ACT Government | ACT Health

Ref FOI18-74

[redacted]

Dear [redacted]

Freedom of Information Request – FOI18/74

I refer to your application received by ACT Health on 22 August 2018 in which you sought access to information under the *Freedom of Information Act 2016* (the FOI Act).

In your application you have requested:

> *"... the independent review and systems level re-design of withdrawal management services and associated documents."*

I am an Information Officer appointed by the Director-General under section 18 of the Act to deal with access applications made under Part 5 of the Act.

ACT Health was required to provide a decision on your access application by 11 October 2018.

Decision on access

Searches were completed for relevant documents and one document was identified that falls within the scope of your request.

I have included as Attachment A to this letter the schedule of the relevant document. This provides a description of the document that falls within the scope of your request and the access decision for the document.

I have decided to grant full access to the relevant document. The document released to you is provided as Attachment B to this letter.

Charges

Pursuant to *Freedom of Information (Fees) Determination 2017 (No 2)* processing charges are applicable for this request because the total number of pages to be released to you exceeds the charging threshold of 50 pages. However, the charges have been waived in accordance with section 107(2)(e) of the Act.

Online publishing – disclosure log

Under section 28 of the Act, ACT Health maintains an online record of access applications called a disclosure log. Your original access application, my decision and documents released to you in response to your access application will be published in the ACT Health disclosure log not less than three days but not more than 10 days after the date of this this decision. Your personal contact details will not be published.

You may view ACT Health's disclosure log at: http://health.act.gov.au/public-information/consumers/freedom-information/disclosure-log

Ombudsman review

My decision on your access request is a reviewable decision as identified in Schedule 3 of the Act. You have the right to seek Ombudsman review of this outcome under section 73 of the Act within 20 working days from the day that my decision is published in ACT Health's disclosure log, or a longer period allowed by the Ombudsman.

If you wish to request a review of my decision you may write to the Ombudsman at:

The ACT Ombudsman
GPO Box 442
CANBERRA ACT 2601

Via email: ACTFOI@ombudsman.gov.au.

ACT Civil and Administrative Tribunal (ACAT) review

Under section 84 of the Act, if a decision is made under section 82(1) on an Ombudsman review, you may apply to the ACAT for review of the Ombudsman decision.

Further information may be obtained from the ACAT at:

ACT Civil and Administrative Tribunal
Level 4, 1 Moore St
GPO Box 370
Canberra City ACT 2601
Telephone: (02) 6207 1740
http://www.acat.act.gov.au/

If you have any queries concerning ACT Health's processing of your request, or would like further information, please contact the FOI Coordinator on 6205 1340 or email HealthFOI@act.gov.au.

Yours sincerely

Emily Harper
Director
Preventive and Population Health

9 October 2018

ACT Government | ACT Health

FREEDOM OF INFORMATION REQUEST SCHEDULE

Please be aware that under the *Freedom of Information Act 2016*, some of the information provided to you will be released to the public through the ACT Government's Open Access Scheme. The Open Access release status column of the table below indicates what documents are intended for release online through open access.

Personal information or business affairs information will not be made available under this policy. If you think the content of your request would contain such information, please inform the contact officer immediately.

Information about what is published on open access is available online at: http://www.health.act.gov.au/public-information/consumers/freedom-information

NAME	WHAT ARE THE PARAMETERS OF THE REQUEST	File No
[redacted]	The independent review and systems level re-design of withdrawal management services and associated documents.	FOI18/74

Ref No	No of Folios	Description	Date	Status	Reason for non-release or deferral	Open Access release status
1	1	ACT Alcohol and other Drug Withdrawal Services Review and Redesign Final Report	8 December 2016	Full release		Yes
Total No of Docs						
1						

ACT Alcohol and other drug withdrawal services review and redesign.

Final report.

360edae.

Linda Jenner
8 December, 2016

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Acknowledgments.

This final report of findings of the review and recommendations for redesigning the ACT withdrawal services system could not have been completed without substantial and meaningful contribution from many organisations, individuals and service consumers.

The review was funded by ACT Health in response to the needs identified by the ATOD sector in the ACT.

Particular mention must be made of the important contribution of service consumers who also participated in face-to-face consultations to offer their invaluable perspectives to the project. We wish you all the very best for the future.

We also acknowledge with deep appreciation the encouragement, active involvement and good will of the ACT ATOD services sector throughout the course of the entire project, which allowed us to facilitate a highly successful co-design process, and submit a design with this report that has been endorsed by the entire sector.

Key stakeholders both internal and external to the withdrawal services system also generously gave their time to offer their valuable opinions.

We are very grateful to staff members of the Alcohol Tobacco and Other Drug Association ACT (ATODA) for their tireless support for the project and for facilitating the extensive consultations and sector-wide forums that were essential to the project's successful completion.

We also wish to thank the staff of the Alcohol and Other Drug Policy Unit, ACT Health for preparing the range of data required to inform this project, and for their invaluable assistance along the way.

A full list of stakeholders that contributed to the review is included as Attachment 5.

About 360Edge.

360Edge (formerly LeeJenn Health Consultants) is an alcohol and other drug specialist consultancy service with an established track record in the alcohol and other drugs sector in ACT and around Australia. With a focus on health services development, we are specialists in alcohol and other drug program evaluation, service system review and design, program design and implementation and workforce development initiatives.

Contents.

Executive Summary of Recommendations.

1. Establish an outpatient withdrawal program delivered through two specialist community based health centres with existing expertise in AOD and associated wrap around services: Althea Wellness Centre (Directions Health), and Winnunga Nimmityjah Aboriginal Health Service, as a key component of a redesigned and expanded AOD withdrawal services system in the ACT (Phase 1), with options for home-based withdrawal (e.g. Hospital in the Home) to be considered in future years (Phase 2). (See Finding 1)

2. The two adult bed based withdrawal services (Inpatient Withdrawal Unit, Alcohol and Drug Service (ADS), ACT Health and Arcadia House, Directions Health Service) develop a service Model of Care (MoC) that is consistent with the ACT Health template and this report. The Arcadia House program would benefit from the use of standardised withdrawal scales for monitoring withdrawal, which could be incorporated into the MoC. The Adolescent Withdrawal Unit should also revise its current MoC to align with those developed by adult services and the outcomes of this Review (i.e. to position itself within the revised systems level MoC). (See Finding 2)

3. Source independent clinical AOD expertise to inform the revision of the Common Assessment Tool (CAT) in collaboration with services, making it consistent with this report and the withdrawal services Models of Care ensuring it contains the data necessary for quality improvement and evaluation purposes (finding 4), and identify how the process of sharing the assessment information between relevant services can be streamlined for consumers and staff. This should include specific consideration of (See Finding 3):
   a. ensuring that when the CAT is completed at one service, any subsequent service the consumer presents to can incorporate the information into their broader assessment questions and simply validate the information with the consumer rather than recomplete the assessment; and,
   b. ensuring the CAT can be completed and forwarded by services electronically without the need to transpose the content to a paper based version of the tool.

4. The Inpatient Withdrawal Unit to provide step-up care for consumers in outpatient withdrawal whose symptoms escalate beyond a level that can be safely managed in the community. An emergency bed may be identified for this purpose and would expand the scope of the Inpatient Unit to accept more complex clients as recommended by the

Winstock review. Appropriate and formalised partnerships between the Inpatient Withdrawal Unit and the new outpatient withdrawal services, would be required and clearly described in the MoC. We recommend that there is no reduction of beds from the current 10 bed capacity of the Inpatient Withdrawal Unit and the current 2 bed capacity at Arcadia House. (See Finding 4).

5. Establish a governance committee to oversee the implementation of the recommendations from this report. This would include participation (i.e. clinical management and Chief Executive Officers) from the existing withdrawal services and the specialist community-based health centres that will deliver the expanded outpatient withdrawal services. Additional advice and support to this group should be provided by ATODA and the AOD Policy Unit, ACT Health. (See Finding 4).

6. Appoint an independent withdrawal review implementation project manager with AOD, clinical and quality improvement expertise for a period of six to 12 months to work across the entire ATOD service system and all withdrawal services (not one single service) to implement the recommendations of this report including to coordinate day to day activities; facilitate linkages between the new service partners and foster relationships; produce the necessary supporting documentation such as protocols, consumer pathways and Memoranda of Understanding between the partners; disseminate information, and report to the Governance Committee and ACT Health on progress against key implementation milestones. (See Finding 4).

7. Improve AOD data and systems for collecting, linking, retrieving and analysing data necessary for quality improvement and evaluation purposes. This would need to include specific consideration of coding, the statistical linkage key, improvement of data management systems and upskilling those tasked with collecting the data. (See Finding 5).

8. Implement a number of strategies to communicate to the service consumers, the public and the sector the availability of the re-designed services system including (See Finding 6):
    a. dissemination of a systems-level MoC to clarify for the ACT community - and the specialist ATOD sector as a whole - the pathways into and out of withdrawal care.
    b. documents (i.e. factsheet) that translates the systems-level MoC into an appropriate format for consumers, families and referrers. This could provide an understanding of available withdrawal options, accessibility, process, outcomes and contacts.
    c. enhancement of the information provided in the ACT ATOD Services Directory including eligibility criteria, which is updated 6 monthly, to ensure the currency of public information regarding the available services.

9. Enhance pathways into and out of the Ngunnawal Bush Healing Farm (NBHF) by including Winnunga Nimmityjah Aboriginal Health Service in Phase 1 of the expanded outpatient withdrawal services system. Winnunga Nimmityjah could provide outpatient withdrawal care for Aboriginal and Torres Strait Islander consumers who are suitable for outpatient withdrawal and choose to access the service; and facilitate a pathway to ADS Inpatient Services for consumers with complex needs prior to entry to the NBHF.

Introduction.

The AOD withdrawal services system review and re-design project focused on examining the current services system and making recommendations for enhancement of this part of the health system.

The review has been informed by the evidence for best and leading practices in withdrawal care; the policy context and priorities for the delivery of health services in the ACT; findings from a previous review conducted by Dr Adam Winstock in 2008; and information gained from extensive consultations with health services consumers; staff of the specialist alcohol, tobacco and other drug (ATOD) sector; and identified key stakeholders. Further information on the methods is available in Attachment 2; further information on the consultation process is available in Attachment 5.

We also considered appropriate withdrawal pathways for Aboriginal and Torres Strait Islander people seeking to enter the new Ngunnawal Bush Healing Farm (NBHF).

In this section, we summarise the main findings, and our recommendations for expanding the current withdrawal services system. Detailed findings from each data source used to inform the review are included as attachments to this report.

The re-design included in this report was endorsed by representatives of the entire ATOD services sector at the final forum on 8 December, 2016.

Why withdrawal services matter.

Withdrawal symptoms may emerge when people who are dependent on alcohol and or other drugs stop abruptly or markedly reduce their consumption. In many cases, withdrawal symptoms are mild and easily managed in an outpatient setting. However, for others the symptoms may be severe and life threatening and these people require specialist inpatient care to withdraw safely.

Dependence on alcohol, tobacco and other drugs is relapsing in nature, and consumers require support for acute periods and to manage physical and psychological risks and harms in the longer-term. A responsive and comprehensive withdrawal services system that is integrated into the broader specialist ATOD treatment and support system is required to maximise consumers' access to health care and improve health outcomes.

In 2014/2015, withdrawal management was the main treatment delivered in approximately 13 per cent of all specialist ATOD episodes of care provided in Australia, and at least six per cent of those delivered in the ACT[1]. The ACT episodes of withdrawal care were somewhat underreported in this period as discussed in finding 4, data issues.

[1] AODTS-NMDS data cubes http://www.aihw.gov.au/alcohol-and-other-drug-treatment-services-data/

Main findings and recommendations.

1. Suite of programs.

At the time of reporting, the withdrawal services system comprised three programs that received funding by ACT Health to deliver specialist withdrawal care. These were:

1. Inpatient Withdrawal Unit, Alcohol and Drug Service (ADS), ACT Health;
2. Arcadia House (Direction Health Service);
3. Adolescent Drug Withdrawal Unit (ADWU), Ted Noffs Foundation.

All programs were bed based; with the ADS Inpatient Unit the provider of medicated withdrawal for symptom management at The Canberra Hospital.

The availability of bed based-only withdrawal care represents a major gap in service delivery in the ACT. The suite of programs required for comprehensive and evidence-based care is outpatient withdrawal through specialist community based health centres or home-based services (Hospital in the Home), supported by specialist bed based and hospital based services for consumers with complex needs.

The current bed based residential-only service system lacks responsiveness to certain consumer populations including parents and carers, the employed, those likely to experience mild to moderate withdrawal, and those who choose not to enter inpatient care for personal reasons. It is also challenging for adult consumers and service providers to navigate pathways through an exclusively bed-based system, resulting in reduced throughput and barriers to timely access.

Outpatient withdrawal services are safe for a large proportion of consumers, and cost-effective in comparison to more expensive bed-based services. The ACT is the only state or territory in Australia that does not currently offer formalised outpatient withdrawal care, and national data shows that demand for the service type is strong. For example, in 2014-15 42 per cent of all withdrawal episodes of care in Victoria were delivered in a non-bed based setting.

Infrastructure exists in the ACT that could be built upon to establish outpatient withdrawal services through specialist community-based health centres at Althea Wellness Centre (Directions Health) and Winnunga Nimmityjah Aboriginal Health Service. The identification of these services as potential providers of outpatient withdrawal leverages off the existing AOD expertise located in these services, their established relationships with a range of wrap around AOD services and the existing funding contributions made by ACT Health and the Australian Government.

We recommend the establishment of an outpatient withdrawal program delivered through two specialist community based health centres with existing expertise in AOD and associated wrap around services: Althea Wellness Centre (Directions Health), and Winnunga Nimmityjah Aboriginal Health Service, as a key component of a redesigned and expanded AOD withdrawal services system in the ACT (Phase 1), with options for home based withdrawal (e.g. Hospital in the Home) to be considered in future years (Phase 2).

2. Models of care.

We found that the activities of the current ACT withdrawal management services system were in line with best practice, and service consumers who were consulted for this review spoke highly of the care they received.

The adult services did not have formalised and detailed service models of care (MoC) in place to describe the way that withdrawal care was delivered, to whom, and how; nor the evidence base for the care provided. Arcadia House used the NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines as a foundation for its program, and the ADS Inpatient Unit was guided by a series of detailed operational documents. The Adolescent Drug Withdrawal Unit (ADWU), Ted Noffs Foundation did operate within a formalised MoC.

The Health Services Planning Unit of ACT Health has recently developed a MoC template and development guide to support its programs to formalise a MoC.

We recommend that the two adult services develop a MoC that is consistent with the ACT Health template. The Arcadia House program would benefit from the use of standardised withdrawal scales for monitoring withdrawal, which could be incorporated into the MoC. The Adolescent Withdrawal Unit should also revise its current MoC to align with those developed by adult services and the outcomes of this Review (i.e. to position itself within the revised systems level MoC).

Similarly, there was no systems-level MoC in place to describe how the overall withdrawal services system worked; who could access the three services that comprise the current system and how access was gained; nor the relationship between each arm of the withdrawal services system and the specialist ATOD sector as a whole. We provide in this report a systems-level MoC based on the ACT Health guideline that takes into account the current system, an expansion into outpatient withdrawal care (Phase 1), and into home-based (e.g. Hospital in the Home) withdrawal services and the involvement of general practitioners in future years after outpatient care has been established successfully and evaluated for effectiveness (Phase 2).

3. Common Assessment Tool.

The Winstock review recommended the development of a 'core common assessment tool'. The tool was intended to contain the essential (core) information required by every ATOD service regardless of specialty, and to streamline referral

between agencies when consumers were found to be more suitable for a service other than their point of first contact. In this way, only additional, service specific questions (i.e. not the core questions) would be asked of the consumer by the service at a subsequent interview.

A Common Assessment Tool (CAT) is in use, and while some service providers did find it helpful, ATOD staff members were in general agreement that the tool required revision and its application is cumbersome. For example, AOD services such as Arcadia House (and Directions Health more broadly) Karralika Programs, Canberra Recovery Services, and Toora Women use a computerised assessment. When referring a consumer to ADS Inpatient Unit, AOD staff must transpose the electronic information onto a paper based version of the CAT and then fax it to the ADS Inpatient Unit. When the consumer is subsequently contacted by the Intake and Assessment nurse from the ADS Inpatient Unit, the person is essentially re-assessed with the CAT. In this regard, the tool has not reduced duplication of effort by service providers, and some consumers are subject to multiple assessments.

We recommend that independent AOD clinical expertise is sourced to inform the revision of the CAT in collaboration with services, making it consistent with the new bed based services MoC and the new MoC for outpatient withdrawal, ensuring it contains the data necessary for quality improvement and evaluation purposes (finding 4), and identify how the process of sharing the assessment information between relevant services can be streamlined for consumers and staff. This should include specific attention to:

- ensuring that when the CAT is completed at one service, any subsequent service the consumer presents to can incorporate the information into their broader assessment questions and simply validate the information with the consumer rather than recomplete the assessment; and,
- ensuring the CAT can be completed and forwarded by services electronically without the need to transpose the content to a paper based version of the tool.

4. Progress since the Winstock review.

Some recommendations made by the 2008 Winstock review of adult withdrawal services have been implemented, but not necessarily as intended. For example, a Common Assessment Tool was developed but the tool has not reduced duplication of effort by service providers or indeed consumers who continue to be re-assessed by different services (see finding 3, Common Assessment Tool).

Arcadia House did alter its service delivery model from a 10-bed social withdrawal program to a residential Transitional Program in response to the Winstock recommendations, but the step-down pathway from the acute ADS Inpatient Unit into transitional care at Arcadia House was not formalised as intended.

As recommended, the ADS Inpatient Unit does have some capacity to admit patients

suitable for transfer from The Canberra Hospital through the AOD Consultation Liaison Service.

