

This section provides a summary of evidence regarding effective treatment interventions for those with alcohol and other drug related problems. The chapter is organised around a notional intervention cycle, from screening and brief intervention through to aftercare and follow up, before considering evidence related to the interaction of service components. It should be noted that throughout this section, reference is also made to potential performance indicators under each component of the service system.

These indicators are also repeated in Chapter 6 to allow consideration of all indicators together when considering the associated recommendation.

5.1 The role of primary health care services

Approximately 80% of the Australian population have contact with a General Practitioner in any twelve month period, and in remote areas, this contact is often with nursing staff at local health centres instead. The available data and earlier reviews of the literature (Heather et al. 1989) highlight that there is a significant proportion of the population who may experience harm from alcohol and other drug consumption, but who are unlikely to seek specialised treatment or benefit from intensive treatment, do benefit from screening and minimal interventions. A range of investigators in 1970s and 1980s provided evidence that provision of assessment regarding alcohol or other drug use and provision of information had a comparable effect to other more intensive forms of treatment (Orford and Edwards, 1977), though this effect related primarily to clients with stable lifestyles in supportive environments.

Accordingly, in developing performance indicators we have assumed that in an ideal system, primary health care services would be undertaking some screening for harmful alcohol and other drug use as a prelude to brief intervention or referral. While the literature provides a range of potential tools to support screening, the primary focus is on assessing the extent to which current alcohol or other drug use may be harmful. Where use may be harmful a range of brief interventions are appropriate

such as the provision of self help materials and may extend to a brief assessment, providing advice (in a one off session), assessment of the client's readiness to change (motivational interview), problem solving, goal setting, relapse prevention, harm reduction and follow up (Heather 1995).

Heather (1995) argued that the evidence indicates clients who are experiencing few problems related to their substance use, have low levels of dependence, or who are not wishing to substantially reduce their drug use benefit from brief interventions. Further a randomised controlled trial demonstrated that brief intervention was beneficial in treating cannabis dependence (Copeland et al. 1999).

5.2 Provision of assessment and treatment matching

The literature provides strong support for detailed assessment of clients, and matching clients to appropriate interventions. This section considers the literature and suggests performance indicators that will reflect application of this evidence base.

5.2.1 Assessment

Where clients are identified as potentially requiring specialist intervention for alcohol and other drug use, or attend such services seeking assistance, there is considerable evidence to indicate that a comprehensive assessment of clients is essential in both engaging clients in treatment and ensuring that the most appropriate interventions are provided. Ideally an assessment will result in a summary of the facts relating to an individual client, establish treatment goals and plans acceptable to the client (Mattick and Hall 1993), and consist of both formal and informal components (Dale and Marsh 2000). Accordingly, it should be stressed that assessment is not simply a process of determining whether or not a client is appropriate for admission to a specific service.

Informal components of an assessment should include (Dale and Marsh 2000 p.4):

- background and personal history (family composition and history, childhood experiences, adolescent experiences,

experiences of school, occupational history, sexual and marital adjustment, legal issues, financial and housing information and risk taking behaviours).

- support networks.
- basic personality.
- strengths and weaknesses.
- previous illnesses.
- drug use history.
- cognitive functioning.
- suicidal ideation.
- motivational interviewing - to assess and enhance readiness to change.

In addition to informal assessment, the literature also supports the use of a range of standardised instruments to facilitate establishment of an objective measure of a client's situation, particularly in terms of dependence to support treatment matching, and level of cognitive function where this may be a concern. In addition, use of standardised measures provides a basis for assessing clients' progress as a result of treatment where these measures are also applied at the conclusion of treatment (Mattick and Hall 1997).

A proportion of clients attending for assessment may choose not to pursue further intervention. As noted above, (5.1) there is clear evidence that the provision of feedback regarding current drug use, provision of information about alcohol or other drug use and available services, and where appropriate utilising motivational interviewing provide a positive benefit to clients.

5.2.2 Matching clients to treatment

Heather et al. (1989) note that a significant question arose regarding the efficacy of alcohol and other drug treatment in the 1970s and 1980s, and that initial findings suggested that traditional interventions were no more effective than providing feedback and information. However, subsequent investigations (e.g. Kite et al. 1996) have suggested that while there is no additional benefit for residential interventions, there is reasonable evidence that a range of

factors impact on the most appropriate type of treatment for an individual, including:

- a social network that supports drinking or drug use requires more intense intervention (Beattie and Longabaugh, 1997);
- alignment of problems addressed by an intervention with those experienced by a client (Miller and Hester 1986);
- matching with a treatment that is congruent with client's cognitive style (e.g. internal versus external 'locus of control') (Miller and Hester 1986);
- those with more severe problems benefit differentially from more intensive (though not necessarily inpatient) treatment (Miller and Hester 1986); and
- those who chose their treatment approach from among alternatives show greater acceptance of, compliance in, and improvement following treatment (Miller and Hester 1986).

5.3 Sobering up shelters

Dale and Marsh (2000) argue that in order for sobering up shelters to operate effectively they need support from and collaboration with local police, community patrols and welfare agencies working from a community development framework that emphasises engagement with other community organisations. In addition, they argue that a sobering up shelter should provide:

- a safe environment for clients sleep off the effects of alcohol and other drugs;
- a clean bed to sleep in;
- a shower and clean clothes or washing facilities for clients;
- regular observation by staff trained in first aid and identifying withdrawal symptoms; and
- a link to further treatment for clients wishing to access it.

