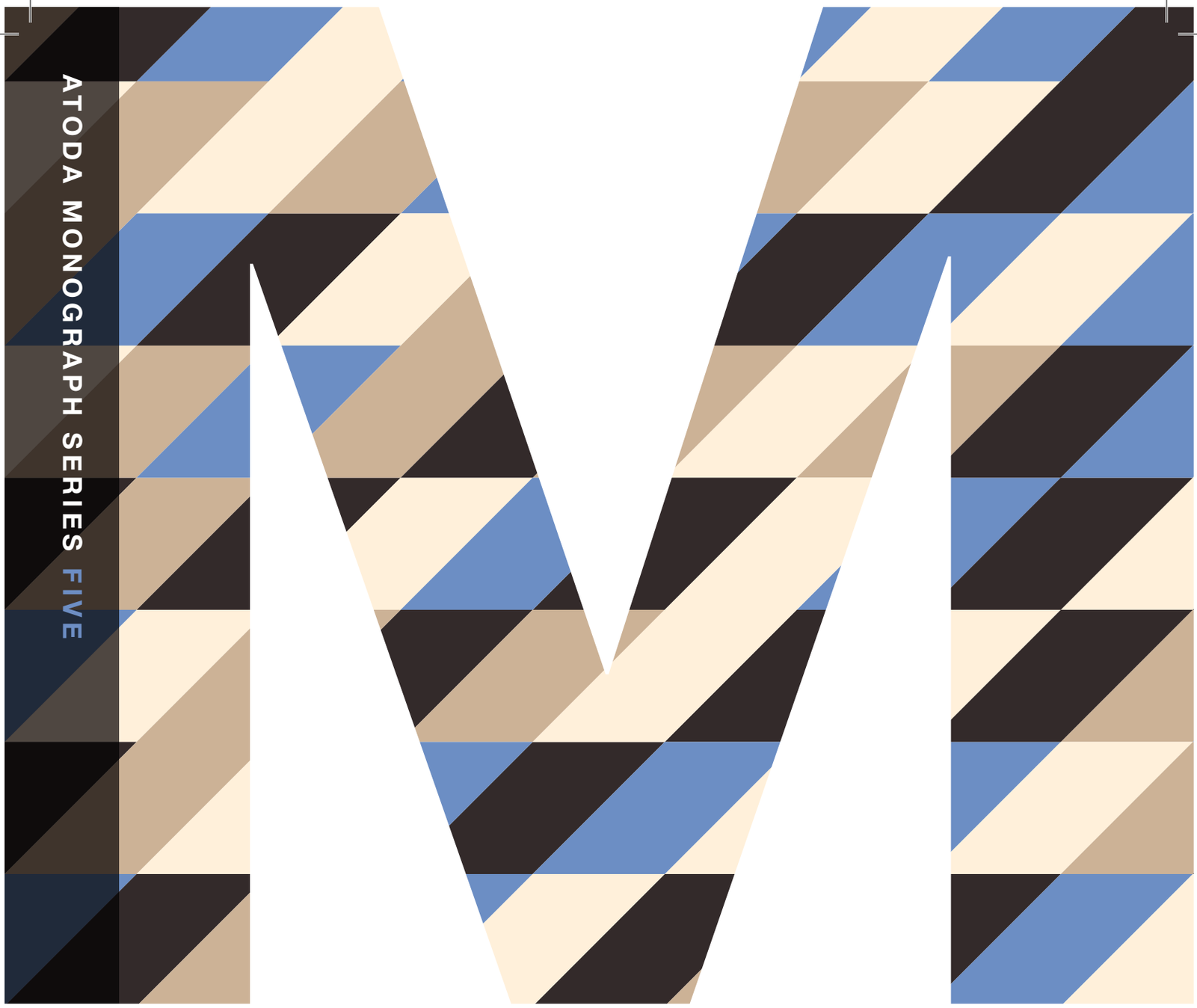

The specialist alcohol, tobacco and other drug sector: a description and examination of treatment and support approaches

ATODA
Alcohol Tobacco & Other Drug Association ACT

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ATODA

This monograph forms part of the Alcohol Tobacco and Other Drug Association ACT (ATODA) Monograph Series.

ATODA is the peak body for the alcohol, tobacco and other drug sector in the Australian Capital Territory (ACT). This includes both government and non-government services.

ATODA's vision is an ACT community and region with the lowest possible levels of alcohol, tobacco and other drug related harm, as a result of the alcohol, tobacco and other drug (and related) sectors' evidence-informed prevention, treatment and harm reduction policies and services.

ATODA works collaboratively to provide expertise and leadership in the areas of social policy, sector and workforce development, research, coordination, partnerships, communication, education, information and resources. ATODA is an evidence-informed organisation.

The ways ATODA works, and the outcomes it strives to achieve, reflect its commitment to the values of population health, human rights, social justice and reconciliation between Aboriginal and Torres Strait Islander people and other Australians.

ATODA strives to achieve better interaction and integration between alcohol, tobacco and other drug researchers, policy workers, practitioners, consumers and their friends and families in the ACT and region. ATODA hopes this will:

- Improve health and social outcomes for individual service users and their families
- Enhance research utilisation in policy development and its implementation and evaluation
- Mobilise and support knowledge transfer and exchange
- Support demonstration of research and service impact
- Improve the quality of the sector's practice and services
- Improve the health and wellbeing of our community.

ATODA has in-house—and a network of external—expertise in alcohol, tobacco and other drug research, policy, advocacy and capacity building, and a proven track record with engaging collaboratively and producing high-quality evidence-informed reports that provide practical expertise to inform policy and decision-making.

Monographs in the series are:

No 1. Reducing smoking in the ACT among Aboriginal and Torres Strait Islander women who are pregnant or who have young children.

No 2. ACT Alcohol, Tobacco and Other Drug Workforce Qualification and Remuneration Profile 2014.

No 3. Strengthening Specialist Alcohol and Other Drug Treatment and Support: Needs and Priorities for the ACT 2016–2017. An independent expert paper for the ACT Primary Health Network's Baseline Needs Assessment.

No 4. Service User Satisfaction and Outcomes Survey 2015: A census of people accessing specialist alcohol and other drug services in the ACT.

We hope this monograph contributes to the sector, and is a useful resource towards our shared goal of a healthy, strong and supported community.

Carrie Fowlie
Chief Executive Officer

About 360Edge

360Edge is a specialist alcohol and other drug consultancy focused on health service development through research and evaluation, training and workforce development, and translation of research to practice. 360Edge comprises a team of ‘pracademics’ with a combination of skills that enables a balance of academic research knowledge, an understanding of the realities of frontline practice, and an ability to make complex concepts accessible to a range of audiences. 360Edge provides a full suite of advisory services to help health service organisations accelerate change.

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Acknowledgements

We acknowledge the Traditional Owners and continuing custodians of the lands of the ACT and region and we pay our respects to the Elders, their families and ancestors.

Many people contributed to this report including the staff from 360Edge including Linda Jenner, Angela Harney, Nicole Lee and Paula Ross. Their experience in alcohol and other drug (AOD) clinical practice, research, training and management were invaluable to the report. ATODA staff involved in the monograph included Asmara Jammali-Blasi, Carrie Fowlie, Amanda Bode and Anke van der Sterren.

The production of this monograph was an iterative process, and expertise from the sector was contributed at each point. Activities included:

- Gaining support from the specialist ACT ATOD sector through the Drug Services Forum as a priority area to demonstrate the bredth, extent and evidence based for the interventions delivered in our field
- Engagement of specialist AOD expertise – 360Edge
- Development of a taxonomy for AOD interventions
- Production of a literature review
- Mapping of services – national, international and ACT
- Development of a working group with ACT Health to contribute National Minimum Data Set (NMDS) information and other data
- Engagement with other state and territory ATOD peaks
- Consultation on draft with specialist ACT ATOD services
- Review of the monograph through an ACT ATOD clinician's workshop
- Revisions to the final monograph
- Presentation on the final document scope and applicability at the Drug Services Forum

We would like to thank the ACT specialist alcohol and other drug treatment and support services who contributed throughout the process of developing this monograph. The members of the Drug Services Forum are:

- Alcohol and Drug Services (ADS), ACT Health
- Alcohol and Other Drug Policy Unit, ACT Health
- Alcohol Tobacco and Other Drug Association ACT (ATODA)
- Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)
- CatholicCare Canberra & Goulburn
- Directions Health Services
- Gugan Gulwan Youth Aboriginal Corporation
- Karralika Programs Inc
- Ted Noffs Foundation ACT
- The Salvation Army
- Toora Women Inc
- Winnunga Nimmityjah Aboriginal Health Service

Contents

List of acronyms

AA	Alcoholics Anonymous
ACT	Australian Capital Territory
ADCA	Alcohol and other Drugs Council of Australia
AIHW	Australian Institute of Health and Welfare
AODTS-NMDS	Alcohol and Other Drug Treatment Services—National Minimum Data Set
AOD	Alcohol and other drugs
ASSIST	The Alcohol, Smoking and Substance Involvement Screening Test
ATOD	Alcohol, tobacco and other drugs
ATODA	Alcohol Tobacco and Other Drug Association ACT
BBV	Blood borne virus
BI	Brief intervention(s)
CAHMA	Canberra Alliance for Harm Minimisation and Advocacy
CBT	Cognitive behaviour therapy
CL	Consultation liaison
CM	Contingency Management
DSM	Diagnostic and Statistical Manual of Mental Disorders
eASSIST	electronic Alcohol, Smoking and Substance Involvement Screening Test
GABA	Gamma-aminobutyric acid
GP	General Practitioner
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
ICD	International Classification of Diseases
MET	Motivational Enhancement Therapy
MI	Motivational interviewing
NA	Narcotics Anonymous
NMDS	National Minimum Data Set
NRT	Nicotine Replacement Therapy
NSP	Needle and syringe program
NSW	New South Wales
PHC	Primary health care
SDS	Severity of Dependence Scale
STI	Sexually transmitted infection
TC	Therapeutic Community

Background

About this monograph

The specialist Australian alcohol, tobacco and other drug (ATOD) sector is comprised of a diverse range of non-government and government services that work to prevent and reduce harms associated with ATOD use in the community. The ATOD sector is an evidence-informed, quality and data driven sector that is transparent and accountable to its service users, the broader public and its funding bodies.

In the Australian Capital Territory (ACT), 10 services are funded by ACT Health to deliver various types of specialist drug treatment and support services. This monograph is one component of a package of work undertaken with the specialist ACT ATOD sector to better support policy, service, treatment, resource planning and to demonstrate collective impact.

This monograph provides an overview of the treatment and support approaches offered by the specialist ATOD sector across Australia. It has applicability to service delivery agencies and policy makers in the ACT by:

- Defining the specialist and unique role of the ATOD sector within the community in an effort to better understand 'who we are, what we do, what we achieve, and how we achieve it'.
- Detailing the diverse capabilities of services and programs in the ACT ATOD sector
- Documenting best practice in ATOD interventions and how these map to the services and programs available in the ACT

This document aligns with the ACT Alcohol, Tobacco and Other Drugs Services Online Directory[1] and contributes to the goals of increasing cross and intra-sectoral knowledge and fostering collaborations.

The overview includes:

- A description of the intervention—describes the scope and evidence for the intervention
- Who is it for?—describes the service consumers who are likely to receive the most benefit from these approaches
- What are the outcomes?—describes the individual and community outcomes
- How is it applied?—describes the settings, duration and models of delivery for the intervention
- Who can deliver it?—describes the skills and expertise of the workforce required to deliver the intervention

The approaches have general application for all service consumers; however adaptations may be required to meet the specific needs of certain groups of consumers such as young people,

women, and those from Aboriginal and or Torres Strait Islander backgrounds. The monograph describes the unique work that is undertaken by the ATOD sector as distinct from that conducted by other service sectors such as mental health and welfare agencies that are also likely to provide care to consumers with problems related to the use of alcohol, tobacco and other drugs. Much of the information within this monograph is relevant across Australia; however, where possible, information on ACT specific considerations has been reported.

The monograph does not describe other important components in Australia's broader approach to ATOD issues as they were beyond the scope of this publication. This includes: criminal justice initiatives and diversion programs; policing and customs responses[a]; health promotion and prevention strategies; and ATOD-related work, such as welfare, housing and generalist health services. In addition, school-based peer education interventions have not been included. These school-based programs generally have more of a prevention focus rather than harm reduction, aiming to prevent uptake of tobacco, alcohol and other drug use among young people.

The section on tobacco use relates specifically to interventions delivered by the ATOD sector, as those who use tobacco exclusively are unlikely to require the types of specialist ATOD treatment described in this monograph.

ATODA expects that this monograph will be a 'living document' and that a number of iterations may be released. Feedback is welcome, and can be provided to info@atoda.org.au.

[a] Interventions delivered as part of diversion programs and prison services have been outlined in this document. Further information on police and diversion services can be found at www.health.act.gov.au/our-services/alcohol-and-other-drugs/diversion-services.

Australia's policy approach to alcohol, tobacco and other drug use

The National Drug Strategy 2010–2015 is Australia's framework for action on alcohol, tobacco and other drugs and describes a vision and direction for government and non-government organisations to develop strategies and allocate resources. This policy framework is based on the central principle of harm minimisation, which aims to build safe and healthy communities by minimising ATOD-related health, social and economic consequences for individuals, families and communities. The harm minimisation approach of Australian policy is comprised of the three pillars of:[2]

1. Harm reduction; aimed at reducing the harmful consequences of ATOD use
2. Reduction of demand; primarily driven by the health sector and specialist ATOD services
3. Reduction of supply; primarily driven by policing and customs activities

Harm minimisation is an evidenced-based policy approach that is focused on addressing the harms that may result from ATOD use. It recognises that individuals will make their own choices about whether or not to use ATOD, and as such the elimination of such use at a population level is seen as an unrealistic goal.[3] Harm minimisation covers a spectrum of approaches from the promotion of abstinence at one end, through to harm prevention and harm reduction strategies, secondary prevention and specialist treatment at the other. Principles of harm minimisation require the adoption of a value-neutral position with regard to ATOD use.

A wide range of medical, therapeutic and other interventions are provided under a harm reduction framework (see page 11 for details). Programs and strategies to reduce harms from ATOD use encompass broad community level approaches as well as interventions specifically targeting the harms experienced by individuals and their significant others. Evidence based harm reduction approaches are relevant to specialist ATOD treatment and support services.

Policies that guide ATOD practice nationally include the following:[b]

- National Drug Strategy 2010–2015[c]
- National Ice Action Strategy 2015
- National Aboriginal and Torres Strait Islander Peoples Drug Strategy 2014–2019
- National Alcohol and Other Drug Workforce Development Strategy 2015–2018
- National Tobacco Strategy 2012–2018
- National Pharmaceutical Drug Misuse Framework for Action 2012–2015

The ACT Alcohol, Tobacco and Other Drug Strategy 2010–2014 guides ATOD practice in the ACT.

b Some document dates may have lapsed; however, the policy context still applies.
c The National Drug Strategy 2016–2025 has been drafted at the time of writing this paper.

Context of specialist ATOD service delivery

The health system in Australia comprises broad groups of services including primary health care and hospitals as well as specialised services, medication providers, and preventive health services in the community. Public, private and non-government agencies, and individuals deliver services from a variety of settings. Primary health care that is provided by general medical practitioners, dentists, nurses and allied health professionals, is a common pathway for individuals to access essential services offered through the wider health care system.

Specialised health services delivered by specialist medical practitioners and other health professionals through hospitals or specialist community-based health-care organisations are an important component of the health system as a whole.[4] Treatment services for ATOD use form part of the range of specialist services that target areas of health and welfare requiring specific expertise. Other such services include community mental health, home and community care, aged care, disability and specialist palliative care.[4] The ATOD treatment sector sits within the wider health and community/human services sector and intersects with the education, law enforcement and criminal justice sectors. ATOD workers deliver services from specialist ATOD agencies or via discrete ATOD programs within agencies whose core business is not ATOD-specific.[5]

The ATOD workforce

The ATOD workforce is drawn from diverse occupational fields and contains multidisciplinary professionals including nurses, psychologists, social workers, counsellors, specialist doctors, pharmacists, psychiatrists, allied health workers, education officers and peer workers. Nationally, the predominant occupations in the sector are ATOD workers (40% of the non-government organisation sector workforce) and nurses (31% of specialist workers in government services).[5] In the ACT, the predominant occupations are ATOD workers (clinical) at 40.7 per cent, nurses at 13.6 per cent and ATOD workers (non-clinical) at 10.7 per cent.[6] Victoria and the ACT have a minimum qualification strategy for ATOD workers; they must hold either an ATOD-specific qualification such as a Certificate IV in Alcohol and Other Drugs or a tertiary qualification in health, social or behavioural science that includes a set minimum level of ATOD specific training.[7]

Overview of specialist ATOD services and complementary service sectors

The ATOD sector, like the harm minimisation policy that guides its practices, is pragmatic and recognises that the views, experiences and goals of service consumers are diverse. For this reason, the sector assists people to address their ATOD use and the consequences of such use through a wide range of treatment and support approaches including: harm reduction; information and education; withdrawal management; counselling; rehabilitation programs; and pharmacotherapy. Non-government, government, and private organisations in residential and non-residential settings provide such interventions.