One recommendation of the Winstock Review that was not implemented was "broadening the scope of the ADS Inpatient Unit to include routine admissions for assessment and stabilisation of complex clients". In the consultations for the current review, senior staff members recalled that meetings were conducted at the time to plan for the recommendation, but the changes required were multi-faceted and complex, and momentum was eventually lost in the context of a busy clinical service delivery environment. The recommendation was revisited by the ADS Inpatient Unit in 2013. A comprehensive internal investigation was performed to determine the needs of the ACT community and the service model that was required to meet those needs.

In conducting the current review, we found no reason not to move forward with enhancing the scope of the ADS Inpatient Unit to accept more complex AOD clients. Enhancement of the operations of the ADS Inpatient Unit beyond its current capacity would support the expansion of the withdrawal services system into outpatient care, and facilitate the acceptance of consumers from the outpatient withdrawal programs at short notice should a consumer's withdrawal symptoms escalate and become more severe. At the moment, there are no formal mechanisms in place to expedite an admission into the Inpatient Withdrawal Unit of consumers that are being cared for by GPs in community-based withdrawal care. An integrated withdrawal services system with bed-based and outpatient services requires formalised pathways such as this.

It appears that a significant barrier to implementing the Winstock recommendations across multiple services as planned was the absence of an identified staff member or system wide coordination position to drive and coordinate the range of activities necessary to achieve the goals.

1. We recommend that the Inpatient Withdrawal Unit provide step-up care for consumers in outpatient withdrawal whose symptoms escalate beyond a level that can be safely managed in the community. An emergency bed may be identified for this purpose, and/or other avenues to provide a rapid response should be explored during the implementation phase. This would expand the scope of the Inpatient Unit to accept more complex AOD clients as recommended by the Winstock review. We recommend that there is no reduction of beds from the current 10 bed capacity of the Inpatient Withdrawal Unit and no reduction of beds in the current two bed capacity at Arcadia House.

2. We recommend that a Governance Committee is established, with suitable secretariat support, to oversee the implementation of the recommendations from this report. This would include participation from the existing withdrawal services (management and Executive Officers), and the specialist community health centres that will deliver the expanded outpatient withdrawal services. Additional advice and support to this group should be provided by ATODA and the AOD Policy Unit ACT Health.

3. In order to progress the recommendations of this review, we strongly recommend the appointment of an independent implementation project officer for approximately six to 12 months with clinical and quality improvement expertise to work across the entire system and all withdrawal services (not a single service) to coordinate day to day activities; facilitate linkages between the new service partners and foster relationships; produce the necessary supporting documentation such as protocols, consumer pathways and Memoranda of Understanding between the partners; disseminate information (see finding 7, communication), and report to ACT Health on progress against key implementation milestones.

5. Data issues.

Through the course of the review, we found a range of issues related to the collection of data that impacted on the way service activity and consumer pathways could be reported accurately. Data management is a significant problem for many ATOD services across Australia, so it is not surprising that the ACT faces similar issues. For example, only one treatment type was recorded for an episode of care at Directions Health (i.e. just rehabilitation was recorded rather than opening and closing a withdrawal episode prior to this), in 2014-2015 Arcadia House delivered approximately forty unreported episodes of withdrawal care as a prelude to residential rehabilitation of consumers in its Transitional Program. This results in a missed opportunity to demonstrate the significant contribution Arcadia House makes to providing withdrawal care to the ACT community. We understand that a solution may since have been found.

Consumer pathways from ADS Inpatient Unit to ACT residential rehabilitation services were also unable to be tracked accurately. The Inpatient Unit enters data through the hospital's Patient Administration System (ACTPAS), and the data reported for the Alcohol and Other Drug Treatment Services National Minimum Dataset (AODTS-NMDS) needs to be extracted from ACTPAS and entered into a separate file for reporting purposes to the Australian Institute of Health and Welfare. The NMDS is an important source of information for policy makers, health planners and researchers in the ATOD sector nationally. The NDMS also provides ATOD services with an avenue to examine and reflect on their own consumer demographic profiles, service activities, and basic outcomes measures for quality improvement purposes.

The ACT Government and ACT Health are committed to reviewing programs and services, and accurate data is essential to these processes. An evaluation of the expanded withdrawal services system can only be conducted successfully if it is based on data that can be extracted, interpreted and reported with confidence.

We recommend that a process is undertaken to improve AOD data and systems for collecting, linking, and retrieving data necessary for quality improvement and evaluation purposes. This would need to include specific consideration of coding, the statistical linkage key, improvement of data management systems and upskilling those tasked with collecting the data.

6. Communication.

In conducting the consultations for this review, we found diverse and sometimes conflicting perceptions among consumers, ATOD specialist staff and key stakeholders about the withdrawal services system including admission criteria, access pathways, and waiting times for admission into the various withdrawal services. Misperception of the available services acted as a barrier to consumers seeking withdrawal support in some cases, particularly for opioids.

Information provided to the community about withdrawal and the services system requires improvement.

We recommend that a number of communication strategies be implemented including:

- dissemination of a systems-level MoC to clarify for the ACT community - and the specialist ATOD sector as a whole - the pathways into and out of withdrawal care.
- a document (i.e. factsheet) that translates the systems-level MoC into an appropriate format for consumers, families and referrers to could provide an understanding of available withdrawal options, accessibility, process, outcomes and contacts.
- Enhancement of the information in the ACT ATOD Services Directory including eligibility criteria, which is updated 6 monthly, to ensure the currency of public information regarding the available services.

7. The Ngunnawal Bush Healing Farm.

Although Aboriginal and Torres Strait Islander people accounted for nine per cent of all episodes of withdrawal care in the ACT between 2012-15 according to NMDS data, opportunities to undertake safe and supervised withdrawal in the community will benefit Aboriginal and Torres Strait Islander people generally and those seeking access to the NBHF particularly.

An Aboriginal and Torres Strait Islander Liaison Worker is on staff within the ADS Inpatient Unit and the service recently established a room especially designed for Aboriginal and Torres Strait Islander consumers. These were seen as strengths of the current withdrawal services system, but the reliance on telephone assessments for withdrawal was seen as a significant barrier for some consumers.

The involvement of Winnunga Nimmityjah Aboriginal Health Service as a key specialist community based health service in the expanded withdrawal services system will also help to establish a culturally appropriate pathway for adults into the NBHF (and other AOD services) as an alternative to the current bed-based options. Winnunga also represents a critical pathway for consumers who complete AOD treatment at the NBHF.

Expanding the withdrawal services system to include Winnunga Nimmityjah represents an opportunity to develop strong partnerships between the key services.

We recommend that culturally appropriate pathways into and out of the NBHF be

considered during planning activities for all phases of the re-designed services system.

The case for expanding the services system.

A flexible, responsive and evidence based withdrawal services system comprises outpatient care supported by bed based care for consumers with more complex needs. Consumers are matched to the most appropriate setting in accord with a stepped-care model where the least intensive intervention considered safe and appropriate for the consumer is initiated first, with care stepped-up only if there is no response to the treatment plan or if the consumer's condition worsens.

The major gap in the current system is the absence of a formalised program of outpatient withdrawal care. We learned through the course of the project that the ADS Inpatient Unit did offer some level of outpatient withdrawal care in years past, but it was not well taken up by consumers, possibly due to limited public transport options, and possibly due to its location in Building 7 where anonymity was difficult to maintain. Furthermore, promotion of the availability of this withdrawal option to the community may not have been pursued actively at the time.

Consultations for this review show that ADS Inpatient Unit staff members strongly supported the establishment of an outpatient withdrawal program, and in light of past experience, recommended it be managed by AOD general practitioners in specialist community-based health centres.

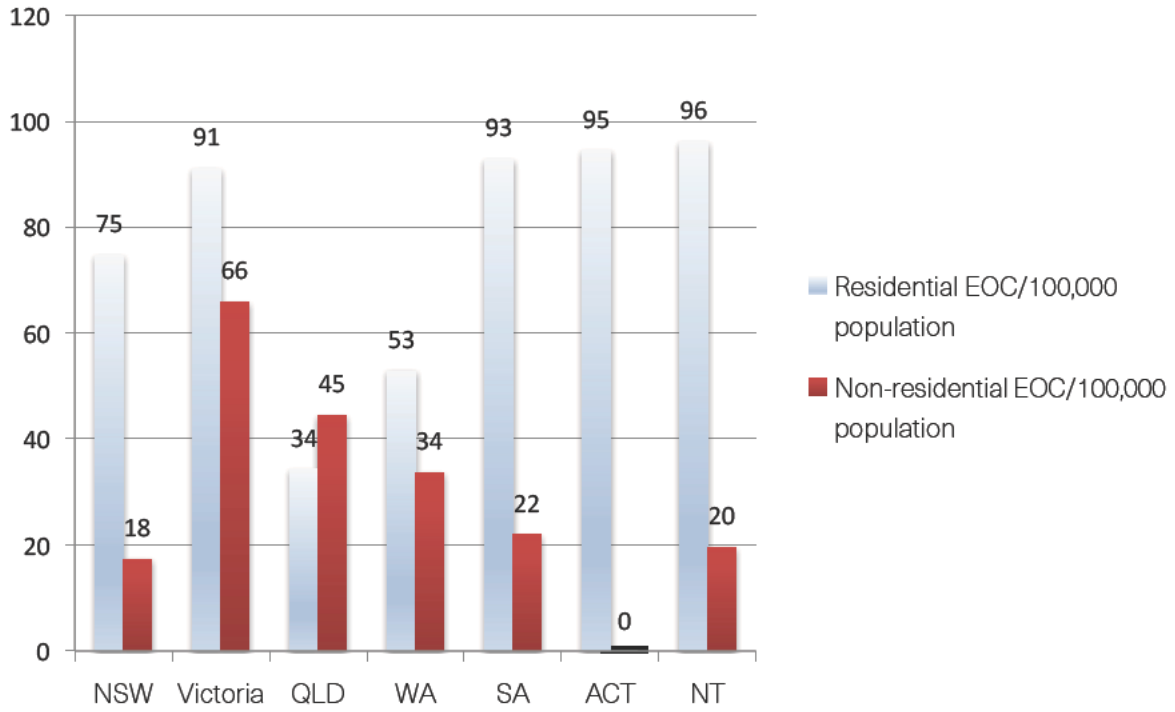
We therefore propose a community-based model for outpatient withdrawal.

Evidence suggests that consumers would like the opportunity to withdraw from AOD in a community setting [1], while some are reluctant to enter bed based services [2]. It's also safe option for consumers not likely to have complex withdrawal [2, 3]. Outpatient withdrawal is also a less expensive treatment option than bed based care [4], and provides an opportunity to manage hospital beds more efficiently.

Based on AODTS-NMDS data for 2014-2015, in other jurisdictions outside of the ACT in Australia, an average of 32 per cent of all withdrawal episodes of care (EOC) provided to those aged ten years and over were delivered in outpatient settings, whereas the ACT delivered zero episodes of outpatient withdrawal care[2].

[2] A small number of non bed based withdrawal episodes appear in the ACT data; however, this reflects occasions of consultation and liaison services being provided within The Canberra Hospital.

Figure 1. Bed-based and outpatient (including home-based and outreach) withdrawal EOC per 100,000 of the population in 2014-2015 across other states and territories.



AODTS-NMDS data also showed that the ACT provided similar rates of bed-based episodes of withdrawal care per 100,000 population[3] as other jurisdictions. The ACT needs to maintain its bed based withdrawal services and grow its outpatient services with a view to ensuring similar patterns of utilisation of other jurisdictions over time.

Based on the ACT EOC for 2014-2015, should outpatient withdrawal services be established in line with Phase 1 and Phase 2 recommended in this report, there would be potential to deliver up to 151 outpatient EOC in future years which would represent approximately 45 episodes of outpatient withdrawal care per 100,000 population, in line with other Australian jurisdictions[4].

Figure 1 shows the bed-based and outpatient withdrawal EOC delivered per 100,000 of the population in 2014-2105 across other states and territories.

Policy priorities.

Expansion of the current system into outpatient withdrawal care is aligned with ACT Government and ACT Health policy priorities. This includes the newly developed

[3] Population data obtained from the Australian Bureau of Statistics (ABS). www.abs.gov.au

[4] These figures are based on assumption of equivalence with other jurisdictions, but are an estimate only. We are unable to determine unmet need for outpatient withdrawal in the ACT as this work was not conducted for this review.

ACT Alcohol, Tobacco and Other Drug Strategy 2017-2021 (currently undergoing consultation).

The Parliamentary Agreement for the 9th Legislative Assembly for the Australian Capital Territory listed seven actions to improve the health of people in Canberra and increase their access to healthcare. These included:

- Increasing frontline nursing staff to provide better healthcare services in hospitals and the community, by expanding Hospitals in the Home, providing more outpatient nurses, reviewing current ACT Health outpatient and community based services, and implementing incentives to raise nurse qualifications and career development opportunities
- Provide better healthcare for Aboriginal and Torres Strait Islanders by building a new health clinic for Winnunga Nimmityjah Aboriginal Health Service.

Outpatient withdrawal care provided through specialist community based health centres would increase access to withdrawal care for the Canberra community as the current bed-based system is complex to navigate. It may also help to reduce bed-block in both the ADS Inpatient Unit and residential rehabilitation services by providing consumers with an opportunity to receive medications to relieve symptoms of withdrawal in a community setting. Some consumers reported the desire for medication management as the primary driver for seeking inpatient care.

Implementation of the recommendations of this review related to the existing withdrawal system with the added provision of outpatient services would also support the goals of the planned ACT Health Clinical Services Framework. This is because reducing the need to hold beds in both the ADS Inpatient Unit and residential rehabilitation services will also increase bed occupancy, and ensure that the 'right people are in the right place', and matched to their assessed level of need.

Access for Aboriginal and Torres Strait Islander people.

Opportunities to undertake safe and supervised withdrawal in the community will also benefit Aboriginal and Torres Strait Islander people generally and those seeking access to the NBHF particularly.

Some Aboriginal and Torres Strait Islander people prefer bed based withdrawal settings as a means to break from a pattern of alcohol and or other drug use or require a residential stay if they are considered at risk for complex withdrawal, while others prefer a non-bed based setting [5]. Many Aboriginal and Torres Strait Islander people use alcohol and other drugs in an on-off (binge) pattern in contrast to daily use, which means that outpatient withdrawal may be a suitable and safe alternative to inpatient withdrawal for those people [5]. The Indigenous adaption of the Drug and Alcohol Clinical Care Packages (DA-CCP) includes outpatient withdrawal as an acceptable treatment option for Aboriginal and Torres Strait Islander people, but the option it is not available in the ACT.

The ADS Inpatient Unit has on staff an Aboriginal and Torres Strait Islander liaison worker, and has a dedicated room with an attached courtyard for Aboriginal and Torres Strait Islander consumers.

While key informants to this review saw these as strengths of the current services system, the reliance on a primarily telephone-based system of assessment was seen as a significant limitation on cultural grounds.

Opportunities for Aboriginal and Torres Strait Islander people to receive face-to-face assessment and supervision by an outpatient withdrawal service, particularly if the service were delivered by Winnunga Nimmityjah AHS, would expand culturally appropriate pathways to care and provide an alternative for those wishing to enter the NBHF.

Following consultations with the Clinical Director and Executive staff of Winnunga Nimmityjah AHS, we are confident that the service would hold a favourable view of participating formally in an expanded outpatient withdrawal services system if sufficient support from the ADS Inpatient Unit was available.

Alignment with other states and territories.

The ACT is the only state or territory in Australia that does not currently offer formalised outpatient withdrawal care. Outpatient withdrawal accounted for approximately 42 per cent of all withdrawal episodes of care in Victoria in 2014 -2015. Community demand for this service type is strong.

The role of community based health centres and GPs.

General practitioners (GPs) in the community play a key role in providing outpatient withdrawal care. Australian research has shown that GPs are willing to provide this service if adequately trained and supported[6]. Resources required to support a strong system include clear eligibility criteria; objective measurement of withdrawal symptoms (scales); at least daily review; and strong links to aftercare options[3].

GPs consulted for this project, including those from the specialist community based health centres with AOD expertise: Althea Wellness Centre and Winnunga Nimmityjah AHS, were in favour of a more formalised role in the overall withdrawal services system, provided they were well supported by the ADS inpatient unit to do so.

The specialist GPs with AOD expertise in community based health centres identified the following support needs:

- standardised assessment and agreed suitability criteria for non-residential withdrawal;
- protocols for prescribing withdrawal medications;
- pathways to expedite admission to ADS inpatient unit for consumers whose symptoms cannot be controlled;
- a training program, and ongoing, responsive support (e.g. telephone, meetings) from specialist staff in the ADS inpatient unit.

The participation of general practitioners in the redesign is consistent with the ACT Primary Health Care Strategy, 2011-2014. The engagement of GPs in the provision of non bed based withdrawal care is recommended, within this report, to occur through a staged approach where Phase 1 occurs with GPs with AOD expertise in existing community based health centres prior to expansion to GPs more generally in community settings in Phase 2 (see Systems Level MoC).

The current services system.

A brief overview of the current AOD withdrawal services system is necessary to provide context for the proposed expansion. A detailed description can be found in Attachment 4.

Description.

The AOD withdrawal services system in the ACT currently comprises three specialist services. Two cater for adult consumers and one caters for adolescents aged 13-18 years. There are currently 14 beds funded specifically for withdrawal care in the ACT.

1. The ADS Inpatient Unit is a 10-bed medicated withdrawal service located in Building 7 of The Canberra Hospital. It operates 24 hours per day, seven days per week. As the only medicated bed based withdrawal service in the ACT, the ADS inpatient unit is primarily reserved for people with complex needs who are unsuitable for non-medicated bed based withdrawal in Arcadia House.

2. Arcadia House provides non-medicated, bed based withdrawal services to adult men and women assessed as unlikely to experience severe or complex withdrawal, but who may benefit from bed based support.

