Review of Community Alcohol and Drug Services

FINAL REPORT (REVISION)

Mental Health Commission (WA)

24 September 2021

nous

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Executive summary

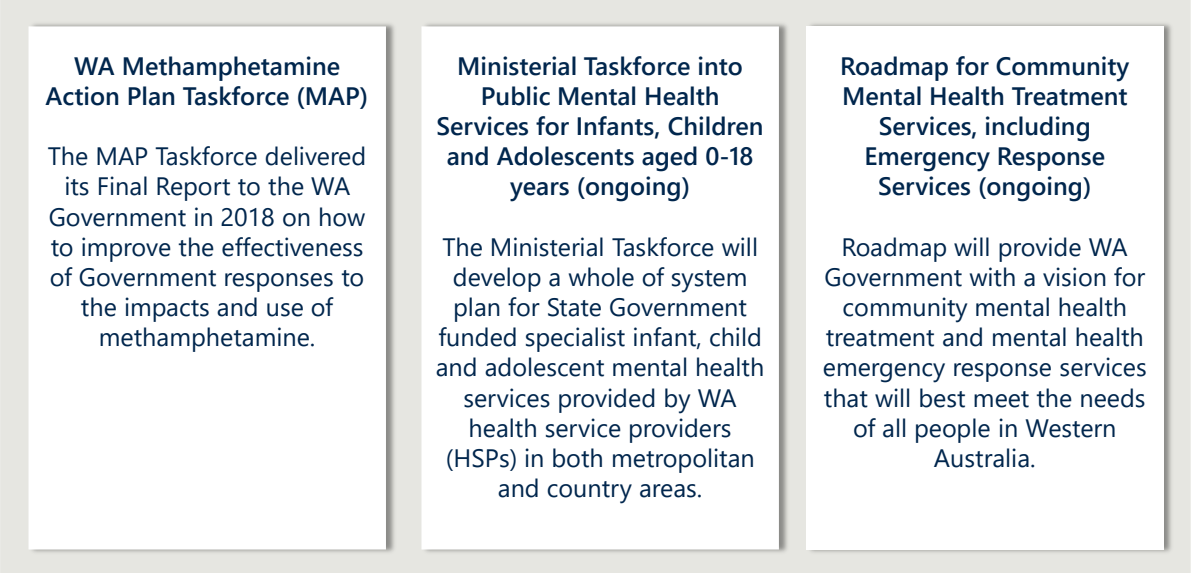
Nous Group (Nous) was engaged by the Western Australian Mental Health Commission (MHC) to conduct a review (the Review) of the Community Alcohol and Drug Services (CADS) across WA – the WA Government's largest collective investment in community-based alcohol and drug (AOD) treatment services. The Review took place over four months (April 2020 – July 2020) and involved a combination of desktop research and comprehensive state-wide and interjurisdictional consultations. These consultations were with providers that deliver AOD services, their clients and key partner organisations, plus other stakeholders and community members invested in the provision of treatment and support to people affected by AOD issues and AOD-related harm.

The Review has been undertaken amidst a major period of reform for WA's mental health and AOD system

The prevalence and complexity of AOD issues amongst Western Australians is growing, and the capacity of current AOD services are increasingly challenged. The Mental Health, Alcohol and Other Drug Services Plan Update 2018 recognised this – identifying that AOD community capacity needs to grow by **178 per cent** between 2017 and 2025 to effectively meet the needs of people with AOD issues in 2025. As at the time of this review, the capacity of AOD community treatment services – **delivered primarily through CADS** – has not grown substantively since 2017.

Demand for health services has been rising in hospitals, emergency departments, and in the community for several years. Recognising the challenge ahead, the WA Government has undertaken/is undertaking several systemic reviews that are looking to how aspects of these challenges can be addressed. Three of these reforms are illustrated in Figure 1.

Figure 1 | WA Government led reforms of the AOD and mental health service systems



This Review is therefore timely. It has been undertaken whilst the broader AOD and mental health system faces significant reform, and in light of the recent and ongoing impact of the COVID-19 pandemic. The review is intended to provide the MHC with a clear set of findings and recommendations to guide the future configuration and commissioning of CADS.

Four key questions have been used to guide the Review:

- To what extent are CADS within regional WA (**Regional CADS**) and within the Perth metropolitan area (**Integrated CADS)** meeting the community treatment and support needs of consumers, families, and the community across WA?
- To what extent is **Regional CADS** delivering its population-based AOD prevention function to effectively meet the needs of regional towns and communities?
- To what extent should **Regional CADS** and **Integrated CADS** services be re-configured, enhanced or expanded to better meet the AOD community treatment and support needs of consumers, families and the community across WA?
- To what extent should the population-based AOD prevention role of **Regional CADS** be re-configured, enhanced, expanded to meet the needs of regional towns and communities more effectively?

The primary findings and recommendations from the Review are summarised below, listed in Section 1 and then expanded upon for the rest of this report.

Whilst delivering safe and reliable treatment, Regional CADS are under pressure to manage increasing service demand, and plug gaps in the service system

There are seven CADS services operating in regional WA, with one in each region[1] delivering low-intensity AOD counselling services to individuals directly and indirectly affected by AOD issues and AOD-related harm. Regional CADS primarily deliver AOD counselling in line with MHCs *Counselling guidelines: Alcohol and other drug issues*, complemented by group programs, pharmacotherapy, and community development and education.

Regional CADS are the primary, and often only, response to the growing demand for AOD treatment and support in Regional WA. The seven services operate in an increasingly complex environment, supporting regional towns and communities with proportionately higher rates of AOD issues and AOD related harm, and co-occurring mental health issues, relative to the Perth metropolitan area.

This Review has found that Regional CADS delivery highly-valued, reliable, and safe treatment to some of the State's most vulnerable and at-risk people. The impact of Regional CADS extends beyond their clients – who value the safe, judgement-free, and reliable care they receive – to the families of people with AOD issues, their partner services, and the communities in which they work. As the prevalence of AOD issues continues to rise in Regional WA – across all demographics – Regional CADS are playing an increasingly important role in reducing AOD related harm. However, as the scale of AOD issues increase, some inconsistencies have been identified in the service delivery of CADS in each region – specifically relating to the extent of outreach activities, and the adoption of capping the number of sessions per client to manage demand in some regions.

Notwithstanding positive feedback provided by clients, families and service partners, Regional CADS face significant barriers to meeting the scale of AOD treatment and support needs in their towns and communities, now and into the future. These barriers and constraints are:

- There has been no substantive addition to CADS funding or service capacity since 2018; and as such Regional CADS are currently constrained in their ability to meet current AOD treatment demands. Current modelling by the MHC has identified that a 156 per cent increase in AOD community treatment capacity is needed in Regional WA by 2025.
- Despite rising prevalence, CADS is limited in its ability to support individuals with AOD issues that are younger than 18 years old. Whilst capacity clearly plays a role in limiting the support that CADS can

[1] 'Region' means health region as defined by he WA Country Health Service, and includes the Kimberley, Pilbara, Mid-West, Goldfields, Wheatbelt, South West and Great Southern.

provide for this cohort, the greatest barrier is the CADS model of care which is not designed to treat individuals that do not exhibit a commitment or readiness to change; something that is less likely in adolescents and young adults.

- CADS providers have adopted inconsistent approaches to ensuring culturally safe and accessible care for Aboriginal clients. In towns and communities where CADS providers are recognised as being culturally safe and appropriate – it is often because they maintain strong employment of Aboriginal staff (i.e. between 40-60 per cent), and invest in building relationships with Aboriginal Community Controlled Organisations, and Aboriginal communities. However, this is not consistent across all regional CADS.
- Inflexible and reactive contract management has meant that CADS providers are not helped to be flexible and responsive to the needs of their communities. Specifically, repeated 12-month contract extensions since 2017, and insufficient clarify of expectations from MHC, have been identified as two factors that have limited recruitment and adaptation of services to meet changing community needs and expectations.
- There is a significant gap in safe places for intoxicated people, and suitable responses to people in an AOD crisis. CADS clients often default to presenting to EDs in crisis and often experience stigma and inappropriate support. Much of this is because EDs in regional hospitals are not the appropriate place for people in an AOD crisis to be attend. They are not configured, equipped or resourced to respond appropriately and safely to people presenting in an AOD related crisis, but in many towns they are the only option. The absence of safe and alternative crisis responses has placed significant strain on EDs and CADS – who often resort to supporting their clients when they are in an AOD crisis, including when acutely intoxicated and exhibiting erratic behaviour.
- There remains a disconnect between CADS services and community mental health services. In all regions other than the Kimberley – there is no integration of CADS and mental health community treatment services, despite efforts to build relationships and establish clearer pathways. This has meant that CADS clients continue to experience significant barriers to accessing mental health support and treatment.
- The absence of reliable, and accessible detox in regional WA has had profound effects on CADS clients, and CADS providers. For CADS clients, the difficulties accessing detox creates a significant barrier to their long-term recovery. As residential rehabilitation services commonly require that clients first under-go detoxification, the lack of accessible detox creates a bottleneck for individuals accessing residential rehabilitation – which itself commonly comes with long wait times.

These constraints are consistent across all regions, and lead to an environment where people who live in regional and remote WA are less likely to access the care they need, when they need it, where they need it.

The Review has made a series of recommendations that are specific to Regional CADS, that will:

- Enhance and increase the capacity of the larger regional hospitals to better support CADS clients and providers.
- Establish a more appropriate crisis response for those experiencing an AOD related crisis.
- Enable more medical support to be available for CADS providers.

Despite unresolved governance issues, Integrated CADS exemplify the impact that successful service integration can have on client outcomes

The Integrated CADS model of service was developed in the early 2000's – with NGO-run Community Drug Service Teams and government-run Next Step Clinics recognising that their siloed services were seeing clients fall through the gaps as they were referred from one service to the other. Following a 2006-pilot,

the Integrated CADS was established, which comprises five integrated medical and counselling AOD services that operate in the Perth metropolitan area and surrounds.

The contemporary Integrated CADS services represent 'best practice' in integrated service delivery for clients with AOD issues. Each individual service is the product of a successful integration process that created services with a single point of entry for AOD community treatment, and shared care for clients requiring both medical and therapeutic treatment. In the 14-years since the establishment of Integrated CADS, they continue to act as a model for the impacts that can be created through effective service integration. Integrated CADS clients are provided with a genuine 'no wrong door' approach, treatment that is client-centred, tailored to their needs, and truly holistic.

In recent years, however, constraints have emerged that negatively impact Integrated CADS service deliver. Left unaddressed this constraints risk impacting CADS service delivery, and ultimately, client outcomes. Specifically:

- Despite MHC modelling in 2018 estimating that AOD community treatment capacity in Perth should increase by approximately **186 per cent** by 2025 there has been no substantive increase in AOD treatment capacity in Integrated CADS since 2017. This capacity constraint is manifesting in rising wait-times for treatment, with the waitlist for counselling services being up to eight weeks, and the waitlist for medical services being up to 10 weeks.
- There is not a supported transition between adolescent and youth AOD services (Drug and Alcohol Youth Service, or DAYS) and the adult Integrated CADS. The absence of supported transitions is an area of concern for stakeholders and DAYS clients, many of whom have stressed that young people are at risk of 'falling through the gaps' between the youth and adult services, and seeing their longer-term recovery stall, or regress.
- No documented 'Model of Service' for Integrated CADS was ever developed, and no Memorandum of Understanding (MoU) or formal partnership has been established between Next Step and the NGOs. In the years since implementation, organisational and philosophical differences have been exposed between the partner organisations and variations in service delivery have evolved that risk impacting client outcomes.
- This governance of Next Step – where it is both commissioned by and managed by the MHC is inconsistent with the governance of the wider WA Health System and represents a significant conflict of interest in the context of Integrated CADS. The absence of clear governance and accountability mechanisms to manage this conflict of interest has exacerbated tensions between Next Step and the NGO partners.

Despite these constraints, and resulting tensions, there remains broad and fervent support to the underpinning principles, and the original intent of an integrated medical-counselling model of service by Next Step and the NGOs. The leaders of all five organisations currently delivering Integrated CADS have all unequivocally stated their commitment and buy-in to the principles of integration and the benefits of the Integrated CADS model. This is echoed by front line staff in all the services.

To ensure the sustainability and longevity of Integrated CADS, it is the recommendation of this Review that an urgent 'reset' of Integrated CADS is required, focused on establishing a standardised and formalised model of service, with clear governance and accountability arrangements. In the medium-to-long term, consideration should be given to how Next Step can be transition from the MHC to an independent service provider.

There are common issues that need to be resolved for both Regional and Integrated CADS

Whilst the two service models are distinctly different, the Review has found some common challenges that need to be addressed. These have been outlined above and include:

- Capacity constraints caused by rising demand and 'flat' funding increases.
- Minimal use of Aboriginal staff or peer workers across providers.
- Issues with CADS clients being subjected to stigmatism in some emergency departments.
- Disjointed commissioning/funding practices between the MHC (as funder of state AOD services) and other commissioning bodies, including WAPHA who commission Commonwealth AOD programs.

The Review has made recommendations to address these common issues.

The primary AOD prevention role of Regional CADS is constrained by impractical role design and insufficient resources

Primary AOD prevention is a separate and distinct role of Regional CADS, and is the responsibility of designated and appropriately qualified prevention officers. Regional CADS prevention officers are in practice an extension of the MHC and are responsible for: facilitating the development of local AOD Management Plans; coordinating, and supporting AOD prevention and health promotion activities in each community; localising the MHC's state-wide campaign materials; and coordinating preventative responses to Volatile Substance Use (VSU).

There are some elements of the prevention officer role that are consistent across each region, and some that are not. Not least of this is resourcing. The Kimberley is the only region with multiple prevention officers. The prevention team of four, led by a team leader, is dispersed across the region, and is more effective in leading and coordinating AOD prevention activities. Across all other regions, the AOD prevention role is the responsibility of a single prevention officer.

In some regions, prevention works well as part of a Regional CADS. This is where the prevention officer is suitable qualified and experience in AOD health promotion and prevention, and that officer is supported by a Regional CADS provider that 'buys-in' to the importance of primary prevention as a distinct service. However, across all regions other than the Kimberley, prevention offers face barriers to their effectiveness – largely owing to their isolation and lack of resources. Specifically:

- A single prevention officer is required to cover several towns and communities, dispersed across very large geographical areas. The limit on their time and presence in communities in which they don't live means their relationships are often superficial, which in turn limits buy-in to prevention strategies and activities.
- Prevention officers are not provided with dedicated funding, or 'seed funding' with which to fund and administer prevention activities. This means that there is no funding for the development of campaign materials, the facilitation of events, and in turn, no funding for the actual 'implementation' of prevention strategies and actions identified by community members.
- Poor or inaccurate expectations by partner services and the community about the role of prevention officers – particularly in relation to the coordination of a 'response' to incidents of Volatile Substance Use.

The impact of these constraints is that prevention offers are isolated, experience burnout, and struggle to make an impact in smaller towns and communities. Regardless of which agency has carriage of AOD prevention in regional towns and communities, the constraints listed above will continue to hinder the effectiveness and impact of any AOD prevention activities. Specifically:

- AOD prevention should receive dedicated funding, including expanded resourcing across all regions (not including the Kimberley), and discrete funding for prevention activities, including seed funding the implementation of AOD Management Plans.
- Funding a dedicated role for Volatile Substance Use in high incidence regions, including the Kimberley, Pilbara, and Goldfields.
- Establishing standardised partnership agreement mechanism that covers all aspects of AOD prevention activities; and clearly define the respective roles and responsibilities of all stakeholders involved in AOD prevention within the community.

1. Summary of findings and recommendations

Findings for Regional CADS

This Review identified twelve findings about the extent to which Regional CADS are meeting the community treatment and support needs of consumers, families, and the community in regional WA. These are listed in Table 1 below.

Table 1 | Findings for Regional CADS

FINDING 1	Regional CADS play a critical role as the primary AOD service in Regional communities
FINDING 2	CADS are the first line of response to increasing prevalence and complexity of AOD issues in regional communities
FINDING 3	Regional CADS are highly-valued, and often the only support and treatment to some of the state's most vulnerable and acutely unwell people
FINDING 4	The nature and extent of service delivery varies by region – a result of different service providers, and the unique geographic, socio-economic and cultural challenges of each region
FINDING 5	There is significant inequity in the AOD treatment services and supports delivered through Regional CADS as compared with Metropolitan-based CADS and AOD services
FINDING 6	There is a significant gap in AOD services for children and adolescents under 15 years of age
FINDING 7	The cultural appropriateness of Regional CADS services varies, is best achieved with strong Aboriginal employment, and when complemented by available Aboriginal Health and Medical Services
FINDING 8	Providers must supplement their core MHC funding with other sources to enable them to meet community need
FINDING 9	Long-standing contracts and one-year extensions have constrained some areas of service delivery, and adversely impacted staff retention
FINDING 10	Peer workers, Aboriginal workers and dual-skilled mental health and AOD workers are essential to a CADS service maximising its client outcomes; but inconsistently employed across the regions
FINDING 11	Stakeholders and clients identified challenges in the regional health and hospital system related to individuals with AOD issues
FINDING 12	Challenges in local health and mental health services are placing increasing risk and pressure on some Regional CADS as the only support to individuals in an AOD crisis
FINDING 13	The absence of reliable and easily accessible detox and withdrawal is a significant AOD-related service gap in Regional WA; and hinders Regional CADS supporting clients through their recovery

Findings for Regional AOD Prevention

This Review identified five findings about the extent to which Regional CADS is delivering its population-based AOD prevention function to effectively meet the needs of regional towns and communities. These are listed in Table 2 below.

Table 2 | Findings for Regional AOD Prevention

FINDING 1	When delivered by qualified staff and a supportive provider, primary AOD prevention is a critical component of a Regional CADS service
FINDING 2	The effectiveness of prevention officers is significantly limited by their isolation and disconnectedness, and lack of resources
FINDING 3	The development and effectiveness of AOD Management Plans is inconsistent, with varying degrees of implementation and buy-in from local stakeholders
FINDING 4	Prevention stakeholders have inconsistent, and often inaccurate perceptions about the roles and responsibilities of CADS prevention officers
FINDING 5	VSU is a significant area of concern in some regions, and is often an overwhelming responsibility on a single prevention officer

Findings for Integrated CADS

This Review identified seven findings about the extent to which Integrated CADS are meeting the community treatment and support needs of consumers, families, and the community in metropolitan WA. These are listed in Table 3 below.

Table 3 | Findings for Integrated CADS

FINDING 1	Integrated CADS demonstrates the impact that can be achieved for clients through the genuine integration of related services
FINDING 2	Integrated CADS demonstrates the impact that can be achieved for clients through the genuine integration of related services
FINDING 3	There are several constraints and barriers that limit the ability of Integrated CADS to extend to their impact
FINDING 4	Despite governance issues, cultural challenges and rising tensions, there is near-unanimous support for the underpinning principles and intent of the Integrated CADS model
FINDING 5	The governance of Next Step (MHC as purchaser and provider) sits in stark contrast to the purchaser-provider split that has taken place in State and Territory health systems (including WA)
FINDING 6	Service of Integrated CADS is limited by infrastructure constraints in some CADS sites
FINDING 7	Cultural and institutional barriers to accessing public mental health services places increasing strain and risk on Integrated CADS to support clients with complex AOD and mental health issues

Recommendations

This Review identified 15 recommendations intended to guide the MHC's future decision-making about CADS. These recommendations aim to:

- Guide targeted investment in the enhancement and expansion of CADS;
- Address inconsistency or variability in service delivery across the State;
- Work collaboratively with service providers to address issues that constrain service delivery; and
- Utilise its policy and commissioning levers to address issues in the broader health and mental health service system that impact CADS clients

The recommendations are listed in Table 4, and are structured as follows:

- **Recommendations 1 to 4** relate to Regional CADS only;
- **Recommendations 5 to 7** relate to primary AOD prevention;.
- **Recommendations 8 and 9** relate to Integrated CADS only;
- **Recommendations 10 to 16** relate to all CADS.

Table 4 | Recommendations

RECOMMENDATION 1	Enhance the Regional CADS services, drawing on the principles of the Integrated CADS model to improve parity in service provision in regional communities.
RECOMMENDATION 2	Invest in appropriate crisis intervention responses, alternative to hospitals, for people in AOD crisis that will keep them, and the community safe.
RECOMMENDATION 3	Invest in effective detox and withdrawal pathways in regional communities – including investing in the implementation of the Alcohol and Other Drug Withdrawal Management Policy, and consideration of 'detox in the home' approaches.
RECOMMENDATION 4	Support the deployment of AOD nurses in the larger emergency departments across regional WA who work closely with the local CADS team
RECOMMENDATION 5	Primary prevention should be commissioned together with Regional CADS, but should receive dedicated funding to align prevention activities with the needs of each region.
RECOMMENDATION 6	VSU response should be separated from the role of prevention officers, and appropriately resourced in regions with higher rates of VSU reports.
RECOMMENDATION 7	The MHC, in partnership with CADS providers, should develop formalised partnership mechanisms with local prevention stakeholders to improve role clarity.
RECOMMENDATION 8	Commence a project to 'reset' Integrated CADS, focused on establishing a contemporary model of service with clear governance and accountability – while maintaining clinical safety and quality standards.
RECOMMENDATION 9	The MHC should explore options to transition the governance of Next Step into a service provider to ensure its independence from the commissioning body; as per the WA health system's purchaser-provider split.

