

# Evaluation of Community Drug Withdrawal Services

# **Evaluation of Community Drug Withdrawal Services**

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**A report for the Drug Treatment Services Program  
Department of Human Services Victoria**

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# Preface

In late 1997, Turning Point Alcohol and Drug Centre was commissioned by the Victorian Department of Human Services to provide an evaluation of the State's redeveloped alcohol and drug withdrawal services. The evaluation included 28 withdrawal services located across Victoria. An individual report was prepared relating to each service. This report presents an analysis of the overall model of withdrawal. The Turning Point evaluation team prepared 27 of the individual service reports. To avoid potential conflict of interest, the Department of Human Services contracted Success Works Pty Ltd to prepare the evaluation report on Turning Point's own outpatient withdrawal service.

The work that has gone into the evaluation represents the efforts not simply of the evaluation team, but also of a wide range of individuals and agencies. First and foremost, the staff of the withdrawal services were remarkable in their level of support and cooperation in what was at times an onerous process for them. Without their active participation, the task would have been much more difficult. Clients too were patient and positive in assisting us with their views. In addition, many staff at Turning Point Alcohol and Drug Centre were generous in their support, expert advice, kindness and consideration. Across the State, members of the Department of Human Services were helpful, as were the wide range of other service providers who contributed their views. Our thanks are due to them also.



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# Executive Summary

Late in 1997, Turning Point Alcohol and Drug Centre was employed by the Victorian Department of Human Services to assess the work of the 28 withdrawal services which were funded in Phase 1 of the redevelopment of Victoria's alcohol and drug services. These were initially set up under guidelines and specifications outlined in *New Directions in Alcohol and Drug Services* (DH&CS, March 1994). The services have since been operating within the framework specified by *Victoria's Alcohol and Drug Treatment Services—The Framework for Service Delivery* (Department of Human Services, 1997). The aim of this evaluation was to assess the extent to which withdrawal services have been operating within these guidelines and to inform the future development of withdrawal services in Victoria.

## The Environment within which Withdrawal Services Operate

A description is given of a number of key aspects of the environment within which withdrawal services have been developing and within which this evaluation has occurred. Most of the evaluated services have been in operation for a relatively short time (between one and three years) and are essentially still in an establishment phase. They are located in a range of different agencies in the community, some with extensive prior alcohol and drug experience, some with practically none. While withdrawal services were being established, a range of other drug and alcohol services were also being redeveloped, and critical changes were taking place in the Victorian drug and alcohol system. The changes involved the introduction of new ways of funding and improved monitoring of services.

## The Four Withdrawal Service Types

This report considers the overall model of withdrawal from the perspective of the four service types:

- Rural Withdrawal Support
- Community Residential Withdrawal
- Home-based Withdrawal
- Outpatient Withdrawal.

Rural services do an impressive job in often difficult circumstances, facing large geographic areas, at times receiving reluctant and inexperienced alcohol and drug withdrawal support from general practitioners and rural hospitals (and sometimes no support at all), and having limited local services to call on to support clients post-withdrawal. Community residential services play an important role for many clients, but they face difficulties in managing a demand for the service that is greater than their capacity to meet it. Home-based and outpatient services creatively provide an important range of non-residential options and it is suggested that consideration be given to the potential value of greater integration of these two service types.

## The Objectives of Withdrawal

The vision inherent in the redevelopment framework remains entirely appropriate, with its focus on the four objectives for withdrawal. Services are considered to be largely operating in such a way as to meet these four objectives. In brief, and on a very generalised basis:

- Safe and comfortable withdrawal is provided by services as a result of skilled and committed staff. Services are affordable, but accessibility is impaired in some instances by distance, hours of operation, assessment processes, waiting lists and a lack of broad marketing to the general public and specific groups within it, most notably people from non-English speaking backgrounds.
- Health promotion and harm reduction work occurs in three contexts: with clients and their family and/or carers; in secondary consultation with service providers in health and welfare; with the general community at large. Rural services in particular work at all three levels, urban non-residential services tend to focus on working with clients, their support people and allied service providers. Residential services work mainly with clients but are inhibited in this by clients' short average length of stay and the pressure on staff due to the wide range of tasks they have to undertake.
- Case management is carried out in the sense that services take a broad view of client needs, undertake extensive assessments, develop individual treatment plans and make efforts to ensure that appropriate post-withdrawal services are in place. Case management is impeded by limitations in the skills and willingness of medical services to enter into partnerships with withdrawal services, and by the perceived lack of available post-withdrawal services.
- Commitment to client rights and dignity is a strong feature of Victoria's withdrawal services. Monitoring and evaluation is done less well, inhibited by a lack of formal mechanisms at the agency level and limitations with systems for data collection and analysis.

As a basic conceptual framework for the model of community drug withdrawal, the four objectives for withdrawal are considered appropriate. However, a number of areas for improvement are identified. A re-statement is needed of the model, including the overall aim and the specific objectives for withdrawal services. Greater collaboration by purchasers and providers would assist in the development of a clearer and shared definition of some of the concepts inherent in the objectives, such as 'case management', 'satisfactorily complete', 'episode' and 'completion'. The underlying framework of key requirements, performance measures and targets which is there to facilitate monitoring and evaluation activities needs to be much more closely linked to the aim and objectives of withdrawal. This monitoring and evaluation framework also needs to be incorporated into agency-based and centralised data systems.

In addition, the Department of Human Services needs to consider how the monitoring framework reflects the full range of the work of withdrawal services, including harm reduction and health education activities, and network and relationship building with other health and welfare services. Again, collaboration between purchasers and providers could result in a more useable and informative framework. The centralised data system ADIS would desirably generate overall evaluation and performance monitoring data and have the capacity to allow services to access and analyse their own data for service level planning and evaluation. Recent initiatives indicate that ADIS may be moving in this direction.

## A Concluding Overview

Finally, the report considers a range of issues relevant to the continued effectiveness of the work withdrawal services do with their clients.

- The need to value and support workers, so as to ensure their continued development and retention. These include opportunities for training and professional development, personal and organisational support, professional and clinical supervision, structures for networking and information sharing amongst workers in similar service types, as well as opportunities for communicating with, and being heard by, the Department of Human Services at regional and central levels.
- The capacity of services to be accessible and sensitive to client needs, and to be flexible when working within service guidelines which do not always reflect clients' circumstances, such as homelessness.
- The extent to which continuity of care is possible in the face of a number of barriers: the environment within which these services work, limited availability of residential withdrawal beds and post-withdrawal services and limited supported accommodation options<sup>1</sup>.
- The reluctance of many hospitals and general practitioners to provide withdrawal support, the lack of specific alcohol and drug skills and the negative attitudes of many medical personnel, remain an issue everywhere but especially in some rural areas.
- The importance of the community setting of withdrawal services, although this in itself does not guarantee an effective, efficient service. This is seen to depend on three critical elements: the quality of the staff, the culture and practices of the host agency, and the attitudes and culture of the community within which the service operates.

Victoria is in the process of building up an excellent service network, providing a range of options to those who wish to reduce or cease their substance use. They are staffed by a body of workers whose skills and knowledge about withdrawal are extensive. Major strengths are the range of withdrawal options, the harm minimisation focus, the case management approach and an overall commitment to clients by a skilled and dedicated workforce. Limitations lie largely in the agency, community and bureaucratic environment (such as adherence to the SAW guidelines) within which the services operate, problems with monitoring and evaluation frameworks, and barriers which services face in accessing post-withdrawal treatment and support options.

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<sup>1</sup> It should be noted that the service system is in an early developmental phase and many of the access issues may be due to the fact that services are not yet able to respond flexibly.



# 1. Introduction to the Model of Community Drug Withdrawal

## 1.1 Victoria's Redevelopment of Alcohol and Drug Services

The 1990s saw some significant and far reaching changes in Victoria's alcohol and drug services. Between 1992 and 1995, the *Services for Alcohol and Drug Withdrawal Project* (SAW) carried out the role of reviewing, developing, demonstrating and advocating for drug withdrawal services in Victoria. This resulted in a series of publications and provided the evidence-based research on which current alcohol and drug withdrawal options are based.

In 1993 a five year strategic plan was adopted in Victoria. This plan formed part of the National Drug Strategy. The strategic plan outlined three main stages of development, with the first stage commencing in 1994 following the closure of large Government run institutions. In early 1994 *New Directions in Alcohol and Drug Services* outlined the then Department of Health and Community Services plans for the redevelopment of alcohol and drug services around the State.

The key policy directions identified within this document include a shift of resources and program orientation from tertiary to secondary intervention; increased access to drug and alcohol services throughout Victoria; regional self-sufficiency of services and enhanced capacity for managed care within the service system (Keenan and King, 1996: 2). The redevelopment adopted a phased approach. Funds from the closure of government-provided services were redistributed to achieve greater parity in per capita allocation across Department of Health and Community Services regions. The first phase involved the establishment of a number of new service types including:

- Drug withdrawal services: metropolitan residential services, home-based and outpatient services in metropolitan and rural areas (these comprise the 28 services which are the subject of this evaluation).
- Specialist methadone programs.
- A centre for leadership in clinical service, research and training—Turning Point Alcohol and Drug Centre.
- Regional grants for independent and advanced clinicians within counselling and therapy services.

A second document, *Tendering Guidelines: Community Drug Withdrawal Services* (Department of Health and Community Services, Sept. 1994) provided a detailed framework for the development of these new services. It describes the 'operating context and functional objectives', and identifies four objectives, six service indicators, fourteen core features and five service specifications.

In 1995 the Premier's Drug Advisory Council was established to explore substance abuse in the community. Its report, *Drugs and Our Community* (1996), recommended a range of new initiatives for alcohol and drug services, many of which were adopted by the Victorian Government and formed the *Turning the Tide* strategy against drug abuse. The strategy involved the spectrum of Government agencies with responsibility for drug supply, demand and reduction and has a focus on the provision of specialist services for young people, strengthening

community-based treatment services, providing training to health professionals and developing a community education and training strategy (DHS, 1997: 2).

The second phase of the redevelopment, with impetus from *Turning the Tide*, saw the development of *Victoria's Alcohol and Drug Treatment Services—The Framework for Service Delivery* (Department of Human Services, 1997) which articulates a continuum of care involving twelve service types and details seven general service requirements and specific service type key requirements. The Framework was supplemented by a purchasing policy articulating resource distribution and benchmark unit costs. The Framework provided the grounding for an identification of the gaps in the system. On this basis, the second phase of redevelopment could occur.

