NSW experience poorer health outcomes than those living in metropolitan communities.<sup>28</sup> Factors including geographic isolation and socio-economic disadvantage impact on these outcomes.<sup>28</sup>

People living in rural and remote NSW are more likely to drink alcohol at harmful levels. Drinking alcohol at levels posing lifetime risk is higher among males living in outer regional and remote NSW than the state average (44 per cent compared to 40 per cent). **Error! Bookmark not defined.** Rates of alcohol-attributable hospitalisations were 8 per cent higher in 2014-15 for people living in rural and remote NSW compared to those living in major cities. **Error! Bookmark not defined.**

The configuration of health services in rural and remote NSW communities may be different to major cities and some people living in these areas may experience longer waiting periods and/or may need to travel further to access specialist health services. Longer travel time to treatment services in rural and remote areas impacts on treatment compliance, and resulting child protection and OOH decision making.

NSW Health continues to invest in AOD treatment services across NSW. Initiatives such as telehealth and outreach services are being used in rural and remote areas in an effort to increase accessibility and bridge the service gap in regional areas.

Each local health district has the flexibility to tailor services where most needed and using methods most appropriate to their communities. Services are continually exploring ways to better meet the needs of their community, particularly through the use of technology.

## People who are in contact with the criminal justice system

While reducing supply is a primary objective of NSW Police, drug diversion programs and treatment services are important and effective strategies for reducing demand. Treatment services offer pathways to reduce or cease substance use, decrease substance dependence and have an important role to play in reducing recidivism and the escalation of criminal activity.

The NSW Bureau of Crime Statistics and Research (BOCSAR) Crime Mapping Tool (available at <http://www.bocsar.nsw.gov.au>) uses NSW Police data relating to incidents of drug offences (including use/possess and deal by drug type) to show the rate per 100,000 population. This tool can be used to conduct a preliminary analysis to determine where drug detections are high compared to the population size, however it will not provide a complete picture as the number of drug detections does not necessarily equate to a more significant drug problem. It may be simply a reflection of proactive policing and targeted operations in the local area, therefore the data must be interpreted with care.

In addition BOCSAR have a Crime Trends Tool (also available online), which allows the data to be broken down by region, local government area, suburb or postcode. It shows actual figures, trends, percentage changes over time and can be displayed by each drug type.

Whilst these tools are useful to conduct preliminary enquiries, consultation with BOCSAR could assist to obtain a more detailed analysis of crime trends and drug detections data.

Juvenile Justice Rural Residential AOD Rehabilitation Services are required to explore all possible options to facilitate clinically supervised detoxification through general practitioners, local AOD services and local hospitals. However, general practitioners are usually not willing to supervise home detoxification for young people. Local AOD services for young people are limited.

The majority of referrals to rehabilitation services are made for young males. However, the referral of young females can result in a different set of rehabilitation needs. These can

include: programs targeting domestic and family violence, identity and self-esteem, and sexual health.

### **Vulnerable young people**

Young people in OOHC and those exiting care are more likely to experience poorer health outcomes, including substance abuse issues, than their peers. Therefore, access to effective drug prevention and rehabilitation services is important for this cohort.

The OOHC Health Pathway is the key mechanism for systematically identifying and addressing substance abuse problems experienced by young people in statutory OOHC and those leaving care.

### **People who are homeless**

People who are in unstable accommodation or experiencing homelessness are more likely to be AOD users, to be involved in crime and experience mental health issues, and be less likely to have gone beyond year 10 at school or be employed.

FACS is leading the development of a new whole-of-government strategy on homelessness which provides a long term plan to prevent and reduce homelessness. The Strategy will provide the framework for new investment in services that address the key risk factors of homelessness, one of which is AOD dependence.

### **Access to primary care, aftercare and wrap-around services**

There is an underutilisation of primary care for management of substance use disorders. Safe, cost effective options for illicit and pharmaceutical drug dependence should be more widely available in primary care settings. There are significant barriers to developing and maintaining the involvement of primary care providers such as general practitioners, psychologists and other primary care practitioners in the care of patients with alcohol and other drug use disorders.

There is a need to develop more effective assistance for general practitioners managing patients with pain and addiction problems. For example, there is underutilisation or lack of awareness of the addiction medicine specialist support service available to rural and remote health professionals such as the Drug and Alcohol Specialist Advisory Service (DASAS) phone line. NSW Health is currently exploring opportunities to increase awareness of currently funded drug and alcohol telephone lines, including the DASAS line.

