



DEFINING ALCOHOL AND OTHER DRUG TREATMENT AND WORKFORCE

leading responses to alcohol and drug issues



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Lynda Berends, Kieran Connolly, Amy Pennay, Janette Mugavin,
Shelley Cogger, Heidi Strickland, Pauline Kenny & Bridget Roberts

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Expert Panel

Professor Steve Allsop	Director, National Drug Research Institute, Curtin University, Australia
Professor Anders Bergmark	Department of Social Work, Stockholm University, Sweden
Dr Shaymaa Elkadi	Planning and Analysis Unit, Victorian Department of Health
Professor Margaret Hamilton	School of Population Health, University of Melbourne, Australia
Mr Trevor King	Deputy Director, Drug Policy Modelling Program, University of New South Wales, Australia
A/Professor Mads Uffe Pedersen	Director, Centre for Alcohol & Drug Research, Aarhus University, Denmark
Professor Anne Roche	Director, National Centre on Education and Training in Addiction, Flinders University, South Australia
Professor Robin Room	Director, Alcohol Policy Research Centre, University of Melbourne /Turning Point Alcohol & Drug Centre, Australia
Professor Brian Rush	Co-Section Head, Health Systems Research and Consulting Unit, Centre for Addiction and Mental Health, Department of Psychiatry, University of Toronto, Canada
Dr Alex Wodak	Director, Alcohol & Drug Service, St. Vincent's Hospital, Sydney, Australia

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ABBREVIATIONS AND ACRONYMS

AA	Alcoholics Anonymous
AOD	Alcohol and Other Drugs
ABI	Acquired Brain Injury
ACSO COATS	Australian Community Support Organisation. Community Offenders Advice & Treatment Service
ACCU	Adolescent Cannabis Check Up
ADCA	Australian Drug Council of Australia
ADIS	Alcohol and Drug Information System
AHS	Area Health Service
AIHW	Australian Institute of Health and Welfare
ARBIAS	Alcohol Related Brain Injury Accommodation Assessment & Support
ATOS	Australia Treatment Outcome Research
ATS	Amphetamines
AWS	Alcohol Withdrawal Scale
BI	Brief Intervention
BWSQ	Benzodiazepine Withdrawal Scale Questionnaire
CALD	Culturally and Linguistically Diverse
CBT	Cognitive-Behavioural Therapy
CCCC	Counselling, Consultancy and Continuing Care
CCTO	Community Corrections Treatment Order
CHS/CHC	Community Health Service/Centre
CIU	Centralised Intake Unit
CM	Case Management
COAG	Council of Australian Governments
COT	Course of Treatment
COWS	Clinical Opiate Withdrawal Scale
CWAS	Cannabis Withdrawal Assessment Scale
DACAS	Drug and Alcohol Clinical Advisory Service
DARP	Drug Abuse Reporting Program (US)
DATOS	Drug and Alcohol Treatment Outcome Study
DH	Department of Health (Victoria)
DPEC	Drug Policy Expert Committee of Victoria
DPU	Drugs and Poisons Unit
DRG	Diagnostic Related Groups
DTO	Drug Treatment Order
EDAS	Eastern Drug and Alcohol Services
EDSP	Early Developmental States of Psychopathology study (Germany)
EFT	Equivalent Full-Time
EMU	Emergency Medical Unit
EOC	Episode of Care
FOCiS	Drug Education for First Offenders Service

GP	General Practitioner
HARP	Hospital Admission Risk Program
ICD	International Classification of Disease
ICO	Intensive Corrections Order
JJ	Juvenile Justice (Victoria)
LAAM	Levo-Alpha Acetyl Methadol
MA	Marijuana Anonymous
MET	Motivational Enhancement Therapy
MMAS	Melbourne Metropolitan Ambulance Service
MM/MMT	Methadone Maintenance Therapy
MORS	Mobile Overdose Response Service
NA	Narcotics Anonymous
NDS/NIDS	National Drug Strategy
NDSHS	National Drug Strategy Household Survey
NSMHWB	National Survey of Mental Health & Well-Being
NEPOD	National Evaluation of Pharmacotherapies for Opioid Dependence
NGO	Non-Government Organisation
NSP	Needle and Syringe Program
NTORS	National Treatment Outcome Study
PCP	Primary Care Partnerships
RCT	Randomised Control Trial
RDNS	Royal District Nursing Service
RWH: WADS	Royal Women's Hospital: Women's Alcohol and Drug Service
SEADS	South East Alcohol and Drug Services
SMS	Specialist Methadone Service
SPS	Specialist Pharmacotherapy Service
SSR	Service System Review
SUSSWEST	Substance Users Service System
TC	Therapeutic Community
TOPS	Treatment Outcome Prospective Study (US)
TRANX	Tranquilliser Recovery & New Existence
TSF	Twelve-Step Facilitation Therapy
UHCHS	Upper Hume Community Health Service
VIFM	Victorian Institute of Forensic Medicine
WHO	World Health Organisation
WADAC	Western Region Alcohol and Drug Advisory Committee
WRAD	Western Region Alcohol and Drug centre

LIST OF TERMS

Bibliotherapy is an expressive therapy that uses an individual's relationship to the content of books and other written words as therapy that has relevance to that person's life situation.

Case management is '*a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes*' (Case Management Society of Australia, 2010 website 2010).

Cognitive Behavioural Therapy (CBT) is based on social learning theory and views drinking behaviour as functionally related to major problems in an individual's life, with an emphasis on increasing the ability to cope with situations that commonly precipitate relapse and overcoming skills deficits.

Consultancy services may range from the provision of phone advice to assisting agencies to design, implement and evaluate programs. There are three levels of consultation; primary consultation is a hands-on approach where the 'consultant' has direct contact with the client. In secondary consultations the 'consultant' does not have contact with the client, but issues are discussed with providers and the consultee assists in developing a treatment plan. Tertiary consultation concentrates on agency structures and programs to enhance service delivery to clients.

Contingency management (CM) uses incentives and disincentives with patients to achieve treatment goals (e.g. abstinence, clear urine sample, attendance) and may include incentives such as financial incentives, vouchers, and take home privileges.

Course of Treatment (COT) is referred to as a period of service provision between a client and alcohol and drug worker(s), with specified dates of commencement and cessation.

Day programs vary in structure and content however a feature of day programs is that clients remain in the community. Day programs aim to 'help to improve social functioning and community rehabilitation' (Standing Conference on Drug Abuse, 1996, p. 2). Day programs hope to aid drug users in rebuilding their lives through participation in various activities during the day, while they are living in the community and maintaining their social networks and commitments. A main aim of the program should be to reduce or stop a participant's drug use.

Episode of Care (EOC) is referred to as a completed course of treatment undertaken by a client, where at least one significant agreed treatment goal is achieved under the care of an alcohol and drug worker.

Motivation Enhancement Therapy (MET) focuses on producing internally motivated change using strategies to mobilise the individual's own resources.

Motivational Interviewing (MI) includes 'expressing empathy, helping the client to see there is a discrepancy between their goals or values and their current target behaviour, minimizing and avoiding resistance to change during therapeutic interactions, and supporting client self-efficacy in achieving change' (Adamson & Sellman, 2008, p. 589).

Opiates The term opiate applies only to drugs derived directly from opium (e.g. morphine, codeine, and heroin). Opioids are a broad class of opiate analogue compounds that have opium- or morphine-like activity (e.g. methadone).

Outreach is a proactive intervention used to locate and engage with populations that are considered to be at high risk and/or hard-to-reach due a multitude of health, behavioural and social factors.

Social Behaviour Network Therapy (SBNET) is an intensive socially based treatment that is based on the principle that social behaviour, social interaction and network support for change play a central part in the resolution of alcohol problems. Implementation involves a manualised time limited intervention consisting of eight sessions.

Twelve Step Facilitation (TSF) is a treatment designed to promote the commencement of the 12-Step Therapy and foster active participation in AA.

EXECUTIVE SUMMARY

The project

In 2009 the Victorian Department of Health commissioned Turning Point Alcohol and Drug Centre to undertake a review, to identify the essential treatment components of a specialist alcohol and other drug treatment service system and the workforce required to deliver these treatment components. This information would be used to identify directions regarding proportional investment.

An Expert Panel was convened, which comprised leaders from Australia, Northern Europe, and North America. The Expert Panel took part in a series of consultations to inform the project. Additional methods comprised reviews of the research literature, analysis of patterns of alcohol and drug use and treatment received among clients in Victoria, a sector workshop, and analysis of information on State and Commonwealth Government investment in specialist alcohol and other drug treatment.

The context

A number of contextual factors provided the basis for project findings.

A: Principles of system design

- As noted in key policy documents, treatment is about preventing and reducing the harms associated with problematic alcohol and other drug use by providing appropriate, timely, high quality and integrated services.
- The focus of treatment is behaviour change; assisting people to cease or reduce their substance use.
- The target client group includes individuals with complex and serious problems who require specialist intervention to address their dependence. Young people identified as ‘experiencing additional problems’ may be experimenting with AOD use and require early interventions.
- Services work within a harm minimisation framework.

B: Practicalities of service delivery

- Treatment is dispersed; provided from community agencies and local government services. More than 20 service types exist, while consolidation into core components would assist with planning and resource allocation.
- Major issues for the workforce focus on remuneration and retention. Parity differentials exist across sectors, particularly in relation to mental health, and also across jurisdictions. Around one quarter of the workforce is fairly new to the sector, while just over half have more than five years experience in the area.

C: Features of the client group and the treatments they receive

- In 2007-08 the most common primary drugs of concern among clients were alcohol, cannabis, heroin, and amphetamines. Polydrug use was common; particularly among clients with amphetamines, heroin, or cannabis, as their primary drug of concern.
- In 2007-08 specialist treatment involved almost 50,000 courses of treatment per annum, delivered to 26,500 clients. Almost half these courses of treatment were behavioural therapies (counselling, consultancy, and continuing care), while withdrawal and outreach were also common.
- As at October 2008, almost 12,000 people received opioid replacement therapy through pharmacies, in correctional settings, and in private clinics (AIHW, 2008).

D: Understandings of investment

- Investment can be considered in terms of the distribution of money or units of treatment (courses of treatment / episodes of care). The distribution of dollars is inaccurate because some treatment components are more expensive than others; the distribution of units of care is also inaccurate because it does not translate easily into financial investment. In this project, both approaches were used.
- In 2008-09 investment in specialist treatment in Victoria was characterised by the following:
 - The majority of State Government funds were allocated to behavioural therapies (42%) and withdrawal services (40%), with a lower proportion going to residential rehabilitation (14%) and pharmacotherapies (4%).
 - When State and Commonwealth Government funds are combined, slightly more funds are allocated to behavioural therapies (47%) and residential rehabilitation (17%), with less to withdrawal (33%) and slightly less to pharmacotherapies (3%).
 - The main investment in courses of treatment by the State Government was in behavioural therapies (67%) and withdrawal (27%), with fewer courses of treatment for residential rehabilitation (3%) and pharmacotherapies (3%).

Within this context, the following treatment components, support functions, and workforce requirements have been identified for a specialist alcohol and drug service system. In turn, these findings have guided our suggestions regarding proportional investment for Victoria.

Major findings

1. Treatment components

There are four essential treatment components:

- Pharmacotherapies ~ including the establishment of a small number of specialist clinics to counter vulnerabilities of the current system;

- Withdrawal ~ residential and non-residential elements which must be provided as part of a regime of treatment;
- Behavioural therapies ~ including indicated prevention, brief intervention, individual counselling, group counselling, family therapy, and day programs;
- Residential rehabilitation ~ comprising therapeutic community and modified therapeutic community treatment elements.

For each of these treatment components and elements a target group has been defined, a definition of treatment provided and associated therapeutic techniques described and common drugs of concern listed. Further information is shown in the table below.

Definition of treatment components and elements	Description of the target group	Outline of techniques	Common Primary Drug of Concern
1. PHARMACOTHERAPIES The provision of a legal, stable source of opioids.	Individuals dependent on opioids who may not be in a position to cease their alcohol and other drug use but wish to make lifestyle changes such as re-establishing relationships and obtaining employment, and reduce the risk of relapse.	Primarily methadone and buprenorphine.	Opioids.
2. WITHDRAWAL Safe and comfortable neuro-adaptation reversal and care. Duration from 1-3 weeks. In-patient and out-patient settings.	People who are alcohol and other drug dependent and wish to undertake withdrawal as the first step toward longer term treatment that addresses their alcohol and other drug problems.	Medical care and monitoring, pharmacotherapy, behavioural therapies (for opioids). Withdrawal must be provided as the first step in a regime of treatment with following treatment organised from the onset of the withdrawal episode.	Residential treatment for complex clients with alcohol, opioids, amphetamines as their PDOC and non-residential treatment for less complex clients whose PDOC is alcohol, opioids, amphetamines, or cannabis.
3. BEHAVIOURAL THERAPIES			
a. Indicated prevention In development, evidence is limited as programs are emerging and few evaluations have been completed. Interventions aim to prevent the progression to dependence and correlating disorders and to reduce the length and frequency of dangerous AOD use (based on IOM and NIDA approach, cited in EMCDDA, 2009).	Young people at high risk, with minimal but detectable signs of substance misuse or related problems, prior to the onset of AOD dependence (EMCDDA, 2009). Clients are from 12 to 21 years of age. The target group may be accessed via pathways that include emergency departments, the medical system, school settings, the court system, and addiction treatment centres providing for parents (EMCDDA, 2009).	While evidence is limited, an international review highlighted three programs: cognitive therapy focusing on skills development; a multi-faceted program providing structure and support that includes skill development and practical resources; and brief intervention that may be part of a stepped care approach (EMCDDA, 2009). Additional approaches for consideration include life skills development and family-based interventions	Cannabis, alcohol. Interventions may also be appropriate for some clients with other drug problems.

b. Brief intervention Single session (very brief) or 2-5 session behaviour change intervention, with varying effectiveness according to individual awareness about treatment needs and interest in treatment.	People with mild to moderately severe alcohol and other drug dependence.	a) A ‘very brief’, or single session brief intervention, involving information and referral (where required; when MI is conducted as a single intervention it is also classified as a brief intervention); b) an extended brief intervention that includes feedback about alcohol and other drug use; recommending a change in behaviour; presenting options to facilitate the change; checking and responding to the client’s reaction; and providing follow-up care (Bien et al., 1993).	Alcohol, cannabis.
c. Individual counselling Medium to high intensity regime of individual counselling utilising therapeutic techniques that vary according to drug use and severity. May be used in combination with pharmacotherapy. Useful with opioid withdrawal.	People with mild to severe alcohol and other drug dependence.	Various, according to individual need. Evidence based methods include cognitive-behavioural therapy, community reinforcement approach, contingency management, motivational enhancement therapy, motivational interviewing, and social behavioural network therapy. Bibliotherapy is appropriate for people with less severe alcohol problems.	Alcohol, cannabis, opioids, amphetamines.
d. Group counselling Medium to high intensity regime of group counselling utilising therapeutic techniques that vary according to drug use and severity. May be used to complement individual counselling.	People with mild to severe alcohol and other drug dependence, particularly those who are willing to engage in group programs.	Various methods outlined above may be adapted to the group setting (e.g. CBT) and TSF is often involved.	Alcohol, cannabis, opioids, amphetamines.
e. Family-based therapies Indicated prevention and treatment interventions that aim to work with family members and the young person to address factors related to alcohol and other drug use and strengthen strategies countering these risks.	Families and young people where a young person is at risk of, or has become alcohol and other drug dependent. Individual assessment needed to ascertain whether family-based therapy is appropriate for the family.	Varying intensity and utilising group therapy (parent-focused), individual and group treatment approaches.	Alcohol, cannabis, opioids, amphetamines.

<p>f. Day programs</p> <p>An intensive, structured, day-long program that uses a holistic approach to enable people to address problematic alcohol and other drug use, largely through the development of associated skills and resources. Four components are involved: life skills, vocational training, education, and recreation (Champney-Smith et al., 2001). Duration is typically from 2-6 weeks, while some models are much longer.</p>	<p>People with less severe alcohol and other drug dependence.</p>	<p>Individual and group counselling, peer support.</p>	<p>Alcohol, cannabis, opioids, amphetamines.</p>
<p>4. RESIDENTIAL REHABILITATION</p> <p>a) The Therapeutic Community (TC) provides a safe, secure environment removed from the wider community, enabling residents to address issues underlying their drug use (Gowing, et al., 2002); b) Modified therapeutic communities (MTC) are based on the TC model and adapted to the needs of particular client groups (e.g., regarding psychiatric symptoms, cognitive impairments, level of functioning (Sacks et al., cited in Skinner, 2005); family circumstances and need for re-integration (Sacks et al., 2004). <u>Key factors for success:</u> duration, intensity, retention, completion.</p>	<p>People with severe drug dependence. Modified therapeutic communities (MTC) have been used for target groups including women, women with dependent children, HIV/AIDS sufferers, and people experiencing homelessness (Sacks et al., 2008a).</p>	<p>a) The TC uses individual and group counselling and there is an emphasis on mutual self-help and peer community. At least 3 months stay is required for effective outcomes (McCusker et al., 1995) with some evidence in support of longer periods, especially for particular groups (e.g Greenfield et al., 2004). b) The MTC may involve shorter meetings and activities, higher staff involvement in activities, smaller units of care (e.g., shorter seminars), greater emphasis on providing instructions and support, assistance to understand mental health problems, and more resourcing for individual counselling in comparison with the TC (Sacks et al., cited in Skinner, 2005; Skinner, 2005). In another example, an MTC targeting women with dependent children focused on parenting, work, housing stabilisation, and building community (Sacks et al., 2004).</p>	<p>Opioids, amphetamines. Poly-drug use. Some evidence for young people and cannabis use.</p>

All Victorians need equity of access. In rural and regional Victoria access to residential withdrawal, residential rehabilitation and pharmacotherapy services is difficult. Strategies to support access include structural intervention targeting hospital beds for withdrawal, a treatment register for residential services, and expansion of the alcohol and other drug nurse practitioner program.

Client choice is important. Service capacity to adapt according to individual client need is critical. A limited number of tailored services may be required for particular client groups.

2. Support functions

All specialist treatment components require support functions that comprise:

- Quality assessment ~ which should be valued as a high level service function that is fundamental to effective treatment planning and intervention.
- Case management ~ involving individual treatment planning; appropriate referrals to the next alcohol and other drug service, and assertive follow-up. In some cases, where clients have complex and multiple needs, the case management function will include linkages to non-alcohol and other drug community and health services. It is important to note that aftercare is understood as one part of the continuum of care involved in case management.

Further, outreach is understood to be a mode of service delivery that is important for client engagement and retention, in addition to service reach.. Outreach is not a specialist treatment in its own right.

Secondary consultation is important to build capacity in other sectors, and this may work: via better integration with mental health; with support from generalist workforces; with funding from other parts of health. Secondary consultation is also a valuable mechanism within the system and it may involve mentoring, supervision, and staff support. For example, addiction medicine specialists may provide mentoring to GPs and advice to senior nursing staff; senior psychologists may provide secondary consultation to support workers.

3. Workforce

Our review of the evidence on workforce, incorporating the academic literature and consultations with the Expert Panel, led to the following conclusions.

- Successful treatment is influenced by both the quality of the service provided and the evidence base to support that service type. A positive staff attitude and approach to clients is a critical component of service provision.
- Attracting staff from relevant disciplines and upskilling them with alcohol and other drug content supports increased capacity in the alcohol and other drug sector. Staff skills as opposed to staff qualifications should not be overlooked and direct training in key areas such as assessment, working with families, and working with groups is advocated.
- Broader workforce development issues, including the routine provision of mentoring and clinical supervision, are required to support the sector. Investment in the specialist alcohol and other drug sector and the generalist health workforce is required.

- Embedding professional registration and continuing education requirements into core aspects of the alcohol and other drug sector can assist with the further professionalising of the sector, support the attraction and retention of staff, and assist with career planning and advancement.
- Increasing alcohol and drug content within undergraduate and postgraduate courses in relevant disciplines can legitimise alcohol and other drug work for relevant professions, improve the perception of the alcohol and other drug sector as a career opportunity and open up employment pathways.

The table below outlines the discipline associated with each treatment component, indicating whether the discipline is central to delivery of these components or less common.

Discipline	Treatment component			
	Pharmacotherapy	Withdrawal	Behavioural therapy	Residential rehabilitation
Psychosocial (Social Work / Psychology)	Adjunct ^a	Adjunct ^b	Core	Core
General Medical	Core	Core ^c	Consultative	Consultative
Nursing	Adjunct ^d	Core	Infrequent	Infrequent
Pharmacy	Core	Core	Infrequent	Infrequent
Addiction Medicine/ Psychiatry	Linked ^e	Linked ^e	Consultative	Consultative
Other				Broad range eg recreation, childcare, nutrition, sports, vocational.
Core AOD knowledge and skills	All treatment components – including support functions			
AOD philosophies, harm minimisation, mental health issues, ethical considerations, statutory responsibilities, access and equity, values and attitudes, screening and assessment, case management and referral. (This content can be covered adequately via competency based training)				

a May be helpful but should not be mandatory (Ritter, A. & Chalmers, J, 2009)

b Adjunctive support improves effectiveness (Heroin – Amato et al 2004; BZD – Morin et al).

c Medication regime prescription and management

d Potential for Nurse Practitioner role (Ritter, A. & Chalmers, J, 2009)

e For complex medication regime and management of complex issues

Please note that terms in the table are defined as follows.

Core: An integral discipline in the provision of this treatment component.

Linked: Established links to this discipline are required for the provision of this treatment component.

Adjunct: Services provided by these disciplines support this treatment component.

Consultative: Referral pathways to these disciplines are advisable within this treatment component.

Infrequent: Occasional contact with these disciplines may be required.

4. Proposed investment

Proportional investment is based on treatment effectiveness (including variations in effectiveness according to primary drug of choice), characteristics of the existing client group, and the recommended treatment components. Consideration has also been given to current distribution of money and treatment and estimated costs per episode of care. Proportional investment should involve the following:

- Proportional investment by funds for treatment components will be higher for behavioural therapies (27%) and withdrawal (28%) and lower for residential rehabilitation (20%) and pharmacotherapies (7%). Funds for assessment represent 15% of the total.
- Proportional investment by episodes of care for treatment components will be higher for behavioural therapies (27%) and withdrawal (19%) and lower for pharmacotherapies (4%) and residential rehabilitation (2%). Episodes of care for assessment represent 48% of the total.
- When allocation is restricted to treatment components (i.e., not including assessment) then the distribution of episodes of care is as follows: behavioural therapy (60%), withdrawal (31%), pharmacotherapies (6%), and residential rehabilitation (3%).

Recommendations

1. Treatment

The nature of treatment

Recommendation 1: that the specialist alcohol and drug treatment system is defined by the provision of specialist interventions that are designed to change behaviour related to problematic alcohol and drug use.

Recommendation 2: that the specialist alcohol and other treatment system in rural and regional Victoria is based on the understanding that drug treatment has the primary goal of reducing or ceasing drug use, although the worker's role should be broadened as required in response to the rural context of limited service availability.

Treatment components

Recommendation 3: that specialist alcohol and drug treatment components comprise pharmacotherapies, withdrawal, behavioural therapies, and residential rehabilitation.

Pharmacotherapies

Recommendation 4: that a small number of specialist pharmacotherapy clinics are established to complement specialist pharmacotherapy services and community programs.

Withdrawal

Recommendation 5: that withdrawal is not a stand-alone service and that both residential and non-residential withdrawal services must be run by a service that also provides behavioural therapies and / or residential rehabilitation programs.

Behavioural therapies

Recommendation 6: that behavioural therapies include treatment elements which have proven efficacy (i.e., indicated prevention, brief intervention, individual and group counselling, family therapy, day programs).

Recommendation 7: that service specifications for the behavioural therapies treatment component are developed, focusing on elements within this component.

Recommendation 8: that indicated prevention service models are explored to inform the development of service specifications. This may require the consolidation of existing evidence on pilot programs and local innovations as well as the trial and rigorous evaluation of pilot programs based on existing evidence.

Recommendation 9: that behavioural therapies include e-based approaches for service delivery.

Residential rehabilitation

Recommendation 10: that residential and non-residential withdrawal are retained as core elements of treatment.

Recommendation 11: that residential rehabilitation comprises two service elements: therapeutic communities and modified therapeutic communities.

Recommendation 12: that service specifications are developed for modified therapeutic community programs.

Special needs groups

Recommendation 13: that a limited number of programs designed for special needs groups (such as youth, women, Indigenous people) are provided to support client choice.

Recommendation 14: that programs designed for special needs groups utilise therapeutic techniques which are evidence based, with modification in terms of service delivery and program structure as appropriate to the needs of these groups.

Regional and rural Victoria

Recommendation 15: that strategies are implemented which improve rural people's access to residential withdrawal, rehabilitation and pharmacotherapies. These strategies may be aligned with other recommendations of this review, including support for the nurse practitioner role, the establishment of pharmacotherapy clinics, and the introduction of modified therapeutic community programs.

Recommendation 16: that structural support is put in place to enable people's access to hospital beds for withdrawal in regional and rural Victoria.

2. Support functions

Assessment

Recommendation 17: that quality assessment is valued as a critical element of service provision.

Case management

Recommendation 18: that case management is supported as a fundamental feature of specialist alcohol and other drug treatment.

Recommendation 19: that case management involves individual treatment planning; appropriate referrals to the next alcohol and other drug service, and assertive follow-up. In some cases, where clients have complex and multiple needs, the case management function will include linkages to non-alcohol and other drug community and health services.

Recommendation 20: that aftercare is understood as one part of the continuum of care involved in case management. It may take different forms. Some individuals will be referred to an appropriate non-specialist program and followed-up. Others may seek occasional contact with their case manager following treatment engagement. Assertive follow-up may be involved, where the case manager contacts the individual to ascertain their well-being and the maintenance of change in drug use behaviour.

Outreach

Recommendation 21: that outreach is regarded as a form of service delivery, which applies across many treatment components; particularly indicated prevention and elements of behavioural therapies.

3. Workforce

Structural review

Recommendation 22: review the funding structure of services to support competitive remuneration to the specialist alcohol and other drug workforce.

Registration, accredited training, and support

Recommendation 23: initiate a two tiered registration strategy where sector staff either adhere to the ongoing professional registration requirements of a relevant professional body (nursing, medicine, psychology, and social work for example) or comply with a revised Minimum Qualifications Strategy.

Recommendation 24: provide continued accredited and non-accredited training and qualifications to the specialist alcohol and other drug workforce.

Recommendation 25: develop and support mentoring and clinical supervision models within the alcohol and other drug sector.

Training for allied health and welfare sectors

Recommendation 26: initiate the provision of targeted training programs to allied health and welfare sectors with emphasis on capacity building, networking, secondary consultation and collegial support.

Staff recruitment in higher education settings

Recommendation 27: initiate a sustained education campaign for the increased provision of alcohol and other drug education in undergraduate courses in relevant disciplines (e.g., nursing, medicine, psychology, and social work).

Recommendation 28: initiate a targeted recruitment drive in relevant higher education settings to promote alcohol and other drug as a vibrant and rewarding career pathway.

Alcohol and other drug nurse practitioner

Recommendation 29: support and advocate for an enhanced nurse practitioner program in the alcohol and other drug sector.

Secondary consultation

Recommendation 30: ensure that secondary consultation is provided to build capacity in the alcohol and other drug sector as well as other parts of health.

4. Proportional investment

Funding

Recommendation 31: that the treatment components and major elements put forward in this review are the foundation for purchasing treatment services.

Recommendation 32: that the proportional investment in residential withdrawal is reduced.

Recommendation 33: that the proportional investment in non-residential withdrawal is reduced.

Recommendation 34: that the reduction in proportional investment for non-residential withdrawal is greater than that for residential withdrawal.

Recommendation 35: that the behavioural therapies treatment component receives a high proportion of investment, consistent with the evidence-base.

Recommendation 36: that funding for the residential rehabilitation (MTC) treatment element has proportional investment similar to that currently available for supported accommodation, with an increased unit cost.

Recommendation 37: that the proportional investment in pharmacotherapies is increased.

Recommendation 38: that assessment is funded as a separate activity from treatment episodes.

Episodes of care

Recommendation 39: that the number of episodes of care for pharmacotherapies is increased.

Recommendation 40: that the number of episodes of care for withdrawal services is reduced.

Recommendation 41: that the number of episodes of care for behavioural therapies is set at a high level.

Recommendation 42: that the number of episodes of care for residential rehabilitation (TC) is maintained.

Recommendation 43: that the episodes of care previously allocated to alcohol and drug supported accommodation are allocated to residential rehabilitation (modified therapeutic communities), with a reduction in the total number of episodes of care given the increased cost per unit of care.

1. PROJECT OVERVIEW

1.1. Introduction

In 2009 the Victorian Department of Health commissioned Turning Point Alcohol and Drug Centre to undertake a review to identify the essential treatment components of a specialist alcohol and other drug (AOD) treatment service system and the workforce required to deliver these treatment components. The project commenced in October 2009 and it was completed in April 2010.

Health systems research is understandably broad and it has been important to maintain a strict focus to meet project obligations within time and resource conditions. Related areas of enquiry¹, which are also important for systems design, have not been addressed.

1.2. Project aims

The project aims were to identify and define the evidence-based, internationally recognised core treatments available within an effective alcohol and other drug service system and characteristics of the associated workforce. In completing this undertaking, it was necessary to consider:

- The range of AOD treatment types
- Critical elements of each treatment type
- The Victorian context
- The appropriate mix of AOD treatment types (i.e., proportional investment)
- The workforce required to deliver each treatment

In defining the essential treatment components, we considered the following:

- Internationally accepted AOD treatment types (e.g., withdrawal)
- Models from different health sectors (e.g., mental health)
- Innovative models of AOD treatment
- Workforce qualifications and experience, along with possible variation according to treatment type, work setting and location

1.3. Method

The project raised a number of contentious issues that could not be fully addressed using available evidence. To guide the project, an Expert Panel was convened, which comprised leaders from across Australia, Northern Europe, and North America. The Expert Panel took part in a series of

¹ For example, organisational structures, service delivery mechanisms, and harm reduction strategies.

consultations to inform the project; commenting on research questions, key statements, and providing additional comment as needed.

We have gathered information from:

- Two sets of consultations with the Expert Panel
- Academic literature on treatment efficacy and effectiveness
- Academic literature on the specialist AOD workforce
- Service data on client characteristics and AOD use
- Service and pharmacotherapy data on AOD treatments received
- Information on State and Commonwealth Government investment in services
- A workshop with sector representatives

Details of the method are included in Appendix A.

1.4. Project report

The report has eight chapters and six appendices:

1. Project overview
2. Background to specialist alcohol and other drug treatment in Victoria
3. Clients in specialist alcohol and other drug treatment in Victoria
4. A summary of the evidence on treatment effectiveness: modalities and workforce
5. Treatment components
6. Workforce characteristics
7. Proportional investment
8. Conclusions and directions

Appendices to the report have been presented as separate documents. They comprise the following:

- A. Detailed method
- B. Briefing papers for consultations with the Expert Panel
 - B1. Discussion Paper for Consultations with the Expert Panel, Round 1
 - B2. Background Paper for Consultations with the Expert Panel, Round 2
- C. Participants in the alcohol and other drug sector workshop

D. Reviews of the research literature on AOD treatment effectiveness

D1. Pharmacotherapy

D2. Withdrawal

D3. Outpatient therapy

D4. Residential rehabilitation

E. Review of the literature on workforce planning and development, for alcohol and other drug treatment in Victoria

F. Patterns of drug use and treatments received, clients in Victorian alcohol and other drug services, 2007-08

1.5. Summary

In 2009 the Victorian Department of Health commissioned Turning Point Alcohol and Drug Centre to undertake a review to identify the essential treatment components of a specialist alcohol and other drug (AOD) treatment service system and the workforce required to deliver these treatment components. The project commenced in October 2009 and it was completed in April 2010. The project aims were to identify and define the evidence-based, internationally recognised core treatments available within an effective alcohol and other drug service system and characteristics of the associated workforce.

Methods comprised reviews of the research literature, analysis on patterns of drug use and treatment received among clients in Victoria, a sector workshop, and analysis of information on State and Commonwealth Government investment in specialist alcohol and other drug treatment. An Expert Panel was convened, which comprised leaders from across Australia, Northern Europe, and North America. The Expert Panel took part in a series of consultations to inform the project; commenting on research questions, key statements, and providing additional comment as needed.

2. BACKGROUND TO SPECIALIST ALCOHOL AND OTHER DRUG TREATMENT IN VICTORIA

This chapter outlines policy and practice contexts for specialist alcohol and other drug treatment in Victoria; the principles of treatment, the services currently delivered, and issues pertaining to the current workforce. Material is drawn from major policy documents, associated technical reports, and the academic literature.