With respect to withdrawal services, the 1994 and 1997 specifications and guidelines form the framework for this evaluation. They were simplified somewhat by grouping them under four objectives for the redeveloped withdrawal services. The four objectives for withdrawal in Victoria are:

- To ensure that the person in withdrawal satisfactorily completes the withdrawal syndrome with safety and comfort, at an affordable cost.
- To promote health promotion and behaviour change directed at managing psychosocial crises and encourage harm reduction.
- To provide case management, supportive counselling and advice to ensure that following treatment of withdrawal, services are available, accessible and coordinated to meet each individual's need.
- To maintain a commitment to the rights and dignity of clients and engage in monitoring and evaluation activities, to ensure high standards of service and outcome.

## 1.2 The Evaluation of Withdrawal Services

Late in 1997, Turning Point Alcohol and Drug Centre was commissioned by the Victorian Department of Human Services to assess the work of withdrawal services funded under guidelines and specifications outlined in *New Directions in Alcohol and Drug Services* (Department of Health and Community Services, March 1994) and in *Victoria's Alcohol and Drug Treatment Services—The Framework for Service Delivery* (Department of Human Services, 1997). The aim of this evaluation is to inform the future development of withdrawal services in Victoria, specifically:

1. To assess the drug withdrawal treatment models consisting of community residential, outpatient, home-based and rural withdrawal services with regard to:
  - Their strengths and weaknesses.
  - The supports and barriers that affect them.
  - Where current models are working well and there have been positive innovations.
  - Where current models are not working so well.
2. To assess the extent to which these withdrawal services have operated within the tender guidelines and service specifications set out in the documents from

the Department of Health and Community Services in 1994 and the revised general and specific key service requirements published by the Department of Human Services in 1997.

3. To draw from this to inform the future development of withdrawal services in Victoria in the best interests of clients and within available resources.

This report contains an overview of the model of withdrawal upon which the redevelopment was founded, and essentially covers the first and third evaluation objectives. It should be noted that this evaluation was never intended to be an outcome study. The second objective is covered in the individual service reports on the 28 withdrawal services established in Phase 1 of the service redevelopment.

### 1.3 The Method

This evaluation was carried out over a short time period of 8 months and the methods were tailored to this constraint. Tight planning was essential, to cover the large number of services and to allow time for a range of perspectives to be covered and a number of sources of data to be utilised. The goal was to gain data from a number of key sources, the services themselves and the agency within which they are sited, their clients, and the surrounding health and welfare service map within which they operate. In addition, some statewide services were approached to provide their views; a literature review was also carried out. A brief summary of the sources utilised is listed below.

- Site visits were made to each service; approximately three days were spent in each agency within the period February to March 1998.
- Service documentation was scrutinised, including client statistics, quarterly reports to the Department of Human Services, annual reports, policy and practice manuals, publicity material, client feedback sheets. Some observation was made within services of practice situations.
- Analysis of service data was carried out where data were available. In some services client file audits were carried out, in others analysis of raw client data was done, in others detailed statistics which had already been compiled were considered.
- In-depth discussions were held with withdrawal staff covering all the fields identified in the *Withdrawal Evaluation Data Checklist* provided to the service prior to the site visit.
- Individual and/or group interviews were carried out with other staff in the agency, particularly in allied fields such as domestic violence, gambling addiction, disability and so on, and with managers of the withdrawal service. As some agencies had up to five levels of management, not all the managers were interviewed.
- Interviews were held with allied alcohol and drug workers in the area, whether co-located or in other sites or agencies. These included methadone services, needle and syringe exchange programs, counselling and youth outreach staff, Koori alcohol and drug workers, and other withdrawal services.
- Interviews were arranged with the nine Department of Human Services regional alcohol and drug coordinators.
- Interviews were held with individual clients of services and with members of a variety of client groups, for example AA, NA, Women for Sobriety.

- Services were requested to distribute client feedback sheets to all service clients over a four week period.
- The evaluation had access to data generated through the Community Residential Withdrawal Service Best Practice project, which included focus groups with clients and staff in all six community residential units.
- Interviews with a wide range of key local stakeholders in allied health and welfare services. These included individuals from services in the health fields such as GPs, Divisions of General Practice, specialist alcohol and drug physicians, general physicians working in hospital settings, Accident and Emergency Department staff, nursing staff in hospitals and the District Nursing Service. Mental health services were also approached including community mental health centres and Crisis Assessment Teams. In addition, interviews were held with staff in services in the fields of justice, family support, children's protection, homeless person's, housing especially crisis and short term, services for young people, women, Kooris, and people from a non-English speaking background. Other individuals were consulted as appropriate in the different regions, for example a solicitor working with alcohol and drug affected clients, the Police, staff from the Education Department, schools, sexual assault centres, women's refuges, the local pharmacy and so on. Efforts were made to cover all of these fields in each area. Relevant stakeholders were identified both independently by the evaluation team and by specific referral by the withdrawal service.
- An open invitation was issued and distributed by services and the evaluation team to solicit feedback from any interested party.
- Interviews were held with key personnel at Direct Line and the Drug and Alcohol Clinical Advisory Service (DACAS), and focus group discussions were conducted with Direct Line staff and DACAS consultants.
- A group interview was held with the Executive Officer and staff of the Victorian Alcohol and Drug Association.

## 1.4 The Report

This report discusses withdrawal services established under Phase 1 of the redevelopment from four different perspectives. Firstly, a description is given of the context or environment within which the services have been developing since late 1994 up to March 1998. Secondly, consideration is given to the specific issues which arise in relation to the operation of each of the four service types—rural support, community residential, outpatient and home-based withdrawal services. Thirdly, an analysis is made of the extent to which the services have worked towards the four objectives for community drug withdrawal. Finally, a concluding section presents an overview of the issues which have emerged during the evaluation and influence the effectiveness of withdrawal services for clients.

## **2. The Environment within which the Model Operates**

This section introduces a number of key aspects of the environment in which withdrawal services have been developing and within which this evaluation took place. The reader is reminded that many of the services have been in operation for a relatively short period of time, from between one to three years and are essentially still in an establishment phase. Also, it should be remembered that the services were visited over a two month period, February to March 1998. Changes and new initiatives have been undertaken since this time, sometimes in response to issues raised during the evaluation, sometimes quite independently.

This section notes the wide range of drug and alcohol services that were also being redeveloped at the time and the other critical changes that were taking place in Victoria. Finally, there is a brief discussion of the systems for monitoring and evaluating services and for statewide data collection, and the absence of extensive quantitative data to inform the evaluation.

### **2.1 Early Stages in Service Redevelopment**

The initial stages of the redevelopment of Victoria's alcohol and drug services began in mid-1994. In practice, few of the withdrawal services were actually in operation at this stage, especially those services of a new type in the form of home-based and outpatient withdrawal. The original intention was that the evaluation would consider services three years after establishment, however, by early 1998 when field visits began, some services had only been in operation for as little as six or nine months, others for a year or so and the majority for around two years. The results of the evaluation must be considered in this light. Most services are essentially still in a formative and early developmental stage, with many still in the process of establishment rather than consolidation.

### **2.2 Withdrawal as Part of the Redevelopment of Alcohol and Drug Services**

Withdrawal services are only one aspect of the redevelopment of alcohol and drug services. A wide range of other service types were established as part of the redevelopment including: Counselling, Consultancy and Continuing Care (CCCC), Youth Outreach Alcohol and Drug services, Specialist Methadone Services, Peer Support Services, and Alcohol and Drug Supported Accommodation Services. These services complemented existing residential rehabilitation and Koori alcohol and drug services. In addition, a comprehensive scrutiny of withdrawal options would have to consider hospital inpatient withdrawals. Hospital withdrawals have never been an explicit part of the redevelopment of withdrawal services in Victoria, but rather an aspect simply acknowledged to be within the spectrum of service delivery. This evaluation was not mandated to consider their role and has not done so except with regard to the contact rural, residential, home-based and outpatient services have with acute hospitals.

### **2.3 Monitoring, Evaluation and Quality Assurance**

The Government has a commitment to monitoring, evaluation and quality assurance (Department of Human Services, 1997: 12), and ideally, this evaluation

would have been informed by service specific and aggregate quantitative data from a number of sources. In fact, it has been difficult to access reliable statistics or quantitative data. Each withdrawal service is required to report to their regional Department of Human Services office within a framework of performance measures and targets which are outlined in their Program Service Plans (PSPs). In addition, each service is required to contribute quarterly client data to the central data system ADIS/SWITCH. This system is designed to inform planning and decision making, as well as monitor trends.

In practice, there have been a number of problems with the data collection. Not all services have supplied data to the Department of Human Services and some have been tardy. In addition, the database is in an early stage of development where technical problems are being identified and resolved and SWITCH is not entirely congruent with ADIS. Due to a combination of these factors, comprehensive statistics were not available.

The evaluation has therefore been informed by minimal quantitative data. The difficulties services describe in relation to data collection has resulted in widespread anger and cynicism in the field about the interim ADIS system. The system is perceived as taking up a great deal of time and energy, with very little information flowing back to services to enhance internal evaluation and review processes. Withdrawal workers and management are disillusioned about the system. However, too much energy goes into complaining about the situation and not enough energy into developing in-house systems which could produce useful information for service monitoring and planning. The Drug Treatment Services Program acknowledges that there have been limitations with the interim system and has been working to address these. They report that a more 'user-friendly' interim ADIS system has since been introduced.

## **2.4 Organisational Contexts**

Withdrawal services have been contracted out to a variety of organisations. Of the 28 services evaluated, thirteen are in community health centres, eleven are under hospital auspices, three are in non-government not-for-profit organisations and one is at the state centre for leadership in clinical services, research and training. Some services existed in another form prior to the redevelopment; others have started from scratch. All have had to develop new policies and procedures, new styles of working, and new organisational relationships.

Some of the auspice agencies have had very little, if any, direct experience in working with alcohol and drug users. Others have worked exclusively with this group for a number of years. The extent of organisational support for the withdrawal service is equally varied. In some agencies, the service works relatively autonomously, in others it is fully integrated with other services. Personal and organisational support varies, as does the extent of professional supervision. The importance of integration, support and supervision is taken up later in this report.