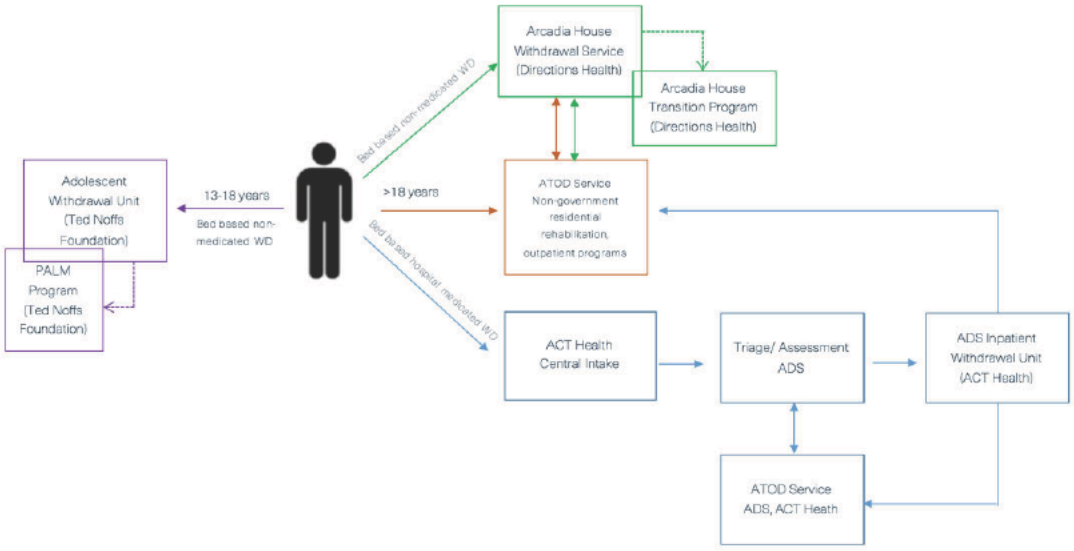
Arcadia House is located in a self-contained unit on the campus of Calvary Hospital in Belconnen. Arcadia House has two beds that are funded specifically for withdrawal. Residents may stay up to ten days, or longer if required to complete withdrawal. Beds are collocated with the Arcadia House Transition Program.

3. The Adolescent Drug Withdrawal Unit (ADWU) is operated by the Ted Noffs Foundation, and provides young people aged 13-18 years residing within and outside the ACT with an opportunity to withdraw from a range of substances in a safe and supportive residential setting.

The ADWU is located in Watson. It has two beds that are funded specifically for withdrawal. Residents may stay for two to three weeks, or longer if required to complete withdrawal or transition to aftercare. Like Arcadia House, the two dedicated withdrawal beds are integrated within the Program for Adolescent Life Management (PALM) residential program also operated by the Ted Noffs Foundation.

Figure 2 provides a diagrammatic representation of the current AOD withdrawal (WD) services system. Arcadia House Transition Program and the PALM Program are identified separately from other ACT residential programs because dedicated withdrawal beds are integrated within these two programs.

Figure 2. The current AOD withdrawal services system and access pathways



Note: The ACT Health Intake Line also refers to other AOD services, and there is cross-referral between the current withdrawal services.

Settings.

All of the current withdrawal programs are bed-based services. There are no formalised options for outpatient withdrawal care in the ACT.

Consumer pathways.

Access to the ADS Inpatient Unit, is primarily via telephone. Consumers call the ACT Health Central Intake Line based at Moore Street Civic, which is the first contact point for all ACT Health Community Services programs between 9-5pm Monday to Friday. Following screening, the contact details of consumers that request inpatient withdrawal are then passed to the Triage and Assessment nurse located in the ADS Inpatient Unit in Building 7, who then telephones the consumer (the aim is within 24 hours of the initial call Monday-Friday), to conduct the intake assessment.

If the consumer is suitable for admission (i.e. is likely to experience withdrawal and benefit from specialist care), a bed is then booked which, in the estimation of staff and experience of consumers we spoke to, is about one week after the assessment. If the consumer has a bed booked in a residential rehabilitation service, staff will attempt to coordinate the admission date to suit. Currently, there are no formalised links with GPs to expedite admissions. Aftercare is offered to consumers via a range of ACT based ATOD programs, and consumers are followed-up at two and six weeks after discharge.

Although out of scope for this review, the capacity of ADS Intake and Assessment Line

warrants further consideration. After 5pm (until the following morning) the ADS Inpatient Unit nursing staff are responsible for answering all AOD-related calls that come through the Alcohol and Drug Services Intake Line from the Canberra community (i.e. a community member contacts the ACT Health Central Intake, transfers through the ADS Intake and the phone rings at the Withdrawal Unit). This means, in practice, that nurses with responsibilities to care for patients on the ward are tasked, without additional staffing capacity, to answer the phone to consumers who are potentially in crisis or in need of counselling. The extent to which their capacity to provide withdrawal care is disrupted by these calls, and their capacity to offer an effective response to callers requires further exploration. In other states and territories, 24/7 dedicated telephone lines with allocated staffing are used for this purpose such as the Alcohol and Drug Information Service in NSW, QLD and WA, and DirectLine in Victoria.

Access to the two dedicated withdrawal beds in Arcadia House is via telephone directly, or through another Directions Health program. Consumers are considered suitable if they are assessed as unlikely to experience a complex or severe withdrawal (e.g. consumers seeking alcohol or benzodiazepine withdrawal are referred to the ADS Inpatient Unit). Aftercare is provided through the integrated Transition Program, or consumers are referred to other ACT ATOD programs, including other Directions Health programs, as appropriate.

The Adolescent Withdrawal Unit accepts young people from the ACT, NSW and elsewhere in Australia. Access to the two dedicated withdrawal beds is gained via face to face assessment, telephone assessment, or alternative methods appropriate for young people such as Skype and telemedicine. Referrals are accepted from a range of sources including Child and Youth Protection Services. Aftercare is provided through the integrated PALM program, or young people are referred to other programs as appropriate.

Care delivery team.

The ADS Inpatient Unit is staffed by Addiction Medicine specialists, nurses, allied health staff, an Aboriginal Liaison Officer, and administration staff. A new Nurse Practitioner position was to be established at the time of reporting, which was thought to have a potential role in supporting general practitioners to care for patients with AOD problems.

One nursing position was assigned to triage and assessment on three days per week, while the remaining two days were staffed by nurses from the unit.

Arcadia House is staffed 24 hours per day, seven days per week. Staff include a program manager, AOD support workers, case managers, and a pool of qualified casual staff. Each holds a minimum qualification of a Certificate IV in Alcohol and Drug Work, consistent with the ACT AOD Qualification Strategy.

The ADWU is staffed by a manager, an intake worker, adolescent and family counsellors, and AOD workers. Two AOD workers are on shift at all times.

Efficiency of the system.

Treatment data from the NMDS for the period 2012-15 showed that the services offered withdrawal support for a range of substances, and generally in the proportions expected based on consumer presentations to ATOD services nationally, with alcohol accounting for the greatest proportion of treatment episodes (70%), followed by cannabis (14%), meth/amphetamine (12%) and heroin (4%).

In 2014-15, completion rates were generally higher in the ACT (89%) than the national average (70%), but lower for cannabis withdrawal (48% in ACT compared with 70% nationally).

The demographic profile of service consumers between 2012-15 was also consistent with the national picture; that is most were male (61%) and in their mid-to late thirties[5]. Aboriginal and Torres Strait islander peoples accounted for about nine per cent of all episodes of care in 2012-15 and at 25-27 years, were younger than the aggregated average age.

Consumers consulted for this project spoke highly of the care they received from each of the three services. The expertise of specialist withdrawal services providers was acknowledged and appreciated by AOD workers, stakeholders and consumers alike. Criticisms made by informants to this review focused mainly on process and systems issues and related to the adult services only.

[5] Data were aggregated to preserve the privacy of service consumers, so will not reflect the profile of AWDU service consumers specifically

These included waiting periods for a bed in a bed based withdrawal setting; restricted days available for admission; complexity of coordinating care between inpatient withdrawal and residential rehabilitation services that resulted in bed-block and limiting access for consumers who were next in line; assessments that were primarily telephone based; the absence of outpatient withdrawal options and lack of integration between ADS Inpatient Unit and community based health providers (primarily GPs)

There were also concerns about the cultural appropriateness of the current system for Aboriginal and Torres Strait islander consumers, particularly the emphasis on telephone assessments.

We found that consumers were generally directed to the most appropriate withdrawal service setting for their needs based on likely severity of withdrawal. However, ADS Inpatient Unit staff observed that consumers who could be safely managed in a social withdrawal setting such as Arcadia House, did at times occupy acute beds unnecessarily, and a small number did not experience withdrawal at all and were primarily admitted to facilitate their admission to residential rehabilitation. This was verified by consumer accounts of needing to seek admission, unnecessarily in a few cases, before they could access residential rehabilitation.

Monitoring and evaluation.

Monitoring of the services system is primarily approached at an individual service level. Systems-wide data is captured through

reporting to ACT Health for the Alcohol and Other Drug Treatment Services National Minimum Dataset (AODTS-NMDS). As described in finding 5, there were issues with the way that data is collected and subsequently interpreted that must be addressed.

A systems-level MoC: Phase 1.

Description of the expanded services system.

For Phase 1, we propose the development and integration into the current AOD specialist withdrawal services system of a formalised, outpatient withdrawal program, led by experienced general practitioners with AOD expertise in two specialist community based health centres – Althea Wellness Centre and Winnunga Nimmityjah Aboriginal Health Service. Both centres have expertise in AOD interventions and currently work with consumers with AOD problems (Figure 3).

An expanded services system will provide equitable access to a flexible, coordinated and responsive withdrawal services system that is consumer centred and based on the best available evidence.

The expanded services system will target adults and young people aged 13-18 years, assessed as needing specialised care to withdraw safely from alcohol and or other drugs. It will also expand the options for Aboriginal and Torres Strait Islander consumers, particularly those seeking access to the Ngunnawal Bush Healing Farm (NBHF).

The system-level model of care is designed to support a wide range of consumer goals for treatment from harm reduction through to abstinence. It recognises that withdrawal is not a stand-alone treatment for alcohol and other drug use, rather it provides the first step in an integrated treatment plan for consumers who wish to engage in one or more post-withdrawal treatment options available in the ACT such as counselling, group therapy, day programs, residential rehabilitation and medication assisted treatment for opioid dependence.

Settings.

The expanded services system will provide both inpatient and outpatient services and will operate from five locations in the ACT.

These are:

1. The ADS Inpatient Unit, Building 7 of the Canberra Hospital in Woden;
2. Arcadia House, on the campus of the Calvary Hospital in Bruce;
3. Adolescent Withdrawal Unit at Watson;
4. Althea Wellness Centre, which is a program arm of Directions Health located in Woden Square, Phillip;
5. Winnunga Nimmityjah AHS, located Narrabundah.

In line with best practice standards, consumers would be cared for in the most appropriate setting. For consumers with mild to moderate dependence on any substance; no history of severe withdrawal or other factors that may complicate withdrawal; (severe physical or mental health problems); a stable home environment and reliable social supports, and would benefit from medications to relieve withdrawal symptoms, outpatient care delivered by Althea Wellness Centre or Winnunga

Nimmityjah AHS would be most suitable. The specialist community based health centres could also provide support to the Adolescent Withdrawal Unit and Arcadia House if required.

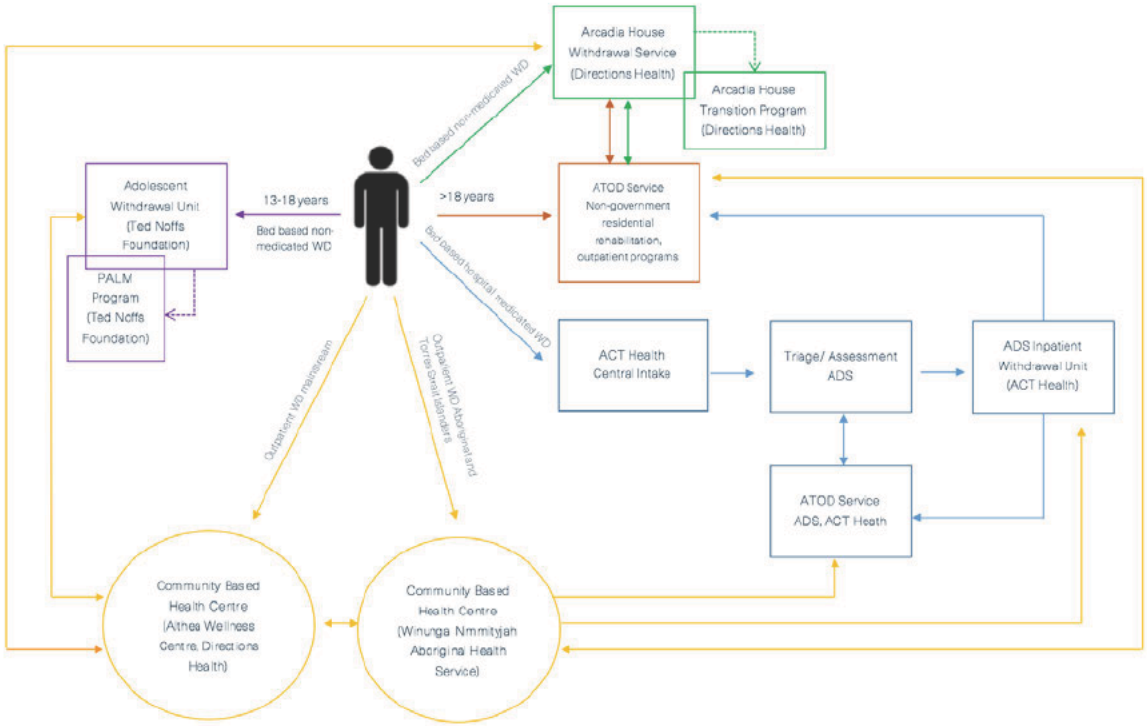
Community bed based withdrawal care provided through Arcadia would be most suitable for adults with unstable housing, previous unsuccessful attempts to withdraw in the community; and those who require more intensive support to complete withdrawal successfully. Consumers with primary dependence on cannabis or methamphetamine would be generally suitable for this setting (provided acute mental health symptoms are not present), while those with alcohol or benzodiazepine dependence would not.

Consumers seeking entry to Arcadia's Transitional Program and are found eligible for withdrawal in Arcadia benefit from the opportunity for integrated care.

Hospital based withdrawal through the ADS Inpatient Unit provides the most intensive management of all withdrawal settings. It is most appropriate for adults at risk of more severe withdrawal, or a past history of complicated withdrawal. It involves medication management, regular monitoring of withdrawal by specialist medical and nursing staff, and planning for after-care.

Young people aged 13-18 years who require withdrawal support, including those who wish to enter the PALM program, will continue to be directed to the Adolescent Withdrawal Unit.

Figure 3. Phase 1 of the expanded AOD withdrawal services system and access pathways.



Note: The ACT Health Intake Line also refers to other AOD services, and there is cross-referral between the current withdrawal services.

Service elements.

The vision is for an integrated withdrawal services system. This requires a number of key service elements. These include:

- A revised core common assessment tool for use by all adult services of the expanded withdrawal services system that can be used to streamline referral between programs when required (the extent to which this tool would be helpful to ADWS should be explored during the implementation phase);
- Agreed consumer suitability criteria for each program;
- Protocols for prescribing withdrawal management medications in outpatient settings;
- Protocols for monitoring progress of withdrawal including the use of standardised withdrawal scales;
- Clear pathways to expedite admission from outpatient settings to ADS Inpatient Unit for consumers whose symptoms cannot be controlled safely;
- Formalised pathways for responsive support for specialist community based health centres from staff in the ADS Inpatient Unit;
- Service level MoC;
- System-wide mechanisms for data collection and reporting;
- Strategies for communication with the specialist ATOD sector and the wider ACT community.

Consumer pathways.

As shown in Figure 3, the service system would have multiple entry points, including a dedicated access point for Aboriginal and Torres Strait Islander consumers through Winnunga Nimmityjah AHS. Assessments conducted by Winnunga will reduce the need for telephone assessments of Aboriginal and Torres Strait Islander people, and facilitate a pathway into (and out of) the NBHF.

Consumers who contact ADS inpatient unit directly will still have a telephone interview, but should be offered the opportunity of face to face assessment if this is possible.

Use of a common assessment tool that will include criteria for suitability for each of the five withdrawal programs will aid service providers to facilitate consumer referral to the most appropriate service, and reduce unnecessary repeat assessments.

Consumers assessed by specialist community based health centres using a revised version of the Common Assessment Tool and found unsuitable for outpatient withdrawal are considered to have entered the withdrawal services system consistent with a 'no-wrong-door' philosophy and should not be required to begin a new process of self-referral to the ADS Inpatient Unit via the Central Intake Line. A suitable referral pathway between non-bed based withdrawal programs and ADS inpatient unit must be established in the planning process.

Similarly, when consumers contact residential rehabilitation services for admission directly, the residential rehabilitation service should assist the consumer to make an appointment for assessment for withdrawal at the most suitable service. Assertive wait list management, such as the 'Early Birds'

program delivered by Karralika, and weekly phone support offered by CRS could continue in the interim.

Aftercare options in the ACT for consumers following withdrawal care include:

- Outpatient services such as ADS outpatient counselling, and ADS opioid treatment services; Directions Health individual and group programs (including SMART Recovery); Toora Day Program (women only); and Arcadia House Day Program (mixed gender).

- Residential services such as Arcadia House Transitional Program (mixed gender); PALM Program (young people 13-18 years); Ngunnawal Bush Healing Farm (Aboriginal and Torres Strait Islander people); Karralika Therapeutic Community (mixed gender; pharmacotherapy maintenance program, family program); Lesley's Place (women only, Toora Women); and Canberra Recovery Services (mixed gender, pharmacotherapy reduction program, Salvation Army).

Care delivery team.

In addition to the existing withdrawal services system workforce, outpatient withdrawal will be provided by highly experienced AOD general practitioners in the specialist community based health centres. Althea Wellness Centre is staffed by two general practitioners and one highly experienced registered nurse.

Efficiency of the system.

The expanded system is likely to increase systems-level efficiency by reducing bed-block in both the ADS Inpatient Unit and residential rehabilitation services through the provision of a new pathway for consumers to receive supervised and medicated withdrawal.

