A CASE FOR RESIDENTIAL ALCOHOL AND DRUG REHABILITATION IN DUBBO

DUBBO REGIONAL COUNCIL

Contents

Executive Summary

The prevalence and impacts of alcohol and other drug (AOD) misuse in Australia are well documented. Qualitative and quantitative data in this business case indicates that the Dubbo Regional Council area is disproportionately negatively impacted by AOD misuse. Accordingly, Dubbo Regional Council's *Social Justice and Crime Prevention Working Party* committed to seeking support for the development of a business case for a residential AOD facility in the Dubbo Regional Council area.

Extensive consultation in the broader Dubbo Regional Council area identified common concerns about AOD misuse in the region:

- Alcohol was most commonly associated with problematic AOD misuse in the Dubbo region
- While alcohol and cannabis are the most prevalent substances misused in the area, many stakeholders identified 'ice' (crystal methamphetamine) as the drug of priority concern
- Heroin is still an issue of concern, with concerns about the increased misuse of prescription opioids such as fentanyl and Oxycontin (oxycodone) and other pharmaceuticals.

Aside from the health impacts of AOD misuse, consultation and research identified the relationship between AOD misuse and a range of poor social outcomes for the broader Dubbo region:

- BOCSAR data demonstrates that the Dubbo Regional Council Area has disproportionately high levels of crime, including high levels of property offences and assaults, which are associated with methamphetamine use
- NSW Family and Community Services data for 2016-17 indicates the Western Region, which includes Dubbo and Wellington, reported children at risk at almost twice the rate of NSW that year. Western NSW also has a high rate of children in out-of-home-care.
- AOD issues were identified as a key factor in cases where tenants become, or at risk of becoming homeless after eviction. This occurs due to rental arrears due to funds being spent on AOD misuse, or due to malicious damage perpetrated by a family member affected by AOD
- A number of Dubbo regional stakeholders identified a link between AOD misuse and suicide and self harm.

There was a consensus across stakeholders that an effective residential AOD facility in the Dubbo region should be accessible and inclusive, should cater for both men and women as well as people with dual diagnoses (the co-occurrence of AOD misuse with a mental illness) and people with criminal histories, including those exiting prison. The vast majority of stakeholders, including Aboriginal community leaders, representative and service providers, suggested the facility should be designed for all community members. Aboriginal service providers and community members in Dubbo and Wellington, Corrections and FACS staff and health experts conveyed that AOD misuse is symptomatic of the intergenerational trauma that impacts Aboriginal families and communities. This requires the service to embed cultural safety in every aspect of program design and delivery.

People who live and work in the Dubbo region are seeking a structured rehabilitation facility, that provides pro-active intake support, holistic person-centred rehabilitation and co-ordinated after-care to support successful community reintegration. Dubbo needs a medically supervised rehabilitation service that had provision for withdrawal ('detox') as well as maintenance of pharmacotherapeutic support.

Establishment of a residential rehabilitation in the Dubbo region will require commitment across three levels of government, service providers and potentially business and philanthropic partners. There is an expectation across the greater Dubbo service provider network that the NSW Government should provide recurrent operational costs for the facility. Council has committed to providing land that has the capacity for the initial 15-bed rehabilitation facility and an 8 bed detox facility, with potential to expand at a later date. Research and consultation suggests significant financial as well as social benefits to be gained from the funding of a residential AOD rehab in the Dubbo Regional Council area.

1. Introduction

The prevalence and impacts of alcohol and other drug (AOD) misuse in Australia are well documented, with research demonstrating a strong correlation between AOD misuse and poor health outcomes, injury and deaths, crime and incarceration, violence, family and community breakdown and risks to workplace safety (MCDS in Australia Institute of Health and Welfare 2016). A comprehensive analysis of the annual economic impact of alcohol, illicit drugs and tobacco on Australian society in 2004/05 found that alcohol accounted for costs of $15.3 billion, illicit drugs accounted for $8.2 billion and alcohol and illicit drugs together accounted for another $1.1 billion (Collins and Lapsley 2008:xi). Given the age of this study, it is likely that those costs have significantly increased. Qualitative and quantitative data in this business case indicates that the Dubbo Regional Council area is disproportionately negatively impacted by AOD misuse.

Consultation with close to 150 stakeholders across the LGA suggests the absence of a residential rehabilitation facility in the area is a key contributing factor to the impacts of AOD on the Dubbo community. The nearest residential rehabilitation facility is operated by *Lives Lived Well* in Orange, close to 150 kilometres away. There is such demand for the service that it only maintains a waitlist for two weeks at a time. Consultation suggests the service's exclusion of clients transitioning out of prison means that, even if placements were available, the service model would not meet the AOD support needs of many in the Dubbo community. *Weigelli Aboriginal Corporation* operates a residential AOD facility in Cowra, more than 230 km west from Dubbo. This service also has such a long waiting list that clients in need are asked to call the centre each fortnight to see if a space has become available. Unlike *Lives Lived Well*, Weigelli does not offer withdrawal services ('detox') and does not accept clients on opioid substitution treatment (such as methadone) or people with serious mental health issues. Orana Haven, which is a four-hour drive from Dubbo, offers residential rehabilitation for Aboriginal men and while it does accept clients exiting prison it does not offer detox or accept clients on opioid substitution treatment. While there are some highly respected outreach AOD counselors in the region, they are significantly under-resourced for the potential client base and so are lucky to engage with clients once a fortnight in many instances. Irrespective, community based rehabilitation simply does not meet the needs of people with entrenched AOD addiction issues.

Recognising community concerns about the impact of AOD use on the broader Dubbo community, Dubbo Regional Council's *Social Justice and Crime Prevention Working Party* committed to seeking support for the development of a business case for a residential AOD facility in the Dubbo Regional Council area. Council subsequently engaged Patrick Shepherdson, a crime prevention and community safety consultant, to develop this business case to support a funding bid to the NSW government for the establishment and operation of a local residential AOD facility.

Methodology

This business case was informed by analysis of quantitative and qualitative data exploring the nature, prevalence of and impacts of AOD misuse on the Dubbo Regional Council area and surrounding areas. Consultation was undertaken with 148 people who live and work in Dubbo and Wellington, managers of six existing residential rehabilitation facilities and representatives of Aboriginal communities from the Western NSW region. Stakeholders represented a range of service providers and networks, including health, justice, child and family services, tenancy advocates, disability services, the State Member for Dubbo, Dubbo Magistrate, Wellington interagency, the Three Rivers Regional Assembly Alliance, NSW Local Aboriginal Land Council and Dubbo Regional Council. Consideration was also given to a previous AOD rehabilitation proposal developed by the Cooperative Legal Service Delivery Program as well as submissions to, and transcripts of appearances before the '*Parliamentary inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales*'.