2.1. Principles of treatment in the Victorian alcohol and other drug sector

A number of principles underpin the design of the current service system in Victoria. These principles, drawn from key policy and research documents, are outlined below.

2.1.1. The vision

According to the Blueprint for Alcohol and Drug Services, 2009 (Victorian Department of Human Services (VDHS), 2008, p. 9), the vision for Victoria's AOD services and interventions is:

To prevent and reduce the harms to individuals, families and communities associated with alcohol and other drug misuse by providing appropriate, timely, high quality and integrated services that help people to address their substance use issues and participate fully in the social and economic life of the Victorian community.

2.1.2. The underlying philosophy

Working within a harm minimisation framework, treatment aims to reduce the adverse health, social and economic consequences associated with alcohol and other drug misuse, by minimising or limiting the harms and hazards of drug use for both the community and the individual, without necessarily eliminating use (VDHS, 2008, p. 9).

2.1.3. The focus of treatment

The focus of treatment, as distinct from other interventions, is on changing behaviour to assist people to cease or reduce their substance use in the longer term (VDHS, 2008, p. 9). This does not include services aimed at support and harm reduction, which are also very important but sit outside this review. As noted previously,

Treatment services are aimed at changing drug use behaviour (rehabilitative) and harm reduction/support services are aimed at reducing drug-related harm. Importantly, these two functions are not mutually exclusive and all treatment reduces drug-related harm. But not all harm reduction activity is rehabilitative (Ritter et al., 2003, p. 80).

2.1.4. The target client group

Some people are more vulnerable than others. The client group targeted by AOD services in metropolitan and regional Victoria constitutes individuals with complex and serious problems who require specialist intervention to address their dependence. AOD services need to reach out to these people and persevere with the most marginalised groups to effect positive and lasting behaviour change. The client group targeted by specialist AOD treatment services in Victoria constitutes individuals with complex and serious problems, who require specialist AOD interventions (VDHS,

2008, p.9). Where appropriate, service activity may extend to those at risk of problematic use (Berends et al., 2004a; 2004b).

The Victorian Department of Health (2008) has developed a consultation framework, the Vulnerable Youth Framework, which describes the needs of young people aged from 10 to 25 years. Different risk levels indicate the nature of interventions required. Young people with co-occurring chronic problems (such as alcohol or other drug and mental health problems) are classified as 'high risk' and viewed as requiring intensive interventions. Young people with significant alcohol and drug problems (who often also experience a range of co-occurring difficulties including poor mental health and / or homelessness) are classified as 'highly vulnerable'. These young people are seen to require comprehensive co-ordinated responses. Young people classified as 'experiencing additional problems' may be experimenting with AOD use and they may require early interventions.

2.2. Alcohol and other drug treatment services

2.2.1. Services delivered

More than 100 community agencies and local government services in Victoria deliver AOD treatment services, advice, support and information to assist people who are experiencing substance use problems. More than 26,000 Victorians access these services every year. In addition, hundreds of pharmacies and general practitioners (GP) provide pharmacotherapy treatment; to more than 11,000 people on any given day.

2.2.2. Treatment elements

The current framework for AOD treatment service delivery in Victoria includes a wide range of service groups. The AOD sector has grown substantially since a major restructure in the early 1990s and while there are a number of major treatment components, such as withdrawal and residential rehabilitation, additional programs have emerged that have a specific orientation. A major review in 2003 recommended the consolidation of treatment programs into seven categories: residential withdrawal, non-residential withdrawal, outpatient therapy, medium intensity residential rehabilitation, therapeutic community, pharmacotherapies, and supported accommodation (Ritter et al., 2003).

2.2.3. Services for young people

Victoria has a range of AOD services that target young people. In 2002-03 more than half the courses of treatment delivered by youth services involved clients aged 18-21 years. A number of reviews suggest these services should have an increased focus on younger people and include interventions focused on indicated prevention (e.g. Berends et al., 2004a). This suggested orientation has implications in terms of treatment configuration and workforce characteristics.

2.2.4. Treatment in regional and rural areas

Treatment for regional and rural clients is based on that for metropolitan clients. Where necessary, the worker's role should be broadened in response to the rural context of limited service availability. Secondary consultation and capacity building may be involved, although treatment itself remains the primary focus (Berends et al., 2004b).

2.3. The alcohol and other drug sector workforce

Numerous issues influence the nature of the current AOD workforce and future planning in this area. These issues are about remuneration and retention, as well as staff skills and experience.

2.3.1. Remuneration

The issue of remuneration is a consistent feature of workforce development literature related to AOD work (Gethin, 2008; King, 2004; Roche et al., 2004; Rosenberg, 2007). Parity differentials have been identified across sectors, notably between mental health and AOD, and also across jurisdictions.

2.3.2. Recruitment and retention

Recruitment and retention of senior staff is difficult in the AOD sector (ADCA, 2003b; King, 2004) and remuneration rates may be a contributing factor. Sustaining change to practice requires ongoing activity and this is often compromised when staff frequently move across organisations and sectors (Roche, A. M., 2001). A stable, experienced workforce is generally more skilled and able to deliver a greater return on investment. It also promotes team cohesion and provides strong opportunities for mentoring and supervision, all of which are integral to effective workforce development (Skinner, 2005).

2.3.3. Experience and skill level of the workforce

Data from a recent report (Connolly, 2008) indicate that 23% of Victoria's workforce is relatively new to the sector (i.e., less than 2 years). For example, 23% indicated 2-5 years experience and 55% indicated more than 5 years experience in the AOD sector. Sixty-two percent of respondents indicated they had attained qualifications at degree or postgraduate levels, with 56% holding qualifications specifically in the AOD area (postgraduate courses, 13%, TAFE diplomas, 24% and Certificate IV, 19%). While the professional discipline of AOD workers was not specifically queried, analysis of their dedicated job role showed representation from the fields of nursing, social work, psychology, welfare, youth and mental health. This is consistent with a 2002 study indicating that 18% of the sector held nursing qualifications, with qualifications in psychology (16%) and social work (9%) also being well represented.

2.3.4. Ageing workforce

In line with the ageing population in Victoria, comes an ageing workforce. Data from 2008 indicate that 25% of the Victorian AOD workforce was in the 50-59 age group and a further 25% were aged 60 years and over. While retirement ages will vary, we can expect a large portion of the current workforce to leave the AOD sector in the next 5–10 years. Given the recruitment issues mentioned earlier, recruiting to fill this void may be extremely difficult. An additional issue with respect to the age of the workforce is its capacity to engage with young people. While being older than 30 does not preclude a worker from engaging effectively with a young person, it is of note that the proportion of Victorian AOD workers aged under 30 has reduced from 24% in 2002 to 13% in 2008 (Connolly, 2008).

2.4. Summary

2.4.1.Principles of treatment

Specialist AOD treatment in Victoria is guided by a number of key principles:

- The treatment aim is to prevent and reduce the harms associated with problematic alcohol and other drug use by providing appropriate, timely, high quality and integrated services
- Services work within a harm minimisation framework
- The focus of treatment is behaviour change; assisting people to cease or reduce their substance use
- The target client group includes individuals with complex and serious problems who require specialist intervention to address their dependence. Young people identified as ‘experiencing additional problems’ may be experimenting with AOD use and require early interventions.

2.4.2.Service provision

Treatment is provided from community agencies and local government services. More than 26,000 Victorians access these services every year. Pharmacies and GPs provide pharmacotherapy treatment to more than 11,000 people on any given day. The current framework for treatment includes a wide range of service groups. A major review in 2003 recommended the consolidation of treatment programs into ‘core components’ based on major treatment modalities.

While adult / general treatment programs usually involve people who are drug dependent, services for young people should include indicated prevention strategies that target vulnerable young people who may be experimenting with AOD. In regional and rural areas, treatment has the same orientation as that for metropolitan areas however the worker’s role may be broadened to allow for the limited other services available. Secondary consultation and capacity building strategies may also be utilised.

2.4.3.The workforce

Major issues impacting the current AOD workforce and future planning include remuneration and retention, as well as staff skills and experience. Parity differentials exist across sectors, particularly in relation to mental health, and also across jurisdictions. Recruitment and retention of senior staff is difficult and recent data suggest around one quarter of the workforce is fairly new to the sector, while just over half have more than five years experience in the area. In line with the general trend in Victoria, the workforce is getting older; with more than 30% being aged at least 50 years.

3. CLIENTS IN SPECIALIST ALCOHOL AND OTHER DRUG TREATMENT IN VICTORIA

3.1. Introduction

In identifying the essential treatment components of a specialist alcohol and other drug system we need to consider characteristics of the client group, the type and nature of their AOD use, and broader issues that may impact on treatment. This chapter includes a discussion on treatment need before moving on to a description of the client group in Victoria and the treatments received. The chapter draws from research literature on AOD clients, service monitoring data, and consultations with the Expert Panel.

3.2. Treatment need

In 2003, an analysis of international research on unmet treatment need was used to calculate the number of Victorians in need of treatment, by major drug type (alcohol, opioids, cannabis; Ritter et al.). Conclusions were as follows:

- The current specialist system treats a very small minority of Victorians with AOD problems
- It is expected and known that some people seek treatment outside the specialist system

AOD treatment needs vary; reflecting heterogeneity in both patterns of AOD use as well as the extent and range of problems that may preclude and / or be exacerbated by this use. Contrasting examples include experimental cannabis use by an adolescent versus long-term alcohol dependence experienced by someone in their mid-forties.

Treatment is often sought when circumstances become difficult. Reasons for treatment entry include legal pressure, family and social problems (Hser et al., 1997), personal reflections on the benefits and costs of AOD use, and pressure from one's spouse (Cunningham et al., 1994). Awareness raising activities such as screening and brief intervention for risky alcohol use (NIDA, 2009) and strategies targeting vulnerable young people exhibiting the first signs of AOD misuse (EMCDDA, 2009) provide valuable opportunities for intervention.

There is an association between marginalisation and treatment. A Swedish study compared the circumstances of clients in treatment for alcohol use with a group in the general population. Previous treatment, unemployment / institutionalisation, and having an unstable living situation were the strongest predictors of being in treatment. This was followed by age, alcohol dependence, and frequency of drinking. The authors concluded that, "the results support a notion of the treatment system as a place for handling marginalized people, beyond and beside their extent of drinking" (Storbjork & Room, 2008, p. 67). In Victoria, Ritter et al.(2003) showed that unmet treatment need was much lower for those with opioid use problems in comparison with groups experiencing problems related to alcohol or cannabis. The authors speculated that this difference by drug of concern may be impacted by ancillary problems encountered by those problematic opioid use; accelerating their entry into treatment (Ritter et al., 2003). Recent work, focusing on the US and Sweden, has characterised the potential client group for alcohol treatment as comprising three categories: marginalised, socially integrated, and an 'in-between group' that has some vulnerability (i.e., loss of employment or housing problems; Stenius et al., in press). We may expect different levels of demand for specialist treatment from these groups.

Most members of the Expert Panel agreed that there are two groups of clients in specialist AOD treatment. The first group is complex, with a multitude of needs – across health, social, economic, and / or legal domains. The second group, which is smaller, has relatively straightforward problems. There was general agreement that clients with chronic and severe problems dominate the treatment system. One member of the Expert Panel suggested this number was around 80%, another said 75%, and others simply stated that the first group was the majority. Members of the Expert Panel that disagreed with this conceptualisation of the client population suggested that they didn't know what 'straightforward' means in terms of alcohol and other drug clients, or whether such clients exist. The following visual representation was provided by one member of the panel, with the comment that heroin-dependent clients are likely to be on the right side of the continuum.

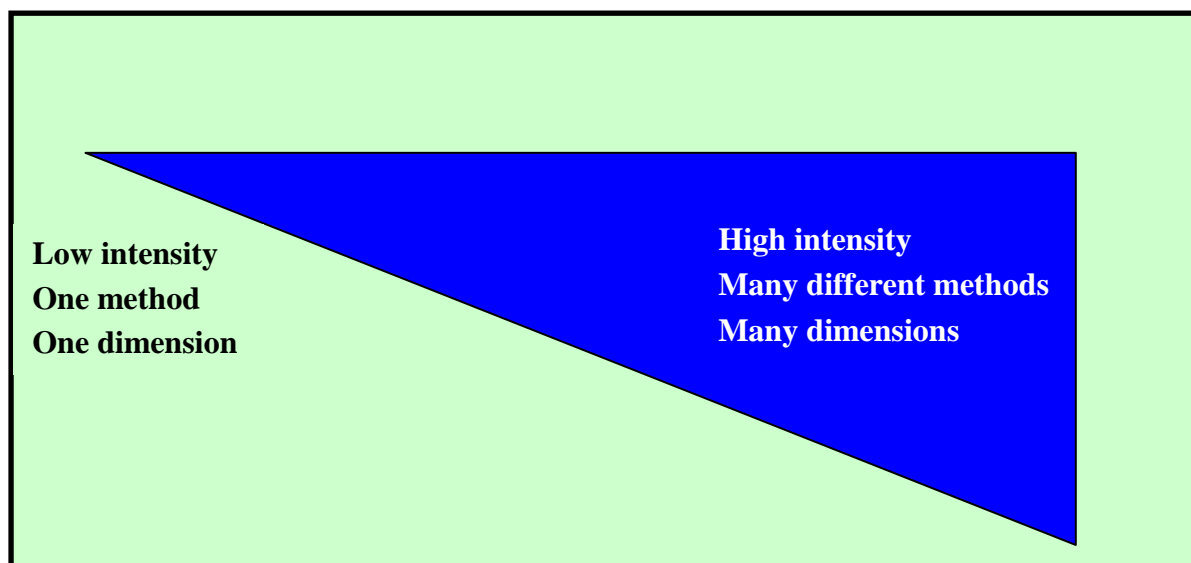


Figure 1. Continuum of need for clients in specialist alcohol and other drug treatment

Some members of the Expert Panel commented on the association between severity of need and treatment. One person felt that 'less severe' cases are pushed to the side and not dealt with well by the system; noting that specific provision is required to bring this group into care. Another commented on the perception that specialist AOD services are designed for clients with severe needs, which means that others don't want to come into contact with these services. As noted above, there was also some commentary around diversity in level of need among the client group.

3.2.1. What clients seek from treatment

The Expert Panel affirmed that clients seek different things from treatment. Some want to cease or control their AOD use, while others seek practical resources. For some clients, there is a level of coercion that involves family, friends or legal representatives. Respite may be the focus, particularly for the young.

There were strong and divergent views among the Expert Panel regarding the role of an AOD specialist system. Some felt that this role is concerned with providing quality, specialist AOD treatment rather than practical resources or respite. Others noted the importance of practical resources and commented on financial structures. In one case, the emphasis on cross-system linkages was emphasised,

I think the system has to figure out how both can be offered. That doesn't necessarily mean it has to be offering it itself but it has to serve as a link that will get it, you know, it doesn't have to offer the bed but it has to help figure out how it can help people find a bed.

Another expert felt the system has a broader focus than treatment, in that it needs to be involved in supporting people's access to critical needs such as housing and food.

I would not agree that the role of the specialist system is only 'treatment'. In _____ we actually are moving away from that word and referring to 'services and supports'. Supports can include practical resources but your term 'practical' diminishes the importance of critical things. Housing for example, is critical. The specialist agency may not provide housing but they should be engaged in the process of supporting the person in that area. Similarly, with food access.

Contrasting perspectives, about treatment being about changing AOD behaviour or including responses to broader needs, have a substantial history. As identified in the 2003 review of Victoria's system (Ritter et al.), the aim of treatment is to reduce or cease AOD use. Strong linkages with associated support services are important for client well-being. This linkage function is revisited in the section on case management, in Chapter Five.

3.3. Alcohol and other drug use among clients in Victoria

In this section we describe the client population, in terms of primary drugs of concern and poly-drug use. The provision of pharmacotherapy through community pharmacies is also outlined.

3.3.1. Patterns of alcohol and other drug use

Characteristics of the client group are described, using data from the Alcohol and Drug Information System (ADIS) and Victorian pharmacotherapy census data.

During 2007–08, almost 50,000 courses of treatment (COT) were delivered in Victoria, involving more than 26,000 clients. While most COT were about personal drug use, around 7% involved clients (e.g., parent, spouse) who were concerned about someone else's use. The most common primary drugs of concern (PDOC) identified among the client group in 2007–08 were alcohol (48%), cannabis (24%), and heroin (15%), as illustrated in Table 1.

Table 1. Number and proportion of COT and clients receiving services in the Victorian AOD treatment system, by primary drug of concern, 2007–08

<i>Primary drug of concern</i>	<i>COT N</i>	<i>COT %</i>	<i>Clients N</i>	<i>Clients^a %</i>
<i>Alcohol</i>	22,081	45.0	12,793	48.2
<i>Cannabis</i>	10,562	21.5	6,472	24.4
<i>Heroin^b</i>	6,847	14.0	4,028	15.2
<i>Amphetamine</i>	3,620	7.4	2,549	9.6
<i>Other opioids^{b, c}</i>	1,941	4.0	1,173	4.4
<i>Benzodiazepines and other tranquillisers^d</i>	1,040	2.1	666	2.5
<i>Other stimulants^{e, g}</i>	544	1.1	431	1.6
<i>Volatile substances</i>	499	1.0	242	0.9
<i>Nicotine</i>	298	0.6	209	0.8
<i>Hallucinogens^{f, g}</i>	58	0.1	49	0.2
<i>Steroids</i>	13	0.0	11	0.0
<i>Other^h</i>	1,612	3.3	1,278	4.8

Source: ADIS Database, DH; analysis by Turning Point Alcohol and Drug Centre.

^a The percentage of clients totals to more than 100% as clients can receive a COT for more than one drug type.

^b The data for heroin and other opioids exclude general practitioner administered opioid substitution therapy (OST) cases and therefore understate the true extent of OST provision in Victoria.

^c Other opioids include: opioid analgesics, methadone, morphine, buprenorphine, codeine.

^d Benzodiazepines and other tranquillisers include benzodiazepines, sedatives/hypnotics and barbiturates.

^e Other stimulants include: ecstasy, cocaine, psychostimulants n.f.d., stimulants/other hallucinogens (n=36).

^f Hallucinogens include: LSD, stimulants/other hallucinogens (n=36).

^g The data in the stimulants/other hallucinogens category cannot be separated into distinct categories in the ADIS dataset. Accordingly, data for stimulants/other hallucinogens (n=36) are presented twice in Table 1 in both the 'other stimulants' category and the 'hallucinogens' category.

^h Other includes: not stated/inadequately described, other drugs n.e.c., caffeine, antidepressants and antipsychotics, analgesics n.f.d., none.

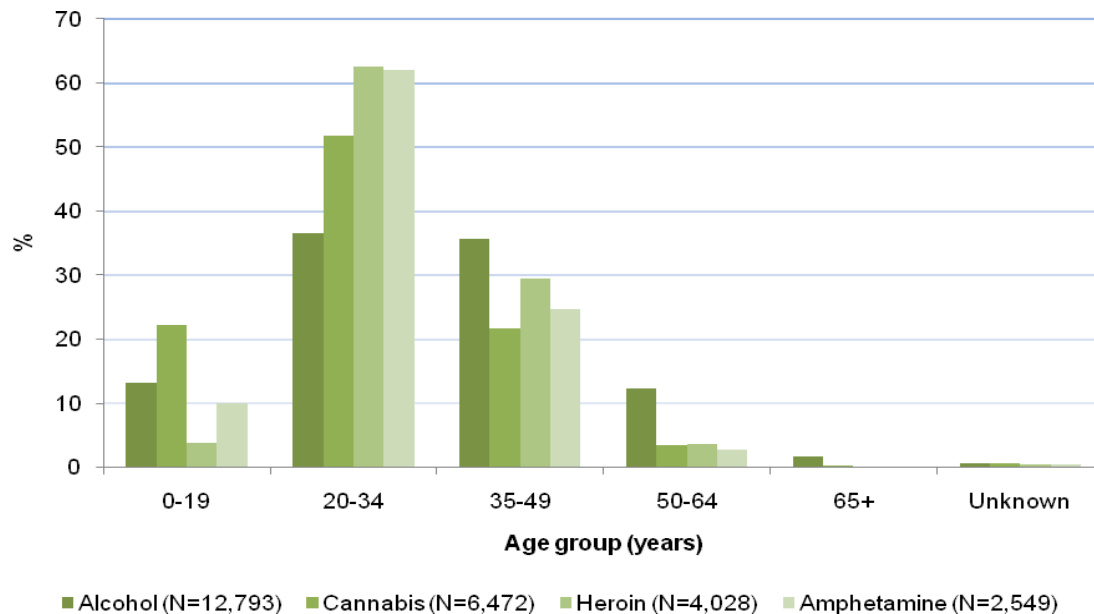
Clients are likely to be male and they are typically aged from 20 to 34 years. The most common age group varies by PDOC. Table 2 presents characteristics of clients who identified alcohol, cannabis, heroin and amphetamines as their primary drug of concern during 2007–08. As shown in the table, clients in AOD treatment who identified alcohol as their PDOC were likely to be older than users of other drugs, with 72% aged from 20 to 49 years. By contrast, in 2007–08, almost all (96%) cannabis users were aged from 0 to 49 years (e.g., 0 to 19 years, 22%; 20 to 34 years, 52%; 35 to 49 years, 22%; Table 2).

Table 2. Characteristics of clients in the Victorian AOD treatment system identifying alcohol, cannabis, heroin and amphetamines as primary drugs of concern, 2007–08

	<i>Alcohol</i>		<i>Cannabis</i>		<i>Heroin</i>		<i>Amphetamines</i>	
	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>
<i>Client status</i>								
<i>User</i>	11,922	93.2	6,124	94.6	3,871	96.1	2,404	94.3
<i>Non-user</i>	871	6.8	348	5.4	157	3.9	145	5.7
<i>Gender</i>								
<i>Male</i>	8,996	70.3	4,368	67.5	2,703	67.1	1,769	69.4
<i>Female</i>	3,751	29.3	2,091	32.3	1,318	32.7	772	30.3
<i>Unknown</i>	46	0.4	13	0.2	7	0.2	8	0.3
<i>Age group</i>								
<i>0-19</i>	1,684	13.2	1,435	22.2	154	3.8	256	10.0
<i>20-34</i>	4,678	36.6	3,351	51.8	2,516	62.5	1,581	62.0
<i>35-49</i>	4,568	35.7	1,401	21.6	1,190	29.5	629	24.7
<i>50-64</i>	1,569	12.3	225	3.5	145	3.6	69	2.7
<i>65+</i>	206	1.6	17	0.3	2	0.0	3	0.1
<i>Unknown</i>	88	0.7	43	0.7	21	0.5	11	0.4

Source: ADIS Database, DH; analysis by Turning Point Alcohol and Drug Centre.

Figure 2, below, shows the age distribution of clients in the Victorian AOD treatment system in 2007–08, by PDOC. The most common client age group for all PDOC was 20 to 34 years, followed by 35 to 49 years. Alcohol was a concern for a substantial proportion of clients across all age groups, from those aged 0 to 19 years through to those aged 65 years and over. Cannabis was the most common PDOC for younger clients in the treatment system, while heroin and amphetamine use dominated in groups aged from 20 to 34 years and 35 to 49 years. Few clients were aged 65 years or older; however, in this group, alcohol was the most common drug of concern, followed by cannabis (Figure 2).



Source: ADIS Database, DH; analysis by Turning Point Alcohol and Drug Centre.

Figure 2. Age distribution of clients in the Victorian AOD treatment system by primary drug of concern, 2007–08

Poly-drug use is prevalent among clients in the AOD treatment system and it has increased in recent years. Table 3 shows the proportion of COT delivered to clients who nominated alcohol, cannabis, heroin or amphetamines as the primary drug of concern from 2004–05 to 2007–08, where poly-drug use was identified. Table 3 also details the four main secondary drugs of concern nominated by poly-drug using clients, as well as the proportion of COT where clients nominated each drug. Poly-drug use appeared to be the norm among clients receiving treatment for amphetamine and heroin dependence, with poly-drug use identified in the majority of COT delivered to these clients. Typically, alcohol was the most common secondary drug of concern in COT where poly-drug use was identified (Table 3).

Seventy per cent of COT where clients identified amphetamines as the PDOC involved poly-drug use, as did 65% of COT where clients identified heroin as the PDOC. More than half of COT (57%) delivered to clients nominating cannabis as the PDOC involved poly-drug use.

Interestingly, COT delivered to clients with alcohol as the PDOC showed lower rates of poly-drug use (38%). Of COT involving poly-drug use where alcohol was identified as the PDOC, the most common secondary drug of concern was cannabis (52%), followed by amphetamines (22%). Over the past four years, the proportion of COT involving poly-drug use where clients nominated alcohol or cannabis as the PDOC has increased.

Table 3. COT delivered to clients² in specialist alcohol and drug services in which polydrug use was identified, Victoria, 2004–05 to 2007–08

	2004–05		2005–06		2006–07		2007–08	
Primary drug of concern	% identifying poly-drug use^a	Most common secondary drug of concern^b (%)^c	% identifying poly-drug use^a	Most common secondary drug of concern^b (%)^c	% identifying poly-drug use^a	Most common secondary drug of concern^b (%)^c	% identifying poly-drug use^a	Most common secondary drug of concern^b (%)^c
Amphetamine	61	Alcohol (37)	64	Cannabis (39)	68	Alcohol (35)	70	Alcohol (43)
		Cannabis (35)		Alcohol (35)		Cannabis (34)		Cannabis (31)
		Heroin (8)		Heroin (7)		Heroin (8)		Benzodiazepines (7)
		Benzodiazepines (8)		Benzodiazepines (6)		Benzodiazepines (6)		Ecstasy (7)
Heroin	53	Cannabis (29)	56	Cannabis (29)	58	Alcohol (28)	65	Alcohol (33)
		Alcohol (26)		Alcohol (28)		Cannabis (24)		Cannabis (26)
		Amphetamines (23)		Amphetamines (22)		Amphetamines (21)		Amphetamines (23)
		Benzodiazepines (17)		Benzodiazepines (13)		Benzodiazepines (12)		Benzodiazepines (11)
Cannabis	42	Alcohol (60)	46	Alcohol (61)	49	Alcohol (58)	57	Alcohol (65)
		Amphetamines (19)		Amphetamines (19)		Amphetamines (18)		Amphetamines (18)
		Heroin (6)		Heroin (5)		Heroin (4)		Nicotine (4)
		Benzodiazepines (4)		Nicotine (5)		Nicotine (4)		Heroin (4)
Alcohol	29	Cannabis (50)	32	Cannabis (50)	35	Cannabis (50)	38	Cannabis (52)
		Amphetamines (20)		Amphetamines (19)		Amphetamines (18)		Amphetamines (22)
		Benzodiazepines (10)		Benzodiazepines (9)		Nicotine (9)		Benzodiazepines (8)
		Nicotine (9)		Nicotine (9)		Benzodiazepines (8)		Nicotine (7)

Source: ADIS Database, DH, unpublished data, analysis by Turning Point Alcohol and Drug Centre.

^a Poly-drug use is defined as the use of two or more drugs on a single occasion, or within a given period, to achieve a particular effect.

^b Agencies can record up to five secondary drugs of concern. Data are presented in order of the most prevalent secondary drug of concern.

^c Percentages refer to the proportion of COT where poly-drug use is reported with each drug identified as the foremost secondary drug of concern.

² Clients of specialist alcohol and drug services include both drug users and non-users. Non-users may include partners, family members or friends.

3.3.2. Opioid substitution therapy from community pharmacies

The Drugs and Poisons Unit (DPU) of the Department of Health (DH), Victoria, conducts a quarterly census of pharmacies to determine the number of clients who receive opioid pharmacotherapy on a particular day. As at October 2008, there were 11,762 pharmacotherapy clients in Victoria, with 61% (n=7,200) receiving methadone maintenance, 29% (n=3,435) receiving the buprenorphine-naloxone combination treatment (Suboxone®) and 10% (n=1,127) receiving buprenorphine (Subutex®).

3.4. Alcohol and other drug treatment in Victoria

Finally, we consider the types of treatment being delivered in Victoria. The number and proportion of treatment modalities delivered by Victorian specialist AOD services in 2007–08 are listed in Table 4. Counselling, consultancy and continuing care (CCCC) made up almost half of all delivered COT (43%, 21,295). Other frequently utilised services included outreach (11%, 5,447), residential withdrawal (11%, 5,280), and non-residential withdrawal (10%, 5,128), with each of these service types representing approximately 10% of all COT delivered. Brokerage services (10%, 5,091) also represent 10% of all COT.

Table 4. COT delivered to clients in specialist alcohol and drug services, Victoria, 2007–08

<i>Treatment types</i>	<i>N</i>	<i>%</i>
<i>Counselling (CCCC)</i>	21,295	43.4
<i>Brokerage^a</i>	5,944	12.1
<i>Outreach</i>	5,447	11.1
<i>Residential Withdrawal</i>	5,280	10.8
<i>Other Withdrawal</i>	5,128	10.4
<i>Other Services</i>	2,218	4.5
<i>Aboriginal Services</i>	1,077	2.2
<i>Supported Accommodation</i>	1,017	2.1
<i>Residential Rehabilitation</i>	889	1.8
<i>Specialist Pharmacotherapy^b</i>	783	1.6
<i>Missing or unknown</i>	1	0.0
<i>Total</i>	49,079	100.0

Source: ADIS Database, DH; analysis by Turning Point Alcohol and Drug Centre.

^a Brokerage includes post-withdrawal linkage. With the exception of post-withdrawal linkage, clients are eligible for brokerage services if they are on a community-based disposition such as a Community-based or Parole Order with a drug or alcohol treatment condition or have come into contact with the criminal justice system.

^b The data for specialist pharmacotherapy do not include general practitioner administered opioid substitution therapy (OST) cases and therefore understate the true extent of OST provision in Victoria.

Given the variation in treatment effectiveness according to PDOC it is worth exploring the relationship between these variables. There was little variation in the most common treatment types by PDOC, as shown in Table 5. Proportionally more counselling (CCCC) COT involved amphetamines (50%) as the PDOC, while fewer involved cannabis (40%). Brokerage was more prevalent in COT where cannabis was identified as the PDOC (18%), but less so for alcohol (13%) – possibly reflecting diversion activity. COT involving heroin (13%) accounted for a slightly higher proportion of residential withdrawal COT than other PDOC. Figures for COT labelled as ‘other withdrawal’ were proportionally higher where alcohol (11%) and cannabis (10%) were the PDOC and lower for COT involving amphetamines (7%) and heroin (6%) as the PDOC. Outreach involved a higher proportion of COT with cannabis as the PDOC (10%), with fewer outreach COT delivered for heroin (6%); Table 5).

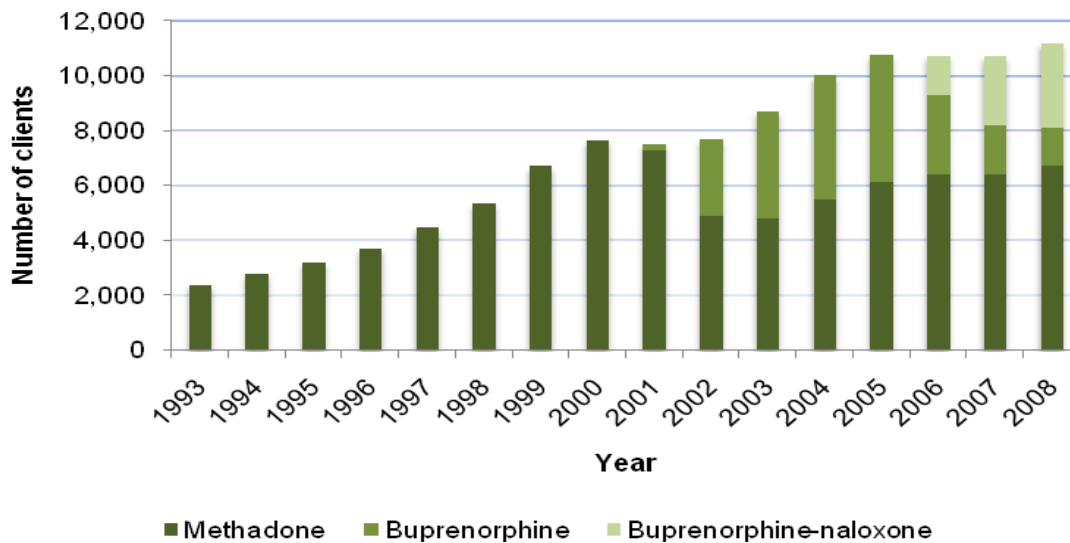
Table 5. Common treatment types in COT delivered in the Victorian AOD treatment system, by primary drug of concern, Victoria, 2007–08

	<i>Alcohol</i>		<i>Cannabis</i>		<i>Heroin</i>		<i>Amphetamines</i>	
	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>
<i>Treatment type</i>								
<i>Counselling (CCCC)</i>	9,853	44.6	4,170	39.5	3,071	44.9	1,810	50.0
<i>Brokerage</i>	2,941	13.3	1,878	17.8	1,012	14.8	630	17.4
<i>Residential WD</i>	2,466	11.2	1,160	11.0	856	12.5	362	10.0
<i>Other WD</i>	2,421	11.0	1,065	10.1	424	6.2	248	6.9
<i>Outreach</i>	1,849	8.4	1,041	9.9	415	6.1	237	6.5

Source: ADIS Database, DH; analysis by Turning Point Alcohol and Drug Centre.