In 2012–13, approximately 108,000 service consumers received almost 162,400 treatment episodes from 714 publically funded ATOD treatment agencies across Australia.[8] Among clients receiving treatment for their own drug use, counselling was the most common main treatment type provided (41%), followed by assessment only (18%), withdrawal management (16%) and support and case management only (9%).[8] In a specific census day in 2013, over 47,000 clients across Australia received pharmacotherapy treatment for opioid dependence, primarily receiving their dose at community pharmacies (88%).[9]

Problems related to the use of ATOD are often complex, multi-faceted and frequently co-occur with other physical and mental health problems such as hepatitis C (HCV) as well as mood and anxiety disorders. Service consumers may also face social and economic disadvantage and require support and assistance to address issues such as homelessness, financial hardship, relationship problems and child welfare concerns. Therefore, the ATOD sector works collaboratively with a range of relevant specialist sectors to improve service co-ordination in order to improve care for service consumers. Figure 1 provides an overview of the components of ATOD treatment and the complementary sectors often involved in collaborative care planning.

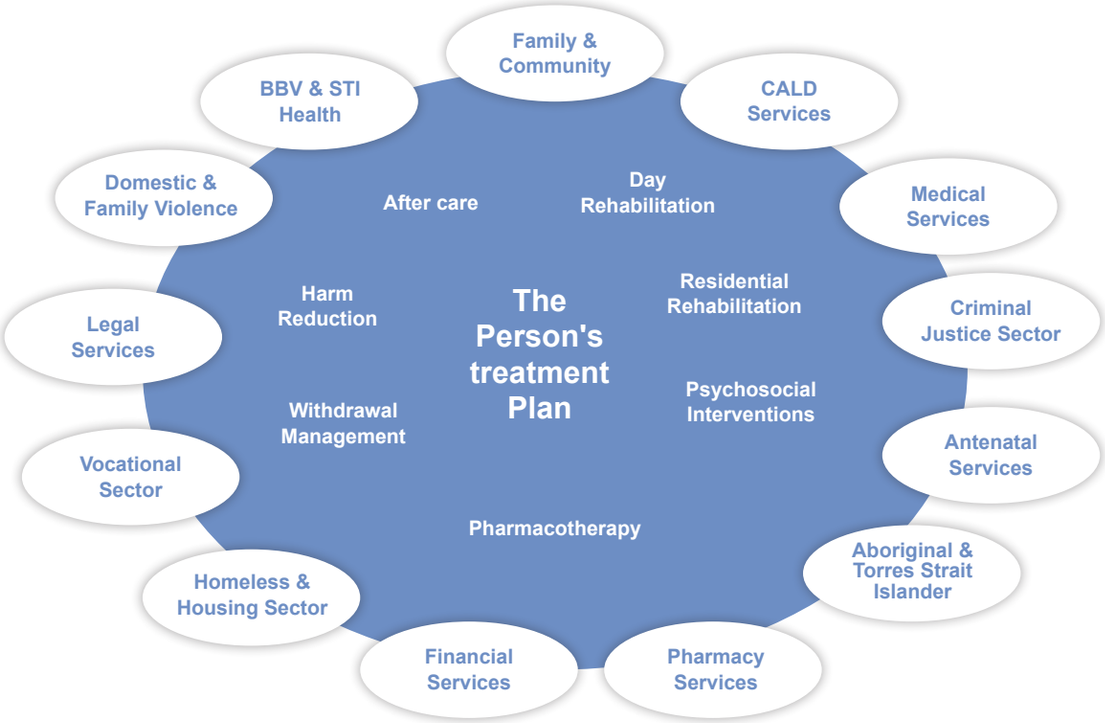

Figure 1. Components of specialist ATOD service delivery and interface with complementary sectors

Source: Adapted from *Principles of Drug Addiction Treatment: a research-based guide, NIDA*[10]

Among people who use ATOD, patterns of use vary widely across the population; from one-off use, occasional and episodic use, through to regular and high level use of one or more substances simultaneously. A range of health and social problems may be experienced from ATOD use, at both individual and population levels. ATOD use contributes to a large range of preventable health problems and social issues such as alcohol-related road trauma, tobacco-related morbidity, overdose, sexually transmitted diseases and blood borne virus transmission through sharing of injecting equipment.

While higher frequencies of ATOD use are generally associated with increased risk of experiencing harms, some problems can occur from one-off ATOD use and some behaviours and patterns of ATOD use hold greater risk of harm, such as drinking alcohol infrequently but at high levels (e.g. alcohol poisoning) or injecting drugs while alone (e.g. overdose).

Australia's broad response to ATOD use includes:

- Primary prevention activities designed to limit uptake of ATOD use by new users
- Secondary prevention activities designed to identify, and offer early intervention to, people who may be at risk of developing ATOD-related problems
- Tertiary treatment designed to offer specialist treatment to people with moderate to severe ATOD-related problems, which is the main focus of this monograph (see Figure 2).

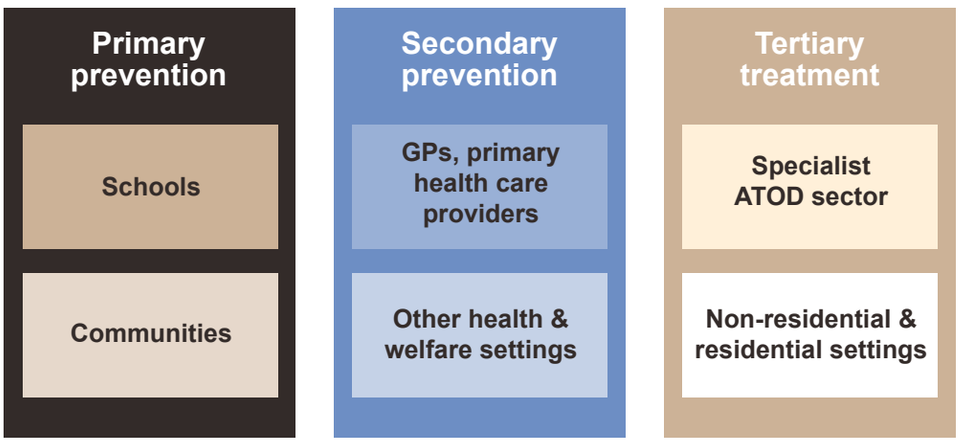

Figure 2. Overview of high-level responses to address ATOD use

Activities that focus on the prevention of ATOD use are generally delivered in schools and within the wider community. A recent systematic review conducted by researchers at the National Centre for Education and Training on Addiction (NCETA) found that effective school-based alcohol education programs were: research-based; focussed on harm minimisation; were interactive; had clear goals and objectives; were delivered by teachers with sound training; and were integrated into a whole-of-school approach to enhancing the resilience and social

connectedness of the students.[11] This is an important finding as some programs have been found to increase the uptake of ATOD use by students, and should therefore be avoided.
Secondary prevention activities such as screening for ATOD use and brief interventions (BI) for mild to moderate problems (see page 28 for a description of BI) are often delivered by general practitioners (GPs) and other health workers in primary health care settings, and by workers in a range of other health and community service delivery settings. Opportunities for self-assessment and self-management are also increasingly offered to consumers online.[d] Brief interventions may also be conducted by staff of the ATOD sector as an adjunct to specialist work, or in settings where contact with service consumers is short-lived.

Tertiary treatment for moderate to severe ATOD-related problems are generally delivered through the specialist treatment sector, with residential treatment services utilised by consumers with more severe and complex care needs. Specialist ATOD treatment is most suitable for individuals whose ATOD use has led them to experience significant impairment or distress.

There are a number of approaches to assessing the extent of an individual's ATOD use, and ATOD services use a structured and comprehensive ATOD assessment that also explores other relevant domains including mental and physical health, and the range of social issues that can be impacted by a consumer's use of ATOD (see page 30 for details on assessment). The severity of an individual's ATOD-related problems, coupled with their goals and readiness to address ATOD use, provides an indication of the level and type of specialist ATOD treatment and support required.

Diagnoses of ATOD disorders are based on a set of criteria, and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) provides the criteria necessary for a diagnosis of ATOD dependence. The DSM-5 acknowledges that substance use disorders can span a wide variety of problems and eleven criteria are used for diagnosing an overarching 'substance use disorder'.[12] These criteria include the development of physical tolerance[e], dependence and withdrawal symptoms, as well as problems such as control over use, the negative impact of use on relationships and social functioning, and experience of craving.

The DSM-5 measures a disorder related to ATOD on a continuum from mild to severe, contingent on the number of problems an individual has experienced. This is a change from previous manuals that made a distinction between the disorders of 'abuse' and 'dependence', and recognises that the symptoms of substance abuse, even without a physical dependence syndrome, can be significant and severe.

An alternative classification system is the International Classification of Diseases (ICD) diagnostic

d For example, see Turning Point Alcohol and Drug Centre's self-assessment page: www.turningpoint.org.au/Treatment Online-Self-Assessment.aspx

e The term tolerance refers to a person's need to use greater quantities of a particular substance to feel the same effect as when first used.

tool. The current version of this tool, the ICD-10, is used to classify all health conditions and is widely used within the broader health system. With regards to substance use disorders, the ICD-10 codes according to nine substance groups with code extensions representing substance use disorder specifiers including abuse, dependence and use (unspecified).[13]

Models of, and pathways through, specialist ATOD care

Like all health care delivered in Australia, the specialist ATOD sector ensures support and interventions are matched to the needs of the service consumer. In treatment settings, the progress of individual consumers is monitored regularly and treatment is adjusted accordingly. A model that is in common use is 'stepped care' in which the least intensive intervention that is likely to work is tried first, and then the intervention is stepped-up in intensity only if the service consumer does not respond.[14]

There are multiple entry points for consumers into the specialist ATOD sector, including self-referral, referral from complementary sectors, and referral from families and significant others. A typical pathway through ATOD care often begins with screening and assessment, followed by supervised withdrawal for those considered to be in need, while others may receive psychological therapies or pharmacotherapy or a combination of the two. Screening has potentially positive outcomes for service users, staff and organisations as it assists in identifying the potential severity of ATOD issues, provides an opportunity to provide clear and targeted feedback as well as providing an opportunity for identification of other conditions and issues. A number of validated screening tools for ATOD-related problems are available, including:

- ASSIST: The Alcohol, Smoking and Substance involvement Screening Test (see page 34)
- AUDIT: The Alcohol Use Disorders Identification Test
- Fagerstrom Test for Nicotine Dependence
- SDS: The Severity of Dependence Scale

Other consumers may enter residential rehabilitation services following assessment, particularly if they have complex care needs or have had multiple and repeated unsuccessful attempts to reduce or cease ATOD use in the community setting. Due to the relapsing nature of ATOD-related problems, aftercare is also a vital aspect of ATOD specialist treatment.

Ethics and principles that guide the specialist ATOD sector in Australia

Recognising a need to develop a national code of ethics for the alcohol and other drug (AOD) sector, the Alcohol and other Drugs Council of Australia (ADCA) published a document in 2007 entitled 'Making Values and Ethics Explicit: a new code of ethics for the Australian Alcohol and Other Drug Field'.[15] While not intended as an exhaustive list, the values suggested by ADCA as important guides for the sector included: ready access to services; enhancement of autonomy; compassion; competence; equity of treatment; respect; honesty; self-interest (self-protection) and transparency.

The values were intended to provide the foundation for an agreed set of principles including:

1. Equity and access is important to service provision: a non-discriminatory approach, taking into account a consumer's cultural, physical, religious, economic and social needs.
2. Services should be responsive to the needs of the individual: respect for the consumer's values, expectations and belief systems, is paramount as is recognition of his or her problems or disabilities.
3. Services should be responsive to community needs: consideration must be given to the broader community in regard to service provision.
4. Services should be effective: service outcomes should be measured and evaluated.
5. A commitment to actioned community consultation and consumer involvement: consumer autonomy is encouraged, and they must be informed of their rights and responsibilities.
6. AOD research should proceed on the basis of ethics committee approval.
7. Services should be cost-efficient.
8. Privacy and confidentiality should be maintained.
9. Training and professional development should reinforce ethical standards.
10. Stress and workload issues contribute to poor ethical standards.
11. The client/worker relationship is of critical importance.
12. Advocacy in relation to public policy and public health outcomes is important.
13. Ethics engagement: ATOD workers should be able to engage with the moral and ethical basis of drug use, and has an obligation to consider the ethical, social, and political dimensions of proposed programs and interventions and in doing so seek the value perspectives and participation of all groups whose interests are affected.

Principles of practice in AOD treatment vary depending on the setting and service system in which they are delivered,[22,16,17] and in 2013 the Victorian Department of Health released a set of treatment principles for the AOD sector in Victoria.[f] These were:[18]

1 Substance dependence is a complex but treatable condition that affects brain function and influences behaviour.
2 Treatment is accessible.
3 Treatment is person-centred.
4 Treatment involves people who are significant to the consumer.
5 Policy and practice is evidence informed.
6 Treatment involves integrated and holistic care responses.
7 The treatment system provides for continuity of care.
8 Treatment includes a variety of biological, psychological, and sociological (biopsychosocial) approaches, interventions, and modalities oriented towards people's recovery.
9 The lived experience of alcohol and drug consumers and their families is embedded at all levels of the alcohol and drug treatment system.
10 The treatment system is responsive to diversity.
11 Treatment is delivered by a suitably qualified and experienced workforce.

The Australian Therapeutic Communities Association also developed a set of standards for Therapeutic Communities (TC) across Australia. The standards cover the following domains:[19]

1 Knowedge of the TC model and application
2 The TC sector
3 Reviewing the TC
4 Staff at the TC (includes code of practice)
5 Working with resident members of the TC
6 Data management at the TC
7 Safety at the TC (includes occupational health and safety issues)
8 Planning at the TC (includes governance).

f At the time of writing, there were no principles of ATOD practice that were applied at a national level across the entire sector..

Evidence-Based Interventions

Patterns of ATOD use range from experimental and occasional use to regular and heavy use, and problems can occur at all points along the spectrum. ATOD-related problems can arise from the direct effects of the substance, the circumstances in which the substance is taken, from the characteristics of the individual taking the substance and from any combination of these factors. Responses to ATOD-related problems must therefore be broad ranging and match the goals of the individual, the feasibility of the treatment setting and what is known to be effective. Services that offer a range of options are required to effectively respond to the needs of individuals, their family and friends as well as the health of the general public more broadly.[20]

This section provides an overview of the range of ATOD-specific education, treatment and support options available to consumers through the specialist ATOD sector. It covers: harm reduction approaches; withdrawal management; psychosocial interventions; pharmacotherapy; residential rehabilitation; day rehabilitation programs; aftercare; and other aspects of ATOD specialist care such as case management. ACT specific examples have been presented against each intervention where appropriate.

1. Harm reduction approaches

Harm reduction programs and strategies encompass broad community level approaches as well as interventions specifically targeting the harms experienced by individuals. Examples of harm reduction strategies in Australia are diverse and include: regulations to reduce harms from passive smoking (e.g. smoke-free environments); random roadside alcohol testing to reduce risks from impaired driving;[g] information campaigns for people at 'dance' parties and nightclubs; and supervised injecting centres to reduce risks of overdose and the spread of blood-borne viruses among people who inject drugs.[21,22]

The specialist ATOD sector provides a range of specific harm reduction interventions and programs, and the examples of needle syringe programs, peer education, peer support, opioid overdose education and sobering-up shelters are summarised below.

A key component of many harm reduction interventions is the use of outreach strategies and programs, which involve peers, ATOD workers or other health and welfare workers making contact with ATOD users in their own communities and non-service settings. Outreach has been found to be effective for accessing hard-to-reach populations, reducing needle sharing and reducing risky behaviours and is commonly used to deliver information about drugs and risky sexual behaviour, provide strategies and equipment to reduce risk and provide support and referral to relevant services.[22]

g As this paper focuses on treatment and support, these approaches are not referred to elsewhere.