RECOMMENDATION 10	Undertake a region-by-region review of AOD treatment demand to align funding with community need.
RECOMMENDATION 11	The MHC should implement more proactive and collaborative contract management with Regional and Integrated CADS.
RECOMMENDATION 12	The MHC should partner with WAPHA to jointly plan and commission AOD treatment and support services to maximise the impact of Commonwealth and State funding.
RECOMMENDATION 13	Expand the employment of peer workers across all CADS, building on the positive impact of peer workers in some CADS.
RECOMMENDATION 14	Invest in building the capacity of an AOD-specialist Aboriginal workforce in partnership with local ACCOs and TAFEs.
RECOMMENDATION 15	Work collaboratively with service providers to identify strategies to support staff wellbeing and reduce burnout and the impacts of vicarious trauma.
RECOMMENDATION 16	The MHC should address the troubling practices in ED and Community Mental Health toward individuals with AOD issues through its available policy and commissioning levers.

2. Introduction

Nous Group (Nous) was engaged by the Western Australian Mental Health Commission (MHC) to undertake a review of the Community Alcohol and Drugs Services (CADS) established across WA ('**the Review**'). This report is the culmination of that review, and is presented as an independent assessment of how CADS services are being delivered with the intent of identifying opportunities to enhance, expand or reconfigure services to better meet community need.

The provision of the AOD support delivered by CADS has evolved over the past 20 years

CADS provide individuals and families with AOD treatment and support services across the entire State. The current model of service for CADS is the result of more than 20 years of refinement and consolidation of AOD treatment services to better meet the needs of communities across WA. A high-level timeline of the progression of CADS services is outlined in outlined in Figure 2.

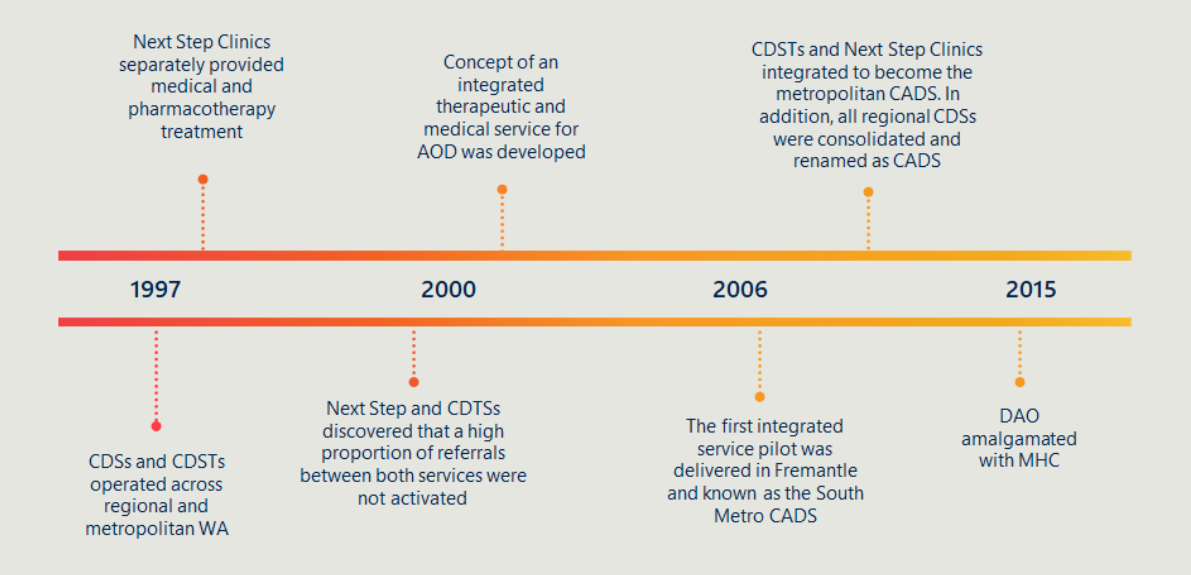
The first incarnation of CADS in the late 1990s was the Community Drug Service Teams (CDSTs), which operated in the Perth metropolitan area and the Community Drug Services (CDSs), which operated across regional towns and communities. At the time, the CDSTs operated alongside the Next Step Clinic, which was delivered by the then Drug and Alcohol Office (DAO). Next Step delivered specialist medical AOD treatment services and pharmacotherapy.

In 2007 there was the most substantive shift in the delivery of AOD treatment services in the metropolitan area. Next Step and the NGOs then delivering the CDSTs recognised an opportunity to integrate the two independent but related services. Following successful trial sites in Fremantle, Rockingham, and Warwick – the CDSTs and Next Step formed a partnership to become the Integrated CADS.

The CADS services in regional WA have not substantively changed during this time, although they have evolved locally to respond to local needs and partnerships.

The final change was in 2015, when the DAO was amalgamated with the MHC. The MHC currently both commission CADS and also operate Next Step.

Figure 2 | Timeline of the evolvement of Community Drug and Alcohol Services



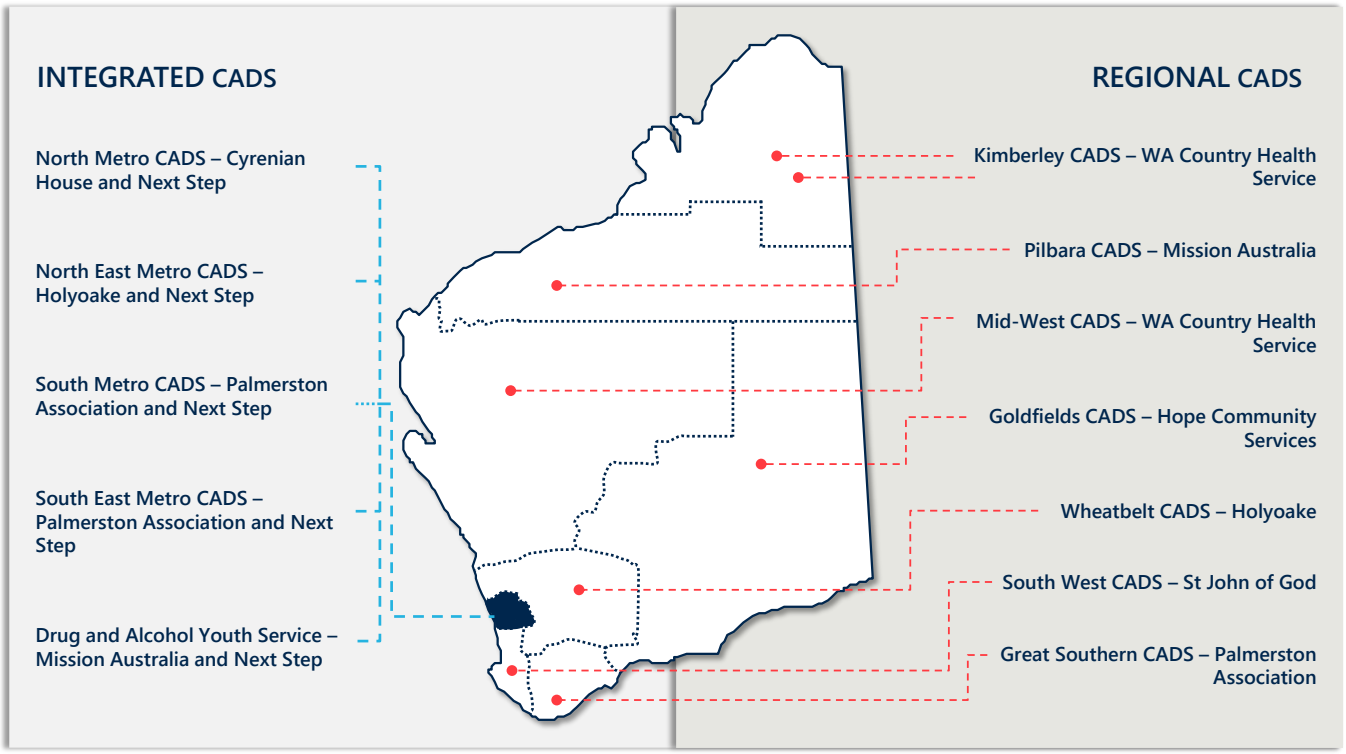
Modern day CADS service delivery now encompasses:

- **Regional CADS,** which deliver AOD counselling in regional towns and communities, alongside primary AOD prevention, pharmacotherapy, community development and education.
- **Integrated CADS,** which deliver AOD counselling and medical treatment services in the Perth metropolitan area, alongside pharmacotherapy, clinical psychology, and community education.

Across these two parts of CADS are 11 catchment area-based services plus the cohort-based Youth service operated in Perth. These 12 services are the focus of the Review, and are visualised in Figure 3 below.

The five Integrated CADS services are run in partnership between a non-government organisation (NGO) and the MHC (Next Step). Five of the Regional CADS services are wholly operated by NGOs. Two of the Regional CADS are operated by the WA Country Health Service, the government Health Service Provider that delivers healthcare across regional WA.

Figure 3 | CADS in WA



This Review is intended to complement, rather than duplicate past AOD reviews and inquiries

The mental health and AOD service system in WA is undergoing a period of significant reform. This Review has been undertaken against the backdrop of several high-profile reviews and inquiries, and the release of new strategic policies, plans and strategies that continue to shape the direction of the service system. As such, Nous has sought to complement rather than duplicate the work that has already been undertaken, drawing on existing stakeholder feedback wherever possible.

Key elements of the WA Governments reform agenda of relevance to this Review are detailed below:

- **Western Australian Mental Health, Alcohol, and Other Drug Services Plan (The Plan) 2015-2025.** The Plan outlined the optimal service mix for mental health and AOD services across the state. It detailed the need to increase AOD prevention, increase community support services for AOD harm-reduction and personal support, increase community treatment services, increase in community bed-based services, increase in hospital-based beds, increased forensic AOD community treatment hours and increased workforce capabilities to manage co-occurring mental health and AOD illnesses.[2]
- **Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025 (Prevention Plan).** The Prevention Plan aims to provide an overview of recommended programs, strategies and initiatives that promote optimal mental health, reduce the incidence of mental illness, suicide, and prevent and reduce drug use and harmful alcohol use in the Western Australian community. Prevention activities are focused on mental health promotion and the primary prevention of mental health and AOD concerns.

[2] Mental Health Commission (2018) *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (Plan) Update 2018 (Plan Update 2018)*

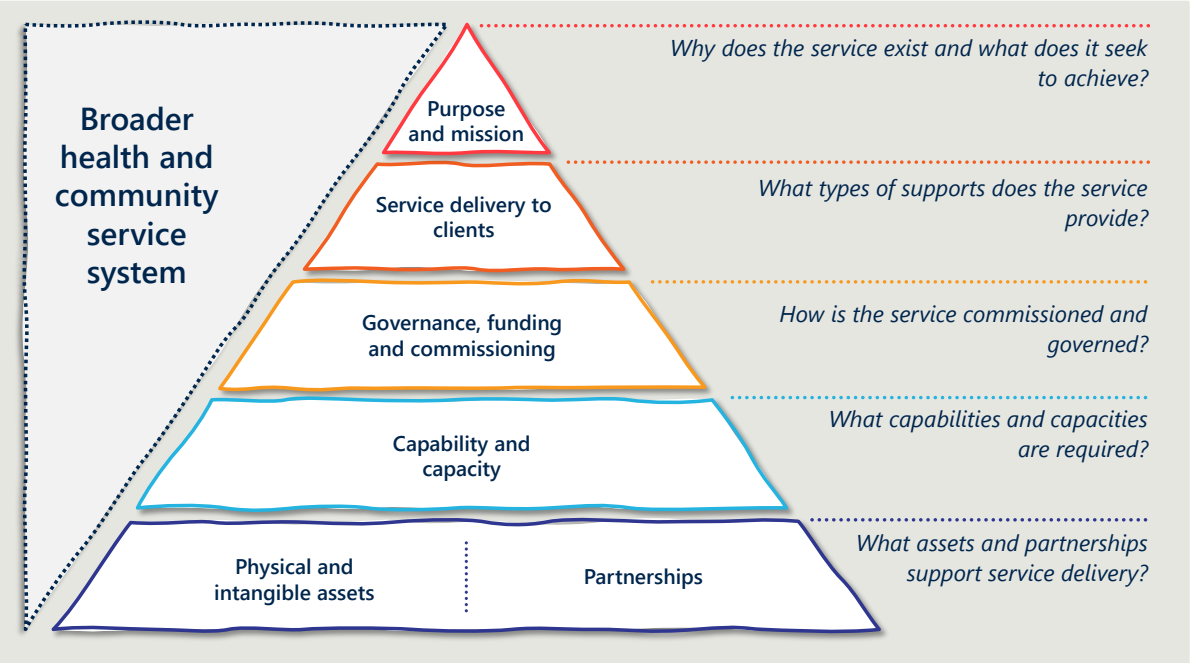
- **WA Methamphetamine Action Plan Taskforce (MAP).** The MAP Taskforce was established in 2017 to provide advice to the WA Government on how to improve the effectiveness of Government responses to the impacts and use of methamphetamine. The MAP Taskforce delivered its final report to Government in November 2018, providing 57 recommendations, 56 of which were supported, supported in principle, or noted.
- **Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0-18 years (ongoing)**. In late 2020, the then Minister for Mental Health established the Ministerial Taskforce to develop a whole of system plan for State Government funded specialist infant, child and adolescent mental health services provided by WA health service providers (HSPs) in both metropolitan and country areas. The Taskforce will include consideration of intersections and pathways between mental health and AOD services for 0-18 year-olds in WA.
- **Roadmap for Community Mental Health Treatment Services, including Emergency Response Services (ongoing)**. The purpose of the Roadmap is to provide the WA Government with a vision for community mental health treatment and mental health emergency response services that will best meet the needs of all people in Western Australia, all ages who require specialist community mental health care, and/or emergency mental health care. Due to the high rate of co-occurrence between mental health and AOD issues, it is expected that this Review will help inform the future interfaces between community mental health, and community AOD services (CADS).

3. Approach and methodology

The Review was guided by a series of key lines of enquiry

Nous used a Service Model Framework to differentiate the different components of the service model; acknowledging that there are factors that impact the effectiveness and efficiency of service delivery, and the impact that a service has on consumers and communities. The Service Model Framework is set out in Figure 4, along with the high-level Key Lines of Enquiry (KLE) that were used to structure the analysis and consultations undertaken. The framework has also been used to structure the key findings and recommendations.

Figure 4 | Service Model Framework



To supplement the KLEs that align with the Service Model Framework, Nous developed a further set of KLEs to ensure the Review identified recommendations for the future:

- To what extent are **Regional CADS** and **Integrated CADS** meeting the community treatment and support needs of consumers, families, and the community across WA?
- To what extent is **Regional CADS** delivering its population-based AOD prevention function to effectively meet the needs of regional towns and communities?
- To what extent should **Regional CADS** and **Integrated CADS** services be re-configured, enhanced or expanded to better meet the AOD community treatment and support needs of consumers, families and the community across WA?
- To what extent should the population-based AOD prevention role of **Regional CADS** be re-configured, enhanced, expanded to meet the needs of regional towns and communities more effectively?[3]

[3] This fourth KLE reflects the MHCs requirement that the Review also assess the efficacy of commissioning prevention services within Regional CADS.

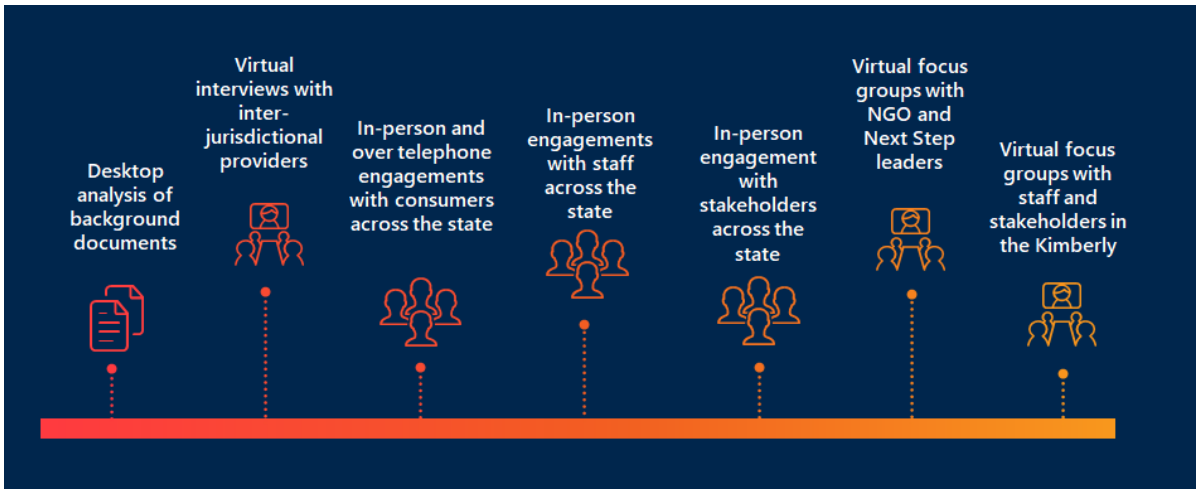
The Review was informed by desktop analysis, state-wide engagement and lessons learned from other jurisdictions

The Review brings together insights from three key sources:

- A desktop analysis of background documentation
- Insights and observations from CADS clients, staff and external stakeholders across the state; and
- the experiences and 'lessons learned' from similar services operating in analogous jurisdictions across Australia.

An overview of the Review process and methodology is detailed in Figure 5 and the sections overleaf.

Figure 5 | Overview of the Review process



Desktop analysis of background documents informed our understanding of the service models

Nous reviewed key background documents which included the service agreements and service reports from the CADS providers, as well as the recent and relevant policies and strategies previously highlighted in this report. These documents provided a high-level overview of the intended model of service including services delivered, partnerships, activity and geographical AOD trends. Additionally, throughout the Review, Nous accessed, and reviewed documents provided by CADS providers and stakeholders, including documented models of care, and client assessment/referral forms.

CADS clients, staff, stakeholders and community members were engaged through a blend of virtual and in-person mechanisms

The Review team undertook broad stakeholder consultation over a three-month period. The majority of consultations were undertaken through in-person interviews and focus groups, with virtual or telephone mechanisms used where necessary. Consultations included:

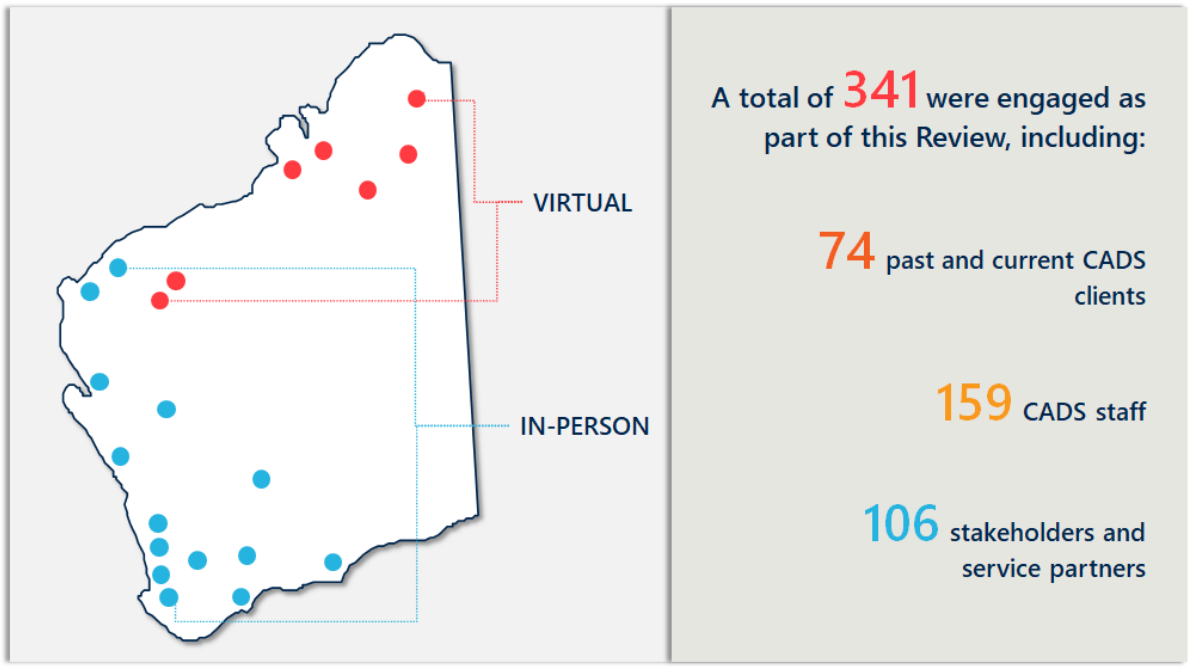
- Engagements with **CADS clients** to understand their experiences in being supported and treated by their local CADS; and to listen to their ideas about ways to improve AOD and mental health services in their town or community. This included both individuals directly affected by AOD issues, and family members of individuals affected by and/or supporting those with AOD issues.
- Engagements with **CADS staff** to understand their perspectives in delivering AOD treatment services in their town or community. This included understanding how each CADS service is delivered, the barriers and enablers to effective service delivery, and opportunities to improve outcomes for their

community. The CADS staff engaged included administration staff, counsellors, doctors, nurses, psychologists, prevention officers and peer workers working in Regional and Integrated CADS.