## **2.5 Summary**

The last four years has been a period of far-reaching and significant change specifically in alcohol and drug services in Victoria. To make conclusive statements about withdrawal services in this formative stage is not an easy task. It should be appreciated that this evaluation is an overview of service development and operations at a particular point in time (early 1998) and should only be viewed as indicative, not definitive.

## 3. The Model: Four Types of Withdrawal Service

This section considers the overall model of withdrawal from the perspective of the four service types: rural withdrawal support services, community residential withdrawal services, home-based withdrawal services and outpatient withdrawal services. A brief introduction is given to each service type and to the on-the-ground services that were the focus of this evaluation. This is followed by the identification of issues specific to the service type. These are the key issues which need to be considered when planning for the future development of withdrawal services. It should be noted that this evaluation does not, and was never intended to, compare service types.

### 3.1 Rural Withdrawal Support Services

Rural Withdrawal Support Services (RWSSs) were established as part of the redevelopment of Victoria's alcohol and drug system, in recognition of the limited alcohol and drug services and the associated considerable travelling time between these services in country Victoria. The service type was developed to utilise general practitioner, hospital and community health centres in the treatment of alcohol and drug withdrawal.

In 1994, RWSSs were required to operate "in association with a country hospital to provide 24 hour 7 day nursing consultant support to a local medical practitioner or hospital in the management of alcohol or drug withdrawal at home or in hospital" (Department of Health and Community Services, Sept. 1994: 8). The combination of a brief inpatient stay (where required) and subsequent care at home was perceived to provide an equivalent level of care to a residential withdrawal unit, where the person has a supportive home environment. Like home-based withdrawal services, RWSSs were to provide nursing support on an on-call basis, with the service to provide seven client visits over a fourteen day period. No eligibility criteria for rural withdrawal were listed in the 1994 document.

More information is detailed in the 1997 RWSS key service requirements. These included that a support person, whether a family member or not, must be present or available and in the immediate vicinity during home-based withdrawal (Department of Human Services, March 1997: 16). Again, the service was to provide nursing support to hospitals and GPs and provide an on-call out-of-hours service.

Current research has identified the importance of partnerships between the community and professional health care workers where resources are scarce (Bushy, 1996). The literature identifies many factors that distinguish rural withdrawal services from those in urban and metropolitan areas. All impact on service delivery—lack of physical and human resources; barriers to services due to remoteness and a lack of public transport; difficulties in recruiting suitably trained and qualified staff; relatively higher numbers of Aboriginal people; a prevailing conservative ideology resulting in gender inequality (Major, 1995, 1996; Bushy, 1996).

Individual rural communities have distinct social and economic structures, demographic groups, health and welfare issues and resource issues. The current literature offers few insights into effective and appropriate treatments for special populations. The challenge, therefore, is to discover other strategies for the delivery of withdrawal services that are appropriate and effective to specific populations.

Miller and Willoughby (1996) claim that there have been no controlled trials that have demonstrated a more effective treatment outcome for specific groups, including rural populations. They state, however, that one finding of importance to rural communities is that brief counselling, when properly applied, has been shown to be effective across cultures. This is contrary to other researchers who urge caution in relation to brief interventions (Drummond, 1997; Humphreys, Moos and Cohen, 1997).

Other strategies identified as important to rural service delivery include student placement, community education, and the use of informal networks (Bushy, 1996). Ultimately, the aim of rural services should be to develop “a seamless continuum of care” (Bushy, 1996: 50). This includes avoiding duplication of services, meaningful discharge planning, case management, anticipating potential adverse events, assessing clients’ personal situation and community education.

### **3.1.1 The Evaluated Services**

Eleven rural withdrawal services in five rural regions are the subject of this evaluation:

- Three under hospital auspices at Warrnambool, Portland and Goulburn Valley.
- Five under community health auspices at Bendigo, Ballarat, Sunraysia, Mitchell, and Upper Hume.
- Three networked together in Gippsland under a consortium of community health services at LaTrobe, Gippsland and Lakes Entrance.

Five of the services evaluated have been operating under the current guidelines since the 1995–96 financial year. Upper Hume has been providing a withdrawal service since 1994, before the redevelopment of alcohol and drug services in Victoria. Portland and Bendigo began service provision in mid-to-late 1995, Warrnambool and Mitchell early in 1996. The other six services commenced during the 1996–97 financial year: Goulburn, Ballarat, and Sunraysia in August 1996; LaTrobe, Lakes Entrance and Gippsland Southern under a consortium in February 1997. Both LaTrobe and Lakes Entrance were first awarded funding for a RWSS in the 1995–96 financial year.

### **3.1.2 Program Service Plans**

The 1997–98 Program Service Plans (PSP) incorporate a set of ‘standard’ performance measures and targets for rural withdrawal support services. All services are required to meet a 75 per cent completion rate; 40 per cent of clients are to be women; and 90 per cent of clients are to have an Individual Treatment Plan (ITP). Performance measures vary from region to region with regard to the achievement of short term goals outlined in the ITP and level of client satisfaction.

Apart from the above performance measures, the 1997–98 PSPs also contain service improvement initiatives particular to each service/region. Examples of service improvement initiatives include:

- Improved service linkages with GPs and hospitals.
- Integrated service delivery with other alcohol and drug services in the region.
- Protocols developed with referral agencies.
- Participation in training and network development.
- Provision of an outreach service to outlying towns.

### **3.1.3 Service Requirements and Performance Targets**

The RWSSs successfully comply with a range of key service requirements and are generally able to fulfill the four objectives of withdrawal, as specified in the 1994 and 1997 Department of Human Services documentation. There is variability, however, in the services' ability to meet performance targets outlined in the PSPs.

Most services were able to meet, or exceed, the number of episodes to be provided in a given twelve month period. Only two services did not meet their targets with regard to the number of episodes provided, however this reflects services that were in an establishment phase and should not be viewed as a matter of concern. It is a concern, however, that only half of the services evaluated have recorded completion rates since service inception. This, together with the disparity in the definition of completion, renders interpretation difficult.

### **3.1.4 Staffing**

All RWSSs are staffed by qualified nurses, many with post-graduate qualifications in alcohol and drug studies. Although not all had prior experience working with alcohol and drug clients, they possess a breadth of experience that is valued and held in high regard by both clients and allied service providers. In many ways, the staff are the core of these services. Their nursing and support skills and their dedication to their clients play a vital role in supporting and reassuring clients and their carers, and in safely overseeing the course of the withdrawal. This is of particular importance in areas where local GP and hospital support is limited. The withdrawal nurses' knowledge of the impact of substance use, of the likely course of the withdrawal syndrome in different types of substance use, and of withdrawal medication, has played an important role in educating medical professionals and hospital nursing staff. Their ability to provide secondary consultation to allied health professionals is another service strength.

Staffing levels vary across services. The EFT loading across the RWSSs range from 1 to 1.9 positions. This discrepancy is interesting, given that all services are funded at the same levels and are required to meet the same performance targets. While the Department of Human Services has an expectation that services provide staffing for one or more positions, agencies are free to determine the number of staff employed. The level of staffing has a number of implications for quality service provision, including the ability to:

- Provide 24 hour 7 day nursing care.
- Participate in ongoing professional development and network development.
- Cover staff on annual, sick or study leave.

- Access peer support.
- Provide clients with some choice (albeit limited), of worker.

A number of RWSSs have reported difficulties recruiting and maintaining staff, and this has created “downtime” in two services. Retention of the experienced withdrawal nurses and fostering of their skills is clearly vital. This can be enhanced by attention to a number of the issues identified below, but organisational contexts which provide appropriate support and supervision processes are essential. Generally, professional and clinical supervision tends to be absent in RWSSs, and attention is needed to develop suitable supervision arrangements. Close networks and collaboration with other alcohol and drug workers is important at the agency or local level, as well as via regional and statewide networks. The ability of RWSS workers to participate in these networks, however, is hampered by the geographic location (and isolation) of many services—particularly those on the State’s periphery. Workers should be involved in identifying training needs and should be consulted as to how these can best be met.

### **3.1.5 Withdrawal at Home or in Hospital?**

The Department of Human Services guidelines for rural withdrawal services do not specify the extent to which withdrawal support should be offered on a home-based, inpatient or outpatient basis. Most RWSSs, particularly those auspiced by community health centres, provide support predominantly to clients in their home setting. Withdrawal staff consistently report working with clients who do not have home environments conducive to withdrawal—there may not be a support person available, they may not have access to a telephone, or they may be living with other people with substance dependence issues. This creates confusion amongst RWSSs as to the legal implications of working outside the guidelines. Where RWSSs have a hospital as an auspicing body, and access to inpatient care is easily facilitated, RWSSs are able to apply the eligibility criteria for service admission more stringently. This is reflected in unusually high rates of inpatient withdrawal (80 per cent) at these services, compared to all other RWSSs. This approach, however, serves to restrict treatment options available to clients.

RWSSs have developed a range of different ways of providing a 7 day a week, 24 hour on-call service for support and advice. This is largely provided on a telephone basis and is essentially for existing clients. This in itself is an onerous task for RWSSs staffed by one person. RWSSs do not operate as 24 hour, 7 day a week crisis services. A number of regional stakeholders, particularly the hospitals, would like the RWSSs to provide this service, as in the absence of such services in country Victoria, this role falls back on hospital’s Accident and Emergency Departments.

### **3.1.6 Legal and Personal Implications for Withdrawal Workers**

The concerns experienced by RWSS staff regarding their legal status and personal safety are not dissimilar to those experienced by staff from the home-based withdrawal services. Readers are advised to refer to the section of this report on home-based services for a detailed discussion of these issues.

### **3.1.7 Access to Expert and Supportive Medical Partnerships**

GPs are expected to play a critical role in the provision of rural withdrawal services. All RWSSs report that many GPs are unwilling to work with alcohol and drug users, or have such negative attitudes and/or poor knowledge that staff are reluctant to refer clients to GPs. This is despite the considerable effort made by the RWSS staff in developing relationships with GPs and in educating and supporting them with withdrawal clients. A number of RWSSs are reliant on one or two GPs to provide medical assessment and pharmacotherapy for clients.