1.1 Needle and syringe programs

What is the intervention?

Needle and syringe programs (NSPs) primarily provide sterile injecting equipment to people who inject drugs. The programs are a public health initiative aimed at reducing the spread of blood borne viruses (BBV) and reducing the physical harms associated with injecting. Sharing syringes and injecting equipment is the primary mode of transmitting BBV, therefore providing access to sterile needles and syringes is an essential component of effective BBV prevention strategies.[23]

NSPs also commonly provide information and education on safer injecting practices, information on safe-sex practices and condoms, and general health information. They also facilitate safer syringe disposal. Many services provide primary health care, link individuals with community and social services and refer people to specialist ATOD treatment.[24,25]

NSPs operate from a diverse range of settings and modes including dedicated services for people who inject drugs, health and community services, pharmacies, mobile outreach programs and automated syringe vending machines.

Who is it for?

NSPs are suitable for anyone who is using any type of drug by injection. There is no minimum age for people attending NSPs; however NSP workers will encourage young people that do attend the service to engage with other health services and ATOD treatment.

What are the outcomes?

International evidence has demonstrated that NSPs effectively reduce injecting risk behaviours such as needle sharing[23] and, as their primary objective, reduce BBV transmission among people who inject drugs.[26,27]

There is a range of other benefits from NSPs, although these are not as well documented or consistently supported in the research. Potential outcomes of NSPs for service consumers include: increased entry to primary health care and specialist drug treatment services; prevention of BBV; reduced injecting-related physical harms such as abscesses; reduced incidence of injecting; increased harm reduction education; psychosocial benefits such as support and encouragement to seek help; and the prevention of AOD-related mental health episodes.[23,25]

How is it applied?

A range of NSP service models operate in Australia, providing varied levels of supplementary services.

- Primary NSPs—dedicated programs that provide sterile injecting equipment and also

provide a range of other services for people who inject drugs, such as health care and testing and support for blood borne viruses

- Peer-based NSPs—operated by people who inject drugs currently or have done so in the past, and provide similar services to primary NSPs
- Secondary NSPs—operate within existing health or community services, including hospitals, and may provide either basic sterile injecting equipment services and equipment disposal, or enhanced services including education and other supports
- Pharmacy NSPs—community pharmacies distribute injecting equipment at a small cost
- Mobile outreach services—the use of vehicles or foot patrols to distribute injecting equipment
- Automated syringe vending machines.[24,25]

NSPs may operate by distributing as many syringes as requested, a maximum number at one time, or as direct exchange for used needles being returned such as one-for-one or two-for-one.[28]

Prison NSPs are cost-effective, safe, and endorsed by international and domestic bodies. They have been introduced in 12 countries, where they have been the subject of extensive evaluation. The results demonstrate that prison NSPs can:

- Reduce rates of needle stick injuries among corrections staff and reduce the likelihood of contracting a blood-borne virus among those who do sustain a needle-stick injury
- Reduce the rate of blood-borne viral transmission among prisoners who inject drugs in prison
- Improve the uptake of appropriate treatment among people who inject drugs in prisons.[29,30,31,32,33]

These services are commonly advocated for due to the high prevalence of HCV and HIV transmission in prison settings.[24] There are currently no prison-based NSPs operational in Australia, although the ACT has been the first state or territory to incorporate a prison-based NSP into Government policy.

Research indicates that the type of NSP or program setting, such as hospital or community service, does not impact how effective the program is in terms of reducing injection risk behaviours and longer term reductions in injecting drug use.[24,25] There is limited evidence available about the impact of the range of harm reduction services NSPs commonly provide; however, different settings and combinations of services have been shown to be beneficial and may assist particular groups of users:

- Services which have fewer or no limits on the number of syringes provided resulted in less needle re-use among people who inject drugs
- Mobile services and vending machines may attract younger drug users with higher risk profiles
- Combining fixed site NSPs with opioid substitution treatment programs has been

associated with reduced HIV and HCV prevalence

- Combining a mobile NSP with provision of outreach community health services reduced use of emergency department services
- Strength-based case management can effectively support drug treatment entry among people who inject drugs

Who can deliver it?

The diversity of NSP service models means a range of people and organisations are required—and suitable—to maintain an effective system and deliver the service. Staff may be employed as NSP workers as their primary role or provide services at secondary NSPs as part of their main duties such as reception, nursing or counselling. Hence, NSP staff may have a social work, counselling or welfare background, be a member of healthcare staff, be trained peer-workers, or work primarily in service administrative roles with suitable training and supervision in NSP work.

There are currently no national standards of training and education for NSP worker positions. However, a range of guidelines indicates best practice for delivery of these services. International literature indicates having trust in healthcare professionals and rapport with staff at NSPs has been associated with reduced sharing of injecting equipment and other health benefits.[24] Accordingly, best practice guidelines generally recommend NSPs should be delivered by well-trained staff that are credible and can facilitate safe, confidential and non-judgemental services.[24,34] In the ACT, legislation requires that health workers are approved by ACT Health to distribute needles and syringes, dependent on completing a training course provided by Directions Health Services and Canberra Alliance for Harm Minimisation and Advocacy (CAHMA).[35]

The Needle and Syringe Program National Strategic Framework 2010–2014 recommends that all NSP staff across the different services models should have an appropriate level of knowledge about the effects of injecting drug use on health and wellbeing and have the skills to provide NSP services confidently and effectively. Core training and education should be consistent across primary, secondary, and pharmacy NSPs, so all staff feel skilled and supported to effectively engage with people who inject drugs. This assumes that NSP workers develop an understanding of drug use, hold a non-judgmental attitude towards drug use and NSP service consumers, and possess sound knowledge of the broader health and welfare service system.[36]

NSPs in the ACT

Needle and syringe programs are currently provided in the ACT by Directions Health Services via the following outlets:

- Primary outlets: Two primary NSPs are provided for men and women of all ages, Monday to Friday.
- Secondary outlets: Eight secondary NSPs are provided and operate Monday to Friday.
- Pharmacy-based outlets: 24 pharmacy outlets are located in the ACT each of varying opening hours
- Syringe vending machines: Six vending machines are located around the ACT and are available for access 24 hours a day, seven days a week

1.2 Peer education

Peer education is a broad term and in relation to the ATOD sector involves trained individuals providing drug-related harm reduction and health promotion information to people with whom they have shared characteristics and experiences. Peer educators are past or current ATOD users who provide targeted information relevant to the needs of a specific group, such as young people at nightclubs, festivals or parties or people who inject drugs. The aim is to actively share harm reduction information, as well as promote a culture within the drug-using community that promotes healthier behaviours.

What is the intervention?

Injecting drug use is a particular focus of Australian drug and alcohol peer education interventions; however a range of peer education harm reduction messages are used and include:

- Safer injecting practices for people who inject drugs to reduce risk behaviours for BBV
- Improving responses to overdose (including alcohol)
- Hydration, nutrition and sleep hygiene
- Understanding drug effects
- Not driving while drug affected targeted towards people who use psychostimulants
- Effects and harms of methamphetamine use for young people
- Safer drinking and how young people can help their peers affected by alcohol
- Accessing treatment and support services.

Peer education can include sharing information by informal discussion, disseminating harm reduction leaflets and materials, one-off brief interactions or events with people who use drugs, and specialised information sessions and workshops. It may also involve dissemination of harm reduction-related resources such as condoms or sterile injecting equipment.[21,37]

Who is it for?

Peer education is suitable for people who are new to drug use, who use drugs only occasionally, and who use regularly and heavily. It is also suitable for people using specific drugs or using in particular settings. Peer education is suitable for all people who could benefit from information and support provided by non-judgemental sources with lived experience of the issues they may be facing. Drug user groups and ATOD services commonly provide peer education for: young people; people who inject drugs; people who use psychostimulants; and Aboriginal and Torres Strait Islander people who use drugs.

What are the outcomes?

ATOD peer education is considered to be a cost effective and credible way to share important health promotion and harm reduction information with people who use drugs. Peer-delivered health and drug education messages aimed at ecstasy users at music festivals, dance events and nightclubs have been shown to contribute to greater awareness of harm reduction information and reductions in use of amphetamine type stimulants at follow-up.[38]

HIV related peer education has been demonstrated to effectively increase HIV knowledge and reduce equipment sharing among people who inject drugs.[39]

Peer education, especially provided as an outreach service, can provide important harm reduction messages for hard to reach ATOD users and young people who may have limited contact with mainstream health and specialist ATOD services.[38,39]

Peer educators also commonly achieve positive personal outcomes from their role in the intervention, such as receiving training, gaining knowledge and enhancing self-esteem.[37] Actively informing and training drug users as peer educators and encouraging them to adopt a new pro-social role among their peers can reduce their own drug injecting risk behaviours.[40]

How is it applied?

Peer education interventions are highly targeted to their audience in terms of content, setting and duration. Peer education models can include:[38,39]

- Outreach models which visit relevant areas, services and events to disseminate harm reduction printed materials and speak with users and commonly also offer free resources such as sterile injecting equipment and condoms
- Small group information sessions, held in relevant services; ATOD-specific services, primary health care peer-based services, NSPs, ATOD treatment, health and other community services
- Larger specialised workshops or courses
- Peer education components combined with education from health professionals or ATOD workers or services such as free BBV testing

- Trained volunteers as peer educators and/or paid educators and formal peer education and health promotion staff positions
- Informal peer education where trained ATOD users share their knowledge one-on-one and among their networks during the course of normal activities.

Who can deliver it?

Peer education is delivered by individuals and groups with shared characteristics and drug-related experience relevant for the target group. Factors such as age, gender, past or present drug use, including drug type and route of administration, may all determine suitability for the role.[37]

Peer education programs provide training for volunteer or paid peer educators concerning the content of the information and how to communicate ATOD-related harm reduction messages to peers.

Peer Education in the ACT

Peer education and support in the ACT is provided by:

- The Connection, Canberra Alliance for Harm Minimisation and Advocacy (CAHMA): Available for Aboriginal and Torres Strait Islander men and women aged over 16 years.
- Canberra Alliance for Harm Minimisation and Advocacy (CAHMA): A peer based user group run by and for past or current/illicit injecting drugs users, their families and friends

1.3 Opioid overdose education and management including the provision of naloxone

Overdose is a significant and preventable cause of morbidity and mortality for people who use drugs, particularly opioids. A range of harm reduction strategies and interventions are used to reduce opioid overdose deaths and related harms.

What is the intervention?

- Opioid overdose education can include providing people with education and information about known overdose risk factors such as using alone, mixing drug types or using drugs after a period of abstinence. Tailored information is often provided through existing services such as needle and syringe programs[22]
- Education programs and campaigns also focus on assisting users to manage overdose by providing information or training on how to identify the signs of overdose, how to provide overdose first aid to peers, and increase knowledge and willingness of peers to contact ambulance and emergency services[21,22]
- Naloxone (previously known as Narcan®) is a Schedule 3 and Schedule 4 opioid antagonist used to reverse the effects of opioid overdose. In Australia and internationally it is widely used by paramedics, supervised injecting centres, first responders and emergency room staff in cases of suspected opioid overdose. Naloxone is not a drug of

dependence and has no psychoactive effect, and is therefore not likely to be diverted or misused. The purpose of expanding naloxone availability is to further reduce and prevent death, disability, and injury from opioid overdoses through provision of training and resources to opioid users and their friends and family members who could be potential overdose witnesses[41]

- Naloxone distribution programs for non-medical personnel are an increasingly used intervention overseas and in Australia. People at risk of overdose and potential overdose witnesses (friends, family) are provided with naloxone after completing a comprehensive overdose education program. Training is provided in how to administer naloxone by intramuscular injection should an overdose occur, and program participants receive naloxone take-home kits.[42,43]

Who is it for?

Education on opioid overdose risk prevention, responses and management should be provided for all people who use opioids and potential overdose witnesses (i.e. families and friends). The provision of comprehensive overdose prevention and management training and naloxone kits target people who are particularly at risk of opioid overdose and/or likely to be bystanders during an overdose. Risk factors for overdose include poly-drug use, homelessness and changes in tolerance related to being released from prison or following completion of a withdrawal program.[44]

What are the outcomes?

Overdose education and provision of naloxone has been shown to reduce the morbidity and mortality associated with opioid overdose. Education and information programs can improve knowledge of opioid overdose risk and response among people who inject drugs. Such programs have been demonstrated to increase the number of peers who can identify signs of overdose, and number of peers who call an ambulance to attend; both of which may result in fewer deaths.[21,45,46]

Peer administration of naloxone is a relatively recent mode of intervention in Australia, and the ACT was the first location to introduce the intervention in Australia. Current international evidence has demonstrated that non-medical staff, predominantly people who use opioids, with adequate training can and will use naloxone to reverse opioid overdose.[42]

Australia's first overdose management program that provides naloxone on prescription to potential overdose victims has been developed and is being implemented in the ACT. The ACT naloxone distribution program, Implementing Expanded Naloxone Availability in the ACT (IENAACT) identifies priority ACT populations for opioid overdose prevention intervention to be people exiting prison, people exiting opioid detoxification, people exiting opioid maintenance therapy, and Aboriginal and Torres Strait Islander peoples who use opioids.[43]

Positive outcomes have also been demonstrated in the ACT program.[47] This has potential to achieve fewer fatal opioid overdoses and reduce overdose related harms such as severe brain injury, which subsequently may reduce costs associated with hospitalisation and emergency responses.

How is it applied?

There is no standard level or duration of education and training for opioid overdose prevention and management. Information may be provided as posters, booklets and video resources, and these are made available by user groups or provided online, in NSPs, ATOD health, or community services.[h]

Information materials and resources may be incorporated into brief education and workshop sessions. This is commonly done using a peer education model, where other people who currently inject drugs or have done so in the past lead the sessions.

Naloxone distribution programs are applied as a comprehensive overdose response training session with naloxone prescribed to participants and provided in a take-home pack for use if required. The model can be applied in a variety of ways such as:[44,45,46]

- Providing injectable naloxone; some programs require naloxone to be administered intra-nasally, though this is less common and not in use in Australia[42]
- Training program duration which may range from 10 minutes to several hours in length
- Training contents including how to identify overdose, naloxone administration and other response strategies including calling an ambulance and procedures for refilling prescriptions
- Providing training and facilitate obtaining naloxone prescriptions, but do not provide the take-home kits
- GP prescribing which may vary depending on treatment setting and local prescribing laws, and participants may need to attend the GP, or program staff may arrange a prescription over the telephone.

Who can deliver it?

Basic education and information on overdose can be delivered by peers (people who use drugs currently or have done so in the past), GPs, NSP workers, ATOD workers, health promotion, and community health workers.

Naloxone is widely used by ambulance services, emergency departments and GPs in Australia. Training in overdose prevention and management for potential overdose witnesses with naloxone distribution is commonly provided by staff affiliated with harm reduction and user groups, such as non-medical health workers and ATOD experienced clinic nurses.

h For examples see: www.anex.org.au/wp-content/uploads/06-Overdose.pdf; hrvic.org.au/overdose/media-resources/

People can get a prescription filled for naloxone at a pharmacy under the Pharmaceutical Benefits Scheme, or they can purchase naloxone directly from a pharmacist without a prescription.

Naloxone in the ACT

The ACT naloxone distribution program, *Implementing Expanded Naloxone Availability in the ACT* (IENAACT) identifies priority ACT populations for opioid overdose prevention intervention.[43] This is administered through the following organisation:

- Canberra Alliance for Harm Minimisation and Advocacy (CAHMA): Provides peer education workshops, rapid induction training, as well as provision of naloxone kits (which include equipment to safely inject the drug).[47]

1.4 Sobering up shelters

What is the intervention?

Sobering-up shelters provide short-term, safe environments and supervision for intoxicated people who are at risk of causing harm to themselves or others. People found to be affected by alcohol and/or other drugs are provided accommodation and monitored throughout their stay. They are generally offered meal and shower facilities, medical intervention is arranged if required, and staff provide brief intervention and referral to other agencies when appropriate.

Who is it for?

Sobering-up shelters are suitable for anyone who is intoxicated and at risk of causing harm to themselves or others. Shelters are generally for adults aged 18 years and over. The shelters are voluntary, non-custodial and are commonly a direct alternative to police custody due to public intoxication.[21,48] A number of sobering-up shelters are focused on providing services to specific target groups including Aboriginal and Torres Strait Islander people or young people under 18.

What are the outcomes?