This data was analysed to identify the factors associated with AOD misuse in the region with a view to identifying the critical elements of a residential rehabilitation service model that would meet the needs of the Dubbo community.

Consultation with current residential rehabilitation providers and an extensive review of (predominantly peer reviewed) literature informed the development of the business case, which identifies a suitable service model, therapeutic approach, partnerships, infrastructure needs, basic design specifications, costings and potential funding sources and a risk analysis.

Thanks to the many people who live and work in Dubbo and Wellington and the broader western region, the staff of existing rehabilitation services who generously shared their knowledge and experience and in particular to John Watts and Jason Yelverton of Dubbo Regional Council who provided advice and support throughout the process.

2. The nature and prevalence of AOD use in Dubbo

Analysis of input from stakeholder consultations identified common concerns about the nature and prevalence of AOD misuse in the Dubbo regional area. While key substances of concern are profiled separately, it should be noted though that many services, including those that work with offenders and their families, said that poly drug use was common.

Alcohol

While many stakeholders voiced greater concern about the social impacts of 'ice', it was generally conceded that alcohol was most commonly associated with problematic AOD misuse in the Dubbo region. Alcohol is strongly associated with violent offending, with *Bureau of Crime Statistics and Research* (BOCSAR) data indicating that 23.4% of domestic violence offences and 31.6% of non-domestic violence related assaults in the Dubbo Regional Council area in 2017 were alcohol-related (BOCSAR accessed 2018). Alcohol was identified by health workers in Dubbo as the most common cause of hospital emergency admissions.

Cannabis

Cannabis was commonly considered to be the 2nd most prevalent substance misused in Dubbo, with some service providers voicing concern that it is so normalized that it is not even considered a drug among many people. However, the majority of stakeholders did not deem cannabis a priority concern in the context of other substances. While people with problematic cannabis use engage with outreach AOD counselling support, it was suggested it is not likely to be a key motivator for engagement with residential AOD rehabilitation. This is evidenced in a national study of AOD treatments in Australia in 2016-17, which found that cannabis was more commonly treated as the primary drug of concern in non-residential treatment and outreach facilities, while residential facilities were the second most common treatment setting for amphetamine, heroin and alcohol (Australian Institute of Health and Welfare 2018).

Crystal methamphetamine ('ice')

While alcohol and cannabis are generally considered the most prevalent substances misused in the Dubbo Regional Council area, many stakeholders identified 'ice' (crystal methamphetamine) as the drug of priority concern. *Bureau of Crime Statistics and Research* (BOCSAR) crime data demonstrates a 37% increase in the detection of amphetamine possession offences in the Dubbo Regional Council Area in the five years up until 2017. Aside from devastating effects on health and well-being, methamphetamine is associated with an increased risk of crime, particularly violent crime and property offences (Goldsmid and Willis 2016). The relationship between ice and crime is evidenced in the findings of the ongoing *Drug Use Monitoring in Australia* (DUMA) project finding methamphetamine use among police detainees increased 14% in 2009 to 37% in 2014 (Goldsmid and Brown in Goldsmid and Willis 2016). A national study of AOD treatments in Australia found that between 2012/13 and 2016/17 the number of 'closed treatment episodes' where amphetamine was the principal drug increased by 123% (AIHW 2018).

The Australian Crime Commission has deemed methamphetamine to be 'the illicit drug posing the greatest risk to the Australian community' (Australian Institute of Health and Welfare 2016:7). Staff from programs that conducted urinalysis indicated that polydrug use was common among methamphetamine users, advising that clients commonly tested positive for both ice and cannabis and sometimes clients on methadone were also testing positive for ice. Research by the Department of Health verifies that poly drug use is common for users of methamphetamine (Department of Health 2008).

Opioids and pharmaceuticals

A number of people raised concerns about opioids in the community. Health workers indicated that heroin is still an issue of concern, estimating that 200 of 460 opioid substitution patients in the Dubbo health region based in the City of Dubbo itself. Opioid substitutes, such as methadone and buprenorphine, are most commonly used to maintain people seeking to transition out of heroin and other opioid dependence. Many stakeholders raised concerns about the increased misuse of prescription opioids such as fentanyl and Oxycontin (oxycodone) and other pharmaceuticals. The rising use of prescription opioids in regional Australia was evidenced in the Australian Criminal Intelligence Commission's wastewater analysis, which indicated that prescriptions opioid misuse in regional centres is twice that of some capital cities. The most recent report found that generally heroin use was lower than that of prescription opioids (Australian Criminal Intelligence Commission 2018).

3. The impact of AOD misuse on the broader Dubbo community

Aside from the health impacts of AOD misuse and the significant burden that AOD use places on our health system, consultation and research identifies the relationship between AOD misuse and a range of poor social outcomes for the broader Dubbo region.

Crime

There is a significant body of empirical evidence that demonstrates the relationship between alcohol and drug use and crime (Goldsmid and Willis 2016). Evidence from the *Drug Use Monitoring in Australia* (DUMA) project, which involves self-reporting surveys and urinalysis with police detainees at multiple sites across Australia, provides us with insights into the levels of substance misuse among offenders and the relationship between different substances and specific crime types (Australian Institute of Criminology 2018).

