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Submission to: Responding to the Problem of Recidivist Drink Drivers

It is our belief that Tasmanian community sector organisations contribute effectively to addressing this problem in the community and that there are solutions to this seemingly intractable problem.

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Alcohol, Tobacco and other
Drugs Council Tasmania Inc.

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The Alcohol, Tobacco and other Drugs Council

The Alcohol, Tobacco and other Drugs Council of Tasmania (ATDC) is the peak body representing the interests of community sector organisations (CSOs) that provide services to people with substance misuse issues in Tasmania. The ATDC is a membership based, independent, not-for-profit and incorporated organisation.

The ATDC is the key body supporting the sector to secure adequate systemic support and funding for the delivery of evidence based alcohol, tobacco and other drug (ATOD) initiatives. We support the sector through training and sector capacity building, as well as undertaking policy and development projects with, and on behalf of, the sector.

We represent a broad range of service providers and individuals working in prevention, promotion, early intervention, treatment, case management, research and harm reduction.

We play a vital role in assisting the Tasmanian Government to achieve its aims of preventing and reducing harms associated with the use of alcohol, tobacco and other drugs in the Tasmanian community.

By working with all levels of government and the community the ATDC seeks to promote health and wellbeing of all Tasmanians through a reduction of the harms caused by substance use. Our priorities are set by the membership and Board and focus on the prevention of the uptake of harmful alcohol or drug use, the provision of effective treatment for alcohol or drug misuse and the long term promotion of health and relapse prevention.

A broad and regionally dispersed membership base ensures the ATDC maintains a strategically relevant position within the overall understanding of what services are provided, what services are needed and how best to achieve the goal of reducing the negative impacts on the Tasmanian community from alcohol and drug use.

The ATDC is committed to the following eight broad principles:

- Harm minimisation
- A population health approach
- A continuum of service types
- Consumer participation
- Consumer self determination
- Evidence based practice and policy
- Partnership and collaboration
- Recognition of Aboriginal and Torres Strait Islander Australians.

Our Submission: key messages

- Staff in our community sector organisations (CSOs) are experienced in treating people with a substance use disorder connected to alcohol and who also have repeat drink driving offences.
- There is no 'one size fits all approach' to working with such presentations. The myriad of issues that present alongside an alcohol use disorder means that treatment is often about 'finding out what is going on underneath an alcohol use disorder'. Finding the key motivator/s for each individual is the key to behaviour change.
- Staff employ an eclectic range of tools and approaches; including one to one counselling and group therapy and use clinical approaches such as motivational interviewing, cognitive behavioural therapy and mindfulness, to name only a few. Moreover, case management, support services, and, referrals, connections and collaborations with allied health and welfare workers, are required to respond holistically to complex presentations.
- Specific drink driving safety measures are incorporated into treatment approaches.
- There are minor differences in treating mandated and voluntary clients.
- CSOs conduct evaluations on treatment outcomes and report 'success'; defined in this context as abstinence or reductions in drinking levels and change to drink driving behaviours. As each presentation is unique, the nature of each outcome is different.
- Any further increase in treatment places in CSOs will require careful and strategic investment.

Each of the above points is expanded upon in the section 'Treatment of recidivist drink drivers in the Tasmanian Community Sector'.

Consultation process

Following a review of the paper produced by the Tasmania Law Reform Institute, *Responding to the Problem of recidivist Drink Drivers*, it was decided to provide additional information to that provided in the paper on treatment of people with a substance use disorder related to alcohol and who had repeat drink driving offences. It is our belief that Tasmanian CSOs contribute effectively to addressing this problem in the community and that there are solutions to this seemingly intractable problem.

In July 2017, the Policy and Research Officer invited ATDC members to participate in this submission process. Consequently, six alcohol and other drug (AOD) workers from the following organisations participated:

- Youth Family and Community Connections,
- Drug Education Network
- Salvation Army Bridge Program
- Missiondale (Launceston City Mission)
- Holyoake (2 workers consulted).

The consultations ran for approximately one hour each and focused on gathering 'practice wisdom'. Specifically the conversation was geared around the following questions:

- How do you treat this group?
- What works and what doesn't?
- How does treatment change if the participant is not voluntary but mandated to attend?