3.4.1. Pharmacotherapies

As noted above, more than 11,000 clients received pharmacotherapy in 2008. Figure 3 shows the number of clients receiving methadone, buprenorphine (Subutex®) and buprenorphine-naloxone (Suboxone®) over the last 10 years. The total number of pharmacotherapy clients increased from 1999 to 2005, at which time the number of clients stabilised at approximately 10,700. The number of methadone clients increased each year up to 2000. Following the introduction of buprenorphine (Subutex®) in 2001, the percentage of clients enrolled in buprenorphine treatment increased to just under half of all pharmacotherapy clients up until 2005. Recently, with the introduction of buprenorphine-naloxone (Suboxone®), the number of clients receiving this pharmacotherapy increased while the number receiving the buprenorphine only preparation decreased (Figure 3).



Source: DPU, DH.

^a 1999–2006 census estimate taken from the first quarter of each financial year. The 2007 and 2008 estimates are taken from the third quarter of 2006–07 and 2007–08.

Figure 3. Number of clients enrolled in opioid pharmacotherapy programs, Victoria, 1993–2008

The distribution of COT by PDOC and clients in pharmacotherapy generally align quite well with the evidence on treatment, as described in the next chapter. Exceptions are the comparatively high proportion of residential withdrawal COT for cannabis use and ‘other withdrawal’ for COT involving alcohol use.

3.5. Summary

3.5.1. Client characteristics

In 2007–08 the client group in the Victorian AOD treatment system had the following features:

- The most common PDOC identified were alcohol, cannabis, heroin, and amphetamines
- Almost half of the clients identified alcohol as the presenting primary drug of concern (n=12,793, 48% of all clients)
- Around one quarter of the clients reported cannabis as their primary drug of concern (n=6,472, 24%)
- People with heroin as their primary drug of concern accounted for 15% of all clients (n=4,028), while other opioids accounted for an additional 4% (n=1,173 clients). These data are an under-representation of clients in treatment for heroin and other opioids, given Victoria’s community-based pharmacotherapy program, which is not included in the ADIS. As at October 2008, almost 12,000 people received opioid replacement therapy through pharmacies, in correctional settings, and in private clinics (AIHW, 2008)

- Less than one tenth of clients (n=2,549, 10%) in the Victorian AOD treatment system identified amphetamines as the PDOC
- Just over 7% of clients were non-drug users, such as parents or partners

In relation to polydrug use:

- In 2007–08, polydrug use was common in COT involving people that reported amphetamines, heroin, and cannabis as their PDOC (70%, 65%, and 57% respectively). The most common secondary drug of concern across all COT where polydrug use was identified was alcohol (43% in amphetamines COT, 33% in heroin COT, and 65% in cannabis COT)
- Just over one third of COT (38%) where alcohol was identified as the PDOC involved people who reported a secondary drug of concern. This drug was likely to be cannabis (involving 52% of COT for polydrug where alcohol is the primary drug of concern)

3.5.2. Treatments received

Specialist AOD treatment in Victoria involved:

- Almost 50,000 courses of treatment (COT) delivered to 26,500 clients in 2007–08
- More than 11,000 clients enrolled in pharmacotherapy treatment during 2008
- Counselling, consultancy and continuing care (CCCC), which made up almost half (43%) of all COT delivered during 2007–08
- Four other main service types; outreach, brokerage, and residential and non-residential withdrawal (comprising around 10% of all COT each)

4. A SUMMARY OF THE EVIDENCE ON EFFECTIVE TREATMENT: MODALITIES AND WORKFORCE

4.1. Introduction

This chapter provides a summary on the efficacy and effectiveness of various treatment modalities using available research evidence. Four categories of treatment are used: withdrawal; outpatient therapy (behavioural therapies), residential rehabilitation, and pharmacotherapy. Factors which impact effectiveness across specific psychological forms of treatment are also described. In the final part of the chapter, we describe workforce characteristics and workforce development strategies that support the delivery of effective, specialist, AOD treatment. These summaries are taken from detailed reviews of the academic evidence which have been prepared for the project. These detailed reviews are included as appendices to the report.

4.2. Treatment modalities

4.2.1. Withdrawal

Alcohol and other drug withdrawal

The term ‘alcohol and other drug withdrawal’ refers to neuro-adaptation reversal, the process by which neurotransmitter adaptation to consistently high levels of a drug is reversed and withdrawal occurs as a result. The onset of symptoms and course of withdrawal are time-limited, specific to the drug used, and dose related (WHO, 1992).

Withdrawal can be supervised in a number of settings including the user’s home; community or outpatient withdrawal clinic; residential withdrawal setting; hospital setting; and specialist withdrawal unit (Saunders & Yang, 2002). Supervised withdrawal can include medicated- and non-medicated withdrawal management (Shand et al., 2003a).

Appropriate screening, assessment and planning strategies are necessary in order to identify potential risks and ensure the most appropriate setting and level of care required for individuals is provided (United Nations Office on Drugs and Crime and World Health Organization, 2008). Withdrawal, while effective in achieving neuro-adaptation reversal needs to be included within a broader continuum of care to increase long-term behaviour change (Raistrick et al., 2006). Assessment is an opportunity to also plan for post-withdrawal support (Griswold, 2007) .

Alcohol withdrawal interventions

Benzodiazepines (particularly diazepam) are effective medications for managing symptoms of alcohol withdrawal and preventing alcohol withdrawal seizures, and have been considered the gold standard in alcohol withdrawal syndrome treatment. A recent meta-analysis did not find, however, prominent differences between benzodiazepines and other drugs in success rates. Symptom-triggered dosing of benzodiazepines is suitable for a medically supervised withdrawal and fixed schedule dosing is most appropriate for those not in a hospital or medically supervised setting. While non-benzodiazepine medications, such as nitrous oxide, are sometimes used to treat alcohol withdrawal, none are recommended as first line treatment in Australia. The anti-craving therapies acamprosate (Campral®) and naltrexone (Revia®), and the aversive agent disulfiram (Antabuse®), are medications used to treat alcohol use disorders however there is no consistent evidence to support the effectiveness of one agent over another. Some research suggests that naltrexone may be suitable in the treatment of patients seeking to reduce heavy alcohol intake and that acamprosate may be suitable for patients

seeking abstinence. There is varying evidence that indicates combination therapy with acamprosate and naltrexone is more effective than monotherapy with either agent.

Benzodiazepine withdrawal interventions

Withdrawal from benzodiazepines can be monitored using the Benzodiazepine Withdrawal Symptom Questionnaire (BWSQ). The most appropriate medication for the management of benzodiazepine withdrawal is dependent on the withdrawal setting. Gradual taper is preferable to abrupt cessation of benzodiazepines. The effects of the selective serotonin reuptake inhibitor (SSRI) paroxetine on tapering doses of benzodiazepines have been examined among a sample of non-depressed, benzodiazepine dependent outpatients. The addition of an SSRI significantly predicted the success of becoming benzodiazepine free at eight weeks. Tapered withdrawal is the recommended regime for outpatient populations, with one recent RCT demonstrating no difference between symptom-triggered and fixed-tapered dosing among an inpatient sample. One small study has reported that CBT can enhance outcomes for patients who are being weaned from long-term benzodiazepine use.

Opiate withdrawal interventions

The term opiate applies only to drugs derived directly from opium (e.g. morphine, codeine, and heroin). Opioids are a broad class of opiate analogue compounds that have opium- or morphine-like activity (e.g. methadone). The Clinical Opiate Withdrawal Scale (COWS) is commonly used in Australia to monitor the symptoms of opioid withdrawal. While α -2 adrenergic agonists such as clonidine and lofexidine are still used to reduce the severity of some symptoms of withdrawal, buprenorphine is becoming more frequently used by registered prescribers. Buprenorphine has provided a significant recent advance in the treatment of opiate dependence and like methadone it can be prescribed for maintenance therapy as well as for symptomatic relief in opiate withdrawal. Methadone is a long-acting opioid agonist used as a tapering agent for opiate withdrawal. A recent review concluded that methadone was inferior to buprenorphine in reducing the duration of opioid withdrawal, and that completion of withdrawal was more likely among those prescribed buprenorphine as compared with methadone. Induced withdrawal usually involves the use of naltrexone to rapidly displace opiates from receptors with the aim of hastening the withdrawal process and linking dependent users to naltrexone maintenance to prevent relapse. A recent study that examined the role of rapid detoxification under heavy sedation concluded that rapid detoxification is not a form of treatment that should be pursued. Reasons include the high cost of anaesthesia-based approaches as well as the potentially life-threatening risks (Gowing, Ali, & White, 2005).

Cannabis withdrawal interventions

A cannabis withdrawal syndrome has been increasingly described since the 1990's. Although benzodiazepines are commonly used to treat some symptoms of cannabis withdrawal such as anxiety and insomnia the approach is based on clinical judgement alone as the efficacy of benzodiazepines in human cannabis withdrawal has not been empirically determined. There are currently no validated cannabis withdrawal scales available; however in current use in Australia is the Cannabis Withdrawal Assessment Scale (CWAS).

Amphetamine-type substance (ATS) withdrawal interventions

Amphetamine-type substances include amphetamines, cocaine and ecstasy. The existence and clinical significance of ATS withdrawal is firmly established. Amphetamine dependent treatment-seekers frequently present with problematic use of other substances particularly alcohol, cannabis and nicotine. They also frequently present with significant and troubling symptoms of depression psychosis, and poor mental health. No medications have demonstrated effectiveness in the treatment of amphetamine dependence, and RCTs have failed to demonstrate efficacy of ondansetron,

gabapentin, baclofen, aripiprazole and sertraline for methamphetamine withdrawal. Benzodiazepines are sometimes used to alleviate anxiety and agitation in ATS withdrawal, although the efficacy of this approach has not been systematically evaluated.

4.2.2. Outpatient therapy (Behavioural therapies)

Effectiveness by PDOC

Alcohol

Research supports the use of psycho-social therapies as tools for reducing and maintaining behaviour change for alcohol dependence. A range of therapies demonstrate positive results. For example, the Mesa Grande, a review of 361 studies on alcohol (Miller, & Wilbourne, 2002) found the highest levels of efficacy include social skills training and the community reinforcement approach. When cognitive-behavioural therapy (CBT) and motivational enhancement therapy (MET) were specifically investigated for efficacy with alcohol users they were also found to have significant effects. Magill and Ray (2009) found small significant effects when CBT was used.

Adamson and Sellman (2008) found four sessions of MET was significantly effective with alcohol dependent persons at six months compared to no counselling or non-directive listening. At five year follow-up all groups had continued to reduce their drinking but there was no significant difference. The authors say this should not detract from the finding that MET achieved greater reduction in alcohol use sooner (at six months) and sustained the changes, improving over time. This is beneficial to reducing the physical and social harms of dependence.

There is positive evidence for using brief interventions with people with alcohol problems compared to control conditions (no treatment or extended treatment) in both treatment-seeking and non-treatment-seeking populations. It appears that brief interventions are more useful for people with less severe alcohol problems. For people with more severe alcohol problems BI can be useful to motivate them to seek more specialised treatment in a stepped-care approach.

Cannabis

Psycho-social treatments were effective at reducing cannabis use and dependence symptoms among dependent users compared to a control group (Denis et al., 2006). There was less success of these interventions with abstinence from cannabis and abstinence rates were low overall. The comparison of CBT, MET and social support groups highlights important questions about the optimal duration, intensity and type of treatment for cannabis users. Other variables to consider are delivery in group or individual sessions and the experience of the therapists. The research to date shows that CBT delivered individually in nine sessions or more is a more effective psycho-social treatment for cannabis users. There was no evidence that one treatment type was more effective when other problems related to cannabis use were measured.

There is limited current research on what treatments work for young people with cannabis use problems. The studies that have been conducted show that a variety of psycho-social treatments have significant effect in regards to reducing cannabis use and associated symptoms up to a year after treatment (Dennis et al., 2004) and abstinence in the short term (Kamon et al., 2005). Kamon's (2005) study shows family based treatment may have positive outcomes for young people with co-occurring conduct disorder problems with regard to substance use and conduct and reducing negative parenting behaviours. The ACCU model shows promise for non-treatment seeking young people for reducing their cannabis use, at least in the short term.

Opiates

From the reviews done to date there was not enough evidence that psycho-social treatments alone are adequate to treat people with opiate abuse and dependence. There is evidence that psycho-social treatments can be beneficial in conjunction with pharmacological treatments. There are indications that the stage of pharmacological treatment is important. (Amato, L. et al., 2008b) review of opioid detoxification found benefits from adding any psycho-social treatment to any substitution detoxification treatment in terms of completion of treatment, treatment attendance, use of opiate and abstinence from drugs at follow-up. This is in contrast to the companion Cochrane review on maintenance treatment where Amato et al. (2008a) found that patients in methadone maintenance therapy do not need additional psycho-social intervention to improve program retention or results at follow-up.

There is limited evidence that contingency management (CM) shows any more promise than other interventions. CM was shown to improve a reduction in positive urine samples in conjunction with MMT in the general population and improve program retention with pregnant women (Griffith et al., 2000).

Methamphetamines

Overall, Lee and Rawson (2008) found applying cognitive and behavioural psycho-social interventions is effective for methamphetamine users. The studies demonstrated good outcomes with CBT (with and without MI) and CM. CM was found to be the most powerful intervention although it is unclear if the changes were sustained after treatment. Further study is required to examine other types of psycho-social treatments.

Poly-drug use

Poly-drug use was found to be common among problem drug users which heightens risks to their well-being and can lead to increased risk-taking (EMCDDA, 2009). There is a high prevalence of alcohol use in almost all the poly-drug-use populations suggesting alcohol needs special attention in targeting interventions. There is limited information on the treatment practices and management of poly-drug use. Results from large treatment outcome studies in Europe show significant reductions in multiple drug use among highly problematic users. Studies to date highlight the importance of long-term treatment planning, attention to individual needs and a multi-disciplinary team approach that is flexible and innovative (EMCDDA, 2009).

Mental health and AOD substance abuse

The literature shows mixed findings on the efficacy of different types of psycho-social interventions with dual diagnosis clients, with some studies showing positive results for group counselling and contingency management (Drake et al., 2008). A smaller review found that BI has promise for dual diagnosis clients with drinking problems, which could be a more cost effective approach than more extensive treatment (Baker et al., 2009). BI may also be useful for dual diagnosis clients with cannabis problems as part of a stepped care approach that includes at least nine sessions of MI/CBT (Babor et al., 2004; Baker et al., 2009). Drake et al. (2008) found that longer term residential treatment appears to be effective for dual diagnosis clients where outpatient interventions have not worked for them.

Outpatient Treatments for young people

The treatments supported by a stronger evidence base for use with young people are “family-based therapy, CBT, brief motivational interventions, CBT adolescent group therapy, parent skills interventions and integrative approaches”. These approaches were generally associated with treatment

gains over time (Becker & Curry, 2008, p.540). Specifically, ecological family therapy, CBT, and brief motivational interventions showed evidence of treatment superiority in two or more of the methodologically stronger studies.

Similar findings were found in another systematic review which identified multi-dimensional family therapy, functional family therapy and group CBT as well-established models for treatment (criteria based on Chambless et al. (1996) cited in Waldron & Turner, 2008) . However the authors note that a number of other models are probably efficacious and none was clearly superior to any others in terms of treatment effectiveness.

Non-CBT adolescent group therapy showed inferior results for immediate treatment outcomes in more than one methodologically stronger study. This suggests it is advisable for providers to use group interventions with a substantial evidence base such as CBT, or rely on other proven modalities (Becker & Curry, 2008).

Self-help and twelve step facilitation

A systematic review compared TSF programs to other types of interventions such as Motivational Enhancement Therapy (MET), Relapse Prevention Therapy (RPT) and Cognitive-Behavioural Therapy/skills training (CBT); and no intervention (Ferri et al., 2006). The authors concluded that:

- TSF reduced alcohol intake in the same way as other interventions
- Patients accepted and remained in therapy in the same way as other interventions
- There was no conclusive evidence to show that AA helped patients remain abstinent, however there was no evidence to suggest that it did not (Ferri et al., 2006).

Kelly et al. (2009) reviewed mechanisms of behaviour change in Alcoholics Anonymous (AA) and concluded that AA may affect longer term abstinence due to boosting participants' confidence in their ability to handle common relapse-related situations. Other reasons included the social group dynamics of AA meetings which offer strong social reinforcement for abstinence and role models. The groups also offer the opportunity to develop broader social networks which offer alternative 'low-risk' social activities (Kelly et al., 2009, p. 252). The accessibility of AA (it is free and widely available, 'on demand') and its long term focus was identified as a major benefit of AA in aiding addiction recovery. Studies measuring relapse prevention suggest that "self-efficacy, motivation for abstinence and commitment to recovery, and behavioural coping, are mechanisms through which AA exert its beneficial effects" (Kelly et al., 2009, p. 252).

Controlled drinking

Studies on controlled drinking generally show that positive outcomes are associated with certain client characteristics, including motivation, social stability, low severity of drinking symptoms, and a comparatively short duration of problem drinking. However a study by Dawe et al. (2002) challenges the view that controlled use interventions are better suited to those with less severe drinking dependence. Treatment factors that enhanced outcomes for clients were the development of a co-operative relationship between the client and clinician to plan treatment aims and, where possible, agreement for temporary abstinence at the beginning of the program to set goals and assist with withdrawal symptoms.

Day programs

Existing programs differ in terms of intensity, attendance requirements, target population and content. While difficult to give an all-encompassing definition, it can be confidently stated that day programs aim to support clients with their re-integration back into the community. Day programs can do this in a way that gives clients freedom to receive treatment while continuing to live in their own environment, which some believe is the easier form of transition in comparison with residential programs that are separate from the general community. Findings from studies to date show the following:

- A well-run community-based day program is equally as effective as a medical day program (i.e., located in a hospital and involving full-time medical staff; (Kaskutas et al., 2004).
- Day programs may assist opiate users to seek further treatment, which has been shown to improve substance and psychiatric outcomes.
- There were positive findings for young people who maintained attendance at a day program. However this could be due to high attrition rates biasing findings. This suggests there should be a focus on facilitating and supporting young people's attendance and retention.

New and innovative approaches

Indicated prevention

Indicated prevention programs are designed to prevent the onset of substance abuse (or dependence) in individuals who are showing early signs of risk. Indicated prevention targets the individual who has been identified as high risk of developing substance abuse. A review of risk and protective factors in the development of substance use identified biological (neurobiology) and psychological aspects of risk factors (EMCDDA, 2009). Target groups included children with high-risk behavioural disorders and children in institutional care. Program components include brief, manualised intervention, for example motivational interviewing and parent training. All the programs provided for individual needs assessment and worked with other organisations to address young people's needs.

There is limited evidence on 'what works' for indicated prevention as this is a new category that is still being defined in the research literature. There are also limited program evaluations and RCTs so meta-analysis is not feasible at this stage. The effectiveness of specific strategies may vary for different target groups.

e-based initiatives

One innovative approach gaining momentum in delivering screening and brief intervention (SBI) is internet-based personalised feedback about an individual's alcohol consumption patterns. Feedback may be given in a report format which includes: current consumption patterns; health and social risks associated with problem drinking; or self-help guidelines to help drinkers reduce alcohol-related harm (Riper et al., 2009). Riper et al. (2009) conducted a meta-analysis of 14 studies which delivered personalised feedback without professional guidance as an alcohol intervention. They found that this form of intervention can be effective for reducing risky alcohol consumption among young people and adults. As this intervention is delivered via an electronic interface as opposed to a clinician it has cost-effectiveness potential for curbing problem drinking in student and general populations. The authors stated that "alternative strategies to reach out to high-risk drinkers are also required, because with effect sizes in the small-to-medium range, not all high-risk drinkers benefit from personalized feedback" (Riper et al. 2009, p. 253).

Two studies using electronic screening and brief interventions (e-SBI) as an intervention for problem drinkers in a student health setting showed beneficial outcomes for patients that received an e-SBI compared to those in the control group (screening only). The second study also showed that multiple sessions of e-SBI were no more effective than a single session. Kypri et al. (2008) reported a statistically significant reduction in alcohol consumption in those receiving the e-SBI at 6 and 12 months follow-up compared to the control group. Given the reported benefits of the e-SBI and the potential cost savings on practitioners' time, the authors advocate for e-SBI systems to be included in student health care settings.

4.2.3. Residential rehabilitation

Effectiveness by PDOC

Alcohol

There is a lack of evidence to support residential treatment for people with alcohol problems. A review of meta-analytic reviews, randomised controlled trials and systematic reviews showed that equal outcomes can be achieved in lower cost, non-residential settings (Shand et al., 2003b). In a comparison of inpatient and outpatient treatment for alcohol dependence involving an 18-month follow-up, Rychtarik et al. (2000) found that there was no evidence supporting the effectiveness of residential treatment for people with mild to moderate levels of dependence; some people with lower levels of alcohol use may actually be worse off in a residential setting. However there are studies indicating the benefits of residential rehabilitation in cases involving impaired cognitive functioning, serious psychiatric disorders, a series of unsuccessful non-residential treatment episodes or unstable social environments (Lennane as cited in Rychtarik et al., 2000).

Opiates

A number of studies have examined the effectiveness of treatment types for heroin dependence. One of these is the Australian Treatment Outcome Study (ATOS) involving 615 heroin users (Darke et al., 2006a). Two year findings of the ATOS found an association between reduced heroin use and longer periods in both residential rehabilitation and maintenance treatment (Darke et al., 2006b). Inpatient drug free residential rehabilitation and maintenance therapies can reduce heroin use considerably (Darke et al; Gossop et al.; Hubbard et al; Ward et al., as cited in Darke et al., 2006a, p. 201).

Stimulants

A recent literature review examining treatment options for ATS users indicates that TCs can be effective for a range of ATS using populations including young people and offenders (Magor-Blatch & Pitts, 2009). A three month follow up study by Stubbs et al. (2004) showed significantly reduced levels of drug use amongst psychostimulant users who completed at least half of a 12-week residential program. Stubbs et al. suggest that MTCs for ATS users should include motivational interviewing, harm reduction strategies, cognitive behavioural therapy, family therapy and skills training.

The Drug Abuse Treatment Outcome Studies (Simpson & Flynn, 2008) found that extended periods of treatment correlated positively with improved treatment outcomes, including reduced cocaine use in the 12 months following treatment. This finding applied particularly to those in long term residential or outpatient drug free treatment, for at least six months.

Mental health and AOD substance abuse

Studies have shown that having a co-morbid mental illness can reduce the effectiveness of treatment (Leff et al., 2009; Shane et al., 2003), while adolescents with a mixed co-morbidity have been found to be much more likely to relapse and experience poorer outcomes (Shane et al., 2003). MTCs

designed to meet the specific needs and characteristics of particular population groups are becoming increasingly common with a number of studies demonstrating the benefits (De Leon, et al., 2000b; McGeary et al., 2000; Sacks et al., 2008a; Skinner, 2005). TCs modified to meet the specific needs of mothers and children have shown reductions in AOD use and depression, increased employment, and improvements in mental health (Coletti et al., 1997; Stevens & Arbiter, 1995; Stevens & Patton, 1998; Wexler, 1999).

MTC has been found to produce significantly better outcomes on several treatment outcome areas including substance use, mental health, crime, HIV risk, employment, and housing (Sacks et al., 2008a). Residential programs incorporating modified mental health and substance abuse treatment approaches have also been shown to be effective for clients with a co-morbidity who are homeless or treatment non-responders (Brunette et al., 2004). There is also evidence that low to medium residential treatment models may be an appropriate option for people with co-morbid mood and anxiety disorders who have been in high intensity residential rehabilitation (Leonard et al., 2007).

Residential rehabilitation for young people

Available evidence on the effectiveness of community based treatment models for high risk youth and their families is limited and inconclusive (Edelen et al., 2009). However there is growing evidence regarding the effectiveness of TCs and aftercare programs for young people. Positive treatment outcomes for youth, include significant reductions in drug use and criminal activity (Morrall et al as cited in Edelen et al., p. 2; Jainchill et al., 2000). A recent outcome evaluation, comparing adolescents on probation attending a TC to those staying in alternative group homes, provides support for structured aftercare and multiple treatment episodes to achieve long-term outcomes (Edelen et al., 2009).

Medium to low level residential rehabilitation programs have also been shown to have some success in addressing youth substance abuse and criminal activity (Jainchill et al., 2005). In a study with USA Recovery House, cannabis was the most common primary drug among the young people prior to treatment, followed by alcohol (Jainchill et al., 2005). Post treatment results show reductions in drug use (other than cannabis and alcohol) and reports of criminal activity (Jainchill et al., 2005).

Residential rehabilitation treatment models

Intensive residential treatment

The research body on intensive residential treatment models is growing, with varied findings in relation to treatment duration, retention, completion and other residential rehabilitation services. Most research indicates that residential treatment is a relatively cost effective treatment approach in which positive treatment outcomes can be achieved within appropriate treatment services and conditions. Methodological limitations of the studies in this area make it difficult to draw strong conclusions in regard to the relative efficacy of residential treatment models. However the data available is generally very positive, particularly for modified therapeutic community (MTCs) models for people with co-morbid mental health and AOD issues who are experiencing homelessness, as well as other marginalised population groups.

Medium to low intensity treatment

The evidence indicates that medium to low level residential service models are important and appropriate for re-integration into the community, particularly after, or as part of, a program addressing problematic substance use. These models involve accommodation, across a range of settings, and include minimal support. The evidence linking this treatment type to improved outcomes

in the areas of substance use, employment and crime is emerging, as is the evidence showing benefits to people with co-morbid substance abuse and mental health issues. Similar to intensive residential treatment models, this treatment type shows promise for people with co-morbid substance use and mental health issues.

Aftercare

There is emerging evidence on the effectiveness of residential aftercare programs, with a number of studies indicating improved treatment outcomes among clients that complete such a program (Greenwood, 2009; Perry et al., 2006). Studies on aftercare programs for offenders within the criminal justice system have shown that this form of treatment is particularly effective for this population group. Medium to low intensity residential models have been found to be particularly beneficial when provided as an aftercare program after discharge from more intensive residential treatment types, including those provided for offenders in criminal justice settings (Burdon et al., 2007; Greenwood, 2009; Hiller et al., 1999). Furthermore, there is preliminary evidence for the effectiveness of a TC-oriented supported housing aftercare program to sustain the improvements brought about by an MTC (Sacks et al., 2003).

4.2.4. Pharmacotherapy

The literature review on substitution pharmacotherapies draws extensively on recently completed work by Ritter and Chalmers (2009) on opioids, and builds on these findings by drawing on seminal work about other drugs of dependence. This summary covers evidence on pharmacotherapeutic options for heroin, alcohol, and amphetamines.

Effectiveness by PDOC

Heroin

Methadone is the most frequently prescribed and cost effective form of pharmacotherapy treatment for heroin dependence. Methadone is well researched and has been found to significantly reduce heroin use and increase treatment retention rates. In terms of treatment outcomes, preliminary studies on buprenorphine have generally found it to be comparable to methadone. The effectiveness of naltrexone and prescription heroin for opioid dependence need to be further explored as there is currently a lack of strong evidence for these treatment types.

In their recent review of the opioid pharmacotherapy system, Ritter and Chalmers (2009) identified a number of areas of concern, the first of which is a lack of access to prescribers, dispensers and services. The second is about inconsistent national policies around the role of unsupervised treatment and take away dosing, and the third is the existence of conflicting evidence base around the need for adjunct psycho-social interventions such as counselling.

Alcohol

Anti-craving medications and selective serotonin reuptake inhibitors (SSRIs) are the two main types of pharmacotherapies that have been trialled for alcohol dependence. The research evidence indicates that anti-craving therapies should be used in conjunction with psycho-social therapy. Naltrexone, acamprosate and disulfiram have all been found to be effective (to varying degrees and for different sub-groups) for the treatment of alcohol dependence, particularly when used in combination with one another. Naltrexone appears to be most appropriate for reducing alcohol consumption, while acamprosate may be more effective for clients aiming to achieve abstinence. Disulfiram treatment may be most effective at reducing heavy drinking days, weekly average alcohol consumption, increasing time to first drink and days of abstinence.

Evidence of the effectiveness of SSRIs in reducing alcohol consumption is limited; however studies show promising results for SSRIs in the treatment of people with co-morbid anxiety disorders and less severe alcohol dependence.

Amphetamines

There have been many research trials of medications for treating amphetamine dependence, with little success. To date there are no medications approved for the treatment of amphetamine dependence. However, the research evidence indicates promising results for the use of bupropion, modafinil and methylphenidate.

Conclusion

There is currently strong evidence for the use of methadone and buprenorphine in the treatment of heroin dependence, and good evidence for the use of anti-craving medications for the treatment of alcohol dependence. However, there are currently no guidelines for the pharmacotherapeutic treatment of amphetamine dependence.

4.3. Common factors as moderators of behaviour change across psychological treatments

The results of two major treatment matching studies, Project MATCH and UKATT concluded there was no evidence that client-treatment matching can lead to an overall increase in the effectiveness of treatment for alcohol problems (UKATT Research Team, 2008, p. 232). In light of these findings, that a variety of structured and well implemented psycho-therapeutic treatments can be similarly effective, the research focus is shifting from ‘which types of treatment are most effective’ to ‘what are the common factors across treatments that lead to positive outcomes’.

Many of these factors are common to treatment implementation and they have implications for workforce development and service delivery arrangements. We provide a conceptual framework to consider how client, treatment and therapist, service provider and service infrastructure are interconnected in a dynamic process that can influence change.

4.3.1. Fixed client characteristics

Fixed client characteristics are unchangeable elements, such as socio-demographic and background variables (e.g., gender, age, ethnicity, education, socio-economic status; De Leon et al., 1997, cited in Schroder et al., 2007).

Gender

Marsh et al. (2009, p. 190) examined prospective data from National Treatment Improvement Evaluation Study (NTIES) to identify any gender differences in the impact of matched services, access services, and outcome-targeted services on substance abuse treatment outcomes. They found that,

Access or linkage services, outcome- targeted services (in this case, substance abuse counselling), and matched services are all relevant to helping clients remain in treatment, whereas receipt of substance abuse and matched services are related to reduced post treatment substance use.

Gender was a significant mediator of the relation between services and treatment outcomes, particularly for women rather than men. It is not clear whether “tailoring services to needs is more

important for women, who, compared with men, enter treatment with more serious dependencies and identify greater needs for health and social services” (Marsh et al., 2009).

Young people and treatment retention

Treatment retention is particularly challenging when young people are involved. Schroder (2007, pp. 26-27) reviewed the literature on retention and noted that:

- High rates of treatment drop-out among young people attending AOD treatment services highlights the need to better understand what makes young people stay in or leave AOD treatment.
- Research examining fixed client characteristics has produced inconclusive findings on which fixed characteristics are associated with treatment retention. To date, the only real conclusion drawn from these studies is that fixed client characteristics alone are not sufficient to explain what makes young people stay in or leave AOD treatment.

4.3.2. Dynamic client characteristics

Dynamic client characteristics can be described as the changing characteristics of an individual. Examples include changes in perception such as motivation and readiness for treatment (De Leon et al. 1997, cited in Schroder et al., 2007).

Client motivation

A person’s motivation to change plays an important role in the process of recovery and healing from addictions (DiClemente et al., 2004). ‘Motivation’ has been described as the “personal considerations, commitments, reasons and intentions that move individuals to perform certain behaviours” (DiClemente, et al., 2004, p.103-104). DiClemente, et al.’s (2004) review of research literature on measuring stages of intentional behavioural changes found that (despite problems in measurement) there is solid evidence that the stages of change provides a meaningful way to understand the process by which change occurs.

These authors advocated for better measurement tools and more frequent assessments. They noted that clinicians have been using the stage model, despite not having “a simple measure to evaluate stage status”, and many use “sensitive and motivational clinical interviews to establish stage status and how to help patients more through the process of change” (DiClemente et al., 2004, p.113).