Sobering-up shelters reduce alcohol and drug related harm, offer a diversionary option from police custody and provide practical care and protection while the individual is at risk and vulnerable to harm or victimisation. Sobering-up shelters also provide opportunities for brief interventions by ATOD workers and referrals for further assistance.[48]

Sobering-up shelters may also have a role to play in helping to relieve pressure on police and other community resources and reduce anti-social behaviour in public places. Each admission to a sobering-up shelter can avert a potentially harmful event occurring during an alcohol or drug consumption episode, and the likely saving of costs due to a medical emergency or serious incident involving police.[49]

There is limited evidence relating to sobering-up shelters but evaluations of shelters in Aboriginal and Torres Strait Islander communities indicate the shelters have received community support and have been effective in meeting objectives such as decreasing arrests and police detentions, and reducing alcohol-related injuries.[49,50]

How is it applied?

The core model of sobering-up shelters appears consistent across services: provision of safe accommodation and practical care until the individual can care for themselves and is no longer at risk. A high proportion of clients are referred by police.

This model is also applied for specific populations, for example, young people aged 16–24 years old. Australia also has a significant number of Aboriginal and Torres Strait Islander-operated or targeted sobering-up shelters, which are often in regional or rural communities. These models may work in conjunction with other harm reduction strategies and programs such as mobile pick-up services or night patrols that provide transport to safe locations for intoxicated persons.[21,48]

Other variations in how the services model is applied nationally include:

- Some shelters have restricted referral pathways, such as accepting referrals from police and community Night Patrols only[i]
- Other services accept a wider range of referrals, including police and ambulance services, other social and community services, public or self-referral
- Some shelters operate seven days per week, either 24 hours per day[j] or operate every afternoon to early morning
- Some operate only at specific periods or on certain days such as weekends.

Who can deliver it?

Sobering-up shelters can be delivered by health and community services or within specialist ATOD services. However services should have staff that can:

- Adequately monitor medical symptoms to provide, or arrange for, medical intervention when and if required
- Provide brief interventions for ATOD use and facilitate referrals to relevant services.

Shelter staff members require training in working with people who use alcohol and other drugs and should possess competency working with people who are intoxicated.

i See for example: Darwin Sobering Up Shelter, Mission Australia, sd.missionaustralia.com.au/270-sobering-up-shelter (Accessed 19 December 2016).

j See for example: Towards Independence Sobering Up Unit, The Salvation Army, Adelaide www.salvationarmy.org.au/en/Find-Us/South-Australia/TowardsIndependence/Sobering-Up-Unit/ (Accessed 19 December 2016).

The staff presence of a registered nurse appears beneficial, and is an approach used by some shelters.[k]

Services operating in Aboriginal and Torres Strait Islander communities provide culturally appropriate services, and should be delivered by Aboriginal and Torres Strait Islander staff and/or staff with adequate cultural competency training.

Sobering-up shelter in the ACT

The ACT sobering-up shelter, operated by CatholicCare Canberra and Goulburn, provides overnight support, care and monitoring for people over the age of 18 who are intoxicated from alcohol and other drugs. The shelter operates on Thursday, Friday and Saturday nights in addition to special event days.

2. Withdrawal management

Regular and chronic exposure to ATOD results in changes to the way a person's brain responds to the presence of these substances, a process known as 'neuroadaptation',[l] which is a hallmark of substance dependence.[m] When a person who is dependent on a particular substance stops using abruptly, a withdrawal syndrome often results.[n] Withdrawal may be unplanned (e.g. symptoms emerge unexpectedly whilst in a custodial setting) or planned (e.g. following admission to a specialist withdrawal unit).

The onset and process of withdrawal is specific to the type of substance(s) used and is also related to the frequency of use and amount usually taken.[20] Withdrawal syndromes occur along a spectrum from mild to severe; so for some people, the symptoms of withdrawal are minor and short-lived and can be managed safely in the community or in a residential setting, while for others the symptoms are severe and protracted and require medical supervision in a hospital setting.

The purpose of withdrawal management is to "provide the appropriate level of support for withdrawal to be completed safely, which then allows the individual to determine his or her optimal ongoing management strategy" (p.4).[52]

k See for example: Watershed service in Wollongong New South Wales (www.watershed.org.au); and BRADAAG in Tennant Creek Northern Territory (www.bradaag.org.au).

l In an effort to maintain normal functioning in the presence of chronic exposure to alcohol and its depressant effects on the central nervous system for example, the brain adapts by inhibiting the natural 'relaxation system' (gamma-aminobutyric acid (GABA)) and stimulating the natural 'excitatory system' (glutamate). When alcohol use is stopped abruptly, these effects are thought to contribute to the agitation and anxiety that is typically experienced during alcohol withdrawal until normal functioning of the GABA system is restored. [51]

m In the fifth and most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the previous categories of 'substance abuse' and 'substance dependence' have been combined into a single 'substance use disorder'; categorised from mild to severe according to the number of symptoms present.

n A withdrawal syndrome is a cluster of symptoms and signs that result from abrupt reduction or cessation of regular and heavy use of psychoactive substances.

With this in mind, the goals for withdrawal management are not limited to initiating abstinence alone, but are also pragmatic and include harm reduction, health promotion and support including:[53]

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

The two main ways a person may undergo withdrawal from alcohol and other drugs are:

1 With supportive care and appropriate medication to manage symptoms and minimise the risk of complicated withdrawal ('medicated withdrawal');

2 With supportive care and monitoring alone ('non-medicated withdrawal').

Both medicated and non-medicated withdrawal can be undertaken in a range of settings and the needs and preferences of the service consumer, identified during a comprehensive ATOD assessment, indicates the most appropriate setting. Factors that inform decision-making include:

- ATOD consumption history
- Course of previous withdrawals
- Risk for complex withdrawal
- Service consumer goals for withdrawal
- Presence of co-existing physical or mental health problems
- Polysubstance use or potential for withdrawal from multiple drugs
- Living arrangements and other psychosocial barriers to, and enablers for, successful completion of withdrawal in the community.

The setting should be appropriate for service consumer's needs and provide the level of monitoring required to ensure withdrawal can be completed safely.[54] The most appropriate model and setting for withdrawal is informed by a comprehensive ATOD assessment of each consumer (see page 32). The settings for both medicated and non-medicated withdrawal include:

- Non-residential
    - Outpatient ('ambulatory withdrawal' by which the service consumer attends a clinic at least daily for review by trained staff and withdrawal may be medicated or non-medicated)
    - Home-based (the service consumer is visited at least daily in their own home by trained staff and withdrawal may be medicated or non-medicated)
- Residential
    - Inpatient hospital
    - Community residential

Assisting service consumers to manage withdrawal safely and effectively is an important aspect of ATOD treatment. However, as relapse rates are high following the process of withdrawal, it is not considered a treatment in and of itself; rather it is a preparation for ongoing AOD treatment and support including structured relapse prevention interventions and other after-care programs.[52,54]

2.1 Medicated Withdrawal

What is the intervention?

Alcohol and other drug medicated withdrawal involves the provision of specific medications to reduce the intensity of withdrawal symptoms and provide relief, to prevent complications such as seizures and delirium, and to treat complications of withdrawal and co-existing conditions.[52] Medicated withdrawal programs also offer key elements of supportive care such as education about the course of withdrawal and reassurance; monitoring of mental health and physical symptoms; and encouragement to learn new, or apply existing, coping skills to manage triggers for relapse including cravings to drink alcohol or use other drugs.[52] Service consumers are also linked to ongoing ATOD treatment post-withdrawal. While consumers may be assisted through withdrawal following abrupt cessation of use, others may choose to taper-off more slowly. A tapered withdrawal is the preferred strategy for consumers who are dependent on a benzodiazepine.[53]

Who is it for?

Medicated withdrawal is suitable for service consumers who, following comprehensive ATOD assessment including risk factors for withdrawal, are assessed as likely to experience a clinically significant withdrawal syndrome following cessation or reduction in ATOD use, are likely to experience relief from appropriate pharmacotherapy, or for whom withdrawal symptoms are likely to trigger relapse.

Medicated withdrawal is strongly indicated for service consumers who are assessed as at risk for severe, complicated or protracted withdrawal, including those with a past history of severe withdrawal. While some young people with severe ATOD use disorders may experience withdrawal and benefit from a medicated program, adults with longer histories of regular, heavy use are more likely to require medication support to complete withdrawal safely.

What are the outcomes?

Medicated withdrawal is effective in preventing or minimising withdrawal complications such as seizures and delirium in alcohol and benzodiazepine withdrawal.[o,55,56] It also assists service

o In the absence of strong evidence for the effectiveness of specific medications in the management of cannabis or amphetamine-type stimulant withdrawal, medications for these syndromes are prescribed on a case-by-case basis.

consumers to complete withdrawal by reducing the discomfort associated with symptoms and offers appropriate treatment for co-existing physical and mental health disorders.[52] Withdrawal programs may also assist in reducing individual harms related to ATOD use[53] and support improvements in nutrition and physical health.[54]

Evidence suggests that withdrawal programs alone have no impact on ATOD use in the long-term;[57,58] therefore medicated withdrawal is simply the first-step in treatment planning and may serve to engage service users into longer-term ATOD treatment. For many, withdrawal may represent the first point of contact with the ATOD treatment system and, in addition to the safe completion of withdrawal, success can be measured against a service user's ongoing engagement in ATOD treatment.[54]

How is it applied?

Although the model for medicated withdrawal is primarily medical, psychosocial support is also provided. Medicated withdrawal can be conducted in both residential and non-residential settings. A hospital setting is most appropriate for service consumers at risk of severe withdrawal and/or for those with co-occurring physical or mental health problems that are likely to complicate the course of withdrawal.

The duration of medicated withdrawal varies according to the type of substance used. Typical durations for withdrawal from the most common types of substances are:[52]

- Alcohol: 3–7 days (up to 14 days in severe withdrawal)
- Benzodiazepines: 3–6 weeks, depending on the type of benzodiazepine used
- Opiates (e.g. heroin): 2–10 days, depending on the type of opioid used
- Opioids (e.g. methadone): low grade symptoms may linger for 3–6 weeks
- Cannabis: 1–2 weeks
- Psychostimulants: 1–2 weeks (up to several months for cessation of some symptoms).

Medication regimes vary according to the substance used and protocols to guide the provision of medication have been published by New South Wales (NSW) Health and Turning Point Alcohol and Drug Centre to name a few.

In general, medications can be provided in the following ways:

1 Loading dose (large doses until withdrawal subsides or sedation is reached), which can only be offered in a hospital setting

2 Fixed schedule (specified doses at fixed intervals, tapered over a set number of days), which can be offered in both residential and non-residential settings

3 Symptom-triggered dosing (doses administered according to the severity of withdrawal symptoms), which can only be offered in residential settings by medically trained staff.

Careful monitoring of the service consumer during withdrawal is required so management may be stepped-up or down in intensity as required. Withdrawal scales have been developed for a range of substances and include:

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

Who can deliver it?

Medications for the management of withdrawal may be prescribed by medical practitioners only. Similarly, only trained nursing and medical staff are able to offer symptom-triggered medications in residential (usually hospital) settings.

Medicated withdrawal may be offered in residential settings where medications are prescribed by a doctor and dispensed by a pharmacist into a blister pack for individual service consumers, where the safety and security of medications can be ensured and careful monitoring maintained.

All staff members involved in medicated withdrawal management are trained to conduct comprehensive ATOD assessments, and in recognising the signs and symptoms of withdrawal from a range of substance types, monitoring the progress of withdrawal, and managing the complications of withdrawal if they arise.

Medicated Withdrawal Services in the ACT

Medicated withdrawal is currently provided by:

- Inpatient withdrawal Unit, Alcohol and Drug Services ACT Health: Provides up to 7 days of medicated, residential inpatient support for male and female adults experiencing withdrawal from AOD.

2.2 Non-medicated withdrawal

What is the intervention?

Non-medicated withdrawal provides all of the non-medication aspects of other withdrawal programs. That is: supportive care including education about the course of withdrawal and reassurance; monitoring of mental health and physical symptoms; and encouragement to learn new, or apply existing, coping skills to manage issues including cravings to drink alcohol and or use other drugs. Some non-medicated withdrawal programs capitalise on the opportunity to offer adjunctive support such as employment support, training, relationships building, mood management, personal growth and development, relapse prevention, life and group skills.

Service consumers are also linked to appropriate aftercare following non-medicated withdrawal. In some residential facilities there is a seamless transition from non-medicated withdrawal to residential rehabilitation for service consumers.

Careful monitoring of the progress of withdrawal is also conducted to ensure that support can be stepped- up if required. For example, a service consumer may require medications to assist in withdrawal if symptoms escalate in intensity, or is at risk of relapse due to withdrawal symptoms. As such, organisations that offer non-medicated withdrawal have close links with medical practitioners.

Who is it for?

Non-medicated withdrawal is suitable for service consumers who, following comprehensive assessment, are found likely to experience a withdrawal syndrome following cessation of ATOD use that is likely to be mild and uncomplicated and is unlikely to require medication management.

Young people with substance use disorders are suitable for non-medicated withdrawal if no complicating factors are identified during assessment.

What are the outcomes?

Non-medicated withdrawal supervised by trained staff can assist service consumers to complete withdrawal by alleviating fears and reducing anxiety and providing supportive care. Withdrawal programs can also provide harm reduction benefits for individuals, facilitate a period of abstinence and offer an opportunity to provide specific harm reduction interventions. As is the case for medicated withdrawal, non-medicated withdrawal is not considered a stand-alone treatment; rather it can be the first step in a comprehensive ATOD treatment plan.

How is it applied?

The model for non-medicated withdrawal is primarily psychosocial. Non-medicated withdrawal can be conducted in both residential and non-residential settings. Service consumers: are educated about symptoms and the course of withdrawal; are provided with a low-stimulus, non-threatening environment in a residential setting or are encouraged to create such an environment if withdrawal is conducted at home; are closely monitored and linked to more intensive support (including medical supervision) during withdrawal if required; and are linked with ATOD aftercare when withdrawal is completed.

Program duration varies according to the organisation providing the service, but is usually offered for 7–14 days. Similarly, the content of the support program and intensity of the support provided vary across programs.

Who can deliver it?

All staff members involved in non-medicated withdrawal management require at least a Certificate IV in Alcohol and Other Drugs and require competency to: conduct comprehensive ATOD assessments; recognise the signs and symptoms of withdrawal from a range of substance types; monitor the progress of withdrawal, and manage the complications of withdrawal if they arise, including enlisting medical support if required.

Workers also require training in basic ATOD interventions such as motivational interviewing and relapse prevention strategies, and must be skilled in delivering support according to the model that guides the practice of their organisation.

Non-medicated Withdrawal Services in the ACT

Non-medicated withdrawal services are provided by the following programs:

- Adolescent Drug Withdrawal Unit (ADWU), Ted Noffs Foundation: Provides up to two weeks of non-medicated residential support for young people aged 13–18 years experiencing withdrawal from ATOD
- Arcadia House, Directions Health: Provides 7 days of non-medicated residential support for people experiencing withdrawal from ATOD for male and females aged 18 years and over.

3. Psychosocial interventions

Psychosocial interventions is an umbrella term used to describe any intervention that focuses on the psychological or social factors that are associated with the use of ATOD, rather than biological factors, which are the primary focus of pharmacotherapy.

This section describes the range of psychosocial approaches employed by the specialist ATOD sector and includes brief interventions, assessment and specialised ATOD therapeutic interventions including cognitive behavioural therapy (CBT), brief therapies, contingency management and group therapy.

3.1 Brief interventions

Brief interventions (BI) are the least intensive of all ATOD psychosocial interventions and describe a suite of possible interventions including self-help and education, though they usually comprise at least screening and feedback on the outcome of screening, usually in the form of brief advice to assist the service user to reduce ATOD-related harms or reduce the quantity or frequency of ATOD use. Although brief advice may be delivered in the context of harm reduction, in this section we refer to a more formalised BI approach.

What is the intervention?

Although BI comprise a variety of approaches, they are commonly time limited, goal driven, and structured. Brief interventions are an important and effective way to reduce ATOD related harm. BI conducted in primary care settings have been shown to be about as effective for high risk

drinkers as interventions of longer duration conducted in primary care settings, are more cost-effective due to their short length, and can be used in a wide variety of primary care settings to reach a large number of service consumers. The effectiveness of BI has been demonstrated more strongly among males than females.[59]

Prior to the BI taking place, screening will take place and this activity is designed to detect the likely presence of symptoms or issues and then used to direct the person to a specific service type or to determine the need for further assessment.[60] Screening can also be a non-threatening way for a person to consider their ATOD use of other issues, as its aim is to be brief and enquiring, rather than judgemental. In the ACT, an online localised version of the Alcohol, Smoking and Substance Involvement Screening Test (ACT eASSIST[p]) has been developed with links to BI and treatment options.

