

CREIDU submission to the VAADA consultation on the Proposed Victorian Alcohol and Drug Treatment Principles

The development of principles to guide the Victorian Alcohol and Drug Service System is supported by the Centre for Research Excellence into Injecting Drug Use (CREIDU) based at the Burnet Institute. While we have a particular interest in the service system from the perspective of people who inject drugs, our comments are broader. We believe that the principles need to reflect changes to service delivery that could be expected from a ‘whole of government’ reform. That is, the treatment system must address the issues faced by people who experience alcohol and other drug problems of varying severity, rather than sole (albeit important) focus on serious dependence. Focus just on the serious problem end of the continuum reinforces stereotypes that all people with alcohol and drug problems require specialist care and that it is beyond the scope of practice and expertise of those who are best positioned to intervene (for example, primary health services and others that are in daily contact with people experiencing alcohol and other drug problems).

It is with that more comprehensive context in mind that we offer the following feedback on each of the proposed principles.

1. The nature of addiction

The NIDA principles make an explicit statement about the nature of alcohol and drug addiction. This principle speaks to the neurological and ongoing impact of alcohol and drug use and treatment opportunities.

Key concepts:

- a) Addiction affects brain function and behaviour
- b) Addiction is complex
- c) Addiction is treatable
- d) Lapse and relapse are a feature of recovery from addiction

1.1 Is a principle about the nature of addiction appropriate?

1.2. Have you any comment about the key concepts provided?

CREIDU response

This is the most problematic of all the principles for a number of reasons.

The most important point to make is that this is not a principle and the concept does not lend itself to easy drafting into a principle. Nor is there any good logic for trying to incorporate it. You could include commentary about addiction (or dependence as we argue below) in a preamble or

introductory section but then it would be important to put it in context (as outlined below) - possibly including reference to:

- Population research that shows that although the dependence liability varies across drug types, the majority of people who use alcohol and other drugs do not become dependent (Wagner & Anthony 2002).
- For drugs such as alcohol, most of the harm that arises is associated with non-dependent use (Cunningham & McCambridge, 2012).
- Most people who do become dependent on drugs such as alcohol resolve it themselves without treatment (Kalant 2010).
- Prevention and early (and often brief) interventions for those at risk but not dependent are critical components of the service system. Such services would be most appropriately provided in primary care settings supported by the specialist treatment system (for example by providing secondary consults and accepting client referrals).
- A smaller clinical sub-population with serious dependence and complex care needs will require a range of harm reduction, treatment and recovery services. Long-term remission for this group, and in particular opioid dependent users may be low (Calabria et al. 2010; Hser 2007) and mortality and morbidity high (Degenhardt et al. 2010). For this group service intensity will be higher to match severity and a broader range of easily accessible services will be needed to address complex treatment and recovery needs.
- A 'whole of government' alcohol and other drug service system will provide a continuum of services to meet the needs of people at risk of or experiencing early stage alcohol or other drug problems (non-dependent or less severely dependent) through to those with serious dependence and complex care needs.

It is important to note that the use of the word 'addiction' is deliberately not used by either of the two main classification systems: ICD-10 (WHO 1992) or DSM-IV (APA 2000). Dependence is the term of choice and with 'drug abuse' makes up the broader DSM-IV category of 'substance use disorders'. This avoids the often pejorative and stigmatising term 'addict' which tends to define the whole person rather than an aspect of their behaviour. This is the same as describing a person as a schizophrenic rather than a person suffering from schizophrenia; or an injecting drug user rather than a person who injects drugs. The term addiction may be reintroduced as part of the development of DSM-V due to be released next year, but change is less likely in the review of ICD-10 that is underway. The terminology should reflect the current state of play. We suggest that if this principle remains, the term dependence should be used.

As mentioned above, a whole of government response that promotes prevention, early intervention and treatment should not focus only on addiction/dependence. Much of the work of health, welfare and specialist practitioners should and does target people who are not dependent (or 'addicted') but may already be experiencing harm as a result of their drug use, or are at high risk of developing harm.