- Engagement with local **stakeholders** to understand their relationship and service pathways with their local CADS. This helped identify what is working well, and where there are opportunities for improvement in referrals, service partnerships, information sharing, and overall service delivery in each community. CADS stakeholders included representatives from WA Country Health Service, the Department of Justice (including community corrections and youth justice), Mental Health Community Treatment Services, Department of Communities (including child protection and housing services), local Aboriginal Community Controlled Organisations and Aboriginal Medical Services, regional prevention agencies, local government, and community members.

Figure 6 summarises the engagements undertaken with each stakeholder group.

Figure 6 | Number of engagements and location



Lessons learned from similar services operating in analogous jurisdictions.

Nous conducted interviews with four service providers delivering AOD or co-occurring AOD and mental health services in analogous jurisdictions across Australia. The purpose of these interviews was to gather information about alternative models of service for community based AOD services used in other jurisdictions. The service descriptions of each organisation and relevant lessons learnt can be found in Appendix A.

Nous' approach to engaging with Kimberley CADS and stakeholders was designed to address recent consultation fatigue

The Kimberley Region has experienced many consultations related to AOD and mental health over the last two-three years. At the outset of the Review, Nous and the MHC agreed an approach that ensured that Kimberley stakeholders would have an opportunity to be heard, but minimised unnecessary consultations in the region. This approach is in two parts:

1. **Draw on recent consultation feedback** from reviews, evaluations and inquiries that engaged Kimberley stakeholders, including:

a. Kimberley-wide AOD Consultations undertaken in 2018 as part of the MAP Taskforce

b. The review of AOD / Mental Health Comorbidity Treatment Service Needs in Wyndham

c. Co-design and consultations for the Kimberley Youth AOD Service

d. The independent review of Sobering Up Centres (SUCs) in 2019; of which half of the regional SUCs are located within the Kimberley.

2. **Targeted engagement with key stakeholders** was undertaken to address specific areas that were not addressed by previous reviews. This included three focus groups, one with CADS staff across the Kimberley, one with preventions officers across the Kimberley, and one with members of the Drug Alcohol and Mental Health Sub-committee of the [Kimberley] Aboriginal Health Planning Forum.

This document is the Final Report of the Review

The Final Report sets out the key findings, and recommendations from the Review. It is structured in three parts:

- **Regional CADS findings,** which includes:
  - A summary of the service delivery model for Regional CADS
  - Findings and insights relating to the treatment component of CADS provided in Regional WA
  - Findings and insights relating to the prevention component of CADS provided in Regional WA.
- **Integrated CADS findings,** which includes:
  - A summary of the service delivery model for Integrated CADS
  - Findings and insights relating to Integrated CADS in Perth metropolitan area.
- **Recommendations,** which sets out primary recommendations that have been prepared by the Reviewers.

Although the review team and the MHC have remained in close contact throughout the Review, the findings and recommendations are independent and have not been influenced by any third party.

4. Regional CADS findings

The service delivery model of Regional CADS provides support and treatment that span the continuum of care

Regional CADS is the primary AOD treatment and support agency in regional WA. Regional CADS are commissioned on a region-basis, with one service provider funded to deliver the service to each region. The current Model of Service for Regional CADS encompasses two distinct areas, which have been the subject of this Review.

- **AOD Counselling**, and related treatment and support services
- **Primary or 'population-based' AOD prevention,** which includes the Volatile Substance Use (VSU)[4] response.

Each role is summarised below.

Regional CADS deliver AOD counselling through a blend of one-to-one and group approaches

Regional CADS are commissioned to deliver low-intensity AOD treatment services – in line with the MHCs *Counselling guidelines: Alcohol and other drug issues* – to individuals and families in regional and remote WA. Utilising the guidelines, AOD counsellors, peer workers, and other AOD support workers deliver the following:

- **Counselling**. AOD counselling treatment aims to reduce AOD use and improve health, overall wellbeing, and community participation. Effective treatment is achieved through the development of a strong therapeutic alliance between counsellor and client, assessment and treatment planning, effective case management and AOD specific interventions.[5] Qualified AOD counsellors use counselling therapies that are tailored to the needs of individuals and assist with long-term recovery from AOD issues. They are founded upon the stages of change transtheoretical model which recognises that different people undertake different stages of readiness for change.
- **Case management**. In addition to counselling, AOD counsellors provide a wraparound support that seeks to identify the diverse needs of consumers and connect them to relevant services. This coordinated and 'no wrong door' approach[6] recognises that AOD issues do not sit in isolation and are often related to other health and social issues.
- **SMART group recovery.** SMART (Self-Management and Recovery Training) supports people with AOD addiction issues. This is delivered by trained peers and AOD counsellors who use a variety of cognitive behaviour therapy and motivational tools and techniques.
- **Community outreach**. AOD counsellors deliver therapeutic supports to underserved communities within their region. This enables them to support 'hard to reach' clients who otherwise would have not have access to any service.
- **Community engagement.** Recognising that CADS sits within a broader health system, counsellors engage with other services to deliver AOD training. In addition, they also engage with community members to deliver yarning sessions.

[4] Volatile substance use (VSU) is the deliberate inhalation of substances, which produce a vapour or gas at room temperature, for their intoxicating effects. It is commonly referred to as 'sniffing', 'solvent use', 'inhalant use' or 'chroming'.
[5] Mental Health Commission (2019) Counselling guidelines: *Alcohol and other drug issues*, Fourth Edition
[6] A 'No Wrong Door' approach refers to where people that seek help, can get it regardless of which service or agency they connect with.

- **Community Program for Opioid Pharmacotherapy (CPOP).** CPOP is delivered by visiting or partner GPs through CADS and includes the provision of methadone and buprenorphine treatment for people dependent on opioids. It is coordinated through the Community Pharmacotherapy Program (CPP).

Regional CADS are responsible for delivering primary AOD prevention through dedicated 'prevention officers'

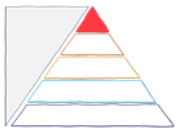
The 'AOD prevention' role of Regional CADS is delivered by prevention officers in each region. Though there are three core types of prevention (primary, secondary and tertiary), the responsibilities of prevention officers fall within the definition of primary prevention – that is, strategies that aim to prevent the uptake of AOD use or delay the age at which use begins. Target groups of AOD prevention activities include the whole community, groups in the community or subgroups of the population at increased risk.

The broad responsibilities of prevention officers include:

- **Facilitating the development of AOD Management Plans (or Community Wellbeing Plans)**. These plans are underpinned by the Prevention Plan and are used to guide community led prevention activities over a two-year period. They are intended to be community-owned, community-developed, and community-led, and:
    - Actively supporting partnerships between community and service providers to identify and address local issues
    - Provide a means to coordinate, implement and evaluate evidence-based, whole of community strategies.
- **Coordinating and supporting AOD prevention and health promotion in the community**. Prevention officers are responsible for leading the coordination of AOD prevention activities, and more broadly support the prevention efforts of key stakeholders in each town or community. This includes supporting Local Drug Action Groups (LDAGs) and Local Drug Action Teams (LDATs), working closely with School Drug Education and Road Aware (SDERA) officers to support AOD health promotion in schools, and attend and bring an 'AOD' perspective to community health and wellbeing events.
- **Localise and disseminate MHC campaign materials**. Prevention officers are responsible for localising the MHCs campaign materials, which are developed in partnership with the Cancer Council of WA. This includes the *Alcohol. Think Again* campaign, *Drug Aware* campaign and others.
- **The Central Coordinating Agency (CCA) of the VSU Incident Reporting and Response System**. Prevention officers are responsible for delivering the role of the CCA as part of the VSU Incident Reporting and Response System. This role includes, but is not limited to: receiving, recording, acknowledging and accessing incident reports, coordinating and monitoring a tailored response to all incidents, and recording the outcomes of VSU responses.

The MHC has recently developed the *AOD Prevention Core Competencies Framework* to guide the recruitment of prevention officers, and define the role of prevention officers. Whilst this framework is relatively recent, it has been used to guide the prevention component of this Review.

The Review has identified 13 findings about the impact and effectiveness of Regional CADS



Finding 1 | Regional CADS play a critical role as the primary AOD service in regional communities

WA's regional communities are unique – both as a collective, and individually. WA's regions are all some combination of large regional centres (i.e. Bunbury, Karratha, Broome, Kalgoorlie), medium-sized towns (i.e. Busselton, Newman, Derby, Esperance), small towns and remote/very remote communities.

Regional towns and communities have low population density, and proportionately higher populations of Aboriginal people than the metropolitan area[7]. They also typically experience higher rates of mental health and AOD issues in their population than in Perth. It is in this context where CADS plays a vitally important role. In regional communities, CADS are the primary, and often only, service that provides AOD treatment and support services.

The first and principal role of CADS is as the primary AOD treatment agency, responsible for providing therapeutic, low-intensity AOD treatment services in line with the MHCs AOD Counselling Guidelines[8]. Regional CADS delivers services that span the entire AOD continuum of care – including health promotion (see Section 0), prevention and harm reduction, treatment, and recovery. Unlike detox and withdrawal, and residential rehabilitation services, Regional CADS have a presence in every region in the State, and coverage of most, if not all towns, and some remote communities. As a result, they are the primary, and often only, commissioned service that delivers the full continuum of non-residential AOD treatment in regional WA.

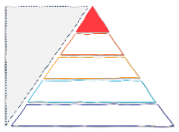
The secondary role of CADS is in community development and education. In most regions, CADS are recognised by service partners and community members as essential community members and service partners. In those regions, CADS invest time and resources into building community and service capacity to understand, and respond to AOD issues, and AOD-related harm. This is undertaken through education sessions, attendance at community and interagency meetings, and general awareness raising activities in community. Most of the CADS providers have been delivering AOD support and treatment for several years, which has helped to build the trust and credibility in the eyes of service partners and community members.

"I came to know about CADS when they did a session about AOD for our staff. It was really good because we learned a lot and have since started to refer to their service.".

- Regional CADS stakeholder

[7] Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. Aboriginal and Torres Strait Islander may be referred to in the national context and Indigenous may be referred to in the international context. No disrespect is intended to our Torres Strait Islander colleagues and community.

[8] Mental Health Commission (2019) Counselling guidelines: *Alcohol and other drug issues*, Fourth Edition



Finding 2 | CADS are not resourced to address the increasing prevalence and complexity of AOD issues in regional WA

The prevalence of AOD issues, and AOD-related harm is growing and changing. This has put renewed pressure and importance on the role of CADS to support those that are directly and indirectly impacted by AOD and build the resilience of regional communities to reduce the harm associated with AOD use.

The increased prevalence and complexity of AOD issues is affecting different age cohorts, and demographics in different ways. For example:

- Amongst adults and older adults, the primary drugs of concern in regional communities are either alcohol, and methamphetamine – with the most prevalent drug varying location by location.
- The COVID-19 pandemic interfered with methamphetamine supply chains, and CADS providers have subsequently observed that alcohol-related harm has increased considerably in the past 18 months.
- Amongst children, adolescents and young people, AOD issues are starting at earlier ages, and experimentation with volatile substances continues to be a significant area of concern for many communities, particularly those in the Kimberley, Pilbara and Goldfields. (Finding 6 explores the current capacity of CADS to respond to this trend).

"'....people have increasingly complex issues like severe addictions, and co-occurring mental health".

- Regional CADS staff

"We've been seeing more young children smoking and using drugs; as young as 9 and 10".

- Regional CADS stakeholder

The need for AOD treatment and support is growing. The 2018 Update to the MHCs Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 revised the optimal service levels for mental health and AOD services in 2020 and 2025. It concluded that in regional WA:

- In 2017, there were 164,000 hours of AOD community treatment services delivered.
- In 2020, an estimated 252,000 hours of AOD community treatment services would be required; and
- In 2025, an estimated 420,000 hours of AOD community treatment services would be required.

Therefore, to meet the optimal level of AOD service capacity by 2025, AOD community treatment hours will need to increase by **156 per cent** from 2017 levels. Despite these estimates, there has been no substantive addition to CADS funding or service capacity since 2018; and Regional CADS are currently constrained in their ability to meet current AOD treatment demands. There will be a significant capacity shortfall by 2025 without additional funding.

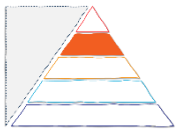
Additionally, the COVID-19 pandemic has brought with it with a new set of challenges for consumers and providers. Whilst there is limited data to evidence increased prevalence or changing complexity related to COVID-19, anecdotal feedback from providers and stakeholders indicates that COVID-19 has exacerbated the pressures on CADS to manage escalating AOD issues in regional communities. Key service partners of CADS across WA indicated that since the start of the COVID-19 pandemic there has been a significant increase in AOD-related harm in the community, particularly family and domestic violence.

"Since COVID hit, we've seen a huge spike in alcohol use and drugs generally. It's caused a lot of issues in the community".

- Regional CADS stakeholder

"My case load and our waitlist has been ridiculous since COVID. We just don't have enough hours in the day to see everyone".

- Regional CADS staff



Finding 3 | Regional CADS are highly-valued, and often the only support and treatment to some of the most vulnerable and acutely unwell people

AOD issues have profound and enduring impacts on both individuals, families, and whole communities. The impacts can be direct – such as injury, chronic conditions, and mental health issues; and indirect – contributing to intergenerational trauma, family and domestic violence, and contact with the criminal justice system[9]. Responding to AOD issues, and AOD-related harm is the joint responsibility of CADS, as well as police, corrections, and local health services.

This Review has found that Regional CADS is highly valued. Collectively, the feedback received from CADS clients, their key stakeholders, and community members reflects services that are deeply trusted by their key stakeholders, valued and appreciated by their clients, and have earned the confidence of their communities.

Service partners and CADS clients across the State emphasised that CADS provide safe care and treatment, and holistic support that often extends beyond counselling to meeting the individual needs of each of their clients. CADS clients consistently praised the support and care they received from CADS. Common feedback from CADS clients included:

- CADS represent a stigma-free and judgement-free place, where all people could access treatment and support free from judgement, or shame. CADS clients spoke often about being met with empathy and compassion by counsellors when they had relapsed, despite fearing they would be judged and reprimanded.
- CADS counsellors are genuinely invested in recovery, with many clients noting that they had been supported by their counsellors for several years. Others, who are no longer CADS clients, stated that they know that should they need support again they would be helped by the service.
- CADS counsellors are advocates for their clients – both in their treatment and recovery, but in helping clients navigate the complex health and social services eco-system. Clients spoke of counsellors supporting housing applications, admissions to detox and rehabilitation, and in extreme cases, sitting with clients in ED when they had an AOD-crisis to ensure they would be seen and treated, rather than summarily discharged.
- CADS counsellors understand the trauma of their clients and invest in treating not just the 'AOD issue' but the social and cultural determinants of an individual's AOD issues. Clients frequently commented that their counsellors allow them to lead the conversation and supported them to navigate the factors in their lives that impact upon their wellbeing and AOD use.
- CADS services are there to support not just individuals directly impacted by AOD – but their families to. CADS support, as clients, several family members across the State in a quasi-case management capacity, building the capacity of family members to support their loved ones with AOD issues.
- CADS services are active in the community, and highly responsive to referrals from other services. Service partners commented that CADS are a trusted partner, whom services feel comfortable referring their clients to. Service partners also commented that CADS counsellors frequently provide 'education sessions' to other services to upskill them in safe practices to people with AOD issues.

"My counsellor does more than counselling, they help me access other services and sort out some of the other things in my life. That's really helped my recovery".

- Regional CADS consumer

"I really like it here because my counsellor understands that I use because of other things. She focuses on the things that make me want to use".

- Regional CADS consumer

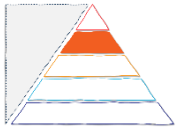
[9] National Drug Strategy 2017-2018, *Department of Health*, Australian Government

"If it weren't for my counsellor, I don't know where I would be. They just understand me and don't judge like other services".

- Regional CADS consumer

"I like the sessions here because I don't feel the pressure to just quit. They care about helping me to manage my use".

- Regional CADS consumer



Finding 4 | The nature and extent of service delivery varies by region – a result of different service providers, and the unique geographic, socio-economic and cultural challenges of each region

The MHCs counselling guidelines[10] for AOD issues offers CADS providers with a blueprint by which AOD treatment in regional WA should be undertaken. Whilst there is a necessary degree of flexibility and localisation of a CADS service there are several examples of variability in CADS service delivery. Some of these examples can be attributed to local factors and challenges, but there are four variations that cannot be solely put down to necessary local variation.

Outreach to small towns and remote communities is inconsistent and insufficient in many regions

Rates of AOD issues and AOD-related harm, while not always higher in smaller towns and remote communities, often have a disproportionately severe impact on the local community. With CADS based mostly in large- and medium-sized towns, outreach to these smaller towns and communities is critical to support at-risk and hard-to-reach clients. However, outreach is costly, and represents high opportunity cost, in that travelling 100kms to see one client in a small town, represents a lost opportunity to see four-five clients locally.

As a consequence, outreach is delivered inconsistently by CADS providers across regional WA. This inconsistency is driven by a range of factors, including limited resources, staff attrition, and high demand in larger population centres.

For example, Kimberley CADS have invested in, and developed strong links in remote communities, but Pilbara CADS has significantly reduced the consistency and volume of outreach activities, resulting in many remote communities having little to no access to AOD services. Whilst the latter is a function of staff attraction and retention issues in the Pilbara, it is nonetheless an inequity that will have long-term issues if not addressed.

"They used to do outreach to us but they stopped. If they were here, more people would go to them cause we have a heap of people with drug issues in this town".

- Regional CADS consumer

"We used to do more outreach, but it takes up a lot of resources to visit one town. There's a lot of driving to see a few people when we could stay here and see a lot more".

- Regional CADS staff

Rising demand for AOD treatment services have seen providers take different approaches to managing client wait-lists

As a result of rising demand for AOD support and treatment, and stagnant investment, some CADS providers are under increasing pressure to manage waitlists to minimise waiting times for clients. The MHCs AOD counselling guidelines require that providers manage waitlists proactively, including providing support to clients on waitlists, and following-up with clients who miss counselling sessions. These practices

[10] Mental Health Commission (2019) Counselling guidelines: *Alcohol and other drug issues*, Fourth Edition

are underpinned by the principle that effective treatment needs to be readily available – and the longer clients are required to wait, the less likely they are to engage with a service and achieve positive outcomes[11].

However, in response to growing waitlists and wait-times, CADS providers have adopted varying approaches to demand and client management. Whilst most providers have continued to support clients on a long-term basis, at least one provider has implemented session caps to their AOD counselling, with clients being limited to 6-8 counselling sessions. The benefits of this approach are that waitlists can be managed more effectively. However, it runs counter to the therapeutic, long-term recovery focus of AOD counselling, with CADS clients and staff both in regional WA, and in the Perth metropolitan area stressing that a 'six-eight session' approach only allows counsellors to 'scratch the surface' of a clients AOD issues.

Some providers have effectively implemented strategies to support clients on extended waitlists. One of these providers has a peer worker periodically calling clients on their waitlist. This approach is valued by clients that are waiting but puts pressure on a single peer worker to provide interim support to clients before they can start counselling.

"We just do 6-8 session otherwise we couldn't see new people and our waitlist would keep growing. 6-8 sessions only scratch the surface".

- Regional CADS consumer

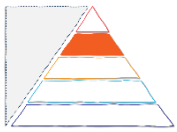
"Because the demand has been insane, we've cut back on community engagement".