An expanded system is also likely to attract people in need of support for withdrawal, but who are reluctant to enter residential services; increasing access to health care for all Canberrans.

Allowing consumers to contact specialist community based health services directly will also provide a solution to some of the barriers for consumers identified with the call-back system currently used by the ADS Inpatient Unit.

It will also provide greater opportunities for referral and shared care across multiple services and programs.

Monitoring and evaluation.

It is recommended that an interim evaluation be conducted at the end of the first year of operation following establishment of the outpatient withdrawal program, and a full evaluation at year three of operation.

The evaluation plan should be finalised prior to implementing the new model, so that process and outcome variables can be developed and collection systems embedded at the outset and monitored across the evaluation points.

Barriers to the collection and reporting of data were found during the review, which must be addressed to facilitate a robust evaluation.

Evaluation questions could include the following:

- How many consumers have been assessed for outpatient withdrawal?
- How many were suitable, and how many were unsuitable?
- Did outpatient withdrawal attract new consumers? (i.e. those who had not accessed inpatient services previously)?
- What was the demographic profile of the consumers who accessed outpatient withdrawal? (e.g. women, employed, parents, Aboriginal and Torres Strait Islander peoples)
- What were the outcomes for consumers? (e.g. substance type, progress of withdrawal, completion rates)
- How many Aboriginal and Torres Strait Islander people were enrolled into the outpatient withdrawal service through Winnunga, and what were their outcomes?
- How many consumers required admissions to ADS Inpatient Unit as a result of worsening symptoms or other issues?
- How satisfied with the new outpatient withdrawal services were consumers, providers, and other specialist ATOD services staff?
- What additional resources were required to establish and run the outpatient withdrawal program?

Possible data collection methods include:

- Systematic collection and recording of agreed consumer outcomes and activity measures
- Focus groups with key stakeholders
- Online survey of consumers and stakeholders

Additions to the systems-level MoC: Phase 2.

Successful evaluation of phase 1 of the expansion could be a logical trigger point to consider phase 2, which would include:

1) home-based withdrawal services; (e.g. Hospital in the Home), and;
2) the expansion of outpatient withdrawal services to include other interested general practitioners.

Home based withdrawal services involves visits to the consumer at least daily in their own home by trained staff (usually nurses in partnership with general practitioners or Addiction medicine specialists), and may also involve telephone contact. Withdrawal may be medicated or non-medicated.

Like outpatient withdrawal, home-based withdrawal is suitable for people with mild to moderate dependence; no history of severe withdrawal or other factors that may complicate withdrawal; and a stable home environment. Services provided include monitoring of withdrawal using standardised scales, monitoring medications and symptom management, education about the course of withdrawal, relapse prevention strategies, and planning for the post-withdrawal period including aftercare.

The home-based withdrawal services could be delivered by any specialist AOD service that could demonstrate their capacity to do so, including possessing the requisite skills, ability and staffing (e.g. trained and experienced registered nurses and medical staff).

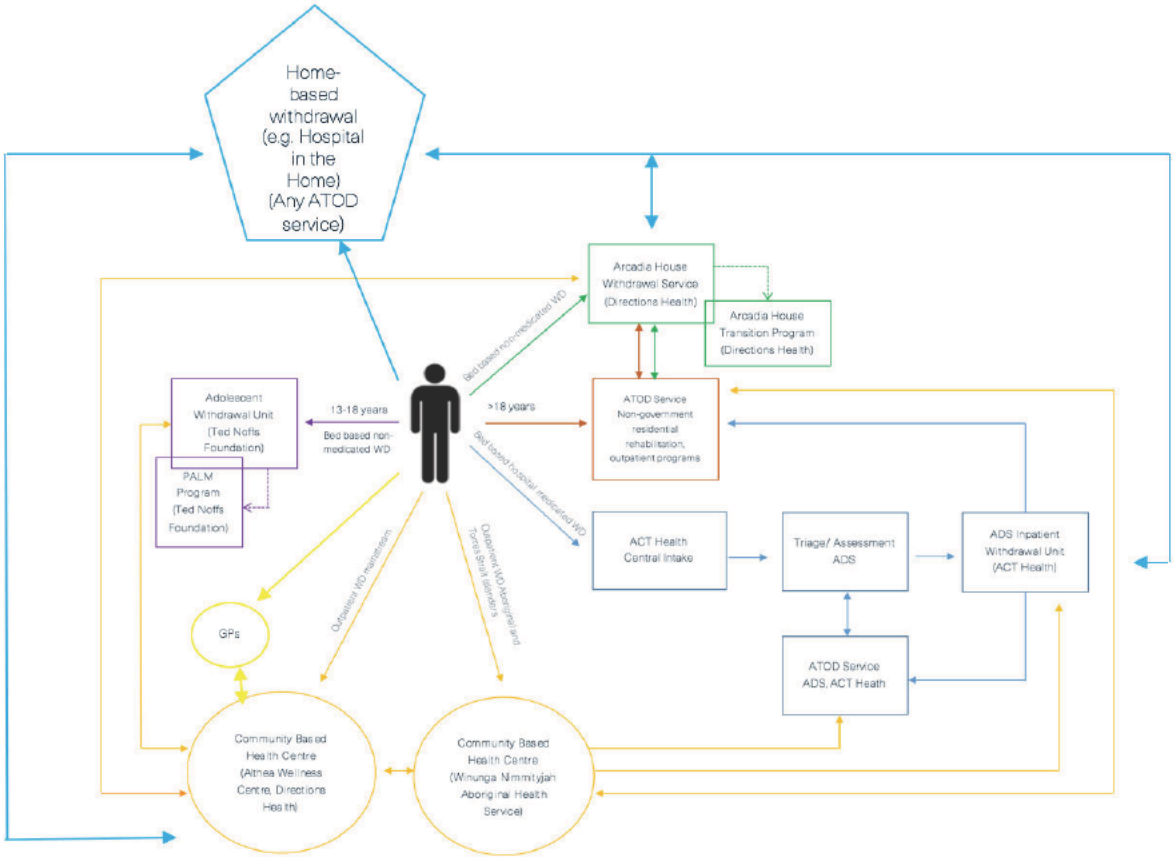
Pathways into and out of the phase 1 expanded system must also be established, to ensure the smooth integration of home-based withdrawal services (e.g. Hospital in the Home).

Interested general practitioners will require training and support to use the tools used in common by the expanded service system as a whole.

Figure 4 provides a vision for phase 2 of an expanded withdrawal services system that includes home-based withdrawal and general practitioners.

Evaluation of phase 2 should be also conducted. The evaluation plan would be informed by what is most appropriate for the service system at that time.

Figure 4. Phase 2 of the expanded AOD withdrawal services system to home-based withdrawal (e.g. Hospital in the Home), and the inclusion of general practitioners.



Recommendations and implementation plan.

1. Establish an outpatient withdrawal program		
The primary finding of this review is that the ACT is the only state or territory in Australia that does not currently offer a formalised program for outpatient withdrawal from alcohol or other drugs. The policy priorities of The ACT Government and ACT Health focus on efficient use of bed-based services and access to outpatient services and home-based withdrawal (e.g. Hospital in the Home). The establishment of an outpatient withdrawal program is recommended.		
How could this be achieved?	**Who?**	**When**
This could be achieved by leveraging existing services delivered through two specialist community based health centres with existing expertise in AOD and associated wrap around services: Althea Wellness Centre (Directions Health), and Winnunga Nimmityjah Aboriginal Health Service. The need for resourcing to support this additional function should be a ley consideration through the development of the service level model of care (Phase 1). To ensure the outpatient system is integrated with the existing bed-based system, strong partnerships and suitable models of care must be developed (see recommendation 2). Oversight of the implementation should be provided by a Governance Committee (recommendation 5), and day to day coordination by a withdrawal review implementation project manager (recommendation 6).	Althea Wellness Centre (Directions Health), Winnunga Nimmityjah Aboriginal Health Service, ADS Inpatient Withdrawal Unit; Arcadia House (Directions Health); Adolescent Withdrawal Unit (Ted Noffs Foundation), with support from the withdrawal review implementation project manager, the Governance Committee, ATODA and ACT Health Policy Unit.	6-12 months

2. Develop service-level Models of Care (MoC)		
Although the adult services were guided by best practice principles, guidelines and operational procedures, formalised and detailed models of care (MoC) were not in place to describe the way that withdrawal care was delivered, to whom, and how; nor the evidence base for the care provided. In developing MoC, the relationship between the adult services should be taken into account, as well as pathways into the NBHF. The new outpatient withdrawal services system should also be considered in alignment with the systems-level MoC included in this report.		
How could this be achieved?	**Who?**	**When**
This could be achieved within existing resources, and ideally supported by the Implementation worker. A collaborative approach between the adult services is recommended to develop the MoC using the template and development guide available from the Health Services Planning Unit of ACT Health. Review of care for consumers undergoing cannabis withdrawal, and adjustments to how these people are supported, could help to increase completion rates which have been below the national average in recent years. Arcadia House should introduce, and use withdrawal scales to measure symptom severity that are used by ADS Inpatient Unit. The Adolescent Drug Withdrawal Service may consider revising its current MoC to align with those developed by adult services.	ACT Health Policy Unit, ATODA, ADS Inpatient Unit, Directions Health, ADWS Ted Noffs Foundation. Althea and Winnunga if the expanded withdrawal services system is established.	6-12 months

3. Revise the Common Assessment Tool (CAT)		
The CAT is considered useful by some ATOD services providers, but has not reduced duplication of effort in assessments, nor has it reduced repeat assessments for some consumers. The tool itself, and the way it is used, require review. It should also be central the newly established MoC (Recommendation 2).		
How could this be achieved?	**Who?**	**When**
Ideally, this would be supported by the implementation worker position recommended in this report. The tool was developed some years ago through a collaborative effort from all ATOD services in the ACT and a sector-wide approach is required again to ensure the CAT is consistent with the new and it contains the data necessary for quality improvement and evaluation purposes. The process of sharing the assessment information between relevant services should be streamlined for consumers and staff.	ACT Health Policy Unit, ATODA, ADS Inpatient Unit, Directions Health, ADWS Ted Noffs Foundation, and the entire ATOD sector.	12 months

4. The ADS Inpatient Unit provide step-up care for consumers in outpatient withdrawal whose symptoms escalate beyond a level that can be safely managed in the community		
In accordance with a stepped-care model, outpatient care is supported by inpatient services for consumers with more complex needs, and to provide care for those whose condition worsens in the community. Currently, there are no formalised pathway between general practitioners in the community and the ADS Inpatient Unit. The Winstock review recommended that the Inpatient Unit accept consumers with more complex needs, including those who require assessment and stabilisation. A formalised arrangement with the outpatient withdrawal service is consistent with the findings of the Winstock review.		
How could this be achieved?	**Who?**	**When**
The pathways into the ADS Inpatient Unit should be explored in detail during the implementation process. Currently, the Inpatient Withdrawal Unit operates at about 65% bed occupancy. An emergency bed may be identified for the purpose of providing rapid step-up care for consumers who are assessed as suitable to undertake withdrawal as an outpatient, but whose symptoms subsequently escalate requiring a hospital admission for assessment and stabilisation. The newly appointed Nurse Practitioner in the ADS Consultation Liaison Service could also act as a conduit between outpatient withdrawal and the Inpatient Unit.	Althea Wellness Centre (Directions Health), Winnunga Nimmityjah Aboriginal Health Service, ADS Inpatient Withdrawal Unit; with support from the withdrawal review implementation project manager, the Governance Committee, ATODA and ACT Health Policy Unit.	6-12 months

5. Establish a Governance Committee to oversee the re-design process		
Perceptions of the withdrawal services system by consumers, key stakeholders, and the specialist ATOD services sector varied considerably. Misconceptions of the services system acted as a barrier to treatment-seeking by some consumers. Information provided to the community about withdrawal and the services system requires improvement.		
How could this be achieved?	**Who?**	**When**
This could be achieved within existing resources with the addition of secretariat support; however, ideally the committee would also be supported by the implementation worker position recommended in this report. Establish a committee that meets regularly and include participation of clinical management staff and Chief Executive Officers from the existing withdrawal services and the specialist community-based health centres that will deliver the expanded outpatient withdrawal services. Additional advice and support to this group should be provided by ATODA and the AOD Policy Unit, ACT Health.	Althea Wellness Centre (Directions Health), Winnunga Nimmityjah Aboriginal Health Service, ADS Inpatient Withdrawal Unit; with support from the withdrawal review implementation project manager, ATODA and ACT Health Policy Unit.	From the inception of the project and ongoing, including throughout the evaluation process.

6. Appoint a withdrawal review implementation project manager		
Some recommendations of the Winstock review were implemented, but not all. A contributing factor was the lack of dedicated staff to drive the processes. The introduction of outpatient withdrawal services and revised models of care will require a considerable and concerted effort. The appointment of a withdrawal review implementation project manager with AOD, clinical and quality improvement expertise for a period of six to 12 months is strongly recommended.		
How could this be achieved?	**Who?**	**When**
This requires new one-off resourcing. Decisions regarding the best placement of this position, including recruitment strategies, should be made by the Governance Committee, and the funding sought from ACT Health.	Governance Committee, with support from ATODA and ACT Health Policy Unit.	From the inception of the project for 6-12 months.

7. Improve systems for data collection and reporting		
Through the course of the review, we found a range of issues related to the collection of data that impacted on the way service activity and consumer pathways could be reported accurately. The ACT Government, ACT Health and specialist ATOD service providers are committed to reviewing programs and services for quality improvement purposes, and accurate data is essential for these activities. A review of systems for data collection and reporting is recommended.		
How could this be achieved?	**Who?**	**When**
This could be achieved using mostly existing resources with the addition of resources for one off advice from a data expert. Ideally, this would also be supported by the implementation worker position recommended in this report. Convene a Data Review Working Group to identify the information needed to inform quality improvement and future evaluation; and the systems that will support reliable data collection, review and reporting. Test the data retrieved through the new system and adjust as required.	ACT Health Policy Unit; ATODA; ADS Inpatient Unit; Arcadia House (Directions Health); ADWS (Ted Noffs Foundation)	6-12 months

8. Improve communication channels.		
Perceptions of the withdrawal services system by consumers, key stakeholders, and the specialist ATOD services sector varied considerably. Misconceptions of the services system acted as a barrier to treatment-seeking by some consumers. Information provided to the community about withdrawal and the services system requires improvement.		
How could this be achieved?	**Who?**	**When**
Ideally, this would be supported by the implementation worker position recommended in this report. When the service-level models of care are developed, a communications strategy should be developed, as well as mechanisms for updating and disseminating information to consumers, the sector and the ACT community.	ACT Health Policy Unit, ATODA, ADS Inpatient Unit, Directions Health, ADWS Ted Noffs Foundation, and the entire ATOD sector. Althea and Winnunga if the expanded withdrawal services system is established.	12 months and ongoing.

The Ngunnawal Bush Healing Farm.

9. Enhance pathways into and out of the NBHF.		
Aboriginal and Torres Strait Islander consumers do access the current mainstream residential (inpatient) withdrawal services system, and their cultural needs have been considered and addressed in treatment planning and delivery. Experts suggest that the system can and should improve its cultural responsiveness however, and in light of the soon to be opened NBHF, the pathways for Aboriginal and Torres Strait Islander consumers into and out of the NBHF must be considered as a priority.		
How could this be achieved?	Who?	When
Ideally, this would be supported by the implementation worker position recommended in this report. Winnunga Nimmityjah AHS should be enlisted as one of two specialist community health services to provide outpatient withdrawal care in the redesigned services system during phase 1 of expansion. Winnunga would provide outpatient withdrawal care for Aboriginal and Torres Strait Islander consumers who are suitable for outpatient withdrawal; and facilitate a pathway to ADS Inpatient Services for consumers with complex needs prior to entry to the NBHF. The establishment of service relationships is critical to an effective role for Winnunga, and relationship building and formalised support pathways for Winnunga would play a central role in an expanded withdrawal services system. .	ACT Health Policy Unit, ATODA, AOD Withdrawal Services System Redesign project officer, ADS Inpatient Unit, Directions Health, Althea Wellness Centre. Winnunga Nimmityjah AHS.	12 months

Attachment 1: Background.

About the project.

Withdrawal symptoms of varying severity may emerge when people who are dependent on alcohol and or other drugs stop abruptly or markedly reduce their consumption. ACT specialist alcohol and other drug (AOD) withdrawal services are a key component of the overall Alcohol, Tobacco and other Drug (ATOD) services system, and often represent the first step in an individual's ongoing treatment journey. Specialist withdrawal services work with people who are experiencing withdrawal, using a range of medical and psychosocial responses.

Patterns of alcohol and drug use are dynamic in nature. For example, population level evidence suggests that there has been a substantial shift among existing users of methamphetamine to the more potent crystalline form (crystal meth, 'ice') in recent years [7]. Assisting people who use methamphetamine, particularly crystal methamphetamine, to withdraw safely and successfully requires a somewhat different approach by specialist services than that offered to people experiencing alcohol or opioid withdrawal. In this context, the ATOD services sector in the ACT considered it timely to endorse a review and redesign of the current specialist AOD withdrawal services system.

In June 2016, the Alcohol Tobacco and Other Drug Association ACT (ATODA) entered into a service agreement with ACT Health to oversee an independent review and redesign of the alcohol and other drug withdrawal management services system in the ACT, including consideration of pathways for Aboriginal and Torres Strait Islander peoples seeking to enter the new Ngunnawal Bush Healing Farm (NBHF).

In July 2016, ATODA engaged 360Edge, an alcohol and other drug specialist consultancy service with an established track record in the alcohol and other drugs sector in ACT, to conduct the independent review and redesign of the withdrawal management services system.

ATODA's role was to support 360Edge in conducting the review, and oversee the governance of the project. In all other respects, the review was entirely independent and the findings are those of 360Edge gained through the examination of a range of data sources and extensive consultation with the alcohol, tobacco and other drug (ATOD) sector in the ACT, key stakeholders, and service consumers.

The project was conducted between July and December, 2016.

Context.