BOCSAR data demonstrates that the Dubbo Regional Council Area has disproportionately high levels of crime. BOCSAR data for 2017 ranks Councils in NSW for 13 of 17 major offence categories. Dubbo Regional Council is ranked in the top 10 Councils in NSW for 7 of those 13 offence categories and ranked in the top 15 Councils in NSW for 10 of those 13 offence categories (Bureau of Crime Statistics and Research 2018). Of note, Dubbo has disproportionately high levels of a range of property offences and assaults, both of which are reported by the Australian Institute of Criminology as being associated with methamphetamine use (Goldsmid and Willis 2016). Alcohol is also commonly associated with assaults. While not included in the '17 Major Offence Categories', BOCSAR data also demonstrates that the Dubbo Regional Council area has experienced a statistically significant increase in the rates of amphetamine possession offences, with an increase of 37% over five years up until 2017 (BOCSAR 2018). The table below summarises data for key offences of interest, detailing:

- The volume of offences in Dubbo in 2017
- The percentage of incidents that were flagged as alcohol-related by NSW Police (where identified)
- The rate per 100,000 population for offences in Dubbo in 2017
- The NSW average rate per 100,000 population for offences in 2017
- Dubbo Regional Council's ranking among all NSW Councils with a population of 3000 or more people (for those offences that are ranked)

BOCSAR reported crime data for 2017 indicates that the Dubbo Regional Council area experienced:

- More than three times the NSW rate per 100,0000 for Break, Enter and Steal (Dwelling) offences
- More than twice the NSW rate per 100,000 for Steal From Motor Vehicle, Motor Vehicle Theft and Malicious Damage offences
- Close to twice the NSW rate per 100,000 for both Assault (non domestic) and Assault (domestic) offences.
- A mental health clinician who works with people engaged in the criminal justice system estimated that 98% of people assessed are AOD users.

Children and families

Consultation with government and non-government child and family service providers indicated that AOD misuse is strongly associated with domestic and family violence and child neglect.

Staff from the *Family Referral Service* in Dubbo advised they receive on average 100 referrals per month and 100% of those would be impacted by AOD issues. Family and tenancy services identified AOD as a factor in most incidents of family violence for their clients. BOCSAR indicates alcohol was a factor in 23.4% of domestic violence incidents in Dubbo in 2017, though it should be noted that domestic violence is significantly under-reported. A major Australian study that utilized data from a national safety survey as well as Police attendance data found that:

- Alcohol was involved in 34 percent of intimate partner violence incidents and 29 percent of family violence incidents; and
- 13% of intimate partner violence incidents and 12% of family violence incidents were drug related (Miller et al 2016).

Nationally there is growing concern about the impact of ice use on child safety, with analysis suggesting a correlation in the increase of children in out-of-home care and the increase in the use of ice in Australia. The number of children in out-of-home-care in Australia increased 33.5% since 2010, while the number of children on care and protection orders increased 45% in that period (Higgins 2018).

NSW Family and Community Services data for 2016-17 identifies the rate per 1,000 of children reported at significant risk of harm. The Western Region, which includes communities from Bathurst to Bourke and Walgett including Dubbo and Wellington, had the second highest rate of the (then) 15 FACS regions in NSW in the reporting period, with a rate of 100.5 per 1,000 compared to the NSW rate of 52.3. The Western Region reported children at risk at almost twice the rate of NSW that year. The Western NSW rate per 1,000 of children in out-of-home-care that year was 23.8 compared to the NSW rate of 11.4 (NSW Government Family and Community Services 2018). Senior officers from Family and Community Services discussed how their client struggle to home detox and undertake rehabilitation in the absence of a local residential rehabilitation. Child and family service providers indicated that access to residential rehabilitation would be critical to the government achieving outcomes against the NSW Premier's Priorities of 'Protecting Our Kids' and 'Preventing Domestic Violence Reoffending' in the Dubbo Regional Council area.

Homelessness and poverty

Staff from the *Western Aboriginal Tenants Advice and Advocacy Service* (WATAAS) explained that AOD issues was a factor in 100% of cases where tenants become or at risk of becoming homeless after eviction. They explained this occurs due to rental arrears due to funds being spent on AOD misuse, or due to malicious damage perpetrated by a family member affected by alcohol and/or drugs. Lifeline financial counselors also advised their clients end up in difficulty due to AOD affected relatives 'trashing' their homes.

Alcohol was cited as the biggest problem related to homelessness but ice was also acknowledged as a growing issue. Homeless NSW research supports WATAAS's staff observation that AOD is a key issue in their clients going to jail, which suggests that AOD issues, along with homelessness or unstable housing 'significantly' increases the risk of reoffending. The Australian Housing and Urban Research Institute also found that homelessness services, AOD services and mental health services shared many of the same clients and were dealing with many of the same issues (Flatau et al 2013).

Financial counselors from Lifeline explained that AOD misuse is not only causing poverty for people who misuse alcohol and drugs, but leads to poverty for their family members. Many of their clients are poor due to being 'humbugged' by drug addicted family members, as well as having items of value stolen by them.

Research undertaken in Dubbo in 2015 into the factors that place young people at risk of criminal justice contact found that the lack of alcohol and drug rehabilitation facilities for adults was a factor in the lack of safe accommodation for some children and families (Shepherdson and Fuller 2015). The establishment of a residential AOD facility in the Dubbo region could assist in outcomes against the NSW Premier's priority of Reducing Youth Homelessness (NSW Government accessed 2018).

Suicide and self-harm

A number of Dubbo regional stakeholders identified a link between AOD misuse and suicide and self-harm. A counselor from Lifeline suggested that 90% of suicide is AOD related, noting that mental health issues were key but AOD is commonly in the system of suicide victims.

The manager of a suicide prevention project in Dubbo estimated that AOD was a factor in about 70% of their admissions for people at risk of suicide but reiterated that AOD was commonly present in the event of suicide. Alcohol was the most common AOD problem related to suicide and self harm but the worker advised there are also issues with ice. A number of Aboriginal workers in the community raised concerns about a perceived increase in suicide in recent times.

The *Australian Bureau of Statistics* 'Causes of Death Australia 2016' report verified that people living with alcohol and drug problems are at higher risk of suicide. The report also demonstrates that Aboriginal and Torres Strait Islander people die as a result of suicide at almost twice the rate of Australia's non-Indigenous population (ABS in Everymind 2017).

Offence	2017 volume in Dubbo	% in Dubbo alcohol-related	Dubbo rate per 100,000	NSW Rate per 100,000	Dubbo ranking among NSW Councils
Steal From Motor Vehicle	622	1.1%	1209.4	504.7	4
Motor Vehicle Theft	220	0.9%	427.8	170.5	4
Break and Enter Dwelling	615	0.3%	1195.8	359.2	6
Assault non-domestic	413	31.6%	803	415.4	8
Assault DV related	404	23.4%	672.8	367.4	14
Malicious Damage	975	7.5%	1895.8	790.2	6
Possess/use cannabis	175	n/a	340.3	331.8	41
Possess/use amphetamine	81	n/a	157.5	Not listed	Offence not ranked

4. What needs to be considered in the design of a residential AOD facility for the broader Dubbo community?

Consultation with 148 people who live and work in Dubbo and surrounds as well as staff of other rehabilitation services identified a number of common issues, priorities and challenges that need to be considered in the design of a residential AOD facility to effectively support recovery for people in Dubbo.