- Regional CADS consumer

Clients in smaller towns and remote communities receive inconsistent access to pharmacotherapy supports

Through the Community Program for Opioid Pharmacotherapy (CPOP) Community Pharmacotherapy Program (CPP), commissioned service providers can provide methadone and buprenorphine treatment for people dependent on opioids. The provision of community pharmacotherapy alongside a CADS services is essential in regional WA, as it allows clients with moderate AOD issues to access low intensity withdrawal support in the absence of intensive withdrawal services. Whilst all CADS providers should provide community pharmacotherapy – not all do. Additionally, providers that do administer community pharmacotherapy often only do so in major town centres This means that clients in smaller towns and remote communities either have no access to pharmacotherapy, or must travel significant distances to access those supports.

[11] Mental Health Commission (2019) Counselling guidelines: *Alcohol and other drug issues*, Fourth Edition



Finding 5 | There is significant inequity in the AOD treatment services and supports delivered through Regional CADS compared with Metropolitan-based CADS and AOD services

The Integrated CADS 'model of service' established in Perth is a separate and distinct service model to the Regional CADS model delivered in regional towns and communities. Through undertaking a review that has looked at each model, it has become clear there is significant inequity in the services available to consumers and community members in regional WA compared with those that live in the Perth metropolitan area.

Table 5, below, summarises the key differences in the model of service, and the impact each difference has on CADS clients in regional towns and communities.

Table 5 | Differences between CADS services in Regional and Metropolitan WA

Service component	Integrated CADS	Regional CADS	Difference
Counselling support	Clients are provided with an assessment and case management by a qualified AOD counsellor	Clients are provided with an assessment and case management by a qualified AOD counsellor	No difference in service delivery
Medical support and review	Clients that are case managed in CADS will undergo a clinical/medical review periodically, allowing GPs and clinical psychologists to input into the progress and treatment of each client	Only one CADS service, Kimberley CADS, has joint clinical/medical reviews, owing to the integration of CADS with the community mental health team	Regional CADS clients are not provided with any clinical/medical oversight or review of their AOD treatment and recovery.
Opiate and pharmacotherapy	All CADS clients are provided with opiate and alcohol pharmacotherapy through Next Step	CADS providers commonly only provide pharmacotherapy in large towns	CADS clients in smaller towns commonly must travel significant distances to access pharmacotherapy
Outpatient withdrawal services	Detox and Withdrawal Network (DAWN) clinical nurses co-located at Integrated CADS offices, offer clients (if appropriate), the option of home-based withdrawal	There is no community or home-based withdrawal support offered through CADS in Regional WA	Regional CADS clients have no ability to withdrawal or detox in the community, or in their own home
Clinical psychology services	Clients under case management have access to treatment by a clinical psychologist	Publicly-funded mental health treatment is accessible only through community mental health services.	Regional CADS clients face significant barriers to accessing mental health treatment services (see Finding 11)

Service component	Integrated CADS	Regional CADS	Difference
Accessibility of detox and withdrawal services	Integrated CADS clients can access the Next Step Inpatient Withdrawal Unit through a relatively straightforward internal referral	There is no inpatient withdrawal unit in Regional WA (see Finding 13).	Regional CADS clients must navigate a complex referral process, and significant geographic barriers to access intensive withdrawal support in Perth.

"It would be great if we had a doctor to do assessments because it's so hard for people to get into GP clinics here. Some GPs won't even see them".

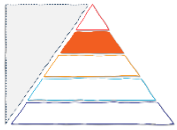
- Regional CADS staff

"We don't have any pharmacotherapy in the town. The GPs haven't got the qualification to do it, so people have to travel over 150km to get it".

- Regional CADS staff

Whilst there is some variation in service delivery across Regional CADS, the comparison above illustrates that individual living in regional towns and communities have access to less support and treatment than those living in the Perth metropolitan area. This inequity is driven primarily by the absence of a medical service working alongside the AOD counselling service supporting clients in regional WA.

The impact of this gap is that despite the high-value placed upon the impact of Regional CADS, their clients are receiving less treatment, specifically medical treatment, than those that live in Perth. CADS clients are less likely to receive treatment for the physical health, and mental health impacts of their long-term AOD dependence. Additionally, they face much more significant barriers to their long-term recovery – specifically with detox and withdrawal being a mandatory pre-requisite for entry to residential rehabilitation.



Finding 6 | There is a significant gap in AOD services for children and adolescents under 15 years of age

Reviews, inquiries, and evaluations undertaken in WA over the past several years have consistently highlighted the gaps that exist in AOD support and treatment for children, adolescents and young people in regional towns and communities. Those gaps have been similarly surfaced through this Review, with a specific focus on children and adolescents aged between eight and 15 years of age.

The specific themes raised about children, adolescents and young people include:

- A lack of activities, and ensuing boredom, is a significant driver of AOD use in children and adolescents
- Where there are activities for children, adolescents and young people, they often are not able to access those that are most disengaged and at-risk
- AOD issues are presenting younger than they have in the past, with children as young as seven and eight years old presenting with substance (including volatile substance) issues
- There is no specialist AOD support or treatment for children and adolescents aged under 16 years old in regional WA

- Whilst CADS is commonly a headspace 'consortium' member, it commonly only involves an AOD counsellor co-located at headspace one day a week
- The Drug and Alcohol Youth Service (DAYS) in Perth being difficult to access by young people in regional WA, particularly those whose parents and guardians are unable to accompany them.

"There's nothing for kids to do. There's not even a PCYC or youth centre here so they drink and use drugs. It's just gotten worse and worse".

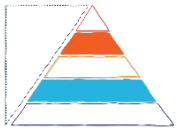
- Regional CADS stakeholder

"I spent months to get my teenage son to agree to go to Headspace. Headspace then sent him to CAMHS who then sent him to ED who asked him to go to Headspace. By the end of it he didn't want to see anyone. I felt so helpless".

- Regional CADS stakeholder

These are recurring themes across regional WA and CADS is limited in its ability to support individuals with AOD issues that are younger than 18 years old. Whilst funding clearly plays a role in limiting the support that CADS can provide for this cohort, the greatest barrier is the CADS model of care. This requires that as part of the development of a therapeutic alliance between counsellor and client, that the client has a 'commitment to change'. Children and adolescents, by their nature are very unlikely to acknowledge, and in turn make a commitment to change.

Addressing the gap in AOD supports for this cohort will likely require the development of specialist models of care, similar to the development of the recent Youth Homelessness Service for those with Mental Health and AOD issues, and the Kimberley Youth AOD Service. Other jurisdictions have also demonstrated how flexibility in served delivery can be used to 'pivot' resources to areas of need. For example, following a recent spike in cannabis use in Hobart amongst young people, Anglicare dedicated a cohort of younger clinicians, who were successful able to engage and work with at-risk young people.



Finding 7 | The cultural appropriateness of Regional CADS services varies; and is best achieved with strong Aboriginal employment, and when complemented by available Aboriginal Health and Medical Services

Regional communities have, on average, higher proportions of Aboriginal people when compared with the Perth Metropolitan area. Whilst Aboriginal people make up approximately one per cent of the population in the Perth Metropolitan area[12], the population of Aboriginal people in regional WA spans between three per cent in the South-West to 45 per cent in the Kimberley.[13]

Past reviews and inquiries have observed that Aboriginal people and communities have a significantly younger age profile and are more likely to experience poor health and higher burden of disease than non-Aboriginal people, including AOD issues and AOD-related harm[14]. In this context, it is critical that CADS deliver culturally safe and appropriate practices and are accessible by Aboriginal people and communities.

This Review has found that the cultural safety and appropriateness of CADS providers in Regional WA communities varies, and is generally strengthened where:

- CADS providers maintain strong employment of Aboriginal staff despite challenges associated with the recruitment and retention of suitably qualified Aboriginal staff.

[12]https://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/SSC51218#:~:text=People%20%E2%80%94%20demographics%20%26%20education&text=In%20the%202016%20Census%2C%20there,up%201.0%25%20of%20the%20population.

[13] https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/About-us/Publications/Strategic-plans/FINAL_WACHS_Aboriginal_Health_Strategy.pdf

[14] https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/About-us/Publications/Strategic-plans/FINAL_WACHS_Aboriginal_Health_Strategy.pdf

- Aboriginal people and communities have the 'choice' of a CADS service, or a local Aboriginal Health or Medical Service.

Each of these features is detailed below.

CADS providers with strong and consistent Aboriginal employment are better able to deliver culturally safe and appropriate treatment to Aboriginal people and communities

The presence of Aboriginal staff in a CADS service is essential to the service being seen as safe and accessible – both by clients, and the community. There are several reasons for this:

- Providing Aboriginal clients with the opportunity to be supported by an Aboriginal counsellor
- The ability to quickly establish connections in local communities, and ensure CADS are seen as safe and culturally appropriate by Aboriginal people
- Uplift capability in culturally safe and appropriate practice in the service more broadly.

However, the employment of Aboriginal staff in CADS services varies significantly. In the Kimberley and Mid-West, Aboriginal staff make up between 40-60 per cent of all CADS staff, whilst in the Wheatbelt, Aboriginal staff make up 25 per cent of the CADs team. In contrast, South-West and Pilbara CADS do not currently employ any Aboriginal staff at the time of this Review. Some regions are better able to recruit and retain suitably qualified Aboriginal staff while others struggle in the absence of appropriately trained Aboriginal AOD workers. This variance has a significant impact on the extent to which external stakeholders, and CADS providers themselves, consider the service as being 'culturally appropriate'.

"Aboriginal people should be able to be supported by Aboriginal people. Cultural awareness training isn't enough.".

- Regional CADS staff

"Not having Aboriginal staff has impacted our ability to go into some towns because they won't even speak with us".

- Regional CADS staff

External stakeholders and community members stressed that Aboriginal counsellors are better able to understand the unique background and experiences of their Aboriginal clients, and in turn provide the most culturally safe response. This allows counsellors to build a deeper connection with their client and provide a more effective service that improves outcomes for their Aboriginal clients. Feedback from staff in a CADS with several Aboriginal staff shared that the presence of Aboriginal staff allows them to offer their clients a choice to have an Aboriginal counsellor, or non-Aboriginal counsellor. That choice itself is welcomed by Aboriginal clients.

"Without Aboriginal staff there is no one with the background to deal with local issues, we need Aboriginal people educated and with life experience behind them."

- CADS client

"Aboriginal counsellors are ten times more powerful than a counsellor that doesn't share the same experience as their Aboriginal clients."

- Regional CADS staff

In contrast, the absence of Aboriginal staff, it follows, has a significant impact on the ability of a CADS provider to effectively engage with, and support Aboriginal clients. For example, staff in a CADS without any Aboriginal staff believe that the service would reach more people if it employed Aboriginal staff, noting that experience and understanding shared by Aboriginal counsellors can be a significant benefit in the healing and recovery of their clients.

Aboriginal people and communities are best supported when provided with the choice to access a CADS, or a local Aboriginal Medical Service (AMS)

AMS' or Aboriginal Community Controlled Health Organisations (ACCHO's) exist in many regions, and commonly provide a diversity of medical and social services, including health and mental health treatment, treatment for chronic conditions, disability supports, dental services, and social and emotional wellbeing services. Whilst not funded by the MHC to do so, many AMS' also provide limited AOD treatment and support services.

This Review has observed that 'choice' is central to providing culturally safe and appropriate AOD responses to Aboriginal clients and communities. Specifically, the majority of providers and stakeholders (but not all) spoke of the importance of CADS working alongside their local AMS. For example, in the South-West, the CADS provider commented that many Aboriginal people with AOD issues will prefer to be supported by the local AMS, rather than a non-Aboriginal service. Additionally, towns like Narrogin and Katanning stressed that the absence of an AMS' significantly limits the support and treatment available to Aboriginal people in the community who are averse to seeking out support from non-Aboriginal organisations[15].

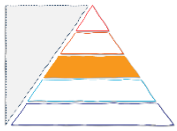
"Aboriginal people should be able to at least have the choice of seeing an Aboriginal staff. Our communities are small, sometimes the Aboriginal staff is a relative".

- Regional CADS staff

"Not having an AMS here affects our Aboriginal people. They don't go to GPs or even ED so you can imagine the state of their health".

- Regional CADS stakeholder

However, an AMS' by its nature, will not be accessible to all Aboriginal people in each region or community. Some stakeholders and Aboriginal clients commented that due to family or cultural barriers, some Aboriginal families will not seek out support or treatment from an AMS. These families are more likely to seek out the support of CADS for AOD support and treatment. This reinforces the importance of choice and ensuring regions have a CADS (with strong Aboriginal employment) working alongside local AMS' and ACCHOs'.



Finding 8 | Providers must supplement their core MHC funding with other funding to enable them to meet community need

As detailed in Finding 2, funding to CADS providers has remained generally static since 2018, despite the Plan Update 2018 indicating that a 156 per cent increase in AOD community treatment hours would be needed by 2025 to meet demand in regional WA. This has created a sizeable shortfall in the capacity of CADS to meet AOD treatment demand. As such, most Regional CADS providers have sought out or redeployed funding from other sources, primarily from the WA Primary Health Alliance (WAPHA) and other State Government agencies, to address capacity constraints and gaps in service delivery. For example:

- Wheatbelt CADS are funded by WAPHA to deliver the 'Integrated Support Team' program to more intensively case management clients with complex AOD issues and co-occurring issues
- Pilbara CADS are funded by WAPHA to deliver AOD counselling and support services, including outreach, to adolescents and young people
- Great Southern CADS are funded by WAPHA to deliver AOD-related community and social support services, including yarning, and parenting and family support programs support, and family support programs (as delivered through Great Southern CADS)

[15] Stakeholders noted that the South-West Aboriginal Medical Service (SWAMS) has received funding to expand into Narrogin and Katanning. In both cases, the intent of this funding is to act as a transition to facilitate the development of a specific Aboriginal Medical Service in each town.

- Goldfields and Pilbara CADS are funded by WAPHA to deliver low-intensity mental health support
- WACHS employ a psychologist in the Midwest (Carnarvon) CADS using funds from WAPHA that predate the formation of the PHNs across Australia.

Other CADS providers are funded to deliver low-intensity mental health support services, family and domestic violence supports, housing and income supports, and other community support services to complement, and address capacity constraints in CADS services.

Supplementary funding enables CADS providers to address some areas of unmet demand. For example, WAPHA funding in Kalgoorlie and the Pilbara enable CADS providers to deliver mental health counselling concurrent to AOD counselling.

The use of supplementary funding addresses critical capacity in regional WA. However, supplementary funding also has unforeseen impacts on service delivery, including:

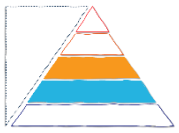
- Unclear or no ability to share data and information between services funded by WAPHA, and those funded by MHC
- Poor or incomplete capture of activity and outcomes achieved in different programs
- Maintaining expectations in community about service delivery when some funding is discontinued due to time-limited, or one-off agreements (e.g. the yarning and parenting support service delivered in Katanning, for which funding has been ceased from July 2021)
- The 'isolation' of counsellors funded by WAPHA, from counsellors employed through CADS funding.

"The inconsistencies in all the funding streams makes it hard. I had a young person become too old for the WAPHA program and I couldn't share his history with CADS so he had to start again.".

- Regional CADS stakeholder

"We look really incompetent delivering services for 6 -12 months then stopping when funding is pulled. Communities struggle to trust that we'll be there for the long term".

- Regional CADS staff



Finding 9 | Long-standing contracts and one-year extensions have constrained some areas of service delivery, and adversely impacted staff retention

Regional CADS service contracts were last tendered in 2014. Following an initial three-year period the MHC have, through exercising extension options and contract variations, extended the contracts of each CADS provider by 12-months each year since 2017. Whilst there have been many shifts in the policy landscape (including the implementation of the Methamphetamine Action Plan from 2017), the MHC's contract management approach has hindered service delivery. Two examples of these issues are detailed below.

Outdated contacts have not enabled or empowered CADS providers to be flexible and responsive to the needs of regional communities

The contract for CADS were last developed in 2014. The seven years since, has seen significant changes in the demand for AOD services, and the configuration of local service systems. CADS providers identified several concerns with this approach, including:

- Limited opportunities to discuss and revise key performance indicators and outcomes measures with the MHC.

- A lack of flexibility to adapt service delivery to be responsive to community feedback and changing community needs.
- Insufficient clarity around the expectations of MHC, and the roles and responsibilities of CADS, particularly relating to service adaptations since 2014.

The fact that this review has been undertaken to inform the next procurement of CADS (in 2022) was welcomed, but with some reservations. Many CADS providers observed that they had limited opportunities to engage with the MHC; with some perceiving that the procurement of services and ongoing contract management and communication from the MHC is too focused on compliance and punitive measures, rather than a more proactive and collaborative approach taken by other commissioning bodies.

For example, WAPHA have recently completed the development of a performance management framework for providers of commissioned services. As part of this work, WAPHA formed a service provider reference group who were part of the co-design of the framework; thereby ensuring it would benefit both WAPHA as the commissioning body and the diverse range of organisations that deliver services commissioned by WAPHA.

"I'd like the MHC to have less of a heavy hand and to be less punitive in their communication and actually meet with us to understand how the service is doing. The bottom up approach works well.".

- Regional CADS staff

"The client feedback form doesn't really capture progress or recovery. People don't feel physically good when they stop using because they are in withdrawal".

- Regional CADS staff

The Salvation Army in Tasmania commented on the positive impact that can be achieved when commissioning bodies are active and responsive to the needs of communities and service providers. The service provider commented that they work closely with their State funder, establishing a regular two-way dialogue to enable flexible and responsive service delivery to meet the needs of their clients and communities.

Repeated 12-month contract extensions has adversely impacted the ability for Regional CADS to recruit and retain skilled and qualified staff.

Regional CADS providers, like most NGOs that deliver government-funded health and social services in regional WA, face several barriers in the recruitment and retention of skilled and qualified staff. These barriers include, but are not limited to:

- Higher than average cost-of-living in regional towns and communities
- Rental housing shortages and higher than average rental prices
- Lower salaries and benefits (i.e. leave entitlements and government employee housing) as compared with the WA and Australian Government agencies
- Vicarious trauma and burnout of staff working in more remote towns and communities
- High transiency of staff due to external factors (i.e. significant other working in mining or in the WA Police Force).

"It's really hard to expect people to take a 6-month or 12-month contract with the promise that it will be rolled over. You can't buy a house with short term contracts.

"Staff burn out is a huge issue. Our job is emotionally draining and we're so busy all the time. We've had a high turnover because they

Why would they take this job when WACHS or other services give them more money and permanency"?

- Regional CADS staff

reach their breaking point and can't handle it. We try to support them as best as we can".

- Regional CADS staff

The consistent 12-month rollover of CADS contracts in most regions has exacerbated this issue for CADS providers, with available skilled and qualified staff commonly opting for roles with permanent contracts, rather than six- or 12-month contracts. Consequently, most CADS providers noted that that recruiting and retaining skilled and qualified staff the most significant barrier to effective service delivery. This has had several direct and indirect impacts:

- Additional workload pressures placed on existing staff, who are often from the local area
- Impaired relationships with remote Aboriginal communities, who rely on consistency and reliability of CADS staff
- Long-term vacancies resulting in reduced service capacity
- Significant mental distress of staff members who must navigate contract uncertainty, and in regions like the Pilbara, face significant barriers to accessing affordable and acceptable housing.

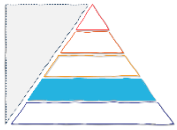
Left unaddressed, these barriers will continue to hinder effective service delivery, particularly in the more remote areas of regional WA.

"We're losing credibility because of the high staff turnover. Community members and clients build relationships with staff who then leave after six months. It's becoming really hard to go to some towns now because of it".

- Regional CADS staff

" I've moved many times in the five months I've been here, I've been basically homeless once. Why would I stay here when I can move back to Perth where I can pay less in rent and save more"?

- Regional CADS staff



Finding 10 | Peer workers, Aboriginal workers and dual-skilled mental health and AOD workers are essential to a CADS services maximising client outcomes; but they are inconsistently deployed across the regions

The successful management and treatment of an individual with acute AOD issues in a community setting requires combining therapeutic, medical, psychiatric, psychosocial, and cultural approaches[16]. Whilst Regional CADS do not deliver medical and psychiatric supports, some CADS deliver valued and essential psychosocial and cultural supports through a number of 'specialist' roles:

- **Peer workers**, who work closely with counsellors in case management, support and facilitate group activities, and support clients on waitlists.
- **Aboriginal counsellors and Aboriginal health workers**, who as detailed in Finding 7 have a critical role in supporting Aboriginal clients, building cultural competency across CADS services, and building relationships with community.
- **Dual-skilled AOD and mental health workers**, who support clients with more complex needs and co-morbidities, particularly those that require mental health counselling.