In 2008, an independent review of the specialist AOD withdrawal services system was conducted by Dr Adam Winstock, and key recommendations were made in his final report. Part of the brief for the current review was to consider the Winstock recommendations and determine the extent to which they had been implemented, and their relevance to the current service system and consumer profile.

The needs of Aboriginal and Torres Strait Islander peoples for withdrawal services was also an area of interest for the review, particularly identifying culturally safe and secure options and pathways into the soon to be established Ngunnawal Bush Healing Farm.

Another important initiative that provided context for the current review was the National ATOD treatment services framework that was under development. Assisting the ACT AOD sector to critically reflect on its current withdrawal services system may provide a springboard for specialist workers to engage in the development of this framework.

The new National Ice Action Strategy also highlights the particular areas for consideration when working with people with methamphetamine-related problems, signalling that the current review is timely and in line with a national focus on optimum responses to the needs of this group of service consumers.

ACT Health is currently developing local plans that complement the national plans, and the withdrawal system review and redesign will contribute to a larger clinical services planning process that was also underway in the ACT at the time of reporting.

The final important resource that informed the review were the clinical care packages produced through the National Drug and Alcohol Clinical Care and Prevention (DA-CCP) Project [8]. The care packages were developed to assist health service providers and policy makers to identify, plan for, and meet the ATOD treatment needs of their communities using a nationally consistent framework.

Objectives.

The objectives of the review and redesign project were to:

1. Build on the review of the ACT withdrawal management services sector conducted by Dr Adam Winstock in 2008, examining the extent to which the recommendations made were implemented; and the barriers to implementing the recommendations if any.

2. Determine best practice in withdrawal management, and identify the suite of programs necessary to deliver withdrawal management in line with leading practice, including those that are culturally sensitive and culturally safe for Aboriginal and Torres Strait Islander peoples.

3. Develop a high-level map of the current withdrawal services system including services that provide withdrawal

management; consumer access to the current withdrawal services system; service system activity; and pathways into and out of the service system in the ACT, and compare it with best and leading practice.

4. Canvas the views and experiences of service agencies' staff; key informants (including those who refer into the service system, and those who partner with the service system such as general practitioners with expertise in managing withdrawal and other relevant services); and service consumers on the strengths and limitations of the current withdrawal service system in the ACT.

5. Synthesise the information obtained during the review to assist in collaboratively planning for a redesign of the ACT specialist withdrawal services system as a whole, and for Aboriginal and Torres Strait Islander peoples in particular, and develop a draft model of care to be endorsed by the ATOD sector.

Attachment 2: Methods.

We undertook a range of activities for the independent review and redesign of the AOD withdrawal services system in the ACT. The activities were conducted in four discrete phases, which are described in this section.

Phase 1: Project initiation.

In this establishment phase, key stakeholders were engaged, setting the foundation for the activities to be conducted in the ensuing months.

Activities included:

- Development of the project's TOR.
- Facilitation of a forum of ACT Health funded specialist AOD services representatives in August 2016 to endorse the TOR (see Appendix 2 for a summary of the forum).
- Preliminary meetings with representatives from the specialist withdrawal services sector to establish the needs of the project.

Phase 2: Exploration.

This was the primary information gathering and consultation phase of the project, which we conducted in August and September 2016.

Activities included:

- A high level review of the literature, including grey literature; an examination of existing withdrawal management guidelines; and evidence for best and leading practices in withdrawal management.
- Desk-based search for innovative models of care, and contact with agencies delivering some of these models.
- A review of existing ACT specific withdrawal services documentation such as policies and procedures, screening and assessment tools, withdrawal scales and clinical protocols.
- Consultations with 38 CEOs, managers and staff of all ATOD service agencies including medical officers in order to determine their views and experiences of the programs available, including their recommendations for service system redesign.
- Four service consumer consultation group sessions to determine their views of the programs available; identify barriers to and enablers of accessing available programs; and their recommendations for future service system enhancement.
- Consultations with ten key stakeholders to determine their views and experiences of the programs available, including recommendations for service system redesign.
- Synthesis and interpretation of the information gained from the literature review and consultations to develop a briefing presentation for use in Phase 3 at the second sector-wide forum.

Phase 3: Solution design.

Phase 3 represented the strategic and technical planning component of the overall project.

Activities included:

- Facilitation of a second forum of ACT Health funded specialist AOD services representatives in October 2016 at which the interim findings from Phase 2 were presented by 360Edge, and collaborative planning for redesign of the service system was begun.
- The collection of additional information required to inform the development of the plan.
- Using the contributions from staff, key stakeholders and consumers; and other findings from Phase 2, 360Edge developed a plan for the redesign of the specialist AOD withdrawal services system in the ACT.

Phase 4: Implementation.

Phase 4 was designed to assist the sector to develop a suitable model of withdrawal care, and to integrate the redesign plan developed in Phase 3 and the associated model of care into the withdrawal management system in the ACT.

Activities included:

- Development of a draft system-level model of care and draft final report.
- Facilitation of a third and final forum for of ACT Health funded specialist AOD services representatives to review the draft model of care and discuss strategies to ensure successful implementation, and a plan for future evaluation of the new model.
- Production of the final report (this report) that includes the agreed system-level model of care, and the implementation and evaluation plans; submission of the report to ACT Health.

Attachment 3: Best practice.

In this section, we report on findings from a high level review of the evidence for withdrawal care. We drew on available evidence based guidelines (grey literature), supplemented with peer reviewed journal articles.

About withdrawal.

It is the nature of the human organism to strive for biological equilibrium; adapting constantly to the internal environment. In the context of regular exposure to alcohol and/or other drugs and the range of psychoactive effects exerted by these substances, the brain alters the conduct of its usual activities in an effort to maintain normal functioning. This process is known as tolerance or 'neuroadaptation'.

When a person who is dependent on a particular substance significantly reduces the amount normally taken or stops suddenly, the internal biological environment is altered abruptly and a time-limited withdrawal syndrome may emerge; lasting until the brain and body can readjust to the absence of these substances [(9)]. As the effects of alcohol and other drugs vary widely, the inception, duration and course of a withdrawal syndrome are specific to the type of substance(s) used.

The signs and symptoms of withdrawal tend to be the opposite of what would be expected during intoxication [(10)]. This occurs because the effects of a given substance largely assume the role of innate biological processes. The withdrawal period provides an opportunity to reverse the effects of tolerance and resume normal functioning.

In many cases, withdrawal symptoms are mild and self-limiting and easily managed at home. However, for others the symptoms may be severe and potentially life threatening and these people require formalised withdrawal care by specialist medical services.

In 2014-2015, withdrawal management as the main treatment type accounted for 13 per cent of all closed treatment episodes delivered by the specialist ATOD sector in Australia, with seven out of ten episodes completed as planned[6].

Practice guides.

A variety of evidence based publications are available to guide practice in withdrawal care. Some focus on withdrawal exclusively such as the *Drug and Alcohol Clinical Practice Guidelines* published by NSW Health [(11)], while guidance can also be found in publications that deal with broader approaches to treatment for a particular substance such as the *Guidelines for the Treatment of Alcohol Problems* published by the Australian Government Department of

[6]Alcohol and other drug treatment services national minimum dataset (AODTS-NMDS) data cubes (http://www.aihw.gov.au/alcohol-and-other-drug-treatment-services-data/

Health and Ageing [12]. The list of relevant guidelines includes:

Withdrawal-specific guidelines:

- Alcohol and other drug withdrawal: practice guidelines (2012) Turning Point Alcohol and Drug Centre
- NSW Health drug and alcohol clinical practice guidelines (2008) NSW Health
- Queensland alcohol and drug withdrawal clinical practice guidelines (2012) Queensland Health
- Management of cannabis withdrawal, National Cannabis Prevention and Information Centre
- Alcohol and other drug withdrawal practice guidelines for acute inpatient and residential services (2011), North-West Mental Health, Victoria

Guidelines that also include withdrawal management:

- Handbook for Aboriginal alcohol and drug work
- Guidelines for the Management of Substance Use During Pregnancy Birth and the Postnatal Period (2014) NSW Health
- Substance use and young people framework (2014) NSW Health

International withdrawal guidelines:

- Clinical guidelines for withdrawal management and treatment of drug dependence in closed setting (2010) World Health Organization
- Detoxification and substance abuse treatment (2006) Substance Abuse and Mental Health Services Administration (US)

Withdrawal care.

The purpose of withdrawal care is to "provide the appropriate level of support for withdrawal to be completed safely, which then allows the individual to determine his or her optimal ongoing management strategy" [11] (page 4).

With this in mind, the goals for withdrawal care are not limited to initiating abstinence alone, but are also pragmatic and include harm reduction, health promotion and psychosocial support.

Frei and colleagues suggest the following goals are appropriate for withdrawal care [9]:

- Preventing complications such as seizures or delirium
- Initiating abstinence from use of a particular substance
- Reducing substance use
- Reducing or initiating abstinence using pharmacotherapy such as methadone
- Interrupting a pattern of heavy, dependent substance use
- Providing respite from substance use
- Linking service consumers to the most appropriate after care to meet their ongoing goals.

Withdrawal care not only attends to the management of the unpleasant symptoms of withdrawal, but also addresses the person's psychological and social needs [13].

Management models.

Broadly speaking, withdrawal is managed in two ways:

1) With supportive care and appropriate medication to manage symptoms and minimise the risk of withdrawal complications ('medicated withdrawal');
2) With supportive care and monitoring alone ('non-medicated withdrawal').

Medicated withdrawal

Medicated withdrawal involves the use of specific medications to reduce the intensity of withdrawal symptoms and provide relief; to prevent complications such as seizures and delirium; and to treat complications of withdrawal and co-existing conditions [11].

Medicated withdrawal helps people to complete withdrawal by reducing the discomfort associated with symptoms, and offers appropriate treatment for co-existing physical and mental health disorders [11]. Withdrawal programs may also assist in reducing individual harms related to ATOD use [9] and support improvements in nutrition and physical health [14].

Medicated withdrawal, including medicated withdrawal in an outpatient setting, is the most appropriate option for those likely to experience a clinically significant withdrawal syndrome following cessation or reduction in AOD use; who are likely to experience relief from appropriate pharmacotherapy, or for whom withdrawal symptoms will trigger relapse.

Medicated withdrawal in a bed-based setting is required for people who are at risk for severe, complicated or protracted withdrawal, including those with a past history of severe withdrawal. While some young people with severe AOD use disorders may experience withdrawal and benefit from a medicated program, adults with longer histories of regular, heavy use are more likely to require medication support to complete withdrawal safely.

Non-medicated withdrawal

The model for non-medicated withdrawal is primarily psychosocial. Non-medicated withdrawal services offer supportive care including education about the course of withdrawal and reassurance; monitoring of mental health and physical symptoms; and encouragement to learn new, or apply existing, coping skills to manage issues including cravings to drink alcohol and or use other drugs.

Non-medicated withdrawal programs can also provide harm reduction benefits for individuals, facilitate a period of abstinence, and offer an opportunity to provide specific harm reduction interventions.

As is the case for medicated withdrawal, non-medicated withdrawal is not considered a stand-alone treatment; rather it can be the first step in a comprehensive ATOD treatment plan. Some non-medicated withdrawal programs capitalise on the opportunity to offer adjunctive support such as employment support, training, relationships building, mood management, personal growth and development, relapse prevention, life and group skills.

Assessment and preparation.

A thorough and specialised AOD assessment is conducted with each person prior to withdrawal to determine the severity

of her or his dependence, risk factors for complex withdrawal, and psychosocial needs. Information about withdrawal and its likely course are provided by the practitioner and the goals of the person are established. The most appropriate plan for withdrawal care is then developed collaboratively between the AOD practitioner and consumer [9].

A formalised strategy to support consumers to plan for alcohol withdrawal has been trialled recently in the United Kingdom. Results showed that six sessions of cognitive behaviour therapy in a group setting increased completion of withdrawal, reduced the number of people who were booked but did not attend for withdrawal, reduced the severity of dependence and was valued by participants [15, 16].

Settings for withdrawal.

Withdrawal may be supervised in bed based or non-bed based settings. The choice of setting should be appropriate for the service consumer's physical and psychosocial needs and provide the level of monitoring required to ensure withdrawal can be completed safely [14]. Medicated and non-medicated withdrawal may be delivered in both bed based and non-bed based settings.

Non-bed based settings

Outpatient or ambulatory withdrawal involves the person attending a specialist clinic or general practice at least daily for review by trained staff such as Addiction Medicine specialists, nurses, or general practitioners. Ambulatory withdrawal is suitable for people with mild to moderate dependence; no history of severe withdrawal or other factors that may complicate withdrawal; a stable home environment and reliable social supports [9].

Home-based withdrawal involves visits to the person at least daily in their own home by trained staff (usually nurses in partnership with general practitioners or Addiction medicine specialists), and may also involve telephone contact. Withdrawal may be medicated or non-medicated.

Home-based withdrawal is also suitable for people with mild to moderate dependence; no history of severe withdrawal or other factors that may complicate withdrawal; and a stable home environment.

Support provided includes monitoring of withdrawal, education about the course of withdrawal, relapse prevention strategies, and planning for the post-withdrawal period including aftercare.

Non-bed based settings may be preferred by some people [1, 17], and non-bed based withdrawal is the first option in a stepped-care approach [11] where the least intensive intervention suitable for the person is initiated first, and care is stepped-up only if required. The stepped-care model is widely applied in Australia to meet the needs of a range of consumers, including those who experience mental health and AOD problems simultaneously [18].

Bed based settings

Community bed based services provide the next step up in care for those with unstable housing, previous unsuccessful attempts to withdraw in the community; and those who

require more intensive support to complete withdrawal successfully.

Bed based withdrawal services offer supportive care including education about the course of withdrawal and reassurance; monitoring of mental health and physical symptoms; and encouragement to learn new, or apply existing, coping skills to manage issues including cravings to drink alcohol and or use other drugs. Withdrawal care may be medicated or non-medicated, depending on the capacity of the service, staffing profile, and the needs of the individual service user.

Hospital based withdrawal provides the most intensive care of all withdrawal settings. It is usually reserved for people at risk of severe withdrawal, including those with polysubstance use or dependence, comorbid physical and or mental health problems, or a past history of complicated withdrawal. Hospital based withdrawal involves medication management, regular monitoring of withdrawal by specialist medical and nursing staff, and planning for after-care.

Monitoring withdrawal.

Monitoring withdrawal as it progresses is a necessary component of withdrawal care, providing crucial information for management to be stepped-up or down in intensity according to the signs observed and symptoms described by the person experiencing withdrawal [9, 11].

Withdrawal scales have been developed to provide a standardised system of monitoring the course of withdrawal from a range of substances. Rating scales can also be used to indicate when medications are required to treat symptoms; to trigger more intensive support if symptoms increase in severity; and to show when medications can be safely reduced or ceased as the withdrawal syndrome abates [19].

Withdrawal scales in common use include:

- Clinical Institute Withdrawal Assessment Scale for Alcohol (CIWA)
- Alcohol Withdrawal Scale (AWS)
- Benzodiazepine Withdrawal Symptom Questionnaire (BWSQ)
- Clinical Opiate Withdrawal Scale (COWS)
- Objective Opiate Withdrawal Scale (OOWS)
- Cannabis Withdrawal Assessment Scale (CWAS)
- Amphetamine Withdrawal Questionnaire (AWQ)
- Amphetamine Cessation Symptom Assessment (ACSA)

Aftercare.

For many, withdrawal may represent the first point of contact with the AOD treatment system [14] and is an opportunity to engage and support people when they are most vulnerable.

There is strong evidence that withdrawal programs alone have no impact on AOD use in the long-term and should not be regarded as a stand-alone treatment for alcohol or other drug use problems [20, 21].
For those wishing to initiate and maintain a reduction in AOD use or who seek abstinence as a treatment goal, withdrawal is the first-step in an individualised treatment

planning process and may serve to engage people into longer-term ATOD treatment that is consistent with their personal goals. Planning for aftercare should begin during assessment for withdrawal [13].
Post-withdrawal aftercare may include community based individual AOD counselling or group therapy that focuses on the prevention of relapse among other important topics, through to more intensive residential rehabilitation in a specialist AOD treatment facility.

Specific withdrawal syndromes.

While the principles and practices of withdrawal care apply broadly to all service consumers, this section briefly examines issues relevant to withdrawal from specific substances.

Alcohol

In 2013, four out of five Australians over the age of 14 years drank alcohol, and 6.5 per cent drank daily [7]. Alcohol was the primary drug of concern for most people seeking treatment from the specialist AOD treatment sector in Australia in 2014-2105 [22] and alcohol accounted for about 47 per cent of all withdrawal episodes of care nationally in that year[7].

Symptoms and course

Approximately 50 per cent of people who are dependent on alcohol experience a clinically significant withdrawal syndrome [23], with most being uncomplicated in nature.

Symptoms of uncomplicated alcohol withdrawal usually emerge between six to 24 hours after the last drink, peak on the second or third day, and resolve by day five. Complicated withdrawal may last for ten days or longer (see Figure 5).

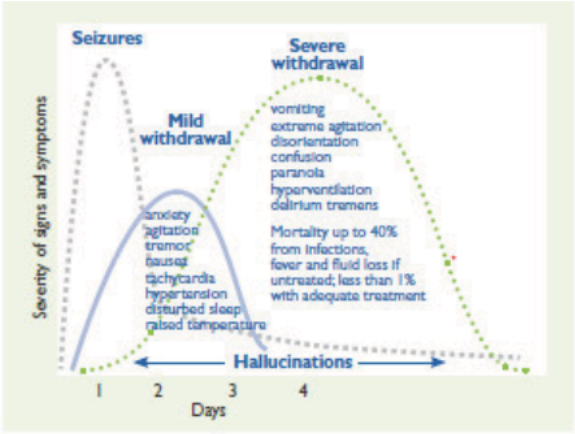


Figure 5. Course and nature of alcohol withdrawal.
Source: Haber et al., 2009 [12]

Between two and nine per cent of people who experience an alcohol withdrawal syndrome without the support of medication may experience withdrawal seizures, which tend to onset within 6 to 48 hours after the last drink, or when a blood alcohol reading is still present in those who are severely dependent.