One of the key concepts listed is "addiction affects brain function and behaviour." This is too narrow and prioritises disease and neurobiology over the many other factors that are known to contribute to dependence. We need to acknowledge genetic predisposition and the neurobiological changes that can occur when someone becomes dependent. But we must not do this at the expense of the

complex psychological and social factors that also contribute to dependence. The biopsychosocial model still provides the best explanation of developing dependence (and associated strategies in combination that provide the most effective ways of treating it) (see Cunningham & McCambridge, 2012).

2. Treatment accessibility

A common principle identified in the literature relates to treatment accessibility. Such a principle draws on theories of individual treatment readiness to highlight the importance of a treatment system that can meet demand and respond to individuals at times most beneficial to their treatment outcomes.

Key concepts:

- a) Treatment should be readily available
- b) The treatment system should be accessible from multiple points of entry i.e. a 'no wrong door' approach
- c) Treatment should be perceived as caring and accepting by the consumer

2.1 Is a principle about treatment access appropriate?

2.2 Have you any comment about the key concepts provided?

CREIDU response

This is an important principle. The important point that we would make again is that a service system needs to provide appropriate treatment opportunities for a wide variety of people. The principle needs to be expressed in the broadest terms to ensure that strategies to be developed to operationalize it are inclusive. Some examples of treatment accessibility issues that should follow from a broadly stated accessibility principle include:

- Access for people experiencing problems of different severity (a continuum from brief interventions for non-dependent users; to medically oriented withdrawal services for serious alcohol-related problems)
- Access to suitable services for people who are not traditional clients of specialist treatment services (e.g. those experiencing problems with prescribed pharmaceuticals)
- Access for those residing in remote locations (with limited capacity/opportunity to travel)
- Access for those who have limited capacity to pay (e.g. those currently struggling to pay pharmacotherapy fees)
- Access for those with a variety of special needs (e.g. cultural sensitivity; mothers with children; victims of domestic/sexual violence; people at risk of re-offending, etc.)

3. Continuity of care

Continuity of care principles typically acknowledge the importance of providing treatment systems and programs which respond to the chronic and relapsing nature of addiction. This means offering multiple episodes of treatment, treatment of adequate duration, post-treatment follow-up and appropriate intra and inter-sectoral linkages.

Key concepts:

- a) Remaining in treatment for an adequate period of time is critical
- b) Effective drug abuse treatment may require multiple treatment episodes
- c) Post-treatment follow-up is important
- d) Continuity of care typically requires working with other providers
- e) Treatment should address community reintegration

3.1 Is a principle about continuity of care appropriate?

3.2 Have you any comment about the key concepts provided?

CREIDU response

Continuity of care is important in a number of ways. The 'system' should have capacity to respond to people who are not dependent but using alcohol or other drugs in ways that are causing harm or have the potential to cause harm to individuals and those around them. This means early intervention for non-dependent use (for example provided by a GP in his/her surgery). The system should also cater for the needs of people who may be dependent that need some advice or assistance to overcome their dependence (i.e. they may be experiencing some problems but it can be resolved without intensive treatment). For these people the term 'chronic and relapsing' does not apply and caution is needed in the use of this term. Importantly, those that experience serious dependence often with psychiatric, physical and social comorbidities need to have access to intensive treatment. Continuity of care in the system therefore requires that people who fall on this drug use and harm continuum have access to advice, support and treatment in a range of settings (of varying intensity to match severity) and that seamless transition from one service to the next is available for those who need it. The recent emphasis on recovery reinforces what good programs already do – from day one they commence the process of preparing a person for the post-treatment phase of their recovery. They offer seamless continuity between the various components of drug treatment (for example from withdrawal to rehabilitation services); they provide continuity with their own service through post-treatment support groups; or they may encourage continuity of care by actively linking people to peer support groups. This principle strongly relates to 'integrated care' and it may be that 'integrated and continuous care' is one principle.

4. Harm minimisation approach

A harm minimisation approach focuses on reducing the harm to individuals and the community from alcohol and drug use. The National Drug Strategy 2010-2015 (2011) identifies supply reduction, demand reduction and harm reduction as key pillars of a harm minimisation approach. In the Victorian treatment sector, harm minimisation approaches are reflected in the provision of safer using information, needle and syringe exchange programs, brief interventions and a range of other work focussed on enhancing the safety of clients.