An accessible, inclusive service

Given the significantly higher population of Dubbo compared to many towns in Western NSW, it is no surprise that consultation and available data indicate the greatest need for residential rehabilitation is within the Dubbo Regional Council area. That said, there was consensus among stakeholders including Dubbo Regional Council staff that, given Dubbo is a service hub, a rehabilitation facility should accept referrals from the broader western NSW region.

Aboriginal people who live and work in the Dubbo regional area emphasised the importance of a facility on Wiradjuri country, citing many examples of people who simply will not leave country to engage with essential services. At the time of meeting with Community Corrections officers they told of a client who was likely to return to custody for failing to comply with court-ordered rehabilitation because she would not leave Dubbo to enter a program. There was however common agreement that care needs to be taken to locate the facility out of town. This was to allow clients to focus on recovery away from family and other commitments, to negate access to alcohol and drugs and to avoid community backlash from residents who may not want a facility in close proximity to their neighbourhood. A community survey conducted by the State Member for Dubbo found majority support for a residential rehabilitation but emphasised it should not be located within a residential area.

Throughout consultations transport was identified as an essential element of effective rehabilitation, particularly given the facility will be outside of the CBD. Transport is essential to ensure safety for people exiting prison, as well as people who have home-detoxed or are going through drug withdrawal transport is essential to avoid the risk of them 'busting' and accessing drugs. Research demonstrates that former inmates are particularly vulnerable upon release from custody, with accidental drug overdoses the major cause of death in the first month after release from custody (Merrell et al 2010 in Gisev at al 2015).

There was consistency in the view that the facility should cater for both men and women as well, with fewer residential rehabilitation options for women in New South Wales. The need for rehab for women is evidenced in BOCSAR data, which shows New South Wales has experienced an increase in the female prison population of more than 50% since 2011 (Bureau of Crime Statistics and Research 2018). Safety for women in a mixed gender facility needs to be planned carefully, as research shows that many women with AOD issues and women in the justice system have experienced domestic violence. NSW Health's residential rehabilitation guidelines suggest that programs that cater for moth men and women should ideally have separate facilities for men and women and provide opportunities for women-only groups and activities (NSW Health 2007).

While some people who participated in consultation indicated the need for a rehabilitation facility that caters for women with children and whole families, advice from experienced rehab providers and other experts suggests this may be challenging at the outset. The need for the facility to accept people with criminal histories raises concerns about the safety of children. Family strengthening programs also require a specific skill set and services that cater for couples and families indicated relationship dynamics can negatively impact other clients. Upon establishment, any rehab facility takes time to establish procedures and programs and develop staff capacity and confidence to support the primary goal of AOD recovery. It is suggested that the facility should be designed with pods that cluster separate accommodation for men and women, allowing the re-purposing of pods or building of additional pods that may provide a 'step down' facility for family reunification in future. Staff from family support programs such as the highly regarded Family Investment Model and non-government family and parenting programs indicated willingness to work with clients in a residential AOD facility.

Despite recognition that Aboriginal people would comprise a significant percentage of prospective clients for rehab, the vast majority of stakeholders, including Aboriginal community leaders, representative and service providers, suggested the facility should be designed for all community members. The service will of course need to embed cultural safety in every aspect of program design and delivery (see Trauma-informed, culturally safe therapeutic support section below).

Dual Diagnosis

There was a consensus across a diverse range of stakeholders that dual diagnoses (the co-occurrence of AOD misuse with a mental illness) was prevalent among people who misuse AOD in Dubbo. Health professionals and justice health workers indicated that a significant number of AOD clients have serious mental health issues, including schizophrenia and bi-polar disorder. This is consistent with research by the Australian Institute of Health and Welfare who found that methamphetamine use was 6.1 times as high among people with 'high or very high levels of psychological distress' compared to the general population (AIHW 2016:12). The study also found the misuse of all illicit substances was higher among certain populations including people with a mental illness (AIHW 2016). Service providers and community members indicated that it was important that a residential rehabilitation service in Dubbo accepted clients with diagnosed mental illness.

Criminal histories

Many stakeholders also emphasised that the strong association between AOD misuse and incarceration in Dubbo and surrounding communities requires a rehabilitation service that will accept people transitioning out of custody and other people with criminal histories. Staff from the Wellington Correctional Centre explained the challenge in finding placements in rehabilitation for people who have been court-ordered to enter rehabilitation as a condition of release from prison. At the time of consultation, Corrections staff had 11 inmates from Wellington on the waiting list for a court-ordered placement, but there were a further 43 inmates from Bathurst and Lithgow prisons in need of a residential rehabilitation placement to comply with a court order. Staff emphasised that people transitioning from prison to rehabilitation on a court order were 'a small fraction' of the potential clients, suggesting that 90% of inmates leaving prison would need rehabilitation. Senior staff from Corrections, NSW Health, NSW FACS and the justice sector all emphasised the importance of a residential rehabilitation in the Dubbo region accepting clients exiting prison and other clients with criminal histories. However a number of stakeholders and managers of existing residential rehabilitation facilities stressed the importance of intake procedures that ensured a balance of clients with and without histories of incarceration so as to avoid recreating 'prison culture' in the facility.

Medically supervised withdrawal ('detox') and pharmacotherapeutic support

Consultation identified the need for a medically supervised rehabilitation service that had provision for withdrawal ('detox') as well as maintenance of pharmacotherapeutic support, which includes opioid substitution and other treatments but also mental health medication. The lack of detox options were highlighted throughout consultations, with the 12-bed detox facility at Lives Lived Well in Orange being the closest option for people from the Dubbo region with Sydney as the next option. Staff from NSW Health, FACS and Corrections all referenced a perceived ignorance of good practice medically supported detox among many local general practitioners as a concern that poses a further barrier to safe detox for their clients.