The issue of GP involvement in rural withdrawal management requires further attention. Many GPs in rural Victoria are working with full client loads and are therefore able to choose which clients they want “on their books”. Given this, many GPs choose not to accept clients with alcohol and drug dependence issues. Even amongst alcohol and drug “friendly” GPs, there is a concern about being readily identified as running a “druggie” clinic. This raises many concerns, firstly regarding inequality of access to health care for substance dependent people in rural Victoria. Secondly, reliance on one or two GPs creates burnout situations or problems when the GP retires, moves from the area, or has a full client load. Thirdly, in some areas clients have to consult GPs who hold quite judgmental views on substance use because of limited, or an absence of, GP choice. Finally, the lack of alcohol and drug knowledge amongst many GPs means that inappropriate pharmacotherapy may be prescribed. This is a significant issue that needs to be further explored due to the potential impact it has on clients’ ability to complete withdrawal in safety and comfort. There is clearly a need for a more extensive network of alcohol and drug “friendly” and knowledgeable GPs in rural Victoria.

Although beyond the scope of this report, the evaluation has found considerable concern amongst RWSS staff with regard to the availability of methadone prescribers in rural Victoria. In some towns there is currently no local prescriber, whereas in other towns there may be only one prescriber (however, in one instance, the GP had a full client load and was not prescribing methadone for new clients). This poses a concern for withdrawal staff, as it restricts the treatment options available to opiate dependent clients accessing RWSSs, and as such impedes their ability to provide a full range of harm reduction options.

### **3.1.8 Access to Inpatient Care at Country Hospitals**

The role of country hospitals is also critical in the management of withdrawal, particularly given the absence of locally available community residential withdrawal services. In both the 1994 and 1997 Department of Human Services documentation, it was specified that RWSS were to operate in association with local hospitals to ensure access to inpatient beds for clients experiencing moderate to severe withdrawal. Although most services have written protocols with hospitals, the degree to which they can utilise inpatient beds varies considerably across services. For instance, two RWSSs auspiced and located in hospitals have unlimited access to inpatient withdrawal. Most other RWSSs have good relationships with a number of local hospitals, with access to inpatient withdrawal dependent on bed availability. There are a few exceptions, however, which are of concern.

There are a number of issues associated with the utilisation of country hospitals for inpatient withdrawal across Victoria that need to be considered. Firstly, low levels of understanding exist regarding substance use and the withdrawal process, as well as negative attitudes towards alcohol and drug dependence amongst some hospital nursing staff, medical registrars and management. Most RWSSs have been providing training and support to hospitals since service commencement, however, the need for this is ongoing and requires considerable effort. Secondly, the appropriateness of a hospital as a suitable environment to provide withdrawal care and support is debatable. Where single rooms are not available, as is the case in most hospitals, the ability of the RWSS to provide confidential counselling and support is limited. Where withdrawal beds have been designated, client anonymity is severely impaired. There are also limited activities available for clients undergoing inpatient withdrawal. Thirdly, with a few exceptions, access to hospital beds can not be guaranteed.

### **3.1.9 Access to Community Residential Withdrawal Service Beds for Rural Clients**

All rural Department of Human Services regions have purchased beds within metropolitan-based CRWSs for clients not suitable for home-based or outpatient withdrawal as a means of expanding treatment options for clients. Although generally good relationships exist between RWSS and CRWS staff, utilisation of community residential beds for withdrawal is problematic. Waiting lists exist at all CRWSs, despite efforts by service staff to fast track assessment and admission. Many clients are reluctant to leave their homes, families and friends to attend a Melbourne-based CRWS. For some clients this involves travelling considerable distances. An unresolved, and related, issue for RWSS staff is the transportation of clients to CRWSs. In the absence of available private transport, some clients have to use public transport to access CRWSs and in some areas, there is no public transport available. Some services do provide transport for clients accessing CRWSs. This, however, is time intensive and may involve a full day, time which can be ill afforded by busy withdrawal workers.

### **3.1.10 Accessibility**

A considerable strength of RWSSs is their ability to provide a responsive and, therefore accessible, service. Only one RWSS reported a waiting list for client admission. This may be related to the fact that this service currently operates predominantly on an inpatient basis with admissions occurring on a weekly basis. Other services have indicated that when client loads are full, telephone support may be provided to a client for one or two days until they can be admitted. Services are perceived by staff and regional stakeholders as already working beyond capacity and fears are held that as knowledge spreads of this service type, demand which exceeds existing resources will grow, followed by the potential for waiting lists and service rationing.

There exist concerns regarding access for clients residing some distance from the town in which the RWSS is based. In many areas public transport is non-existent, and where there is an agency policy that clients attend the service for an assessment, this may preclude clients from accessing treatment.

### **3.1.11 Geographic Location: Distance and Isolation**

All RWSSs cover extensive areas, entailing considerable driving time and distances to provide outreach services to outlying towns and clients. The services, however, are funded at the same level, and for the same performance targets, as metropolitan home-based withdrawal services which, in the main, cover much smaller geographic areas. The geographic location of many RWSSs, particularly those located on the State's periphery, actively impacts on the capacity of workers to participate in ongoing professional development and network development, both of which tend to be metropolitan-based. The lack of suitably qualified staff to provide local professional supervision also contributes to staff isolation. Recognition of the demands of providing a service to large geographic areas, such as telephone allowances, rent for outreach offices and travel allowances for conference attendance, should be incorporated into RWSS budgets.

### **3.1.12 Service Expertise in Relation to Specific Client Groups**

RWSSs are expected to provide a service that is sensitive to a range of different issues and attempt to do so within available resources. Most services are working to, but fall below, the target of 40 per cent female access to the service. Only two services recorded percentages higher than the required 40 per cent. Services are utilising community services, such as family respite care, to ensure parents undergoing withdrawal at home do not have to look after their children at the same time. This is not always the client's preferred choice, however, and is an issue with which services continue to struggle.

Only one service has alcohol and drug literature available in languages other than English however, it should be noted that the need for such information is minimised in some areas where the population is predominantly Anglo-Australian. There is also a cost implication in providing this information. Although attempts have been made, most services report difficulties accessing Koori populations, withdrawal workers and Koori workers state that Koori people prefer to work with Koori specific services.

All services, with the exception of one, report some difficulties and frustration in working with mental health services. This issue is not specific to rural areas and is being addressed in a number of projects across the State. RWSSs have difficulties meeting the needs of homeless and itinerant workers. There is a lack of accommodation services generally in rural areas, which precludes these people from participating in treatment, particularly where access to inpatient care is not available.

Services can and are working to improve relationships with agencies that work with these specific clients groups. The development of formal protocols with statutory and other agencies is occurring and will assist in addressing the needs of these client groups.

### **3.1.13 Health Promotion and Harm Reduction in Rural Victoria**

All RWSSs are involved in a range of health promotion and harm reduction activities in their local communities, from hosting stalls at local agriculture shows to running alcohol and drug education sessions at schools. This has been identified by regional stakeholders as a particular strength of these services, as often RWSS staff are the only workers in the region who are able to provide this role and it is seen to be essential in terms of developing and maintaining service linkages. This work is time intensive and impacts on the services' ability to meet direct care targets. Greater recognition of this role should be accorded in monitoring requirements and data collection.

### **3.1.14 Transition to Post-Withdrawal**

Continuity of care and linkage into post-withdrawal services is a critical aspect of the model of community drug withdrawal. The major barriers for those working in rural withdrawal services are access and smooth transition into group and individual counselling, residential post-withdrawal, and a range of accommodation options. Where services are co-located with alcohol and drug counselling services, the transition to counselling tends to be easier and quicker. Limited access to residential options (both for accommodation and for alcohol and drug rehabilitation) are a constant issue. This has significant implications for the capacity of withdrawal services to direct clients to options which will assist them to maintain long term changes in problematic substance abuse.

## **3.2 Community Residential Withdrawal Services**

Of the four service types, community residential withdrawal has the longest standing history. Although its form has changed over the years, its role is entrenched in the alcohol and drug service system. Community residential withdrawal services (CRWSs) target "clients who require 24 hour supportive care to withdraw, with some pharmacotherapy and medical care for non-acute illness" (Department of Human Services 1997: 16). CRWSs are seen as suitable for clients without adequate supports at home or with psychological or social crises that require a high level of support (Department of Human Services 1997: 16).

In the original redevelopment of CRWSs, the Department stipulated that the residential units be located in a house or adjacent pair of houses in a suburban setting, provide 24 hour supportive care by closely supervised and trained non-medical personnel and have readily available medical care to address routine problems that may arise (Department of Health and Community Services, Sept. 1994: 5-6). The staffing profile was to include a diverse range of trained professionals (psychologists, social workers, welfare workers, nurses) and a senior nurse working a five day week and on call 24 hours, 7 days a week, who would be responsible for continuous oversight of medical problems and pharmacotherapy and out of hours consultation (Department of Health and Community Services, Sept. 1994: 5-6). In 1997, the Department of Human Services slightly modified previous requirements stating that CRWSs were designed to provide a short stay in a suburban setting close to a public hospital with psychiatric facilities. Core requirements around 24 hour service provision remain unchanged.

In recent times, many aspects of CRWS service provision have been explored in research and the literature. The reader is referred to the report *Community Residential Withdrawal Services: A Report on Best Practice* (Alberti and Swan, in preparation) which outlines current best practice principles. Generally, literature in the area of CRWSs is descriptive and focuses on certain aspects of service delivery. Given this, the relevant findings are integrated throughout the discussion of this service type.

### **3.2.1 The Evaluated Services**

All of the six Victorian CRWSs were part of this evaluation. They are located in the metropolitan area, two in the Southern Metropolitan Region, one in the Eastern Metropolitan Region, one in the Western Metropolitan Region and two in the Northern Metropolitan Region. They include:

- Two services at non-government, not-for-profit agencies at Moreland Hall in Coburg and The Windana Society (Windana) in St Kilda.
- One under the North Western Health Network at Western Hospital (Western) in Footscray.
- One under the Inner and Eastern Health Care Network at Box Hill Hospital—Community Drug and Alcohol Services (CDAS).
- One in a hospital affiliated to the Inner and Eastern Health Care Network (St. Vincent's Hospital) at Depaul House (Depaul) in Fitzroy.
- One in the Southern Healthcare Network under the community health division in Dandenong, Westernport Drug and Alcohol Services (WDAS).

The CRWSs have been in operation in their present form for a variable amount of time. Moreland Hall piloted the current service type from mid-1994, Depaul, Windana<sup>2</sup> and WDAS began in 1995, and Western Hospital opened in October 1996. CDAS opened on its present site in July 1997, but was operated by Depaul between 1995 and 1996, and the Salvation Army between 1996 and 1997 while the Box Hill site was being built.