Key concepts:

- a) the safety of clients is paramount
- b) interventions range from information and education to the provision of safer using equipment
- c) delivered in treatment settings as well as through harm reduction services

- 4.1 Is a principle about harm minimisation appropriate?
4.2 Have you any comment about the key concepts provided?

CREIDU response

As harm minimisation is the overarching principle of the national and state policies it is important and should appear earlier on this list (possibly first). As currently stated, the key concepts are skewed towards harm reduction. This is important but needs to be broadened a little to capture the broader concept of harm minimisation. In particular, demand reduction needs to be emphasised. The key point is that the current and future reality is that a continuum of screening, assessment and treatment services is required to meet the needs of people experiencing alcohol and drug problems of varying severity. It also needs to stipulate that services can and will be effectively provided by a wide range of specialists and non-specialists. The second point is to give a little more emphasis to the educative role played by the treatment service system to prevent problems: to advise and support those who are concerned about their own drug use or that of others; or to intervene early to arrest a developing problem. Examples of this role include resources provided to the public by the ADF; on-line access to quizzes/screening to assist decisions about seeking help; anonymous telephone advice and support for family members concerned about drug use of a family member; and early intervention programs including drink/drug driving interventions.

5. Individualised and holistic care

Principles addressing individualised care focus on providing services that respond to the individualised needs of clients. This requires a service system that can provide multiple service types and treatment modalities, appropriate treatment pathways, capacity to engage in care coordination and leverage intra and inter-sectoral linkages. This includes responding to co-occurring conditions such as mental illness and working with forensic and other specialist treatment systems. In some literature, a holistic service response is a key component of individualised care. Holistic care reflects a broad understanding of the life circumstances of individuals in treatment and recognises the importance of responding to diversity in the treating population. Holistic practice is cognisant of the age, gender, race, ability, location, social, cultural, economic, family, and relationship circumstances of the individual. It requires cultural competence, gender sensitivity, capacity to work across different ages and stages of life and to work with client, family and other people in caring relationships.

Key concepts:

- a) Treatment systems should offer a variety of treatment types, interventions and modalities
- b) Treatment should be individualised according to unique needs of clients
- c) Effective treatment attends to multiple needs of the individual, not just his or her drug abuse

- 5.1 Is a principle about individualised and holistic care appropriate?
5.2 Have you any comment about the key concepts provided?

CREIDU response

We agree that this principle is important, particularly the reference to gender and cultural sensitivity. We make the point in relation to integrated care that there are often multiple comorbidities experienced by people seeking treatment. '**Complex care needs**' is a term that captures this well. This addresses the issue of inappropriate use of terminology such 'dual-diagnosis' and 'comorbidity' (when the conditions are not defined/listed) which are presumed to mean AOD and psychiatric problem co-occurrence. Throughout this document mental health comorbidity is often the example given. We suggest mentioning others on occasions as evidence of complex presentations. For example someone who injects drugs who is HIV, HBV and HCV positive demonstrates the need not to underemphasise physical comorbidity. Adding some of the social comorbidities (e.g. homelessness and unemployment) emphasises the need for the 'complex care needs' or similar terminology.

6. Evidence-based practice

Principles focussed on evidence-based practice articulate a need for robust and timely knowledge transfer from research and practice to the field of direct service delivery and treatment. Some evidence based practice principles are high level and systems-oriented, identifying the importance of using the best evidence available, while others identify specific clinical interventions known to be effective.

Key concept:

a) Treatment should be based on the best evidence available

6.1 Is a principle about evidence-based practice appropriate?

6.2. Have you any comment about the key concept provided?

CREIDU response

This principle is the cornerstone of a system concerned with maximising client outcomes. It is worth noting that this principle should be supported by evidence-based policy (mentioned in 'other comments' below). The evidence-based practice principle, as with harm minimisation should provide the context for other principles. That is, principles such as 'individualised and holistic care' and 'recovery approaches' should be informed by the best available evidence. For this reason we argue that it should be listed as the second principle after harm minimisation.