Some stakeholders did not support the idea of rehabilitation that allows opioid and other substitution treatments, which is reflective of the 'abstinence-based' drug treatment philosophy behind 'twelve step' and other rehabilitation approaches. The growth in support for evidence-based practice however has raised questions

about the effectiveness of such abstinence-based approaches. Evidence of abstinence-based approaches is limited by the fact that many 'twelve step' programs such as Alcoholics Anonymous formally don't allow for research into program outcomes (Allan 2016). However, the Cochrane Collaboration, a global independent network of researchers that promote evidence-based medical practice undertook a review and found little evidence of success for group-based twelve step programs. Subsequent research suggested a proven success rate of between 5% and 8% for the approach (Dodes in M McGraw 2018). This is not to suggest that these approaches don't benefit many people as part of a broader recovery plan. However, increasingly evidence suggests person-centred approaches that are flexible and accommodate the recovery needs of a diverse community are more appropriate, particularly for clients living with trauma, cognitive disability and mental illness.

Stakeholders highlighted that there are few rehabilitation facilities that accept patients on methadone, buprenorphine and other opioid substitution treatments and that the majority of stakeholders in the Dubbo recommended a facility that supports recovery for people with different needs. Accordingly, it is argued that a rehabilitation facility should provide for pharmacotherapy if it is to meet the needs of the broader Dubbo community. This is consistent with NSW Health rehabilitation guidelines, which recognise that many treatments are 'an aid to abstinence' and that some clients 'may be helped by combining residential treatment with maintenance pharmacotherapy' (NSW Health 2007:40). Current trials of 'N-Acetyl Cysteine (NAC)' as a treatment to reduce cravings and support people to cease using ice suggests there may soon be a pharmaceutical ice substitution treatment. This strengthens arguments for a medically supervised rehabilitation service given the levels of ice use in the Dubbo region (National Drug Research Institute 2018).

Many health professionals and other stakeholders recognised that some people are not able to engage with residential rehab due to family commitments or other issues. It was suggested that there is a need for access to range of detox options, including ambulatory detox, and also for a broad education strategy to address the apparent gaps in knowledge of good detox practice among general practitioners in the region.

Supportive intake, holistic person-centred rehabilitation and after care support

It is clear from analysis of consultations that people who live and work in the Dubbo region are seeking a structured rehabilitation facility, that provides pro-active intake support, holistic person-centred rehabilitation and co-ordinated after-care to support successful community reintegration.

In-take processes, which could be undertaken by rehab workers if the facility is adequately staffed, would seek to build trust to encourage clients to feel safe engaging with rehabilitation. This would also support clients to overcome a number of barriers that were identified to people engaging with rehabilitation, including housing arrangements, child care and transport.

The concept of holistic, person-centred rehab is consistent with evidence that AOD misuse is symptomatic of underlying social and psychological causes, including mental health and primary health issues, trauma, poverty, criminalization and social marginalization (Australian Medical Association 2017). NSW Health rehabilitation guidelines suggest 'multidimensional' treatment that involves therapy, education, nurturing of values and skill development (NSW Health 2007:25). They encourage programs that are flexible and tailored to the individual, especially for people with dual diagnoses (NSW Health 2007:35). Many stakeholders, including family and parenting program coordinators, financial counselors and tenancy support workers indicated willingness to deliver programs and support within a rehab facility. It is common for vocational skills and employment programs to partner with rehab providers so that clients can transition to employment in the community.

Many stakeholders emphasised that co-ordinated after-care is as important as the residential rehabilitation component of recovery. This would involve linking clients with outreach AOD counselors, other health service providers, working with them to ensure stable housing and welfare and linking them with men's groups, women's groups and other cultural supports. Given the geography of potential clients and the fractured nature of service delivery in Western NSW it is recommended that two dedicated after-care support workers be funded. After care workers can also monitor client outcomes which is a requirement of some Commonwealth AOD funding streams.

Trauma-informed, culturally safe therapeutic support

Aboriginal service providers and community members in Dubbo and Wellington, Corrections and FACS staff and health experts conveyed that AOD misuse is symptomatic of the intergenerational trauma that impacts Aboriginal families and communities. This echoes research by The Aboriginal and Torres Strait Islander Healing Foundation that explains intergenerational trauma as being the result of the cumulative impact of dispossession, child removal and other past and present government practices (The Healing Foundation et al 2017). In some instances this has eroded cultural identity and connectedness, manifesting in family breakdown, entrenched disadvantage, substance misuse, violence, offending and incarceration, child abuse and neglect. Research demonstrates Aboriginal people are disproportionately impacted by AOD misuse (Australian Institute of Health and Welfare 2016). The Orange Lives Lived Well rehab confirmed that more than 50% of their clients are Aboriginal. This suggests that a rehab in Dubbo will need to provide cultural safety for Aboriginal people, which requires recognition of Aboriginal healing approaches that balance therapeutic support with strengthening of cultural identity and connectedness. This can be achieved through the recruitment and professional development of Aboriginal staff, consideration of Indigenous culture and country in the design of the premises, strong partnerships with Aboriginal health, community networks and other support services and the inclusion of Aboriginal cultural healing programs within the service.

Research though suggests that trauma, triggered by different factors, is a common reality for other people in the criminal justice system and people with mental illness and cognitive disability. Trauma expert van der Kolk observed 'People with childhood histories of trauma, abuse and neglect make up almost our entire criminal justice population' (van der Kolk 2005). This suggests a rehab facility in the Dubbo region should adopt trauma-informed therapeutic approaches, with NSW Health AOD experts recommending approaches that draw from dialectical behaviour therapy. This is a narrative, cognitive behavioural psychotherapy approach that creates safety for people with trauma, mental illness and cognitive disability who may lack emotional regulation (Grohol 2018). Other theoretical practice frameworks, such as compassion-based therapy which is based in neurobiological theories of attachment, can nurture pro-social contact and behaviour for people who may lack pro-social connection (Gilbert 2009).

5. A residential AOD rehabilitation service model for Dubbo

As stated a three-staged approach to support AOD recovery is recommended for the Dubbo Regional Council area:

Supportive, inclusive intake

Inclusive program criteria is encouraged to ensure the program is accessible to men and women with mental illness, those who need to sustain pharmacotherapy, people with cognitive disability and criminal histories, including those exiting prison. There are precedents for rehab providers that implement client risk assessment on a case-by-case basis rather than adopt extensive exclusion criteria. Assessment and intake processes should seek to maintain a balanced dynamic that supports recovery, avoiding a disproportionate number of high needs clients at any one time. Corrections staff encouraged care to avoid concurrently accepting clients with histories of drug-using, co-offending or other problematic behaviour together. Other rehab providers encouraged careful consideration of concurrently accepting clients who are in or were in

a relationship, are related or whose interaction could be detrimental to the recovery of other clients.