### **3.2.2 Program Service Plans**

Standard parameters for CRWSs in the 1997–98 PSPs stipulate that they operate at a 100 per cent occupancy rate and provide 720 episodes, with an 85 per cent completion rate and an average length of stay of six days. Of the 720 clients, 40 per cent are to be women, 90 per cent are to have an individual treatment plan and 80 per cent are to achieve the short term goals outlined in the plan. Further to this, between 75 per cent and 90 per cent of clients are to be satisfied with care received, the environment and access to the service<sup>3</sup>. Services receive a variable sum ranging from \$770,300 to \$792,140.

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<sup>2</sup> It should be noted that Moreland Hall had provided withdrawal services since 1969, Depaul had provided withdrawal since 1988 and Windana since 1984.

<sup>3</sup> Percentages varied across PSPs.

### **3.2.3 Service Requirements and Performance Targets**

CRWSs are required to comply with a number of service specifications, service requirements, performance measures and targets. Whilst overlap between these various requirements exists, there is a level of confusion.

The four areas of most concern to CRWSs relate to completions, occupancy rates, length of stay and access for rural clients. With the exception of one CRWS, completion rates are lower than specified, however, it is difficult to reach definitive conclusions concerning service performance in relation to completion rates. Variable definitions of completion across the field (such as, completion may be when an episode is finished, or after a long length of stay, or when the client has withdrawn, or when the client has reached their goal, or when the client is substance free) mean that data relating to this must be read with caution. Keeping this in mind, completions across the CRWSs range from 45 per cent to 72 per cent, with most services having rates of around 50 to 60 per cent. Similarly, statistics regarding separations must also be regarded with caution given variable definitions of 'separation' or 'episode'.

The requirement for a six day average length of stay poses another challenge for CRWSs. Data from the services indicate that, with the exception of one CRWS where average length of stay is around seven days, the majority of the CRWSs vary from three to six days. Anecdotal evidence provided to the evaluation suggests that shorter stays are common. A number of reasons have been given for this including insufficient activities in the unit, lack of contact with family, seclusion from contacts for a length of time and mix of clients in the unit at any one time.

The requirement for a 100 per cent bed occupancy rate is a constant pressure faced by services. While they demonstrate a keen commitment to maximum bed occupancy, the reality of managing unpredictable vacancies (such as unanticipated voluntary discharge at 7pm at night) makes 100 per cent occupancy an impossible task. Therefore, this requirement is not an achievable goal and needs to be further explored.

The contractual arrangements between a number of CRWSs and rural areas have proven to be problematic. Despite the efforts of rural and CRWS staff to fast track assessment and admission for rural clients, utilisation rates of the residential units by non-metropolitan clients remain low. The issues seem to be that the 'beds' required by rural areas are not readily available when needed, in some cases distance makes travelling for assessments very difficult, and the requirement that rural clients leave their environment and supports to attend a CRWS based in Melbourne is seen as inappropriate and insensitive to their needs. Given this, many rural clients choose not to access CRWSs. Where local inpatient care is an option, clients access it in the place of CRWSs. Where inpatient care is not an option, a significant service gap exists.

### **3.2.4 Staffing**

The research exploring staff in alcohol and drug services suggests that staff attributes such as genuineness, empathy, compassion, flexibility, skill and honesty are important (Mereki, 1996; Nelson-Zlupko et al, 1996; Haver and Franck, 1997). Given that staff play a critical role, literature reviewed supports the view that staff supervision, support and debriefing is important to avoid potential burnout for staff (VLPN, 1996; NDS, 1996).

Generally, staff employed in the CRWSs are dedicated, supportive, well trained individuals who are accepting and caring. They are well regarded by the people who access the service and have well developed skills and expertise in withdrawal. Although staff composition varies, the mix usually includes nurses, alcohol and drug workers, welfare workers, people with training in complementary therapies and individuals with a personal history of substance dependence. The EFT staffing across the CRWSs ranges from 11.4 to 13.5 positions. The staff day shift ratios vary across the CRWSs.

The demands on staff within the residential units are considerable. In any one shift, withdrawal staff must do regular client observations, monitor withdrawal, dispense medication, conduct admissions, facilitate discharge, attend to individual inquires, consult with staff on the previous shift, consult with GPs where appropriate, complete the required file and ADIS documentation, conduct groups, organise and facilitate activities, spend time with clients individually, case plan, make required case planning and consultative phone calls, speak to family members and organise for new admissions. These demands impact on the capacity of the CRWSs to facilitate full group programs.

Given that staff are identified as the greatest strength of CRWSs, additional effort must be directed towards providing them with adequate support, supervision, debriefing and training.

### **3.2.5 Access to Medical Support**

The role of nurses in CRWSs is recognised as being of considerable importance. Most services have a senior person responsible for the Unit who provides medical support, crisis and emergency on-call and supervision to staff. They also have a registered nurse on each shift who works closely with other experienced withdrawal staff. One service contracts the District Nursing Service to attend the Unit four times daily to dispense medication and attend to any medical issues. Another Unit has a nurse on duty from 7am to 10pm.

There are three main ways in which CRWSs access medical support, these are the use of hospital doctors, the use of sessional GPs and the use of community-based GPs. The level of GP involvement in the management of a client's withdrawal varies considerably, with some GPs having ongoing contact and others having once-off contact. While these various arrangements are met with a range of positive and negative responses, key informants noted that the shared care model is the most controversial method of GP involvement. Clearly the different models have various strengths and weaknesses, however little is known about the actual

impact of these models of medical intervention on an individual's withdrawal. A more thorough exploration of this area would prove valuable in any future developments affecting CRWSs.

Another issue relating to medical support pertains to the role of hospitals in the withdrawal model. The SAW model (Frank and Pead, 1995) suggests that hospitals are the most appropriate place for those clients who require maximum support due to very complicated withdrawal. Although all CRWSs have protocols linking them with a hospital, hospitals are not bound by specific alcohol and drug withdrawal service requirements, are not accountable for their performance in the area of withdrawal assistance and may not be willing to maintain close relationships with the CRWSs for a range of reasons. This poses some difficulty for CRWSs that rely on hospitals for back-up and referral when required.

### **3.2.6 Assessment and Admission Processes**

The purpose of assessment in a CRWS is to "establish the significance of the three dimensions of withdrawal in order to predict the nature and severity of withdrawal and to determine appropriate treatment interventions" (Frank and Pead, 1995: 9). The need to balance information collection against minimal personal intrusiveness and unnecessary duplication were raised in the literature (VLPN, 1996) as requiring constant attention by those conducting assessments.

The assessment process across the CRWSs varies. Three CRWSs adopt a central assessment model, where a team or one staff member is responsible for conducting all alcohol and drug assessments. Two CRWSs use an assessment officer, whose sole focus is on conducting assessments, and the other CRWS has members of staff rostered on evening shifts conducting assessments. Some services use a telephone assessment method, others use a face-to-face assessment method, and some use a combination of both. The depth and potential personal intrusiveness of assessments varies as does the length of time clients wait to be assessed. Where central assessment occurs, duplication and intrusiveness appear to be reduced. For example, at one CRWS, unnecessary duplication is avoided when clients are referred from another alcohol and drug agency because the two organisations are prepared to share information, with the client's permission, rather than each service conducting a full assessment. Admission processes across the CRWSs are similar, with variations relating to phoning-in procedures.

Waiting lists continue to be a problematic issue for the CRWSs. Service statistics indicate that waiting times before admission are generally no longer than seven days. Anecdotal information from stakeholders and clients consulted throughout the evaluation indicates that the wait can be up to two weeks or more. While most agencies provide little support for clients on the waiting list, two units provide support to some clients via the outpatient withdrawal worker (this does not apply to all clients) and one unit facilitates two groups a week for clients on the waiting list.

### **3.2.7 Affordability**

The hidden costs for clients associated with the CRWS can pose access issues. These costs include phone calls clients need to make, in some cases on a daily basis, the cost of travel to and from the service, and the voluntary contributions they are asked to make by some services (varying from \$5 to \$25). Generally, the contributions cover pharmaceuticals, complementary therapies and activities. It should be noted that the costs incurred for this service type are minimal, especially when considering the high cost of pharmaceuticals which are essentially free of charge to people in residential services. However, the place of financial contributions in a 'free' service needs to be further explored.

### **3.2.8 Diversity, Specialisation and Client Choice**

The report *Community Residential Withdrawal Services: A Report on Best Practice* (Alberti and Swan in preparation) cites that there are many special needs groups for whom access to the CRWSs may be problematic. Included are people who live in rural Victoria, women, parents with small children, people with a dual diagnosis, young people, people from culturally diverse backgrounds, Aboriginal people, homeless and poor people, and people who are disabled. Other reports (Success Works, 1997; Hartley, 1998) have also recently researched access for special needs groups making a range of recommendations regarding this. From these reports and other literature (Clark, 1990; Swift and Copeland, 1996; Byrne and Gucciardo-Masci, 1997;) it is apparent that delivering a service which is appropriately sensitive and responsive is complex, requiring considerable thought, planning and resources.

Currently, the CRWSs are required to develop expertise in most areas. Given the constraints within which they operate, it is difficult for the Units to be able to cater appropriately for all special needs groups. However, some of the Units have demonstrated a capacity to respond well to particular special needs groups. For example, one Unit has developed significant expertise with older men and women who are alcohol dependent and may also be homeless. Further encouragement of the development of specific skills and expertise in particular areas across the CRWSs may result in a service system that is more responsive to the needs of individuals.

One of the unintended consequences of regionalisation has been the restriction of client choice regarding residential withdrawal. Information obtained throughout the evaluation from staff, clients and stakeholders demonstrated that treatment matching now occurs on the basis of regional options, rather than client choice or specific needs. A more flexible approach may provide greater balance and optimise client choice.

### **3.2.9 CRWS Programs**

The program in CRWSs potentially includes group sessions, one-to-one interventions, activities, outings, use of complementary therapies, working with family and/or significant others, and a focus on nutrition. Albert and Swan (in preparation) thoroughly explore each of these aspects, making recommendations

for best practice principles in each area. They conclude that program components are of critical importance to withdrawal outcome. The literature strongly supports the inclusion of families and/or significant others (Manning, 1995; Waltman, 1995; NDS, 1996), maintains the importance of a range of psycho-social interventions (Copeland et al, 1993; NDS, 1996), advocates the inclusion of complementary therapies alongside further research into their effectiveness (Nebelkopf, 1988; Mereki, 1996) and raises the significance of organised activities and outings (Potthoff, 1995).