NSW Health is working closely with the Primary Health Networks and the Royal Australian College of General Practitioners (RACGP) on raising awareness of drug and alcohol services and issues in service delivery. The Agency for Clinical Innovation Drug and Alcohol Clinical Network is also leading the development of a Shared Care Project for clinicians working in drug and alcohol.

Aftercare should routinely be offered following all forms of AOD treatment, including residential rehabilitation. As previously mentioned substance use disorders are chronic, relapsing conditions. Despite this, standard treatments are typically short. Patients commonly discontinue treatment before the treatment is complete. In 2014-15, 79 per cent of closed treatment episodes Australia-wide were less than three months in duration; the median duration was 22 days.<sup>1</sup> Fewer than 8 per cent of closed treatment episodes were for six months or longer. Approximately 62 per cent of treatment cessation is due to treatment completion; the remainder leave for other reasons.<sup>1</sup> Aftercare and wraparound support for clients is often very limited.

## **I.2. Threats to the provision of rehabilitation services**

The NSW Government has made a number of investments in drug and alcohol services in recognition of the increased demand for services, particularly for vulnerable populations and in regional and rural NSW.

In 2011, \$10.9 million over four years was committed to enhance and deliver drug and alcohol treatment services across NSW for people with multiple and complex needs, for people exiting custodial settings and people wishing to stabilise or reduce opioid treatment. Twelve non-government organisations deliver 17 different programs across the state, including residential rehabilitation services, community based day rehabilitation programs, multidisciplinary case management and outreach and aftercare programs. These programs targeted vulnerable and disadvantaged population groups in recognition of the need for increased services.

In 2015 in recognition of an increase in methamphetamines use and related harms in the community the NSW Government committed to an enhancement of \$11 million over four years to deliver a suite of methamphetamine specific treatment services.

- \$7 million over four years was committed to the enhancement of the Stimulant Treatment Programs in St Vincent's Hospital Network and Hunter New England local health district and deliver in more locations in NSW. Stimulant Treatment Programs are now delivered in Illawarra Shoalhaven, Mid North Coast/Northern NSW and Western Sydney local health districts.
- \$4 million over four years was committed to expanding to delivery of community based methamphetamine services in regional and rural NSW. Three non-government services have now been established in Dubbo (delivering to surrounding areas including Wellington), Wagga Wagga (delivering to Griffith and surrounding areas), and Goulburn (delivering to Yass and surrounding areas).

In 2016, the NSW Government committed to delivering an additional \$75 million over four years to tackle drug misuse in communities. The investment focuses on supporting more young people, more families and more people into treatment.

These commitments are focused on delivering services where they are most needed, such as:

- Additional Substance Use in Pregnancy services for vulnerable women.
- Residential rehabilitation places for women and children in rural and regional NSW.
- Additional Assertive Community Management treatment services for people with chronic and complex needs.
- Delivering a new Continuing Coordinated Care program to provide continuing care and intensive support in the community to maintain their engagement with treatment services and to maximise their wellbeing.
- Additional drug and alcohol treatment services for young people.

## **I.3. Issues relating to the provision of appropriately qualified health professionals to fill positions in rehabilitation services**

Public health services typically provide a specialised workforce, including addiction medicine specialists and addiction psychiatrists, psychologists, nursing staff and other drug and alcohol staff with post graduate training and/or significant experience in AOD treatment. However, there is a national lack of addiction medicine specialists. This issue is felt most acutely in regional and rural Australia. Accumulated knowledge is lost with retiring staff, and



if growth funding for programs does not match increased service demand concurrent with population growth, existing personnel are also spread thin.

Rural areas, especially smaller towns, often struggle to recruit to nursing/allied health positions in a range of fields, including AOD service delivery. There are a number of other organisations that also provide AOD staff and treatment services in these areas, however, it should be noted that the skills and qualifications of these workers can be variable.

Qualification requirements for staff at non-government community based and rehabilitation services vary according to the type of service provided. However most have a minimum requirement of Certificate 3 or 4 in Drug and Alcohol studies obtained through TAFE or OTEN (Open Training Education Network) NSW. These challenges are also experienced in the recruitment and retention of specialised staff such as Aboriginal and Drug and Alcohol or Health Workers.