Following screening, the 'intervention' component of BI comprise activities that include providing information and advice designed to achieve a reduction in risky ATOD use or problems related to ATOD use. BIs are designed to identify current or potential problems with ATOD use, help a person understand the risks associated with their ATOD use, and enhance a person's desire to change health-limiting behaviours. Brief interventions can be used as early intervention opportunities to prevent the development of significant problems or ATOD use disorders.

BI can take many forms, ranging from five minutes of brief advice to 30 minutes of focused and structured discussion and can include:

- Informal conversations around ATOD use and associated risks
- Telephone services
- Self-help manuals or booklets provided at screening for a ATOD use issue or another issue
- Computer based questionnaires or screening
- Provision of harm reduction information in a primary care setting
- Motivational interviewing (see page 31 for more information)

'Opportunistic' BI are delivered to people who have not sought help for an ATOD problem but who have been identified as being at risk of harm from their use of ATOD following screening in a primary health care setting for example.

'Scheduled' or 'programmed' BI are planned responses to service consumers who themselves recognise or question that their ATOD use may be placing them at risk of harms.

Who is it for?

BI are suitable for service consumers using a range of substances, who have been found to be drinking alcohol at levels higher than those recommend for low-risk drinking, and are

p The ACT eASSIST tool can be accessed through www.act-eassist.org.au. This tool has been designed for use outside of the ATOD sector also.

considered first-line interventions for people using tobacco. Although BI are not the optimum interventions for people with ATOD dependence, they can be used to encourage those with more serious problems to accept ATOD treatment within the primary care or other health setting, or to facilitate referral to a specialised ATOD service.

What are the outcomes?

Research shows that BI assist people who use alcohol above recommended levels and are at risk of developing alcohol related problems but do not seek treatment specifically for their alcohol use. The World Health Organization Brief Intervention Study Group found that five minutes of simple advice were as effective as 20 minutes of counselling. Brief interventions have been shown to be a cost effective way of reducing alcohol consumption and associated problems.[61] A comprehensive review of studies into brief alcohol interventions in primary care found consistent findings for reduced drinking among men who received brief intervention when compared to people who received no intervention.[59] There is also strong evidence that BI assist people to reduce tobacco use.[62] Researchers from the National Cannabis Prevention and Information Centre (NCPIC) have also trialled a BI for cannabis users in an emergency department setting and early results appear promising.[63] In contrast to 'brief therapy' (see page 37), evidence for the effectiveness of BI on other drug classes is lacking.

How is it applied?

Although BI consist of a variety of approaches, common themes to the models are that they are time-limited and goal driven. Although unstructured counselling can be considered a BI, the models are more usually structured. Regardless of the intervention, the following features, described by the acronym FRAMES, provide a framework for workers to conduct BI.

Feedback—providing personally relevant feedback following screening, including current and/or potential risks and harms, connecting the person's presenting issue with their substance use, and providing comparison between the person's use and presenting issues with those experienced by similar people in the population

Responsibility—acknowledging that the person is responsible for their own behaviour and enabling the person to maintain control over their behaviour and its consequences

Advice—providing clear advice regarding harms of continued use and advice on reduction in risk of harm associated with cutting down or stopping

Menu of alternative change options—providing a range of alternatives to assist the person to cut down or stop their substance use. See examples below

Empathy—Utilising a consistently warm, empathic and reflective approach

Self-efficacy (confidence for change)—encouraging confidence in a person's ability to make changes.

Examples of items for a menu of change options:[61]

- Keeping a diary of substance use (where, when, how much, who with, why)

- Helping people to prepare substance use guidelines for themselves
- Identifying high risk situations and strategies to avoid them
- Identifying other activities instead of drug use—hobbies, sports, clubs, gymnasium, etc.
- Encouraging the person to identify people who could provide support and help for the changes they want to make
- Providing information about other self-help resources and written information
- Inviting the person to return for regular sessions to review their substance use
- Inviting the person to work through manual for reducing substance use, together or on their own
- Providing information about other groups or counsellors that specialise in drug and alcohol problems
- Providing advice about putting aside the money they would normally spend on substances for something else

The role of the Stages of Change Model

The 'Stages of Change Model' developed by Prochaska and DiClemente warrants separate discussion as it is a useful model to assist workers to consider a service consumer's readiness to change, and to tailor brief interventions accordingly.[64] It is important to note however, that within the ATOD sector there are mixed views on the application of the model to practice and evidence regarding the effectiveness of stage-based interventions (e.g. in relation to smoking cessation[65]). The model can be considered clinically useful but should not be relied on to dictate treatment.

The stages of change model describe five potential stages that people may move through when changing their substance use (or other behaviours):

1 Pre-contemplation, where a person is not considering changing their use of ATOD
2 Contemplation, where a person is able to consider the possibility of change but is ambivalent about change
3 Preparation (planning), where a person is usually taking steps to change their ATOD use, or is planning steps for change
4 Action, where a person is actively taking steps to change
5 Maintenance, where a person is able to maintain their new behaviour (reduced ATOD use or abstinence) by utilising new ways of coping, anticipating risky situations and managing lapses.

The role of motivational interviewing in brief interventions

Although not theoretically related to the stages of change model, motivational interviewing (MI) is consistent with the stages of change model's framework and is a skill that is widely applied by specialist ATOD workers across Australia in a range of interventions from BI to brief therapy and ATOD treatment of extended duration.

Developed by Miller and Rollnick as an alternative to the confrontational approach that was the cornerstone of ATOD interventions,[66] MI emerged from a humanistic psychology framework (e.g. the work of Carl Rogers) as style of engaging and communicating with ATOD users to increase a person's readiness to change. Core skills of MI include showing empathy; active listening; asking open-ended questions; simple and complex reflection; summarising content; and 'rolling' with a consumer's perceived resistance to change rather than using confrontation in an effort to persuade.[67]

MI is not an ATOD intervention in and of itself.[q] Rather, when employed skilfully by workers trained in the style, the use of MI can enhance a service consumer's engagement in therapy by reducing resistance and emphasising personal responsibility for change.[68] Most specialist ATOD workers are trained in MI and the skill is covered in the Certificate IV in Alcohol and Other Drugs.

Who can deliver it?

Any ATOD support or specialist treatment provider trained in the delivery of BI, including screening, can deliver a BI. The Certificate IV in AOD covers BI as part of the curriculum.

The developers of MI recommend considerable training and ongoing feedback and support for workers to achieve adequate skill development in the communication style.[69]

Brief Interventions in the ACT

Brief interventions are provided through most ATOD services in the ACT, and are a required skill for the workforce through the ACT ATOD Qualification Strategy.

3.2 Assessment

All specialist ATOD medical and psychosocial interventions rely on a formalised, structured and well-conducted assessment of each service consumer. Assessment of the use of ATOD involves detailed questioning and is a specialist activity conducted to identify the type and severity of a specific problem in order to gather the detailed information needed to develop a comprehensive treatment plan that meets the individual needs of each service consumer. Assessment is arguably the single most important element of ATOD treatment as it provides information for effective case formulation and treatment planning, case management and treatment monitoring, and can be an effective brief intervention in its own right.[70]

q MI differs from Motivational Enhancement Therapy (MET) that was trialled in a large-scale consumer-treatment matching research project conducted in the United States – Project MATCH. MET applies principles of MI to a brief therapy. For the manual see http://pubs.niaaa.nih.gov/publications/ProjectMatch/match02.pdf.

What is the intervention?

In a specialist ATOD service, assessment involves detailed appraisal of a person's ATOD use, patterns and treatment history plus some level of screening for other important issues, such as psychological distress, that may affect ATOD treatment outcomes.

A typical ATOD assessment involves, but is not limited to, enquiry into the following domains:[60]

- Types of substances used
- Quantities of each substance used
- Frequency of use of each substance
- Route of administration
- Time of last use of each substance (day, hour)
- Experience with current and previous withdrawal symptoms
- Experience with previous treatment (where, when, length of abstinence if any, time until reinstatement of substance use, attitudes to treatment)
- Barriers to change (e.g. substance-using partner or peer group, lack of confidence, cravings, readiness to change, other triggers for substance use)
- Risk-taking behaviour (e.g. sharing injecting equipment, high-risk sexual practices, driving whilst intoxicated, poly substance use)
- Severity of dependence and risk for withdrawal
- Risk assessment (including suicide and self-harm, violence and homicide)
- Current and past mental health issues including exposure to trauma and the relationship between mental health symptoms (including trauma-related symptoms) and substance use
- Current and past physical health issues, cognitive impairment (including acquired brain injury)
- Social supports, legal, financial and employment factors
- Readiness and desire to change substance use
- Confidence to change substance use
- Service consumer's treatment goals.

Who is it for?

Assessment is suitable for people seeking ATOD treatment, and ideally every person that identifies a personal ATOD issue, is concerned about their use and seeks assistance should receive an assessment.

What are the outcomes?

Assessment is an important element of the therapeutic process. A well-conducted and thorough assessment can be used to:

- Establish rapport and trust between the ATOD specialist and the service consumer

- Assist service consumers to recognise patterns of substance use and triggers for use
- Assist service consumers to link substance use with other concerns related to health and wellbeing
- Develop a comprehensive care plan
- Identify co-occurring issues
- Highlight a service consumer's strengths and resilience that may in turn increase their confidence in their ability to make changes.

How is it applied?

There are a number of models of assessment. Assessment may involve the use of a formal assessment tool or protocol, or may involve a clinician ensuring they are covering a list of areas without specific questions being prescribed.

It is often not possible to complete an assessment in one session, nor should this be the aim. Assessment is often conducted over several sessions.

Who can deliver it?

Any worker with the training and skills to conduct an ATOD assessment including case managers, psychologists, Addiction Medicine specialists, nurses and counsellors in specialist ATOD treatment and support services can complete an assessment for the purposes of treatment planning and conducting ATOD interventions. A Certificate IV in Alcohol and Other Drugs equips workers with the skills to conduct ATOD assessments.

ATOD Assessments in the ACT

Most ACT ATOD treatment services undertake assessment processes as a means of developing treatment plans. There is a shared assessment tool utilised by some residential programs, though protocols are not consistent across the entire service system

3.3 Specialised ATOD Therapeutic Interventions

Evidence-based psychosocial therapies for adults with ATOD use problems include cognitive behavioural therapies, brief therapies, and contingency management (CM), which is primarily a behavioural intervention.[10]

3.3.1 Cognitive behavioural therapies

What is the intervention?

Cognitive and behavioural therapies are a collection of therapies (including mindfulness based therapies, Acceptance and Commitment Therapy, Dialectical Behaviour Therapy, and coping-skills therapy) derived from two theoretical approaches. Cognitive therapy is concerned with understanding how people think about their experience and teaching new ways of thinking. Behavioural therapy is concerned with identifying behavioural responses to situations and teaching new responses. These therapies are practised separately, but more commonly are practised in combination as cognitive behavioural therapy (CBT) that draws on learning theory principles to teach new ways of thinking about and responding to experiences.

CBT helps an individual to identify thoughts and associated behaviours considered unhelpful, and learn alternative and more helpful habits. CBT aims to assist individuals to reduce current symptoms and to learn new skills that will assist them to manage difficulties in the future.

In the specialist ATOD field, the delivery of relapse prevention (a CBT-based intervention) is a core competency for workers.[71] Relapse prevention interventions focus on the cognitive, emotional and situational triggers for ATOD use and teach skills and strategies for alternative ways of coping. These include:

- Identification of internal and external triggers to use
- Self-monitoring to identify craving
- Coping with craving skills training
- Coping skills training (both cognitive and affective e.g. anger management, managing negative thoughts, decision making, problem solving)
- Motivational interventions (e.g. Motivational Enhancement Therapy—MET)
- Contingency management
- Substance refusal skills training
- Social skills training
- Increasing non-using related activity.

Who is it for?

CBT can be delivered to individuals, couples, groups and families. It is suited to people interested in a short to medium term treatment option (e.g. six to 12 weeks duration), and who are ready for active involvement in psychosocial treatment. In an extensive review of the literature, Magill and Ray found that:[72]

- Women appeared to benefit more from CBT than men
- CBT has a positive effect for people with co-existing substance use and mental health disorders
- CBT may be more effective with more severely dependent users[73]
- CBT may be more effective with individuals with a higher level of abstract reasoning.[73]

What are the outcomes?

Numerous large scale trials attest to the effectiveness of CBT for ATOD-related problems.[74] The research supports the use of CBT in maintaining abstinence and reducing the severity and length of relapses. Group or individually delivered programs do not differ in their effectiveness.[72] Current research demonstrates the overall effectiveness of CBT for alcohol and other substance use disorders in adults. Where abstinence is the goal, CBT has been shown to be most effective for the treatment of cannabis use, followed by cocaine, opioids and poly substance use.

Research suggests that because CBT has been found to have a positive effect on longer-term relapse, its effects may be durable. Individuals who received CBT-based coping skills training had shorter and less severe relapses than those receiving a relaxation training program.[75]

In addition, CBT with couples and families has shown positive results in terms of reduced frequency of use, higher levels of retention in treatment and greater relationship satisfaction. Some studies have suggested that couple and family versions of CBT, in particular Behavioural Couples Therapy and Community Reinforcement Approach, may have benefits over individual treatment.[74]

How is it applied?

CBT can be delivered to individuals, couples, families and groups. It can be delivered in a brief format (see page 34) or over a longer duration. Specialist CBT practitioners (e.g. psychologists trained in the model) develop a tailored program of CBT to suit the needs of individual consumers that is based on a specialised CBT assessment and case formulation. Specialised CBT strategies such as exposure therapy and treatment of mental health symptoms may also be used. Progress is measured regularly, and treatment is constantly reviewed according to the consumer's treatment response and needs.

In recognition of the benefits of CBT and to maximise exposure to the therapy of a greater number of people than may be realistically treated by a relatively small number of CBT trained specialists, CBT is often delivered in a structured style by ATOD workers utilising protocols or structured manuals, with prescribed assessment, session plans, homework and handouts.[76,77]

CBT can also be provided via computer/internet or self-help books and manuals, which is also referred to as low intensity CBT.[20]

CBT is typically of shorter-term duration, with treatment provided over four to twenty sessions on average.

Who can deliver it?

Specialist CBT is delivered only by workers with tertiary level qualifications and/or training in delivering CBT. The Australian Association for Cognitive and Behaviour Therapy accredits CBT practitioners in Australia using a set of accreditation criteria that includes professional registration and supervised CBT practice.[78]

ATOD workers trained in MI and relapse prevention, who hold a Certificate IV in Alcohol and Other Drugs, and who have appropriate ATOD professional supervision in place may deliver manual-guided CBT in accordance with a practice protocol or a structured program. Pathways must be in place to refer consumers to a CBT specialist if they do not respond to the manualised program.

Additional training in delivering CBT to couples, families and groups is also required if treatment is to be delivered to these consumers.

3.3.2 Brief therapy

Brief therapy differs from brief intervention as brief therapy provides consumers with the tools and strategies necessary to make changes to their ATOD use, beyond providing simple feedback and advice that are the cornerstones of BI.[79]

What is the intervention?

Brief therapy is an umbrella term for a variety of psychosocial intervention approaches that all share the assumption that people can change in a short period of time. With regard to ATOD use problems, these approaches are typically goal driven, and are applied using evidence-based models such as CBT as described in the previous section.

Brief therapy is best delivered to consumers who recognise, and are seeking treatment for, their ATOD use problems. Brief therapy is delivered following a comprehensive assessment rather than simple screening, as is the case for BI. Brief therapy addresses personal issues that arise for each consumer.

Who is it for?

Brief therapy has been shown to be useful for the following service consumers:

- Those whose ATOD use problems are more severe than those targeted by brief interventions
- Those who recognise their ATOD use problems and are motivated to seek treatment
- Those with clear short and medium term goals
- Populations for whom there may be specific client issues (e.g. aged populations, pregnant women)
- Those with limited time available for treatment (e.g. family or work commitments)
- Those with strong family, work and community supports and connections.

What are the outcomes?

Brief therapies comprise structured sessions from two up to about ten in number. Brief therapies have demonstrated positive outcomes with a range of service consumers, including people who use amphetamine regularly (CBT, Acceptance and Commitment Therapy, and MET)[70,80] and ATOD consumers with mental health problems.[81]

Outcomes of brief therapy also benefit treatment providers in certain ways such as:

- The ability to provide services to people in rural and remote communities for whom longer therapy is unavailable
- The ability to provide services in cases where there are large numbers of people on a treatment waiting list

- The ability to deliver tailored therapy where treatment duration is fixed (e.g. fixed term residential programs or correctional facilities).