The importance of having a full program which includes the components outlined above is noted by all staff. However, the extent to which Units deliver such a program is variable. This is to some extent affected by the heavy and competing demands on staff time, but strategies need to be adopted to increase the level of program activity. The range of program components which are currently in place in CRWSs includes a mix of household duties, house meetings, groups, outings, individual treatment planning sessions and the occasional activity. With the exception of one CRWS, clients consistently reported feelings of boredom, requesting greater emphasis on groups and activities. In addition, despite research findings indicating the value of working with family members, the CRWSs have minimal involvement with the families of clients. In some instances, family members are allowed to visit clients, however, the degree to which families and significant others are involved in treatment could be improved.

The evidence suggests that length of stay is affected by level of activity. For example, at one CRWS where there is a full program, average length of stay is highest. Where the daily program is limited and there are minimal activities, outings and groups, length of stay is lower.

### **3.2.10 Case Management in the CRWSs**

The CRWS staff take a broad view of case management as inclusive of all aspects of an individual's life, however, their ability to provide broad based case management is significantly constrained by a length of stay which varies between three to seven days. Although attention is given to assisting individuals to access the service, most case planning occurs once the client is in the Unit and focuses on appropriate post-withdrawal referrals. Long-standing issues such as homelessness, entrenched substance use patterns, social and emotional difficulties, financial and legal issues and psychological and familial problems are frequently identified amongst the client group, however, it is difficult for the CRWS staff to assume the role of case manager, coordinating all necessary interventions. Therefore, a more focused and specific case planning, rather than broad based case management, is what occurs where the staff work to link the individual with a service or worker who can offer ongoing support.

### **3.2.11 Tensions**

CRWSs work constantly to maintain a balance between the tensions inherent in the service type. They work to achieve a balance in the face of the following tensions:

- Providing close medical supervision whilst sustaining a community, home-like environment where non-medical personnel play a significant role.

- Maintaining an environment which is 'drug free' (where individuals are discharged, and in some cases banned for drug use in the Units) whilst adopting a harm minimisation approach where relapse is actively acknowledged and worked with.
- Balancing the demand that CRWSs respond quickly, reduce waiting lists and accommodate crisis or emergency situations is difficult whilst operating as close to capacity as possible.
- Meeting the requirement that staff adopt a broad-based case management approach in the face of three to seven day stays.
- Facilitating thorough and comprehensive assessments and treatment plans, whilst being mindful of the intrusive nature of these processes.
- Dealing with the reality that CRWSs attract a mix of self-motivated or 'voluntary' clients as well as 'involuntary' clients who enter the Unit in hopes of influencing the outcome of a court case, or as a condition placed on them by others such as family members, Protective Services, or the courts.
- Balancing the perceived need to protect and support clients by imposing a range of restrictions (around visits, activity levels, going to bed and getting up times) against individual rights and self-determination<sup>4</sup>.

These tensions, together with the other factors which impact on service delivery mentioned throughout this section, makes this service type the most complex of all withdrawal service types.

### 3.3 Home-Based Withdrawal Services

In 1994, when the home based withdrawal service type was first described in the redevelopment documents, it was characterised as appropriate where

“the withdrawal syndrome is likely to be of moderate severity and uncomplicated by illness or significant psychosocial problems. The home environment must be suitable with family members or residents being supportive and prepared not to consume alcohol or illicit drugs themselves during the course of the withdrawal. There must be a phone available. A support person, whether family member or not, must be present and in the immediate vicinity during withdrawal. A medical practitioner, preferably the client's own local practitioner, must be available to participate in the initial assessment and specifically to conduct a physical examination and order pharmacotherapy where necessary.” (Department of Health and Community Services, Sept 1994: 7)

The service was to be provided around the clock and a senior nurse or medical practitioner associated with the service was to be available out of hours to advise on and manage difficulties or queries as they arose. The service would provide 7 visits over a 14 day period.

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<sup>4</sup> The individual service reports provide a range of examples which speak further to each of the tensions outlined above.

In 1997 the Department of Human Services modified these requirements and described home based withdrawal as a service for

“young people and adults requiring withdrawal where the withdrawal syndrome is of mild to moderate severity and not complicated by illness or significant psychosocial problems, and where a support person is available and in the immediate vicinity during withdrawal.”

(Department of Human Services March, 1997: 17)

No mention of a drug free environment or the need for telephone access was made. The key service requirements specified that the service was to be staffed by a nurse who would provide case management, work in conjunction with a GP and provide an on-call out-of-hours service.

Research suggests that the thinking behind these parameters of home-based withdrawal remains appropriate. It is reported that home-based withdrawal has been found to be appropriate for people experiencing mild to moderate withdrawal symptoms from alcohol and other drugs (Heather and Tebbut, 1989). It is, however, more frequently associated with alcohol withdrawal where home-based withdrawal (or hostels in the case of the homeless) has been found to be a safe, cost-effective alternative to inpatient treatment for problem drinkers (Haigh and Hibbert, 1990; Holder, Longabaugh, Miller et al. 1991; Bartu and Saunders, 1994; Mattick and Jarvis, 1994; Klijnsma, Cameron, Burns et al. 1995; Cooper, 1995; Bennie, 1998). Furthermore, it has been found that clients and their close family expressed high levels of satisfaction with this type of service, as well as increasing support from general practitioners (Stockwell, Bolt and Hooper, 1986) and a gradual move away from hospital-based treatment in favour of client's homes (Stockwell, Bolt, Milner et al., 1990; McKechnie, 1995). There is a suggestion that women might find this a more acceptable option than residential withdrawal (Major, 1993). Generally, proponents of this form of treatment caution that it is not appropriate for persons with severe withdrawal symptoms or inadequate home support, suggesting that access to inpatient facilities will continue to be needed (Fleeman, 1997).

### **3.3.1 The Evaluated Services**

Six home based withdrawal services are the subject of this evaluation:

- Two services are located in community health centres at Heathlands and Geelong. The Heathlands service operates out of the community health centre in Mentone.
- One service run by the Salvation Army Bridge Programme in St Kilda.
- One under a health care network and within a hospital auspice at the Box Hill Hospital Community Drug and Alcohol Service (CDAS), where two HBWSs are in place with two separate PSPs, however they have been reported on as one service for the purposes of the evaluation.
- Two services are under health care networks, one is located within a community health division at Westernport Drug and Alcohol Service (WDAS) in Dandenong, the other within the community health centre at Frankston.

Four of these services are in the Southern Metropolitan Region, one in the Eastern Metropolitan Region and one in the Barwon South Western Region. Three other home-based services at Moreland Hall, Western Hospital, and Turning Point Alcohol and Drug Centre were funded in 1997 and were not covered in this evaluation. The Salvation Army Bridge Programme is the only stand alone home-based service. All the other home-based services have companion outpatient services under the same auspices. CDAS and WDAS also run residential withdrawal services.

The evaluated services have been operating between approximately one and three years. The Geelong service commenced in June 1995, the Salvation Army and CDAS services began in early 1996, and the Frankston, WDAS and Heathlands services have been in operation since early 1997.

### **3.3.3 Program Service Plans**

The 1997–98 Program Service Plans incorporate a set of standard performance measures and targets for home-based services. Services are contracted to provide 110 episodes, or multiples of this, with a 70 per cent completion rate. Some 40 per cent of clients are to be women, 90 per cent are to have an individual treatment plan and 70 per cent are to achieve the short term goals outlined in the plan. Performance measures regarding average hours of counselling and level of client satisfaction vary from region to region.

### **3.3.4 Resources and Performance Targets**

Services generally are assessed by staff and regional stakeholders as working at full capacity and concern was voiced that as knowledge spreads of this service type, demand exceeding existing resources will grow, followed by the potential for waiting lists and service rationing. Currently, only one service has a waiting list. This may be related to the fact that one of the two staff members is not a nurse, so a certain amount of duplication of effort may be needed in the provision of nursing and support.

Most services are working close to target; two are significantly exceeding it. It is possible that services can work more effectively in environments where there is a 'critical mass' of alcohol and drug workers who adopt a team approach with shared roles and a focused and supportive organisational context. This is touched on again in the outpatient section below, and discussed at greater length in the concluding section to this report.

Data on completion rates are difficult to compare, again because of inconsistent interpretation by services, and are not available for all services. Rates are consistently reported as above the required 70 per cent and vary from between 83 per cent to 77 per cent.

### **3.3.5 Staffing**

Home-based withdrawal staff are well qualified and broadly experienced, all (with one service as the exception) are qualified nurses and many have postgraduate qualifications in alcohol and drug studies. Not all were experienced in alcohol and

drug work prior to working in the withdrawal service, but almost without exception they are highly regarded by clients and allied service providers. In many ways, the staff are the core of these services. Their nursing and support skills and their dedication to their clients play a vital role in supporting and reassuring clients and their carers and in safely overseeing the course of the withdrawal. Very few home-based clients are transferred to hospital. The withdrawal nurses' knowledge of the impact of substance use, of the likely course of the withdrawal syndrome in different types of substance use and of withdrawal medication, has played an important role in educating medical professionals. Risks associated with home-based withdrawal are minimised by clear inclusion and exclusion criteria and the use of extensive assessment procedures.

Retention of experienced withdrawal nurses and fostering of their skills is clearly vital. This can be enhanced by attention to a number of the issues identified below, but organisational contexts which provide appropriate support and supervision processes are essential. Professional and clinical supervision tends to be largely absent in the HBWSs included in the evaluation and it is necessary to develop suitable supervision arrangements. Close networks and collaboration with other alcohol and drug workers is important at the agency or local level, as well as via regional and statewide networks. Workers should be involved in identifying their training needs and need to be consulted as to how these can best be met.

### **3.3.6 Guidelines Regarding the Home Environment**

As stated above, Department of Human Services specifications for these services require the home environment to have certain features which will enhance safety and comfort. In addition the SAW guidelines for home withdrawal (Frank and Peard, 1995: 129–130), which act as a practice 'bible' for home based workers, also emphasise the importance of a range of social supports in the strongest terms. Nevertheless, withdrawal workers consistently report working with clients who do not live in environments meeting these criteria. There may be no support person at the home or nearby, substance use may be continuing among fellow residents, a telephone may not be accessible and so on. Concern from the field has resulted in a joint effort currently underway between the Department of Human Services and the non-residential services network to reframe the guidelines for home-based withdrawal to reflect the reality of the work services do, and to allay some of the fears services have about the legal implications of working outside the guidelines.