[16] Sdrulla, Andrei & Chen, Grace; Multidisciplinary Approach to the Management of Substance Abuse; Springer; 2015.

"We have one [peer worker] here and she's great but one isn't enough. It's really good to talk to someone who has been where we are".

- Regional CADS client

"It would be good to have mental health staff here because we have a lot people with mental health issues that are beyond our capabilities".

- Regional CADS staff

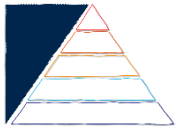
Where they exist, individuals occupying these roles across Regional CADS have had a positive impact on client outcomes. The consistent employment of these specialist roles, as appropriate to the local context of each town and community, aligns with the direction and priorities set by the Australian and WA Government's in relation to health service delivery in regional and remote WA. However, the employment of staff in these roles is inconsistent across different regions. The absence of fixed and funded positions for each of these 'specialist' roles contributes to their sporadic employment across different regions.

Table 6 summarises the value and impact of each role, and the frequency of their employment across different regions:

Table 6 | Impact and presence of specialist roles across Regional CADS

Role	Impact and value	Presence across CADS
Peer workers	• Peer workers have a positive influence on clients recovery, with clients emphasising the value of speaking to someone that had undergone a similar journey. • The joint case-management approach, where a case manager works in partnership with a peer worker, has been effective in supporting clients with more complex issues.	• Peer workers are only employed in Great Southern CADS. Whilst there is a peer worker in Wheatbelt CADs, they work as part of the WAPHA-funded Integrated Support Team service.
Aboriginal counsellors and health workers	• Aboriginal staff are able to provide more culturally safe and appropriate care to Aboriginal clients, that brings culture together with therapeutic treatment. • Aboriginal staff often act as the 'face' of CADS to Aboriginal communities, and play a large role in building the trust of those communities in CADs.	• As detailed in Finding 7, while some providers have high Aboriginal employment (i.e. Kimberley, Mid-West and Wheatbelt CADS), others have little or no Aboriginal staff (South-West and Pilbara CADS).
Dual-skilled AOD and mental health workers	• Dual-skilled workers are able to support individuals with complex co-occurring issues, particularly in the context of the more high-risk clients that Regional CADS are increasingly supporting.	• The presence of dual-skilled workers is very inconsistent, and is generally present in services with WAPHA-funded mental health services.

Peer workers are used effectively in AOD services in other jurisdictions. For example, Anglicare Tasmania has developed a strong clinical and peer workforce, where clients are jointly supported by AOD counsellors, who lead the provision of care and treatment, and peer workers, who provide support to clients as needed.



Finding 11 | Stakeholders and clients identified challenges in the regional health and hospital system related to individuals with AOD issues

Long-term AOD use can have significant, and often-times extreme impacts on an individual's health and wellbeing. Specifically, long-term AOD dependence is linked with acute physical health issues (including impacts on the respiratory, reproductive, and nervous systems) and mental health issues (including depressive disorders, and complex behavioural disorders). There is extensive research that articulates the co-occurrence between AOD-dependence, and mental health issues, and that[17]:

- At least 55 per cent of people experiencing an AOD use issue have co-occurring mental health issues
- 60 per cent of people with a mental health disorder are also experiencing AOD dependence.[2]

In this context, CADS make up only one component of a systemic response to AOD issues in regional communities and needs to be complemented by responsive mental health services, physical health services, and crisis response services.

This Review has found, however, that for people with AOD-issues there are challenges and inconsistencies with regards to how their treatment for AOD issues integrates with mental health treatment and crisis response when required. The feedback heard by this Review was consistent across all regions about the limitations of hospitals, specifically emergency departments, and community mental health treatment in responding to people with AOD-issues. This feedback can be grouped into two themes as summarised below.

An emergency department is often not an appropriate place to support CADS clients experiencing crisis

This Review has heard from CADS clients, stakeholders, and community members from across WA who stressed that emergency departments are not appropriate for individuals who experiencing an AOD related crisis. The feedback received included the following themes:

- The majority of people (with or without AOD issues) who present to ED are commonly required to wait for a period of time in the ED waiting area, even when intoxicated.
- Some people present intoxicated only to subsequently not receive treatment because they do not have a health issue appropriate for treatment within an ED.
- Clients who present to ED in drug-induced psychosis – sometimes with suicidal ideation – can be discharged without treatment and/or a care plan and/or a referral to an appropriate AOD service.
- Many clients feel they are 'labelled' as someone with a historic AOD problem and experience stigma from doctors and nurses.

Some CADS staff and clients expressed sympathy for hospital staff, noting that many regional hospitals are significantly capacity constrained and are not designed to support an individual in an AOD related crisis. However, there remains a broad consensus amongst CADS staff and client that there is a need for EDs to

[17] https://adf.org.au/reducing-risk/aod-mental-health/

explore more appropriate and compassionate responses to those in AOD crisis or with a history of AOD issues.

"I've some horrible experiences in ED and I know many people who have as well. They don't treat us like others".

- Regional CADS client

"They use terms like "belligerent", "drug seeking" and "manipulative", which creates a stigma. It drives clients back to us".

- Regional CADS staff

In response, WACHS acknowledge there are ongoing challenges across many of its hospitals with regards to the safety of both individuals presenting with an AOD issue and in particular staff working within the hospital. There are multiple reasons for these challenges:

- Stigmatisation caused by an accumulation of behavioural incidents by some of those presenting in an intoxicated state – in some cases at an individual level but also at an overall level. This includes staff being verbally and physically assaulted by individuals who are intoxicated.
- Only a small number of WACHS hospitals deploy an AOD Nurse within the emergency department – a position that was noted as highly beneficial by the Methamphetamine Taskforce.
- A lack of awareness in many staff as to how to deal with someone presenting to the emergency department in an intoxicated state; an issue compounded by a high reliance on locum staff.
- An absence of defined referral pathways and processes to AOD services – including CADS.
- Emergency departments in the majority of regional hospitals not being the appropriate environment for an intoxicated individual, including the requirement for people to have to wait to be seen – something that an intoxicated person has less patience for than a non-intoxicated person.

Some of these challenges can be overcome with investment, but others will remain an enduring challenge.

With the exception of the six regional hospitals operated by WACHS (Bunbury, Albany, Kalgoorlie, Geraldton, Hedland and Broome), WACHS operates small to medium sized hospitals, with modest levels of staffing and often with challenges in staff turnover. Establishing safe places for intoxicated people is critical for their safety and the safety of staff working in the ED, especially in a crisis situation, but an emergency department within a small regional hospital is unlikely to provide the safety required for all parties.

"Some staff in our hospital have been placed into dangerous situations, others have been assaulted. It's not surprising they are not comfortable when dealing with someone who is intoxicated".

- WACHS staff member

"There is stigmatisation, we need to address this and we could definitely be better trained – but with some individuals there is a long history and in the past they have been violent towards staff".

- WACHS staff member

Community mental health treatment services are capacity constrained and operate on a different philosophy to CADS

This Review has found that in all regions other than the Kimberley – there is no integration of CADS and mental health community treatment services. Specifically, CADS clients, stakeholders and staff consistently spoke of the high-barriers to access, and the capacity constraints on mental health community treatment services which have driven them in some regions to act as a "assess and immediately refer on" service.

In some regions, this Review has observed that CADS and mental health community treatment teams have sought to overcome this disconnect by building strong relationships, and in some cases, clear pathways

between the services. However, these relationships and pathways have not translated into CADS clients being able to more easily access mental health support and treatment. Specifically, this Review has observed that:

- Pathways between CADS and mental health community treatment are commonly 'one-way' with CADS accepting referrals from community mental health teams, whilst community mental health teams are less likely to accept referrals from CADS.
- CADS clients commented that they felt stigmatised when seeking support from mental health community treatment teams, noting sometimes dismissive and judgemental attitudes by mental health staff.
- In many regions, mental health community treatment services continue to operate under the philosophy of "AOD issues must be treated before mental health issues can be treated" – limiting options for shared care and case management.
- The inability to share information about patients due to confidentiality issues between services.

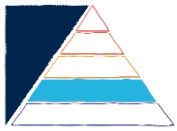
Ultimately, this Review has identified that there remains philosophical and systemic differences between AOD community treatment (CADS), and mental health community treatment services. CADS operate on a therapeutic, long-term recovery model, with a low barrier to entering the service. In contrast, mental health community treatment commonly sets a high barrier to entry, focused more on short-term stabilisation, and managing significant service demand, and therefore long waitlists. Until these divergent approaches are addressed, it appears unlikely that efforts to improve the integration between AOD and mental health community treatment services will be effective.

"I went to community mental health because of suicide attempts. They told me to go home, sober up and come back if I want to commit again. I received no support or anything".

- Regional CADS client

"As soon as they find out they have an AOD problem, they push them back to us. They don't do dual diagnosis. They say AOD is giving them a mental health illness. The mental health service works as a revolving door".

- Regional CADS staff



Finding 12 | Challenges in local health and mental health services are placing increasing risk and pressure on some Regional CADS as the only support to individuals in an AOD crisis

CADS services are low-intensity, therapeutic services – they generally do not employ staff who are qualified to support clients in crisis, or with complex mental health issues – nor are they funded to do so. Regional CADS staff are commonly made up of AOD counsellors, prevention officers, peer workers, intake and allocation staff. The minimum qualification for an AOD counsellor is a Certificate IV in Alcohol and Other Drugs, however, many AOD counsellors are pre-qualified with a tertiary social, behavioural or health sciences degree (i.e. Bachelor of Social Work, or Bachelors of Psychology).

The limitations of emergency departments (noted above) to support individuals in an AOD crisis is placing considerable strain on these AOD counsellors, as well as CADS services, and CADS clients. This strain represents significant risks – both to the CADS clients, CADS staff, and the MHC more broadly as the commissioner of CADS.

The risk to CADS is manifesting in different ways. These are:

- Supporting individuals in crisis in the absence of adequate crisis response services
- Supporting individuals with complex mental health issues, in the absence of accessible mental health treatment and supports for individuals with co-occurring AOD issues.

"We hold a lot of risk because people are getting more complex, they don't want to go to ED, community mental health won't take them, so they come to us".

- Regional CADS staff

"I do a lot of risk assessments and send so many to ED. Sometimes I struggle to even sleep at night because of the stress".

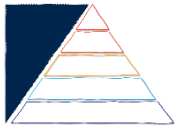
- Regional CADS staff

The impacts of no, or limited, crisis response services places considerable strain on CADS staff to support individuals in an AOD crisis situation. Because of the 'open door' philosophy of many CADS providers, and the care exhibited by staff, CADS staff are often situationally required to support their clients who are in an AOD crisis, including those who are acutely intoxicated and exhibit erratic behaviour. Examples of this support include:

- Supporting clients who present to the CADS service acutely intoxicated, and in crisis
- Supporting clients who present to the CADS service exhibiting signs of suicidality
- Accompanying clients to EDs, and supporting them whilst in ED to ensure they are seen and treated, rather than discharged.

The impacts of high-barriers to accessing community mental health services compound this. Many CADs counsellors, and stakeholders from other health and social services report having to support their clients in a crisis related to a severe and complex mental health issue. These staff spoke of feeling ill-equipped to support their clients, but feeling responsible for ensuring the well-being of them and fearing that harm may come to them if they do not.

These are just some of the examples of the risks placed on CADS staff and services. In the absence of accessible and responsive crisis response services, and/or mental health treatment services in regional communities – these risks will continue.



Finding 13 | The absence of reliable and easily accessible detox and withdrawal is a significant AOD-related service gap in Regional WA; and hinders Regional CADS supporting clients through their recovery

The absence of reliable and accessible withdrawal management or detoxification services in regional WA has been the subject of several reviews and inquiries, including the 2018 Final Report handed down by the Methamphetamine Action Plan Taskforce. Withdrawal can be undertaken in four settings, based on the risks to the individual detoxing, and the acuteness of their AOD issues:

- **At home** (e.g. the Drug and Alcohol Withdrawal Network, or DAWN), people are provided with the medication and clinical supervision to detox in their home, if safe to do so.
- **In the community**, in a low-medical withdrawal service. There are currently only four low-medical withdrawal beds in regional WA – two in the Pilbara, and two in the South-West.
- **In a specialised treatment unit**. There are currently no specialised treatment units in regional WA. The only facility in WA is the Next Step Drug and Alcohol Services 17-bed unit in East Perth.
- **In a hospital setting**, as part of the Department of Health's mandatory Alcohol and Other Drug Withdrawal Management Policy.

Whilst detox and withdrawal services are not specifically within the scope of this Review; it has found that the absence of accessible detox and withdrawal management service remains one of the biggest AOD-related gaps in regional communities and this has a significant impact on CADS. This service gap manifests in several ways.

Firstly, there is no support for 'detox-in-the-home' in regional communities. Detox in a home-based environment requires clinical management and supervision, usually through clinical nurses who can safely

do home visits to support individuals withdrawing in a home environment. There is currently no funding, nor support from local health services for individuals to detox in their homes.

Secondly, there are very limited low-medical withdrawal community beds in regional WA. These beds are located in two places – Roebourne, in the Pilbara, and Nannup, in the South-West. These beds commonly come with long wait-times, and are unable to support higher-risk individuals, who require clinical supervision to withdraw safely. Most stakeholders engaged as part of this Review noted their reluctance to send their clients to these services, noting that they often came with long waitlists, significant travel distances, and an inability to manage complex withdrawal.

"I wish we could do detox-at-home but some people don't even have homes. And GPs aren't usually open to it. It takes a while to find a good one who will do it".

- Regional CADS staff

"The low-medical detox services have a lot of restrictions which has made it difficult. They don't do mental health, and some don't do meth".

- Regional CADS staff

Thirdly, there are no options for individuals requiring intensive withdrawal in regional WA. The only specialist withdrawal unit is based in Perth, run by Next Step. This unit comes with significant barriers to access for clients in regional and remote communities, including:

- Taking people away from their homes and communities for extended periods of time, which sits in contrast to recognised best practice approaches to AOD treatment and withdrawal, which should be undertaken as close to home as possible.
- Lack of transport options for most clients with AOD issues, who often rely on services to support them to travel often significant distances to Perth
- The risk that clients who are unfamiliar with the Perth metropolitan area become lost, or find that they have no support when arriving in Perth.

Lastly, the Alcohol and Other Drug Withdrawal Policy has not been implemented in hospitals in Regional WA. The Alcohol and other Drug Withdrawal Policy requires that Health Service Providers provide access to a range of available AOD services closer to home, which may include inpatient, outpatient and community based AOD withdrawal services, to meet the needs of their communities. Feedback from CADS and service partners has indicated that regional hospitals are unable to support individuals to detox in a hospital setting.

Feedback from WACHS is that there are multiple limitations on the ability to support detox within a hospital, including:

- A very limited number of clinicians who have the training and expertise to oversee and administer the detox process.
- A lack of bed capacity to ring-fence a bed that can be safely used for detox.
- Ambiguity over who has clinical governance for someone detoxing (confusion as to whether it is the AOD/Mental Health service or the hospital).

WACHS acknowledged that detox within their six larger regional hospitals is theoretically possible, but there would need to be an investment in training and workforce for this to be a reliable and safe option.

The absence of reliable, and accessible detox has had profound effects on CADS clients, and CADS providers. For CADS clients, the difficulties accessing detox creates a significant barrier to their long-term recovery. As residential rehabilitation services commonly require that clients first under-go detoxification, the lack of accessible detox creates a bottleneck for individuals accessing residential rehabilitation – which itself commonly comes with long wait times. A foundational principle of the MHC's AOD counselling guidelines is that services be available for clients when they are ready for treatment. Because people using

AOD are commonly ambivalent about entering treatment – the wait-times associated with detox and rehabilitation often results in clients changing their mind.

"The Hospital doesn't do detox. They see it as a waste of a bed. We've sent people there and they've been sent home. It means that a lot of people can't start their journey to recovery and just keep using or drinking".

- Regional CADS staff

"Sometimes it takes a miracle to get someone to detox. There are so many barriers. In one year, we put about 250 people on the bus to Perth and only about 7 made it there and through the program".

- Regional CADS staff

"We don't have the clinicians who are trained to deliver a detox service".

- WACHS staff member

This barrier has a more indirect impact on CADS themselves. CADS staff spend a significant amount of time supporting their clients through the process of deciding to access, and then navigating the admission processes. The barriers to accessing detox both creates a resource strain on CADS services, but in turn hinders CADS from supporting clients in the next stage of their recovery. The outcome of this, is that CADS support clients for much longer periods of time than they would otherwise if clients could reliably and easily access detox.

The Review has identified five findings about the impact and effectiveness of primary AOD prevention in Regional CADS

The following five findings relate specifically to the primary AOD prevention role of Regional CADS. These findings, and the associated recommendations set out in Section 0 intended to guide the MHCs commissioning decisions around primary AOD prevention, and inform the development of a Community-Based Model of Service for AOD Prevention in WA.

Finding 14 | AOD prevention can work well when delivered by qualified staff and a supportive provider

The MHC delivers and commissions three tiers of AOD prevention:

- Primary prevention, which aims to prevent AOD use or delay the age at which use begins.
- Secondary prevention, which aims to limit the harms associated with AOD use and prevent use becoming problematic among people already using.
- Tertiary prevention, which focuses on individuals with problematic AOD use and is concerned with ensuring the problem does not get worse, and wherever possible, is reversed and health is restored.

Through their role in providing 'treatment' services, AOD counsellors within CADS (also known as counsellor-educators in some regions) are responsible for population-based secondary and tertiary prevention through their case management role, and broader community development and education role. Primary prevention is a separate and distinct role of Regional CADS, and is the responsibility of designated, and appropriately qualified prevention officers.

Staff and stakeholders consistently identified two key factors integral to the success of a prevention officer:

- **They are suitably qualified and experience in AOD health prevention and promotion** – the effectiveness of primary AOD prevention activities in Regional WA requires suitably capable and experienced prevention workers, which is set out in the MHCs Alcohol and Other Drug Prevention: Core Competencies Framework that prevention officers should be responsible for developing, implementing and evaluating evidence-based AOD prevention activity. In most cases – Regional CADS providers deploy suitability qualified prevention officers leading primary prevention activities and strategies.

  Where this is not the case, it is commonly due to prevention officers being unfamiliar with the unique (and often distressing) context of regional and remote communities, or lacking in core prevention knowledge and expertise, particularly in 'evidence-based' prevention strategies.

- **They are supported by a service provider that 'buys-in' to the importance of primary prevention as a distinct service –** whilst most Regional CADS providers acknowledge the importance of 'primary' prevention, a small minority do not. Some lack understanding of population-based primary prevention and how it differs to other types of prevention. Specifically, this minority perceive the 'education' and the secondary and tertiary prevention responsibilities of AOD counsellors to be the primary prevention responsibility of CADS and deploy the 'prevention officer' as a predominantly administrative position. Much of this is related to their difficulty implementing an AOD Management Plan in their region.

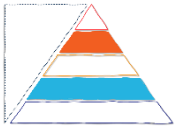
"The work of our prevention officer is critical. They can take what we learn from our clients and put in place initiatives that are really specific to our community".

- Regional CADS manager

"I strongly think prevention belongs with CADS. We're better supported here and having assess to treatment staff is really valuable".

- Prevention Officer

Most Regional CADS operate as an extension of MHC's public education and health promotion, and the Community Support and Development teams, and ably coordinate community efforts around AOD prevention. Additionally, their integration with the 'treatment' arm of Regional CADS enables information sharing to ensure a collective and coordinated understanding of community issues that help inform future strategies and actions of prevention officers.



Finding 15 | The effectiveness of prevention officers is significantly limited by their isolation and disconnectedness, and lack of resources

As detailed earlier in this Review, Regional WA is a unique and complex environment in which to deliver any service – this is also true for prevention activities. Regional WA has a highly dispersed population across large geographic areas. Regional CADS differentially configured in how they deliver the AOD prevention role:

- Kimberley CADS has a **team of prevention officers**, with four dispersed across the East and West Kimberley, led by a 'team leader'.
- Great Southern, Wheatbelt, Mid-West and Pilbara CADS, who have a **single dedicated prevention** officer (between 0.5 and 1.0 FTE).
- Goldfields CADS, where it is the joint (0.5 FTE) responsibility of an AOD counsellor in Esperance and 1 FTE in Kalgoorlie.

As at the time of this Review, the prevention officer role in the South-West is vacant and has been unfilled for almost six months.

Prevention officers are required to support multiple communities through supporting the Local Drug Action Groups (LDAGs), development of AOD Management Plans, and the coordination of the Volatile Substance Use Incident Reporting and Response System (see Finding 18), amongst several other responsibilities.

With the current responsibilities and resources, prevention officers struggle. This is due to two factors.

Prevention officers struggle to create buy-in from community members and stakeholders in communities they do not live in.