An example of the impact of staffing can be seen in Far West LHD where there are staffing and service barriers experienced in the addiction medicine specialty, limited non-government service availability and limited opioid prescribers, leading to reduced ability to deliver services. Far West LHD is exploring the merits of a number of innovative programs, to address these issues including:

- Addiction medicine specialist support via video-conference (in partnership with a metropolitan LHD)
- Drug and alcohol day rehabilitation program
- Naloxone self-administration as a harm minimisation strategy.

LHD capacity to address alcohol-related harm in regional NSW has been limited partly because of the difficulty in recruiting and retaining workers in these areas. There are strategies to promote the successful recruitment and retention of staff in rural areas. These include:

- Provision of funding for the ongoing professional development of staff, travel and leave
- Locally based supervision (no solo positions), strong management and clinical support for personnel
- Clearly defined management and governance structures
- Clearly defined roles including after-hours and on-call arrangements.

Workforce development strategies need to take into account service development needs, service delivery contexts, and consider both specialist and generalist service providers. They need to consider building the capacity for staff not directly engaged in AOD work but who work with clients who have substance use issues.<sup>29</sup> The 'National Alcohol and Other Drug Workforce Development Strategy' 2015-2018, provides a framework for jurisdictions to consider. NADA has a Workforce Development Plan 2016-2019 in place for the non-government organisation workforce. NSW Health implements specific initiatives that are tied to priorities such as the Ice election commitment to build the capacity of the system, and implement reforms to the Opioid Treatment program to increase access for vulnerable populations. This includes the Opioid Treatment Accreditation Course and the work being undertaken with the RACGP to provide information and capacity to the primary health care sector.

Capacity building activities for AOD agencies by non-government alcohol and other drug peak bodies improves service delivery and outcomes for clients.<sup>30</sup> However non-government organisations face strong competition for their staff from some of the 'pay for service' private rehabilitation clinics and local health districts, as they are able to offer higher wages.

Additionally, workers in the non-government sector are paid under a different award to those working in the public system.

## **J. Evidence of rehabilitation services that have had both successful and unsuccessful outcomes, including what characteristics constitute a successful outcome and how reliable is the data collection and reporting mechanisms currently in place**

### **Importance of a tailored, stepped care approach**

AOD dependence is a chronic condition, with multiple relapses over time. Multiple episodes of treatment are often required. In order to determine the most appropriate treatment, clinicians assess patients by considering a range of factors through information gathering. Clinicians will ask the patient about their history of drug use, medical and mental health problems, psychosocial information, and other information needed to complete validated screening tools such as the Australian Treatment Outcomes Profile<sup>31</sup> (for example, for current mental health and child protection risks).

A stepped care approach is applied to matching a patient to the appropriate type and intensity of treatment to achieve the optimal outcome. Treatment progress is monitored and adjusted as needed to ensure that treatment remains suited to the patient's current needs.

There are gaps in the evidence for the effectiveness of the range of current AOD treatment options, a limited number of medications to assist psycho-social interventions and some areas where there are no effective medications. However there are some areas where the evidence is strong, for example opioid substitution treatment. There is extensive research evidence demonstrating the effectiveness of methadone, buprenorphine and buprenorphine-naloxone for the treatment of opioid dependence. Opioid treatment reduces criminal activity associated with drug use and saves lives.<sup>32 33 34 35</sup> There is also evidence that opioid substitution treatment protects against blood borne virus acquisition (HIV and hepatitis C) for people who inject drugs.<sup>36 37</sup>

Residential rehabilitation treatment is often effective for those who remain in treatment. However, early drop out is common, with a substantial proportion of people dropping out in the first few weeks of treatment. Relapse after completing treatment is also common. This reflects the nature of severe substance dependence.

Residential treatment for alcohol and other drugs dependency is generally not more effective than non-residential treatment.<sup>38</sup> However, evidence indicates that residential treatment is more effective for clients with more severe deterioration, less social stability and high relapse risk.<sup>39</sup>

### **Access to primary care, continuing care and wrap-around services**

As noted above, there is an underutilisation of primary care for management of substance use disorders. Wraparound psychosocial services may facilitate access, improve retention, and address clients' co-occurring problems.<sup>40</sup> Co-occurring problems may encompass health, psychological, social or personal issues. There is good evidence that providing wraparound services to AOD clients can enhance both treatment retention and treatment outcomes.<sup>41</sup> This could include measures such as child care, transport, employment assistance and medical, primary health or mental health treatment services.<sup>42</sup>

While alcohol and other drug services in NSW typically provide an element of wraparound services and aftercare, they are generally limited in scope and intensity.