### **3.3.7 Legal and Personal Implications for Withdrawal Workers**

The field is concerned about a number of legal issues, and in many instances this is related to concerns about their personal safety. One issue, alluded to above, is the implications of working outside the Department of Human Services guidelines should an incident occur. A second concern is the legal liability of a withdrawal worker should a client die. They are unclear about where their responsibilities in relation to duty of care begin and end, what the GP's legal responsibilities are, and what the legal situation is regarding withdrawal nurses holding and handing out withdrawal medication and disposing of unused medication for clients, without a

formal signed agreement from the client. The implications of carrying and supplying needles for IV drug use without needle exchange accreditation (as a harm minimisation technique) is also of concern. A clear statement of advice on all of these is required.

Associated with these concerns are issues relating to the personal safety of withdrawal workers. Visiting clients at home presents a potential risk. Services have developed a number of ways of attempting to deal with this. In most services, initial visits are made to a client's home by two workers, or clients are required to come to the service for the first visit. One service does not do this, and solo first visits are routine. Subsequent visits are almost always made by a single worker, unless particular safety concerns are held. Safety policies exist in many agencies, involving leaving destination details and estimated time of return with agency colleagues, so that emergency procedures can be activated if a worker does not return or telephone in.

Solo visits present two concerns. Firstly, where there is an agency policy that solo visits should not be done, or certain procedures should be adhered to, then workers may be unsupported by their agency if an incident does occur and they have not followed the policy. Workers maintain that these policies are not always realistic and they could not provide the service and meet Department of Human Services targets if they had to work within the limitations of no solo visits and constant provision of a detailed itinerary. Again the legal situation is unclear. Secondly, withdrawal workers frequently express the view that there is a lack of understanding by their agency of the dangers inherent in their work. Even if agencies do not have safety policies, staff would like greater recognition of the risks they face.

### **3.3.8 Geographic Spread**

A number of home-based withdrawal services cover large geographic areas. Two HBWSs cover extensive urban and semi-rural to rural areas which, to some extent, resemble the kind of territory and population that rural withdrawal services cover. The demands of servicing clients across a wide geographic area needs to be recognised and reflected in the service budget.

### **3.3.9 Withdrawal as a 24 Hour, 7 Days a Week, 52 Weeks a Year Business**

All services are staffed on a 1.5 EFT per 110 episode basis, and have developed a range of different ways of providing a 7 day a week 24 hour on-call service for support and advice. This is largely on a telephone basis and essentially for existing clients. HBWS do not operate as 24 hour, 7 day a week crisis services. Two services operate a weekend service where home visits are made and new referrals can be accepted. Other services find that, despite the benefits for clients, their auspice agency has concerns about a service running outside standard agency hours and days. The lack of a weekend capacity means that services can rarely take on a new client on a Friday because they have no capacity to visit them during the first two, often critical, days of withdrawal. Weekends can be high stress times for alcohol and drug users and from a harm minimisation perspective weekend accessibility has definite advantages.

Replacement of staff when they are on leave, sick or in training is rare. Where services are larger, and where they operate closely with outpatient withdrawal or other alcohol and drug services there is a capacity to rotate staff and cross fill positions. In other services this does not occur and withdrawal support cannot be offered every week of the year.

### **3.3.10 Access to Expert and Supportive Medical Partnerships**

GPs are expected to play a critical role in home-based withdrawal, essentially in partnership with withdrawal nurses. All services have excellent working relationships with some GPs; all find that many GPs are unwilling to work with alcohol and drug users, or have such negative attitudes and poor knowledge of alcohol and drug issues that they are unsuitable partners. Withdrawal workers have often put a considerable amount of work into developing relationships with GPs, and into educating and supporting them. Many GPs speak highly of their role in this regard.

An impressive array of resources has been developed by services to inform GPs of the role of the withdrawal service, to guide medical assessments, and to suggest medication regimes. Formal referral and discharge processes are usually in place which emphasise the shared nature of partnership between the withdrawal nurse and the GP. It is usual practice in three services for the withdrawal worker to go with the client to their initial appointment with the GP. In the other three services this does not occur, but telephone and fax contact is made. Where co-visits are possible, this is an excellent way to build a team approach to the withdrawal, as well as providing an opportunity for all concerned to share their knowledge.

There are two main issues. Firstly, there are still too many GPs who are unwilling to work with alcohol and drug users, or who will work with them but are so obviously judgemental about their substance use that clients feel treated like 'scum'. Secondly, there are GPs who are prescribing inappropriately to people in withdrawal, at times against or without the advice of the withdrawal nurses, at considerable risk to the patient. These GPs are not necessarily aware of their own limitations and therefore are not prepared to seek expert advice.

### **3.3.11 Access to Hospital and Residential Withdrawal Beds**

Where home-based services assess someone as unsuitable for a withdrawal at home, there are frequently issues associated with accessing residential withdrawal beds. Waiting times are too long and assessment procedures can duplicate existing home based assessments. Regional boundaries can inhibit access to appropriate units. For example, clients of one service used to be able to access a specific CRWS with expertise in working with the older, alcohol dependent semi-transient males who live in boarding houses or special accommodation houses in the St Kilda area. Post-regionalisation, they can only use Southern Region residential services, which many find antithetical. At one Southern Region CRWS the client group is predominantly younger IV drug users, and at the other, it is too far for them to travel, and there is no special expertise in working with people in their situation.

Access to hospital beds varies. In one semi-rural service, in a similar manner to RWSSs, the home-based service has nominal access to two withdrawal beds at the local Hospital. This is a long standing relationship which has been formalised through the development of protocols. In other areas HBWSs essentially do not have access to hospital beds for withdrawal and can only use hospitals for a medical emergency, which may or may not be related to the withdrawal.

### **3.3.12 Service Expertise in Relation to Specific Client Groups**

All services are expected to address the needs of a range of special client groups including Kooris, people with a dual disability, people who are homeless, people from a non-English speaking background and young people. Women are specifically mentioned, with a target of 40 per cent participation included in PSPs. The extent to which the development of expertise in all these areas is possible within 1.5 EFT services is inevitably limited. Where services are a component of a range of services, the development of expertise is more realistic and could be pursued with greater energy. A portfolio process may be an option, where a specific staff member takes up a portfolio with a brief to become a source of knowledge regarding a particular client group or issue and to resource other staff in the agency.

Services can and are working to improve relationships with allied services in ethnic, youth, homeless and women's services areas, as well as Koori alcohol and drug and related services. The development of formal protocols with other statutory agencies such as VOSA COATS, Protective Services, Accident and Emergency Departments and services in the psychiatric and mental health area are slowly getting underway. It seems this is a relatively new concept and it is taking time to become established. A number of services identified a further group for whom adequate service provision may be enhanced by the development of protocols. Currently there are few ways in which non-Aboriginal people in police custody who are likely to enter withdrawal can be supported. The development of protocols with Victoria Police would facilitate this.

### **3.3.13 Transition to Post-Withdrawal Services**

Continuity of care and linkage into post-withdrawal services is a critical aspect of the model of community drug withdrawal. The major barriers for those working in home-based withdrawal are access and smooth transition into group and individual counselling, residential post-withdrawal, and dry, supported, crisis, short, medium and long term accommodation. Where services are co-located with alcohol and drug counselling services, the transition to counselling tends to be much easier and quicker. In some cases, the transition is supported by group opportunities offered by Women for Sobriety, AA, NA and specific alcohol and drug groups which can provide a useful bridge into counselling. Lack of residential options both for accommodation and for alcohol and drug rehabilitation are a constant issue. This has significant implications for the capacity of withdrawal services to direct clients to options which will assist them to maintain long term changes in problematic substance abuse.

### 3.4 Outpatient Withdrawal Services

In 1994, when the outpatient withdrawal service type was introduced, the Department of Health and Community Services redevelopment documents described it, together with home-based withdrawal, as offering “a limited amount of medical care and pharmacotherapy, and some supportive care” (DH&CS, Sept 1994: 2). Outpatient withdrawal services (OPWS) were described as working out of an existing health service on a five day a week working hours basis. Clients were to have stable accommodation, be able to commute readily and have a withdrawal syndrome of mild to moderate severity without illness or problems of a significant psycho-social nature (Department of Health and Community Services, Sept 1994: 8). In 1997 the specifications simply stated that OPWSs are provided to adults and young people who have a withdrawal syndrome of mild to moderate severity, which can be appropriately managed without admission to a residential service. (Department of Human Services, 1997: 16) In both 1994 and 1997 clients were described as likely to be

“a greater proportion of problem drinkers and individuals consuming benzodiazepines attending outpatient withdrawal than residential or home based services. This means that an average duration of withdrawal may be longer, with more gradual reductions in drug use to negotiated levels of consumption. The service provides a series of intensive individual outpatient consultations over a short period, followed by ongoing counselling and support to complete the withdrawal.”

(Department of Health and Community Services, Sept. 1994: 8 and Department of Human Services, 1997: 17)

In 1994, the specifications included details of how many consultations (seven over a 14 day period), may be provided by a nurse or an allied health professional. In 1997, the documentation remains silent on these issues and does not specify a target for the number of consultations, but three key service requirements for this service type were laid down, stating that the service was to provide intensive counselling, case management and “appropriate services where relevant to carers and families of those affected by alcohol and drug use” (DHS, 1997: 18).

The literature concerning outpatient withdrawal is difficult to use in the context of the Victorian service type. Many of the outpatient services described and evaluated in the literature are medical practitioner managed hospital or community-based outpatient services, others more closely resemble the Victorian home-based service type or fail to distinguish between the two types of withdrawal service. (This issue of the distinctions between outpatient and home-based withdrawal are discussed below on page 33) The research is primarily concerned with the type of client most likely to benefit from this form of treatment. For example, age, sex, marital status, length of dependency, type of drug and mode of use, readiness for change and supportive family involvement have all been identified as important factors in successful outcomes. Severe medical or psychiatric illness, lack of a stable family system, or failure at previous outpatient attempts, are seen to be associated with poor outcomes (Frances, 1988; Bischof et

al., 1991; McCann, Miotto, Rawson et al., 1997). As with assessment of other service types, reliable measures of outpatient treatment need to be developed in order to gain a clearer understanding of long term effectiveness (McCaffrey, 1996).