To support large regions, prevention officers must travel to smaller towns and remote communities to contribute to LDAG meetings, build relationships with community members, localise MHC campaign materials, and support the development of AOD Management Plans, among other responsibilities.

When you get funding for prevention to be 0.5 of a clinician's role, prevention will be pushed to the background.

- Regional CADS stakeholder

"The Kimberley have four prevention officers. Yet the Goldfields and Pilbara each have one for the entire region, which is setting their work up to fail from the outset"

- Prevention officer

However, prevention officers are dispersed across several towns and communities within their region – meaning their presence in these communities is often limited and time-constrained. The absence of a

strong and consistent community presence means their relationships are often superficial, and do not enable strong community presence, or input into the development of AOD Management Plans. The outcome is that AOD Management Plans have limited buy-in from community members and service providers.

It has already contributed to the burnout of prevention officers, and issues with recruitment and retention of prevention officers in some Regional CADS. In those regions, prevention officers struggle with many barriers faced in their role and expressed frustration at being unable to overcome them. The attrition of prevention officers in turn contributes to the difficulty of Regional CADS building relationships and creating buy-in from smaller and more remote communities.

"We just don't see them much. Coming here once a fortnight or once a month isn't enough".

- Regional CADS stakeholder

"It's really hard for us to get stakeholders to attend the meetings when they don't see us in their community. We are just strangers sending them invitations to attend a meeting. I can't be everywhere all the time".

- Prevention officer

The absence of dedicated funding means that prevention officers cannot invest in community development and implement prevention strategies

Prevention officers are not provided with dedicated funding, or 'seed funding' with which to fund and administer prevention activities.

On a practical level, this means that there is no dedicated funding for the development of campaign materials, the facilitation of events, and even trivial expenses like catering for community meetings.

From an implementation perspective, this means that prevention officers are asked to develop and build buy-in for prevention strategies with communities (as part of a AOD Management Plan or Community Wellbeing Plan), but with no funding behind them to implement the strategies, or authority to require communities to prioritise the funding of implementation. This results in prevention officers drawing on CADS 'treatment' funds, or having to seek funding from alternative sources (i.e. LDAGs Inc.). This has caused tensions between community members and partner organisations, with Regional CADS providers. The predominant, and reasonable view of community members is that the funding and delivery of AOD Management Plan is the responsibility of Regional CADS, and by extension the MHC.

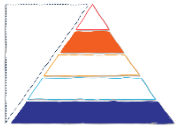
"A plan is a redundant document if they do not resource the actual implementation of strategies within that plan".

- Regional CADS stakeholder

"Our team spends 50 per cent of their time, getting funding for communities to implement the AODMPs and CWP".

- Regional CADS stakeholder

Ultimately, the absence of implementation funding acts as the most significant barrier to prevention officers discharging their responsibilities, and the implementation of AOD Management Plans.



Finding 16 | The development and effectiveness of AOD Management Plans is inconsistent, with varying degrees of implementation and buy-in from local stakeholders

AOD Management Plans (or Community Wellbeing Plans, as they have been called in some communities) are one of the primary responsibilities and deliverables of Regional CADS prevention officers. These plans – which are commonly two-year strategies – are intended to be community-owned, community-developed, and community-led strategies to guide the reduction of harmful AOD use in communities through:

- Actively supporting partnerships between community and service providers to identify and address local issues.
- Providing a means to coordinate, implement and evaluate evidence-based, whole of community strategies.

However, the effectiveness and impact of AOD Management Plans as a community-based tool to guide AOD prevention is inconsistent, and in many communities across Regional WA, limited. Specifically:

- While the implementation of AOD Management Plans is the responsibility of community members, they do not have dedicated funding to implement associated actions and often do not prioritise funding the Plans
- In many communities, Regional CADS struggles to gain buy-in and support from community members – leaving prevention officers with the responsibility of developing and implementing the AOD Management Plans.
- The two-year lifespan of AOD Management Plans are perceived as not being responsive to the changing needs of communities.
- The standardisation of AOD Management Plans (perceived by stakeholders to be driven by the MHC) does not allow for true localisation of strategies and actions to reflect the unique contexts and needs of each community.
- The absence of ongoing monitoring and evaluation of AOD Management Plans limits any accountability for the actual delivery of the commitments in each plan.

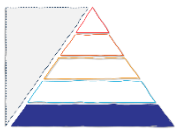
"The consistency in AODMP that is being pushed by the MHC is a flaw. It does not allow for the nuances of individual towns and communities. Standardisation does not work in prevention".

- Regional CADS stakeholder

"There isn't any evaluation of AODMPs. Who is ensuring they actually get developed?"

- Regional CADS stakeholder

Consequently, AOD Management Plans having become perceived as a 'tick-box' exercise, with many community members and stakeholders losing confidence, and interest in the process; and in some cases, being resistant to participating in the development of future plans.



Finding 17 | Prevention stakeholders have inconsistent, and often inaccurate perceptions about the roles and responsibilities of CADS prevention officers

The intent of having prevention officers in a Regional CADS is not that they operate in isolation – but that they work within a connected network of agencies, organisations and community members that lead primary prevention efforts. These organisations and individuals include, but are not limited to:

- Health Promotion Officers (HPOs) within WACHS
- School Drug Education and Road Aware (SDERA) officers
- Cancer Council Regional Education Officers (REO)
- Local Drug Action Groups, and Local Drug Action Group Inc.
- Local Drug Action Teams, and the Australian Drug Foundation
- Local Government.

With most of these organisations funded in whole, or in part by MHC, prevention officers should be able to work as part of a coordinated network in each region – leading prevention efforts in some spaces, and supporting in others. However, in practice this is not always the case. Rather, several factors have led to a disconnect between the different bodies, and varying awareness of the roles and responsibilities of each body. Those factors include:

- Funding limitations, which leads to organisations narrowing their activities to those prescribed clearly in service agreements.
- Partnerships are based on goodwill and relationships, which have weakened in regions with high turnover of prevention officers.
- Inconsistent communication about the respective roles of each body, and expectations around collaboration.
- The absence of formalised partnership mechanisms (i.e. Memorandums of Understanding) that clarify roles, responsibilities and expectations.
- The absence of prevention officers as a permanent presence in smaller towns.

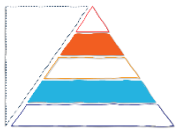
"I don't really understand what the CADS prevention officers do. I just try to keep in my lane".

- Regional CADS stakeholder

"I have a good relationship with the SDERA rep here but in other regions we don't get along".

- Regional CADS staff

Ultimately, the lack of effective collaboration, and what is expected of each organisation and individual – has resulted in networks that are based on goodwill and prior relationships – relationships that commonly end due to the high attrition of staff in regional towns. This in turn, has created inconsistent understandings of 'who does what' in relation to AOD prevention, and broadly poor awareness of the role and remit of prevention officers in Regional CADS.



Finding 18 | VSU is a significant area of concern in some regions, and is often an overwhelming responsibility on prevention officers

Volatile Substance Use (VSU) broadly means the deliberate inhalation of substances, which produce a vapour or gas at room temperature, for their intoxicating effects. In the latest survey of Australian secondary school students it was identified that 13 per cent of students had used a volatile substance in the past year – a rate that is commonly much higher in regional and remote communities, and disproportionality impacts Aboriginal children, adolescents, and young people[18].

The MHC, with partner agencies, coordinates the state-wide response to VSU through various mechanisms to reduce the demand and supply of volatile substances, and limit the risk of harm from VSU. Regional CADS are responsible for coordinating the regional response to VSU. This comes with two key roles:

- The inclusion and consideration of VSU in prevention strategies targeting individuals, families and communities
- As the Central Coordinating Agency (CCA) of the VSU Incident Reporting and Response System in each region.

The recent impacts of the COVID-19 pandemic has led to an observed increase in VSU, especially amongst children and adolescents in the Kimberley, Pilbara, Goldfields and Wheatbelt. This has overwhelmed the ability of prevention officers to manage the VSU response across entire regions – particularly those with high prevalence of VSU. This Review has observed:

- In regions with high incidence of VSU, there is a significant effort required to discharge the responsibilities of the CCA and coordinate a tailored response.
- The demand of the CCA role in high incidence regions has become more than prevention officers can manage, which draws their time and efforts away from their core prevention responsibilities.
- Prevention officers have a distinct skillset – one that is not especially relevant to managing and monitoring VSU incidents.
- Community expectations of the CCAs in coordinating responses (e.g. to provide interventions and treatment for children and adolescents using volatile substances) is inconsistent with the MHCs expectation of the CCAs (e.g. coordinating interagency responses).

"VSU overwhelms me. We have so many young children sniffing, and the community expect me to do something, but I'm not a clinician".

- Prevention officer

"I feel like I spend most of my time going through reports and entering data related to VSU. I have to lean on the AOD counsellors for assistance".

- Prevention officer

This has in turn, impacted the effectiveness of the VSU response. Specifically:

- In high incidence regions, some VSU incident reports are left unacknowledged and/or unaddressed.
- Tensions have emerged in communities, where community members and stakeholders expect that Regional CADS provide a direct clinical response to individual users.
- Perceptions that therefore no action is taken to support children and adolescents that are impacted by VSU – particularly in the absence of targeted youth AOD services.

Ultimately, prevention officers in Regional CADS are not resourced or equipped to effectively administer a region-wide response to VSU. In some circumstances, this has undermined faith and trust in the VSU response, and reduce the likelihood that community members report VSU in the future.

[18] MHC: Western Australian ASSAD survey results, 2017. <https://vsu.mhc.wa.gov.au/about-vsu/prevalence/statistics/>

5. Integrated CADS findings

The service delivery model of Integrated CADS combines counselling and medical approaches into a single wrap-around service

Integrated CADS provides a wraparound medical and therapeutic service to individuals and communities in the Perth metropolitan area. As part of the Integrated CADS model, medical staff (doctors, nurses and clinical psychologists) and counselling staff (AOD counsellors and peer workers) work in partnership to support people with AOD issues. The service is delivered in partnership between Next Step, and commissioned NGOs who deliver the integrated model, underpinned by six core principles:

- A single point of entry for AOD treatment
- Integrated models of assessment
- Collaborative case management
- Multidisciplinary team review
- Client-centred treatment matching
- Shared recovery planning.

People can access Integrated CADS either through a self-referral, by referral from other services or through the AOD Community Treatment Diversion program. A brief summary of each service component of Integrated CADS is set out below:

- **AOD Counselling** (see summary provided in Section 0).
- **Opiate and alcohol pharmacotherapy treatment**. Pharmacotherapy is the use of prescribed medication to assist in the treatment of addiction and withdrawal from AOD use. GPs in Integrated CADS use pharmacotherapy to reduce the intensity of withdrawal symptoms, manage cravings and reduce the likelihood of a lapse or relapse. This support is often beneficial before therapeutic treatment can be effectively delivered.
- **Medical reviews**. GPs and nurses conduct medical examinations of people undergoing withdrawal or people with AOD related health issues. This involves a physical examination and consultation. Medical reviews are often delivered to people experiencing moderate to severe AOD related issues.
- **Clinical psychology**. Psychologists screen, assess and treat AOD issues using various screening tools and treatment interventions. They recognise that substance use may be a symptom of other underlying mental health issues. Using a shared care approach, clients within integrated CADS are internally 'referred' to psychologists by nurses and counsellors.
- **Group programs**. Counselling, nursing staff and peer workers deliver group programs such as SMART recovery. These programs aim to facilitate peer networks among consumers to assist long-term recovery.
- **Case management**. In addition to counselling, AOD counsellors and nurses provide a wraparound support that seeks to identify the diverse needs of consumers and connect them to relevant supports within CADS or external services. AOD counsellors 'refer' clients to nurses if medical supports are required to deliver a medical case management support. This coordinated and 'no wrong door'

approach recognises that AOD issues do not sit in isolation and are often related to other health and social issues.

- **Community outreach**. Counselling and medical staff deliver therapeutic and medical outreach services to underserved communities within their geographical area. This enables them to support 'hard to reach' clients.
- **Community engagement**. Recognising that CADS sits within a broader health system, counselling and medical staff engage with other services to deliver AOD training. They also engage with community members in public events and community forums.

Integrated CADS also work collaboratively with St John of God's Drug and Alcohol Withdrawal Network (DAWN) which provides in-home detox and withdrawal support for clients who can safely undergo low-medical withdrawal.

This Review has identified eight findings about the impact and effectiveness of Integrated CADS

In contrast to regional and remote WA, the metropolitan Perth region is densely populated and undergoing urban sprawl. The population of Perth has grown by 21.07 per cent over the last five years and although only one per cent of the population identifies as Aboriginal, over one third of WA's Aboriginal population reside in Perth.[19][20]

The prevalence rate of AOD issues in WA was last estimated to be 2.7 per cent – which would place more than 57,000 people in the Perth metropolitan area as having a mild, moderate or severe AOD issue.[21] It is in this context that Integrated CADS operates, as the primary outpatient service providing AOD treatment and support in Perth.

The Integrated CADS service model is strongly supported in principle and seen by other jurisdictions as an example of best practice service integration. However, there are governance and operational challenges that need to be responded to; as outlined in the seven findings set out below.

Finding 19 | Integrated CADS demonstrates the impact that can be achieved for clients through the integration of related services

This Review has found that the Integrated CADS model of service is closely aligned with best practice approaches to AOD treatment. The integration of complementary AOD treatment services reflects the direction set for the WA health system, particularly through Enduring Strategy 4 of the Sustainable Health Review, which prioritised the development and commissioning of integrated models of care, particularly those that support people with complex conditions who would otherwise likely present to hospital. It also aligns with the direction set for the mental health and AOD system in the 2015 Plan, which prioritised improved service integration in the mental health and AOD sectors.

Integrated CADS addresses the critical need AOD medical and therapeutic treatment and support services, which when delivered holistically can uniquely address the complex and multifaceted needs of people with AOD issues.

[19] Australia Bureau of Statistics, Statistics about the population and components of change for Australia's capital cities and regions. <https://www.abs.gov.au/statistics/people/population/regional-population/latest-release>
[20] Australia Bureau of Statistics Census of Population and Housing: Census Dictionary, 2016. < https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/2901.0Chapter23002016>
[21] Mental Health Commission (2018) *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (Plan) Update 2018 (Plan Update 2018)*

The model of service is underpinned by a recognition that long-term AOD dependance has broad impacts on an individual's physical and mental health, and social health and wellbeing, and addresses each component through counselling, medical reviews, pharmacotherapy, and clinical psychology.

"I really like CADS because I can come here to receive everything. Having doctors, the psych's and counsellors all working with me is a huge benefit".

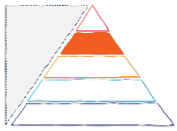
- Integrated CADS client

"There's no judgment here, they want to get to know me and help me out. I'm treated like a normal person".

- Integrated CADS client

The Integrated Medical-Counselling model of service has had a broadly positive impact on CADS clients, and key service partners. Consumers especially value the care and treatment they receive. Specific feedback from consumers and stakeholders on Integrated CADS includes:

- Clients receive a wraparound medical and counselling support that addresses their diverse needs, reflecting a genuine 'no wrong door' approach to healthcare.
- Integrated CADS provides a shared case management model, whereby clients with complex needs can be supported concurrently by a medical, and counselling case manager, who jointly plan client care.
- Each client – regardless of whether they are case managed by a nurse or AOD counsellor, undergo a clinical review, whereby their care is reviewed by a multi-disciplinary team, which quickly identifies a need for more intensive or alternative treatment.
- Clients experience a seamless 'internal referral' pathway between medical and counselling staff, ensuring that no client 'falls through the gaps'.



Finding 20 | Integrated CADS sites are under pressure to manage increasingly long waitlists, causing frustration with clients and referrers

Effective therapeutic treatment for individuals with AOD issues relies on strong motivation and readiness for change.[22] Because of this, it is recognised as 'best practice' in AOD treatment that services are available at the point an individual expresses their willingness to engage. Whilst across Integrated CADS sites, clients and service partners acknowledge the positive impact that Integrated CADS is having, the ability to continue having that impact is closely linked with the ability to manage the increasing demand for AOD services, and in turn, the waitlist for medical and counselling supports. This demand is growing.

The Plan Update detailed the 2017 'actual' and 2020 and 2025 'optimal' levels of AOD community treatment hours in the Perth Metropolitan area. The modelling stated that:

- In 2017, there were 447,000 hours of AOD community treatment services delivered
- In 2020, 767,000 hours of AOD community treatment services would be required
- In 2025, 1,280,000 hours of AOD community treatment services would be required.

Despite the modelling estimating that AOD community treatment capacity in Perth should increase by approximately **186 per cent** by 2025 there has been no substantive increase in AOD treatment capacity in Integrated CADS since 2017.[23]

With demand increasing as expected, Integrated CADS are struggling to manage the demand for their services. In most sites, the waitlist for counselling services is up to eight weeks, while the waitlist for medical services can be up to 10 weeks. This has impacted the experiences of consumers who expressed

[22] Mental Health Commission (2019) Counselling guidelines: *Alcohol and other drug issues*, Fourth Edition
[23] Correct during the development of this report

frustration at the long wait times and discussed challenges associated with accessing AOD services, especially as CADS is one of few services that deliver AOD supports in metropolitan Perth.

"The waitlist is insane. I tried getting into CADS once and was told several months, it took me being pregnant before I was moved up the list".

- Integrated CADS client

"Our waitlist blows out to eight weeks and it's hard because I know all those people need help now. There's a small window of opportunity".

- Integrated CADS staff

Integrated CADS providers are observing an increase with clients in crisis and clients with complex needs which includes trauma, severe co-occurring mental health conditions and cardiovascular diseases. Providing case management support to these clients is time and resource intensive. This places a strain on the capacity to deliver low-intensity support to less complex clients.

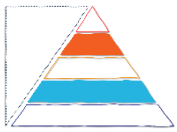
"We have a lot more presenting in crisis and with severe mental health issues. We spend hours with them that we can't spend on others".

- Integrated CADS staff

"It's a lot of pressure on us, having to emotionally deal with a crisis every other day. We signed up to do counselling not crisis response".

- Integrated CADS staff

The increasing wait times for accessing CADS has had many impacts. Firstly, it inhibits the short and long-term recovery of people experiencing AOD related issues, and can result in some clients 'falling through the gaps' when support is not available at a time, they are ready to engage. Additionally, the increasing wait-times has caused tension between counselling and medical staff when a client is referred between them. For example, in some Integrated CADS sites, internal client referrals between counselling and medical staff can take up to six-weeks.



Finding 21 | There are several constraints and barriers that limit the ability of Integrated CADS to extend to their impact

Whilst the Integrated CADS service model closely aligns with 'best practice' approaches to AOD community treatment this Review has identified five constraints that inhibit the impact of the service; including addressing inconsistencies between Integrated CADS sites, gaps in the model of service, and constraints in the capacity and resources of different Integrated CADS sites.

1: Session-capped approaches to treatment limit longer-term recovery for some clients

AOD recovery is not linear and cannot be achieved within a specified timeframe, people have unique needs, strengths, and background (including trauma histories) that can impact their recovery journey and needs.[24] The recovery pathway is highly individualised and to accommodate for this, a flexible service delivery approach is required to facilitate long-term recovery. Despite this, some Integrated CADS providers have adopted a strict six-eight session counselling model in response to managing increasing service demand. Many stakeholders observed that this approach is inconsistent with the person-centred support required to treat AOD related issues, and only allows some clients to 'scratch the surface of their long-term recovery. This approach can be contrasted by the approach taken by most Regional CADS services, which are not session-capped, and empower clients to lead the decision-making about their care and treatment.

"I know six-eight sessions is not enough. I've been with my counsellor a year and we're just getting through things now".

- Integrated CADS client

"We're experiencing so much demand that we only offer six-eight sessions unless there is an exception".

- Integrated CADS staff

2: The absence of support transitions between youth and adult services is a barrier to effective continuity of care

DAYS supports young people aged 12 to 23 years through three primary modes of service delivery – outpatient/community treatment, bed-based withdrawal and respite, and residential rehabilitation.[25] Whilst the age that a young person 'ages out' or are no longer eligible for DAYS varies between the three services, there is broad recognition that there is a considerable gap in supported transitions between DAYS and the adult Integrated CADS services. DAYS, like many youth services, is underpinned by a model of care that emphasises assertive outreach and wrap-around supports and facilitates strong relationships between young people at DAYS. The absence of supported transitions is an area of concern for stakeholders and DAYS clients, many of whom have stressed that young people are at risk of 'falling through the gaps' between the youth and adult services, and seeing their longer-term recovery stall, or regress.

"I don't know what my options are after I can't be [at DAYS], it's really stressing me out that I'll be 23 in six months and have heard nothing".

- Integrated CADS client

"I'm really scared about going into adult services. I've known for a while that I have to transition out of DAYS but it's a completely different service".