About five per cent of people in unmedicated alcohol withdrawal may experience the most severe form of withdrawal, delirium tremens (DTs), which is characterised by confusion, disorientation, agitation and tremor [23]. DTs may be fatal in up to 15 per cent of people in unmedicated withdrawal, one per cent of people receiving medications, and up to 20 per cent of

[7] (AODTS-NMDS) data cubes (http://www.aihw.gov.au/alcohol-and-other-drug-treatment-services-data/

medically ill patients with multiple and complex physical comorbidities [24].

Medication management of withdrawal

The symptoms of alcohol withdrawal are thought to be largely due to disruptions in the GABA (gamma-aminobutyric acid) system, which is responsible for inhibiting activity in the central nervous system (CNS). The inhibitory role becomes assumed largely by the sedating effects of alcohol in those who are dependent. When alcohol is stopped abruptly, the CNS becomes hyperactive resulting in the typical symptoms of alcohol withdrawal (tremor, agitation, insomnia, sweats, rapid pulse, and in more severe cases seizures and DTs), until the GABA system is able to restore normal functioning, or alcohol consumption is resumed.

Benzodiazepines, diazepam in particular, are used to manage a range of alcohol withdrawal symptoms and to prevent alcohol withdrawal seizures [25]. Regimes include:

1. Loading dose (large doses until alcohol withdrawal subsides or sedation is reached);
2. Fixed-schedule (specified doses at fixed intervals, tapered over a set number of days);
3. Symptom triggered dosing (doses administered according to individually experienced symptoms of alcohol withdrawal).

Fixed-schedule dosing is appropriate for people at risk of withdrawal who are not in a hospital or supervised environment (e.g. home based withdrawal), while loading dose regimes and symptom-triggered dosing may only be provided in a medically supervised setting [11].

Settings for alcohol withdrawal

People with mild to moderate alcohol withdrawal are suitable for withdrawal management in a non-bed based setting [12], and NSW Health withdrawal guidelines indicate that a non-bed based setting must be considered first [11]. Those with severe dependence, polydrug use, comorbidity of mental health or physical problems, and past or present history of severe withdrawal (e.g. withdrawal symptoms are present on waking) require specialist medical monitoring in a bed based setting [12].

Careful monitoring of alcohol withdrawal in is required [12]. The CIWA-Ar is a validated scale, and the AWS is also widely used.

Pharmacological support

In conjunction with suitable aftercare, Australian clinical researchers recommended that pharmacotherapy to prevent relapse should be considered during post-withdrawal treatment planning[26].

The medications available for this purpose include acamprosate (reduces anxiety, and craving), and naltrexone (reduces craving and the rewarding effects of alcohol) [13].

Benzodiazepines

Benzodiazepines comprise a range of drugs that inhibit activity in the CNS including diazepam, nitrazepam, temazepam and oxazepam.

Dependence can occur in users of benzodiazepines within weeks or months [27], and between 15 and 50 per cent of people taking low doses of benzodiazepine for six weeks or more may experience withdrawal symptoms [11].

Benzodiazepine was the primary drug of concern for one per cent of people seeking treatment from the specialist AOD treatment sector in 2014-2015, but represented an 'additional' drug of concern in about seven per cent of closed treatment episodes, most commonly in conjunction with alcohol, cannabis and nicotine [22]. Benzodiazepines accounted for approximately 1.8% of all withdrawal episodes of AOD specialist care nationally in 2014-2015[8].

Symptoms and course of withdrawal

Withdrawal typically occurs within two days after ceasing short-acting benzodiazepines (e.g. oxazepam), and between two and ten days after ceasing long-acting benzodiazepines (e.g. diazepam). However, the onset of benzodiazepine withdrawal may be as late as three weeks after cessation of drugs with a long half-life such as diazepam and symptoms may endure for several months [28]. Like alcohol, withdrawal symptoms may be mild, moderate or severe, are thought to be influenced by the GABA system [27] and include anxiety, insomnia, restlessness, irritability, poor concentration and memory, depression, muscle aches, and less commonly perceptual disturbances and panic attacks. Seizures and symptoms of psychosis may also occur.

Medication management

Reviewers for the Cochrane Collaboration concluded that gradual taper was preferable to abrupt cessation of benzodiazepines [27]. Australian guidelines recommend a gradual taper of ten per cent of the usual dose every one to two weeks, reducing in 1mg increments when the dose reaches 5mg [9].

Settings for benzodiazepine withdrawal

Non-bed based settings are preferred, with oversight from the person's general practitioner [11]. Unsuitable for non-bed based withdrawal are those at risk of severe or complex withdrawal, including those with poly-substance dependence and or comorbid mental health disorders; a history of high-dose benzodiazepine use; and unstable home environment or exposure to benzodiazepines [9].

Careful monitoring of the progress of withdrawal is required, and withdrawal scales (e.g. Benzodiazepine Withdrawal Symptom Questionnaire (BWSQ) should inform ongoing and careful clinical review of the course of withdrawal [11].

Cannabis

Cannabis is the most commonly used illicit drug in the general population. About 10 per cent of Australians aged 14 years and over used cannabis in 2013, and 35 per cent reported use at some time during their lives [7]. Researchers have estimated that about 10 per cent of people who have ever used

[8] Alcohol and other drug treatment services national minimum dataset data cubes http://www.aihw.gov.au/alcohol-and-other-drug-treatment-services-data/

cannabis may become dependent at some time [29].

Cannabis was the primary drug of concern for the second greatest proportion of people seeking treatment from the specialist AOD treatment sector in Australia in 2014-2105 [22] accounting for approximately 18 per cent of all withdrawal episodes of care nationally in that year[9].

Symptoms and course of withdrawal

A withdrawal syndrome is typically associated with ceasing heavy or daily cannabis use, while the extent to which withdrawal symptoms occur among people who use lightly or irregularly is less clear [30]. Common symptoms of cannabis withdrawal include anger, aggression, irritability; anxiety/nervousness; decreased appetite and weight loss; restlessness; and sleep disturbance including strange dreams. Less common symptoms include depressed mood; chills; aches and pains; sweating and tremor [30].

Symptoms of cannabis withdrawal begin on day one or two after stopping and peak between days two and six (see Figure 6). Most symptoms resolve within two to three weeks of abstinence [30, 31].

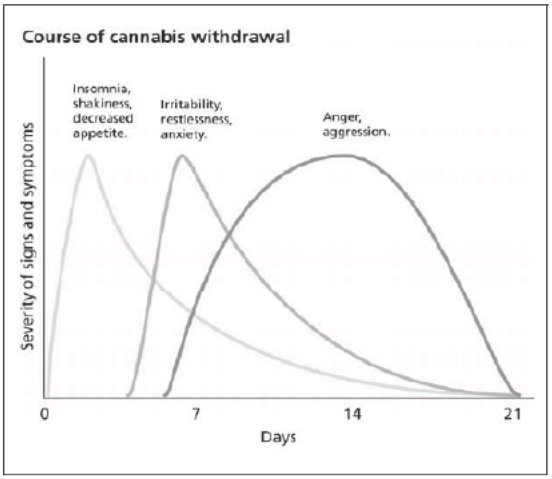


Figure 6. Course of cannabis withdrawal. Source: NSW Health clinical practice guidelines [11].

Management of cannabis withdrawal

The two main models of cannabis withdrawal are 1) sudden cessation, or 2) tapering dose to reduce the severity of withdrawal symptoms [11]. Psychosocial support, including relapse prevention and monitoring of progress, are central to both approaches.

To date, no medications have proven effective in the treatment of cannabis withdrawal overall, and Australian guidelines describe symptomatic relief that is based on clinical wisdom. Tapering doses of benzodiazepines for up to seven days may be helpful in managing anxiety, irritability and sleep disturbance for example [9], and careful monitoring of progress is required in a stepped care approach to management. The Cannabis Withdrawal Assessment Scale (CWAS) may be a useful tool for this purpose in conjunction with clinical judgement.

As continuing to smoke tobacco increases the risk of relapse to cannabis use (and other drugs) [32], support and encouragement to abstain from tobacco should be central to the treatment plan.

[9] AODTS-NMDS data cubes http://www.aihw.gov.au/alcohol-and-other-drug-treatment-services-data/

Settings for cannabis withdrawal

Symptoms of cannabis withdrawal vary in intensity from one person to another, but symptoms are not life threatening and in general may be managed in a non-bed based setting with appropriate support [9].

Residential care may be more appropriate than non-bed based care for those with numerous previous unsuccessful attempts to withdraw from cannabis in the community; for people with significant mental health problems; and for people with poly substance dependence [9, 11]

Opiates and opioids

The term opiates describe drugs derived from plant-based opium such as morphine, codeine, and heroin.

Opioids are a broad class of opiate analogue (synthetic) compounds that have opium- or morphine-like activity, and include medications such as methadone and buprenorphine [9].
About 0.2 per cent of the population aged 14 years and over had used heroin in 2014-2015, and about 1.2 per cent had used heroin at some time in their lives [7]. However, the harms associated with the use of opiates are significantly greater than expected from the low prevalence of use [33].

Heroin was the primary drug of concern for about five per cent of people seeking treatment from the specialist AOD treatment sector in Australia in 2014-2105 [22], and heroin accounted for approximately seven per cent of all withdrawal episodes of care nationally in that year[10]. Methadone accounted for approximately one per cent of all withdrawal episodes of care nationally in the same year, while 'other opioids' accounted for about three per cent.

Symptoms and course of withdrawal

The onset and course of withdrawal depend upon the half-life of the substance used. Symptoms of heroin withdrawal manifest within six to 24 hours after last use, peak between 24 to 48 hours and reside within five to 10 days. In contrast with alcohol or benzodiazepine withdrawal, heroin withdrawal is not life threatening to those without medical complications [34], although death from severe dehydration may occur in rare cases [35].

The signs and symptoms of heroin withdrawal include sweating, runny eyes (lacrimation) and nose (rhinorrhoea), urinary frequency, diarrhoea, abdominal cramps, nausea, vomiting, muscle spasm, headaches, back aches, cramps, twitching, piloerection (goose flesh), dilated pupils, elevated blood pressure and heart rate, anxiety, irritability, dysphoria, disturbed sleep, and cravings to use [34] (see Figure 7).

Symptoms of methadone withdrawal mimic those experienced during heroin withdrawal and due to the long acting nature of methadone, emerge within 36 to 48 hours after the last dose. Some low-grade symptoms can linger for three to six weeks [36].

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[10] AODTS-NMDS data cubes www.aihw.gov.au/alcohol-and-other-drug-treatment-services-data

Buprenorphine withdrawal is generally milder than those experienced during withdrawal from heroin or methadone, symptoms typically emerge within three to five days of the last dose, and mild withdrawal features can continue for up to several weeks [34].

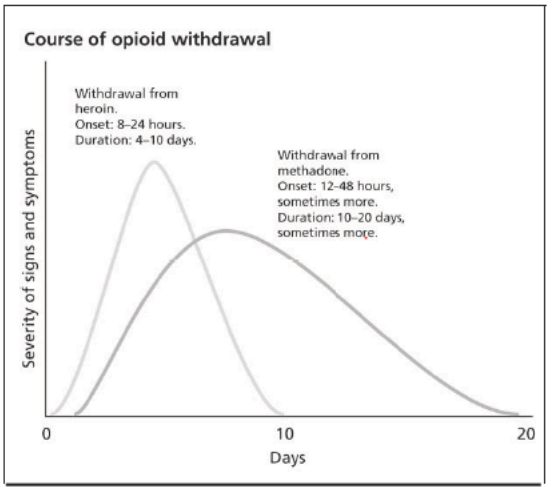

Figure 7. Course of opioid withdrawal.
Source: NSW Health clinical practice guidelines [11].

Management of withdrawal

As is the case for withdrawal from alcohol and other drugs, planned withdrawal from opiates and opioids is not considered effective as a standalone treatment and relapse following withdrawal is common [37-39]. This is of particular concern as withdrawal results in rapidly reduced tolerance and the risk of overdose following withdrawal is high [33]. For this reason, advising people of the significant benefits of engaging in opioid pharmacotherapy is recommended, particularly for those at the greatest risk of relapse [9].

For those who do opt for withdrawal, non-opioid medications are used to relieve uncomfortable symptoms during the acute withdrawal period, while some consumers may be prescribed a short course (e.g. one month) of buprenorphine [33].

Mental health problems, particularly depression [40] and the use of other drugs such as benzodiazepines commonly co-occur among people who use opioids [41]. A thorough assessment is required for treatment planning and to monitor progress.

Due to generally poor outcomes for withdrawal as a standalone treatment, the addition of psychosocial interventions to withdrawal care has been found to increase completion rates, reduce relapse and increase linkages with aftercare when compared to those who received pharmacological treatment of heroin withdrawal alone [42].

Settings for withdrawal

People may withdraw in a non-bed based setting if they have a stable home environment, are not poly drug dependent and do not have mental health or physical problems that increase risk of severe or complex withdrawal. For those with identified risk factors, bed based or hospital-based withdrawal is preferred [33].

Methamphetamine

Methamphetamine, a CNS stimulant, comes in several forms including powder ('speed') and crystal ('ice'). Crystalline methamphetamine is the most potent of the

forms. About two per cent of Australian adults had used methamphetamine in 2013, and about half used crystal [7].

Treatment seeking among this group has increased by about 50 per cent in recent years. Amphetamines were the primary drug of concern for about 20 per cent of people seeking treatment from the specialist AOD treatment sector in Australia in 2014-2015 [22], and accounted for approximately 17 per cent of all withdrawal episodes of care nationally in that year[11]. Poly substance use was commonly reported by treatment seekers.

Symptoms and course of withdrawal

The clinical picture of withdrawal from methamphetamine differs substantially from that of alcohol and heroin that have been the traditional targets of withdrawal care. Methamphetamine withdrawal appears to occur in several phases, the first of which is a 'crash' period of a few days during which people recuperate from prolonged overstimulation by eating, drinking and sleeping. Low mood is common.
In the next phase, withdrawal symptoms such as irritability and agitation, fatigue, disturbed sleep, poor concentration and intense cravings to use typically peak over seven to ten days and generally subside in intensity over two to four weeks. Acute mental health symptoms may also emerge during this time.

Withdrawal symptoms gradually diminish during the final phase, which may last for many months [11, 43]. Cognitive functioning is often significantly and adversely affected following abstinence, in particular concentration, attention, memory, impulse control and decision making ability [44]. Cognitive functioning can decline significantly in the early period of withdrawal, which can affect a person's ability to engage in withdrawal programs that involve adherence to scheduled programming and participation in therapeutic groups.

Management of withdrawal

To date, no pharmacotherapy has proven effective for use during withdrawal or as a maintenance medication, despite extensive research efforts [44]. Guidelines suggest that medications should target symptoms of withdrawal as required for each individual, including symptoms that may be protracted such as depression [9, 11].

The focus of management is supportive care (including education about protracted withdrawal and cognitive impairments), careful monitoring of mental health and the course of withdrawal, and the prevention of relapse in the context of strong cravings to use. Linking people with AOD aftercare is strongly recommended as people appear to be vulnerable to relapse particularly around week twelve [21, 45, 46].

Settings for withdrawal

The relative safety, extended duration of methamphetamine withdrawal, variable course, and lack of a formal medication regime suggest that a non-residential setting is the most appropriate. If risk factors for

[11] AODTS-NMDS data cubes http://www.aihw.gov.au/alcohol-and-other-drug-treatment-services-data/

complex withdrawal are present, including mental health problems, poly substance dependence and physical health problems, bed based care may be required [43, 47].

Many people do want to enter a bed based setting to withdraw however, in which case services need to adjust treatment as usual for this group; accounting for irritability of mood, impulsiveness and other cognitive impairments, and extended duration of withdrawal.

An innovative model was developed by UnitingCare ReGen, in which people were supported through the 'crash' period in the community, then stepped-up to bed based withdrawal care for up to seven days, then stepped down to post-withdrawal care. Evaluation showed a high level of consumer satisfaction, shorter duration in bed based stay, and more rapid resolution of withdrawal symptoms than those not in stepped-care. There was also a relationship between improved quality of life and lower relapse rates among a small sample of consumers at three month follow-up [48].

Polysubstance use and withdrawal

Many consumers of AOD services use multiple substances. Poly substance use does not necessarily mean that the consumer is dependent on all substances. To determine the most suitable withdrawal treatment care plan, a thorough assessment of dependence on all substances is required. Withdrawal care should focus on the substance that puts the consumer at most risk of complex withdrawal [9].

Needs of sub-groups of consumers.

In this section, we briefly examine the particular withdrawal services needs of two sub-groups of consumers that were of interest to this project; Aboriginal and Torres Strait Islander peoples and young people.

Aboriginal and Torres Strait Islander people

Treatment for alcohol and other drug problems among Aboriginal and Torres Strait Islander people can be provided by mainstream services, Aboriginal and Torres Strait Islander primary health-care services, Aboriginal-specific substance use services, and general practitioners.

In 2014-2015, 9.4 per cent of all AOD withdrawal episodes of care provided by ATOD specific services nationally were for Aboriginal and Torres Strait Islander people, which is consistent with findings in the ACT (9%).

Cultural issues in treatment

The National Indigenous Drug and Alcohol Committee (NIDAC) stresses that workers in mainstream services must deliver treatment within a framework of *cultural competence*, in which respect for Aboriginal people's culture is recognised, respected, and safeguarded; *cultural safety* that ensures an environment for Aboriginal people that is free from 'assault, challenge, or denial of a person's identity"; and *cultural security* in which cultural values are actively incorporated into the planning, delivery and evaluation of their practice [49].

Without attention to the culture of Aboriginal and Torres Strait Islander peoples, including the enduring legacy of colonisation mainstream services may appear impersonal and too clinical [50]. Aboriginal and Torres Strait Islander peoples require ATOD treatment, including withdrawal care that is not only evidence based but adapted to meet their cultural needs.