Client preference

Swift and Callahan (2009) reviewed 26 studies comparing the treatment outcomes achieved by clients matched to a preferred treatment compared to clients not matched to a preferred treatment. Compared to non-matched clients, clients matched to their preferred treatment tended to show greater improvements in the outcome measures, and were less likely to discontinue (drop-out of) treatment (Swift & Callahan, 2009). Swift and Callahan (2009, p. 368) acknowledged there are risks in matching treatment based on clients’ preferences; recommending “a collaboration where both parties [therapist and client] share information and discuss options and preferences openly”.

Meeting client needs

Friedmann et al. (2004, p. 185) found partial support for duration as a factor mediating the relation between ‘need-service’ matching and drug use improvements. Individuals were more inclined to remain in treatment when they felt their treatment needs were being met.

Treatment retention for young people

In their review of the literature on treatment retention for young people, Schroder et al. (2007) found that research examining dynamic client characteristics was more useful in providing information about client-related variables associated with treatment retention.

In studies examining motivation as a more dynamic process, internal motivation to engage in treatment has been consistently associated with longer treatment retention. Other dynamic client characteristics have not been investigated in as much depth, but further research in this area is likely to prove helpful in determining other dynamic client characteristics associated with treatment retention (Schroder et al., 2007, p 27).

4.3.3. Program related variables

Program related variables include staff experience and attitudes, interpersonal style of the therapist; credibility of therapy to patient and therapist, dimensions of therapies (e.g. degree of structure and directiveness; focus on emotional content), emphasis on engineering social support, and how far these match the personality and needs of the patient.

A series of papers produced by UK Drug and Alcohol Findings (Ashton, 2005a, 2005b, 2005c, 2006; Ashton & Witton, 2004) reviewed literature on “how treatment services can encourage clients who make contact to return and stay the course, not by what type of therapy they offer, but by the manner in which they offer it”. Key findings include:

- Enhancing treatment recruitment through considerations of service response time, wait-lists, style of reminders and follow-up.
- Practical help to overcome access obstacles such as transport and childcare directly improves retention and also shows that the service is responsive and caring.
- In “every induction study in which MI has apparently had a positive overall impact, this can be explained by ‘non-specific’ factors common to other therapies rather than the specific approach”. The most common finding was the enthusiasm and faith of the therapists; extra assessment and/or feedback of assessment results; spending time with a sympathetic listener.
- How directive the therapist is in the face of client resistance is emerging as one of the strongest and most consistent influences on the outcomes of therapy. There is no one right answer – it all depends on the client, in particular on how much they perceive and react against threats to their autonomy.
- Non-directive styles generally suit clients characterised by anger or resistance; directive approaches profit clients who welcome a lead (Ashton, M., 2005a, 2005b, 2005c; Ashton, M & Witton, 2004).

Treatment retention for young people

Program-related variables have consistently been shown to be associated with treatment retention. In particular, variables such as level of staff experience, staff/client relationships and services that address the holistic needs of young people have been associated with longer treatment retention.

Services including family based interventions for young people

Recent systematic reviews on treatments for adolescent substance abuse found family based interventions among the most effective interventions (Becker & Curry, 2008; Waldron & Turner, 2008). A meta-analysis of RCTs examining the effect of family based interventions for young people's alcohol use suggests family interventions are effective regarding alcohol initiation and frequency of alcohol use in young people. Furthermore, the effects were maintained over time as a reduction in young people's alcohol consumption was found even at 48 months (Smit et al., 2008).

4.3.4. Service variables

Service variables include the approach and philosophy, as well as the setting, resourcing, organisational structure and management. These variables impact on the treatment provided, the support provided to therapists and other workers in an organisation, policies in regards to access criteria, and waiting lists.

Linkages to services via case management

A systematic review of case management interventions found this to be an effective strategy for linking people with AOD problems "to community and treatment services, compared to treatment as usual or other viable treatment options like psycho-education or brief interventions" (Hesse et al., 2007, p. 13). Common factors that may increase case managers' ability to successfully link clients to services include: availability of a manual to guide the interventions; service availability in the community; case management model and how effectively it is applied and its integration in the local network of services (Hesse et al., 2007, p. 2); and availability of training and supervision for clinicians. Individual studies also identified possible linkage enhancement factors including: provision of free transport or vouchers for public transport; case managers purchasing necessary treatment services; and providing clients with vouchers for free (Hesse et al., 2007). No single model of case management could be identified as more effective in facilitating linkages to services due to the variability of the studies reviewed.

Services for Aboriginal and Torres Strait Islanders

Elements of best practice have been identified from case studies of five of Australia's most successful Indigenous AOD projects that were assessed as outstanding in their field (Strempel et al., 2004). The authors found that, while key themes can be identified across services, a key factor in the implementation of best practice was the unique history and context of particular services. The key themes they identified include:

- Sound structure of management and governance to guide organisations and maintain high levels of professionalism and accountability.
- The ability of an organisation to attract and maintain quality staff³.
- Good collaboration with other agencies helped these organisations grow and stay strong.

³ We sought a definition of 'quality staff' to provide some detail on this point. Organisations view six categories of staff attributes as valued qualities of competence: knowledge and experience; organisational citizenship; interpersonal skills; service orientation; personal attributes; and leadership skills (Grosenick & Hatmaker, 2000).

- The presence of a committed and skilful manager or leader who plays a leading role in furthering a vision for what needs to be achieved and maintains enthusiasm of a core group to implement the vision. This was important to sustain good staff, a strong board of directors and a solid network of partnerships.
- The importance of adequate and continuing funding. Most of the case studies were successful in establishing funding security for their projects and services. This was achieved by demonstrating above-average financial management and accountability and maintaining good relationships with funding agencies (Strempe et al., 2004).

4.3.5. Service system variables

Service providers work within the context of the wider AOD (and mental health) service infrastructure where variables such as service availability impact on waiting lists and the availability of services. Key variables such as state legislation and policies influence the nature of work undertaken by providers and their staff.

Compulsory treatment

Compulsory AOD treatment refers to mandated treatment based on legislation and refers to a range of programs and levels of coercion. This can be diversion into optional treatment through to court-ordered treatment as part of a sentencing order, where the person has no choice (Pritchard et al., 2007). Compulsory treatment has an element of coercion and it has been suggested that for those offenders who are not 'treatment ready' that MI be included into the program design to enhance their motivation (Berends et al., 2007).

Therapeutic Communities (TCs) with aftercare have been found to be effective in reducing AOD use and criminality in both community and custodial settings. At least one study that included MI and TC had more positive outcomes than TC alone (Czuchry et al., 2006, cited in Swan et al., 2007). More research is required on the interplay of coercion and motivation as some studies show compulsory treatment has the same outcomes as voluntary treatment while some authors argue coercing people into treatment is counterproductive to motivation and behaviour change.

While there is some evidence to suggest that some people benefit from compulsory treatment it is fairly weak (Perry et al., 2006; Pritchard et al., 2007). However, there have been some positive findings from evaluations of diversion initiatives including pre-arrest, pre-trial and Drug Court diversion and programs in custody. Despite methodological limitations (small sample sizes and retention rates, short follow-up periods and lack of suitable comparison groups and RCTs) the findings from studies show reductions in substance use and recidivism and increases in social functioning and health for those who complete programs. There is also evidence that diversion is facilitating access to treatment for previously hard to reach groups. To enhance engagement and retention in treatment it is suggested that as well as including MI in the program design, practical support be provided via case management and outreach services. A review of eligibility criteria and flexibility of program design are important to address some of the unintended negative findings such as net widening and limited access to indigenous and minority groups (e.g. women, CALD, those with mental health).

4.4. Workforce

The literature on workforce planning and development underlines the need for a strategic, multi-faceted, multi-level, evidence-informed approach supported by adequate investment. The relevant workforce for effective treatment delivery, and the prevention and reduction of AOD-related harms, extends beyond that funded for the delivery of specialist AOD treatment. The specialist workforce is therefore required to collaborate effectively with other services.

The knowledge, skills and abilities required for AOD work include a broad and applied understanding of social, legal and medical contexts, knowledge of the effects of alcohol and other drugs and of treatments and the ability to deal with a wide range of issues and situations. Input from medicine and nursing is required for pharmacotherapy and withdrawal.

The body of research evidence is at best indicative of the effect of practitioner characteristics and other workforce variables on client outcomes. The field requires more use of research and evaluation approaches that will illuminate change processes.

Capacity building and partnerships are inter-related concepts that can guide developments at the organisational level. Systemic strategies must address growing and changing populations, increasing complexity of need, a divide between metropolitan and rural and regional needs, and the need for a skilled and well-resourced workforce.

Enduring needs for the AOD workforce are concerned with pay and conditions (including the transferability of entitlements), recruitment, retention and sustainability. The national and state policy context promises health system reform directed at longstanding workforce shortages and at improving the quality and safety of health care. System-wide flexibility and ongoing learning are emphasised. The AOD sector needs to be involved in such developments and ensure that its workforce planning and development strategy is consistent with wider reforms.

5. TREATMENT COMPONENTS

5.1. Introduction

A major challenge for AOD systems research is the extent to which treatment is about behaviour change related to substance use versus the provision of support for related needs. The Expert Panel was asked to comment on this issue. There were different views about how these related needs may be met, however opinions converged in reference to meeting AOD needs and other concerns concurrently. The importance of strong links with other sectors was emphasised by the Expert Panel.

This chapter provides some background on treatment before describing core treatment components. Each component is described in terms of the target group, definition of treatment, therapeutic techniques involved, and common primary drugs of concern. Where relevant, a description of elements within treatment components is provided and modifications for particular client groups are outlined. Throughout, reference is made to the reviews of research literature conducted for the project and views of the Expert Panel.

While the project focus is on treatment, a number of critical support functions have been raised by the Expert Panel. These functions are also outlined.

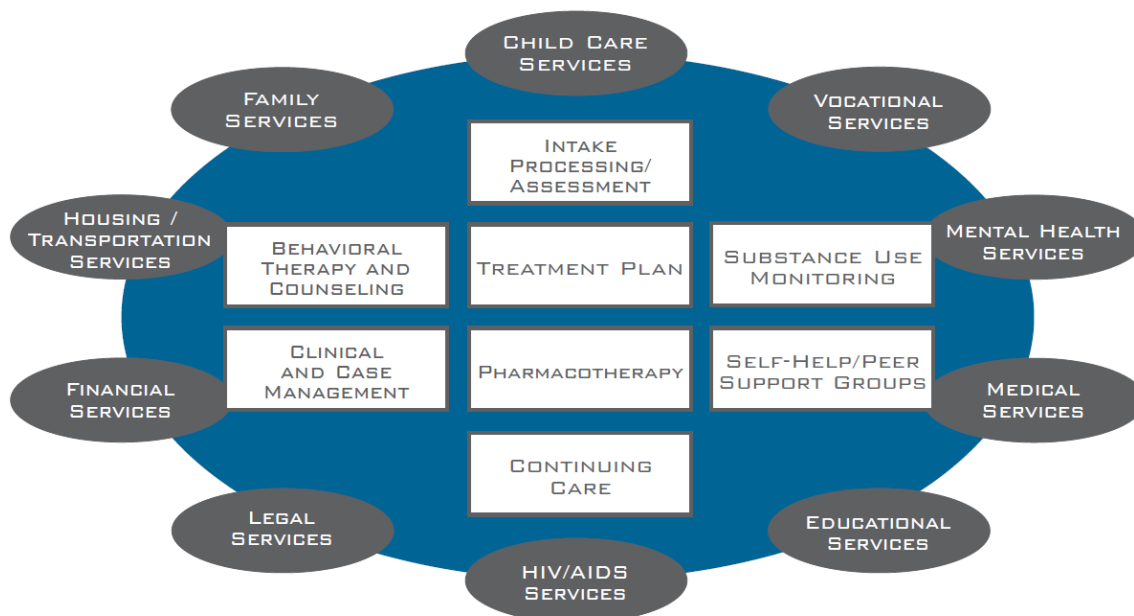
5.2. Background

The US National Institute on Drug Abuse (2009, p. 8) explained that,

The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient.

As shown in Figure 4, below, a comprehensive program will comprise:

- Specialist strategies to guide people through and beyond treatment (e.g., intake and assessment, continuing care)
- Specialist therapeutic techniques to effect behaviour change (e.g., behavioural therapy, pharmacotherapy)
- Support services (e.g., child care, housing/transportation services, educational services)



Source: NIDA 2009, p. 8.

Figure 4. Components of comprehensive drug abuse treatment

Client complexity and the broad range of concerns that may impact on client well-being have been well recognised, as described in the *Blueprint for Alcohol and Drug Services, 2009-2013* (VDHS, 2008, p. 5),

Multiple health issues, the most prevalent being mental health problems, affect a substantial proportion of our clients. Families are increasingly seeking our help and young people are identifying a range of other health, welfare, housing, education and employment needs that impact upon the success of their treatment programs.

The ‘Blueprint’ notes the importance of having a clear definition of therapeutic interventions (VDHS, 2008). The current project focuses on specialist therapeutic components that are offered from dedicated AOD services while considering functional or support aspects of the system which help to engage people and guide them through treatment.

Broader support services, such as housing, are understood to be the province of allied systems and partnership approaches at policy and practice levels are important for a co-ordinated approach to care. The ‘Blueprint’ policy states that, “forging stronger links and improving co-ordination across sectors with stronger financial incentives that promote and support collaborative efforts will improve treatment options and support for these clients” (VDHS, 2008, p. 16).

5.3. Core components of treatment

Some experts to the review reduced treatment to three or four broad approaches:

Psycho-pharmacological, pharmacological, outpatient, residential

Detoxification, recovery, and maintenance, backed up by “plain case work around needing a bed, how are they going to support themselves etc”

Drawing on advice from the Expert Panel and the research literature, we suggest four core components of treatment:

- Pharmacotherapies
- Withdrawal
- Behavioural therapies (outpatient therapy)
- Residential rehabilitation

In some cases, these components include multiple elements of treatment (e.g., brief intervention, indicated prevention) and these elements have been outlined. The Expert Panel has endorsed these treatment components.

5.3.1. Component one: Pharmacotherapies

Target group: individuals dependent on opioids who may not be in a position to cease their AOD use but wish to make lifestyle changes such as re-establishing relationships and obtaining employment, and reduce the risk of relapse.

Definition: the provision of a legal, stable source of opioids.

Techniques: primarily methadone and buprenorphine.

Common primary drugs of concern: opioids.

Pharmacotherapies for opioid addiction allow clients to maintain control over their drug use. Methadone prevents withdrawal, blocks the effects of illicit opioid use, and decreases opioid craving. Buprenorphine reduces or eliminates withdrawal symptoms without the euphoria and sedation caused by opioids (NIDA, 2009). It is equally effective as methadone in treating heroin dependence (Lintzeris et al. as cited in Ritter & Chalmers, 2009).

There is substantial evidence in support of substitution pharmacotherapies. A recent Cochrane review reported that methadone maintenance treatment (MMT) at proper doses is the most effective treatment for patient retention and suppressing heroin use (Amato et al., 2008a). Methadone dosages from 60 to 100 mg per day are more effective than lower doses in retaining patients and reducing heroin use during treatment (Faggiano et al., 2003).

Evidence on combining psychotherapy with substitution pharmacotherapy has provided conflicting results; with some studies indicating benefits in relation to treatment retention, outcomes and the quality of therapeutic relationships while others reporting that counselling does not result in improvements superior to standard care (refer to Ritter & Chalmers, 2009 for details). Amato, et al. (2008a) undertook a Cochrane review involving 28 trials to examine whether a specific psycho-social intervention provides any additional benefit to pharmacological maintenance treatment. All but two of the trials took place in the USA. The control intervention was a maintenance program, which routinely offers counselling sessions in addition to pharmacological treatment. The authors concluded that adding psycho-social support to this control intervention does not change the effectiveness of

retention in treatment. Benefits include reducing heroin use during treatment. NIDA (2009, pp. 38-39) suggested that a combination of pharmacotherapy and psychotherapy is best. They stated that,

The most effective methadone maintenance programs include individual and/or group counselling, as well as provision of or referral to other needed medical, psychological, and social services....patients stabilized on these medications can also engage more readily in counselling and other behavioural interventions essential to recovery and rehabilitation.

Members of the Expert Panel noted that a “really well functioning pharmacotherapy service is critical” and change is needed in Victoria. The current pharmacotherapy system was described as requiring “a fairly substantial injection of funding...it’s really under-funded and it’s struggling and the way it’s operating is based pretty much on good will”. Further, pharmacotherapies need to be seen as part of the specialist AOD system rather than as a separate system. In 2003, Ritter et al. recommended the establishment of a small number of specialist clinics to complement Specialist Pharmacotherapy Services (SPS) and community programs (p. 115). These clinics would engage GP prescribers on a sessional basis and have a community pharmacist in the immediate vicinity. They would be able to treat large numbers of heroin users.

Recent research into pharmacotherapy services across Australia highlights vulnerabilities of the systems in place, which are particularly salient to Victoria. These vulnerabilities include the limited number of prescribers and the substantial impact on service availability if these services reduce. As fewer places will be available, it will be more difficult for clients to obtain treatment. With longer periods between treatments, concomitant costs to health and other sectors will result (Ritter & Chalmers, 2008). On the basis of this information, the current review supports the need to establish a small number of specialist clinics in the state. This notwithstanding, it should be noted that Victoria’s pharmacotherapy services are currently undergoing a separate review that will provide further direction for system development.

5.3.2. Component two: Withdrawal

Target group: people who are AOD dependent and wish to undertake withdrawal as the first step toward longer term treatment that addresses their AOD problems.

Definition: safe and comfortable neuro-adaptation reversal and care. Duration from 1-3 weeks. In-patient and out-patient settings.

Techniques: medical care and monitoring, pharmacotherapy, behavioural therapies (opioids). Withdrawal must be provided as the first step in a regime of treatment with following treatment organised from the onset of the withdrawal episode.

Common primary drug of concern: residential treatment for complex clients with alcohol, opioids, amphetamines as their PDOC and non-residential treatment for less complex clients whose PDOC is alcohol, opioids, amphetamines, or cannabis.

Withdrawal comprises safe and comfortable neuro-adaptation reversal and care. It cannot be offered in isolation from subsequent treatment as psychological, social, and behavioural problems associated with addiction have not been addressed. Comprehensive assessment, treatment planning, and case management functions should commence during the withdrawal episode.

A range of medications can be used to reduce the effects of withdrawal, as detailed in the withdrawal review. Psycho-social interventions are also useful for people withdrawing from opioid use. Adding any psycho-social treatment to any substitution detoxification treatment provides benefits in terms of treatment attendance and completion, and drug use at follow-up (Amato, L. et al., 2008b).

Two settings for withdrawal are required for the system; residential and non-residential. Residential withdrawal is most appropriate for clients with severe withdrawal syndrome or complex behaviours. Alcohol and opioids are the customary primary drugs of concern where residential withdrawal may be required. Complex clients with problematic ATS use may also be involved. Non-residential withdrawal requires access to a medical practitioner and it may include a combination of visits to an AOD service and service delivery in the client's home. This form of service delivery involves clients who have a level of stability in their lives, including support people and stable circumstances. Attendance at a health care facility and home visits must be matched to client need.

5.3.3. Component three: Behavioural therapies (outpatient treatment)

Behavioural therapies are evidence-based clinical interventions which target behaviour change related to AOD use. These therapies can increase people's motivation for AOD treatment, offer strategies for harm reduction and relapse prevention, and support people if relapse does occur. Strategies for communication, building relationship and parenting skills, and addressing family dynamics are also incorporated (NIDA, 2009).

Elements of behavioural therapies put forward for the specialist AOD treatment system comprise:

- Indicated prevention
- Brief intervention
- Individual counselling
- Group counselling
- Family therapy

Therapeutic day programs are also described, although this is a multi-system model that is best supported through cross-system partnerships.

Indicated prevention

Target group: young people at high risk, with minimal but detectable signs of substance misuse or related problems, prior to the onset of AOD dependence (EMCDDA, 2009). Clients are from 12 to 21 years of age. The target group may be accessed via pathways that include emergency departments, the medical system, school settings, the court system, and addiction treatment centres providing for parents (EMCDDA, 2009).

Definition: in development, evidence is limited as programs are emerging and few evaluations have been completed. Interventions aim to prevent the progression to dependence and correlating disorders and to reduce the length and frequency of dangerous AOD use (based on IOM and NIDA approach, cited in EMCDDA, 2009).

Techniques: While evidence is limited, an international review highlighted three programs: cognitive therapy focusing on skills development; a multi-faceted program providing structure and support that includes skill development and practical resources; and brief intervention that may be part of a stepped care approach (details shown below; EMCDDA, 2009). Additional approaches for consideration include life skills development (outlined below) and family-based interventions (described later in the report).

Common primary drug of concern: cannabis, alcohol. Interventions may also be appropriate for some clients with other drug problems.

Indicated prevention programs have the following features:

- They target high risk individuals with the first indicators of AOD use (e.g., alcohol consumption, school failure, cannabis use), prior to the onset of dependence.
- Target group indicators need to have a stronger correlation with AOD abuse than the indicators in selective prevention (i.e., indicators specific to the individual and involving AOD use rather than indicators that are associated with membership of a specific sub-population but do not include detectable AOD use).
- Programs do not focus on abstinence but aim to prevent progression to dependence and correlating disorders and reduce the length and frequency of dangerous AOD use.
- Individual risk and protective factors need to be known to determine the specific intervention to be utilised (IOM and NIDA approach, cited in EMCDDA, 2009).

Indicated prevention program components include brief, manualised intervention; for example motivational interviewing and parent training (EMCDDA, 2009). They include individual needs assessment and working with other organisations to address young people's needs. There is limited evidence regarding effective models. The EMCDDA (2009) review highlighted three programs (from 53) that showed good promise:

1. The **Utrecht Coping Power Program** (UCPP; Netherlands) is an intervention that teaches children to think before they act out, which can help them avoid substance abuse in adolescence using manualised cognitive therapy (23 weekly sessions, 1.5 hrs, involving children and parents). An RCT compared the intervention with treatment as usual and

involved children with disruptive behaviour disorder who were aged 8 to 13 years. A healthy control group was included in the RCT. At five year follow-up there was a reduction in cannabis and nicotine use but no differences in delinquent behaviour.

2. **Supra-f** is an indicated prevention program from Switzerland. The program targets at risk youth (11 – 20 years), with problematic behaviour identified via schools, youth court and parents. There are different components aimed at supporting and structuring children's lives, which vary from 3 to 42 hours a week. The program includes school and job work, problem analysis, problem solving skills and social competence training.
3. **Bundesprojekt Hart am Limit - HaLT** is a German program that targets young people in intensive care after binge drinking. The program aims to identify the reasons for risky alcohol consumption and to initiate therapy and rehabilitation if appropriate, with a view to preventing repeat visits to intensive care for problems related to alcohol. The program involves a minimum of two counselling sessions.

Life skill programs have been used with mainstream populations of young people, usually within school-based settings (Dusenbury & Falco, 1995). As the name suggests, these programs aim to facilitate skills development so that young people are better placed to deal with challenges that increase their risk of problematic substance use. There is some overlap with the programs outlined above.

Brief intervention

<p><u>Target group:</u> people with mild to moderately severe alcohol and other drug dependence.</p> <p><u>Definition:</u> single session (very brief) or 2-5 session behaviour change intervention, with varying effectiveness according to individual awareness about treatment needs and interest in treatment.</p> <p><u>Techniques:</u> a) a 'very brief', or single session BI, involves information and referral (where required; when MI is conducted as a single intervention it is also classified as a BI); b) an extended BI that includes feedback about AOD use; recommending a change in behaviour; presenting options to facilitate the change; checking and responding to the client's reaction; and providing follow-up care (Bien et al., 1993).</p> <p><u>Common primary drug of concern:</u> alcohol, cannabis.</p>
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The Screening, Brief Intervention and Referral into Treatment (SBIRT) tools are advocated for use in all primary care settings, to identify people before AOD problems accelerate and / or to provide a pathway into specialist AOD treatment (NIDA, 2009). Extended BI (from two to five sessions) utilise theoretically derived behaviour-change strategies. This form of BI is useful for adolescents and adults, usually in relation to cannabis or alcohol use.

A two session brief intervention for young people who were ambivalent about addressing their cannabis use incorporated an individual assessment session and a subsequent personalised feedback session a week after the assessment. Most participants were drug dependent and over time there was a significant reduction in the frequency of cannabis use (Martin et al., 2005). In an extensive review of research, BI has been shown to be effective for both treatment seeking and non-treatment populations in relation to alcohol use. It is more useful when people have less severe alcohol problems. For those

with more severe problems, BI should be part of a stepped care approach (Moyer et al., 2002). Follow-up will allow a determination about whether further treatment is required (UKATT Research Team, 2008).

Internet-based personalised-feedback interventions are another form of BI; allowing people to explore their own alcohol consumption patterns and access behaviour change interventions. This form of intervention is effective for reducing risky alcohol consumption among young people and adults (Riper et al., 2009). Kypri and colleagues suggest offering e-screening and brief intervention systems in student health care settings (Kypri et al., 2008). Bibliotherapy (see next session, on individual counselling) may also be involved.

Individual counselling

Target group: people with mild to severe alcohol and other drug dependence.

Definition: medium to high intensity regime of individual counselling utilising therapeutic techniques that vary according to drug use and severity. May be used in combination with pharmacotherapy. Useful with opioid withdrawal.

Techniques: various, according to individual need. Evidence based methods include cognitive-behavioural therapy (CBT), community reinforcement approach (CRA), contingency management (CM), motivational enhancement therapy (MET), motivational interviewing (MI), and social behavioural network therapy (SB-NET). Bibliotherapy is appropriate for people with less severe alcohol problems. (For details, see below and Appendix D3).

Common primary drug of concern: alcohol, cannabis, opioids, amphetamines.

Moving beyond very brief and extended brief intervention models, a longer-term regime of individual counselling is another core component of a specialist system. It is essential that approaches are theoretically sound and aim to change behaviour associated with problematic substance use. One member of the Expert Panel suggested that outpatient therapy must be, “precise and specific and specialist and deliberative and related to some sort of theoretical and knowledge based set of skills...with expectations of what a percentage success would be for each of those treatments”.

A review of 53 controlled trials of CBT for adults with AOD disorders demonstrated the efficacy of CBT across a large and diverse sample of studies. Review authors found that CBT was more effective, in comparison with no treatments or treatment that did not include this approach (Magill & Ray, 2009). The ‘Mesa Grande’ project demonstrated the efficacy of four psycho-social approaches to address problematic alcohol use; social skills training, the community reinforcement approach, behaviour contracting, and behavioural marital therapy (Miller, W. R. & Wilbourne, 2002). Project MATCH and UKATT support the use of CBT, TSF, MET, and SBNET for people with alcohol dependence. As noted elsewhere, psycho-social interventions combined with withdrawal improve retention (Amato, L. et al., 2008b).

Bibliotherapy, involving the use of written material and possibly assignments in addition to contact with a clinician, is an opportunity for people to learn more about their situation outside the treatment encounter; facilitating active involvement in recovery and promoting personal responsibility. This approach may address people’s concerns regarding privacy and stigma. Available evidence suggests it is most appropriate when people do not have severe alcohol problems (Berglund et al., 2003).

Group counselling

Target group: people with mild to severe alcohol and other drug dependence, particularly those who are willing to engage in group programs.

Definition: medium to high intensity regime of group counselling utilising therapeutic techniques that vary according to drug use and severity. May be used to complement individual counselling.

Techniques: various methods outlined above may be adapted to the group setting (e.g. CBT) and TSF is often involved.

Common primary drug of concern: alcohol, cannabis, opioids, amphetamines.

Group therapy is a useful way to complement individual counselling, providing therapeutic interventions and utilising peer support and AOD free social networks. When group therapy is structured according to principles of CBT or CM positive outcomes are achieved (NIDA, 2009).

CBT based programs are useful for adults with co-morbid mental health conditions, where these clients are willing to attend group sessions (Drake et al., 2008), as well as adolescents (Waldron & Turner, 2008). Twelve-step programs assist people with alcohol dependence (UKATT Research Team, 2008). The group dynamics of TSF (alcoholics anonymous) meetings offer strong social reinforcement for abstinence and provide opportunity for networks to be developed which include 'low-risk' social activities (Kelly et al., 2009).

One study from Thailand, involving almost 1,000 people aged 18-25 years, supported the use of group interventions in relation to methamphetamine use. Findings showed substantial rates of abstinence from methamphetamine use at 3-month follow-up across two intervention conditions. These conditions were involvement in a peer network intervention or a best practice, life-skills curriculum on methamphetamine use, sexual behaviour and sexually transmitted infection (Sherman et al., 2009).

Family therapy

Target group: families and young people where a young person is at risk of, or has become AOD dependent. Individual assessment needed to ascertain whether family-based therapy is appropriate for the family.

Definition: indicated prevention and treatment interventions that aim to work with family members and the young person to address factors related to AOD use and strengthen strategies countering these risks.

Techniques: varying intensity and utilising group therapy (parent-focused), individual and group treatment approaches.

Common primary drug of concern: alcohol, cannabis, opioids, amphetamines.

Family-based interventions deal with issues in the context of the young person's family relationships and, in some cases, in relation to broader systems and networks. Recent systematic reviews on treatment for adolescent substance abuse showed that family-based techniques are among the most effective interventions (Becker & Curry, 2008; Waldron & Turner, 2008).

Various theoretical perspectives have been developed on family therapy. Multi-dimensional family therapy (MDFT) aims to enhance 'pro-social' and appropriate developmental functions; focusing on individual, family, and social connections. Family Support Network (FSN) uses family education and therapy components (Diamond et al., 2002). Multi-systemic therapy (MST) seeks to address social and ecological factors contributing to the development of 'anti-social problems', including substance use. These techniques share a conceptual framework, "that acknowledges the contribution to substance abuse problems made by dysfunctional family environments... [conversely] adolescent problems and substance misuse also disrupt family relationships and can be a cause and not only a consequence of family dysfunction" (Liddle, 2004, p. 77).

A recent Australian review of family-based therapies identified three categories of intervention, with varying focus and intensity:

1. Support interventions for family members of a young person with a substance use problem, regardless of the young person's treatment status.
2. Family-based interventions which utilise family members in the engagement and retention of young people in substance abuse treatment programs, thereby improving treatment outcomes (substance use and other psycho-social variables) and indirectly supporting and assisting family members.
3. Intensive, multi-systemic, interventions that broaden the family therapy framework to include other factors in a young person's social ecology, thereby improving treatment outcomes and indirectly supporting family members (Frye et al., 2008).

The first category of family-based therapies is about parent education, a technique put forward in relation to indicated prevention (Lubman et al., 2007) that also has application when children have become AOD dependent. These programs aim to improve parental well-being, skills, and understandings in relation to their child's AOD problems. A series of group sessions is involved.

The second category of programs employs modified versions of behavioural therapies that are described elsewhere in this document; principally CBT (incorporating CM) and skills training, with the possible inclusion of strategies to improve parental well-being.

The third category of intervention (MDFT) is intensive and multi-modal. It operates in three phases: focusing initially on engaging and establishment before moving on to parenting practices, and then individual and family sessions that focus on building capacity and maintaining treatment advances. This final category is well supported by the research evidence and it has been applied in preventative and treatment situations (refer to Frye et al., 2008 for details). Highly-trained, multi-disciplinary teams conduct functional assessments of young people in the context of their family, school, community and peer relationships. Individualised plans are devised to enhance the effectiveness of parents, promote constructive interaction with service systems and build the capacity of young people to avoid situations that can lead to problematic substance use.

The appropriateness of family-based interventions depends on the specific needs of the family and the young person. Factors requiring consideration include:

- The age of the young person

- The chronicity of the young person's substance use problem
- The nature of the family member's distress and psychological functioning
- The current level of engagement or contact between family members and the young person
- The profile of risk and resilience factors within the family's ecological context (Frye, et al., 2008, p. 59).

Day programs

Target group: people with less severe alcohol and other drug dependence.

Definition: an intensive, structured, day-long program that uses a holistic approach to enable people to address problematic AOD use, largely through the development of associated skills and resources. Four components are involved: life skills, vocational training, education, and recreation (Champney-Smith et al., 2001). Duration is typically from two to six weeks, while some models are much longer.

Techniques: Individual and group counselling, peer support.

Common primary drug of concern: alcohol, cannabis, opioids, amphetamines.

Evidence on the effectiveness of day programs is limited. The program model generally incorporates a holistic approach, which reaches beyond AOD problems, and arguably sits across different systems such as education, employment, and primary care. In some descriptions of day programs there is not a specific AOD therapeutic element, however the literature shows that many programs aim to reduce or stop a participant's AOD use. For example, Drummond et al. (1986) cite the inclusion of counselling to address problematic AOD use.