Effective in-take should seek to overcome identified barriers to engaging in rehabilitation, which include sustaining housing, support to arrange child care, transport to the facility and pre-entry engagement with clients transitioning from custody. It is recommended that the staffing structure allow for rehab workers to support clients to:

- Access provisions from NSW Family and Community Services which provide for absence of up to 6 months from public housing to enter rehabilitation, $5 minimum rent during rehabilitation and other housing options
- Work with client who have dependent children to explore options for child care support while in rehabilitation
- Support those that need to undertake detox prior to rehabilitation
- Provide transport to enter rehabilitation for people in the Dubbo area and negotiate with partner agencies such as Aboriginal Medical Services and NGOs to coordinate transport for people from outside Dubbo
- Undertake regular visits to build trust with clients in Wellington Correctional facility prior to their release and provide transport upon release to maximise their engagement in rehabilitation.

Holistic, person-centred AOD recovery

The 'in-reach' residential rehab component should provide person-centred support for individuals to not only manage cravings and/or triggers for AOD use, but to address the factors that underlie addiction. A partnership with a GP could facilitate on-site pharmacotherapeutic support if the service is not able to employ an addiction medicine specialist, though there is potential for such a position to support clients in detox as well as those in rehab.

Best practice models provide access to both one-on-one counselling support, which could be provided by allied health professionals engaged with brokerage funds, as well as group work, which could be supported by rehab workers with counselling qualifications and experience. Aboriginal rehab workers could facilitate Aboriginal specific men's and women's groups with support from Aboriginal cultural knowledge holders, cultural practitioners and expert service providers. Research suggests group can provide an ideal context for strengthening cultural identity and connectedness, behaviour change, developing communication skills, parenting skills, understanding intimacy and respectful relationships and anger management (Healing Foundation et al 2017). Consultation in Dubbo and Wellington suggested potential for support in rehab from a range of service providers, including financial and gambling counsellors, grief and loss counselors, Wellways, housing providers, Ability Links, Shine for Kids, Beyond Barbed Wire, as well as NGOS that can deliver classes in cooking and nutrition, healthy lifestyles, fitness and relaxation techniques and other issues.

Consultation with existing rehab providers revealed there is a strong focus on education, vocational skills development and employment pathways in residential rehabilitation facilities. Program providers provide literacy and numeracy education and partner with TAFE and other further education providers to build vocational skills in computer literacy, small motors, carpentry, operating machinery, agriculture, art and print- making, basket weaving and didgeridoo making. A number of stakeholders suggested the opportunity for pathways into employment, citing local companies including Fletcher who provide opportunities for people with criminal histories and other barrier to mainstream employment.

Advice from therapeutic service providers suggests that exit-planning should commence with clients from the moment they enter rehabilitation. This can require rehab workers to provide casework support, linking clients with a range of service providers to ensure stable housing, health support, welfare or employment pathways and other supports to enable successful transition. This ideally involves workers from programs engaging with clients in rehabilitation to build trust so they are more likely to connect when they exit.

After-care to support community reintegration

NSW Health rehabilitation guidelines highlight the importance of establishing links between clients and 'continuing care services and support networks' (NSW Health 2007:27). It is recommended that a male and female after-care worker be recruited to support a smooth transition from rehabilitation to community-based after-care. This is particularly important for clients who will be leaving Dubbo to return to other communities.

A range of partners indicated willingness to support clients post release with others identified as being crucial to successful reintegration, including:

- Aboriginal Medical Services
- outreach AOD counsellors, including Salvation Army, Lives Lived Well, Royal Flying Doctors, Wilberforce Foundation
- Aboriginal Housing and community housing providers
- job service providers and TAFE
- Aboriginal men's and women's groups, Men's Sheds and mums and bubs groups
- AA and NA groups.

A number of existing AOD service providers and Aboriginal health workers indicated that some people will need to relocate after residential rehabilitation if they want to remain free of harmful AOD use. This is especially for clients who live in communities where AOD misuse is common among family and friends. This suggests that a strong partnership with community housing providers will be a crucial element of successful reintegration for rehab clients.

6. Infrastructure, staffing and operational costs

Establishment of a residential rehabilitation in the Dubbo region will require commitment across three levels of government, government and non-government service providers and potentially business and philanthropic partners. Consultation with a number of other rehab providers suggest this is essential as there is no single stream of funding that will cover all costs related to a residential AOD facility. Recent media statements from the local State Member suggest the NSW government will look more favourably on proposals that demonstrate collaborative public/private partnerships. However advice from existing service providers is that, should NSW Government support the establishment of a rehab in Dubbo, a tender process would require potential providers to submit proposed service models within a specified budget. Nonetheless cost estimates for the recommended model have been developed based on information from existing rehab services, advice from managers of residential programs for people with complex support needs and NSW research that sought to establish standardized costing for residential rehabilitation.

Infrastructure:

Land

Dubbo Regional Council has committed to providing a land package to accommodate a residential facility within the LGA. A location will be chosen that has the capacity for the initial 15-bed rehabilitation facility and 8 bed detox facility, with potential to expand at a later date. The property will be outside of the CBD for reasons outlined. Council has also committed funds to support rezoning of the land to enable the AOD facility to operate.

Capital works – Specifications

Consultation with existing service providers and advice from council's Property Development Officer indicates that a professional builder would have to be engaged to scope specific costs for the capital works. However advice from existing service providers suggests the costs of building a residential facility with capacity for 15 rehabilitation patients and 8 detox patients would be in the vicinity of $5 million. While the Commonwealth government has previously funded the capital costs for establishing residential rehabs, advice from senior Commonwealth staff suggests capital costs are no longer funded. Advice suggests NSW government is also reluctant to cover capital works. There are some precedents were rehab providers have funded capital works as part of long term funding agreements. There is also potential for philanthropic support, with two philanthropic organizations currently investing in strategies to improve justice outcomes for Aboriginal people in Dubbo, Bourke and other western communities.

Details of the specifications for the proposed facility are attached at Tab A.

Staffing

Prospective rehab service providers will develop their own staffing proposal, but other services suggest the core staffing for the rehab component would include at least a Manager, a Senior Counsellor/Caseworker,

3 Rehab workers, a male and a female after care coordinator, an administration officer, a cook and a maintenance/programs officer. Most services have 'stand up' staff overnight.