- Integrated CADS client

[24] Mental Health Commission (2019) Counselling guidelines: *Alcohol and other drug issues*, Fourth Edition
[25] Mission Australia (2021) Drug and Alcohol Youth Service (DAYS). < https://www.missionaustralia.com.au/servicedirectory/185-alcohol-other-drugs/drug-and-alcohol-youth-service-days-youth-withdrawal-and-respite-service>

We need to have better connections with adult services. We struggle referring to them, and supporting young people to go there. If they miss an appointment, they get a letter saying they might close their file.

- Integrated CADS staff

"DAYS is very youth friendly. In adult services, the responsibility to get help is on the client. In DAYS, we take some of that responsibility"

- Integrated CADS staff

3: Peer workers are used inconsistently across different sites

Mutual support and mutual aid groups play an important role in the recovery of people with AOD related issues.[26] The sharing of first-hand knowledge and skills, including the opportunity for informal social learning can be invaluable to recovery. Peer workers form part of the core workforce of only some Integrated CADS services, with others expressing a desire to develop and employ peer workers – but being unable to access suitable funding.

"Having peers in [CADS] is really effective. I always like talking to people who have been there rather than just people that have studied it. There just doesn't seem to be enough peer workers within CADS and not all sites have them which is a huge shame".

- Integrated CADS client

4: The absence of Aboriginal staff impacts Integrated CADS ability to deliver accessibly and culturally safe care

Best practice in terms of working with Aboriginal people involves delivering a culturally safe service within a workforce that includes Aboriginal staff.[27] Services should be cognisant of the complexity of factors contributing to AOD problems among Aboriginal people and enable Aboriginal clients to be supported by Aboriginal people at their choosing.

As previously stated, over half of the Aboriginal population of WA reside in Perth, but most Integrated CADS providers do not have Aboriginal staff. Staff across several sites discussed the implications this has had on the accessibility of the service for Aboriginal people – and observed that this constrained their ability to reach many at-risk people.

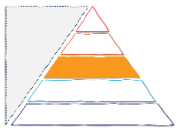
"The value of having Aboriginal health workers that facilitate access to Aboriginal community members to access to the services is really important. We are very proud of our staff, but we need more Aboriginal staff"

- Integrated CADS staff

"A quarter of our clients are Aboriginal. We do not have near enough Aboriginal staff. We need more support from the MHC."

- Integrated CADS staff

[26] Mental Health Commission (2019) Counselling guidelines: *Alcohol and other drug issues*, Fourth Edition
[27] Mental Health Commission (2019) Counselling guidelines: *Alcohol and other drug issues*, Fourth Edition



Finding 22 | A lack of clear governance and partnership mechanisms has magnified cultural differences between the NGOs and Next Step, and created a significant strain across the Integrated CADS sites

As detailed in Section 0, the concept of an integrated medical-counselling AOD treatment model was developed in 2006 and rolled out across the now Integrated CADS sites (including DAYS) through 2007 and 2008. At the time, the motivation for the development of the Integrated CADS model was a broad recognition by the NGOs and Next Step that siloed service delivery was not in the best interest of clients, and the integrated model was established using the collective goodwill of each party to explore more innovative approaches to service delivery.

The absence of clear governance and accountability mechanisms underpinning the Integrated CADS model of service has, over time, created tensions in the NGO-Next Step relationships. These tensions have intensified in recent years and especially during the COVID-19 pandemic.

No documented 'Model of Service' was ever developed, and no Memorandum of Understanding (MoU) or formal partnership has been established between Next Step and the NGOs. In the years since implementation, organisational and philosophical differences have been exposed between the partner organisations and variations in service delivery have evolved that risk impacting client outcomes.

The absence of a documented Model of Service has enabled variations in service delivery between Integrated CADS sites

The absence of a clear Model of Service, and close monitoring of service delivery by the MHC has, over time, allowed for each Integrated CADS site to adapt their service delivery. Whilst some variance in service delivery should be expected to reflect local constraints, these variations now mean that clients are provided with different levels of service and care based on where they live. For example:

- Some Integrated CADS sites continue to deliver longer-term therapeutic supports (i.e. no-cap on counselling sessions), whilst others have established a cap of six-eight counselling sessions as a way to manage increasing demand and long wait-lists.
- Some Integrated CADS sites have opted to deliver outreach services to under-serviced areas, whilst others deliver primarily office-based care.
- Some Integrated CADs sites have developed more proactive ways to manage and engage clients on their waitlists (i.e. through SMART recovery groups, and peer worker check-ins), whilst others have not.

"I thought all the different services around Perth were identical. I was able to have frequent sessions over a year at one site but when I moved, I could only have six-eight sessions".

- Integrated CADS client

"We do outreach to consumers further North but some of the other CADS are just office based".

- Integrated CADS staff

This variability has had two key impacts. The first is that this has created tensions between Next Step and each NGO. Next Step has no mechanism to ensure consistent service delivery across different Integrated CADS sites, and its staff are in turn required to navigate different processes and policies in place across different sites. This impact is magnified by 'light-touch' contract management by MHC which has not established minimum service standards or identified what is and is not acceptable in terms of service variation. The second impact is on clients, many of whom move between Integrated CADs services, and have observed the different approaches taken by providers, including for some, seeing their level of care and treatment change.

The absence of any partnership agreement has exacerbated tensions and organisational differences between Next Step and the NGOs

NGO-Government partnerships in service delivery are inherently complex. NGOs have different motivations and drivers and are more likely to be constrained by funding and contractual requirements. Government organisations, in contrast, are less likely to experience these constraints, but are typically more closely regulated and often lack direct control on some policies that are imposed upon them. The NGO-Next Step partnership has an added layer of complexity – being that MHC acts as both contract manager of the NGO, and the agency delivering the 'Next Step' service (see Finding 24).

Despite these differences, there is no formal partnership agreement between the NGOs and Next Step. As such, there are no typical partnership mechanisms you would expect to see, including:

- Defined roles and responsibilities of each partner
- Joint operational planning between Next Step and the NGO
- Agreeing and meeting against agreed service levels and performance standards
- Mechanisms to arbitrate disagreements in decision-making
- Clear guidelines and policy around clinical governance.

Whilst there are established groups such as the Overseeing Management Group and the Clinical Governance Committee, there is little guidance over the roles, responsibilities, and authority of those groups. Instead, the operation and management of the Integrated CADS have relied on the goodwill of staff and management, and the knowledge/expectations of the few individuals still working in Integrated CADs who were present when the services were originally integrated.

"We don't know what we're supposed to do and what they are supposed to do. It causes problems".

- Integrated CADS staff

"So many trivial issues come up that we can't even solve. It's affected the nurses and counsellors too".

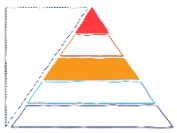
- Integrated CADS staff

In recent years, the absence of defined partnership arrangements has created significant tensions between Next Step and the NGOs. For example:

- Disagreements about the nature of the relationship – with some partners seeing it as a 'partnership' whilst others have referred to it as a 'co-location'.
- Tensions, and positioning about which partner is the 'lead' of Integrated CADS model, with each partner vocalising their belief that they should lead service delivery.
- Each partner feeling 'disenfranchised' in their ability to make decisions.
- Disagreements about policies resulting in vague guidance that does not align with expected clinical governance standards.
- Disagreements about the appropriate case load of staff, resulting in the development of different guidelines and protocols across sites.
- Trivial matters occupying time and attention that would be better directed to service delivery.

These tensions where most visible during the April 2020 COVID-19 WA lockdown. During the 'lock-down' NGO services closed their sites, despite a government mandate for state health services (including Next Step) to remain open. There were also disagreements about 'hand-washing' standards.

Simply put, without any formal partnership agreement, there is no mechanism to arbitrate the very real and reasonable differences and pressures each partner is experiencing.



Finding 23 | There is a unanimous commitment for the underpinning principles and intent of the Integrated CADS model

Despite the tensions that have surfaced in the NGO-Next Step partnership – there remains broad and fervent support to the underpinning principles, and the original intent of an integrated medical-counselling model of service. The leaders of all five organisations currently delivering Integrated CADS – including the four NGOs and Next Step – have all unequivocally stated their commitment and buy-in to the principles of integration and the benefits of the Integrated CADS model. This is echoed by front line staff in all of the services.

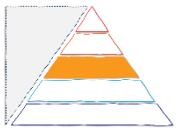
"We genuinely support the integrated model. It just makes sense. We don't want to lose it because that is what's best for clients".

- Integrated CADS staff

"I understand and respect Next Step and what they do. We learn so much from them and vice versa. Clients get the best of both".

- Integrated CADS staff

As individuals that were present at the time of integration leave the services, the collective goodwill that has ensured the success of Integrated CADS in the absence of a documented model of service is at risk of dissipating. Day to day operational challenges have escalated and could undermine the intended benefit of the integrated services. This would be a poor outcome for CADS clients, and the community more broadly.



Finding 24 | The MHC as both purchaser and provider of Integrated CADS sits in stark contrast to contemporary governance arrangements

The introduction of the *Health Services Act 2016* (WA) established a devolved model of governance to the state governed health system in WA. In summary, it established:

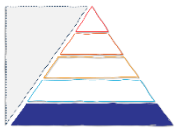
- The Department of Health is the 'System Manager' of WA Health, responsible for overall management, performance and strategic direction of the health system.
- Health Service Providers (HSPs) as separate statutory authorities responsible for the delivery of health services; and
- The MHC as responsible for **purchasing** mental health services and drug and alcohol services.

The governance of the system, and the roles and responsibilities of each organisation align with the National Health Reform Agreement established in 2011 and implemented in all other States and Territories. Similarly, the *Review of Medicare Locals* in 2014 led to the abolishment of Medicare Locals (who funded and provided primary care services) and the establishment of the Primary Health Networks as solely commissioning bodies. The rationale for a 'purchaser-provider split' is to:

- Ensure commissioning authorities focus on designing and monitoring a connected system-of-care, and managing the performance of service providers (government and non-government)
- Enable greater efficiency and flexibility in service delivery
- Prevent competition between government-provided, and government-commissioned health services.

Next Step is provided by the MHC however there is no contractual arrangements between the MHC and Next Step for the clinical components of the integrated services. Indeed, the same division within the MHC is responsible for running Next Step and the contract management of NGO providers of Integrated CADS. This governance structure is both inconsistent with the governance of the wider WA Health System and represents a significant conflict of interest. **The Mental Health Commissioner is ultimately accountable for clinical governance, safe service delivery and managing outcomes in Next Step but is also ultimately**

responsible for holding Next Step to account. This Review does not believe this is an acceptable governance model.



Finding 25 | Some of the Integrated CADS sites are limited by infrastructure constraints

The nature of the NGO-Next Step partnership is such that, through commissioning of the NGOs, Next Step essentially 'lease' office space in each Integrated CADS site. Those sites, comprising the land, infrastructure, and facilities, are owned, and operated by each NGO partner. In most cases, the partner organisations have been operating from the same facilities since integration in 2007, with the NGOs' ownership or tenancy of the sites going back even further.

As a consequence of rising service demand, and targeted expansion, some Integrated CADS sites are reaching capacity, and beginning to constrain areas of service delivery. Additionally, the wear and tear of some sites is impacting the quality of service that can be provided. For example:

- Next Step are constrained in their ability to grow the medical team in each Integrated CADS site due to limited space.
- At least one Integrated CADS site has reported having counselling rooms that are not sound proof, which has impacted on clients' feelings of safety and security.
- General wear and tear are present across all Integrated CADS sites, with increasing costs associated with remediation.

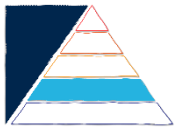
Even if funding was increased in line with the estimated growth in demand presented in the 2018 Plan Update – the current infrastructure and facilities of Integrated CADS would most likely constrain service expansion.

"We've been in the same building for 20 years; no work has been done to it. We don't even have sound-proof counselling rooms. People can hear the voices of people talking but they may not hear what is being actually said".

- Integrated CADS staff

"It feels like we don't even have room to grow our medical team because we're using the NGO space. We've had the same space for many years. We can't hire more staff if we don't have the space for them to work".

- Integrated CADS staff (Next Step)



Finding 26 | Cultural and institutional barriers to accessing public mental health services places increasing strain and risk on Integrated CADS to support clients with complex AOD and mental health issues

Experiences of stigma and discrimination are not uncommon experiences for people living with AOD and mental health issues. For many CADS clients – there is a common and persistent fear that presenting to hospital or a community service will see them be judged for their current or historical AOD issues. Experiences of stigma – both within health services, and the broader community – compounds the social and economic disadvantage faced by people with AOD issues, and can often compound experiences of trauma.[28]

CADS clients across all Integrated CADS services, and the DAYS services have through this Review, described their experiences of trauma, stigma and judgement when presenting to ED, hospital, and community mental health services. These experiences were common.

[28] Queensland Mental Health Commission (2020) *Alcohol & other drug stigma.*

Examples of CADS client experiences in health and mental health services include:

- Adolescents and young people referring to their experiences in youth inpatient units as "like an outcast" or "like being in prison".
- Adolescents and young people intentionally moderating their responses to suicide risk assessment questionnaires to avoid an $800 ambulance fee, and resulting presentation to ED.
- CADS clients who present to ED in crisis being misunderstood, judged, and dismissed as they "need to just stop their drug use".
- CADS clients presenting to ED in mental health crisis being discharged without a safety plan or care plan.
- Waiting for longer periods than average in ED before being seen.
- Experiences of being 'labelled' as a drug addict or alcoholic, despite being in recovery.
- CADS clients being refused support or treatment from community mental health services, told that their mental health issues are a consequence of their AOD issues.

For many CADS clients, experiences like these have caused them to avoid seeking support, either from community mental health services, or hospitals when in crisis. This places increased pressure on Integrated CADS staff to support clients with complex mental health issues, or those in crisis, in place of more appropriate services. This represents both a risk to Integrated CADS – one they are not equipped or staff to manage – and a barrier to the proper treatment, support and care of people with AOD issues.

"I was treated like an alien at an inpatient unit, it was so horrible. I felt like an outcast, I thought I would receive help but I honestly left feeling a lot worse".

- Integrated CADS client

"I waited for hours in ED and wasn't taken seriously. They made me feel like I shouldn't be there and like I was wasting their time"?

- Integrated CADS client

"Community Mental Health just doesn't understand us. We just get handballed back to AOD even with severe mental health issues".

- Integrated CADS client

"Young people water down how they're feeling so we don't pick up how bad they are to avoid the $800 ambulance bill".

- Integrated CADS staff

6. Recommendations

This Review has identified **15 recommendations** to guide the MHC's decision-making on the future of CADS services. The recommendations in this section are structured in four parts:

- Recommendations 1 – 4 are specifically related to Regional CADS (Section 0)
- Recommendations 5 – 7 are specifically related to Prevention services within Regional CADS (Section 0)
- Recommendations 8 and 9 are specifically relate to Integrated CADS (Section 0)
- Recommendations 10 – 16 relate to all CADS and AOD services more broadly (Section 0)

The recommendations for Regional CADS are targeted at addressing service inequity, and alleviating pressures on CADS providers

Recommendation 1 | Enhance the Regional CADS service model, drawing on the principles of the Integrated CADS model to improve parity in service provision for regional communities

The Regional CADS model should be enhanced to address the inequity in service provision between regional and metropolitan WA services. Whilst the full Integrated CADS model is impractical for regional services, the Regional CADS model can draw upon some of the principles and strengths of the Integrated CADS model.

In the first instance, it would be appropriate to pilot an integrated medical-counselling model of service in selected regional locations; whereby the existing Regional CADS model of service is integrated with medical services. This could include a local medical service, or the co-location of local GPs, nurses, and clinical psychologists. The MHC may also wish to consider the feasibility of utilising virtual care mechanisms in regional communities with low numbers of medical practitioners.

After an initial pilot period (i.e. six-months), the pilot services should be evaluated to inform a fuller roll-out of an integrated medical-counselling model across all other regional locations.

It is likely that WACHS will be the primary partner in an integrated regional model, though there may be potential for Next Step to provide some specialised services utilising virtual care. Consideration should also be given to partnering with a local Aboriginal Medical Service in some locations.

This recommendation reflects the WA Government's acceptance of Recommendation 23 from the MAP Taskforce which states that the MHC should work with the DOH and other key stakeholders to establish a 'no wrong door' approach by applying tools to deliver more integrated services.[29]

Recommendation 2 | Invest in appropriate crisis intervention responses in regional WA, as an alternative to hospitals for people in AOD crisis

The MHC should develop and commission services in regional WA that provide safe places for people in AOD, or AOD-induced mental health crisis. As part of this, the MHC may consider similar models to the Safe Haven Café services established in Royal Perth Hospital and Kununurra District Hospital. These

[29] Department of the Premier and Cabinet (2018) *Methamphetamine Action Plan*

services should be consistent with the recent process undertaken by the MHC to establish a system model of care for AOD crisis intervention across the State.

In smaller, or more remote communities, the MHC should explore alternative approaches to crisis intervention, including the consideration of virtual crisis care.

This recommendation reflects the WA Government's acceptance of Recommendation 29 from the MAP Taskforce which specifies that the MHC, WA Police Force and Department of Health (DOH) establish an appropriate alternative crisis intervention response that provides a short-term place for methamphetamine users in crisis.[30]

Recommendation 3 | Establish effective detox and withdrawal pathways in regional communities – including investing in the implementation of the Alcohol and Other Drug Withdrawal Management Policy where appropriate, and consideration of 'detox in the home' approaches

Appropriate detox and withdrawal pathways need to be established in each region to address the significant gap of reliable and accessible withdrawal supports in regional WA.

As part of this process, the MHC should consider a multi-tiered approach, including:

- Working collaboratively with WACHS to appropriately resource the application of the Alcohol and other Drug Withdrawal Policy in the six regional hospitals (Bunbury, Albany, Kalgoorlie, Geraldton, Hedland and Broome). Consideration should also be given to the feasibility of implementing this in Northam as the largest district hospital in the Wheatbelt.
- Establish equivalent services to the Detox and Withdrawal Network (DAWN) run by St John of God in all regions.
- Assess the need for and proactively establish and commission withdrawal units where necessary; working in partnership with preferred providers to overcome the historical barriers to the funding and delivery of withdrawal services.

This recommendation reflects the WA Government's acceptance of Recommendation 14 from the MAP Taskforce which states that DOH and WACHS should ensure that its agreed state-wide detox policy, the 'Alcohol and other Drug Withdrawal Policy', is implemented by its health services as a priority.[31]

Recommendation 4 | Support the deployment of AOD nurses in the larger emergency departments across regional WA who work closely with the local CADS team

The deployment of appropriately qualified AOD nurses within emergency departments can support better experience and outcomes for individuals who present at the emergency department for an AOD related issue. This can involve supporting assessments and being a liaison to other services, most notably the local CADS team.

Where this has been implemented (e.g. Bunbury hospital) clients and CADS staff have acknowledged there is a better connection between the hospital and CADS and a better experience for clients.

The type of activities that the AOD nurse can undertake include (as per the Methamphetamine Action Plan):

- Supporting care coordination activities across different providers, including CADS
- Providing advice regarding treatment and intervention options

[30] Department of the Premier and Cabinet (2018) *Methamphetamine Action Plan*
[31] Department of the Premier and Cabinet (2018) *Methamphetamine Action Plan*

- Supporting discharge planning and referrals
- Contributing to the development and review of local policies related to the management of individuals with an AOD issue.

WACHS operates over 80 hospitals, of which six are larger regional hospitals, 12 are district hospitals and the others are small community hospitals. At a minimum, an AOD nurse should be deployed in the six regional hospitals, with consideration given to deploying AOD nurses in the 12 district hospital as well. Consideration should also be given to how this aligns with the Psychiatric Liaison Nurse role as it may be more appropriate and sustainable to combine the roles into a single Psychiatric and AOD liaison nursing role.

This recommendation aligns with the findings related to Recommendation 29 from the MAP Taskforce which states that 'Alcohol and other drug clinical nurse liaison services provide specialist assessment, advice and recommendations regarding the management of patients with significant alcohol and other drug-related issues under the care of the emergency department team".[32]

The recommendations for Regional CADS are targeted at addressing the barriers to effective AOD prevention in Regional WA

Recommendation 5 | Primary prevention should be commissioned as part of Regional CADS, but with dedicated funding to align prevention activities with the needs of each region

The MHC should continue commissioning AOD prevention as part of Regional CADS. In doing so, there is an opportunity to uplift the effectiveness of AOD prevention efforts in regional WA, including:

- Provide dedicated funding for prevention, including resourcing (staff), and funding for prevention activities, including seed funding the implementation of AOD Management Plans.
- Retain the flexibility to award the AOD prevention component of CADS to an alternative provider if there is not a suitable provider to deliver both the treatment and prevention components of CADS within a single region.
- Expand the resourcing of prevention officers to better mirror the investment in prevention officers in the Kimberley region.