For example NIDAC offers the following suggestions for cultural adaptations [49]:

- Flexible, open and culturally sensitive services and practices that understand it may be difficult for Aboriginal and Torres Strait Islander people to share personal information in groups, so provision of one-to-one counselling may be more effective. Likewise, aftercare is often best provided face to face with the person rather than over the phone.
- Involve family.
- Use cultural traditions that are relevant and meaningful to the person receiving treatment.
- Use of storytelling to share information.

The National Drug and Alcohol Clinical Care and Prevention (DA-CCP) Project estimated that resourcing requirements to deliver ATOD services to Aboriginal and Torres Straits Islander peoples were two-three times greater than those delivered to non-Aboriginal consumers to account for the additional elements needed to provide culturally appropriate and effective care [8].

Settings for withdrawal

Withdrawal may be undertaken in both bed based and non-bed based settings. Bed based withdrawal settings must take into account the particular cultural needs of consumers as described above. The Indigenous DA-CCP allows for an additional residential bed for families or support people of Aboriginal and Torres Straits Islander peoples to stay with the person during withdrawal. The Aboriginal and Torres Straits Islander withdrawal unit operated by the WA Drug and Alcohol Office in Perth also provides this option for consumers.

While some Aboriginal and Torres Strait Islander peoples prefer bed based withdrawal settings as a means to break from a pattern of alcohol and or other drug use or require a bed based stay if they are considered at risk for complex withdrawal, others prefer a non-bed based setting [5].

Service providers who supervised Aboriginal and Torres Strait Islander peoples through withdrawal in the community in NSW observed that staff education and training; access to immediate assessment; development of rapport and trust; offering a transport service to the clinic where public transport was irregular; tailored counselling; relapse prevention planning; and support from the local hospital for the rare cases when a person's withdrawal symptoms escalated in the community were key to successful non-bed based withdrawal services [5].

Young people

Evidence based practice in responding to the needs of young people with AOD problems [51]:

- involves an holistic approach that is consistent with the young person's developmental stage, matched to the their patterns of use and mental health issues; accounts for the role of peers; and integrates their vocational, educational and social needs.
- involves families;
- fosters continuing engagement and participation;
- is delivered by qualified staff;
- is culturally and gender appropriate;
- plans for aftercare; and
- measures outcomes.

Management of withdrawal in young people is consistent with the general approach used for adults. Due to the shorter duration of exposure to alcohol and other drug use and physical health of young people generally, psychosocial support is usually sufficient, unless dependence is severe or the need for medicated bed based withdrawal is otherwise indicated[51].

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Attachment 4: The current withdrawal services system.

The specialist AOD withdrawal services system in the ACT sits within a broader AOD treatment system that delivers a suite of evidence based programs and services to consumers with substance use problems and their families. The AOD treatment system works with other sectors that are accessed by service consumers including primary care, homelessness, and justice.

At the time of reporting, the withdrawal services system comprised three programs, all bed based, funded by ACT Health to deliver specialist withdrawal care. These were:

1. ACT Health Alcohol and Drug Service (ADS) Inpatient Withdrawal Unit
2. Arcadia House (Direction Health)
3. Adolescent Drug Withdrawal Unit (ADWU), Ted Noffs Foundation.

In 2008, the adult withdrawal services system was reviewed by Dr Adam Winstock and a three key recommendations were made. These were:

1. Increase the occupancy of the ADS Inpatient Withdrawal Unit by expanding its role beyond withdrawal to provide assessment and stabilisation of people with complex AOD problems;
2. Enhance the role of Arcadia House as a transitional care unit for those leaving the ADS inpatient unit and improve linkages between the two units;
3. Develop and implement a common core assessment tool for use by Directions Health, the Alcohol and Drug Program, and youth and Aboriginal services.

In this section, we describe each service using information gained through the review and redesign project, with consideration of the extent to which the Winstock recommendations were implemented and or remain relevant.

Alcohol and Drug Services Inpatient Withdrawal Unit.

The service

Alcohol and Drug Services (ADS) ACT Health offer a bed based withdrawal program with a medicated management approach, to men and women aged 18 years and over who are assessed as in need of specialist bed based withdrawal care. People may stay for up to seven days, and in some cases longer if required to complete withdrawal. While priority is given to ACT residents, the service is available to those residing outside the territory.

The ADS inpatient unit is located in Building 7 on the campus of The Canberra Hospital[12] has a 10-bed capacity, operates 24 hours per day, seven days per week, and is staffed by Addiction Medicine specialists, nurses, allied health staff, an Aboriginal Liaison Officer, and administration staff. A new Nurse Practitioner position was to be established at the time of reporting, which was thought to have a

[12] The unit was not purpose built.

potential role in supporting general practitioners to care for patients with AOD problems in the community.

One nursing position was assigned to triage and assessment on three days per week, while the remaining two days were staffed by nurses from the unit.

As the only medicated bed based withdrawal service in the ACT, the ADS inpatient unit is primarily reserved for people with complex needs who are unsuitable for non-medicated bed based withdrawal in Arcadia House.

Model of care

The ADS inpatient unit uses a medical model of withdrawal care for a range of substances, and remains largely consistent with the model described by the Winstock review in 2008. The medical model is supplemented by psychoeducation, encouragement to attend peer support groups such as Alcoholics Anonymous that are held outside of the unit on the hospital campus, and other activities such as cooking groups.

Withdrawal scales are used to monitor the progress of withdrawal in line with best practice, and the day to day conduct of care is guided by a series of operational documents in lieu of a formalised model of care.

While relapse prevention groups were offered in the past, they are no longer conducted, mainly due to lack of staff capacity to facilitate groups outside of the ward. Staff indicated that they would be keen to initiate these groups again if staffing capacity increased. Continuing care following withdrawal is consistent with best practice, and relapse prevention groups are delivered by other withdrawal programs such as the Nepean Hospital Blue Mountains Local Health District Inpatient Withdrawal Unit.

Specialist medical staff also work in the opioid treatment program located upstairs in Building 7, and are available for consultation by the ADS inpatient unit at short notice.

To address the cultural needs of Aboriginal and Torres Strait Islander consumers, the ADS inpatient unit follows operating procedures in accord with "Improving access for People of Aboriginal and Torres Strait Islander origin into the Withdrawal Unit". An Aboriginal and Torres Strait Islander AOD liaison worker is on staff; the unit has a room especially designed for Aboriginal and Torres Strait Islander service consumers, who also have greater access during withdrawal to their identified support people by telephone and in person.

Admission pathways

Admission is by appointment only, with assessments conducted primarily by telephone. Self-referral is generally required. A prospective service consumer calls a central intake line for all ACT Health Community Programs based at Moore Street Civic, and their details are subsequently provided to the triage and assessment nurse in the unit, who then telephones the person as soon as possible to conduct the assessment for withdrawal (the aim is within 24 hours). The Common Assessment Tool is used, which was developed in accordance with the recommendation made by the Winstock review in 2008 to facilitate ease of information sharing among AOD services in the ACT.

If the person has a bed booked in a residential rehabilitation program for post-withdrawal aftercare, efforts are made to coordinate the withdrawal admission with the rehabilitation admission at the time of assessment (formal withdrawal is required prior to admission). On average, there is a one-week delay between assessment and admission. People with a booked admission date for withdrawal are telephoned by ADS inpatient unit staff a day or two prior to admission to confirm their intention to proceed. According to staff, some people are lost to the service at this point for a variety of reasons (e.g. not receiving or accepting the call; changed plans; reduced motivation for withdrawal), which ultimately impacts on bed occupancy rates that average at about 65 per cent (as reported by the ADS based on ACTPAS data).

As medical coverage is unavailable on weekends, admissions are usually arranged Monday – Thursday. Exceptions are made for patients of the Canberra Hospital who have been assessed by a specialist from the AOD Consultation Liaison service, who are medically and psychiatrically stable, and who require transfer to the ADS inpatient unit to complete withdrawal that began during an inpatient stay elsewhere in the hospital.

The hospital Medical Emergency Team is not available to attend to service consumers should their physical condition deteriorate during withdrawal. In this case, an ambulance would be called to transport the person to the Emergency Department on the main campus of the hospital. In this regard, the unit performs the function of a specialist bed based withdrawal program rather than a specialist hospital inpatient unit.

The ADS inpatient unit accepts admissions of service consumers who have abstinence as a treatment goal, but does not exclude people who seek admission for harm reduction purposes (see discharge pathway). Staff members estimated that there may be twenty people who wish to be admitted for withdrawal at any one time, and the waiting period for admission was approximately one week (up to two weeks) at the time of reporting. The reasons for this, including issues related to the holding of beds, are explored throughout this report.

Discharge pathways

Following withdrawal, service consumers are followed up by ADS inpatient unit staff at two weeks' post-discharge, and again by the unit's social worker four weeks later. ADS inpatient unit staff estimate that 75% of people are lost to follow-up by four weeks' post-discharge (e.g. they do not answer their phone).

Consultations suggest that a proportion of service consumers who had completed withdrawal were exited to a residential rehabilitation program in the ACT, however the number could not be verified with existing data.

Arcadia House, Directions Health.

The service

Arcadia House is one of a suite of programs, both bed based and non-residential, offered by Directions Health. Althea Wellness Centre, a primary care service for people who use alcohol and other drugs, is also an important part of this suite. Arcadia House provides non-medicated, bed based withdrawal services to adult men and women assessed as unlikely to experience severe or complex withdrawal, but who may benefit from bed based support.

Arcadia House is located in a self-contained unit on the campus of Calvary Hospital in Belconnen. Arcadia House has two beds that are funded specifically for withdrawal. Beds are collocated with the Arcadia House transition program (see Discharge pathways). Residents may stay up to ten days, or longer if required to complete withdrawal.

Arcadia House is staffed 24 hours per day, seven days per week. Staff include a program manager, AOD support workers, case managers, and a pool of qualified casual staff. Each holds a minimum qualification of a Certificate IV in Alcohol and Drug Work, consistent with the ACT AOD Minimum Qualifications Strategy.

Model of care

Withdrawal care provided at Arcadia House is supportive, and non-medicated. Residents may remain on prescribed medications for existing conditions when the medications are packed in a blister pack and stored securely by staff. Arcadia works with the resident's general practitioner, and has close links with general practitioners and the nurse in Althea Wellness Centre. The Althea nurse provides outreach to Arcadia House.

Arcadia accepts service consumers wishing to withdraw from cannabis, methamphetamine and opioids. In 2015-2016, over half of the service consumers seeking withdrawal only (i.e. not residential rehabilitation), wanted support for methamphetamine withdrawal, while one quarter withdrew from cannabis. People who are likely to experience complex withdrawal are referred to the ADS inpatient withdrawal unit for assessment.

In the absence of a formalised model of care, conduct of the program is guided by the NSW Health Clinical Practice Guidelines. While the progress of withdrawal is monitored by Arcadia House staff (hourly checks during the first week), no validated withdrawal scales are used. NSW Health Clinical Practice Guidelines recommend the use of the Cannabis Withdrawal Chart or direct questioning for cannabis withdrawal; and the Clinical Opiate Withdrawal Scale or Subjective Opiate Withdrawal Scale for heroin. The guidelines recommended no scale for methamphetamine withdrawal; however, since the guidelines were published in 2007 we have advanced in the management of methamphetamine withdrawal and the Amphetamine Cessation Symptom Assessment (ACSA) and Amphetamine Withdrawal Questionnaire (AWQ) are often used. Should Arcadia measure symptoms with standardised scales, hourly monitoring is unlikely to be necessary after the first few days.

If a service consumer's symptoms escalate during withdrawal at Arcadia House, prompt

medical attention can be sought via the Emergency Department at Calvary Hospital.

If the person is found to have withdrawal needs that exceed the capacity of Arcadia House (e.g. daily alcohol use), the assessment information is transcribed onto the paper based Common Assessment Tool, which is then faxed to the ADS inpatient withdrawal unit to inform a subsequent assessment of the prospective service consumer by the inpatient staff. Arcadia House also accept referrals from other agencies, including general practitioners and other AOD services.

At the time of reporting, waiting times to access the two dedicated withdrawal beds was short. This is due in part to staff reserving the beds for people who choose withdrawal only and who are not seeking access to the 12-week Arcadia House transitional program. In the latter case, prospective residents are supervised through withdrawal in a transitional program bed.

Due to data collection processes, these episodes of withdrawal care were not reported (i.e. episodes are reported as residential rehabilitation only), which is a missed opportunity for Arcadia House to demonstrate the significant contribution it makes to providing withdrawal care to the community. A manual search of data conducted by Arcadia House staff for this project showed that forty episodes of withdrawal care were provided in 2015-2016, but not formally reported as such. Directions Health were attending to this issue at the time of writing this report.

Discharge pathways

The two withdrawal beds are located within the Arcadia House transitional program. The program was established in 2009/10 as a 'transitional program' in response to the recommendations by the Winstock review[13]. The vision was to provide a step-down service for people leaving the ADS inpatient withdrawal unit to engage them in non-medical care and provide a safe place to make plans for, and be linked with, aftercare. To some extent this had occurred, although there are no formal pathways to move between the two services, and there are no formal pathways back to the ADS inpatient unit from Arcadia should withdrawal symptoms escalate.

For residents who complete withdrawal in Arcadia House and do not intended to stay on for the therapeutic residential program, transfer to the Arcadia transitional program is seamless. Alternatively, service consumers have access to the 12-week Arcadia Day program post-withdrawal that is a rolling program, comprising a range of therapeutic activities including SMART Recovery and relapse prevention.

Data supplied by Arcadia House showed that between July 2015 and June 2016, about 37.5 per cent of service consumers who had completed withdrawal only accessed longer term residential services offered by Karralika Programs, and about eight per cent stayed on to join the Arcadia transitional program. About 30 per cent were linked with the suite of other programs offered by Directions Health including case management, outpatient counselling and group therapy.

[13] At the time, Arcadia was operating as a ten-bed social residential withdrawal unit.

Adolescent Drug Withdrawal Unit, Ted Noffs Foundation.

The service

The Adolescent Drug Withdrawal Unit (ADWU) is operated by the Ted Noffs Foundation, and provides young people aged 13-18 years residing within and outside the ACT with an opportunity to withdraw from a range of substances in a safe and supportive residential setting.

The ADWU is located in Watson. It has two beds that are funded specifically for withdrawal. Residents may stay for two to three weeks, or longer if required to complete withdrawal or transition to aftercare.

The ADWU is staffed by a manager, an intake worker, adolescent and family councillors, and AOD workers (including Aboriginal and Torres Strait Islander people). Two AOD workers are on shift at all times.

Model of care

The ADWU has a well-established model of care that "works from a harm minimisation model, valuing support and education as well as teaching relapse prevention and strength based resiliency strategies" (*ADWU Model of care*, p4).

Consistent with the evidence for best practice with young people, the ADWU program sits within a wider therapeutic framework designed to support all areas of a young person's life including intrapersonal, emotional, physical and mental health, social, living skills, vocational/educational, sport and recreation. ADWU staff estimate that 90 per cent of young people are still connected with their families and qualified counselling staff (psychologists) work with families as part of the program.

The ADWU assists young people to address problems with a range of drugs. Data supplied by Ted Noffs showed that in 2014, methamphetamine overtook cannabis for the first time as young peoples' principal drug of concern (about 50% compared to 40% respectively).

The withdrawal model of care is non-medicated, and prior to admission to ADWU, young people are assessed by a general practitioner. The ADWU works with a number of general practices in the ACT including primary care services for Aboriginal and Torres Strait Islander young people who represent approximately 30 per cent of young residents overall. The progress of withdrawal is supervised by residential staff in the unit in accordance with the needs identified by the general practitioner and the subsequently developed treatment plan. Formalised withdrawal scales were not in use.

The ADWU also adopts the principles of a modified therapeutic community, in line with standards set by the Australasian Therapeutic Community. These include modifying the community to fit the developmental needs of young people, a staged approach to treatment, and providing opportunities for peer mentoring and support.

Admission pathways

The ADWU accepts referrals from a range of sources including youth justice and self-referral. Young people are screened initially by the admin/intake officer at the ADWU, and then

booked for a comprehensive assessment conducted by an adolescent and family counsellor. Assessments are conducted face to face, by telephone or Skype, according to the needs of the young person and their physical location.

The assessment covers AOD use, mental health, physical heat, social functioning, and justice involvement. The ADWU used the Common Assessment Tool in the past, but now uses an electronic assessment system built into the TED database that guides both narrative assessment and a battery of validated scales such as the Beck Youth Inventory and Briere Trauma Symptom Checklist for Children.

At the time of reporting, young people had prompt access to the ADWU, and admission had been arranged on the same day of enquiry in some cases. Admissions ae generally accepted Monday – Thursday to allow for the medical assessment to be conducted.

Like Arcadia House, young people may undertake withdrawal in one of the therapeutic program beds (see discharge pathways below).

Discharge pathways

Like Arcadia House, the two dedicated withdrawal beds are integrated within the Program for Adolescent Life Management (PALM) residential program also operated by the Ted Noffs Foundation. The PALM program has eight beds and young people transition seamlessly from the ADWU to PALM. This was also the perspective of young people consulted on the day of the site visit, who positively described their experiences in ADWU and PALM as one and the same.

Young people are followed-up by staff for up to five years. Aside from telephone follow-up, Ted Noffs Foundation staff utilise young people friendly social media such as Facebook to maintain contact with previous service consumers, providing a safety net and soft entry back to treatment should it be required.

Activity of the service system as a whole.

Data in this section were prepared by the ACT Health AOD Policy Unit, and endorsed for inclusion in this report by senior staff from each of the three specialist withdrawal services. Data were aggregated at the systems level to preserve the privacy of service consumers. The years 2012-2015 were chosen as representative of recent activity of the services system as a whole.

Data used to compare ACT withdrawal services episodes of care with national activity in 2014-2015 were obtained from the AODTS-NMDS online data cubes.

Treatment seekers in the ACT

The principal drugs of concern for those who received any AOD treatment in the ACT generally reflects those described nationally in 2014-2015. Alcohol was the most frequent principal drug of concern, followed by amphetamine, cannabis, and heroin (see Figures 8 and 9).