Care should be taken to recruit suitable Aboriginal rehab workers with other services suggesting people should be recruited for integrity and suitability along with appropriate life experience primarily, with the option of engaging in professional development if they don't have minimum mental health qualifications. NSW Health staff suggested Indigenous Psychological Services vocational programs could support professional development. A national study of AOD treatment in Australia in 2016-17 found that males accounted for 66% of all clients receiving AOD treatment that year (Australian Health and Welfare Institute 2018). On that basis, it is suggested that 2 Aboriginal male and one Aboriginal female rehab worker be recruited. Aboriginal people should be strongly encouraged to apply for all positions in the facility.

The detox unit requires 24/7 qualified medical staff, with other services employing a full time psychologist in addition to a clinical nurse, though advise suggests there could be economies of scale with medical staff shared across rehab and detox. Advice suggests a detox unit with 8 beds would require 7 – 8 FTE staff.

Operational costs

Rehabilitation

Research and consultation revealed there is no consistent funding model or staff to client ratio for residential rehabilitation in New South Wales or elsewhere. Similarly, user pay fees varied across providers that were consulted, as did the streams of government funding that supported them. The table below provides a snapshot of five residential rehabilitation services and their operational budgets, which excludes rental costs for facilities unless otherwise stated. Most of these programs are funded by government and supplemented by client fees, Medicare rebates and in some instances philanthropic contributions. Research found that the average income from government for a residential rehab in NSW was around 78% (NSW Department of Health 2005). It should be noted that for government supported facilities, user fees do not cover all costs and are supplemented significantly by government funds.

A number of community members and Corrections staff suggested Dubbo would require a rehab facility with large capacity. However consultation with existing rehabilitation services, mental health facilities and other health professionals suggests the rehabilitation component of the facility should initially be capped at 15 (with a separate 10-bed withdrawal unit detailed below). A budget of $1.5 million is suggested to enable a facility that can provide addictions specialist medical support and accredited psychological services for clients with dual diagnosis. While this model does require a higher budget than some 'therapeutic community' models, research that shows service models that provided individual counselling, had adequate levels of therapeutic staff, had lower counselor caseloads, better staff to client ratio, fewer beds and single rooms resulted in better client retention and program completion rates (Meier and Best 2006).

The following proposed budget breakdown draws from a NSW guideline on residential rehabilitation funding models (2005) as well as the advice of some current rehab providers. Note that additional funds to enhance allied health and provide life skill programs could be obtained through a user fee of 75% of welfare payments, and potentially from Commonwealth Primary Health Network and other funding streams.

There is an expectation across the greater Dubbo service provider network that the NSW Government should provide recurrent operational costs for the facility. This budget does not allow adequate Social and Emotional well-being support, but advice from the Commonwealth suggests that funding may be accessible to supplement core funding with funds for additional SEWB support, cultural programs and possibly allied health support. It was suggested that agencies including Family and Community Services and the Magistrates Early Referral Into Treatment (MERIT) program would 'buy' beds if a residential rehab was established. While this would provide necessary funding enhancement, care should be taken to ensure this doesn't result in beds that could otherwise be utilized remaining empty.

Withdrawal facility ('detox')

Withdrawal ('detox') facilities are comparatively costly as they require 24/7 staffing by health professionals. Advice was provided on the costings of two such services:

- One service provides 12 detox beds at an estimated annual cost of $1.6 million. This provides 9.6 full time equivalent staff.
- Another service provides 4 'high needs' detox beds at an estimated cost of $600,000 $700,000. Staffing numbers could not be confirmed.
- While potential service providers would be invited to develop a service model within a prescribed budget it is anticipated that a detox facility for 8 clients would cost in the vicinity of $1.2 million.

	Annual operational budget	Capacity	Staffing	Eligibility	User costs
A	$1.2M	15 (men and women)	6.5 FTE + psychologist and GP brokered	Accepts dual diagnosis; Does not accept inmates exiting prison; GP's supervise pharmacotherapy on site.	$240 per week
B	$1.5M (includes lease)	18 (14 men + 4 women)	12 – all staff minimum Cert 4 in Mental Health	Accepts dual diagnosis, inmates exiting prison, most criminal histories. Does not support pharmacotherapy.	75% of welfare
C	$1.1M	18 beds – men only (share rooms)	11 including 2 counsellors	Accepts dual diagnosis, inmates exiting prison, most criminal histories. Does not support pharmacotherapy	$200 per week
D	$1.2M (estimated)	10 beds	Not stated	Accepts dual diagnosis, inmates exiting prison, most criminal histories. Pharmacotherapy support unknown.	Not stated
E.	$2.2M (includes operational costs for farm)	8 beds for men and women	6 staff	Not stated	Free of charge

Indicative Rehabilitation Budget breakdown

Item	Comment	Eligibility
Salaries and related expenses	65%	Salaries and leave entitlements for Mgr, rehab workers, admin officer, cook & maintenance staff
Staff development and professional support	10%	Includes training courses, membership of professional associations, clinical case practice and professional supervision
Health brokerage/contract funds	8%	For allied health and GP support (offset my Medicare)
Food and sundries	10%	
Administration, office supplies, IT insurance & miscellaneous program costs	3.5%	IT equipment depreciates over 4 years
Utilities, maintenance and vehicles	3.5%	Water, electricity, vehicle hire and fuel (grounds/maintenance staff in salaries budget)

7. Summary of costs and cost benefits, funding options, governance, partnerships, risk analysis and evaluation

Summary of AOD Rehabilitation costs, funding options and potential cost benefits:

Item	Cost estimate	Potential funding source(s)
Land (including rezoning and development application)	$700,000	Commitment from Dubbo Regional Council
Facility – capital works (15 bed rehab and 8 bed detox)	$5 million	Contributions from rehab service provider; philanthropics; Commonwealth and State
Recurrent operational costs - rehab	$1.5 million + annual 2.5% CPI – recurrent	NSW Government
Recurrent operational costs – detox	$1.2 million	NSW Government
Additional program costs – additional Allied Health support, resources for life skills and cultural programs	To be confirmed	Commonwealth Government (Primary Health Network, Prime Minister and Cabinet) Client user fees

Cost benefits

A number of studies suggest significant costs benefits from rehabilitation as a means of breaking the costly cycle of repeat incarceration.