How is it applied?

Brief therapies are consistent with a stepped-care model of ATOD treatment in which the least intensive therapy that is likely to work is tried first, and then stepped-up in intensity only if the service consumer does not respond.[14] Although there are many models of brief therapy, the following applies across all models:[79]

- A focus on the present rather than the past
- Clearly defined goals related to a specific change or behaviour, rather than large scale or broad change. This targeted change can be ATOD-specific or focus on other factors associated with ATOD use such as relationships or psychological distress
- Early and rapid establishment of engagement and rapport is essential
- Responsibility for change rests with the client
- Duration of therapy, and therefore termination, is discussed from the beginning of therapy
- Outcomes are well defined and measurable.

Brief therapy should not be thought of as a short or summarised version of longer therapy. Rather, it targets specific behaviours or symptoms using the techniques and tools of the specific therapeutic model used (e.g. brief CBT).

Who can deliver it?

Workers with a professional background that have been trained in the specific therapeutic approach that guides the sessions (e.g. CBT, MET, Acceptance and Commitment Therapy) are able to deliver brief therapy.

As is the case for CBT, workers trained in MI and relapse prevention and who hold a Certificate IV in Alcohol and Other Drugs can deliver brief therapy in accordance with a practice manual or a structured program. A number of manuals to guide practices are available in Australia.[r] Ongoing supervision of workers providing brief therapies is also recommended.

Brief Therapies in the ACT

Many ACT ATOD treatment services provide brief therapies as part of other programs (e.g. within residential programs). Specific programs (that can be accessed independent of participation in other programs) are provided by:

- Treatment and Support, Directions Health: Provides psychosocial interventions (including Solution Focussed Brief Therapy) for individuals, their partner, families and friends impacted by ATOD.
- Counselling and Treatment Service, Alcohol and Drug Services ACT Health: Provides ATOD psychosocial interventions and brief therapies for adults, young people and family members and carers including a range of therapeutic and education groups

r For example, A brief cognitive behavioural intervention for regular amphetamine users: a treatment guide.[82]

3.3.3 Contingency Management

What is the intervention?

Contingency management (CM) is a behavioural therapy based on operant conditioning principles; the premise being that reinforcing 'desirable' behaviours will result in an increase of these behaviours. CM involves the provision of often tangible and immediate rewards to reinforce treatment goals, usually attendance and participation in therapy, compliance with pharmacotherapy, or abstinence demonstrated by clear or negative urine drug screens. Examples of rewards used in CM approaches include vouchers exchangeable for retail goods, prize draws, and program privileges or staff recognition. The size of the reinforcement usually increases in accordance with the consumer's sustained abstinence from the target drug or drugs.[83] CM was developed in methadone clinics, where take-away dosing and flexible dosing appointment times were offered in response to patients maintaining frequent and regular visits.[84]

Who is it for?

CM is suitable for a range of service consumers in different treatment settings[83] and the efficacy of the intervention is not impacted by client ethnicity, income or psychiatric severity.[84]

Research suggests that CM is likely best suited for consumers working towards a goal of abstinence and is more effective when abstinence from one drug at a time is targeted.[85]

CM has been found to be useful for individuals with co-existing substance use and mental health disorders. Several studies demonstrate its effectiveness for reducing cocaine and cannabis use in people with mental health disorders and CM has shown promise for reducing smoking in individuals with schizophrenia.[86]

What are the outcomes?

There is a substantial body of literature documenting the efficacy of CM[84] and a meta-analysis of psychosocial treatments for substance use disorders showed that contingency management was the intervention with the greatest effect size.[83] Outcome studies have demonstrated that CM effectively encourages consumers to comply with medications designed to reduce/eliminate drinking, maintain abstinence from alcohol and cocaine, adhere to opiate substitution programs, and attend a specialist ATOD service.[87]

Although abstinence has been the primary goal of CM interventions, growing evidence suggests that CM may also reduce consumers' ATOD use[85] and has been found to reduce tobacco consumption, even amongst consumers that did not have this as a treatment goal.[83]

Secondary positive outcomes can occur with CM, for example an increase in consumers' exposure to care, support and other interventions, and an increase in provider morale as a result of CM reinforcing treatment attendance.[83,86]

The effects of CM appear to fade over time when the contingencies have been removed.[88]

How is it applied?

CM can be conducted in withdrawal programs, residential and non-residential settings, in individual or group programs.

As behavior change is the goal of CM, objective measures of behaviour are used; abstinence is measured by urine screens and attendance or medication compliance is monitored and documented. In accordance with behavioural principals, the targeted behaviour is measured frequently (for example, thrice weekly urine drug screening) and rewards are usually provided as immediately as possible once the desired behaviour has been demonstrated.[85]

Who can deliver it?

CM can be delivered by staff trained in both behavioural principles and the particular CM program protocols. Training in delivering CM programs is relatively straightforward and the efficacy of CM interventions is clearly documented; however, it has not been a widely accepted or adopted by ATOD treatment programs. Barriers to its use include the financial costs for organisations, service provider lack of understanding of behavioural principles and ethical concerns in relation to misuse of the rewards or perceptions of rewards as gambling or bribery.[84,86]

3.3.4 Group Therapy

What is the intervention?

Group therapy is an umbrella term for a number of different group-based approaches. Groups usually belong to one of the following models:[89]

- Psycho-educational groups, which provide education about substance use issues and/or other issues
- Skills development groups, which teach skills for making changes in substance use or managing mood states which may be triggers to substance use such as anger or anxiety
- Cognitive behavioural groups, which teach techniques to understand and manage the thoughts and actions that trigger substance use
- Support groups, which support participants to make or maintain changes in substance use or manage issues of daily life

- Interpersonal process groups, which explore underlying, historical and developmental and interpersonal issues that may be connected to the development or maintenance of substance use.

Types of groups for ATOD service consumers include:[89]

- Relapse prevention groups
- Skills building
- Expressive therapies groups (e.g. art or psychodrama)
- Groups drawing on specific cultures' healing practices
- More intensive combination group programs, e.g. Matrix, that combine different types of groups with individual sessions for participants and their families
- Family therapy groups
- Relaxation groups
- Health and wellness groups.

It is important to note the distinction between group therapy and 12–step peer support groups (see page 55 for a description). Group therapy is led by one or two trained facilitators, while 12–step groups have a chairperson opening and closing the meeting but do not have a counsellor or leader running the group. 12–step peer-support groups[s] focus on members sharing their personal stories and supporting each other to achieve and maintain abstinence, while group therapy is generally more goal and agenda driven.

Who is it for?

Group therapy is suitable for service consumers living in stable accommodation; who want group support and are willing to participate; who will honour group rules and agreements, including respecting opinions, privacy and confidentiality of group members; who can commit to regular, punctual attendance; and those who do not experience anxiety or who find groups of people intimidating and uncomfortable.

Research suggests that women do better in women-only groups than in mixed gender groups. Their retention and treatment completion rates are higher[91] and they are more likely to use other services and feel positive about their progress when in women-only groups.[92]

There is also evidence that groups may be more effective than individual treatment where people experience a combination of severe levels of substance use, flat mood (negative affect) and lower levels of coping skills.[93]

s A therapeutic alternative to 12–step peer support is 12–step Facilitation Therapy (TSF), which is led by a worker trained in the model and has proven to be effective in linking people with 12–step programs and improving ATOD treatment outcomes.[90]

What are the outcomes?

Group therapy can enrich interventions offered to individuals as it: enables peer support and feedback; reduces isolation; provides real-life examples of others who have made progress towards their treatment goals; and offers opportunities for social skills training and practice.[89] Group therapy is also a valuable way to assist many service consumers at one time.

The research shows that in some cases, group therapy can be more beneficial than individual therapy.[94] Psycho-educational groups have been found to be effective with people with co-occurring ATOD and mental health issues, including schizophrenia.[95] Relapse prevention groups can reduce the duration and intensity of lapses and relapses.[93]

Where abstinence is the desired goal, group therapy may result in people being more likely to maintain abstinence as the group process provides benefits in itself regardless of the content of the group. These benefits include affiliation, support and identification.[96]

How is it applied?

Therapeutic groups may be open; that is members may join at any time. Other groups are closed, so members can only join when the cycle of groups (e.g. and eight week program) is complete. Some groups are designed for particular groups of service consumers only (e.g. women, and people with mental health and ATOD use issues). Groups can run over a fixed or open-ended period of time.

Who can deliver it?

Delivering group therapy effectively requires a set of skills and qualities beyond the therapeutic skills required for individual work with clients; therefore group facilitators require training in group facilitation skills. Effective group leaders are confident and consistent in their approach, communicate optimism, and are active listeners and express empathy. They are familiar with the material being delivered and prepare thoroughly for each session. In addition, effective leaders:[89]

- Adjust their professional styles to the particular needs of different groups and appreciate and adapt to the needs of service consumers at different stages of treatment
- Model group-appropriate behaviours
- Resolve issues ethically
- Manage emotional content and ensure emotional safety in the group
- Work only within treatment models for which they are trained
- Prevent the development of rigid roles among group members
- Use a motivational approach to assist members to reach their treatment goals and complete the group program
- Maintain a safe therapeutic environment (e.g. recognise a lapse or relapse and intervene early, protect physical boundaries according to group agreements)
- Stimulate helpful and supportive communication among group members
- Manage conflict among members

ATOD workers, including those with a professional background and those who hold a Certificate IV in Alcohol and Other Drugs, and who have received training in group facilitation and the treatment model applied, may deliver group therapy.

Group Therapy in the ACT

Many ACT ATOD treatment services provide group counselling or therapy as part of other programs (e.g. within residential programs). Specific group therapy programs (that can be accessed independent of participation in other programs) are provided by Directions, Toora Women ATOD Programs and Alcohol and Drug Services, ACT Health.

4. Pharmacotherapy

Pharmacotherapy refers to any treatment for an ATOD use disorder that involves the prescription of medication as part of a comprehensive ATOD treatment plan aimed at maximising a service user's quality of life. Treating ATOD use disorders with pharmacotherapy is no different from treating other physical and mental health disorders with prescribed medicines and has similar aims: to eliminate or manage symptoms of the disorder; improve health and wellbeing; and prevent relapse. Pharmacotherapy for ATOD use disorders is most effective when used in combination with psychosocial interventions.

The three most common types of pharmacotherapies for ATOD use disorders are summarised in this section: pharmacotherapies for opioid dependence, nicotine replacement therapy, and pharmacotherapies for alcohol use disorders.

4.1 Pharmacotherapies for opioid dependence

Although less than one per cent of the Australian adult population is dependent on opioids, the impact is profound and disproportionate to the prevalence of dependence. The social, health and economic costs of opioid dependence include:[97]

- Loss of life due to fatal overdose at an age younger than deaths caused by alcohol or tobacco use
- Transmission of hepatitis C and B, and HIV
- Non fatal overdose and associated morbidity
- Loss of quality of life of the person who is dependent and their families, including the consequences of incarceration
- Community losses due to criminal activity
- Law enforcement and judicial costs.

Although psychosocial interventions are an important aspect of the treatment of opioid dependence, pharmacotherapy[t] is the treatment of choice in Australia due to the relapsing nature of dependence and the seriousness of the associated risks.

What is the intervention?

Medications used for the treatment of opioid dependence fall under the two broad categories of 'opioid agonists' and 'opioid antagonists'. Agonist medications have morphine-like action and work by binding to and then activating the mu opioid receptor in the central nervous system, thereby limiting the effects of other opioids and relieving symptoms of opioid withdrawal. Methadone is an example of an agonist medication and it is used as a substitution (maintenance) therapy for opioid dependence.

Antagonist medications block the effects of opioids by occupying mu receptors, but unlike agonists, they do not activate the receptors and have no morphine-like effect. Naltrexone is an example of an antagonist medication and it is used to prevent relapse in formerly opioid dependent persons. Naltrexone can be administered orally or via sustained release formulations (implants or depot injections). However there is only limited, early evidence for the use of sustained release products, their use is not recommended for opioid dependence, and products are not currently registered with the Therapeutic Goods Administration.[97,98] Naloxone, another blocking agent, is used to reverse opioid overdoses (see 'Harm Reduction' section—page 17—of this paper for more information).

Another important medication is buprenorphine; a 'partial agonist' that binds to, but only weakly activates the mu receptors and blocks the effects of other opioids by occupying a large proportion of available receptors. Buprenorphine is also used as a substitution therapy for opioid dependence and is administered either on its own, or as a combination preparation containing buprenorphine and naloxone (trade name Suboxone).

Who is it for?

Methadone and buprenorphine as substitution therapies are only suitable for those who have established diagnoses of opioid dependence.[97] Opioid substitution therapies are recommended for people who are dependent on opioids and who have hepatitis B or C, and or HIV. Methadone maintenance treatment is best practice for pregnant women who are dependent on opioids as it provides a steady concentration of opiate in the mother's blood, preventing the negative effects on the developing infant who would otherwise experience repeated withdrawals.

What are the outcomes?

A substantial body of research shows that opioid maintenance pharmacotherapies contribute to positive outcomes for service consumers including:[99]

t The 2014 National Guidelines for Medication-Assisted Treatment of Opioid Dependence, replaces the term 'pharmacotherapy' with 'medication-assisted treatment' as it is thought to better describe the different treatment approaches that combine medication and psychosocial support.

- Engaging people who use opioids into treatment, enabling underlying psychosocial issues to be addressed
- Reducing or ceasing illicit opioid use
- Relieving cravings and opioid withdrawal symptoms
- Reducing harms from injecting
- Reducing the spread of HIV and hepatitis B and C
- Reducing criminal activity
- Reducing the incidence of opioid overdose
- Reducing the risk of miscarriage and premature labour in pregnant women who are dependent on opioids.

How is it applied?

The model for pharmacotherapy for opioid dependence is primarily medical; however the important role of psychosocial support is well recognised and is offered in accordance with individual needs.[97] Psychosocial support includes relapse prevention and motivational enhancement and attention to the range of needs of each service consumer including those relating to relationships, legal, housing, mental and physical health. Some residential rehabilitation programs also offer a place to people receiving pharmacotherapy.

Pharmacotherapy may be prescribed by general practitioners or by specialist medical staff in pharmacotherapy services that offer specific programs.

Generally, people receive the medication daily in the form of syrup for methadone and a dissolvable wafer for buprenorphine at either a specialist clinic, or through a community pharmacy that offers a pharmacotherapy dispensing service.

Evidence suggests better outcomes on drug use and quality of life measures for those who remain on pharmacotherapy for twelve months or more.[100,101]

Who can deliver it?

Pharmacotherapy for opioid dependence can be prescribed by medical practitioners only. Adjunctive psychosocial support can be provided to service consumers by a range of ATOD workers including peers, those with a minimum of Certificate IV in Alcohol and Other Drugs, and specialist ATOD workers in pharmacotherapy services.

Pharmacotherapy in the ACT

Pharmacotherapy treatment for opioid dependence is provided by the following program:

- Opioid Treatment Services, Alcohol and Drugs Services, ACT Health: Provides opioid substitution therapy and coordinated care by working with other health and pharmacotherapy services. Adult men and women are eligible to access this program that operates 7 days a week

4.2 Nicotine replacement therapy

In Australia, smoking caused more than 1 in every 10 deaths in 2003, and was responsible for the greatest disease burden.[102] While around 12.8 per cent of Australians smoke daily,[103] smoking rates are significantly higher among people experiencing social and economic disadvantage, and those with ATOD or/and mental health problems than are seen in the general population.[104] It has been estimated that among people with substance use disorders, 85% also smoke tobacco[105]. A recent survey conducted by ATODA revealed that 82% of service users smoked tobacco when they first entered or started using the ATOD service.[106]

Service consumers who stop smoking after ATOD treatment are more likely to be abstinent from drugs or drugs and alcohol combined up to nine years later.[107] In contrast, continuing to smoke after ATOD treatment is a risk factor for relapse for adults[108] and adolescents.[109] Addressing consumers' tobacco use is a core function of the specialist ATOD sector.

What is the intervention?

Nicotine Replacement Therapy (NRT) comprises a range of products that deliver low doses of nicotine without the harmful chemicals found in cigarette smoke. The aim of the therapy is to temporarily replace the nicotine from cigarettes in order to minimise withdrawal symptoms and reduce a person's motivation to smoke.[110] A variety of NRT forms are available, including skin patches, chewing gum, nasal and oral sprays, inhalers, sublingual tablets and lozenges. These forms deliver a controlled nicotine dose more slowly than cigarettes and the dose can be stepped down accurately, thereby assisting the transition from smoking to smoking cessation.[111]

Who is it for?