Equivalent rates of effectiveness have been shown when the community day program is compared with other models, such as a (more expensive) hospital day program (Kaskutas et al., 2004) and as measured by retention (Guydish et al., 1998, cited in Smith et al., 2006), ASI composite scores and withdrawal severity scores (Smith et al., 2006). However, treatment outcomes are not as favourable as those for residential treatment (Smith et al., 2006). Further evidence is needed regarding the therapeutic elements of day programs and their effectiveness for people with AOD problems.

Day programs may be a useful adjunct to more intensive treatment, 'filling the gap' while clients wait for a place in residential treatment. Greater rates of engagement in residential rehabilitation were evident for clients in a day program versus those in withdrawal who were seeking a substitution pharmacotherapy place (Chun et al., 2008). However, the uptake of residential treatment or substitution pharmacotherapy may have been impacted by the availability of places.

5.3.4. Component four: Residential rehabilitation (TC, MTC)

Target group: people with severe drug dependence. Modified therapeutic communities (MTC) have been used for target groups including women, women with dependent children, HIV/AIDS sufferers, and people experiencing homelessness (Sacks et al., 2008a).

Definition: a) the Therapeutic Community (TC) provides a safe, secure environment removed from the wider community, enabling residents to address issues underlying their drug use (Gowing, et al., 2002); b) Modified therapeutic communities (MTC) are based on the TC model and adapted to the needs of particular client groups (e.g., regarding psychiatric symptoms, cognitive impairments, level of functioning (Sacks et al., cited in Skinner, 2005); family circumstances and need for re-integration (Sacks et al., 2004).

Techniques: a) the TC uses individual and group counselling and there is an emphasis on mutual self-help and peer community. At least 3 months stay is required for effective outcomes (McCusker et al., 1995) with some evidence in support of longer periods, especially for particular groups (e.g. Greenfield et al., 2004); b) the MTC may involve shorter meetings and activities, higher staff involvement in activities, smaller units of care (e.g., shorter seminars), greater emphasis on providing instructions and support, assistance to understand mental health problems, and more resourcing for individual counselling in comparison with the TC (Sacks et al., cited in Skinner, 2005; Skinner, 2005). In another example, an MTC targeting women with dependent children focused on parenting, work, housing stabilisation, and building community (Sacks et al., 2004).

Key factors for success: duration, intensity, retention, completion.

Common primary drug of concern: opioids, amphetamines. Poly-drug use. Some evidence for young people and cannabis use.

Therapeutic Communities (TC)

Targeted use of **medium to high intensity residential treatment** was supported by members of the Expert Panel. In Victoria, residential rehabilitation services are based on the **Therapeutic Communities (TC)** model. TCs provide a safe, drug-free environment where staff, activities, and the setting are all designed to bring about positive attitudinal and behavioural change. The focus is 're-socialisation', encouraging people to address social, psychological and behavioural factors underlying their drug use (Gowing, et al., 2002).

Duration

Length of stay varies from at least three and up to 12 months (NIDA, 2009) and increased time in treatment is frequently associated with treatment success (e.g. Darke et al., 2006b; Hubbard et al., 2003). A recent systematic review showed an association between TCs of longer duration and improved outcomes; however findings were not statistically significant (Smith et al., 2006). NIDA (2002) emphasised that individuals who complete at least three months of treatment have significantly better outcomes on average than those who stay for shorter periods. (McCusker et al., 1995) found minimal differences in program effectiveness with varied planned duration from three to 12 months. Stays as long as 12 months may be necessary to achieve lasting change (e.g., De Leon, 1995; Mattick et al., 1998).

Intensity

Intensity is another important predictor of treatment success. Recent studies indicate treatment intensity may be more important than duration (Hser et al., 2004). A systematic review of 55 treatment evaluation studies found more intensive programs produced better treatment outcomes (Holloway et al., 2005).

Retention and completion

Retention is a particular challenge for TCs, with up to 50% of clients dropping out (De Leon et al., 2000a; Gowing et al., 2002). Attrition is highest in the first month of treatment. It is important to note that about one-third of people who leave a TC before completing treatment seek readmission (NIDA, 2002).

Modified Therapeutic Communities (MTC)

Modified therapeutic community models have been developed in response to particular needs of groups; including adolescents, women, people with HIV/AIDS, the homeless, those with co-morbid mental health problems, and offenders. Program design is similar to the TC in terms of structure, processes and interventions but with modifications to allow for client characteristics such as psychiatric symptoms, cognitive impairment and level of functioning (Sacks et al., 2008a). There is a growing body of evidence in support of MTC.

Separate and integrated community models

In our review of the evidence on intensive residential rehabilitation we examined whether services situated as separate communities or dwellings within the general community. A summary of these findings, as shown below, supports both separate and integrated models of TC as well as possibilities for combining elements of the TC with existing / designated community housing. It should be noted that all this research is from the US, there is limited evidence from Australia.

- Treatment may involve a separate TC followed by another course of treatment in the general community. Nemes et al. (1999) showed that 10 months TC plus two months outpatient services resulted in higher treatment completion and higher rates of employment post-treatment in comparison with ‘abbreviated treatment’ which involved six months TC plus six months outpatient services. Wexler (1999) examined the effectiveness of a prison TC followed by a community-based TC or no treatment. Significantly fewer offenders who were in the treatment groups were re-incarcerated 12 months after release from prison.
- Modified TCs may be delivered in the general community. In one study an MTC that used group homes in the general community was compared with ‘treatment as usual’, which involved a range of settings and agencies (principally community residences, psychiatric hospitals, shelters). Those in the MTC showed significantly greater behavioural improvement at 12 months (De Leon et al., 2000b).
- MTCs may be offered in collaboration with existing accommodation services. An MTC was delivered at a men’s shelter and findings were compared with a general shelter program. Clients from the MTC showed better outcomes in the areas of medication compliance, discharge status, and housing placement (Skinner, D. C., 2005).

Finally, it is worth noting there is a lack of evidence to support residential treatment for people with alcohol problems. A review of meta-analytic reviews, randomised controlled trials and systematic reviews showed that equal outcomes can be achieved in lower cost, non-residential settings (Shand et al., 2003b). In a comparison of inpatient and outpatient treatment for alcohol dependence involving an 18-month follow-up, Rychtarik et al. (2000) found that there was no evidence supporting the effectiveness of residential treatment for people with mild to moderate levels of dependence.

This treatment type is appropriate for people with heroin dependence, with the ATOS showing an association between reduced heroin use and longer periods in residential rehabilitation (Darke et al., 2006a). There is some evidence that residential rehabilitation may also be appropriate for people using ATS (Magor-Blatch & Pitts, 2009) or cocaine (Hubbard et al., 2003). It has been shown to be effective for young incarcerated people using cannabis (Hubbard et al., 2003). The table below summarises major residential rehabilitation models and characteristics of the target client group. (Refer to Appendix D4 for details).

Table 6. Effective forms of residential treatment by client characteristics and drug use

<i>Technique</i>	<i>Characteristics of the target client group</i>
Therapeutic Community ~ individuals learn to identify and correct problematic behaviours by applying a range of skills to address drug abuse and a range of associated problems. Multiple behavioural therapies used. ‘Re-socialisation’ through community immersion. TC may be followed by outpatient component.	<p>Opioids, amphetamines, cocaine, as the primary drug of concern. Polydrug use common.</p> <p>Clients with severe and complex problems. Models developed for youth, offenders.</p>
Modified Therapeutic Community ~ adapted form of TC, often involving shorter sessions and including greater emphasis on instructions, support, and individualised care. Has been used in shelter settings (i.e. with the homeless), and with group homes in the general community. Versions of MTC include modifications to allow for clients having special needs.	<p>Opioids, amphetamines, or cocaine as the primary drug of concern. Polydrug use common.</p> <p>Clients with severe and complex problems.</p> <p>Models developed for groups including the mentally ill, women with dependent children, women with a history of early trauma, youth, long-term homeless.</p>

Victoria currently has a low level residential support option; alcohol and drug supported accommodation. The Expert Panel was asked to consider whether this should be part of a specialist treatment system. Some members felt that supported accommodation should be part of the spectrum of services given that homelessness is a potential alcohol and drug-related problem and homeless people should be supported as much as people with accommodation. Others agreed with the need for supported accommodation but were sceptical about whether it needs to be alcohol and drug specific (and thus part of the AOD system). MTC models, with high level support and a structured program, provide a more viable therapeutic rehabilitation option for a specialist system.

5.3.5. Support factors

A number of other factors were highlighted in comments made by the Expert Panel: treatment entry; quality assessment; case management; outreach; and secondary consultation. These factors are

important to treatment but do not constitute treatment in their own right. Each of these factors is considered below.

Treatment entry

Two members of the Expert Panel spoke about the entry point for treatment. One person commented on problems arising from thinking about harm reduction and treatment services separately; whereas harm reduction programs form an important step into treatment. These services, which were explained as including NSP and telephone help-line programs, assist treatment entry by “breaking down the enormity of the first step into a series of smaller steps”. NSPs act as ‘gateways’ to AOD treatment for some clients. Many drug users who attend NSPs subsequently request treatment (cf. Dolan et al., 2005, p. 17 for details).

Harm reduction programs form part of the continuum of services available to people with AOD problems. While these services form an important component of care, the role of harm reduction services and the nature of access and entry models could not be given due attention within the brief of the current project. Our focus has been on effective treatment components. A thorough review on the role and benefits of harm reduction services would be valuable – particularly in relation to the gateway function involved.

Quality assessment

Members of the Expert Panel explained that a proper assessment and treatment plan is the *key element* when a client is admitted. They felt quality assessment is critical to specialist AOD treatment and it should be valued as a high level service function that is fundamental to effective treatment planning and intervention. Quality assessment can inform factors which support treatment success, such as readiness for change, client preference and satisfaction with treatment, and a sound understanding of co-morbid mental health conditions.

A person’s motivation to change is important in the process of recovery. There is strong evidence that when appropriate measures are used, the stages of change model is a meaningful way to understand the process of change. More frequent assessments, along with better measurement tools, are recommended (DiClemente et al., 2004). While the effectiveness of treatment-matching *per se* has been brought into question (UKATT Research Team, 2008), a review of 26 studies showed that clients matched to a *preferred* treatment experience better outcomes and they are less likely to drop-out of treatment (Swift & Callahan, 2009). Similarly, when clients felt that treatment was meeting their needs they were more inclined to continue – and of course retention is an important factor in treatment success (Friedmann et al., 2004). Put simply, quality assessment enables the identification of treatment that is clinically appropriate for clients and consistent with client preference. This supports treatment retention and thus increases the scope for successful outcomes.

Case management

In 2003, Ritter et al. noted that the Victorian AOD specialist system was fragmented and clients were at risk of ‘falling through the gaps’, while services did not necessarily see themselves as part of a cross-agency continuum of care. Case management was generally in place ‘as part of the usual clinical function’ and it was supported *within the specialist system* but not with regard to linkages to other systems.

Case management was identified by members of the Expert Panel as a necessary part of treatment provision, generally in the context of client complexity and also the orientation of treatment. For example, one member of the panel commented that, “case management provides the frame of reference that is holistic, but you can’t do everything within one institution. You have to find a way of reaching across.”

A recent systematic review of case management interventions shows inconclusive findings about the efficacy of case management for reducing AOD use. One difficulty was the diversity of case management models in use. However, there is evidence that case management is valuable for linking people with AOD problems “to community and treatment services, compared to treatment as usual or other viable treatment options like psycho-education or brief interventions” (Hesse et al., 2007, p. 13). It appears that case management is a fundamental aspect of treatment provision; however the exact definition of the term needs attention.

There is also some evidence regarding cost effectiveness of the case management approach in reducing duplication of services and accessing appropriate services (if available) to enhance outcomes. Hesse et al. (2007) emphasised that case management should not be viewed as a stand-alone intervention “but rather as a complement and reinforcement” of other interventions. It provides a useful support function; involving practical help to overcome obstacles to access such as transport and childcare, which directly improves retention and also shows that the service is responsive and caring (Ashton, M., 2005a, 2005b, 2005c; Ashton, M & Witton, 2004).

One member of the Expert Panel emphasised that in complex cases the case management function would require linkages to non-AOD community and health services. As reflected elsewhere in this report, the linkage function to non-AOD services has received general support from members of the Expert Panel.

Finally, the Institute of Medicine (IMO, 2006) provides a description of typical activities within a co-ordinated care, or case management, approach.

Typical activities include assessment of the patient’s need for supportive services; individual care planning, referral, and connection of the patient with other necessary services and supports; ongoing monitoring of the patients’ care plan; advocacy; and monitoring of the patient’s symptoms (Gilbody et al., 2003; Marshall et al., 2004, in IOM 2006, pp. 238-239).

As a consequence the following definition of case management is put forward.

Case management involves individual treatment planning; appropriate referrals to the next AOD service, and assertive follow-up. In some cases, where clients have complex and multiple needs, the case management function will include linkages to non-AOD community and health services.

Aftercare

The Substance Abuse and Mental Health Services Administration / Center for Substance Abuse Treatment (2002) provided the following explanation of aftercare:

Aftercare, or continuing care, is the stage following discharge, when the client no longer requires services at the intensity required during primary treatment. A client is able to function using a self-directed plan, which includes minimal interaction with a counselor.

Counselor interaction takes on a monitoring function. Clients continue to reorient their behavior to the ongoing reality of a pro-social, sober lifestyle. Aftercare can occur in a variety of settings, such as periodic outpatient aftercare, relapse/recovery groups, 12-Step and self-help groups, and halfway houses.
(<http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=A50018#A50058>)

It is important to note that aftercare is understood as one part of the continuum of care involved in case management. It may take different forms. Some individuals will be referred to an appropriate non-specialist program and followed-up. Others may seek occasional contact with their case manager following treatment engagement. Assertive follow-up may be involved, where the case manager contacts the individual to ascertain their well-being and the maintenance of change in drug use behaviour. In each instance, case management involves follow-up to provide support for clients post treatment.

Outreach

Victoria has a number of outreach models, such as staff being outposted to regional community health centres or visiting clients in their homes or at a public place. There are designated outreach programs, for example involving youth or regional clients who have been diverted into treatment, or providing GP support in relation to methadone maintenance.

Members of the Expert Panel described outreach as a mode of service delivery, with application across treatment components, which is appropriate for clients irrespective of age. It occurs to support access and retention and includes a follow-up function for no shows. One expert spoke passionately about the need for assertive outreach across all treatment components and in relation to client access and retention.

The other thing I think we must do more of in the drug field, in all of those [treatment] areas is much more assertive outreach. I think the mental health field, and assertive outreach in terms of the hours that we provide the service, where we provide the service and what we do with people who are maybe a little bit reluctant to come and I think that it's been a highly neglected area in the drug field partly because of the paradigms that have had influence. So if a patient doesn't turn up it's because they've not got any motivation, it's their fault. It's sort of like, I've worked in services like that, the patient doesn't turn up and that's time to make a cup of tea. It's not time to ring them up.

According to the research literature, outreach has the essential purpose of engaging with hidden and hard to reach populations and delivering a flexible treatment response. Multi-disciplinary teams and peer workers often feature in this service model. Outreach is important for engaging with young people (United Nations, 2004). It has a long history within HIV/AIDs prevention work in IDU communities, and the evidence-base is strong regarding effectiveness in reducing risk behaviours and increasing protective behaviours. Outreach has also been used to engage with populations such as the homeless, and people with a dual diagnosis who present with complex or multiple needs. Beneficial outcomes include connecting people with services, increasing their sense of stability (e.g. connecting with housing services) and increased engagement with service providers. For example, studies conducted with HIV populations indicate that outreach-based interventions have impacted risk behaviour; including a reduction in the incidence of shared injecting equipment and increased use of condoms (Needle et al., 2004).

The majority of Expert Panel members endorsed the following definition of outreach:

Outreach is a mode of service delivery that may involve providing treatment at regional outposts or at a group forum (e.g. an indicated prevention session targeting young people at a sporting club). Service delivery may occur in a client's home or an agreed public place. Specialist interventions that may involve an outreach approach include pharmacotherapy, non-residential withdrawal, and outpatient therapy. Outreach is not a specialist treatment in its own right.

They felt that outreach is important for client engagement and requires associated skills, whereas it does not constitute specialist treatment. One member of the panel noted that outreach is used for preventing, treating, counselling, and supporting young people and providing counselling, support and care to AOD clients with co-existing psychiatric disorders. As such, this person felt that outreach is an important component of treatment.

Findings suggest that outreach should be understood as a useful mode of service delivery, especially for young people and hard to reach groups. The actual treatment being provided within the outreach delivery model will vary according to client need, but may constitute skills development or individual counselling along with a group intervention. Treatment will be consistent with the components and elements described previously.

Secondary consultation

Secondary consultation, to build capacity in other sectors, was raised in the first round of consultations and the Expert Panel was subsequently asked to comment on whether it was appropriate for other policy areas from health and human services to provide support that would enable this capacity building function. Most members agreed and there was considerable discussion on how this may work: via better integration with mental health; with support from generalist workforces; with funding from other parts of health.

Secondary consultation is also a valuable mechanism within the system; via mentoring, supervision, and staff support. For example, addiction medicine specialists may provide mentoring to GPs and advice to senior nursing staff; senior psychologists may provide secondary consultation to support workers.

5.3.6. Particular client groups

Some client groups are defined by geographical settings, cultural status, age, gender, drug use and so on. The Expert Panel felt that client choice was important while service capacity to adapt according to individual client need was critical. While some members of the Expert Panel agreed that tailored services for special needs groups should be provided, some did not support this view.

There was some discussion in the first round of consultations that clinicians need to adapt their techniques, but not necessarily have a different approach. Some examples were described, where clients could choose to have a same sex clinician, or attend a culturally-based service. In both cases, there was substantial diversity among client choice; many clients preferred a male clinician and many in the ethnic minority preferred to attend a mainstream service. Put simply, it was important to provide both options as client preference will vary. One stakeholder suggested that, “what we probably should be doing is providing really solid secondary consultations services to those people that are currently responding to CALD groups”.

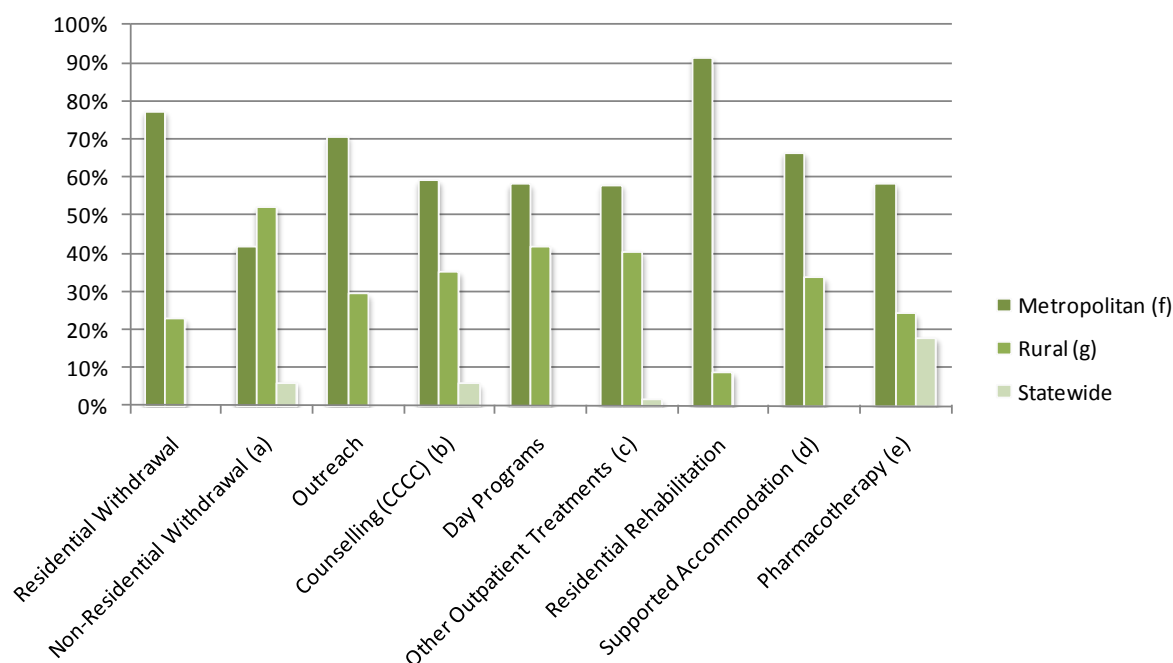
Some members of the Expert Panel were in a position to comment on Koori services and they felt “things were improving” and there was opportunity for further advancement. They commented on people who operate in networks “who know how these things work...it’s all quite informal...with the right sort of support they can do some really good work”. The literature suggests that key factors in the implementation of best practice in Koori services are about organisational strengths, strategies for workforce development, external linkages, and adequate and continuing funding (Strempel et al., 2004), all features that fall outside the therapeutic strategies applied in treatment; however they are important for engaging and retaining people.

The research literature suggests benefits from services that are tailored to the needs of young people, as well as MTCs for specific high needs groups including women, young people, homeless people, and people with mental health problems. It is also worth noting the importance of interventions targeting risky versus dependent young people. A member of the Expert Panel noted that, “we need to differentiate between early uptake users and those who are already in real strife and dependent and have separated as well as differentiated service interventions”.

In conclusion, our findings suggest the need for tailored services where client preference indicates this would be appropriate. Therapeutic interventions should nevertheless be based on effective treatment approaches. Some modifications will be about service configuration rather than therapeutic strategies with the aims of engaging and retaining clients in treatment. Other modifications, such as a reduction in the length of therapeutic sessions or the inclusion of counselling focused on particular mental health concerns would require minor modifications to treatment that can be incorporated at agency level, within program design. Examples include the formation of a six week group counselling session that targets transient men with alcohol dependence or the development of an MTC for women with a history of trauma.

Regional and rural Victoria

For the current project, we have considered the proportional investment of State Government funds according to location. Figure 5, below, shows the distribution of COT by metropolitan, rural, and statewide locations.



Source: Service Agreement and Management System (SAMS) (de-identified data) 2008/09, DH; analysis by Turning Point Alcohol and Drug Centre).

^a Non-Residential Withdrawal includes: Home-based Withdrawal; Outpatient Withdrawal; Rural Withdrawal

^b Counselling (CCCC) refers to Counselling, Consultancy and Continuing Care.

^c Other Outpatient Treatments includes: Ante & Post Natal Support; Community Education; Client Education; Peer Support; Aboriginal A&D Worker; Aboriginal A&D Resource Service; Parent Support; Mobile OD Response; Post Withdrawal Linkage; Outdoor Therapy

^d Supported Accommodation refers to Alcohol and Drug Supported Accommodation (ADSA).

^e Pharmacotherapy includes: Specialist Pharmacotherapy and Pharmacotherapy Outreach.

^f Metropolitan regions include: North-West Metro; Eastern Metro; Southern Metro

^g Rural regions include: Barwon South-Western; Gippsland; Grampians; Hume; Loddon Mallee.

Figure 5. COT investment by treatment type for Department of Health regions, Victoria, 2008-09

As shown, there is a key difference between the system in regional and metropolitan Victoria. This difference pertains to the low proportion of COT for intensive services in regional parts of the state when compared with that for metropolitan Victoria (i.e., residential withdrawal and residential rehabilitation / TC).

Access to pharmacotherapies in regional Victoria is also problematic. Almost 10,000 people accessed pharmacotherapies in Melbourne each day (9,809) and almost 2,000 accessed this treatment in rural Victoria (1,927)⁴.

⁴ An additional 26 people were listed as being in NSW.

Figure 6, below, illustrates the distribution of pharmacotherapy treatment by health region. In 2008, the Barwon South-West region had the highest number of clients receiving pharmacotherapy (694), while the Hume region had the lowest (198).

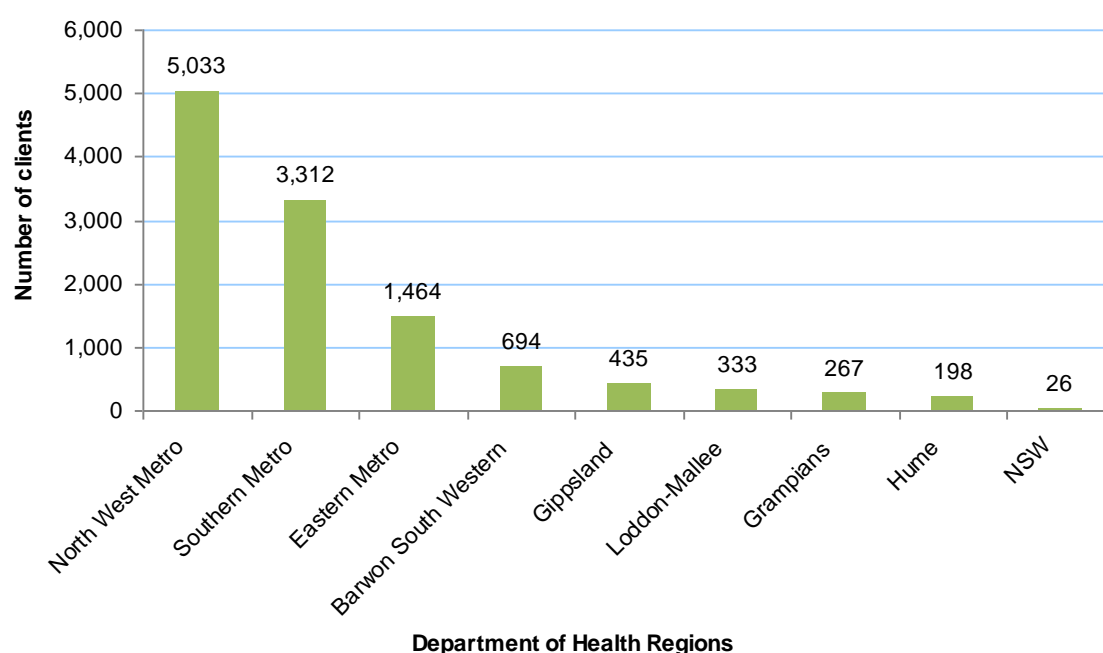


Figure 6. Clients accessing community-based pharmacotherapy by health region, Victoria, 2008

In 2003, a review of the regional and rural AOD treatment system was completed (Berends et al., 2004a). A number of distinguishing characteristics were identified as well as some structural impediments to accessing particular types of treatment. The understanding of treatment extended beyond reducing or ceasing AOD use to include attention to other issues, where these have a direct bearing on AOD use. The target client group would comprise those with complex and serious problems and also include family members of the AOD user and those at risk of problematic use. While access to treatment was proportionally greater in regional and rural Victoria in comparison with that for Melbourne, there were difficulties accessing hospital beds for withdrawal, accessing statewide residential rehabilitation treatment services and obtaining pharmacotherapies (Berends et al. 2004a).

The findings detailed above show that some of these issues still apply; access to residential withdrawal, residential rehabilitation, and pharmacotherapies is limited. A number of studies show that access to hospital beds for withdrawal is problematic and requires structural intervention (e.g., Berends et al., 2004a; Berends et al., 2009).

A number of policy imperatives provide further insight on access to residential rehabilitation. The 'Blueprint' (VDHS, 2008, p. 43) noted that,

A treatment access register for residential services could improve coordination between treatment services, increase the timeliness of access for clients, improve client information about treatment options and help people get their lives back on track sooner.

While this suggestion has not been translated into an action within the 'Blueprint' the treatment register is a strategy that may alleviate access issues in rural Victoria while having application across the state.

The nurse practitioner role also has potential to support treatment access. The 2004 review of Victoria's regional and rural AOD system noted that the nurse practitioner model could be utilised to enhance and extend existing drug treatments (Berends et al. 2004a). AOD nurse practitioners would work autonomously, in collaboration with local medical and health professionals, specifically in reference to withdrawal and maintenance pharmacotherapies.

The nurse practitioner model is being progressively introduced throughout Australia. An exploration of nurse practitioner roles in Victoria showed that in February 2010, there were 50 nurse practitioners. The most common area of practice was emergency care (24), there were two rural and remote nurse practitioners, and one alcohol and drug specific nurse practitioner. Service planning for the nurse practitioner role has been undertaken at a number of rural health services (not specific to AOD) (www.health.vic.gov.au/nursing/furthering/practitioner; accessed March 2010).

Recent work from NSW examined barriers to authorisation of nurse practitioners among senior rural AOD nurses in that state (Ling et al., 2009). At October 2009, NSW had three AOD nurse practitioners, despite plans (in 2003) for up to 18 practitioners. Barriers that were identified include a lack of dedicated funding, concerns about potential role ambiguity, lack of confidence in seeking authorisation, lack of time to pursue authorisation, and worry about a lack of support to enact the role. This research provides direction on strategies to increase the number of AOD nurse practitioners.

In Victoria, planning is underway to build on the successful establishment of more than 20 nurse practitioners in the area of emergency care. The Victorian Nurse Practitioner Project aims to realise an effective and strategic integration of sustainable models of nurse practitioner practice through planning, relationship building, and the development of structural supports (www.health.vic.gov.au/nursing/furthering/practitioner; accessed March 2010). The establishment of additional AOD nurse practitioners in Victoria is supported by past reviews and the current project.

5.4. Summary

5.4.1. Treatment components

The following treatment components and elements are suggested for Victoria's specialist alcohol and other drug treatment system:

- Pharmacotherapies ~ including the establishment of a small number of specialist clinics to counter vulnerabilities of the current system
- Withdrawal ~ residential and non-residential elements which must be provided as part of a regime of treatment
- Behavioural therapies ~ including indicated prevention, brief intervention, individual counselling, group counselling, family therapy, and day programs
- Residential rehabilitation ~ comprising therapeutic community and modified therapeutic community treatment elements

5.4.2. Support functions

Quality assessment is critical and it should be valued as a high level service function that is fundamental to effective treatment planning and intervention.

Case management is essential and involves individual treatment planning; appropriate referrals to the next AOD service, and assertive follow-up. In some cases, where clients have complex and multiple needs, the case management function will include linkages to non-AOD community and health services.

Outreach is a mode of service delivery that may involve providing treatment at regional outposts or at a group forum (e.g. an indicated prevention session targeting young people at a sporting club). Service delivery may occur in a client's home or an agreed public place (e.g., café). Specialist interventions that may involve an outreach approach include pharmacotherapy, non-residential withdrawal, and outpatient therapy. Outreach is not a specialist treatment in its own right.

5.4.3.Secondary consultation

Secondary consultation is a valuable means to build capacity in other sectors. It requires a partnership approach at policy level.

5.4.4.Services for particular client groups

Client choice is important and tailored services may be required. Service capacity to adapt according to individual client need is critical.

In rural and regional Victoria access to residential withdrawal, residential rehabilitation and pharmacotherapy services is difficult. Strategies to support access include structural intervention targeting hospital beds for withdrawal, a treatment register for residential services, and expansion of the AOD nurse practitioner program.

6. WORKFORCE CHARACTERISTICS

6.1. Introduction

Common factors related to the workforce are described in this chapter along with conditions under which the workforce will have the capacity to deliver on the above treatment components. The content of this chapter is informed by the literature and consultation with the Expert Panel. We have used national and international data from workforce development literature in a range of sectors but have used a body of work from NCETA⁵ as a foundation, given its AOD focus, extent and its consideration of the Australian context. Reviews of evidence pertaining to elements of treatment that have been completed for the current project were also scanned for points relating directly to the workforce. Several members of the Expert Panel have substantial experience relating to workforce issues specifically in the AOD sector although it is worth noting that some members of the Expert Panel commented that workforce development was not an area they felt particularly knowledgeable on.

This chapter provides background in terms of policy context, workforce planning issues and contributing workforce or staffing factors that lead to positive outcomes. The qualifications level, professional disciplines and required skill levels of staff involved in the delivery of therapeutic interventions will also be discussed and a multidisciplinary workforce profile will be proposed.

6.2. Policy context

Health workforce reform is a significant focus of national and state policy. Drivers expressed in the policy literature include expedience (a shortage of skills, budgetary concerns), evidence (multidisciplinary working is effective) and values (the desire for flexible, person-centred care) and the need to build the capacity of the AOD specialist workforce within the broader health environment. A multilevel, systems perspective on workforce development is used incorporating national workforce reforms and quality frameworks. National and Victorian workforce strategies are also influential.