Evaluations of the Housing and Accommodation Support Initiative have identified positive outcomes for consumers that include fewer hospital admissions and shorter length of stay,

improved mental health, more stable tenancies and increased independence in activities of daily living.<sup>43</sup>

NSW Health is currently evaluating tenders received in response to the Alcohol and Other Drugs Continuing Coordinated Care Program, a \$12 million investment in community treatment in aftercare.

Family and Community Services advises that young people in OOHC and care leavers with substance issues require treatment services that are developmentally and age appropriate. Young people in OOHC and care leavers require treatment approaches that give consideration to their other service needs including housing, employment and education. Models that incorporate therapeutic care principles have been demonstrated to ensure that the individual and complex needs of young people in OOHC are met, given the trauma they have experienced.

### **Measures of success**

Juvenile Justice is strengthening the service specifications under the service agreements as part of its next open tender.

As part of the new agreements, a new assessment process will be implemented, which will measure success over a shorter period of time. The agreements will include increased aftercare and exit planning requirements, and a requirement for Aboriginal staff involvement in the decision making on referrals of young Aboriginal people.

The assessment process will involve pre and post assessments, as well as a progress assessment at four and eight weeks. This will measure progress at different stages during the program, as young people often do not complete the 12 weeks but may have made significant changes in the course of doing four or six weeks of the program. Currently, one of the main measures of success is completion of the full 12 weeks. The new assessment process will measure success over a shorter period.

Currently, aftercare is provided only to young people who complete the program. The new agreements will require the provision of assistance whenever there is a planned discharge from the program.

### **Effectiveness of the Magistrates Early Referral into Treatment (MERIT) Program**

There is strong evidence for the effectiveness of the MERIT Court Diversion program in terms of both health outcomes and justice outcomes.

Re-offending is almost three times more likely to occur for program non-completers than program completers, in the first 12 weeks of starting the MERIT program and a term of imprisonment was almost five times more likely to be received by program non completers than program completers.

The completion rate of the MERIT program is around 62 per cent. A similar 12 week counselling program outside the criminal justice system has a 56 per cent completion rate.

Of MERIT participants in 2016, 33 per cent were assessed as experiencing 'severe' psychological distress upon admission. However, upon exiting the program, levels of 'severe' psychological distress declined to just 9 per cent.

Amongst MERIT participants in 2016, there were considerable reductions in both the frequency and intensity of all forms of self-reported substance use at program exit, compared to program entry. The largest reductions recorded were for cannabis and amphetamines usage.

## **Reliability of data collection**

NSW Health mandates that all government and non-government AOD services receiving NSW Ministry of Health funding for the provision of specialist services to people with alcohol and/or other drug problems collect and report the NSW Minimum Data Set for Drug and Alcohol Treatment Services (NSW MDS).

The NSW MDS consists of 44 separate items to be collected throughout the course of the service episode. Data is reported monthly, with annual reporting being on a financial year basis. The data collection makes it possible to compare and aggregate information across NSW on drug problems, service utilisation and treatment programs for a variety of clients, communities and service settings. It also provides agencies with access to basic data relating to particular types of clients, their drug problems and treatment responses.

The data derived from this collection is considered in conjunction with other information sources (e.g. admitted patient data and national surveys) to inform policy decisions and strategies related to the AOD treatment sector in NSW.

The NSW Ministry of Health is currently developing an implementation, monitoring and evaluation framework in line with the current NSW Health Analytics Framework. This framework will be developed with input from stakeholders, including consumers, clinicians, research partners, and NGOs. The aim is to measure progress in achieving NSW Health's AOD related goals and objectives, and to provide data on a regular basis to improve implementation decisions and drive better outcomes.

NSW Health has funded a consortium to develop improvements in measuring clinical outcomes and quality. The Clinical Outcome and Quality Improvement Project (CoQI) has developed an outcome measurement tool and a complexity rating scale that is being implemented in all LHDs across NSW as part of the electronic medical record. Data will become available from this project to measure and compare clinical outcomes at a patient level and at service level. This is a significant innovation in the Australian AOD field.