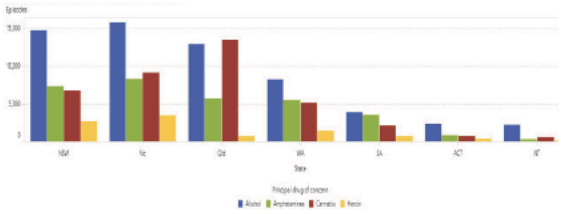

Figure 8. Principal drugs of concern, closed treatment episodes states and territories 2014-2105
Source: AODTS-NMDS data cubes
http://www.aihw.gov.au/alcohol-and-other-drug-treatment-services-data/

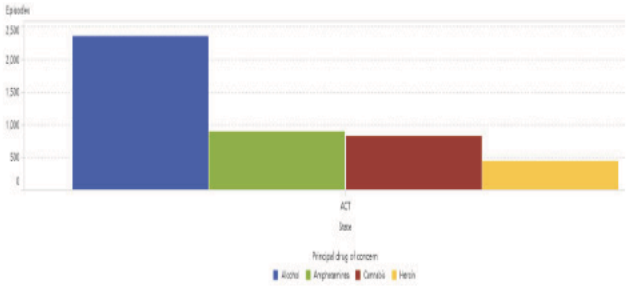

Figure 9. Principal drugs of concern, closed treatment episodes ACT 2014-2105
Source: AODTS-NMDS data cubes
http://www.aihw.gov.au/alcohol-and-other-drug-treatment-services-data/

These data suggest the potential demand for withdrawal assistance in relation to particular substances among service consumers in the ACT community.

Episodes of withdrawal care

Between 2012-2015, 1146 episodes of withdrawal care were provided by the three specialist withdrawal services in the ACT (these episodes exclude unreported episodes as referred to previously in this report).

Consistent with the principal drugs of concern among those who received treatment from any AOD service in the ACT, the greatest proportion of withdrawal episodes of care were for alcohol (70%), followed by cannabis (14%), amphetamine (12%) and heroin (4%). (Figure 10).

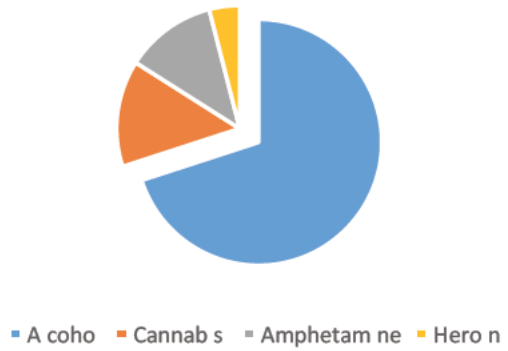

Figure 10. Episodes of withdrawal care by principal drug of concern, 2012-2105.

Completions

There are a number of reasons why service consumers do not complete withdrawal. They may elect to leave the program for personal reasons, they may be asked to leave if they have breached the program rules (e.g. bringing drugs or alcohol onto the premises), or they may be transferred to another service if deemed more suitable. In general, an episode of care is considered complete if the person stays in care for the duration planned.

Among all withdrawal episodes of care nationally in 2014-2015, the completion rate was about 70 percent. In the ACT in the same year, the completion rate was 89 per cent. By substance, the completion rate for alcohol was 95 per cent, 83 per cent for amphetamine, and 87 per cent for heroin. Notably, less than half of all cannabis withdrawal episodes were completed (48%). In contrast, 70 per cent of cannabis withdrawal episodes of care delivered across Australia were completed in 2014-2015. This suggests that there is room for improvement in managing cannabis withdrawal in the ACT.

Overall completion rates for withdrawal in the ACT during 2014-2015 were substantially higher than in the previous year (Figure 11).

Withdrawal Management Treatment Episodes							
Heroin							
2012-13		2013-14		2014-15		2012-2015- 3 year totals	
Number of treatment episodes	Number of episodes successfully completed	Number of treatment episodes	Number of episodes successfully completed	Number of treatment episodes	Number of episodes successfully completed	Number of treatment episodes	Number of episodes successfully completed
18	15	20	9	9	7	47	31
%	83%	%	45%	%	78%	%	66%
Ethanol (Alcohol)							
2012-13		2013-14		2014-15		2012-2015- 3 year totals	
Number of treatment episodes	Number of episodes successfully completed	Number of treatment episodes	Number of episodes successfully completed	Number of treatment episodes	Number of episodes successfully completed	Number of treatment episodes	Number of episodes successfully completed
242	220	320	158	231	220	793	598
%	67%	%	49%	%	95%	%	75%
Amphetamine							
2012-13		2013-14		2014-15		2012-2015- 3 year totals	
Number of treatment episodes	Number of episodes successfully completed	Number of treatment episodes	Number of episodes successfully completed	Number of treatment episodes	Number of episodes successfully completed	Number of treatment episodes	Number of episodes successfully completed
37	32	62	39	36	30	135	101
%	86%	%	63%	%	83%	%	75%
Cannabis							
2012-13		2013-14		2014-15		2012-2015- 3 year	

Figure 11. Number of ceased episodes of withdrawal management against those that had the reason for cessation recorded as 'successfully completed'.

Profile of service consumers

Males comprised 61 per cent of those receiving an episode of withdrawal care between 2012-2015, and the average age across those years ranged from 36-39 years (median 38 years).

The average age range of female service consumers (49% of all consumers) over the same period was 36-40 years (median 36 years).

Aboriginal and Torres Strait Islander people accounted for nine per cent of all episodes of withdrawal care over this time, and had and average age range of 25-27 years (median 21 years).

Referral source

The majority of service consumers self-refer (74% in 2014-2105), while referrals into the service system are received from another AOD

service (7% in 2014-2015), and the justice system (4% in 2014-2015).

Setting

All withdrawal services in the ACT are bed based. Staff of the ADS inpatient program report that outpatient withdrawal services were offered from Building 7 in years past, but staff report it was not well used, possibly because of the lack of public transport to the Canberra Hospital.

Outpatient withdrawal is offered in all other locations around Australia however, and is considered an essential component of withdrawal care as evidenced by Australian guidelines and the peer reviewed literature.

Figure 9 shows the settings for withdrawal across Australia[14] in 2014-2015. The non-bed based (referred to as non-residential) episodes of care for the ACT shown below were provided by the Consultation Liaison team to patients in the hospital.

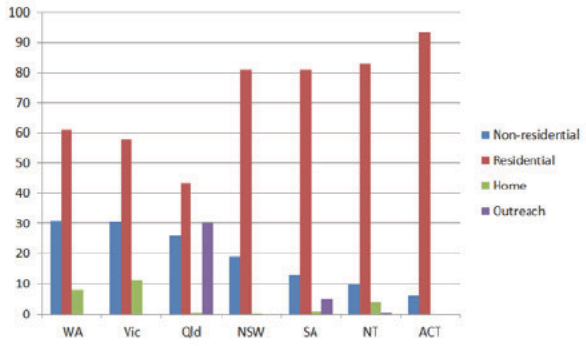

Figure 12. Settings for withdrawal care nationally in 2014-2015
Data source: AODTS-NMDS data cubes

[14] Due to data issues, Tasmanian settings are not shown

Summary.

The specialist withdrawal services system in the ACT comprises three programs; two adult programs and young persons' program. All programs are bed-based, and one provides medication management of withdrawal symptoms.

The service system model is designed predominantly for planned admissions, and the service system performs better than the Australian average against a benchmark of completed episodes of care for all substances other than cannabis. This may be reflective of the planning conducted prior to admission, and the bed based focus of the system.

Most service consumers self-refer, and in the case of the ADS inpatient withdrawal unit, this is largely a requirement.

Most assessments of adults are conducted by telephone, and access is either through a central intake line in the case of the ADS inpatient unit, or by contacting either Directions Health or Arcadia House directly.

The assessment process for young people is generally face to face, and uses flexible systems such as Skype or videoconference for those outside of the ACT.

There are a range of pathways to aftercare following withdrawal including outpatient counselling, case management, day programs, and residential rehabilitation.

The major gap is the absence of a formalised and coordinated program of outpatient withdrawal care that is integrated within the

wider withdrawal service system; a critical component of a stepped care model.

Attachment 5: Consultations.

Between August and September 2016, 360Edge conducted consultations with CEOs, managers and staff of all ACT Health funded specialist ATOD services during site visits to every organisation. Our aim was to determine their views and experiences of the withdrawal services and programs available, and to gain their input on redesigning the service system.

We also consulted with a range of key stakeholders outside of the specialist service system including representatives from Justice Health, Community Corrections, and general practice. ATODA and ACT Health also provided their perspectives to the review as key stakeholders.

The perspectives of consumers were also crucial to this review, so we conducted four consultation groups with service consumers during this time, and spoke to adults and young people about their experiences.

Stakeholders invited to participate are listed here.

Specialist AOD withdrawal service providers:
- Alcohol and Drug Services, ACT Health
- Directions Health Services
- Ted Noffs Foundation ACT

Additional specialist AOD services:
- Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)
- CatholicCare Canberra and Goulburn – Sobering Up Shelter
- Gungan Gulwan Youth Aboriginal Corporation – AOD Programs
- Karralika Programs Inc
- Ngunnawal Bush Healing Farm Aboriginal and Torres Strait Islander Residential Rehabilitation Service
- Salvation Army – Canberra Recovery Services
- Toora Women Inc – AOD Programs
- Winnunga Nimmityjah Aboriginal Health Services – AOD Programs

Other specialist AOD services:
- AOD Policy Unit, ACT Health
- ATODA

Four consumer focus groups were hosted by:
- Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)
- Directions Health Service
- Karralika Programs
- Ted Noffs Foundation ACT

Key Informants:
- Dr Tuck Meng Soo- Practice Principal, Interchange General Practice
- Dr Michael Levy- Director, Justice Health Services
- Janet-Lee Hibberd- General Manager, Community Corrections
- Dr Peter Norrie- Director of Clinical Services and Chief Psychiatrist, Mental Health, Justice Health and Alcohol and Drug Services, ACT Health
- Dr Nadeem Siddiqui- Clinical Services Director, Winnunga Nimmityjah Aboriginal Health Services
- Katrina Bracher- Executive Director of

Mental Health, Justice Health and Alcohol and Drug Services, ACT Health

We summarise our findings in this section, presenting the major themes that emerged from an extensive consultation process.

Strengths of the current system.

Geographically unique

There was wide agreement that the ACT is geographically unique in Australia, service providers are well connected, and the project was thought to offer an excellent opportunity to redesign a strong and responsive AOD withdrawal services system.

Expertise and quality care

Expertise of specialist withdrawal services providers was acknowledged and appreciated by AOD workers, stakeholders and consumers alike.

Adult consumers and young people spoke highly of their experiences of care in all three specialist withdrawal settings.

Some consumers also liked the proximity of the opioid pharmacotherapy program to the ADS inpatient unit for ease of dosing, while others found it uncomfortable to be surrounded by peers during selective withdrawal.

Collaboration

The cooperative relationship between individual workers, services, particularly residential rehabilitation and withdrawal services, was emphasised. Collaboration was considered to be of great benefit to consumers, particularly the practice of coordinating admissions to withdrawal services to coincide with beds being held in residential services. On the other hand, this arrangement had limitations which are discussed in the service issues section.

> “
>
> I don’t think I’d even be here if it wasn’t for this place...
>
> *Young person, consumer*

Positive developments

There was also recognition of the positive changes that have been made to the service system over the years. Expanding the ADS inpatient unit to a seven day per week service was an example, as was the appointment to the unit of the Aboriginal and Torres Strait Islander AOD liaison worker.

The Common Assessment Tool was also seen as a positive development, allowing services to essentially “speak the same language”, however it too had some drawbacks that are described in this section.

Service issues.

Access to services

Waiting lists

There was a general perception that the waiting period for access to the ADS inpatient unit was too long. AOD staff and external stakeholders estimated a wait list of two-four weeks. Consumers reported an average wait of one-two weeks, some of whom appreciated the opportunity to 'prepare', while others felt it was too long as their substance use continued to escalate while their motivation waned.

There was also a perception that there was a waiting list for access to Arcadia House withdrawal beds, while this is generally not the case.

Improved access to information for consumers and service providers on the status of waiting lists is required.

Telephone assessment

The reliance on telephone assessments for access to both adult services was seen as a barrier for many people (e.g. those with no phone credit, flat battery, lost phone). Some consumers also felt that the telephone assessment experience was quite impersonal, while others preferred it as a means to disclose personal information in a non-threatening way. One consumer was at work when the ADS inpatient unit intake nurse called, couldn't proceed with the assessment for privacy reasons, and was anxious about missing the next call and losing the opportunity for admission.

Some service providers felt that a telephone assessment was not culturally appropriate for Aboriginal and Torres Strait islander peoples who prefer face to face contact and a yarning style of sharing information, particularly information of such a personal nature.

Broadening opportunities to account for service consumers who prefer face to face assessment was recommended by the Winstock review and strategies for providing this service should be re-considered.

Admission days

The restriction on days available for admission to the ADS inpatient unit in particular was a strong theme in the consultations. Consumers spoke of the pressures of attending the unit for admission on a specific day and specific time, service providers spoke of the need to re-reserve beds in residential services for consumers that missed their planned date of withdrawal admission. A seven-day admission cycle was widely advocated.

Admission criteria

There was broad opinion among stakeholders and consumers alike that the criteria for admission to adult withdrawal services was too narrow. There was a perception that withdrawal from heroin and other opioids was unavailable in the ADS inpatient unit and consumers indicated that for this reason, people do not seek admission for this in the main.

Stakeholders also spoke of the limitations of the ADS inpatient unit to accept consumers with complex physical and mental health needs due to its geographical dislocation from the main hospital.

There was also a broadly held perception that the ADS inpatient unit did not accept people for admission who did not have an established aftercare plan (usually residential rehabilitation). This was also raised as an issue by the Winstock review in 2008, and was a consideration in recommending the establishment of Arcadia as a transitional (or step-down) program to allow consumers exiting the unit to plan for aftercare. Staff of the ADS inpatient unit report that although consumers are encouraged to have an aftercare plan, it is not compulsory for admission, and data show that about 24 per cent of consumers who completed withdrawal went on to residential rehabilitation in the ACT over the past three years. Clearer communication of the unit's criteria for entry to consumers and the sector is required.

Coordinating care

Holding beds in multiple services

As highlighted elsewhere in this report, consumers are required to undertake a formal process of withdrawal (or detoxification) from alcohol and or other drugs prior to admission for residential rehabilitation. To coordinate care when one program is contingent on the completion of the other, we were informed during consultations with service providers that beds are reserved in the ADS Inpatient Unit for approximately one week and if consumers miss the first admission date in the ADS Inpatient Unit, for four to six weeks in residential rehabilitation services in some cases. Data collection methods were not sophisticated enough to allow us to investigate this 'bed-block' with confidence.

There is considerable pressure on the ADS Inpatient Unit, as consultations suggest some consumers prefer medicated withdrawal over non-medicated (several consumers said that they chose the unit specifically for medication assistance), and the complex needs of some consumers is such that an inpatient stay is required to ensure a non-eventful admission to residential rehabilitation.

Consumers also found the process of juggling consecutive admission dates stressful. One consumer reported leaving the withdrawal unit early - before the symptoms had entirely abated - in order to secure the residential rehabilitation bed on the date it was booked.

Linkages with specialist ATOD community based health centres and primary care

While Arcadia and ADWU each have established links with general practitioners in the ACT, no formal links exist between primary care providers and the ADS inpatient unit. General practitioners are unable to refer directly to the ADS inpatient unit, nor do they have the means to expedite an admission to the unit for patients whose symptoms of withdrawal escalate in the community.

General practitioners would value the opportunity for a two-way dialogue with the ADS inpatient withdrawal unit, including support to manage patients who choose, and are initially assessed as suitable, to withdraw in the community.

Common Assessment Tool

There are pros and cons to the use of the Common Assessment Tool. The main benefit is the ability for all services to standardise consumer assessments, however there is considerable duplication of effort, particularly for services that use an electronic version of the form. In that case, the information must be transcribed onto a paper version and faxed to the ADS inpatient unit. Consumers are required to complete the same assessment again with unit staff, and indeed multiple times if they wish to register for a bed in several residential services simultaneously.

There was general agreement that the Common Assessment Tool requires revision and an update, with a system developed to allow consumers to tell "one story, once".

System gaps

There was general agreement that discrete groups of consumers may not be well served by the current bed based-only withdrawal services system. These groups included:

- the employed, including professional people who want to maintain their privacy
- parents and other full-time carers
- women who have experienced trauma and who are sensitive to being accommodated with males
- partners wishing to enter withdrawal services together
- people who are homeless
- people who want to withdraw from opioids (including those released from the Alexander Maconochie Centre)
- people with mental health symptoms, including younger people experiencing psychotic symptoms as a result of methamphetamine use

Recommendations.

The consultations

By far the most common recommendation made by all groups consulted was the establishment of a formalised non-bed based withdrawal service.

Other recommendations included:

1. Expanding the capacity of the ADS inpatient unit to accept admissions seven days per week.
2. Strengthen pre-withdrawal preparation and planning (e.g. education about withdrawal, assertive wait-list management, treatment matching), and post-withdrawal planning for aftercare.
3. Increase access to withdrawal services for consumer groups considered to be under-serviced by the current service system.
4. Improve linkages with multiple sectors including mental health, justice health, community corrections and general practice.

The second ATOD sector-wide forum

The purpose of the second ATOD sector-wide forum was to consider the interim findings of the review phase of the project, and to begin a co-designed plan for the future.

Attendees envisaged a redesigned withdrawal services system that would include non-bed based withdrawal care.

> People need to be able to enter the system at a place and time that's appropriate for them.
>
> *Specialist ATOD worker*

Their vision was:

- A clearly described, accessible, responsive, coordinated yet flexible services system with multiple entry and exit points, to provide a menu of options for a wide range of service consumers and treatment goals
- Based on a stepped-care model
- Consumer centred and goal driven
- Integrated with primary care
- Evidence based, and routinely evaluated

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