- Are there any safety provisions around drink driving built into your treatment approach?

Treatment of recidivist drink drivers in the Tasmanian Community Sector

We are already treating this group: staff in our community sector organisations (CSOs) are experienced in treating people with a substance use disorder connected to alcohol and who also have repeat drink driving offences.

All six AOD workers interviewed for this submission process reported working regularly with people who had a substance use disorder connected to alcohol and who also faced multiple drink driving charges. This means our staff are already working with this population as part of their treatment loads. Staff interviewed for this submission worked in community contexts, meaning in organisations across Tasmania and outreach settings (for example: running group counselling sessions in the prison). Staff who provide treatment in CSOs have a mixture of qualifications and experience subject to their role. Senior practitioners often have a degree in psychology or social work, while others have a Diploma in Community Services with additional post-grad counselling diplomas. All CSOs are deeply committed to ongoing professional development and reflective practice processes.

There is no ‘one size fits all approach’ to working with such presentations. The myriad of issues that present alongside an alcohol use disorder means that treatment is often about ‘finding out what is going on underneath an alcohol use disorder’. Finding the key motivator/s for each individual is the key to behaviour change.

“Unless you address trauma then things are not going to change, what is needed is a holistic approach, you need to focus on everything that is going on for the client”

All AOD workers interviewed overwhelmingly agreed that each client presentation is distinct and so therefore they adopt a ‘client or person centred’ approach. This is a distinct philosophical approach to service development and delivery that means that services are geared in a way that is respectful and responsive to the preferences, needs and values of people accessing the service and their family and friends.

Person-centred care is a way of thinking and doing things that sees the people using health and social services as equal partners in planning, developing and monitoring care to make sure it meets their needs. This means putting people and their families at the centre of decisions and seeing them as experts, working alongside professionals to get the best outcome.¹

It is a way of thinking that sees the client as a resource for understanding and driving behaviour change. It sees the practitioner acting in partnership with the client to find the best way forward, rather than a paternalistic model where the practitioner directs or prescribes actions.

With the above in mind, our AOD practitioners conduct holistic assessments that include examining, to name but a few, alcohol and drug use, physical health, medication intake, sleep patterns, dietary intake, children and family dynamics, accommodation issues, legal and justice charges (drink driving charges arise here); screening for mental

¹ Health Innovation Network, *What is person-centred care and why is it important*, accessed from http://www.hin-southlondon.org/system/ckeditor_assets/attachments/41/what_is_person-centred_care_and_why_is_it_important.pdf on 2/8/2017

health issues, violence incidents, suicide risk, and an assessment of any existing trauma. All of these factors (and more) can impact on alcohol use and consequently problematic behaviours that arise.

The end result of this assessment stage is a profile unique to each client that outlines the underlying issues that may explain how the person has reached the point that they have. From here, a treatment regime is designed in concert with the client. This will most likely include a combination of clinical and support services as well as external case coordination with other allied health and welfare service providers to address the combination of needs that present. It was unanimously agreed that determining the underlying issues, in concert with the client, is the key factor to behavior change.

Staff employ an eclectic range of tools and approaches; including one to one counselling and group therapy using clinical approaches such as motivational interviewing, cognitive behavioural therapy, mindfulness, to name only a few.

“It’s the combination that works. You see individual issues like trauma addressed in one to one sessions while the group acts as motivation to change, as new people can see others who are already down the journey further than they are and who have made lots of changes.”

The role of an AOD worker was described in consultations as essentially an agile practitioner who selects approaches from an eclectic array of clinical tools, support services and who also connects, collaborates and refers with and to external providers. Counselling can occur both in individual and group settings. As per the opening quote to this section, it is the interplay between both methods that is key in driving meaningful change.

Counselling, education and practical support are the cornerstone of treatment in the AOD sector. The primary counselling tools used included:

- Motivational interviewing
- Cognitive Behavioural Therapy
- Mindfulness

Underpinning counselling in many settings in our AOD sector in Tasmania is the idea of ‘harm reduction’ (often interchangeably used with the term ‘harm minimisation’), whereby the focus is not necessarily on achieving abstinence, rather it is about reducing the harm associated with substance use. Whether the goal is abstinence or the reduction of harm through decreases in drinking levels, this will be dependent on the presenting issues. Some clients will want and require a harm reduction approach, but if they have a dependency on alcohol, this approach may not be feasible.