For example, in late 2008 COAG (Council of Australian Governments, 2008) announced new investment in the health workforce aimed at increasing supply (through education and training, recruitment and retention strategies and facilitated immigration of overseas trained health professionals) and workforce reform (including mechanisms to support new models of care and new and expanded roles, the redesign of roles and encouragement of multidisciplinary working). A new national health workforce agency will oversee and manage reform. Concurrently with the COAG reforms, the NHHRC (National Health and Hospitals Reform Commission, 2009) was working on recommendations aiming for 'an agile and self-improving' health workforce, promoting a culture of mutual respect and patient focus of all health professions; supporting effective communication across all parts of the health system; investing in management and leadership skills at all levels of the system; promoting quality and a continuous improvement culture. A new education framework for the education and training of health professionals is proposed, moving towards a flexible, multi-disciplinary approach and incorporating an agreed competency-based framework as part of broad teaching and learning curricula for all health professionals; ensuring clinical training infrastructure across all settings (public and private, hospitals, primary health care and other community settings);

⁵ The National Centre for Education and Training on Addiction

and the setting up of a National Clinical Education and Training Agency, possibly the same body as that intended by COAG' (National Health and Hospitals Reform Commission, 2009, pp. 30-31).

The National Drug Strategy (Ministerial Council on Drug Strategy, 2004) recognises that a multifaceted approach to developing the workforce, organisations and systems is required, to address the range of factors that impact on the ability of the diverse workforce to function with maximum effectiveness. A special goal is to 'improve the capacity of community-controlled and mainstream organisations to provide quality services to Indigenous communities' (Ministerial Council on Drug Strategy, 2004, p. 8, p8).

Victoria's AOD Workforce Development strategy, covering the years 2004-2009 focused on ensuring a minimum qualification level for the workforce (VET Certificate IV in Community Services , Alcohol and Other Drug Work) (Drugs Policy and Services Branch Victorian Department of Human Services, 2004, 2005).

Victoria's current mental health reform (Mental Health and Drugs Division - Department of Health, 2009a) has a workforce development thrust involving recruitment and retention strategies, workforce redesign, consolidation of workforce development activities under a new institute and coordination of a rolling training program for all relevant health and welfare sectors. Critical success factors are identified as investment, partnerships, research and data, and leadership (Mental Health and Drugs Division - Department of Health, 2009b).

The next iteration of Victoria's AOD Workforce Development strategy must give consideration to national and state policy, and incorporate a broader workforce development agenda to address key long term workforce issues.

6.3. Workforce planning

The importance of workforce planning has long been identified as a key component of healthcare provision. A World Health Organisation (WHO) review of health workforce planning worldwide (O'Brien-Pallas et al., 2001) concluded ten years ago that planning needed to be better conceptualised, sustained, inter-professional and informed by adequate vision and data. Governments must plan ahead to ensure there is an integrated workforce that can realise their policies. Planning has been defined as determining the numbers, mix and distribution of health providers that will be required to meet population health needs at some identified future point in time – in 5-15 years for intermediate and 15-30 years for long term needs (O'Brien-Pallas et al., 2001). The task is complex as well as long term. Community opinion, population trends, changes in health needs, developments in knowledge and technology, and industrial arrangements with professions, employers and unions are among the many relevant considerations.

Whilst it is acknowledged that effective specialist AOD responses depend on collaboration among a number of distinct workforces: such as police, criminal justice staff, pharmacists, social and welfare workers, teachers, school counsellors, emergency departments, gastroenterologists, dentists, local government and employers (Allsop & Stevens, 2009), the focus in this report will be given to the discussion of key elements as related to the specialist AOD sector in Victoria.

6.4. Common factors that lead to positive outcomes

Two major research projects (MATCH, UKATT) concluded there was no evidence that client-treatment matching leads to an increase in treatment effectiveness for alcohol problems (UKATT Research Team 2008). As a result, there has been a shift to identify common factors across treatments that lead to positive outcomes.

The literature on treatment effectiveness that has been reviewed for the current project shows that research studies do not often explore or report on the skills and experience of the practitioner as a variable (e.g. Magill and Ray on CBT). There are exceptions: strong associations between therapeutic relationship, treatment improvements and retention were found by a group researching pharmacotherapy (Joe, Flynn, Broome & Simpson, 2007; Joe, Simpson, Dansereau & Rowan-Szal, 2001, cited by Ritter & Chalmers, 2009).

Generally, the association between treatment outcomes and workforce characteristics is inadequately researched. Various reviews have, however, made strong arguments that 'non-specific' factors, such as the therapist's skills and interpersonal style and the organisational setting of treatment, contribute importantly to treatment effectiveness. For example, an 'environmental scan' of the literature and consultations with 128 US addiction treatment stakeholders found: a need for studies that examine the relationships among level of clinician education, type of education, training and treatment outcomes. The relationships among clinician and patient/client cultural, demographic and other characteristics and treatment outcomes were also unknown. More studies were also required to identify the clinician characteristics, training and skills that enhance therapeutic alliance (Whitter, 2006).

Members of the Expert Panel also identified a number of factors that support treatment success which are concerned with service quality and evidence-based practice.

Some experts explained that the **quality of the service** and whether it is evidence-based are more important than the treatment type involved. "Have we adequately defined what that service should be doing, is there a staffing profile in that service that will allow the service to deliver quality care and safe care?" Research on intervention effectiveness should inform the content of education and training provided and should also be the focus of ongoing supervision and mentoring programs. This is essential to maximise client outcomes.

So I'm of the view that you wouldn't spend one dollar on any training that was associated with you know a set of skills that haven't been demonstrated through research to be a set of skills that are needed by people working in the sector.

Members of the Expert Panel emphasised four areas pertaining to staff: attitude, skills, qualifications and AOD knowledge, in addition to strategies for workforce development such as professional registration, supervision and workforce investment. These are seen as key factors that contribute to treatment success and are further discussed below.

6.5. Staff attitude and approach

A UK analysis of a systematic review of CBT effectiveness (Drug and Alcohol Findings Review, 2009) proposes factors in treatment effectiveness that are common to different therapies. Four of eight common factors are directly related to the therapist's beliefs and abilities: the credibility of the therapy to patient and therapist, the therapist's ability to create a supportive environment, the interpersonal style of the therapist and their ability to exercise discretion and flexibility.

Members of the Expert Panel explained the importance of staff liking the clients; having a positive regard for clients and an optimistic view about their chance of success in treatment. Staff capacity to engage with clients and build a **therapeutic relationship** was described as important.

First and foremost the ability to connect a client....The ability to be pragmatic, the ability to form a relationship because probably forming a relationship particularly with this client group, but not exclusively, is essential.

The importance of staff capacity to engage with clients is also well supported in the academic literature. A review of studies in the UK found that in “every induction study in which MI has apparently had a positive overall impact, this can be explained by ‘non-specific’ factors common to other therapies rather than the specific approach”. The most common finding was the enthusiasm and faith of the therapists; extra assessment and/or feedback of assessment results; and spending time with a sympathetic listener (Ashton, 2005a, 2005b, 2005c; Ashton & Witton, 2004).

Interestingly, how directive the therapist was in the face of client resistance is emerging as one of the strongest and most consistent influences on the outcomes of outpatient therapy. There is no single right answer – it all depends on the client, in particular on how much they perceive and react against threats to their autonomy. Non-directive styles generally suit clients characterised by anger or resistance; directive approaches profit clients who welcome a lead (Ashton, 2005a, 2005b, 2005c; Ashton & Witton, 2004)

Workforce initiatives must therefore incorporate strategies that attend to improving worker attitudes and their capacity to select an appropriate directive or non directive approach based on the clients presentation. This could in part be achieved via additional training or a broader delivery of clinical supervision or formal mentoring services.

6.6. Formal qualifications and AOD treatment knowledge

Formal qualifications were identified by members of the Expert Panel as being important. A two tiered qualification level was described by some members of the Expert Panel, involving people with tertiary qualifications and others with vocational training certificates. This was reflective of a tiered workforce with differing skill sets dependent upon the specialist nature of the work undertaken.

It may well be that Certificate IV is adequate for people working in those welfare and support roles but I think we need to be absolutely clear about different roles and different service types and the requirements and the qualifications for working in them.

The goal is to have people with advanced qualifications, especially in more intensive areas of AOD work. Professional disciplines routinely identified for this sector of the workforce included nursing, medicine, social work and psychology. Experts generally felt that while it was important to have a skilled workforce, this workforce did not have to be “uniquely drug skilled” on commencement. “A very good clinician will be a very good clinician”. Staff with non-AOD qualifications in relevant disciplines could, with relevant support, gain the knowledge and skills needed to operate within an AOD service.

We need good nurses, good doctors, good social workers, good psychologists who also have some expertise in alcohol and drugs.

However, concern was expressed about the limited opportunities to obtain AOD specific content in many of the undergraduate degrees that sector staff are traditionally drawn from.

This (AOD) has been a field which has been orphaned in a way by the higher education system. And that's true not only in Australia but also in you know other English speaking countries and others as well because of this problem that alcohol and drugs didn't fit comfortably.

There was also support for the provision of specialist qualifications for those that want to pursue a career in the AOD sector.

There should be an option for people to be specialised, move into these more specialist areas and achieve a qualification specifically in this area.

In Australia as elsewhere you're going to move into a circumstance where you know it'll be eventually sort of people with Masters' Degrees in alcohol and drug counselling by a generation from now.

The increased presence of AOD content in higher education (undergraduate and postgraduate) not only has the potential to legitimise AOD work for relevant professions, improve the perception of the AOD sector as a career opportunity and open an employment pathways, it also offers potential to impact positively on retention issues by providing access to advanced skills and learning and establishing career advancement benchmarks.

6.7. Staff skill

Core skills include the ability to support clients in making informed choices; facilitate long term behaviour change, work with families and groups, provide psychotherapeutic approaches and understand their integration with “the appropriate use of pharmacotherapies particularly in terms of symptom relief”.

Client complexity and the likelihood of involving other services means that skills in collegiate relations and shared care are important for the AOD clinician. For example, “what we should be doing is helping, providing the resources and providing the skills to work in shared care or whatever you want to call it...that ability to work collegiately”....”you need to know when to seek additional expertise and how to work with that expertise”. This is consistent with other comments from the Expert Panel on the secondary consultation and shared care role of the AOD clinician and their need to provide primary care services or support others in this role as appropriate to the needs of the client.

Direct training was seen as a means to increase broad clinical skills (King, 2004; Roche, 2001) although it was recognised that training in isolation of other strategies was likely to have limited effect (Bero et al., 1998), hence the importance of investing in additional support activities.

Identifying the evidence on the mix of specialist qualifications or skills for each treatment component is difficult as this topic has received little attention in the research literature. Relevant references are discussed below as a step towards building a matrix of the workforce needs for each treatment component (defined as pharmacotherapy, withdrawal, outpatient therapy and residential rehabilitation).

6.7.1. Pharmacotherapy

Medical doctors and pharmacists are key professional groups involved in the delivery of pharmacotherapy treatment. Prescription and dispensing is highly regulated and restricted to medical doctors and pharmacists. A recent review of the issues in Australian pharmacotherapy treatment suggests that other professionals could have a greater role in prescribing opioids and supervising care. 'The nurse practitioner models are worth exploring in this regard, particularly in light of the recent Cochrane Review indicating that appropriately trained nurses can provide a quality of patient care equivalent to that provided by doctors ' (Laurant, et al., 2006 cited by Ritter & Chalmers, 2009, p. 28). Specialist support for the frontline doctor (or nurse practitioner) is available from Fellows of the Australasian Chapter of Addiction Medicine (FACHAM), 'many of whom hold specialty accreditation with other disciplines, including psychiatry, internal medicine or general practice. Stepped or shared care is an accepted model, with general practice providing support and care for uncomplicated cases while complicated cases will be managed by FACHAM doctors '(Ritter & Chalmers, 2009, p. 58). It should however be noted that attracting doctors in general practice to become involved in the delivery of pharmacotherapy treatment is difficult and that there are significant regional gaps in the availability of general practitioners to take on this role. Similarly, the number of doctors with membership of FACHAM is small.

Pharmacotherapy clients may or may not receive counselling. Ritter and Chalmers (2009) cite findings by Rowan-Szal, Chatham, Greener et al. (2004) that those pharmacotherapy clients who spent a longer time in counselling had better therapeutic relationships, and that manualised counselling treatment can improve participation.

6.7.2. Withdrawal

Requirements depend on the level of medical and nursing supervision indicated for each client and service model. Adjunctive psychosocial support improves effectiveness (Amato and others (2004) demonstrated this for heroin withdrawal; Morin (2004) et al for benzodiazepine withdrawal).

6.7.3. Behavioural therapy

Skills in the major therapy techniques are required. Short technique-specific training courses, with follow-up support and supervision, can build on tertiary qualifications or VET level skills. Most practitioners of cognitive-behavioural interventions have a combination of training gained from their degree (psychology, social work, occupational therapy, medicine, nursing) and professional development activities, such as workshops (AACBT).

6.7.4. Residential rehabilitation

As found in the review of the evidence for residential rehabilitation, empirical evidence is lacking and the field does not shed light on the effect of workforce variables (Messina et al., 2001). According to the Australasian Therapeutic Communities Association, TCs employ multidisciplinary teams, including AOD workers, psychologists, medical personnel, social workers, group therapists, vocational trainers, teachers, sports instructors, childcare workers and family support workers. Staffing structures in TCs include, within the range of qualified staff, 'members who have themselves also completed a TC program.'(ATCA).

6.7.5.Support function

Quality assessment

Conducting an effective and efficient assessment is an essential prerequisite in determining the most appropriate intervention for your clients. Assessment of drug problems is a complex and dynamic process that occurs throughout the treatment processes. In some settings, a single initial assessment might be the only intervention at this point in time because the client may not return for further sessions. Some clients may still benefit from that one contact. In most situations, however, assessment is a continuous process throughout treatment, which identifies problems and changes (such as psychosocial functioning) as they emerge. Ongoing assessment provides valuable information for planning treatment as well as establishing a baseline to evaluate a client's progress.

While there is general agreement that an effective and thorough assessment of the client is necessary for planning treatment options, there is very little literature on what constitutes an effective and thorough AOD assessment. Despite this, the general consensus is that the actual assessment does significantly influence whether or not a person enters and/or remains in treatment. Therefore, the therapeutic process is greatly enhanced by an assessment tool that is broad enough to cover all major areas of interest, while also being sensitive enough to specific issues.

Case management

Kolind et al. (2009) recently examined the “real world” challenges of case management practices, specifically the roles and responsibilities associated with the intervention. Based on a qualitative comparison of case managers' experiences in Denmark and Belgium, they found that case management practices varied from one project to the next and even within the same project. Such differences were apparently related to the way in which case managers approached dilemmas such as those existing between control versus self-determination, or between systematic versus ad hoc planning. The conclusion was that it is vital to discuss these dilemmas during training courses and supervision meetings in order to ensure that the intended form of intervention is actually delivered on the ground (Kolind et al., 2009).

Hesse et al., (2007) in reviewing studies of the effectiveness of case management, noted that workforce factors - availability of a manual to guide the inventions, and of training and supervision for clinicians - were among the contributors to successful linkages, but reached inconclusive findings which in part related to the lack of available evidence about the specific elements and features of different models.

Outreach

Needle et al. (2004) emphasised that the skills and personal/professional attributes of an outreach worker are critical to the intervention's effectiveness. Gaining the target population's trust and being recognised as a non-judgemental source of harm reduction information and services enables the workers to address and reduce risk taking practices (Needle et al., 2004).

6.7.6. Workforce requirements

Although identifying the evidence on the mix of specialist qualifications or skills for each treatment component is difficult given it is an under researched area, the table below is included as a step towards building a matrix of the workforce needs for each treatment component (defined as pharmacotherapy, withdrawal, outpatient therapy and residential rehabilitation). Information on core skills that apply to these treatment types and the support functions is also identified.

Table 7. Workforce needs by discipline and treatment component

Table 4: AOD philosophies, harm minimisation, mental health issues, ethical considerations, statutory responsibilities, access and equity, values and attitudes, screening and assessment, case management and referral. (This content can be covered adequately via competency based training)				
Discipline	Treatment component			
	Pharmacotherapy	Withdrawal	Behavioural therapy	Residential rehabilitation
Psychosocial (Social Work / Psychology)	Adjunct ^a	Adjunct ^b	Core	Core
General Medical	Core	Core ^c	Consultative	Consultative
Nursing	Adjunct ^d	Core	Infrequent	Infrequent
Pharmacy	Core	Core	Infrequent	Infrequent
Addiction Medicine/ Psychiatry	Linked ^e	Linked ^e	Consultative	Consultative
Other				Broad range eg recreation, childcare, nutrition, sports, vocational.
Core AOD knowledge and skills	All treatment components – including support functions			
AOD philosophies, harm minimisation, mental health issues, ethical considerations, statutory responsibilities, access and equity, values and attitudes, screening and assessment, case management and referral. (This content can be covered adequately via competency based training)				

a May be helpful but should not be mandatory (Ritter, A. & Chalmers, J, 2009)

b Adjunctive support improves effectiveness (Heroin – Amato et al 2004; BZD – Morin et al).

c Medication regime prescription and management

d Potential for Nurse Practitioner role (Ritter, A. & Chalmers, J, 2009)

e For complex medication regime and management of complex issues

Core: An integral discipline in the provision of this treatment component

Linked: Established links to this discipline are required for the provision of this treatment component

Adjunct: Services provided by these disciplines support this treatment component

Consultative: Referral pathways to these disciplines are advisable within this treatment component

Infrequent: Occasional contact with these disciplines may be required

6.8. Supervision and support

Clinical Supervision is a central but underutilised workforce development strategy that is fundamental to workers' professional development, can contribute to worker satisfaction and retention, and may improve client outcomes. There is a common conceptual confusion between administrative supervision and Clinical Supervision. Clarification of the role, function and implementation of Clinical Supervision is required. Priority issues for the AOD field include: enhancing belief in Clinical Supervision; ensuring adequate resource allocation; developing evaluation protocols; and addressing specific arrangements under which supervision should occur (Roche et al., 2007).

Mentoring can contribute to workforce development by providing support and guidance to workers, managers and policy makers as they implement organisational change activities. Mentoring is defined in the literature as a 'less structured and more informal approach to leadership and supervision'

(Todd, 2005, p. 4), which can: facilitate a supportive environment (Roche & McDonald, 2002); provide guidance and support (Skinner et al., 2003); provide informal learning (Skinner et al., 2003); act as an incentive to stay within the sector (Roche & McDonald, 2002). From the perspective of the organisation it can: facilitate work practice change at an organisation level (Bywood et al., 2009; Skinner et al., 2003); act as an incentive to recruit workers (Roche & McDonald, 2002); establish and strengthen linkages between professionals and organisations (Roche & McDonald, 2002).

According to members of the Expert Panel and the academic literature (Roche et al., 2007), there are substantial gaps in the provision of ongoing support mechanisms to ensure clinicians are transferring skills and knowledge gained in training to their daily practice. Mentoring and clinical supervision are major supports that are not generally available to AOD staff. One member of the Expert Panel described the potential gains as follows:

But the issue, what made a difference was when they started doing clinical work they had clinical supervision....In the early days and that's what made the difference. Not the brilliant teaching but the careful support as they went into their clinical pathways.

Strategies need to be put in place to respond to evident gaps in the provision of clinical supervision and or mentoring programs in the AOD sector.

6.9. Professional registration

Several members of the Expert Panel indicated that a move toward ongoing professional registration incorporating a professional development requirement / continuing education requirement should be considered, similar to existing models in nursing and medicine. For example,

I like the idea of the medico equivalent of CME points, the Continuing Medical Education points. Now if all of the professional groups don't have that then I think we should establish something for those that don't.

Although there was not consensus about a move in this direction, most informants felt this was an appropriate strategy. When asked if they would support a move towards accreditation that involved a registration process, ongoing CME points similar to other professions, one member of the Expert Panel responded as follows:

Absolutely. It provides accountability, helps with planning and supports consistency. I see this as a speciality division in existing professional bodies rather than a new one.

Figure 7 below presents an academic/educational hierarchy with a distinction proposed between service types. In this diagram service types involved in therapeutic intervention would require staff to have a relevant undergraduate degree which has been extended by further **AOD specific** study from a range of academic levels (Certificate IV competencies to Masters level). This group would also require ongoing professional registration in a relevant body (Psychology, Social Work, or Nursing).

Notwithstanding the important contribution of staff working in support functions, that is staff working in areas not focussed on therapeutic intervention (assessment, case management for example) they would have a lesser requirement in terms of educational attainment and no requirement to maintain membership with a professional registration body. A requirement to achieve competencies

linked to a revised Minimum Qualifications Strategy (MQS) would provide an additional quality indicator for staff in this category.

It should be noted that the pyramid does not represent the proposed mix of staff with large number of staff in the lower level and a small number in the higher level, as the mix of staff will be influenced more so by types of service invested in as proposed in Figure 14.

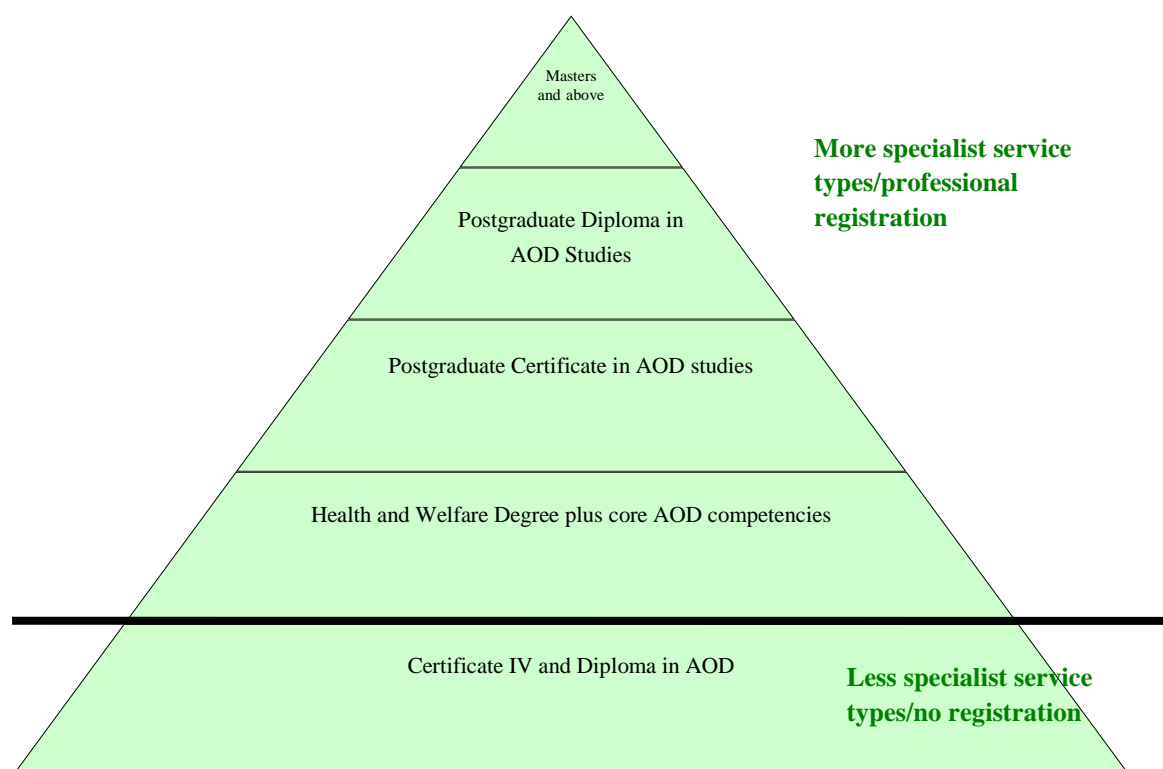


Figure 7. Correlation between qualifications and level of specialisation

In the above model staff who are employed in support functions, as opposed to one of the four nominated service types, would not be required to have professional registration, but they would however be required to meet MQS requirements in terms of core knowledge and skills. Staff working in the specialist service types would require this knowledge plus professional registration in their relevant discipline (Psychology, Social Work, or Nursing etc.).

6.10. Capacity building in the generalist health workforce

The importance of other workforces in responding to AOD issues has been made previously. Capacity building (Crisp et al., 2000) emphasises the development and maintenance of partnerships, allows for a continuous and reciprocal transfer of knowledge, seeks a flexible and innovative problem solving approach, and an investment in social, human and economic capital. A partnerships approach extends beyond a traditional top-down or bottom-up methodology and improves the capacity of workers in a broad range of health and welfare settings to respond to the AOD issues of their clients (Wilkinson et al., 2002). Partnerships can assist with the sharing of resources, knowledge and skills, and enhance service delivery through improved coordination between services (Skinner et al., 2003). A rigorous evaluation of partnership strategies in Victorian primary care found that partnerships were most

successful when there was: a common purpose, effective communication and clarity about roles and relationships; positive attitudes by stakeholders about the common purpose and by member agencies towards the partnership and each other; supportive policy, planning and resources; and relevant effective skills and leadership (Saxon, 2008).

Increasing the capacity of other workforces was also a common theme for members of the Expert Panel. For example, this member of the Expert Panel felt increasing skills in general practice settings and the broader workforce was important:

It's much more about up-skilling the workforce in general and having good GPs and of course you need to know, you need to know some of the psychopharmacology, you need to know the particular issues of conflict and what some people call denial that are not unique to the drug area but are specifics of the drug area.

In addition to the provision of training, the expansion of secondary consultation both within the AOD sector and within allied health sectors has the potential to increase the capacity of other sectors to respond to AOD uses in the community.

6.11. Workforce investment

Ongoing investment in the AOD workforce is necessary to deliver quality services. This relates not just to the establishment of MQS or similar strategies, and associated education and training activities, but also investment in the sector more broadly to ensure that it both attracts and retains staff from the relevant disciplines required to deliver core components of AOD treatment. Recruitment and retention rates partly depend upon the attractiveness of the sector to potential and existing employees relative to other opportunities. The appeal of a sector can be influenced by factors such as remuneration and work conditions, clear career development opportunities, and the working environment (Skinner et al., 2005). The value of retaining skilled and qualified staff reaches beyond the individual level as it enhances the collective workforce through encouraging cohesive team work and provides increased opportunities for mentoring and supervision (Skinner & Roche, 2005).

It is also important that organisational structures support the retention of staff who participate in training programs. Resnick and colleagues (2007) caution that without the opportunity for advancement both financially and professionally, staff trained by an organisation are likely to eventually leave for another organisation or even another sector, with the organisation forfeiting the advantages of their increased knowledge and skill.

The implications of issues described above were apparent to many members of the Expert Panel, with several commenting on the financial implications linked to workforce development considerations of this project.

"We need to get serious about this sector. We need significant changes to the funding system - SACS no longer cuts it in the specialist AOD sector – we need high quality staff from a range of professional groups and need to firstly attract them and then retain them. It needs considerable funding input to attract and retain the best staff and compete with other sectors."

Future workforce initiatives require an appropriate level of funding to ensure workforce sustainability and ongoing provision of core treatment components.

6.11.1. Summary

6.11.2. Workforce characteristics

The following considerations influence the workforce development approaches advocated.

- A broad workforce development agenda in line with national and state policy is required to address key long term workforce issues and support effective workforce planning within the AOD sector.
- Successful treatment is influenced by both the quality of the service provided and the evidence base to support that service type.
- A positive staff attitude and approach to clients is a critical component of service provision as are core AOD knowledge and skills.
- Attracting staff from relevant disciplines, remunerating them accordingly and upskilling them with AOD content is vital to ongoing service provision within the AOD sector.

6.11.3. Workforce development

The following actions are suggested for the Victoria's specialist alcohol and other drug treatment system:

- Review the funding structure of services to support competitive remuneration to the specialist alcohol and other drug workforce.
- Develop and support mentoring and clinical supervision models within the AOD sector.
- Initiate a two tiered registration strategy where sector staff either adhere to the ongoing professional registration requirements of a relevant professional body (nursing, medicine, psychology, and social work for example) or comply with a revised Minimum Qualifications Strategy.
- Provide continued accredited and non-accredited training and qualifications to the specialist alcohol and other drug workforce. Staff skills as opposed to staff qualifications should not be overlooked and direct training in key areas such as assessment, working with families, and working with groups is advocated.
- Initiate the provision of targeted training programs to allied health and welfare sectors with emphasis on capacity building, networking, secondary consultation and collegial support.
- Initiate a sustained education campaign for the increased provision of alcohol and other drug education in undergraduate courses in relevant disciplines (nursing, medicine, psychology, and social work for example).
- Initiate a targeted recruitment drive in relevant higher education settings to promote alcohol and other drug as a vibrant and rewarding career pathway.

- Support and advocate for an enhanced nurse practitioner program in alcohol and other drug sector.
- Ensure that secondary consultation is provided to build capacity in the alcohol and other drug sector as well as other parts of health.

7. PROPORTIONAL INVESTMENT⁶

7.1. Introduction

In this chapter we consider the current investment in treatment, by funding and COT. Findings are shown for State and State and Commonwealth Governments combined where this is possible. Unit cost by treatment component is explored. The proposed investment mix is described, by EOC and funding amount. The chapter closes with a consideration of common pathways through treatment.

There are a number of caveats on the analysis⁷. (Our approach is described in Appendix A). Importantly, this project did not include a review of the cost structure or unit costs for each treatment element. The information shown here is indicative only and may require adjustment following a detailed review of the cost structure and unit costs for Victoria.

7.2. Current investment, by funding amount

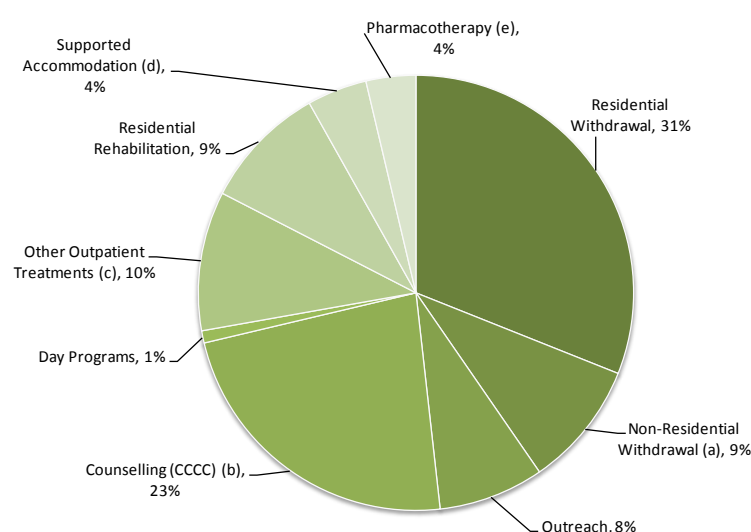
7.2.1.State Government

Information on the State Government's investment is explored here, within treatment categories that exist in the current system. This provides an indication of the distribution of finances by treatment type.

As shown in Figure 8, the largest financial investment by the Victorian Government is in residential withdrawal (31%). This is followed by counselling (CCCC; 23%). Other areas with substantial financial investment comprise 'other outpatient' (10%), non-residential withdrawal (9%), and residential rehabilitation (9%).

⁶ The approach to analysis has been developed following consideration of the method used in Ritter, et al. (2003).

⁷ In particular, please note that data do not include funds for non-treatment activities. COT are target figures. Figures are approximate and rounded.



Source: Service Agreement and Management System (SAMS) (de-identified data) 2008/09, DH. Analysis by Turning Point Alcohol and Drug Centre.

^a Non-Residential Withdrawal includes: Home-based Withdrawal; Outpatient Withdrawal; Rural Withdrawal

^b Counselling (CCCC) refers to Counselling, Consultancy and Continuing Care.

^c Other Outpatient Treatments includes: Ante & Post Natal Support; Community Education; Client Education; Peer Support; Aboriginal A&D Worker; Aboriginal A&D Resource Service; Parent Support; Mobile OD Response; Post Withdrawal Linkage; Outdoor Therapy

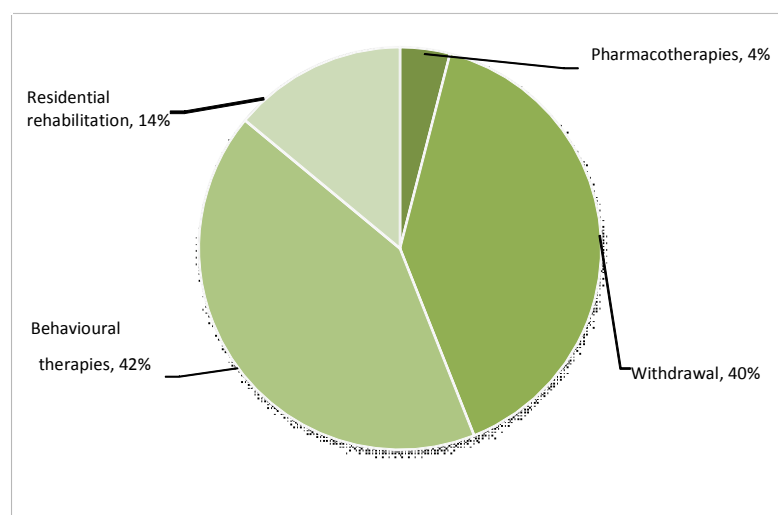
^d Supported Accommodation refers to Alcohol and Drug Supported Accommodation (ADSA).