To operationalise the principle there needs to be reference to what constitutes evidence. What we mean is a combination of:

- Evidence derived from scientific study (efficacy and effectiveness). This allows us to base service funding decisions on what we know to be important in achieving better treatment outcomes (e.g. needle and syringe programs, pharmacotherapy maintenance, brief interventions, programs incorporating Motivational Enhancement Therapy ; Cognitive-Behavioural Skills Training; Behavioural Couples Therapy, etc.). It should not constrain government from supporting 'promising practice' with built in evaluation, but should assist

decision making about programs and approaches that have been consistently demonstrated to be ineffective or counterproductive.

- Evidence based on the collective wisdom of experienced alcohol and other drug clinicians/practitioners.
- The lived experience of people who have experienced substance use disorders, have an experience of the treatment system and who have experience of the recovery journey.

The adoption of evidence-based practice that flows from this principle would have a number of implications. Service funding may need to be re-oriented to support approaches that have been clearly demonstrated to be effective. Service agreements may need to specify the evidence-based strategies that would be expected to be provided in funded agencies. Some resources may need to be allocated to support agencies to implement evidence-based practices (training, provision of tools, support to evaluate strategies, etc.).

It will also be important to ensure that innovation is not stifled. As mentioned above 'promising practice' also needs to be supported. These are practices where there is some scientific support or data showing positive outcomes but insufficient to support generalizable conclusions. Adding an evaluation component to such practice will be important and would require additional resources.

7. Integrated care

Integrated care principles typically focus on the need for coordinated care responses across a range of providers to meet the multiple needs of alcohol and drug clients. Integrated care may involve practitioners from different sectors.

Key concepts:

- a) alcohol and drug treatment systems should be integrated with mental health systems to reflect comorbidity among alcohol and drug clients
- b) alcohol and drug treatment providers should coordinate with related specialist and generalist health providers, according to client need
- c) alcohol and drug treatment providers should coordinate with housing, employment and other community service providers, according to client need

7.1. Is a principle about integrated care appropriate?

7.2. Have you any comment about the key concepts provided?

CREIDU response

This principle is important and supported. We think there is considerable overlap between this principle and others such as 'individualised and holistic care' and the 'recovery approach' – although we acknowledge that it would be difficult to remove any or all overlap. An important consideration is that integrated care at the service level will be easier to operationalise if it is supported by tangible evidence of integration at a policy level. That evidence will include collaboration/integration between different parts of government (health, justice, child protection, education etc.) The expectation is that this will be achieved through the articulation of the 'whole of government approach' due shortly. The integrated care principle is addressed to some extent in the feedback on other principles. We want to reinforce (as discussed above) that reference to comorbidities needs to

include psychiatric, physical and social - given the extent to which they are present in many of those with serious dependence. We urge the use of terms such as **complex presentations, complex care needs** and **complex care**.

8. Recovery approach

A recovery approach is strength and hopes based. It recognises and builds on an individual's strengths and resilience, connecting them with systems and supports to assist them in their journey towards wellbeing. A recovery approach sees the individual's time in treatment as just part of this journey and acknowledges meaningful social engagement, self-determination and choice.

Key concepts:

- a) individuals can and do recover
- b) service providers build on individuals' strength and resilience
- c) collaborative partnerships with other services and systems are critical
- d) social inclusion as a treatment goal

8.1 Is a principle about recovery appropriate?

8.2 Have you any comment about the key concepts provided?

CREIDU response

A recovery orientation is not a new concept to those who have traditionally provided good quality, evidenced based services, even at times when policies and resource constraints have limited the capacity to do this well. Including it as a principle may be an important way to emphasise how it fits within a harm minimisation framework and what the research evidence clearly demonstrates:

- Treatment needs to be tailored to meet the specific needs of individuals and they must play a central role in the treatment planning process. This leads to improved treatment outcomes.
- Clients with severe dependence issues often present with complex care needs (multiple comorbidities): physical (Hepatitis, cardiovascular diseases, STIs etc.), psychiatric (particularly anxiety and depression) and 'social' comorbidities (homelessness, legal problems, unemployment etc.). The treatment phase of the recovery process requires that these issues are adequately assessed and plans implemented to commence what might be a long (sometimes life-long) process in addressing them. This will frequently require collaboration/integration with other service providers. Resolving or better managing these issues will be an important step in the recovery process (i.e. achieving a better quality of life rather than just abstinence from drug use).
- Building on strengths and developing resilience is critical and this can be achieved through the quality of therapeutic engagement; involving families in all aspects of the process where it is feasible to do-so; providing evidence-based interventions to motivate (e.g. Motivational Interviewing and Motivational Enhancement Therapy) to develop skills (e.g. cognitive behavioural skills training) to enhance family support (behavioural couples or family therapy) and to promote ongoing support for the post-treatment phase of the recovery process (by families, employers and peer support groups, etc.).

As discussed under the 'evidence-based practice' principle, it is important to recognise that evidence is most usefully understood to be a combination of the scientific research literature, the practice wisdom of experienced clinicians and the experience of those who have experienced a substance use disorder and those that care for them. It is this combination that will provide the best opportunity for reinforcing important evidence-based strategies to assist long-term recovery.

It is worth noting that 'recovery' implies illness and this is not a term universally agreed to by staff or clients of the alcohol and drug service system who subscribe to the biopsychosocial model of drug dependence. It also has less applicability for people who may be experiencing harm but are not dependent, or people experiencing less severe dependence. These people typically will not have experienced the social disintegration and other problems often associated with serious dependence and are less likely to view alcohol or other drug problems as an illness. The use of illness and recovery terms for these groups may add to stigmatisation and reduce treatment seeking behaviour. The term is more applicable for the smaller proportion of people who experience severe dependence who typically present to the specialist service system with multiple and complex issues. We suggest that the term 'recovery' therefore needs to be better defined and used more cautiously.

9. Client, carer and family participation

Reference to meaningful participation by clients and those in caring relationships is articulated in the 2007 COCE principles and as an underpinning commitment (rather than principle) of the National Drug Strategy 2010-2015. Key Victorian policy documents, including the Alcohol and Other Drug Client Charter 2011, also articulate the importance of client, carer, family and community participation in care.

Key concepts:

- a) The knowledge and experience of alcohol and drug clients, carers and families should be recognised at all levels of the alcohol and drug treatment system
- b) Clients should be active participants in their treatment planning
- c) Where appropriate, carers and family of the primary alcohol and drug client should be meaningfully engaged in treatment planning
- d) The community has a vital role in supporting the recovery of alcohol and drug clients

9.1 Is a principle about client, carer and family participation appropriate?

9.2 Have you any comment about the key concepts provided?

CREIDU response

This is an important principle and in its broadest sense refers to participation in (1) treatment planning and delivery, (2) participation in organisational policy development, and (3) development of policy at the state-wide systems level. The research evidence is supportive showing that people presenting for treatment have different needs, goals and expectations of treatment. The notion of 'one-size-fits-all treatment' or treatment agencies know best' are long gone. Treatment needs to be tailored for people based on their input into the treatment planning process. Research also points to better engagement in treatment, treatment outcome and recovery when family members are engaged/informed/supportive.

It is also critical that people with direct experience of the service system have an opportunity to influence policy at the organisational and system level. Therefore the strategies that will align with this principle would be expected to include structural arrangements (such as board membership, committee involvement, routine consultation strategies etc.) for client, carer and family participation at all three levels.

10. Workforce

A strong and capable workforce is an essential component of any robust service system. Victoria's Specialist Alcohol and Other Drug Workforce Framework: Setting the Agenda identifies opportunities to build, strengthen and grow the alcohol and drug workforce consistent with contemporary knowledge about treatment, systems and workforce development.

Key concepts:

- a) Suitably qualified and experienced workforce
- b) Competencies should be based on requisite skills, knowledge, values and attitudes
- c) Staff are supported at team, organisational and sector levels

10.1 Is a principle about workforce appropriate?

10.2 Have you any comment about the key concepts provided?

CREIDU response

Workforce is critically important and a principle that emphasises the need for a strong and capable workforce makes sense. The first point to make is that with the introduction of the whole of government strategy we need to think of the workforce as extending well beyond the specialist component of the service system. The training and support needs should be considered in this context.