Analysis of data from 2014 concluded that the cost of imprisonment for one individual in Australia was $109,500 per year (Bushnell 2017). By contrast, 2010/11 data analysis by that National Council on Drugs published in 2012 indicates the average costs of treating a person in residential drug treatment was then $16,110 (ANCD 2012 in Smith et al 2014). Allowing a CPI increase of 2.5% per year, that figure would increase to approximately $17,348 for the 2013/14 financial year. While residential rehabilitation placements are ordinarily significantly shorter than a year (commonly 12 weeks), residential rehabilitation is still significantly cheaper than prison. With research suggesting a relapse rate in the vicinity of 50% (Lee 2018), this still suggests 50% of people successfully recover from addiction through residential treatment.

An Australian Institute of Health and Welfare study found there were 13,849 public hospitalizations and 6,928 private hospitalizations in 2010-11 due to a principal diagnoses related to illicit drugs alone. (Smith et al 2014). With the average cost of a stay in public hospital at that time estimated at $4,649, cessation of harmful AOD use can have significant savings in terms of health, as well as policing, courts, and corrections among other positive outcomes.

Deloitte Access Economic undertook a cost-benefit analysis of the impacts of residential rehabilitation on Aboriginal people with problematic AOD misuse. That study, published by the Australian National Council on Drugs, found savings of $111,458 per offender, in addition to improvements in health and mortality, by diverting offenders from prison to community-based rehabilitation (Deloitte Access Economic 2013). This suggests significant financial as well as social benefits to be gained from the funding of a residential AOD rehab in the Dubbo Regional Council area.

Governance and partnerships

A number of people, including Aboriginal health professionals and community leaders stressed the importance of a quality service being run by experienced professionals, as opposed to a 'community' rehab model. While it is expected that the lead agency should be selected through a competitive tender process, there is potential for a consortium advisory group comprising program partners. This would include partners whose support is essential to successful AOD recovery and community reintegration. This would include social housing providers, AMSs and other primary and mental health services, child and family services, Community Corrections and employment providers.

Risk analysis

A number of risk factors have been considered in the design of this business case.

Given the suggestion that the facility will accept male and female clients and clients with diagnosed and undiagnosed mental illness, cognitive disability and offending histories, a risk assessment process will need to be established that considers the safety of all clients and workers at intake. This includes women and others who may have experienced violence. Current rehab providers indicated that there are challenges in accessing all necessary information to support an informed client risk assessment.

The prevalence of trauma among clients creates a risk of staff experiencing vicarious trauma. This should be factored into a sound staff safety plan, with staff clinical supervision, general supervision and employee assistance program. Growing recognition of the benefits of staff with lived experience suggests that care must be taken to ensure that any staff who themselves have recovered from AOD addiction are supported and not at risk of experiencing relapse.

Research highlights that residential health facilities can be vulnerable to crimes including assaults (both within premises and in car parks), thefts and in particularly drug theft. All AOD treatment facilities require secure perimeter restricting unauthorized access and comprehensive surveillance (both natural and electronic) to negate the risk of people entering the premises (eliminating efforts to steal drugs and/or deliver drugs to patients). Further, the prevalence of dual diagnoses (mental illness and addiction) and the effects of withdrawal from certain drugs and alcohol require a facility that eliminates opportunities for suicide and self-harm, avoiding potential hanging opportunities, suicide-jump opportunities and ensuring surfaces are smooth (so that ropes and other materials cannot be attached). Residential rehabs draw from principals that guide security in hospitals and mental health facilities. It should be noted that rehabilitation is voluntary and so patients are free to move in and around the facility (rooms are not locked). Generally, secure design principles for a residential rehabilitation can be drawn from Crime Prevention Through Environmental Design (CPTED) principals, giving consideration to:

- Access control – limiting access points and influencing movement in and around spaces
- Surveillance – maximizing surveillance of the entire building, both inside and out, by promoting clear sightlines, adequate lighting, good landscaping,eliminating hiding spaces and ensuring that CCTV can effectively monitor both inside and outside the facility and grounds
- Territorial reinforcement – ensuring staffed areas provide oversight and can monitor patient areas and that signage and design send cues to ensure spaces are used for legitimate purposes (Atlas 2013).

Evaluation

While evaluation is likely to be a requirement of any government funding agreement, ideally a rehab service provider will develop a Program Logic so that program inputs, goals and outcomes can be clearly measured. This should reflect the holistic nature of the proposed service, considering outcomes beyond AOD use to reflect the goals of behaviour change, strong cultural identity and connectedness, social and support service connection, parenting skills and family relationships, pathways to employment, stable housing and offending behaviour. Note though the employment of after-care workers who can maintain contact with clients will be essential to monitoring client well-being after exiting the residential component of recovery. Any evaluation framework should also be mindful that the completion rate for all types of AOD treatment is in the vicinity of 65% and the relapse rate after treatment is in the vicinity of 50% (Lee 2018). Given the likely significant number of clients with dual diagnosis, cognitive disability, trauma and offending histories, success rates from a client's first attempt at rehabilitation may be lower.

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Tab A – Design specifications for proposed rehab and detox facilities

Perimeter
- Single/limited vehicle access
- Security fencing/lighting/CCTV
- Significant frontage/boundary setbacks for surveillance

Residential Rehabilitation
- Car parking for staff/visitors/buses/emergency vehicles
- Administration building - possibly central
- Staff rooms/amenities/night quarters
- Commercial kitchen
- Dispensary
- Consultation rooms - 2 rooms
- Residential Buildings - 15 Rooms/Beds
- Central shared gender-specific amenities/facilities/gym/recreation areas
- Large multi-purpose space
- Outdoor weatherproof space
- Area for expansion

Separate Detox Facility
- Residential Buildings – 8 - 10 Rooms/Beds
- Consultation Room - 1 room
- Central/shared amenities/facilities/recreation areas
- Area for expansion

Landscaping
- Courtyards
- Healing Garden (to be designed and established with Aboriginal clients with support from community members)
- Working gardens & possibly agricultural fields
- Maintenance/grounds keeping/farming facilities

Design Principles
- Safe healthcare facility design (suicide prevention)
- Commercial food design - public health
- Fully disabled accessible
- Secure Design & Surveillance - CPTED (possibly even reference to prison design principles for surveillance).
- Indigenous design principles - views/cultural features

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