^e Pharmacotherapy includes: Specialist Pharmacotherapy and Pharmacotherapy Outreach.

Figure 8. Financial investment by treatment type, Victorian Government, 2008-09

It is useful to consider the State Government investment within the framework of treatment components put forward in the review. This provides a basis for developing suggestions regarding proportional investment.

Four treatment components have been put forward, as described in Chapter Five (pharmacotherapies, withdrawal, behavioural therapies, residential rehabilitation). The State Government investment is shown again below, within these categories.

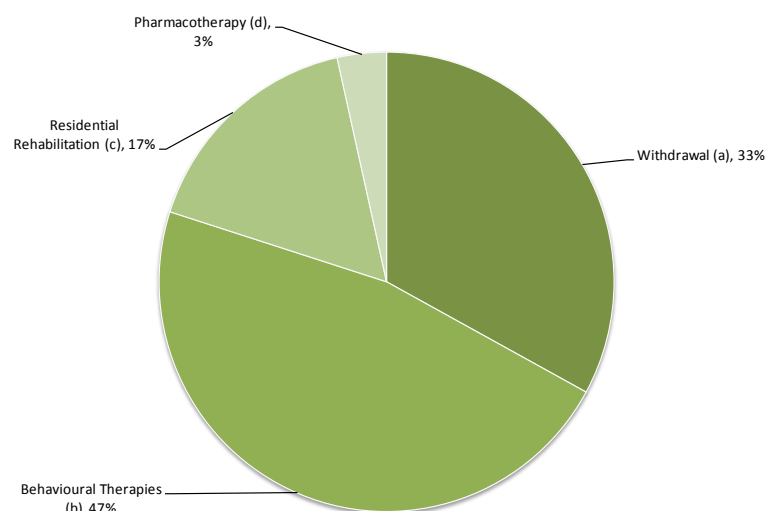


Source: ADIS Actuals and Targets Report, 08/09 Q1 to 08/09 Q4 (draft only), DH; analysis by Turning Point Alcohol and Drug Centre.

Figure 9. Financial investment by treatment components, Victorian Government, 2008-09

Almost half the financial investment in AOD treatment, by the State Government, is in behavioural therapies (42%). The second largest category of investment is withdrawal (40%) and this is followed by residential rehabilitation (14%) and then pharmacotherapies (4%).

This framework, of core treatment components, is used to show the financial investment from both State and Commonwealth Governments, as shown in Figure 10. Almost half the combined investment is in behavioural therapies (i.e., CCCC and other outpatient therapy; 47%) and this is followed by withdrawal (33%) and residential rehabilitation (17%). Pharmacotherapy (i.e., SPS and pharmacotherapy outreach) is at 3% (but note this does not include MBS contributions).



Source: Service Agreement and Management System (SAMS)(de-identified data) 2008/09, and National Illicit Drug Strategy - Illicit Drug Diversion Initiative (NIDS-IDDI) funding (de-identified data) 2008/09, and Non-Government Organisation Treatment Grants Program (NGOTGP) 2008/09, DH; analysis by Turning Point Alcohol and Drug Centre.

^a Withdrawal includes Residential Withdrawal; Home-based Withdrawal; Outpatient Withdrawal; Rural Withdrawal

^b Outpatient Treatments includes: Counselling, Consultancy and Continuing Care (CCCC); Outreach; Day Program; Ante & Post Natal Support; Community Education; Client Education; Peer Support; Aboriginal A&D Worker; Aboriginal A&D Resource Service; Parent Support; Mobile OD Response; Post Withdrawal Linkage; Outdoor Therapy

^c Residential Rehabilitation includes Alcohol and Drug Supported Accommodation (ADSA) and Residential Rehabilitation.

^d Pharmacotherapy includes: Specialist Pharmacotherapy and Pharmacotherapy Outreach.

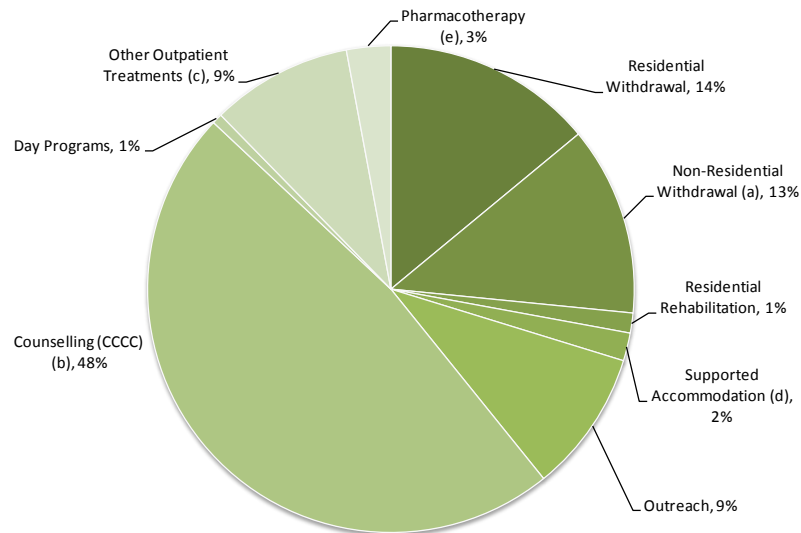
Figure 10. Financial investment by treatment type, Victorian and Commonwealth Government, 2008-09

The distribution of funds is similar to that when Victorian Government figures are considered in isolation. The main difference is a proportional increase in funds for withdrawal (from 33% to 40%) and a proportional increase in funds for behavioural therapies (from 42% to 47%).

7.3. Current investment, by COT

It is useful to consider treatment investment by COT, as some treatment categories are more expensive than others and thus may appear under-represented in the analysis of financial investment. Please note that our analysis is restricted to State Government investment as Commonwealth Government figures have not been provided by COT.

As shown in Figure 11, State Government investment by COT is predominantly for counselling (CCCC; 48%), with substantial COT in residential and non-residential withdrawal (14%, 13%), 'outpatient therapy outreach' (9%) and 'outpatient therapy other' (9%).



Source: ADIS Actuals and Targets Report, 08/09 Q1 to 08/09 Q4 (draft only), DH; analysis by Turning Point Alcohol and Drug Centre.

^a Non-Residential Withdrawal includes: Home-based Withdrawal; Outpatient Withdrawal; Rural Withdrawal

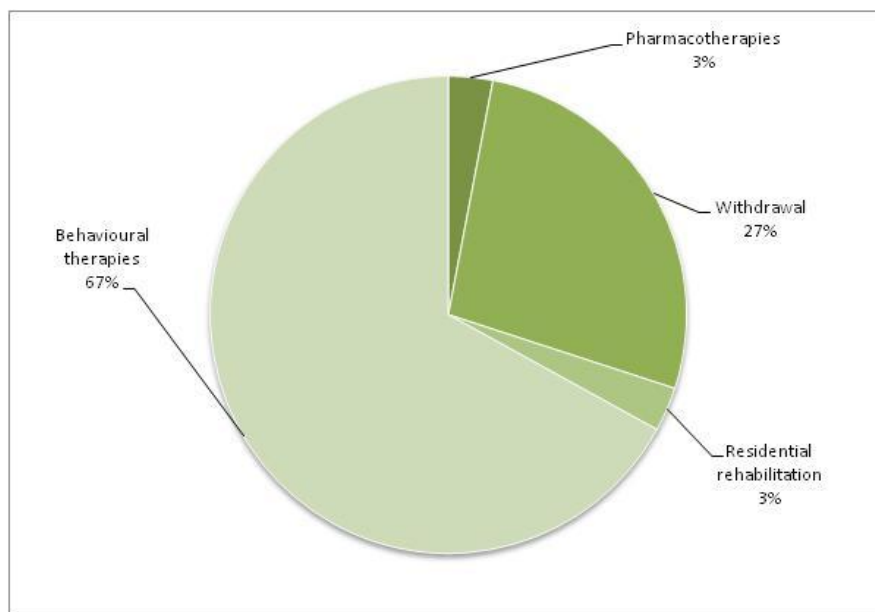
^b Counselling (CCCC) refers to Counselling, Consultancy and Continuing Care.

^c Other Outpatient Treatments includes: Ante & Post Natal Support; Community Education; Client Education; Peer Support; Aboriginal A&D Worker; Aboriginal A&D Resource Service; Parent Support; Mobile OD Response; Post Withdrawal Linkage; Outdoor Therapy

^d Supported Accommodation refers to Alcohol and Drug Supported Accommodation (ADSA).

Figure 11. Treatment investment based on COT, treatment types, Victorian Government, 2008-09

These data are shown again within core treatment components, in Figure 12, to provide a perspective on proportional investment by COT. The State Government's major investment by COT is in behavioural therapies (67%), followed by withdrawal (27%). Fewer COT have been assigned to residential rehabilitation (3%) and pharmacotherapies (3%).



Source: ADIS Actuals and Targets Report, 08/09 Q1 to 08/09 Q4 (draft only), DH; analysis by Turning Point Alcohol and Drug Centre.

Figure 12. Investment by COT, treatment components

7.4. Suggestions for proportional investment by COT

In Victoria, AOD services are purchased using a purchaser-provider model. The key output being purchased is an episode of care, which is defined as “a completed course of treatment undertaken by a client under the care of an AOD worker which achieves significant agreed treatment goals” (DH, 2004). To provide recommendations regarding proportional cost, it is necessary to consider the cost attached to each COT.

The proportional investment by COT has been developed on the basis of existing unit costs (2008-2009), with adjustment according to CPI and modifications according to recommendations from the 2003 review (Ritter et al.)⁸. The following information has been considered:

- The expectation that assessment will be a separately funded activity
- The expectation that particular components of treatment may involve some / all sessions that are delivered in an outreach capacity (particularly elements of behavioural therapies and non-residential withdrawal)
- Disbanding of the outreach treatment type

⁸ For example, in 2003 it was recommended that the unit cost for CCCC be increased.

- Disbanding of the counselling (CCCC) treatment type
- Disbanding of the AOD supported accommodation treatment type
- Addition of the behavioural therapies treatment component
- Addition of the modified therapeutic community treatment element
- Investment in a limited number of specialist pharmacotherapy services
- Unit costs for 2008-09
- CPI adjustment of 2.9% per annum, for two years (i.e., to 2010-2011)

Table 8. Rationale behind proposed unit costs for treatment components and assessment

<i>Treatment component</i>	<i>Comments</i>
<i>Pharmacotherapies</i>	Based on 2008-09 unit cost, with CPI adjustment
<i>Withdrawal</i> <ul style="list-style-type: none"> • <i>Residential</i> • <i>Non-residential</i> 	Based on 2008-09 unit cost, with CPI adjustment
<i>Behavioural therapies</i> <ul style="list-style-type: none"> • <i>Indicated prevention</i> • <i>Other</i> 	Based on 2008-09 unit cost for youth outreach and CCCC (increased with consideration of recommendation put forward in Ritter et al., 2003), with CPI adjustment
<i>Residential rehabilitation</i> <ul style="list-style-type: none"> • <i>TC</i> • <i>MTC</i> 	TC based on 2008-09 unit cost, with CPI adjustment. MTC based on TC, with slight reduction to allow for reduced time period (n.b., unit cost review required given this is a new treatment element)
<i>Assessment</i>	Based on 2003 review (CIU)

As shown in the table above, the following approach has been used for costing each treatment component:

- Pharmacotherapies; 2008-09 unit cost, with adjustment for CPI
- Withdrawal; 2008-09 unit cost, with adjustment for CPI
- Behavioural therapies; the new behavioural therapies treatment component is modelled on a therapeutic intervention which may extend over 4 to 6 weeks, involving individual / group counselling, or being configured as a day program. The unit costs for this component are based on the current unit cost for outpatient therapy, with an increase to account for that

recommended in the 2003 review and the expectation that this is a substantive, intensive intervention. Indicated prevention is likely to involve a substantial number of sessions where outreach is the preferred mode of service delivery and the unit cost for indicated prevention is based on that for youth outreach.

- Residential rehabilitation (TC/MTC); the therapeutic community model has been maintained and the unit cost is based on that for 2008-09 with CPI adjustment. The new treatment element of modified therapeutic communities comprises intensive therapeutic input while services may be provided in collaboration with housing services (e.g., transitional housing; homeless shelters) and the length of treatment may be reduced in comparison with the TC. This means an increased cost in comparison with ADSA but lower than the TC. The unit cost for MTC has been set at \$10,000, which is slightly less than that for TC. Review of the unit cost for MTC is required.

7.4.1. Support components

Assessment

Given the importance of quality assessment and the configuration of behavioural therapies as involving multiple sessions (with commensurate funding), we suggest that assessment is costed independently of other COT. The unit cost for assessment has been set at \$400, which is a slight increase on the figure put forward in 2003 (Ritter et al.).

Case management

Case management occurs across episodes and the cost needs to be covered within individual treatment units. However, the existing unit cost requires adjustment as assessment will be supported through a separate unit cost. As a result of these adjustments, there will be no change in the overall unit cost for treatment components to account for case management.

7.5. The proposed investment mix

Proportional investment refers to the allocation of units of care and associated funds to each treatment component. Our focus shifts to EOC rather than COT, as unit cost figures are available for EOC. As noted elsewhere, a full review of unit costs would be useful. Proportional investment has been adjusted to allow for:

- Revised unit costs, based on EOC unit cost figures
- The new treatment components and elements
- The inclusion of separate funding for assessment
- The increased proportion of clients with alcohol as their PDOC
- The reduced proportion of clients with heroin as their PDOC

The proposed investment mix is shown in the graphs below and then explained. This is followed by an outline of the rationale involved, for each treatment component.

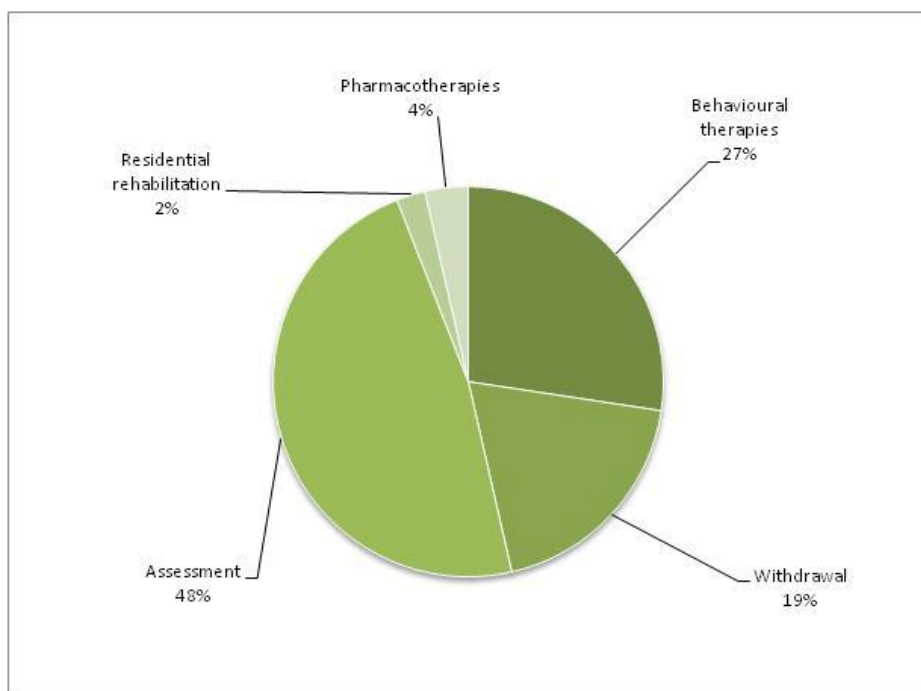


Figure 13. Proposed EOC investment, major treatment components and assessment

As shown, almost half the EOC are for assessment (48%). Behavioural therapies has the largest proportion of treatment EOC (27%) and this is followed by withdrawal (19%). Fewer EOC are allocated to pharmacotherapies (4%) and residential rehabilitation (2%)⁹.

When allocation is restricted to treatment components (i.e., not including assessment) then the distribution of episodes of care is as follows: behavioural therapy (60%), withdrawal (31%), pharmacotherapies (6%), and residential rehabilitation (3%).

⁹ Proposed investment is shown in EOC because unit cost figures were available for EOC rather than COT. Data for the review show that figures for target EOC are the same or slightly lower than figures for target COT. Numbers of EOC are estimates only and would require adjustment with a full review of unit costs.

Figure 14 shows the proposed financial investment, by major treatment components and including assessment.

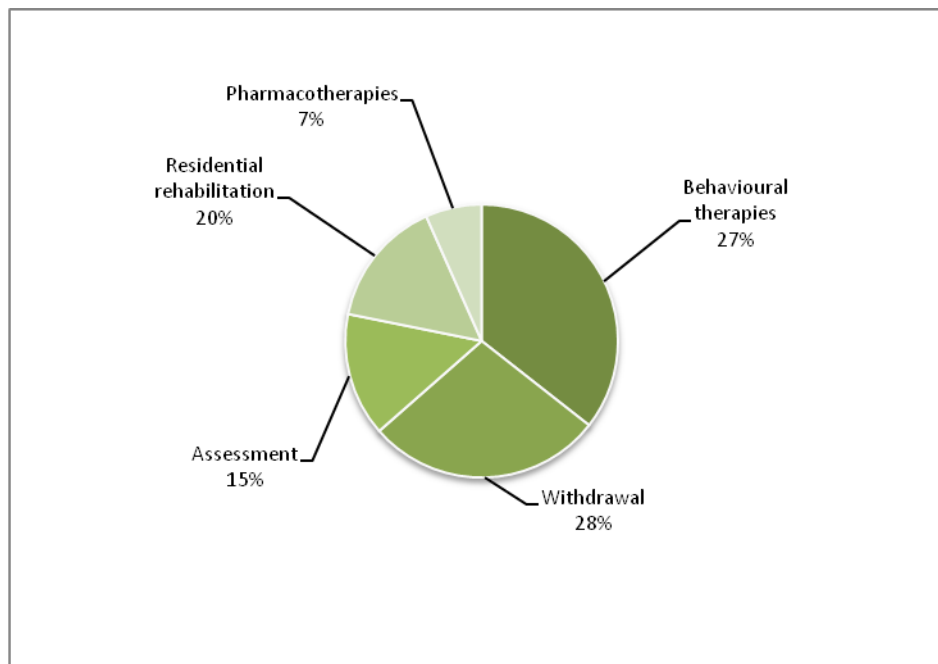


Figure 14. Proposed financial investment, major treatment components and assessment

As shown, similar proportions of funding have been allocated to withdrawal (28%) and behavioural therapies (27%). Residential rehabilitation accounts for one fifth of funding (20%), with 15% going to assessment, and 7% to pharmacotherapies.

When funding allocation is restricted to treatment components (i.e., not including assessment) a larger proportion is invested in behavioural therapies (41%), and residential rehabilitation (18%), with a similar amount going to withdrawal (33%), and pharmacotherapies (8%).

7.5.1. Pharmacotherapies

In 2003, it was recommended that Victoria establish a number of specialist pharmacotherapy clinics to complement the existing SPS and community pharmacotherapy program. The proportional investment needs to be increased accordingly.

7.5.2. Withdrawal

The current investment in withdrawal is substantial given the limited evidence base. However, with increased presentations for alcohol problems there is an increased need for withdrawal services given that pharmacotherapies are not as prevalent in this area in comparison with treatment for opioid dependence. Residential withdrawal for alcohol problems is better supported by the evidence than non-residential withdrawal. We recommend the proportional investment in withdrawal services is slightly decreased, with a greater reduction in non-residential withdrawal compared to residential withdrawal.

7.5.3. Behavioural therapies

Behavioural therapies are well supported by the evidence, for people with alcohol, cannabis, and amphetamine dependence. The proportional investment in this treatment component should be high. Further, we suggest the inclusion of indicated prevention which will target young people engaging in

risky substance use. We recommend the proportional investment in this treatment component is increased.

7.5.4. Residential rehabilitation

The evidence base provides support for both TC and MTC forms of residential rehabilitation, involving complex clients and for heroin rather than alcohol. The inclusion of MTC requires exploration to determine which models are most appropriate for Victoria and at what cost. This will be impacted by the extent to which the residential element of care is supported from within or beyond specialist AOD treatment funds. In the interim, we suggest maintaining the current investment in TC. Funds previously allocated to alcohol and other drug supported accommodation have been redirected to MTC, with unit cost adjustment as explained previously.

7.6. Funding pathways through treatment

There are concerns about system fragmentation (VDHS, 2008), client retention, and an episodic approach to care in Victoria (Ritter et al., 2003). Factors contributing to this sense of fragmentation may include the segmentation of treatment pathways and the complexities of working across multiple agencies to support client access to a sequence of treatment episodes.

Treatment clusters have been formulated on the basis of the common primary drugs of concern among clients in Victoria and the treatment evidence, as shown in Table 8.

Table 9. Common pathways through treatment by primary drug of concern

<i>Primary drug of concern</i>	<i>Common treatment pathway</i>
<i>(Mediated by clinical judgement and individual client need)</i>	
Alcohol	Assessment, withdrawal (residential, with fewer non-residential), behavioural therapies (possibly with pharmacotherapies)
Cannabis	Assessment, non-residential withdrawal, behavioural therapies
Heroin	a) Assessment, withdrawal (residential, non-residential; possible combination with behavioural therapies), behavioural therapies or TC / MTC b) Assessment, maintenance pharmacotherapies (with / without behavioural therapies)
Amphetamines	Withdrawal (non-residential), behavioural therapies
Risky use of alcohol or cannabis	Behavioural therapies (indicated prevention)

Alternative methods to cost investment may support treatment pathways, rather than align with an episodic experience of care. It would also be useful to consider how to maintain sufficient flexibility in the system to allow modifications in accordance with changing patterns of AOD use. These areas warrant further investigation.

7.7. Summary

7.7.1. Current investment

- The majority of State Government funds are allocated to behavioural therapies (42%) and withdrawal services (40%), with a lower proportion of funds going to residential rehabilitation (14%) and pharmacotherapies (4%)
- When State and Commonwealth Government funds are combined, the distribution is different. Slightly more funds are allocated to behavioural therapies (47%) and more to residential rehabilitation (17%), with less to withdrawal (33%) and slightly less to pharmacotherapies (3%)
- The analysis of current investment by COT, based on State Government figures, shows the main investment is in behavioural therapies (67%) and withdrawal (27%), with fewer COT for residential rehabilitation (3%) and pharmacotherapies (3%)

7.7.2. Proposed investment

- Proportional investment is shown by EOC. The proposed investment for treatment components is higher for behavioural therapies (27%) and withdrawal (19%) and lower for pharmacotherapies (4%) and residential rehabilitation (2%). EOC for assessment represent 48% of the total available.
- When allocation is restricted to treatment components (i.e., not including assessment) then the distribution of episodes of care is as follows: behavioural therapy (60%), withdrawal (31%), pharmacotherapies (6%), and residential rehabilitation (3%).
- Proportional investment by funds for treatment components is higher for behavioural therapies (27%) and withdrawal (28%) and lower for residential rehabilitation (20%) and pharmacotherapies (7%). Funds for assessment represent 15% of the total available.

8. CONCLUSIONS AND DIRECTIONS

This project has considered the research evidence on treatment effectiveness and the patterns of AOD use among clients in specialist treatment in Victoria. We have sought the views of international experts on fundamental concepts such as the level and nature of client need and the focus of treatment. The views of sector representatives and the current policy context and proportional investment have been considered. The following recommendations have been put forward on the basis of this information.

8.1. Treatment

The nature of treatment

Recommendation 1: that the specialist alcohol and drug treatment system is defined by the provision of specialist interventions that are designed to change behaviour related to problematic alcohol and drug use.

Recommendation 2: that the specialist alcohol and other treatment system in rural and regional Victoria is based on the understanding that drug treatment has the primary goal of reducing or ceasing drug use, although the worker's role should be broadened as required in response to the rural context of limited service availability.

Treatment components

Recommendation 3: that specialist alcohol and drug treatment components comprise pharmacotherapies, withdrawal, behavioural therapies, and residential rehabilitation.

Pharmacotherapies

Recommendation 4: that a small number of specialist pharmacotherapy clinics are established to complement specialist pharmacotherapy services and community programs.

Withdrawal

Recommendation 5: that withdrawal is not a stand-alone service and that both residential and non-residential withdrawal services must be run by a service that also provides behavioural therapies and / or residential rehabilitation programs.

Behavioural therapies

Recommendation 6: that behavioural therapies include treatment elements which have proven efficacy (i.e., indicated prevention, brief intervention, individual and group counselling, family therapy, day programs).

Recommendation 7: that service specifications for the behavioural therapies treatment component are developed, focusing on elements within this component.

Recommendation 8: that indicated prevention service models are explored to inform the development of service specifications. This may require the consolidation of existing evidence on pilot programs and local innovations as well as the trial and rigorous evaluation of pilot programs based on existing evidence.

Recommendation 9: that behavioural therapies include e-based approaches for service delivery.

Residential rehabilitation

Recommendation 10: that residential and non-residential withdrawal are retained as core elements of treatment.

Recommendation 11: that residential rehabilitation comprises two service elements: therapeutic communities and modified therapeutic communities.

Recommendation 12: that service specifications are developed for modified therapeutic community programs.

Special needs groups

Recommendation 13: that a limited number of programs designed for special needs groups (such as youth, women, Indigenous people) are provided to support client choice.

Recommendation 14: that programs designed for special needs groups utilise therapeutic techniques which are evidence based, with modification in terms of service delivery and program structure as appropriate to the needs of these groups.

Regional and rural Victoria

Recommendation 15: that strategies are implemented which improve rural people's access to residential withdrawal, rehabilitation and pharmacotherapies. These strategies may be aligned with other recommendations of this review, including support for the nurse practitioner role, the establishment of pharmacotherapy clinics, and the introduction of modified therapeutic community programs.

Recommendation 16: that structural support is put in place to enable people's access to hospital beds for withdrawal in regional and rural Victoria.

8.2. Support functions

Assessment

Recommendation 17: that quality assessment is valued as a critical element of service provision.

Case management

Recommendation 18: that case management is supported as a fundamental feature of specialist alcohol and other drug treatment.

Recommendation 19: that case management involves individual treatment planning; appropriate referrals to the next alcohol and other drug service, and assertive follow-up. In some cases, where clients have complex and multiple needs, the case management function will include linkages to non-alcohol and other drug community and health services.

Recommendation 20: that aftercare is understood as one part of the continuum of care involved in case management. It may take different forms. Some individuals will be referred to an appropriate non-specialist program and followed-up. Others may seek occasional contact with their case manager following treatment engagement. Assertive follow-up may be involved, where the case manager contacts the individual to ascertain their well-being and the maintenance of change in drug use behaviour.

Outreach

Recommendation 21: that outreach is regarded as a form of service delivery, which applies across many treatment components; particularly indicated prevention and elements of behavioural therapies.

8.3. Workforce

Structural review

Recommendation 22: review the funding structure of services to support competitive remuneration to the specialist alcohol and other drug workforce.

Registration, accredited training, and support

Recommendation 23: initiate a two tiered registration strategy where sector staff either adhere to the ongoing professional registration requirements of a relevant professional body (nursing, medicine, psychology, and social work for example) or comply with a revised Minimum Qualifications Strategy.

Recommendation 24: provide continued accredited and non-accredited training and qualifications to the specialist alcohol and other drug workforce.

Recommendation 25: develop and support mentoring and clinical supervision models within the alcohol and other drug sector.

Training for allied health and welfare sectors

Recommendation 26: initiate the provision of targeted training programs to allied health and welfare sectors with emphasis on capacity building, networking, secondary consultation and collegial support.

Staff recruitment in higher education settings

Recommendation 27: initiate a sustained education campaign for the increased provision of alcohol and other drug education in undergraduate courses in relevant disciplines (e.g., nursing, medicine, psychology, and social work).

Recommendation 28: initiate a targeted recruitment drive in relevant higher education settings to promote alcohol and other drug as a vibrant and rewarding career pathway.

Alcohol and other drug nurse practitioner

Recommendation 29: support and advocate for an enhanced nurse practitioner program in the alcohol and other drug sector.

Secondary consultation

Recommendation 30: ensure that secondary consultation is provided to build capacity in the alcohol and other drug sector as well as other parts of health.

8.4. Proportional investment

Funding

Recommendation 31: that the treatment components and major elements put forward in this review are the foundation for purchasing treatment services.

Recommendation 32: that the proportional investment in residential withdrawal is reduced.

Recommendation 33: that the proportional investment in non-residential withdrawal is reduced.

Recommendation 34: that the reduction in proportional investment for non-residential withdrawal is greater than that for residential withdrawal.

Recommendation 35: that the behavioural therapies treatment component receives a high proportion of investment, consistent with the evidence-base.

Recommendation 36: that funding for the residential rehabilitation (MTC) treatment element has proportional investment similar to that currently available for supported accommodation, with an increased unit cost.

Recommendation 37: that the proportional investment in pharmacotherapies is increased.

Recommendation 38: that assessment is funded as a separate activity from treatment episodes.

Episodes of care

Recommendation 39: that the number of episodes of care for pharmacotherapies is increased.

Recommendation 40: that the number of episodes of care for withdrawal services is reduced.

Recommendation 41: that the number of episodes of care for behavioural therapies is set at a high level.

Recommendation 42: that the number of episodes of care for residential rehabilitation (TC) is maintained.

Recommendation 43: that the episodes of care previously allocated to alcohol and drug supported accommodation are allocated to residential rehabilitation (modified therapeutic communities), with a reduction in the total number of episodes of care given the increased cost per unit of care.

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APPENDICES

Appendix A: Detailed method

Planning and project establishment

The project incorporated a number of meetings and other activities to share information about and receive input on aspects of the project. A detailed project plan was prepared. Ethics approval was obtained from the Eastern Health HREC.

Data collection

Review of the academic evidence-base

A review of the academic literature on AOD treatment was completed, drawing on the broader health field as appropriate. Cochrane reviews and systematic reviews regarding treatment effectiveness were sourced. The reviews are concise and focus particularly on treatment modality and effectiveness matched to drug type and client group (where applicable). We have also considered the key qualities of an AOD workforce in domains such as formal qualifications and experience, and where possible as applied to particular treatment types. Limitations on existing knowledge about treatment effectiveness and workforce profile have been noted. Questions that were addressed include:

- What does available evidence tell us about treatment effectiveness?
- What is known about the effectiveness of new / improved treatment technologies?
- What is known about the effectiveness of new workforce models, innovation, redesign etc?
- What is known about the essential characteristics of a workforce that is well equipped to provide AOD treatment? (This may include qualifications, skills, knowledge, attitudes and experience).

Background papers from the service system review (Ritter, et al 2003) formed the basis for some outputs from this aspect of the project; these reviews were updated with more recent evidence from the academic literature. A recent review on pharmacotherapies (Ritter & Chalmers 2009) was also updated.

We have provided a summary of the research evidence within particular categories of AOD treatment:

- Treatment effectiveness in outpatient settings [face / web / telephone counselling, group therapy, brief intervention, day programs, self-help, outreach]
- Withdrawal [residential, non-residential]
- Residential rehabilitation [medium intensity, therapeutic community]
- Pharmacotherapies

The final review focused on the AOD workforce.

Consultations with a panel of experts

The Expert Panel comprised ten individuals and included people with state, national, and international profiles, who were contacted by Turning Point and invited to take part in the project. Panel members

have one or more of the following:

- Knowledge of the Victorian AOD sector, including patterns of AOD use and the range of treatment types provided
- Knowledge of treatment effectiveness on specific drugs (e.g., alcohol, amphetamines)
- Expertise regarding dual diagnosis, including innovative models of care and interventions from different areas of health
- Expertise in pharmacotherapies
- Knowledge of AOD treatment responses in other parts of Australia and / or internationally, including recognised and innovative models of care
- Expertise regarding adolescent substance use and appropriate interventions, including people from CALD backgrounds
- Expertise regarding the characteristics of a workforce that is well equipped to provide essential components of AOD treatment

A list of possible participants was provided to DH and finalised in consultation with the Department and according to people's availability. The final panel combines people with practice and academic expertise as well as individuals with experiences from contrasting treatment systems.

Initial consultations were face / telephone interviews that addressed key questions for the review. Prior to the consultation, participants were provided with a brief discussion paper that included a description of the Victorian AOD sector (treatment types, workforce characteristics) and a list of underlying principles and definitions. The Department sighted the document prior to its distribution and provided comment. (Refer to Appendix B1 for a copy of the paper).

The Expert Panel was asked a series of open questions, with follow-up prompts to ensure core areas were addressed. Nine of the 10 members of the Expert Panel took part in an interview.