Residential rehabilitation services (The Salvation Army Bridge Program in Hobart and Ulverstone, Launceston City Mission’s Missionsdale in Evandale) employ the therapeutic community model:

A therapeutic community is a treatment facility in which the community itself, through self-help and mutual support, is the principal means for promoting personal change. In a therapeutic community, residents and staff participate in the management and operation of the community, contributing to a psychologically and physically safe learning environment where change can occur. In a therapeutic community, there is a focus on social, psychological and behavioural dimensions of substance use, with the use of the community to heal individuals

emotionally, and support the development of behaviours, attitudes and values of healthy living.²

Some CSOs run group therapy in conjunction with individual sessions as well. For example, Holyoake's Gottawanna³ program is a group program run in conjunction with individual counselling if required.

Specific drink driving safety measures are incorporated into treatment approaches.

As noted above, if drink driving is an issue for a client, it is usually identified during the comprehensive assessment processes described above. The issue of drink driving is then addressed as one element of any treatment and support regime. Addressing drink driving includes the following factors:

- Readiness for change – some clients will accept that their drink driving is enough of a risk to require behaviour modification and then working with them to see what form that takes. Other clients are less accepting of the risk associated with drink driving and so for this group it is about getting them to move to acceptance of the risk. Risk matrix - Some services explore the issue of drink driving through a risk matrix – if then it is identified as a risk associated with their drinking, the worker will conduct sessions and approaches outlined below.
- Education sessions – for example: around how alcohol works in the body, tolerance and intoxication, relation between number of standard drinks and intoxication. Workers reported that they might conduct an education session with a client who appears not to take it in at the time, however, in a subsequent session, the client demonstrates increased knowledge and cogence around the issue.
- Exploration of consequences- sometimes in conjunction with the above, the client is guided through thinking about the consequences of drink driving.

There is little difference in treating mandated to voluntary clients.

“So what brings you to The Bridge?”

“I have been told that I have to come here”

Our AOD workers regularly work with mandated clients and suggested overall that treatment approaches were not different, however, logically it follows that there is more ‘front end’ work to enable a client to become ready for treatment. This can often involve drawing on motivational interviewing techniques to gauge readiness for change. With this group, rapport building between practitioner and client is a challenge; essentially reporting that is about ‘rolling with the resistance’ and ‘getting the seeds planted’ for change.

With regard to group therapy, there is potential for problems to emerge because if the client is not ready it can cause problems for existing group members. Workers reported that getting the membership of the group right, was critical in outcomes for all. However once the mandated client becomes ready to enter the group setting, as noted in the

² Definition from the Australasian Therapeutic Communities Association, access at: <http://www.atca.com.au/wp-content/uploads/2012/07/Therapeutic-Community-Model-of-Treatment.pdf> on 2/8/2017.

³ The Gottawanna program addresses specific issues for adults who are seeking help for their alcohol or drug use, gambling or other addictive behaviours. For more info, please see here: <http://www.holyoake.com.au/gottawanna.html> accessed 2/8/2017.

above section the group acts as a motivator; with peer led conversations and support becoming a real driver of change.

Some workers reported that some mandated clients are more motivated to change due to the prospect of custodial sentences. This was especially so for those who had never been to prison. In this sense, the spectre of a prison sentence is seen as a motivator to make a change in behaviour. Services generally reported however that they have a limit on the number of mandated clients, (a lower proportion of mandated to voluntary clients is important in any group therapy setting) due to the above factors.

CSOs conduct evaluations on treatment outcomes and report 'success'; defined as abstinence or reductions in drinking levels and change to drink driving behaviours. As each presentation is unique, the nature of each outcome is different.