NRT is suitable for service consumers aged 12 years and over[u] who are dependent on nicotine, and are willing to use NRT to reduce or quit smoking. NRT is primarily aimed at, and the efficacy evaluated for, people smoking at least 10–15 cigarettes per day. It is recommended that prior to beginning NRT, pregnant service consumers and service consumers with pre-existing medical conditions that are known to put them at risk if NRT is used (e.g. allergies, skin sensitivities) seek guidance from a medical officer and/or relevant health professional (e.g. nurse, midwife or pharmacist).

What are the outcomes?

NRT has been proven to help people quit smoking and greatly increase the odds of quitting when compared to placebo by up to 50–80%.[111,112] The different types of NRT have been found to be equally effective in helping people to quit smoking, while the use of patches combined with other forms of NRT was found to be more effective than using a single type.[112]

u NRT is not authorised for use by those aged under 12 years in Australia.

The combination of behavioural therapy with NRT has been found to effectively assist smoking cessation, and there is evidence of better outcomes when NRT is provided free of charge and when training for health professionals in smoking cessation is provided.[113]

How is it applied?

The choice of which type of NRT to use can be based on individual service consumer needs, severity of dependence and lifestyle, with the timing and length of treatment also tailored to individual needs. For example, while patches are easier to use than oral forms, gum or a nicotine inhaler are more suited to relieving acute cravings or for people with sensitive skin, and these forms can be used on a fixed dose or as-needed basis.

NRT can be safely used while continuing to smoke and there is some evidence that using patches for a short period before attempting to quit is moderately more effective than commencing NRT on the specific quit date.[111] Use of combined NRT is recommended when single NRT treatment has not been effective, particularly for people who need to manage sudden, intense cravings. Use of patches for eight weeks (shorter duration is not recommended) has been found to be as effective as longer term use and smokers can choose to taper their dose or stop abruptly as no difference in effect between these methods has been found. While the efficacy of longer term NRT use is less clear and nicotine does have the potential to cause harms, the risks of harm from longer-term use of NRT are considered very small compared to the risk of continued tobacco smoking.[111,114]

Who can deliver it?

NRT can be prescribed by a doctor or authorised medical practitioner but NRT products are also available over the counter at pharmacies and some supermarkets. NRT can be provided to service consumers by pharmacists or ATOD workers who have been trained in smoking cessation approaches and ATOD workers can deliver behavioural therapy to enhance NRT treatment effect.

Nicotine Replacement Therapy in the ACT

ATODA administers a program to provide subsidised NRT to workers and clients of specialist ATOD services in partnership with community pharmacies.

4.3 Pharmacotherapies for alcohol use disorders

Approximately five per cent of the Australian population are dependent on alcohol.[115] A range of effective interventions for people with alcohol dependence are available, including harm reduction approaches, psychosocial interventions, and pharmacotherapy.

What is the intervention?

Three medications are approved in Australia as part of a comprehensive treatment plan for the treatment of alcohol dependence: acamprosate, naltrexone and disulfiram.

Acamprosate is thought to work on the glutamate and GABA systems, which are involved in both tolerance to the effects of alcohol and the typical symptoms of alcohol withdrawal. Naltrexone blocks opioid receptors, thereby reducing craving for alcohol. Disulfiram, the oldest of the three pharmacotherapies, is an 'aversive agent'[v] so someone taking disulfiram will have very unpleasant physical reactions such as flushing, vomiting and headache should they drink alcohol while taking this pharmacotherapy.

Who is it for?

Pharmacotherapy is suitable for adults with alcohol dependence who are willing to take pharmacotherapy as part of their treatment plan. Pharmacotherapy should be considered for all people with alcohol dependence post withdrawal in conjunction with psychosocial support.[115]

What are the outcomes?

Acamprosate and naltrexone have been shown to reduce heavy drinking, reduce craving and prevent relapse.[116,117] Acamprosate is particularly effective following alcohol withdrawal.[117,118] The evidence for disulfiram is weaker, with studies failing to clearly establish its benefit for maintaining abstinence or relapse prevention; however it has been shown to promote short-term abstinence following withdrawal.[119]

How is it applied?

The model for pharmacotherapy is primarily medical, but the role for psychosocial support in maintaining treatment gains is an important one.

The usual treatment period for alcohol pharmacotherapy is three to six months, but can be adjusted to meet the needs of individuals.[115]

Who can deliver it?

Pharmacotherapy for alcohol dependence must be prescribed and reviewed regularly by a medical practitioner. ATOD workers have a significant role to play in providing the psychosocial support such as motivational enhancement and relapse prevention that is recommended to strengthen treatment outcomes.

v Disulfiram acts by inhibiting alcohol dehydrogenase that is required for alcohol metabolism.

5. Residential rehabilitation

Of the suite of effective ATOD treatment options available, residential rehabilitation is the most intensive. It provides a longer-term option for ATOD service consumers (three months to one year) and the goal is usually abstinence-orientated. Residential rehabilitation is not a specific treatment in itself; rather it is a setting in which a range of intensive supports and therapeutic approaches are offered.

What is the intervention?

Residential rehabilitation offers service consumers 'live-in', structured alcohol and drug treatment and support in accordance with the established model of care such as therapeutic community (TC), modified therapeutic community or a model that delivers other evidence-based therapies including cognitive behavioural therapy. Residential programs commonly include living skills training, parenting skills, case management and counselling and most programs use group work as part of a structured program.

The majority of residential rehabilitation programs provided in Australia are based on the therapeutic community model. A TC is a specific type of residential rehabilitation which utilises a hierarchical model of community where residents (not 'clients' or 'patients') progress through treatment stages or phases with increasing levels of personal and social responsibility. TCs differ from other treatment approaches principally in their use of the community, comprising treatment staff and those with past-lived experience of substance use issues, as key agents for change. This approach is often referred to as 'community as method'.[120] Residents are expected to participate in a variety of scheduled activities, including community, educational, therapeutic, recreational, and work functions connected with the daily running of the community as a whole.

TCs are sometimes modified to suit the needs of specific populations, for example, Aboriginal and Torres Strait Islander people, adolescents, people with children and pregnant women, people with co-occurring ATOD issues and mental illness and prisoners. Modified TCs commonly adapt the traditional TC approach and include less confrontational therapeutic styles, greater flexibility in treatment phases and more individualized treatment. Other modifications to the traditional TC include allowing admission to residents who are on an opioid pharmacotherapy maintenance program for example. Modified TCs may also employ more health professional staff, including doctors, psychiatrists, and counsellors with postgraduate training.[121]

Other residential rehabilitation programs, not based on the TC model are also available, which deliver usual ATOD treatment such as counselling, skills training and relapse prevention in a residential setting. Other residential program types include: short term residential treatment (often combined with residential medicated withdrawal programs); longer term residential treatment (12–52 weeks); low intensity residential treatment and extended care where consumers live semi-independently with support; and opioid substitution treatment tapering to abstinence.[122]

Who is it for?

Residential rehabilitation services are most appropriate for individuals that: have been unsuccessful in maintaining treatment goals from non-residential ATOD treatment; have a long history of dependence or a severe dependence; and have a range of complex issues beyond their drug use, including mental health issues, involvement in the criminal justice setting, unstable housing and other factors that put them at risk of relapse in the community.

Residential treatment and/or TCs are suitable for:[123]

- People with a long history of chronic alcohol use and who are severely dependent (research indicates this is likely to apply to other substances)
- People with alcohol dependence (or other substances) who do not have social networks or supports that would support reduced use or abstinence
- People with substance dependence who are unable to support themselves financially.

What are the outcomes?

Although research on TCs and residential rehabilitation compared with outpatient treatments is limited, it offers some support for the practice wisdom of the sector. Research shows that residents who have completed a TC program demonstrate a lasting reduction in heroin use and criminal behaviour and an increase in employment when compared with their pre-treatment status. It appears from a few studies that these behavioural changes have associated psychological gains.[73]

Good outcomes from TC treatment are strongly related to treatment duration, which likely reflects benefits derived from the underlying treatment process. Treatment duration is a convenient and robust predictor of good outcomes. Individuals who complete at least 90 days of treatment in a TC have significantly better outcomes on average than those who stay for shorter periods. Although a review of the literature found that duration of treatment was the most important outcome predictor, further investigation found that both time in treatment and treatment level achieved (i.e. the higher the phase or stage reached by the resident) have a relationship with outcome.[124] The authors concluded that the level achieved by residents at program exit was a better predictor of being abstinent in future than length of stay.

In addition, Marsh et al. found that:[123]

- Retention is improved when modifications to TCs that support specific groups (e.g. adolescents, parents with children, pregnant women) are made
- Offering a broad range of interventions in a residential program improves its effectiveness.

How is it applied?

Residential rehabilitation is conducted in settings free from non-prescribed drugs and alcohol. The model is usually abstinence based. Residential rehabilitation can be short or long-term. Typically, a short-term program would be of four weeks duration, with long-term being anything up to a year.

Within this setting, a variety of modalities and treatment approaches, including both individual and group based, can be delivered. They include:

- Cognitive behaviour therapy
- Motivational interviewing
- Psycho-education, including social and living skills training and parenting training
- 12–step approaches
- Holistic approaches, including delivery of complementary health services, yoga, meditation
- Recreational and activity based approaches
- Life skills
- Educational and occupational/employment training.

TCs differ from other treatment approaches principally in their use of the community as a whole, utilising staff and residents (both considered TC members) as the agents of change. Residents participate in the daily running of the TC and decision making by the community. TC members interact in structured and unstructured ways to influence attitudes, perceptions, and behaviours of other residents that are associated with drug use. Residents are expected to comply with rules and codes of behaviour. Self-discovery, behavioural change, new relationships and peer and staff influences are viewed as crucial to the achievement of a life free from ATOD dependence and improving quality of life.

Who can deliver it?

Residential programs are usually staffed by a variety of workers who are qualified to provide different parts of the program. Staff members who work in residential programs, particularly TCs, may also be workers with lived experience of ATOD use issues.

Residential Rehabilitation in the ACT

Residential rehabilitation programs are provided by a range of services in the ACT including:

- Arcadia House, Directions: Provides 7 days of non-medicated residential support for people experiencing withdrawal from ATOD and a 12–week transition program (incorporating residential and day program elements) for adult men and women.
- Canberra Recovery Service—Bridge Program, Salvation Army: Provides a residential rehabilitation program up to 10 months in length for adult men and women.

- Karralika Family Programs, Karralika Programs: Provides up to 12 months residential rehabilitation within a therapeutic community setting for adults with ATOD problems with accompanying children aged up to 12 years.
- Karuna Short Stay Program, Karralika Programs: Provides 8 weeks of residential rehabilitation within a community setting for single men and women and couples with ATOD issues.
- Karralika Therapeutic Community Adult Program, Karralika Programs: Provides up to 12 months residential rehabilitation within a therapeutic setting for single men and women and couples with ATOD problems.
- Program for Adolescent Life Management (PALM), Ted Noffs Foundation: Provides up to 3 months residential rehabilitation for young people aged between 13–18 years of age experiencing ATOD issues.
- Solaris Therapeutic Community, Karralika Programs and ACT Corrective Services: Provides a therapeutic community approach for adults males in the Alexander Maconochie Centre (AMC) with moderate to severe alcohol and other drug dependence.

6. Day rehabilitation programs

What is the intervention?

Day programs describe the setting in which evidence based interventions are delivered. Day programs provide outpatient based ATOD treatment. There is no one definitive theoretical approach and as such day programs vary widely in program content, delivery style and intensity. The content of the day program is often similar to that offered by residential rehabilitation programs, and group work is often central to the program. The content of day programs is also influenced by the service consumers that attend (e.g. women, young people).

Content of specialist ATOD day programs can include:

- Therapeutic groups focusing on relapse prevention and maintaining motivation for change
- Alcohol, tobacco and other drug education
- Psycho-education with a focus on the interaction between ATOD use and mental and physical health
- Individual counselling
- Family counselling
- Peer-led support groups
- Recreational activities/non-ATOD using associated activities and adventure based therapies
- Creative therapies
- Vocational training
- Life skills development
- Case management.

Who is it for?

Day programs are suitable for individuals who wish/need to address their ATOD use in a more intensive way than with weekly counselling but also wish to maintain their commitments to work, family or study. Day programs are suitable for individuals with strong social supports and stable accommodation. Although the risk of lapse and relapse can be higher for individuals in day programs than for those in residential settings due to greater access to alcohol and other drugs in the community, this risk can be balanced by the opportunity to practice new skills and strategies in the real world, whilst undertaking treatment.

Day programs may also be designed for specific groups of service consumers such as women, young people, and Aboriginal and Torres Strait Islander people.

Day programs are less suitable for people who are homeless or those with unstable accommodation or other social and environmental issues that increase their risk of relapse.

What are the outcomes?

Day programs, particularly intensive programs that deliver evidence-based interventions to service consumers have been associated with reductions in ATOD use as well as improvements in mental health, social functioning, and employment status.[125]

How is it applied?

Due to the variability in the theoretical model chosen for day programs, some programs are abstinence-orientated (e.g. 12–step facilitation therapy), while others will accommodate a range of service consumer goals. Day programs may use structured timetables, or may offer individualised treatment planning and goal setting or a combination of these elements.

Day programs vary in duration but often run for a period of one to three months. Some programs offer half or full-day sessions, four to five days per week, while others may offer shorter sessions once or twice per week.

Who can deliver it?

Day programs can be delivered by ATOD staff with a minimum qualification of Certificate IV in Alcohol and Other Drugs and adequate training to deliver the particular program. Day programs are usually guided by a facilitator's manual or similar, and adherence to the guide is important to maintain the program's effectiveness for service consumers.

Day Programs in the ACT

In the ACT, the following structured day programs are delivered:

- Arcadia House, Directions: Provides an 8–week day program for men and women aged over 18 years.
- Alcohol and Other Drug Day Program, Toora Women Inc.: Provides an 8–week ATOD day program including information, education, counselling and resources to women over 16 to minimise the harms associated with ATOD and other dependency. Women with children under 12 months are also eligible to participate.

7. Aftercare

ATOD use issues are by nature prone to relapse and service consumers often require multiple attempts before they are able to fully meet their treatment goals. Relapse rates among people with ATOD dependence are similar to those of other chronic medical illnesses such as diabetes, hypertension and asthma, which are also influenced by behavioural and physiological factors.[10] Service consumers require access to structured aftercare programs.

What is the intervention?

Aftercare refers to any interventions that occur subsequent to initial ATOD treatment. Aftercare is differentiated from follow-up, which usually involves checking in at agreed post treatment time intervals with a person to monitor and support their progress and/or evaluate the impact of treatment.

Aftercare can comprise individual or group therapy, support, debriefing, revision of previously taught material, and teaching new skills and coping strategies. Aftercare is often provided by the service that provided the initial treatment, but service consumers may arrange their own aftercare with alternate service providers.

Who is it for?

Aftercare is suitable and indicated for all service consumers following ATOD treatment, and is of particular importance for those with more severe ATOD issues, those with significant symptoms of craving to use ATOD, those with co-existing ATOD and mental health disorders, and young people.

What are the outcomes?

Aftercare has been shown to assist service consumers to prevent relapse to ATOD use following inpatient withdrawal[126] and intensive ATOD treatment.[127,128] Aftercare has also been shown to have a positive effect on reducing recidivism.[129] Aftercare delivered via telephone has also been shown to be effective for some service consumers.[130]

How is it applied?

There are a number of models of aftercare. These include:

- 12–step groups/programs: Participants are encouraged to attend regular, meetings over the long-term in keeping with the disease model of dependence that advocates for life-long abstinence. 12–step programs provide a number of valuable elements including community, support and sponsors (see page 55)
- Support groups: Treatment services that have provided initial treatment often run their own support groups. These groups may be ongoing or for a finite period of time. Participants are encouraged to attend regularly. They may provide debriefing on living without using ATOD, a refresher of strategies and skills previously taught and new strategies and skills and/or exploration of underlying and new issues for participants (see page 43)
- Family support groups: As part of aftercare, some treatment services provide groups to the participants and their family members to assist with re-integration into family life and offer support to family members
- Psychosocial interventions: Following initial treatment ongoing access to psychosocial support may be offered by the same service utilising a number of approaches, including relapse prevention (see page 28)
- Booster sessions: These sessions are typically less frequent than the above options. They are designed to occur a few months after initial treatment has finished and provide debriefing on living without using ATOD, a refresher of strategies and skills previously taught and new strategies and skills. They often draw on motivational interviewing and enhancement approaches.