## **K. Potential and innovative rehabilitation services and initiatives including naltrexone**

### **NSW Health translational research and innovation funds**

The Translational Research Grants Scheme funds research projects that will translate into better patient outcomes, health service delivery, and population health and wellbeing. The scheme provides grants to staff within NSW local health districts and specialty health networks. Applicants may include medical staff, nursing staff, allied health professionals and population health practitioners.

Two rounds of the scheme have been awarded, with four alcohol and other drug research projects funded:

- Improving management of comorbid substance use and mental illness with an integrated and stepped care approach
- Implementation and evaluation of take-home naloxone for opioid overdose prevention in drug and alcohol treatment and needle syringe programs attendees
- Counselling and nicotine (CAN) QUIT in pregnancy rewards plus
- Management of mental health, drug health and acute severe behavioural disturbance in emergency departments.

A third round of the scheme is currently underway.

The Early Intervention Innovation Fund is part of the NSW Drug Package and comprises an investment of \$8 million over four years. It aims to help build the evidence base for early intervention models to support people at risk, with a particular focus on young people who are vulnerable to using drugs or are already participating in risky drug use. The Fund supports the meaningful co-production of research and the translation of this research into policy and practice, including scaling up the findings across a system or to other settings. The round 2 funding process is currently underway.

The fund comprises two grants schemes:

1. NGO Evaluation Grants Scheme: for NGOs in the AOD sector to evaluate existing programs or initiatives to build the evidence base
2. Innovation Grants Scheme: for NGOs and partners to specifically drive AOD innovation, with a particular focus on young people who are vulnerable to using drugs or are already participating in risky drug use.

The following organisations were awarded funding under Round 1 of these schemes:

#### **Innovation Grants**

- The Salvation Army: to conduct a randomised controlled trial of a continuing care telephone intervention following residential substance abuse treatment.
- Lyndon Community: to examine the feasibility of adolescent AOD interventions in headspace centres.
- SMART Recovery Australia: to develop and examine the implementation of a novel routine outcome monitoring (ROM) procedure in Self-Management and Recovery (SMART) Recovery groups

- Hunter New England Local Health District: to examine the feasibility of the ERIC (Emotion Regulation and Impulse Control) intervention across NSW Health youth AOD services and inform the implementation model required to deliver ERIC to scale.

#### NGO Evaluation Grants

- Ted Noffs Foundation: to evaluate their Street University, a program that attracts and engages marginalised young people through a diverse range of artistic, cultural and educational programs.
- Kedesh Rehabilitation Services: to conduct an evaluation of the new and innovative client centered care model used at Kedesh Rehabilitation Services.
- ACON: to evaluate ACON's Substance Support Service for lesbian, gay, bisexual, transgender and intersex people.
- Mission Australia: to evaluate the effectiveness of a modified dialectical behaviour therapy group program in treating adolescents and young people attending a residential program (Triple Care Farm).
- Odyssey House: to conduct an evaluation of the Odyssey House Residential Rehabilitation program on substance dependence, mental health and general wellbeing.

### **Emerging pharmacotherapies for opioid dependence**

There is emerging evidence regarding the effectiveness of alternative pharmacotherapies to treat opioid dependence, including long acting buprenorphine depot and naltrexone depot. These alternatives may improve the efficiency of treatment delivery, for example, by only requiring weekly or monthly dosing instead of a daily regimen, which may reduce the burden on pharmacies and dosing clinics. There may be merit in exploring these longer-acting alternative medications to allow for more flexible treatment delivery, to significantly reduce the burden on pharmacies, and to facilitate patient treatment stability.

Oral naltrexone is an effective medication with high level evidence for alcohol dependence, however, uptake by general practitioners for patients with alcohol dependence is poor nationally, including in rural areas. Long acting naltrexone depot injections (Vivitrol), are not registered for treatment in Australia. Rusan Pharmaceuticals (India) has used a naltrexone depot in a clinical trial with the National Addiction Centre, UK. Recruitment for the study was disappointing (10 patients in the UK in one year).

Currently, naltrexone implants are an experimental product for opioid detoxification. The Therapeutic Goods Administration (TGA) is yet to approve them for use in Australia, as evidence for their safety and efficacy has not been presented to enable registration.

Naloxone is a well-tolerated life-saving medicine with minimal adverse effects. Overseas experience and the outcomes of a program conducted in the Australian Capital Territory show that easier availability of naloxone will decrease the proportion of opioid overdoses that result in death.<sup>44</sup> NSW Health is currently evaluating a program to increase the accessibility of naloxone to people in the community who are most vulnerable to opioid overdose.