5.4 Community-based counselling services

Heather et al. (1989) report that there is limited evidence to support general counselling as an effective intervention for alcohol and other drug problems when compared with the impact of a thorough assessment and provision of feedback, advice and information. However, where a more structured approach to counselling drawing on a theoretical base is applied positive outcomes can be identified.

Accordingly, counselling should include:

- behavioural approaches such as contingency management (aversion therapy, covert sensitisation, contingency management, broad spectrum approaches tailored to individual client needs);
- behaviourally oriented family therapy (Miller and Hester, 1986);
- self management training (Miller and Hester, 1986);
- motivational interviewing (Allsop et al. 1988 (cited in Heather et al. 1989)); and
- relapse prevention (Marlatt et al. 1985).

Consistent with the above findings, Dale and Marsh (2000) argue that counselling should include:

- linking clients with appropriate services whilst client is still engaged;
- anticipating and developing strategies with the client to cope with difficulties before they arise;
- specific evidenced based interventions where appropriate (e.g. goal setting, motivational interview, problems solving etc);
- focus on positive internal and external resources and successes as well as problems and disabilities; and
- where appropriate, involve a key supportive other to improve the possibility of behavioural change outside the therapeutic environment.

5.5 Detoxification Services

Detoxification represents a relatively straight forward intervention for alcohol and other drug problems for which broadly accepted clinical guidelines exist. Medicated and non-medicated detoxification can be undertaken on an inpatient basis or at home. Where there is no history of severe withdrawal, fits or acute organic brain syndrome, no current signs of withdrawal, no medical illness or evidence of psychiatric disorder or suicidal ideation home detoxification is indicated (Heather et al. 1989).

Dale and Marsh (2000) conclude that detoxification should be a gateway to further treatment including links to other services, that non-using significant others should be engaged as supports and that detoxification of pregnant women should include involvement of a specialist obstetric service.

5.6 Pharmacotherapy

While pharmacotherapies are available for a range of substances, the discussion here focuses on treatment of opioid dependence as this is the primary focus of pharmacotherapy in the Northern Territory. Heather et al. (1989) argue that due to controversy over the goals of treatment and differences in treatment policy there is little firm evidence that methadone maintenance is more effective than other interventions, but that it is a treatment of choice for opioid users.

Similarly, a range of studies have found that buprenorphine is as effective as methadone (e.g. Ritter et al. 1997) with the added advantages of no rush when it is injected and the withdrawal symptoms appear milder than for heroin or methadone (Dale and Marsh 2000).

However, Heather *et al* (1989) argue that pharmacotherapy for opioid dependence provides additional benefits due to retention of clients in treatment and improvements in health, reduction in drug use and reduction in criminal behaviour. Dale and Marsh (2000) suggest that best practice methadone and buprenorphine maintenance will include:

- maintenance treatment is provided over extended periods of time (2 to 3 years); and
- gradual withdrawal with approval and support from the prescribing doctor.

5.7 Community-based rehabilitation programs

It was noted during site visits and service mapping that a number of services provided a structured program for clients in the community. Review of the literature undertaken by Dale and Marsh (2000) indicated that a number of activities or characteristics were shown to provide a positive impact on clients participating in this style of intervention, and particularly:

- interventions to address drug use difficulties and issues identified in assessment;
- efforts to match clients to interventions with the flexibility to address the needs and goals of individual clients;
- provision of linkages to ancillary services, such as medical services, housing, employment and recreation services;
- provide both individual and group therapy;
- cognitive behavioural based interventions related to stress management, assertiveness, relapse prevention; and
- exploration of harm reduction strategies.

5.8 Residential rehabilitation

Heather et al. (1989) argue that there is no empirical evidence to support residential treatment over non-residential treatment, and that the content of programs should be comparable to those programs operated in the community (see 5.7 above). However, it is also noted that some client characteristics indicate that residential treatment is more appropriate. These characteristics include (Dale and Marsh 2000):

- social support networks that support continued alcohol or drug use;
- lack of a primary relationship;

- poor or no stable housing; and
- cognitive deficits requiring a highly structured environment.

The components of a residential rehabilitation program found to be effective are comparable to those for community based rehabilitation programs with an additional focus on planning and supporting the reintegration of clients into the community at the conclusion of treatment.

5.9 Aftercare and follow up

The literature primarily views follow-up as an opportunity to collect data and assess the extent to which treatment affects have been maintained (Dale and Marsh 2000). However, in the course of the current project, it was noted that from a clinical perspective most services aspired to follow-up and provide aftercare for clients, though the clients were often highly mobile and difficult to keep in touch with. Dale and Marsh (2000) suggest key requirements for after care and follow up services include:

- agreement to follow-up by clients and arrangement for the follow-up process prior to the completion of treatment;
- incorporation of follow-up and after care as a key component of treatment, rather than simply an add on;
- undertaking follow-up within three months of treatment completion; and
- provide continued support and referral to other services where appropriate.