Who can deliver it?

Aftercare can be delivered by an ATOD worker skilled in delivering group interventions with a minimum qualification of a Certificate IV in Alcohol and Other Drugs or a clinician skilled in delivering individual alcohol and drug interventions if the aftercare is provided in individual sessions.

8. Other aspects of ATOD care

8.1 Peer Support Groups

What is the intervention?

Peer support is considered an important part of the process for individuals' addressing ATOD-related issues, and may be extended to their families and friends. Peer support is provided in a range of ways. Drug user support and advocacy groups (e.g. CAHMA) and family support services (e.g. Family Drug Support) provide a range of peer-based services and information for people who use ATOD and their families, and may do so in a group-based setting. However, this section primarily focuses on peer support groups, also known as mutual-aid or self-help groups.

The meetings of these peer support groups are a significant part of support options for people who use ATOD in Australia. On their own, peer support groups are not considered specialist treatment, but are frequently incorporated into ATOD treatment programs and attendance at support groups as part of an aftercare program has been shown to reduce relapse. Common self-help and peer support groups in Australia are Self Management and Recovery Training (SMART Recovery[w]) based on the CBT model, and 12–step fellowships that include Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and Al-Anon. In Australia it is estimated there are approximately 18,000 members of AA and over 400 weekly NA meetings[131,132], indicating the significant resource and contribution such groups make in the ATOD sector.

What is the intervention?

Peer support groups are groups of two or more people who share an experience or problem and who come together to provide problem-specific help and support to one another.[133] Peer support for ATOD users may be specifically related to the use of one drug type, such as alcohol, or focused on shared issues more generally. Regular meetings are operated by not-for-profit self-help groups and peer-operated organisations. Meetings are generally free to attend, facilitated by non-professionals and often provided on a drop-in informal basis. Groups focus on providing support, encouragement and shared knowledge with group members.[133,134]

Who is it for?

Peer support is for ATOD users who recognise their use as problematic and/or dependent and are aiming to reduce or abstain from use. Some groups are for users of specific substances (e.g. AA, Cocaine Anonymous).

What are the outcomes?

Peer support, particularly in combination with ATOD treatment, is generally associated with improved ATOD use outcomes. While the majority of research evidence has focused on participation in AA and other 12–step programs, similar benefits are expected to be gained from other peer support groups.

Studies show that AA attendance is associated with positive outcomes including reduced use, and fewer symptoms of dependence and Cocaine Anonymous attendance is associated with better drug outcomes such as greater levels of abstinence.[133,134]

Engagement with peer support groups, particularly after completing a treatment program, can significantly reduce relapse after treatment, result in longer periods of ongoing abstinence than treatment alone, and help improve social functioning of substance users who are focused on maintaining changes to their ATOD use.[134] Peer support provides continuing care and may reduce burden and costs in the health care system.[133]

w See: www.smartrecoveryaustralia.com.au/

How is it applied?

Peer support groups are based on the model of facilitating regular meetings of 1–2 hours for people with problematic ATOD use and dependence to share experiences, provide support and assist each other to resolve problems and cope with issues. Meetings are generally free or by donation and most are abstinence focused.

Important differences in how this model is applied relate to the specific program or philosophy of the group. The main models in Australia are:

- 12–step fellowships (AA, NA etc.), which use a 12–step spiritual program, and emphasise the acceptance of a "Higher Power" and spiritual growth to achieve 'recovery'. All members are in 'recovery' and the programs encourage long-term membership in their fellowships and newer members are supported by 'sponsors' who are senior fellowship members
- SMART Recovery groups use a cognitive behavioural therapy (CBT) based program focussed on key points of building and maintaining motivation to change, coping with urges, problem solving and lifestyle balance.

Other variations to how the peer support model is applied:

- Meeting participation is generally voluntary and participants can attend groups as intensively or for as long as they want
- Access to meetings can also be facilitated during residential treatment programs and can be considered a compulsory component of the treatment program
- Meetings are commonly face to face but some programs provide online support (e.g. SMART Recovery)
- Peer support groups can be focused on providing aftercare on completion of specific ATOD treatment program.

Who can deliver it?

Peer support groups are generally facilitated by non-professional peers with previous experience of problematic ATOD use or dependence. In some cases, groups can be assisted or led by health and drug and alcohol service staff (e.g. SMART Recovery groups).

Peer Support Groups in the ACT

Group based support services located in multiple settings throughout the ACT. These services include Al-Anon, Alateen, Narcotics Anonymous and Alcoholic Anonymous

Peer education and support in the ACT is provided by:

- The Connection, Canberra Alliance for Harm Minimisation and Advocacy (CAHMA): Available for Aboriginal and Torres Strait Islander men and women aged over 16 years, Monday to Friday.
- Canberra Alliance for Harm Minimisation and Advocacy (CAHMA): A peer based user group run by and for past or current/illicit injective drugs users, their families and friends.

8.2 Case management

Case management is employed in a wide range of service settings including health, welfare and the criminal justice arena. Case management is a particularly important aspect of care in the specialist ATOD sector as ATOD service consumers often have multiple and complex social, physical and mental health treatment needs.[135].

What is the intervention?

The NSW Health Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines define case management as:[87]

> A direct client service in which case managers and clients collaborate in comprehensive assessment, individual care planning, service facilitation, outcome monitoring and advocacy.

Who is it for?

The Substance Abuse and Mental Health Services Administration (SAMHSA) recommend using case management in a variety of ATOD settings especially for service consumers with special treatment needs including those who have a blood borne virus, those with mental health and chronic and acute health problems, and those experiencing social and economic disadvantage.[136] Service consumers with young children may also benefit from case management.

As many day-to-day difficulties are compounded by ATOD use, providing a continuum of services promotes positive outcomes for ATOD service consumers. Case management is the conduit to providing engagement and support to maintain motivation for treatment, primary treatment services at the appropriate level, and other services that will support consumers in their communities.[136]

What are the outcomes?

Research focusing on case management in the ATOD field is limited; however, some studies have shown that it is effective in retaining ATOD service consumers in care, thereby adding to the success of ATOD treatment more broadly. By linking service consumers with other important services required for a holistic approach to care and support; and may have a role in reducing ATOD use by service consumers when compared to psycho-education for example.[87,135]

How is it applied?

A number of models for the application of case management are used to guide practice and several are suitable for the specialist ATOD sector. The most common models utilised and evaluated for their efficacy of application to the ATOD sector include brokerage case management, clinical case management, and strengths-based case management:[136,137]

Brokerage/generalist model

The brokerage model is the foundation of case management. In this model, the case manager's role is to connect the service consumer to other relevant services and to coordinate the various service providers involved in the consumer's care. The major emphasis is on assessing the service consumer's needs, referring to appropriate services and coordinating support/care/treatment, while advocacy plays a minor role and monitoring of outcomes tends to be brief. The case manager connects the service consumer to clinical or treatment services without actually providing clinical care. This model is appropriate for ATOD services that employ workers with no clinical background or that offer a narrowly defined service.

Clinical case management

The clinical case management model builds upon the basic brokerage model and was developed in recognition that case managers must often act as clinicians by providing direct clinical services.

The role of the clinical case manager is to provide appropriate clinical interventions as well as sourcing the extra support needed by the service consumer (that is, brokerage + treatment = clinical case management). Clinical case managers provide services in four broad areas:[137]

1 Initial phase (engagement, assessment, planning)
2 Environmental interventions (linkage with resources, consultations with families and other care givers, collaborations with physicians and hospitals, advocacy)
3 Patient interventions (for example, psychotherapy, training in independent living skills, psycho-education)
4 Patient-environment interventions (for example, crisis interventions, monitoring)

Case managers need to be ATOD clinicians with skills in areas such as assessment, psycho-education and psychosocial interventions.

Strengths-based case management

This model was developed in response to concerns that approaches to case management tended to overemphasise the limits and impairments associated with psychiatric illness at the cost of overlooking personal assets that patients can harness toward achieving individual goals.[138] Rather than aiming for stabilisation and maintenance in the community, strengths-based case management emphasises improved quality of life and community reintegration. In this model, the case manager acts as collaborator and companion to the service consumer. The principles of the strengths- based model are:

- Focus is on individual strengths rather than pathology
- The case manager-service consumer relationship is primary and essential
- Interventions are based on a service consumer's self-determination
- The community is viewed as an oasis of resources not as an obstacle
- Contact with service consumers take place in the community not in the office or clinic
- Service consumers with severe disorders can continue to grow and learn.

Practitioners of strengths-based case management are also required to have a professional clinical background and specific training in this approach.

Who can deliver it?

Alcohol, tobacco and other drug workers with a minimum Certificate IV in Alcohol and Other Drugs and who have suitable supervision and supports in the workplace are able to provide brokerage case management to service consumers. Clinical case management is a step-up from brokerage, and case managers are clinicians with skills in areas such as ATOD assessment, monitoring of treatment progress, and evidence-based ATOD psychosocial interventions such as motivational enhancement and relapse prevention. Practitioners of strengths-based case management are also required to have a professional clinical background and specific training in this approach.

Case Management in the ACT

In the ACT, case management is provided through the following programs:

- Treatment and Support, Directions: Provides assessment, counselling, case management and support services for individuals of all ages and their families and friends impacted by ATOD
- Integrated Multi-agencies for Parents and Children Together (IMPACT), Alcohol and Drug Services, ACT Health: Provides ATOD counselling for adults, young people, family members and carers including therapeutic and education group.
- Police and Court Drug Diversion, Alcohol and Drug Services, ACT Health: Provides programs that aim to divert people apprehended for ATOD use or ATOD related offences from the judicial system into the health system.

8.3 Specialist ATOD primary health care

Primary health care (PHC) is often the first point of entry into the health care system for health care consumers, particularly through GPs and other PHC clinics. PHC is socially appropriate, collaborative, accessible, evidence-based, and delivered by a trained workforce in such a way as to prioritise care for those in most need.[139] People with ATOD-related issues however, are often marginalised and may have difficulty accessing mainstream PHC due to stigma, complex health problems, or lack of a Medicare card or Health Care concession card. Therefore specific services for people with ATOD-related issues can be a valuable way to reach this population. Specialist ATOD-focused PHC can also enable consumers to receive longer and more comprehensive consultations where required that are matched to complex health issues within a clinical setting that may also provide other forms of specialist treatment (e.g. AOD therapy).

What is the intervention?

PHC for the general community encompasses health promotion strategies, preventative health care (e.g. immunisation and general health checks), early intervention, and the treatment of illnesses. Specialist ATOD-focused PHC is inclusive of more specialised primary care checks. These include:[140,141]

- Assessment and management of general health issues
- Withdrawal management
- Smoking cessation
- Opioid overdose prevention including the provision of naloxone
- Blood testing for BBVs
- Immunisations for BBVs
- Monitoring and treatment of BBVs and associated therapy (e.g. Hepatitis C)
- Healthy liver clinic
- Sexual health testing and treatment
- Women's health checks, contraception
- ATOD assessment, therapy and referral
- Crisis intervention, support and therapy
- Welfare assistance and referral
- Medical and allied health services such as podiatry and dental care
- On-site or visiting support services such as legal services, financial counselling or housing assistance
- NSP services, vein and wound care
- Pharmacotherapy
- Basic material support services such as food and drink, telephone, showers.

Who is it for?

Specialist ATOD-focused PHC is suitable for all ATOD service consumers, although it is particularly suitable for people who inject drugs, young people, people working in the sex industry, those who are homeless, people experiencing complex and multiple health problems, and those due to other social and economic disadvantages are unable to access mainstream PHC services.

What are the outcomes?

Research into specialist ATOD PHC is lacking, possibly due to the challenges faced in conducting studies in these settings and lack of dedicated funding for the purposes of evaluation.[142] However, a recent review of PHC services for people who inject drugs found evidence for high levels of satisfaction among service consumers, increased access to health care, increased testing for BBVs, reduced severity of drug dependence, and continuity of care through return visits and follow-up.[140]

How is it applied?

Models of specialist ATOD PHC include 'distributive' models that offer harm reduction along with basic health care and referral for specialist health care, 'one-stop-shops' that provide basic and specialised health care onsite, and PHC clinics that operate from NSPs or other specialist drug treatment services.[140]

Who can deliver it?

Specialist ATOD primary health care services are typically provided by a multi-disciplinary team comprising general practitioners, nurses, psychologists, AOD workers, and other allied health practitioners who are also trained to respond sensitively and effectively to people who use alcohol, tobacco and other drugs.

Specialist ATOD primary health care in the ACT

In the ACT, primary health care for ATOD consumers is provided through the following service:

- The Althea Wellness Centre, Directions Health: Provides a primary health care centre for ATOD service consumers and specialises in medical issues related to ATOD use including immunisations, vein care, wound care, chronic disease management, therapy and referral.

8.4 Consultation liaison by specialist ATOD services

Consultation liaison (CL) is a service designed to provide specialist ATOD advice, secondary consultation and services within non-ATOD specific health care environments such as general hospitals.

What is the intervention?

Similar to those offered by CL psychiatry services for example, ATOD CL services are conducted in hospitals or other relevant service settings such as mental health and homelessness services. Specialist ATOD services offered to service consumers include ATOD assessments, brief interventions, motivational interviewing, psycho-education concerning ATOD use, and referral to ATOD treatment. ATOD CL staff members also assist the primary treatment or support team by providing secondary consultation and advice about the management of ATOD issues within their particular service setting, as well as providing activities to increase the capacity of these services to better respond to people with ATOD issues. Staff members of ATOD CL services also provide information and support to families of those with ATOD-related issues.

Who is it for?

ATOD CL services are suitable for service consumers in other health and welfare settings in which CL services are offered, and who have been identified as having an ATOD issue by the staff of those service settings.

What are the outcomes?

Issues related to the use of ATOD are frequently not detected in health settings such as emergency departments and acute care settings.[143] ATOD CL services are designed to increase the identification of service consumers with ATOD problems in non-ATOD service settings, to

improve treatment pathways for service consumers with ATOD-related issues, and to build the capacity of mainstream services to detect and respond to people with ATOD problems. Specialist ATOD CL services have been shown to be effective in linking service consumers with ATOD treatment.[143] An evaluation of ATOD CL services in NSW is currently being conducted by the National Drug and Alcohol Research Centre.

How is it applied?

Staff members of ATOD CL services respond to referrals from workers in partner services/ settings and conduct individualised assessments and provide other services to consumers in the setting where the referral originated.

Who can deliver it?

ATOD CL services are provided by a range of staff members with backgrounds such as medicine, nursing and allied health who are trained in the CL model.

ATOD Consultation Liaison Services in the ACT

In the ACT, Consultation Liaison Service are provided through the following program:

- Consultation and Liaison and Comorbidity Service, Alcohol and Drug Services, ACT Health: Provides consultation and liaison support, assessment information and referrals for adult males and females in The Canberra Hospital who are experiencing ATOD issues.

APPENDIX 1

Table 1. Mapping of the ACT specialist alcohol, tobacco and other drug treatment sector to the Alcohol and Other Drug Treatment Services National Minimum Dataset (AODTS-NMDS)[144]

ACT Specialist Alcohol, Tobacco and Other Drug Treatment Sector Area	Corresponding AODTS-NMDS category
Harm reduction approaches:	
Needle and syringe programs	Other
Peer education	Information & education only
Opioid overdose education and management including the provision of naloxone	Information & education only Pharmacotherapy
Sobering up shelters	Other
Withdrawal management	Withdrawal management (detoxification)
Medicated withdrawal	
Non-medicated withdrawal	
Psychosocial interventions	
Screening	Assessment only Other
Brief intervention	Information & education only
Assessment	Assessment only
Brief therapy	Counselling
More intensive psychological therapies	
Cognitive behavioural therapies	Counselling
Contingency management	Other
Group therapy	Counselling
Peer support	Other
Pharmacotherapy	Pharmacotherapy
Pharmacotherapies for opioid dependence	Pharmacotherapy
Nicotine replacement therapy	Other
Pharmacotherapies for alcohol use disorders	Pharmacotherapy
Residential rehabilitations	Rehabilitation
Day programs	Rehabilitation
Aftercare	Other
Other aspects of ATOD care	
Case management	Support and case management only
Primary health care for ATOD service consumers	Withdrawal management Counselling Pharmacotherapy Support and case management only Information and education only Assessment only Other
Consultation liaison by specialist ATOD services	Counselling Support and case management only Information and education only Assessment only Other

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