### **Implementing new ways of providing treatment**

NSW Health is implementing a new Assertive Community Management program to help people with severe substance dependence, who have highly complex needs, are well known to be frequent emergency service users, and have limited access to primary health and specialist treatment services. The program will provide support to assist in the client's stabilisation and reintegration, and where relevant, assist in managing the client's underlying

cognitive impairment. The program is being implemented in Hunter New England and Northern NSW LHDs as well as in Sydney, South Eastern Sydney, St Vincent's Health Network, Nepean Blue Mountains, Western Sydney and South Western Sydney.

Tenders are currently in process for suitable non-government providers to deliver treatment services to young people and for the Coordinated Continuing Care program, a state wide program of ongoing case management and support for clients who have recently participated in residential treatment, or who are currently receiving treatment in the community, but need additional wrap around support. This is a new approach of providing ongoing care for the AOD sector. It will be implemented from early 2018 and will be evaluated.

Drug rehabilitation can be an important part of providing holistic responses to vulnerable children and families. As part of the Their Futures Matter reforms, the NSW Government has committed \$90 million over four years, to July 2020, to provide 900 places per year through intensive family preservation and restoration services aimed at keeping families together. Half of the 900 places will be for Aboriginal children and their families.

The models, Multisystemic Therapy for Child Abuse and Neglect (MSTCAN®) and Functional Family Therapy - Child Welfare (FFTCW®), have already been shown to be successful with families internationally, and aim to:

- reduce entries into out of home care
- increase exits from out of home care
- respond to trauma and other underlying causes of child abuse and neglect.

The new home and community-based support services are delivered by healthcare professionals in priority locations across NSW including regional and rural areas. Vulnerable children and families referred to the service will receive counselling and support to develop positive ways to problem solve and build a safer home environment. These intensive family preservation and restoration models target the causes of harm and have a proven record in addressing underlying trauma that contributed to AOD use problems and mental illness.

The treatments under these evidence-based models are informed by cognitive, behavioural and family systems theory and require qualified practitioners to deliver the services. MSTCAN includes a specific AOD treatment component, Reinforcement-Based Treatment (RBT), for clients who have problems with substance use problems. RBT is an intensive, behavioural treatment model that reinforces non-substance using behaviours and teaches avoidance of substance use triggers. Treatment strategies include contingency management, motivational interviewing, and community reinforcement.

The Housing First Program, provided by FACS, targets people who are rough sleeping. Housing First provides immediate access to permanent housing, and offers a range of supports such as counselling, case management, health services, and access to outpatient and inpatient care, including AOD services. Participation in these programs is voluntary and tenants are empowered to step up/down their support based on their level of need.

One of the core principles is immediate access to permanent housing with no housing readiness requirements. Clients are not required to first demonstrate sobriety or abstinence. Previous models required some level of demonstration that people were addressing their mental health and any substance abuse issues prior to being considered eligible for housing assistance. Housing First challenges the idea that people experiencing homelessness need to earn access to accommodation by considering access to housing as a human right.

Internationally, Housing First shows encouraging signs of success and has been adopted by countries including, USA, Canada, UK, and numerous European countries. There is some evidence that Housing First models have potential to reduce overall costs to Government.<sup>45</sup>

Michael's Intensive Supported Housing Accord (MISHA) is a housing model based on the Housing First approach. It is a philanthropically funded initiative based in Parramatta which aims to support men in long-term accommodation, providing wraparound services and intensive case management.

Micah Project's Integrated Healthcare and Supportive Housing model consists of a multidisciplinary team of health, psychosocial, and housing professionals. It enables tenants' needs to be identified, external resources accessed, and the delivery of a coordinated response that ensures that external service providers and the on-site service providers are operating in a way that realises tenant identified objectives.

Way2Home is an integrated street-to-home assertive outreach program that provides assertive outreach case management and Housing First. The program is team-based and works with an integrated health team from St Vincent's Hospital to provide flexible and responsible approach to clients. The homeless health outreach team includes specialists in mental health, AOD issues and medical care with links to a range of other health workers. The program targets rough sleepers in inner city Sydney. An evaluation conducted by the University of Queensland found successful tenancy outcomes, and that exiting rough sleeping and gaining housing was associated with reductions in AOD use.<sup>42 46</sup>



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