Each CSO in our sector employs evidence based practice approaches and regularly conducts evaluation of services. Moreover, quality improvement processes demand a level of accountability as well as continual reflective practices embedded into organisational processes. The following are discrete examples in treatment outcomes that were taken from discussions with each worker when outlining de-identified cases:

- Changes in alcohol use: one worker reported that around 70% of their clients will make changes and experience reduced risk around alcohol, and within that, 25% of that group will choose to abstain from alcohol use; another worker reported a reduction in drinking levels in clients with the example of daily use to drinking once a week.
- Changes in driving behaviour: one example provided included a client who decided to hand their drivers licence in and therefore not drive.
- Changes in thinking patterns: cognitive shift in thinking about the impact of alcohol use on family and friends; shift in attitudes toward drinking and increased personal accountability around alcohol shown through responsible decision making; the effect drink driving had on the community with the example of thinking about if a drink driver hit their child.
- Changes in physical and mental health: examples provided included changes in liver function tests from very high to low, noticeable change in self-esteem.

Any further increase in treatment places in CSOs will require careful and strategic investment.

CSOs provide cost effective treatment and are connected to their communities, however there are many other factors across the wider AOD and health system that impact on the efficacy of AOD treatment in CSOs, these include:

- Funding does not meet demand – consistent anecdotal reports across many years suggests there is a level of unmet demand for AOD services in Tasmania and this is further demonstrated by the existence of waiting lists to enter treatment with many of our CSOs .
- Access and capacity of withdrawal services - a substantial proportion of people with repeat drink driving charges will most likely require access to detoxification and withdrawal services, prior to entering treatment as described above. It is long recognised (and the subject of a recent external review process) that pathways and capacity of accessing these services is a barrier to streamlined treatment provision across the AOD sector.

- Access to mental health treatment – as described above accessing mental health treatment is a critical element to recovery for some recidivist drink drivers. Staff in our CSOs regularly report access and capacity issues in this area.
- Access to GPs – our staff report access issues to General Practitioners that bulk bill and who are also equipped to work with complex comorbid alcohol and other drug and mental health presentations.
- Specific drink driving programs and measures may need to be developed- if our CSOs are funded to treat more recidivist drink drivers, there may be need for the development of specific drink driving harm reduction measures.

Three Case Examples

Each worker was asked to provide a de-identified case scenario. The case example notes below are written in informal language and seek to illustrate issues and outcomes, essentially showing how each presentation and outcomes are unique. Most importantly, it shows that the outcome is borne from a person centred process and has been driven in part by the client him or herself.

Case 1: from peer pressure and daily drinking to handing licence in and considerable reductions in drinking.

- Female, 50 years old,
- Repeat drink driver,
- Reported peer pressure by friends to drive,
- Had experienced several accidents,
- Reported drinking alcohol daily,
- Treatment: assessment by CSO, then went to Serenity House in Suphur Creek (sobering up facility), then back to CSO, for a combination of individual and group counselling approaches across 15 weeks,
- Outcome: reduction in drinking frequency to once a week, decided to surrender drivers licence on the basis of her assessment of own alcohol consumption, following this then made a decision to not drive due to identifying peer pressure to drive while drunk as a key variable.

Case 2: substantial reduction in use and improvements in liver health

- Female, 52 years old,
- Repeat drink driver, had just lost licence again and this time for a considerable period of time,
- Treatment: involved individual and group sessions, specifically CBT and MI approaches worked well,
- Outcome: her thinking changed around drink driving. She is now open to the impact drink driving has on her family and friends and has cut back alcohol use, liver function tests vastly improved and reduced to normal range. She has not used her car since she lost her licence.

Case 3: cognitive shift led to behavioural change

- Male, 40 years old,
- Repeat drink driving charges,
- Family violence issues, good family and friend supports, currently employed,
- Had been seen by the service three times previously,



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- Was always happy go lucky and blasé about drink driving, had to match him with right case manager to address attitudes to drink driving,
- Now faces risk of going to prison due to drink driving, possible 6 months custodial sentence,
- Treatment: case management focused on drink driving issues, talking through what prison would be like, CBT, engaged with external psychologist to discuss drink driving, taking responsibility for actions, specifically looked at the effect his DD had on the community- what if someone hit your kid?, accountability through CBT
- Outcome: a shift in attitude to drink driving, used to be blasé, now reflective and aware of the consequences, instigated forward planning around drinking, and taking accountability through decision making, client is now remorseful on past actions and currently abstinent from alcohol.