In relation to specialist services, the research is clear about the extent to which worker experience and personal characteristics (values, interpersonal skills etc.) are important in the establishment of therapeutic alliances and the extent to which this influences client outcomes. This may be more important than the knowledge and skill necessary to deliver specific treatment technologies. What seems important is the capacity to attract and retain people that are suited to this work. This means increasing the talent pool to draw from by making work in this sector more attractive (career opportunity; parity of salary and conditions, etc.).

It will also be necessary to increase the skill of the workforce overall. This can be achieved through an overall increase in basic qualifications (from Cert-IV to diploma level), higher level qualifications for senior clinicians, better supervision and mentoring opportunities etc. The workforce strategy needs to prepare all staff for changing expectations about how they do their work. For example, more emphasis on evidence-based practice; evaluating service processes and outcomes; and greater expectations about service integration. This will require changes to role statements, professional development, supervision and possibly some funding arrangements (to name a few).

Another important consideration is the strategies that can be introduced to ensure that those with lived experience can be assisted to combine that experience with the skills needed provide effective treatment for others.

In relation to concept b) that states that ‘competencies should be based on requisite skills, knowledge, values and attitudes’ – by definition that’s what competencies are.

11. Other CREIDU comments

The service system reform process should be underpinned by a principle of **evidence-based or informed policy** and a principle to this effect would be welcome. This would support the widespread introduction of evidence-based practice and assist government to prioritise finite funding to programs that have been demonstrated to be effective or are promising.

A theme that should appear as a principle is that the treatment service system must emphasise **earlier intervention**. This will be particularly important when the whole of government approach is articulated. There are aspects of the current service system that are designed to intervene earlier and this would be expected to increase (as would primary prevention services) when the base of treatment is broadened by the inclusion or better integration of other service providers. The research clearly demonstrates the need for earlier interventions, particularly for young people where early onset harmful drinking is predictive of dependence and associated problems later in life (Chen et al., 2009)

Another principle that could be formulated relates to **high quality care provision**. This is sufficiently different from evidence-based practice to warrant separate inclusion. This relates to adherence to quality processes (e.g. as outlined in QICSA requirements) rather than approaches/services that have been demonstrated to directly improve treatment outcomes for individuals.

12. References

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington DC.
- Calabria, B, Degenhardt, L, Briegleb, C, Vos, T, Hall, W, Lynskey, M Callaghan, B Rana, U and McLaren, J. (2010). Systematic review of prospective studies investigating remission from amphetamine, cannabis, cocaine or opioid dependence. *Addictive Behaviors*, 35, 741-749.
- Chen C-Y, Storr CL, Anthony JC. (2009). Early-onset drug use and risk for drug dependence problems. *Addictive Behaviour*; 34:319–322.
- Cunningham, J., & McCambridge, J. (2012). Is alcohol dependence best viewed as a chronic relapsing disorder? *Addiction*, 107(1), 6–12.
- Degenhardt, L, Bucello, C, Mathers, B, Briegleb, C, Ali, H, Hickman, M and McLaren, J. (2010). Mortality among regular or dependent users of heroin and other opioids: a systematic review and meta-analysis of cohort studies. *Addiction*, 106, 32-51.
- Hser, Y-I. (2007). Predicting long-term stable recovery from heroin addiction: Findings from a 33 year follow-up study. *Journal of Addictive Diseases*, 26(1), 51-60.
- Kalant. H. (2010). What neurobiology cannot tell us about addiction. *Addiction*, 105, 780–9.

Wagner FA, Anthony JC. (2002). From first drug use to drug dependence: Developmental periods of risk for dependence upon marijuana, cocaine, and alcohol. *Neuropsychopharmacology*, 26, 479–488.

World Health Organization. (1992). *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*. Geneva, Switzerland: World Health Organization.

Author: Trevor King

September 28th, 2012