As part of expanding the number of prevention officers in Regional WA, consideration should be given for how prevention officers can best create local connections and relationships. For example:

- Full time prevention officers based in the East Pilbara and West Pilbara
- Full time prevention officers based in the Upper and Lower Great Southern
- Full time prevention officers based in two of the larger Wheatbelt towns (e.g. Northam and Narrogin)
- Full time prevention officers based in Kalgoorlie and Esperance
- Full time prevention officers based in the Upper and Lower South-West; and
- Full time prevention officers based in Geraldton and Carnarvon.

The FTE of prevention officers in each location should be based upon the level of community engagement required; which may be driven by factors other than population (e.g. the number of AOD Management

[32] Department of the Premier and Cabinet (2018) *Methamphetamine Action Plan*

Plans in a given region or catchment area, and modelling outputs of current and future mental health and AOD service plans).

Recommendation 6 | VSU response should be separated from the role of prevention officers, and appropriately resourced in regions with higher rates of VSU reports

To better support communities experiencing high incidence of VSU – specifically the Pilbara, Kimberley, and Goldfields – the MHC should establish a dedicated and suitably trained/qualified resource with responsibility for VSU response within the CADS service (i.e. not within the remit of Prevention).

In all regions, including those with dedicated VSU resources, staff responsible for coordinating VSU responses should have health promotion expertise however those delivering individual responses (i.e. specifically to adolescents and young people) require clinical expertise. This separation will enable effective coordination and delivery of community-based responses to VSU.

Recommendation 7 | The MHC, in partnership with CADS providers, should establish formalised partnership agreements with local prevention stakeholders

There is a lack of effective partnerships in the broader prevention space within regional communities. The MHC should take the lead in establishing a standardised partnership agreement mechanism that covers all aspects of AOD prevention activities; and work collaboratively with Regional CADS providers (or the service provider commissioned to deliver AOD prevention) to embed the use of this partnership agreement with local prevention stakeholders, including WACHS, Cancer Council, SDERA, and LDAG Inc, amongst others.

The partnership agreements should clearly define the respective roles and responsibilities of all stakeholders involved in AOD prevention within the community and how the partnerships will be supported to thrive.

The recommendations for Integrated CADS are targeted at improving governance and accountability

Recommendation 8 | The MHC should drive a 'reset' of Integrated CADS, focused on establishing a standardised and formalised model of service with clear governance and accountability

MHC should lead a process to 'reset' Integrated CADS and establish clear governance and accountability arrangements as part of the formalised agreements with the NGO partners. The model of service needs to have sufficient flexibility to reflect local constraints but should be standardised as much as possible.

In doing so, it is recommended that:

- The MHC commission a series of independently chaired workshops between each NGO partner, Next Step and the MHC to agree on the approach to establishing standardised governance arrangements.
- Co-design a detailed 'model of service' for Integrated CADS, that guides consistent service delivery across all Integrated CADS sites.
- Develop and document the new model of service and the agreed partnership arrangements to guide decision-making at all levels, and set clear expectations relating to clinical and organisational governance.
- Establish MoUs and SLAs between each NGO partner and Next Step as part of operationalising the partnership.

Recommendation 9 | The MHC should explore options to transition Next Step from the MHC to a service provider in order to ensure its independence from the commissioning authority

In line with the devolved governance structure of the wider WA health system and the Health Services Act 2016, the MHC should work with the Department of Health to actively explore options to transition the management and delivery of Next Step out of the MHC; thereby ensuring its independence from the MHC as the commissioning body.

In exploring the options for doing so, due consideration should be given to the following three options:

- Moving accountability for Next Step to one of the established government Health Service Providers
- Establishing Next Step as a standalone Health Service Provider (using a similar model to PathWest)
- Commissioning an NGO to provide Next Step.

The recommendations for all CADS are targeted at extending the influence of current services, and addressing issues in the broader service system

Recommendation 10 | Undertake a region-by-region review of the demand for AOD treatment services and align funding with current and future demands

There has been minimal uplift in funding for CADS since the MHC updated the Mental Health and AOD Plan in 2018; despite the update identifying that CADS service hours needed to increase by over 150 per cent by 2025.

A comprehensive region-by-region review of AOD treatment needs should be undertaken to assess current and future demand for AOD community treatment services with planned service capacity/funding. This review should be cognisant of the human resource, training and development, and infrastructure requirements of CADS services.

This review should use service capacity modelling from the 2018 Plan Update as a guide and update any assumptions in line with the new National Mental Health Service Planning Framework which is due to be released in the next 12 months.

Recommendation 11 | The MHC should implement more proactive and collaborative contract management with all CADS providers

The MHC should implement a more proactive and collaborative contract management model with its Regional and Integrated CADS service providers to address some of the barriers to service efficiency.

Specifically, the MHC should explore fixed rolling contract terms to give CADS providers improved funding certainty. This may include:

- A fixed initial term of three-years, with a specified maximum term (e.g. eight-years)
- Annual contract reviews, whereby meeting defined performance outcomes would see the current term extended by an additional year (creating rolling three-year terms).

This commissioning approach was introduced by the Commonwealth Department of Health in 2019 for the contracts to operate the 31 Primary Health Networks across Australia. This was in response to issues of staff attraction and retention within the PHNs under the previous fixed term contract model. This approach

ensures that high-performing providers are consistently rewarded for their performance, whilst MHC retains the flexibility to performance manage under-performing providers.

Additionally, the MHC should expect its contract managers to build more collaborative relationships with service providers, so that they can more proactively and flexibly work with providers to address barriers to service delivery.

Recommendation 12 | The MHC should partner with WAPHA to jointly plan and commission AOD treatment and support services to maximise the impact of Commonwealth and State funding

As noted in the findings, many CADS providers are pooling funding in order to meet their obligations and demands upon the service. In the majority of cases, this funding is from WAPHA and reflects that AOD is one of the seven service priorities that the Commonwealth have established for PHNs across the country.

However, much of this funding is ad hoc and in some cases a legacy funding arrangement that dates back to the former Medicare Locals. There is an opportunity for the MHC to collaborate with WAPHA to jointly plan and commission community AOD treatment and support services that are delivered in each region.

This collaboration should include consideration of co-commissioning services, including pooled funding, and establishing better mechanisms for information sharing and planning.

This recommendation is consistent with the National Health Reform Agreement (2020) which seeks to establish greater collaboration between the PHNs and state commissioning bodies, especially in the seven PHN priority areas (including AOD services).

Recommendation 13 | Expand the employment of peer workers across all CADS, building on the positive impact of peer workers in some CADS

To build upon the positive impact of peer workers within some Regional CADS providers, the MHC should adapt the CADS model to include the deployment of peer workers as part of a multi-disciplinary team; including the appropriate roles and responsibilities of peer workers with the CADS model. The 'Integrated Support Team' service in the Wheatbelt provides a useful guide for how peer workers can be used effectively in a CADS service, through the 'joint' case management of clients with complex needs.

The MHC will also need to invest in the establishment of an appropriately trained and supported peer workforce within CADS providers across Regional and Integrated CADS.

This recommendation reflects the WA Government's acceptance of Recommendation 17 from the MAP Taskforce which states that the MHC, in consultation with service providers, should prioritise strategies to increase the use of peer workers as a way of 'bridging the gap' between when users decide to seek treatment and when they commence treatment.[33]

Recommendation 14 | Invest in building the capacity of an AOD-specialist Aboriginal workforce in partnership with local ACCOs and TAFEs

The MHC should partner with local ACCOs and TAFEs to invest in building the capacity and capability of Aboriginal AOD Counsellors and fund the employment of specialist Aboriginal AOD counsellors within all Regional and Integrated CADS providers and locations.

This recommendation reflects the WA Government's acceptance of Recommendation 36 from the MAP Taskforce Final Report which states that the MHC should work with Aboriginal community leaders, and peak bodies for Aboriginal health services and the alcohol and other drug sector to develop and

[33] Department of the Premier and Cabinet (2018) *Methamphetamine Action Plan*

implement a strategy to recruit, train and retain Aboriginal staff in both mainstream and Aboriginal-specific alcohol and other drug services.

Recommendation 15 | Work collaboratively with service providers to identify strategies to support staff wellbeing, and reduce burnout and the impacts of vicarious trauma

The MHC should actively work with service providers to identify, fund and implement initiatives that better support staff wellbeing; reducing the risk of burnout and the impact of vicarious trauma across the Regional and Integrated CADS providers.

This recommendation reflects the strategies and suggested actions set out Priority Area 1 of the Mental Health, Alcohol and Other Drug Strategic Workforce Strategic Framework 2018-2025.

Recommendation 16 | The MHC should proactively address the issues of stigmatisation in ED and Community Mental Health toward individuals with AOD issues

The MHC should, in collaboration with the Department of Health and Health Service Providers, establish and implement a plan to address the cultural issues in ED and community mental health services with regards towards individuals with AOD issues. Specifically, the MHC should:

- More actively use its policy and commissioning levers (including its service agreements with the HSPs) to address how ED responds to individuals that present in an AOD crisis.
- Develop integrated and/or shared models of care between CADS and community mental health services to address the current disconnect between these services, especially with regards to individuals with co-occurring mental health and AOD issues.
- Ensure the Infant, Child and Adolescent Taskforce and Community Treatment Roadmap projects are briefed on the outcomes of this Review as they both consider the future design of Community Mental Health services.

This recommendation reflects the WA Government's acceptance of Recommendation 23 from the MAP Taskforce which states that the MHC should work with the DOH and other key stakeholders to establish a 'no wrong door' approach by ensuring service providers apply the nationally developed and validated tools to deliver more integrated services.[34]

[34] Department of the Premier and Cabinet (2018) *Methamphetamine Action Plan*

Appendix A Learnings from other jurisdictions

Nous undertook four interviews with AOD or co-occurring AOD and mental health non-government service providers in Tasmania, the Northern Territory and Victoria. The purpose of these interviews was to gather information regarding what works well in delivering community based AOD services in other jurisdictions. The service descriptions of each organisation and applicable lessons learnt are detailed below.

A.1 Anglicare TAS | Tasmania

Service Model

Anglicare is commissioned by the Tasmanian State Government and the Federal Government to provide state-wide services to individuals and families struggling with AOD related issues. They have delivered AOD services for over 20 years and have evolved their service delivery model over time. Four core AOD services are delivered across the South, North and Northwest areas of Tasmania. An overview of each service is outlined below.

- **Anglicare Drug and Alcohol Treatment Services (ADATS).** ADATS provides a 6–12-week therapeutic support using a case management model of care. Counselling supports are person centred and also delivered to people who have completed a detox or rehabilitation program.
- **Anglicare Drug and Alcohol Treatment Services Plus (ADATS+).** ADATS+ is for young people aged 12 and above experiencing co-occurring AOD and homelessness or mental health issues. The service has a greater emphasis on chronic management and delivers counselling, case management and care coordination supports.
- **Care Coordination Service.** The Care Coordination Service coordinates services for people already involved in AOD programs and with other co-occurring issues such as an acquired brain injury, mental or physical health issues, intellectual or cognitive impairments, risk-taking behaviours and at risk of homelessness.
- **Family support service**. The family support service provides information and support to family members or significant others of people struggling with AOD related issues. Short and long-term is delivered through counselling, home visits and community education sessions.

Lessons learnt from Anglicare Tasmania

AOD service models should be supported by both clinicians and peer workers

Anglicare has transitioned its AOD service delivery model over the last 10 years from being predominantly delivered by peer workers to one that is delivered by clinicians with the support of peer workers. A solely peer support workforce had benefits to consumers, however, peer workers held significant risks in the absence of a clinical workforce capacity. The training peer workers receive is not sufficient to effectively deliver an end-to-end therapeutic AOD support. Clinicians such as AOD counsellors receive evidence-

based education and training that enable the delivery of evidence-based supports. Anglicare determined that the ideal AOD service model should be clinician led and supported by peer workers.

It is essential to adapt service delivery to local contexts and trends

Anglicare employs staff and tailors its services to ensure AOD services are responsive to the needs of communities and AOD trends. The recent spike in cannabis use in Hobart significantly affected young people who used it as a recreational drug. To address this, Anglicare dedicated a cohort of younger clinicians to this area to deliver targeted AOD services. These clinicians understood the demographic context and were able to better relate to consumers. The success of this program and many others highlighted the need to adapt models of services to local contexts and trends.

Technological based alternatives are not effective for all cohorts

Anglicare found that Tasmania's regional context and cohorts of clients are not suited to virtual service delivery. During COVID-19, Anglicare shifted its service delivering mode from face-to-face to telephone and video conferencing, however, this was largely unsuccessful and saw a lot of people disengage. As cohorts of Anglicare's clients are either computer illiterate and/or have limited access to telephones and the internet, the COVID-19 lockdowns significantly impacted these clients. In addition, clients who could access services remotely preferred face-to-face service delivery. Anglicare has since returned to solely face-to-face service delivery due to the minimal uptake of other service delivery modes.

A.2 The Salvation Army | Tasmania

Service Model

The Salvation Army is one of Australia's largest providers of alcohol and drug treatment services. Their services are funded by both the Tasmanian State Government and the Federal Government and support people aged 18 and above. The model of service is founded on clinical psychotherapy and is clinically driven. An overview of the state-wide services delivered are outlined below.

- **Bridge Program.** The Bridge Program is a ten-week AOD rehabilitation program that delivers comprehensive and tailored interventions. The program uses a community reinforcement approach which focuses on social, recreational, family and vocational reinforcement.
- **Day Program.** The Day Program is an eight-week program that is delivered two days a week by AOD specialists and peer support workers. It is a harm minimisation service that is designed to equip individuals with the necessary skills to decrease the impacts of AOD use.
- **Residential Program.** The Residential Program delivers a four-week and ten-week program where residents participate in treatment planning, group work, therapy, and assignments sessions. The service also delivers a short stay option for people unable to engage in the four-week and ten-week options.
- **After Care.** After Care is a flexible program designed to provide ongoing care post completion of the Residential Program. It is delivered for up to 12 months and is grounded on encouraging independence and community reintegration.

Lessons learnt from the Salvation Army

No exclusion and equipped services are essential to supporting high-risk cohorts

The Salvation Army have adopted a no exclusion approach to accommodate a broad range of clients who are often high-risk and struggle to access supports. The Residential Program delivers a no exclusion service to complex clients such as people with co-occurring AOD and mental health issues, and people with complex behavioural issues. The service is tailored to meet the needs of each client using a wraparound approach and staff are equipped to manage complex issues. The service workforce consists of AOD specialists, mental health specialists, AOD counsellors and mental health counsellors. This inclusive approach has led to an increase in cohorts of high-risk clients that struggle to access services due to not 'fitting in the box'. AOD services should utilise a no or minimal exclusion criteria to support high-risk cohorts.

Close relationships to funding bodies lead to better client outcomes

The Salvation Army receives a combination of State and Federal funding and works closely with both funders to ensure services commissioned are in alignment with the needs of the community. This approach led to improved service models that are appropriate to the Tasmanian context and improved KPI's that better capture client outcomes. A two-way regular communication between funding and service delivery organisations has benefits to both parties and ultimately benefits consumers.

A.3 Odyssey House | Victoria

A.3.1 Service Model

Odyssey House is a specialist AOD treatment organisation that was established in 1979 and operates throughout Victoria. They offer a range of residential and community-based services and are one of few lead intake providers in the state. In addition, Odyssey House services are primarily funded by the Victorian Government. An overview their core AOD services are outlined below.

- **Centralised intake provider**. Odyssey House is one of few providers that undertake client intake assessments into AOD services in Victoria. The Victorian government selected a few AOD providers to conduct intake assessments and refer people to relevant services. Odyssey House operates intake through a digital call centre with six FTE experienced clinicians.
- **Residential Rehabilitation**. Odyssey House operates three residential rehabilitation centres across Victoria with a capacity of over 200 beds. The residential rehabilitation delivers structured programs for people with AOD or co-occurring AOD and mental health issues. It does not operate a detox or withdrawal program but supports access to relevant detox supports.
- **Therapeutic Day Rehabilitation Program (Discovery).** The Discovery program delivers a five-week community-based intervention support to individuals and their families. The program uses cognitive behavioural therapies, life skills and positive relationships to reduce or eliminate problematic AOD use.
- **Counselling and support.** Counselling supports are delivered face-to-face, online, or over the telephone to individuals and their families. The service supports people with AOD and co-occurring AOD and mental health issues through one-on-one, family, and group sessions.
- **Financial Counselling**. Financial counselling is delivered by qualified financial counsellors and available to people with AOD and/or experiencing a gambling problem. The aim of financial counselling is to decrease the stress of experiencing financial hardship by developing strategies to help individuals better manage their finances.

- **Youth and family services.** Odyssey House delivers a range of services focused on catering to whole families. Services such as Kids in Focus deliver a specialist child, and family support to highly vulnerable families with children aged 0-12 years old who are affected by AOD.

A.3.2 Lessons learnt from Odyssey House

A centralised intake system better links people to services equipped to meet their needs

A centralised intake system mitigates bias and aims to effectively link people to appropriate services. Prior to this system, all AOD services undertook their own intake assessments, however, a review conducted by the Victorian state government found biases where people were restricted to services offered by the organisation undertaking their intake assessment. Many services were assessed for issues they could address within their organisation and were hesitant to refer clients to services that were better equipped to meet their needs. These adverse behaviours had a negative impact on many people with AOD issues. People who needed detox support and rehab would only receive counselling because the organisation they happened to approach only delivered counselling. A centralised intake system has addressed most of this issue to ensure that people access services that are equipped to meet their needs.

Employing a biopsychosocial approach addresses the diverse factors that underpin alcohol and other drug use

Odyssey House utilises a biopsychosocial and human centred approach over a medical mindset as this recognises that AOD illness occur as a result of diverse factors, and each individual is unique. Their model of service is tailored to this approach, specific examples are detailed below.

- **Odyssey house employs social workers as case managers**. Social workers deliver a holistic support and have the skills needed to address the multi-faceted needs of clients through linking them into relevant services.
- **Odyssey House emphasises services which act as Therapeutic Communities.** Therapeutic communities are recovery based and focus on overall lifestyle changes. Abstinence from drug use is seen as part of a broader recovery model. This approach is utilised within the community and residential based services where clients are assisted with finding employment, reconnecting to families and finding housing.

A.4 Drug and Alcohol Services Australia | Northern Territory

Service Model

Drug and Alcohol Services Australia (DASA) delivers AOD rehabilitation (rehab) programs in Alice Springs and Central Australia. Its service model is driven by the therapeutic community approach which is recovery oriented and focuses on overall lifestyle changes. All programs deliver supports to people aged 17 and above. An overview of DASA's four key programs are outlined below.

- **Aranda House.** Aranda House is a 20-bed residential rehab facility in Alice Springs that delivers a 12-week AOD program and an eight-week or 16-week program for volatile substance users. The service is delivered within a therapeutic community approach which uses a participative, group-based method to treat AOD addiction. Aranda House provides one-on-one case work, group therapy, sport,

recreation and healthy lifestyle activities to residents. It relies on external service to deliver allied health supports to residents.

- **Transitional After Care Unit (TACU).** The TACU is a semi-independent residential facility for people with AOD related issues. The service is linked to Aranda House which provides flexibility to residents in terms of making their own meals and undertaking employment or study. TACU provides a safe and sober environment for residents to further progress in their journey of AOD rehabilitation. All residents are allocated case managers who assist in finding employment, enrolling in education courses, reconnecting with family members, and re-integrating into the community.
- **Methamphetamine Outreach Program (MOP).** The MOP delivers intervention and intensive case management support to communities in Central Australia. It supports people struggling with meth use and or addiction to reduce the impact of use and facilitate addiction recovery. The program is also delivered intensively through Aranda House and supports people aged 17 and above.
- **Sobering Up Shelter.** The Sobering Up Shelter provides supervised accommodation and care for intoxicated individuals to 'sober up'. Clients are provided with a bed for the night, a meal, shower facilities and monitored throughout their stay. Where appropriate, the Sobering Up Shelter also delivers brief intervention and refers clients to relevant AOD services.

Lessons learnt from DASA

Follow-up outreach services are essential post rehabilitation

Effective long-term AOD recovery following the completion of rehab programs can be achieved through outreach follow-up services. DASA's rehabilitation programs are located in Alice Springs which is not easily accessible for people in rural and remote communities. They found that following the completion of rehab, clients returned to their rural communities which have limited and often no AOD services. To bridge the geographical gap, DASA delivers follow-up outreach services to clients within their communities. This approach has led to longer term AOD recovery and opened access to underserved communities.