Follow-up consultations were based on an extensive consultation paper which summarised findings and provided a series of statements and questions for comment. These consultations were held face to face by telephone or involving the supply of feedback electronically. Eight of the 10 members of the Expert Panel provided input. (Refer to Appendix B2 for a copy of the paper).

Final consultations provided opportunity for experts to critique and comment on the draft report. Four of the 10 members of the Expert Panel provided comment on the report.

Budget analysis

The current level of investment in AOD treatment in Victoria has been explored. Investment and target episodes of care by treatment type were sought from the Department, for 2008-09. This information includes Victorian and Commonwealth funds. Analysis of these data involved the cost per course of treatment and the proportional investment by treatment type. Findings comprise a breakdown of the total budget by proportional investment in the essential treatment components and support functions that have been put forward in the report.

Patterns of AOD use among clients in Victoria

Service monitoring data (ADIS) and information from the DH pharmacy census were analysed. An ethics amendment was submitted to address the use of information for the drugs statistics handbooks

for this project. Questions that we have addressed include:

- What are the most common primary drugs of concern among clients of specialist AOD services in Victoria?
- What treatment is provided?
- What are the recent trends in AOD use among the treatment population?
- What treatment is provided for significant others of problematic AOD users and what proportion of total treatment is involved?

Workshop with sector representatives

DH convened a workshop of sector representatives which occurred in December 2009. Participants were identified in consultation with the Department and selection was based on people's knowledge and experience in the AOD sector. Information obtained during the workshop was included as data for the project. Participants in the workshop are listed in Appendix C. The workshop structure was conducted by researchers and the structure was as follows:

- Introduction to the project; purpose and design
- Group discussion and report back, on key questions for the project
 - What do service users seek from treatment? And with regard to particular client groups? [e.g., CALD adolescents, significant others, rural, Koori, aged] What are the implications for the AOD workforce?
 - Here is a list of essential treatment types that was put forward in a 2003 review of Victoria's AOD service system. [Provide list based on Ritter et al 2003]. What is your view about the appropriateness of this set of treatment types? Is anything missing? What about current innovations? What are the implications for the AOD workforce?
 - Here is a list of essential treatment types that was put forward in a 2003 review of Victoria's AOD service system. [Provide list based on Ritter et al 2003]. What are the essential characteristics of a workforce that is well equipped to provide these treatments?
- Information on project timeline and strategies for dissemination

Appendix B: Briefing papers for consultations with the Expert Panel

B1. Discussion Paper for Consultations with the Expert Panel, Round 1

Introduction

This paper provides some background information on the Victorian alcohol and other drug sector, the purpose of the *Defining alcohol and other drug treatment and workforce project*, and the consultation process for the Expert Advisory Panel¹⁰.

Principles of treatment In the Victorian alcohol and other drug sector

The vision

According to the new blueprint for alcohol and other drug treatment services in Victoria (2009-2013), the vision for alcohol and other drug (AOD) services and interventions is:

To prevent and reduce the harms to individuals, families and communities associated with alcohol and other drug misuse by providing appropriate, timely, high quality and integrated services that help people to address their substance use issues and participate fully in the social and economic life of the Victorian community.

The underlying philosophy

Working within a harm minimisation framework, treatment aims to reduce the adverse health, social and economic consequences of misuse of alcohol and other drugs, by minimising or limiting the harms and hazards of drug use for both the community and the individual, without necessarily eliminating use.

The focus of treatment

The focus of treatment, as distinct from other interventions, is on changing behaviour to assist people to cease or reduce their substance use in the longer term. This does not include services aimed at support and harm reduction, which are also very important but need consideration as part of a separate process.

The client

Some people are more vulnerable than others. Our service system needs to reach out to these people and persevere with the most marginalised groups to effect positive and lasting behaviour change. The client group targeted by specialist AOD treatment services in Victoria constitutes individuals with complex and serious problems, who require specialist AOD interventions to address their addiction.

¹⁰ This information is taken from a number of key policy and research documents on the Victorian alcohol and other drug service sector, in addition to literature on workforce development.

The client group targeted by AOD services in regional and rural Victoria constitutes individuals with complex and serious problems who require specialist drug intervention to address their addiction. Where appropriate, service activity may extend to those at risk of problematic use.

Victoria has a range of services that target young people. In 2002-03 more than half the courses of treatment delivered by youth services involve clients aged 18-21. A number of reviews suggest services should have an increased focus on younger people and include interventions focused on indicated prevention. This has implications in terms of treatment configuration and workforce characteristics.

Alcohol and other drug treatment in Victoria

Services delivered

More than 100 community agencies and local government services deliver alcohol and other drug (AOD) treatment services, advice, support and information to assist people who experience substance misuse problems. More than 26,000 Victorians access this system every year. Hundreds of pharmacies and general practitioners (GP) provide pharmacotherapy treatment to more than 11,000 people on any given day.

Treatment elements

The current framework for AOD treatment service delivery in Victoria includes a wide range of service groups. In 2003, a major review of Victoria's AOD treatment service system recommended that treatment elements should be limited to seven types, as identified and described in the table below.

Treatment type	Key feature
Residential withdrawal	Goal = safe and comfortable neuro-adaptation reversal. Residential setting suitable for those with severe withdrawal syndrome or complex behaviours. Cannot be provided as a stand alone service.
Non-residential withdrawal	Goal = safe and comfortable neuro-adaptation reversal. Outpatient attendance & home visits matched to client need. Cannot be provided as a stand alone service.
Outpatient therapy (non-residential rehabilitation)	Behaviour change interventions, including individual and group programs, day programs and individual therapy. Relapse prevention, cognitive-behavioural interventions. Skills training.
Medium intensity residential rehabilitation	A medium intensity, residential rehabilitation option. Average duration six weeks. Cognitive-behavioural skills program.
Therapeutic community	A high intensity rehabilitation option – therapeutic community model, flexible length of stay, up to 12 months.
Pharmacotherapies	Maintenance programs for heroin dependency – methadone and buprenorphine.
Supported accommodation	A very low intensity, post-rehabilitation option. A minimum support program in partnership with designated housing provided through Office of Housing.

Services for young people

In a separate review, the characteristics of youth drug treatment services in Victoria were identified. These characteristics are: relationship-based service delivery, treatment flexibility and responsiveness, a harm minimisation / harm reduction approach, a youth-friendly environment, and a holistic response / continuity of care.

While these elements are also relevant to general services, the degree to which youth drug treatment services reflect these features distinguishes them from general services. Characteristics that are clearly particular to youth drug treatment services include the youth-friendly environment, holistic response, unique service types, and core business of indicated prevention and treatment.

Indicated prevention seeks to equip young people with mechanisms that support resistance to drug dependence. The target group is young people, particularly those aged less than 18 years, who have yet to develop a dependency or serious drug problem, but who are currently experiencing harm from their drug use. These interventions may include brief motivation and harm reduction approaches. Risks associated with drug use, such as overdose and BBI transmission, may be targeted. Program features may include individual counselling and case management, information and referral for family members, and group mentoring sessions. This set of interventions may form part of an outreach worker's role.

Treatment in regional and rural areas

Treatment for regional and rural clients is based on that for metropolitan clients. Where necessary, the worker's role should be broadened in response to the rural context of limited service availability. Secondary consultation and capacity building may be involved, although treatment itself remains the primary focus.

The alcohol and other drug sector workforce

There are numerous issues that influence the current workforce and future planning in this area. These issues include remuneration, staff retention, skills and experience, and predicted population growth.

Remuneration

The issue of remuneration is a consistent feature of workforce development literature specifically related to AOD work. Parity differentials have been identified across sectors, notably between mental health and AOD, and also across jurisdictions.

Recruitment and retention

Recruitment and retention of senior staff is difficult in the AOD sector (ADCA, 2003a). Remuneration rates may be a contributing factor. Sustaining change to practice requires ongoing activity and this is often compromised when staff frequently move across organisations or across sectors. A stable, experienced workforce is generally more skilled and is able to deliver a greater return on investment. It also promotes team cohesion and provides greater opportunities for mentoring and supervision, all of which are integral to effective workforce development.

Experience and skill level of the workforce

Data from a recent report indicated that 23% of Victoria's workforce is fairly new to the sector (less than 2 years). Twenty-three percent indicated 2-5 years experience and 55% indicated more than 5 years experience in the AOD sector. Sixty-two percent of respondents indicated they had attained qualifications at degree or postgraduate levels, with 56% holding qualifications specifically in the AOD area (postgraduate courses, 13%, TAFE diplomas, 24% and Certificate IV, 19%). While the professional discipline of AOD workers was not specifically queried, analysis of their dedicated job role shows representation from nursing, social work, psychology, welfare, youth and mental health. This is consistent with a 2002 study indicating that 18% of the sector held nursing qualifications, with qualifications in psychology (16%) and social work (9%) also being well represented.

Ageing workforce

In line with the ageing population in Victoria, comes an ageing workforce. Data from 2008¹⁴ indicate that 6% of the Victorian AOD workforce was aged 60 or over and a further 25% were in the 50 – 59 age group. While retirement ages will vary, we can expect that a large portion of the current workforce will leave the AOD sector in the next 5 – 10 years. Given the recruitment issues mentioned earlier, recruiting to fill this void may be extremely difficult. An additional issue with respect to the age of the workforce is its capacity to engage with young people. While being older than 30 does not preclude a worker from engaging effectively with a young person, it is of note that the proportion of Victorian AOD workers aged under 30 has reduced from 24% in 2002 to 13% in 2008.

The Defining Alcohol and Other Drug Treatment and Workforce Project

As noted elsewhere, this project has the following purpose:

The review will identify the essential treatment components of an AOD service system, with attention to core AOD treatment types and elements within each of these treatment types. This information will be considered in the Victorian context and policy environment; ensuring consistency with key principles, such as harm minimisation, and underlying definitions that include a shared understanding of the target client group and the goals of drug treatment.

In turn, this will inform the conclusions that can be drawn about the workforce required to deliver each treatment type and provide the basis for workforce planning in the future.

The project is *not* about service delivery models, although this is also an important consideration in system design.

The project has five elements:

- A review of the academic literature
- Budget analysis
- The examination of patterns of alcohol and drug use among treatment clients
- A workshop with sector representatives
- Consultations with a panel of experts

Consultations with the Expert Advisory Panel

A series of three consultations is planned:

- The first consultation is a semi-structured interview using the questions shown below
- The second consultation is to seek your comments on findings from the first round of consultation and other aspects of the project
- The final consultation is to seek your comment on draft project findings. This may be in the form of a draft report

The Expert Advisory Panel will be asked to validate the final project report.

Questions for the initial consultation

Background

Preliminary: Please outline your professional role and area(s) of expertise.

Treatment types

1. What do service users seek from treatment?
2. What are the essential AOD treatment types for a specialist AOD service system?

What are the critical elements of these treatment types?

And with regard to particular groups of clients? [young, CALD adolescents, significant others, rural, Koori, aged]

And those using particular substances [poly, alcohol, amphetamine like substances, other]

3. Here is a list of essential treatment types that was put forward in a 2003 review of Victoria's AOD service system. [Refer to the table on page two]. What is your view about the appropriateness of this set of treatment types?

Is there anything missing?

Are there treatment models from different areas of health (e.g., mental health) that we should consider?

What are the priority areas for investment?

4. Are there innovative models that may need consideration for the review?

Workforce

5. Now we are going to talk about the essential characteristics of a workforce that is well equipped to provide these essential AOD treatment types (as you identified in Q 2).

For each of the treatment types identified.

What formal qualifications are required? (level, domain)

What specific skills are required?

What level of practical experience is required?

6. Are there workforce models / groupings from different areas of health (e.g., mental health) that need consideration?

7. Now, thinking back to your comments on the essential characteristics of the workforce that is required, please think about the implications for the system. What are the implications in relation to:

Education and training requirements?

Investment in workforce development?

Other?

Other

8. Remembering that this project seeks to identify the essential treatment types for Victoria and the associated workforce requirements, what is the single most important issue for the project to take account of?

9. Is there anything you'd like to add?

B2. Background Paper for Consultations with the Expert Panel, Round 2

Introduction

This paper provides a brief orientation to the project before outlining some preliminary findings. Our focus is not comprehensive, but targets controversial and challenging areas. We are keen to obtain your views on these issues.

Each finding is accompanied by one or more statements and / or questions. We would like to obtain your agreement or disagreement with these statements and further comments where necessary. We will approach you for a telephone interview shortly; however you may wish to respond via email.

The project

As you know, the project aim is to identify and define the evidence-based, internationally recognised core treatments available within an effective alcohol and other drug service system. We will also identify the characteristics of a workforce that is able to deliver these treatments.

We have gathered information from:

- Consultations with key experts (round 1)
- Academic literature on treatment effectiveness and workforce
- Service data on client characteristics and drug use in Victoria, for 2007-08
- Budget documents
- A workshop with sector representatives

Discussion points

There are eight discussion points, on:

1. The nature of the client group
2. What clients seek from treatment
3. Polydrug use and the treatment response
4. Components of treatment
5. Key issues
6. Treatment for special needs groups
7. Workforce characteristics
8. Treatment clusters

Discussion point one: The nature of the client group

Experts to the project often described the client group in Victoria as being complex, desperate, and marginalised. Desperation is often what brings them to the sector, arising from health, social, economic, legal grounds or a combination of these. A second group, with lesser representation in specialist AOD treatment was described as having comparatively straightforward problems.

One expert described a continuum of client need, involving:

- a) Those at risk, who feel they may have a problem and want to know what the treatment options are, “it might come about from simply a niggling question or doubt in my mind about my drinking or my cannabis use or my son’s cannabis use or something like that”
- b) People with chronic, severe problems, “who’ve never sought treatment but the circumstances have now become so difficult, so complex, so intolerable that they are desperately seeking some kind of intervention”
- c) People with acute problems; something very profound has happened, “it may be an overdose or it may be an injury associated with overdose of alcohol as opposed to overdose of illicit”

Do you agree or disagree with the following statements?

There are two groups of clients in specialist alcohol and other drug treatment in Victoria. The first group is complex, with a multitude of needs - across health, social, economic, and / or legal domains. The second group, which is smaller, has relatively straightforward problems.

There is a continuum of need, which encompasses people exploring treatment options because they may have a problem, people with chronic AOD problems that are in difficult circumstances, and people with acute AOD problems; a crisis has occurred.

Are you able to provide a comment on the proportion of clients in each group (i.e., the complex, with multiple needs and those with ‘straightforward problems’)? This may be in reference to Victoria’s specialist AOD treatment system *or* another context (e.g. NSW, Sweden, generally)?

Comments?

Discussion point two: What clients seek from specialist AOD treatment

While a range of motivations for treatment was identified, the central theme from experts to the study was that clients are looking for “something that will help them manage their [AOD] use....but also the ramifications of that”.

Experts suggested that clients seek different things from treatment:

- Some people want to ‘kick the habit’; they are seeking a life without drugs or perhaps controlled use. They have made a decision to stop using and “they’re looking for pretty much any advice that they can get to assist them with that sort of process”. This may include medications.
- Some clients seek “practical resources of one sort or another...if they’re marginalised they’re very likely to be looking for a bed and meals”.
- Others are in treatment because someone else has suggested strongly that they come; family or friends or formal mechanisms such as the courts and referral services. Being in treatment may serve a ‘vouching function’, a fulfilment of their obligation to someone else.
- Respite may be the focus, to “get out of the situations they’re in and I think that applies typically for young people and the residential withdrawal services. I think it certainly applies for people going into therapeutic communities”. Importantly, client motivation is a dynamic construct and readiness to change may develop after the client is engaged in treatment.

Do you agree or disagree with the following statements?

Clients seek different things from treatment. Some want to cease or control their AOD use, while others seek practical resources. For some clients, there is a level of coercion that involves family, friends or legal representatives. Respite may be the focus, particularly for the young.

The role of an AOD specialist system is to provide quality, specialist AOD treatment rather than practical resources or respite.

What is the most common reason people seek treatment?

Comments?

Discussion point three: Polydrug use and the treatment response

AOD services in Victoria report on primary drugs of concern and other drugs of concern. In 2007-08, the majority of courses of treatment involved clients that had more than one drug of concern.

Polydrug use was reported for:

- 70% of courses of treatment where amphetamines was the primary drug of concern
- 65% of courses of treatment where heroin use was the primary drug of concern
- 57% of courses of treatment where cannabis was the primary drug of concern

The secondary drug of concern for clients experiencing these courses of treatment was typically alcohol.

Interestingly, courses of treatment delivered to clients with alcohol as their primary drug of concern showed lower rates of polydrug use (38%). The secondary drug of concern in this instance was usually cannabis.

A recent report on polydrug use notes the high rates among member states of the EU and, further, that:

Managing the care of problem polydrug users requires long-term treatment planning with attention to individual needs and multidisciplinary teams working together with flexible and sometimes innovative treatment options (EMCDDA, 2009, p. 26).

Do you agree or disagree with the following statements?

Given the high rates of polydrug use among clients in Victoria, it is particularly important that long-term treatment planning is utilised. This treatment must be aligned with individual needs.

While a substantial proportion of clients have complex and multiple needs, the role of a specialist system is to provide quality, specialist treatment. Remaining needs should be addressed through other systems.

Comments?

Discussion point four: Components of treatment

We have reviewed the evidence on treatment modalities and effectiveness. In addition, comments from experts - on essential treatment components and the salience of the treatment types put forward in the 2003 review of Victoria's system - have been considered. Here is a summary of the main points made by experts and an extract from research findings where needed.

Some experts reduced treatment to three or four broad approaches:

Psycho-pharmacological, pharmacological, outpatient, residential

Detoxification, recovery, and maintenance, backed up by "plain case work around needing a bed, how are they going to support themselves etc"

Core components put forward in the 2003 review were endorsed by many experts and discussed in some detail.

Residential and non-residential withdrawal modalities were both supported. Some experts noted that residential withdrawal should be highly targeted, involving only clients that need this level of intervention.

Outpatient therapy was regarded as important and needing to be "precise and specific and specialist and deliberative and related to some sort of theoretical and knowledge based set of skills...with expectations of what a percentage success would be for each of those treatments". Our review of the evidence on outpatient therapy identified particular elements of treatment with good effectiveness according to clients' primary drug of concern. Across the drug categories, therapeutic techniques that often featured include CBT, MET, MI, and social support. Staff clarity and capacity in terms of the therapeutic approach being used and the expected outcomes is essential.

Targeted use of **medium to high intensity residential treatment** was also supported. One international expert noted that they have a short residential program for alcohol users (2-3 months) and a longer program for other drug users (6-9 months). The short program is too short, while heroin users require a longer period. A recent Cochrane review was unable to make a firm stand on the relative effectiveness of therapeutic communities due to data limitations. The majority of research in this area indicates that positive treatment outcomes can be achieved with particular groups, given appropriate treatment services and conditions. Treatment intensity is emerging as a significant predictive factor affecting outcomes, beyond length of stay. Retention is a major challenge for services.

A "really well functioning **pharmacotherapy** service is critical" and a number of experts familiar with Victoria's system commented on the need for change in this area. The system needs "a fairly substantial injection of funding....it's really under-funded and it's struggling and the way it's operating is based pretty much on good will". It needs to be seen as part of the system and not as a separate system.

Some experts commented on Victoria's low level residential program; **alcohol and other drug supported accommodation**. It was understood as providing for clients who are marginally homeless, serving "to maintain some quality of health and well-being" and providing "a sort of a place holder for a broader range of things that are in some way or another supporting people to get their act

together”. International experts also supported the model. One person noted it was particularly important in inner city areas, which typically have elevated rates of homelessness. Another suggested that, while the model is useful, it needs an active partnership at policy level to function effectively (i.e. involving Drugs Policy and the Office of Housing).

The research literature suggests that low intensity residential models are appropriate for people who are able to live independently and have a moderate to high level of cognitive functioning, as well as the capacity to control their own behaviour and establish relationships with others. These services are useful for people in transition from higher intensity treatment.

There is a tension here. While alcohol and other supported accommodation is a welcome model that provides low level care in combination with accommodation, the question remains as to whether this support function should be part of a specialist AOD treatment system.

Your views on this matter would be very useful. In 2003, review authors recommended the development of a medium intensity residential rehabilitation service type that would involve community dwelling with specialist intervention. This is one way to provide an appropriate level of intervention within a specialist system. There is still a question about the usefulness and place of low level housing with AOD support - as represented by the AOD supported accommodation service type.

Do you agree or disagree with the following statements?

The specialist AOD service system in Victoria should consist of the following treatment components:

- *Pharmacotherapies*
- *Withdrawal (residential and non-residential)*
- *Outpatient therapy (indicated prevention, non-residential rehabilitation)*
- *Residential rehabilitation (TC, medium intensity)*

The specialist system requires a residential model that involves community dwelling with medium intensity intervention.

The alcohol and other supported accommodation model has merit, however it should not be part of a specialist treatment system.

Comments?

Discussion point five: Key issues

Four other aspects of the system were raised by a number of experts: assessment, case management, outreach, and secondary consultation.

a. Quality assessments. Experts explained that a proper assessment and treatment plan is *the key element* when a client is admitted. Quality assessment underpins some of the factors that support treatment success across different modalities. Examples include the client's motivation to change, matching treatment to their preferences, and client perceptions about whether their needs are being met. It is particularly important for clients with co-morbid mental health and AOD conditions who constitute the majority of those in treatment. Two experts commented that the manualisation of treatment and contractual obligations to complete particular assessments takes away from the establishment of the therapeutic relationship.

b. Case management. In 2003, the review authors noted that the Victorian AOD specialist system was fragmented and clients were at risk of 'falling through the gaps', while services did not necessarily see themselves as part of a cross-agency continuum of care. Case management was generally in place 'as part of the usual clinical function' and it was supported *within the specialist system* but not with regard to linkages to other systems. The model of case management that was supported has three elements: individual treatment planning; appropriate referrals to the next AOD service, and assertive follow-up.

Case management was identified by experts as a necessary part of treatment provision, generally in the context of client complexity and also the orientation of treatment. For example, one expert commented that, "case management provides the frame of reference that is holistic, but you can't do everything within one institution. You have to find a way of reaching across." Another expert emphasised that treatment was about changing one's life and addressing AOD use as part of that, "the only thing that's missing (in the list of treatment types put forward in the 2003 review) is that, to what extent is addiction simply about drugs and alcohol or is it about one's life as well".

A recent systematic review of case management interventions found it was an effective strategy for linking people with AOD problems 'to community and treatment services, compared to treatment as usual or other viable treatment options like psycho-education or brief interventions'. It appears that case management is a fundamental aspect of treatment provision; however the exact definition of the term needs attention.

Do you agree or disagree with the following statements?

Quality assessment is critical to specialist AOD treatment and it should be valued as a high level service function that is fundamental to effective treatment planning and intervention.

Case management has a fundamental support function in a specialist AOD treatment system. It involves individual treatment planning; appropriate referrals to the next AOD service, and assertive follow-up. In some cases, where clients have complex and multiple needs, the case management function may include linkages to non-AOD community and health services.

Comments?

c. Outreach is another term that has different meanings. Victoria has a number of models in place, such as staff being outposted to regional community health centres or visiting clients in their homes or at a public place. There are designated outreach programs, for example involving youth or regional clients who have been diverted into treatment, or providing GP support in relation to methadone maintenance.

Experts described outreach as a mode of service delivery, with application across treatment components, which is appropriate for clients irrespective of age. It occurs to support access and retention and includes a follow-up function for no shows. It is important that we are quite clear about the intended meaning behind the use of the term outreach.

d. There was also some discussion about **secondary consultation**. Some experts considered the role of a specialist AOD workforce in the context of broader health systems and the prevalence of at risk or problematic substance use in the general population. Specialist services should develop capacity to provide quality assessment and high level support for other services to facilitate intervention by non-AOD workers in other systems.

There are budgetary implications from this suggestion and, while it has clear advantages it is important that we are clear on the priority to assign to secondary consultation in comparison with the delivery of high quality, specialist treatment.

Do you agree or disagree with the following statements?

Outreach is a mode of service delivery that may involve providing treatment at regional outposts or at a group forum (e.g. an indicated prevention session targeting young people at a sporting club). Service delivery may occur in a client's home or an agreed public place (e.g., café). Specialist interventions that may involve an outreach approach include pharmacotherapy, non-residential withdrawal, and outpatient therapy. Outreach is not a specialist treatment in its own right.

Ideally, specialist services will have capacity to provide quality assessment and high level support that facilitates intervention by non-AOD workers in other systems. However, in the context of limited funding and considerable demand, treatment funding should be restricted to clinical intervention.

Given the prevalence of AOD problems in the general population and the AOD system's focus on high quality, specialist treatment that is primarily for entrenched users, it would be appropriate for other policy areas from health and human services to provide support that would enable this capacity building function.

Comments?

Discussion point six: Treatment for special needs groups (e.g., Indigenous, youth, women, ethnic minorities)

Some experts identified features of services that were useful for rural clients, including service access, flexibility, and innovation. The use of secondary consultation in this context would include upskilling staff at local community health centres so they can take on a client load.

Similarly, features of ‘youth friendly’ services were identified, including the physical surroundings and the attitudes of staff at reception and in treatment roles. One expert noted the “need to differentiate between early uptake users and those who are already in real strife and dependent”; providing separated as well as differentiated service interventions.

Some experts reflected on the need for tailored services; one person noted there “are no hard and fast rules”. Client choice is important and the setting and skill of the clinician is critical. Clinicians need to adapt their techniques, but not necessarily have a different approach. Examples were cited where clients in special needs groups chose a mainstream service over a targeted service, while the point was also made that treatment approaches may be fairly traditional, but repackaged according to cultural mores. The research literature provides some insights on the need for tailored services. For example, this includes high intensity residential services when they are tailored to client needs (including services for women, young people, homeless, and the mentally ill). Program variables associated with treatment retention for young people include staff experience, staff/client relationships and services addressing the holistic needs of young people.

Do you agree or disagree with the following statement?

Clients with special needs may or may not choose to attend an AOD service that is designed to meet these needs. Client choice is important; while service capacity to adapt according to individual needs is critical.

A specialist AOD treatment system will include tailored services for special needs groups where there is an identified need for these services. Examples include Indigenous services and residential services for women, in addition to youth specific services.

All services should operate according to evidence based practice and staff throughout the system should have the capacity to adapt good therapeutic techniques to the background and demographic of clients.

Comments?

Discussion point seven: Workforce characteristics

Established areas of concern regarding workforce development were highlighted by experts and in the research literature, including recruitment and retention, entry level qualifications, and accredited training.

Some experts explained that the **quality of the service** and whether it is evidence-based are more important than the specific treatment type being provided. One person asked, “have we adequately defined what that service should be doing, is there a staffing profile in that service that will allow the service to deliver quality care and safe care?”

A number of common factors lead to positive outcomes across treatment modalities and many of these pertain to staff and workforce development. Four themes stand out from the consultations.

Staff attitude and approach

Experts explained that it is important that staff *like* the clients; they have a positive regard for clients and an optimistic view about their chance of success in treatment. Staff capacity to engage with clients and build a **therapeutic relationship** was described as important. “First and foremost the ability to connect a client....The ability to be pragmatic, the ability to form a relationship because probably forming a relationship particularly with this client group, but not exclusively, is essential”.

Staff skill

Skills include the ability to support clients in making informed choices, psychotherapeutic approaches and their integration with “the appropriate use of pharmacotherapies particularly in terms of symptom relief”.

Interestingly, client complexity and the likelihood of involving other services means that skill in collegiate relations and shared care are important for the AOD clinician. For example, “what we should be doing is helping, providing the resources and providing the skills to work in shared care or whatever you want to call it....that ability to work collegiately”....”you need to know when to seek additional expertise and how to work with that expertise”. This is also consistent with other comments from experts on the secondary consultation role of the AOD clinician.

Formal qualifications and AOD treatment knowledge

A two tiered workforce, or ‘split system’, was alluded to in some comments made by experts, involving people with tertiary qualifications and others with vocational training certificates. One tier would involve specialist treatment, such as pharmacotherapy, withdrawal, and outpatient therapy, while support services would require different training and credentialing.

The goal is to have people with advanced qualifications, especially in more intensive areas of AOD work. We need good doctors, good social workers, good psychologists who also have some expertise in alcohol and drugs. Some staff, who work in welfare and support roles, will have Certificate IV and that is adequate.

While experts generally felt that while it was important to have a qualified workforce, this workforce did not have to be “uniquely drug skilled” when commencing work in the AOD sector, a focused ‘top-

up' specific to AOD would be sufficient. As one expert noted, "a very good clinician will be a very good clinician". Staff with non-AOD qualifications could quickly learn the content needed to operate within an AOD service.

Workforce development

According to experts, and the academic literature, there are substantial gaps in the provision of ongoing support mechanisms to ensure clinicians are transferring skills and knowledge gained in training to their daily practice. Mentoring and clinical supervision are major supports which are not generally available to AOD staff. One expert described the gains as follows:

But the issue, what made a difference was when they started doing clinical work they had clinical supervision....In the early days and that's what made the difference. Not the brilliant teaching but the careful support as they went into their clinical pathways.

Accreditation

Several experts indicated that a move toward ongoing professional development requirement / continuing education requirement could be considered, similar to existing models in nursing and medicine. For example,

I like the idea of the medico equivalent of CME points, the Continuing Medical Education points. Now if all of the professional groups don't have that then I think we should establish something for those that don't.

There should be an option for people to be specialised, move into these more specialist areas and achieve a qualification specifically in this area.

We have a number of questions for you:

Do you agree or disagree: a) on the importance of these characteristics, and b) on the way they have been described?

What are the implications, in terms of qualifications and the focus of education and training?

Would you support a move towards accreditation that involved a registration process, ongoing CME points etc similar to other professions?

Is a two tiered/split system a viable option for consideration in relation to workforce requirements/ qualifications/ accreditation etc?

Discussion point eight: Treatment clusters

Victoria's AOD services are purchased using a purchaser-provider model. The key output being purchased is an episode of care, which is defined as 'a completed course of treatment undertaken by a client under the care of and AOD worker which achieves significant agreed treatment goals' (DHS, 2004).

There are concerns about system fragmentation, client retention, and an episodic approach to care in Victoria. This may be impacted by the way treatment is conceptualised; as individual, discrete episodes of care that represent one aspect of a treatment pathway. Clients interviewed for the 2003 review described their treatment experiences in episodes such as withdrawal, or a stay in residential rehabilitation, or seeing a counsellor. One stakeholder to the review suggested that the sector has moved away from specialist skills to output delivery and that program aims should be about treatment outcomes, not the minimum or 'bottom line' (i.e., what is required to reach output requirements).

An alternative way of conceptualising treatment involves the use of treatment clusters; which combine typical pathways through treatment according to the nature of AOD use and the evidence-based treatments required. For example, chronic heroin user may require assessment and residential withdrawal, then a stay in a therapeutic community, followed by outpatient therapy, or assessment and then pharmacotherapy. Someone with risky drinking may need, assessment and then outpatient therapy (individual, group, assertive follow-up).

This change in configuration to clusters of treatment may have a positive impact on the nature of treatment goals; being more about retention and recovery / maintenance than goals which are matched to what is essentially one component in a treatment pathway, such as withdrawal or outpatient therapy. It has implications, too, in relation to the workforce required at agency level to deliver on treatment. The system could be understood as offering clusters of care which combine evidence-based components and represent a pathway through treatment.

Of course this is speculative and needs further work but your thoughts would be very useful.

Do you agree or disagree with this notion of treatment clusters and pathways through treatment?

What is the rationale underpinning your answer?

Thanks very much for your input

Do you have any other comments to contribute to the review?

Appendix C: Participants in the alcohol and other drug sector workshop

Participant	Agency
Moses Abbatangelo	DAS West
Matt Berry	Caraniche
Sam Biondo	VAADA
Keith Edwards	Windana
Jo Famularo-Doyle	Turning Point Alcohol & Drug Centre (Eastern Health)
Matt Frei	Eastern Health
Craig Holloway	YSAS
Demos Krouskos	North Richmond CHC
Greg Logan	St Vincent's Health
Rose McCrohan	UnitingCare Moreland Hall
Helen Mentha	Inner Eastern CHS
David Murray	YSAS
Suzi Nielson	Turning Point Alcohol & Drug Centre (Eastern Health)
Donna Ribton-Turner	UnitingCare Moreland Hall
Simon Ruth	Pendap

Appendix D: Background Papers

This appendix is attached as a separate document titled Background papers: Defining Alcohol and Other Drug Treatment and Workforce. This document includes the following sections.

- Pharmacotherapy
- Withdrawal
- Outpatient therapy
- Residential rehabilitation
- Review of the literature on workforce planning and development, for alcohol and other drug treatment in Victoria