### **3.4.1 The Evaluated Services**

Five outpatient services are the subject of this evaluation:

- One service is auspiced by the community health service at Heathlands and works out of the Mentone centre and the East Bentleigh Community Health Centre.
- One is under a health care network and placed within a hospital auspice at the Box Hill Hospital Community Drug and Alcohol Service.
- Two services are under health care networks, one within a community health division at Westernport Drug and Alcohol Service at Dandenong and one in the community health centre at Frankston.
- One service with a statewide focus, based within an organisation with a wide range of clinical, research and training activities at Turning Point Alcohol and Drug Centre.

Funded in 1997 and not part of the evaluation, are outpatient services now running out of Moreland Hall, Western Hospital, Geelong Community Health Service and Warrnambool and District Base Hospital. Thus, all of the evaluated outpatient withdrawal services are in agencies that also have home-based withdrawal, and two are in agencies which run residential withdrawal services. The outpatient services have been operating between six months and three years. The Turning Point service was the first to open its doors in March 1995, CDAS in early 1996, Heathlands and Frankston both started in early 1997, and the WDAS service began operating in September 1997. This is perhaps the youngest, least extensive and least well known of the service types.

In summary, the Department of Human Services contracted five agencies to provide 1302 outpatient episodes of care during the 1997–98 funding period at a cost of \$326,100. The majority (3) of services are in the Southern Metropolitan Region, one is in the Eastern Metropolitan Region, and the Turning Point service is located in central Melbourne and has a statewide focus.

### **3.4.2 Program Service Plans**

There is a certain degree of standardisation in the parameters for a single outpatient service contract as described in the 1997–98 PSPs. Services are to provide 220 episodes, or multiples of this number, with a 70 per cent completion rate. Of these clients, some 40 per cent are to be women, 90 per cent are to have an individual treatment plan and 70 per cent (50 per cent in one instance) are to achieve the short term goals outlined in this plan. Performance measures around expected average hours of counselling and level of client satisfaction vary from region to region. As with home-based services, some services felt ill-informed about their PSPs, confused by the changing nature of them on an annual basis and puzzled by the variation across the field. There is a perception amongst service providers that the targets are not based on identifiable, rational or empirical grounds.

### 3.4.3 Episodes and Completion Data

The main concerns were expressed by the field with this PSP framework, with its focus on episodes and completion data. Firstly, episode and completion are seen to be ill-defined concepts that do not adequately reflect outpatient work and are interpreted differently across services. As noted above, there is a common concern about lack of consistency across all service types. Secondly, it is felt that if completion data are supposed to indicate fulfillment of the first objective of withdrawal work, that is 'completion of the withdrawal syndrome', then they do not reflect the goals of many people using an outpatient service, who are focused on reduction or controlled use<sup>5</sup>.

Finally, episode targets may be too high for outpatient services at the equivalent of 220 episodes per annum per EFT. Three of the outpatient services are, on current trends, likely to be under target by the end of the financial year.

There may be a number of reasons for this. Firstly, where a 1 EFT staffed outpatient service operates semi-or wholly autonomously it may be extremely difficult to meet the 220 episodes target. Where the outpatient service is integrated into a broader team within a coordinated agency approach, then there is greater capacity for other staff to fill in when the withdrawal worker is on leave, sick, in training and so on. In the 1 EFT staffed service it may not be possible to offer a service when the withdrawal worker is not available. In addition, in a more integrated and larger team a number of opportunities for sharing tasks may be possible, such as service marketing, development of linkages with other services, data input, training, assessment, intake duties and so on.

Secondly, practice methods may also play a part. In outpatient services, where the definition of withdrawal support is unclear and the boundaries between it and counselling are blurred, client contact may be more drawn out, thus reducing the capacity of the service to take on new clients and meet targets. In three services with lower episode data, counselling support tends to be slightly prolonged with withdrawal clients. This is partly to provide a bridge for clients while they are waiting to access alcohol and drug counselling, and partly because discharge processes after withdrawal are not explicit.

Thirdly, staff profiles may also have an influence on practice methods. Where withdrawal workers are counsellors or non-nurses, the distinction may not be so clear between the withdrawal support role on the one hand and the broader counselling role on the other. This too can mean more prolonged contact between client and service. This is exacerbated where the workers share these roles across positions. For details of the training and qualifications of withdrawal workers see the staff profile paragraphs below.

The issue of staff qualifications is discussed below (section 3.4.4) where the question is raised as to whether outpatient and home-based withdrawal are discrete service types, or whether there is a case to be made for a reconsideration

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<sup>5</sup> If completion refers to 'completion of episode' this problem does not arise.

of this and possibly the development of metropolitan withdrawal support services, as a complement to rural withdrawal support services.

Data on completion rates are difficult to compare, again because of inconsistent interpretation by services, and are not available for all services. Rates are consistently reported as below the required 70 per cent and range between 35 per cent and 70 per cent.

#### **3.4.4 Staffing**

The 1994 the Department of Health and Community Services documentation states that this service can be supplied by “a health practitioner, being either a nurse or allied health professional, in collaboration with a staff or private medical practitioner” (Department of Health and Community Services, Sept. 1994: 9). The 1997 documents do not specify staffing background. In practice, services have made different decisions about staffing profiles. One service has a range of medical and nursing staff, as well as welfare workers. Two services have a qualified nurse, one of which operates a rotation system where one of four withdrawal nurses spends three months per year in the role of outpatient worker, while the other three work in the home-based service. The other two services are staffed by people without nursing qualifications; one by a person with a science degree and a naturopathy qualification, the other by two part-time psychologists, who also work in the alcohol and counselling service in the same agency. The comments in relation to the training needs of withdrawal workers made in the previous section on home-based services are also relevant here.

#### **3.4.5 Outreach**

A number of outpatient withdrawal services cover extensive areas and some have adopted outreach strategies to increase client access. One service covers an extensive urban and semi-rural to rural area, which to some extent resembles the kind of territory and population covered by a rural withdrawal support service. The service attempts some outreach options. Establishing an outreach service incurs expenses in the form of additional costs such as rent and travel time. Recognition of the demands this can place on a service should be considered in setting budget and performance targets.

#### **3.4.6 Out-of-Hours Outpatient Services**

Outpatient services are not required to provide an out-of-hours service, but a number of the evaluated services attempt to meet the needs of working clients by providing appointments before and after standard working hours. Some also provide after-hours telephone support. There is one service which is open at the weekend, where the pharmacy, but not clinic, is open for two hours on weekend days and public holidays to dispense methadone. The question of whether weekend services are a feasible and desirable option for both OPWSs and HBWSs is raised above in the home-based services section.

### **3.4.7 Access to Expert and Supportive Medical Partnerships**

Although all OPWSs prefer that clients visit a GP as part of the assessment process, a proportion of outpatient withdrawals do not involve a medical practitioner. These may include non-medicated cannabis withdrawals; situations where a client refuses to see a medical practitioner, or where a client is expected to experience an uncomplicated, non-medicated withdrawal. However, where a GP visit is sought, then difficulties in accessing skilled and supportive medical involvement remain the same as those detailed above in the HBWS section. In addition, some medical personnel appear reluctant to refer clients to outpatient withdrawal services or accept referrals from them, apparently on the basis of a lack of understanding of the role of an outpatient service or reservations about losing clients to a 'rival' service.

### **3.4.8 Service Expertise in Relation to Specific Client Groups**

Outpatient services, like all other service types, are expected to be able to respond to the needs of a range of specific groups. The comments made above regarding the capacity of home-based services, with their 1.5 EFT staffing, being able to meet all client needs, are even more pertinent in relation to the 1 EFT staffed outpatient services. Integration in some way to a broader service base may provide a solution.

### **3.4.9 Transition to Post-Withdrawal Services**

The most pressing need for clients of an outpatient withdrawal service seems to be for ongoing post-withdrawal counselling. In most areas there are waiting lists of some weeks, with some access to group sessions run by AA, NA, Women for Sobriety and occasionally by regional alcohol and drug counselling services. Outpatient services either discharge clients and refer them to counselling knowing they will have to wait, and may relapse during this time, or the service continues to provide support to help them bridge the gap between withdrawal and counselling. This may restrict entry to the service, result in the development of a waiting list, and compound difficulties in meeting performance targets. Smooth transition from withdrawal to post-withdrawal has not been achieved across the field and is particularly important, given research findings that demonstrate the role of counselling in increasing the overall effectiveness of outpatient drug treatment (Fiorentine and Anglin, 1997).

### **3.4.10 Outpatient Withdrawal as a Distinct Service Type**

Excluding for a moment one service which operates differently (discussed below), the question is raised as to whether the outpatient withdrawal service type, as implemented in Victoria, is really a distinct service type. Clearly, the option of clients being able to withdraw from a substance with expert support, in the community, but with no home visits, is one that some people want. However, whether this should be separated from the other metropolitan non-residential withdrawal option, and run by non-nurses, is seen to be debatable. There are a number of reasons why this query is raised.

First, there is a lack of understanding of 'outpatient' as a service type. One service, with its provision of medical, nursing, pharmacy and support services and 'clinic' terminology is unique among the five OPWSs, and is close to what the lay person generally interprets as an 'outpatient' service. The other four services provide withdrawal support, but theoretically this is not nursing/medical support. These four services rely on community rather than 'clinic' (as in hospital or practice) based medical and pharmacy services. In general, the community understanding of what is implied by an 'outpatient' service is not what is supplied under the current service type.

Second, the distinction between those eligible for home-based and for outpatient withdrawal is somewhat blurred and tends to be based on social rather than medical grounds. Most services rely on exclusion/inclusion criteria which make minor distinctions between home-based and outpatient services. The medical or physical criteria tend to be explicit that clients who can be accepted into both service types need to be assessed as likely to have an uncomplicated, mild to moderate withdrawal syndrome, and as having no previous history of complicated or severe withdrawals, no history of seizures, and no concurrent physical or psychiatric disorders which may be exacerbated by the withdrawal. On the other hand the inclusion criteria for outpatient clients/exclusion criteria for home-based clients tend to focus on social factors. These include those who have no support person available through the withdrawal; the client or support person must have access to a telephone; those who do not wish to disclose substance abuse to significant others; those whose home environment is unsuitable for home-based withdrawal, due for example to domestic tension; people who are working. Clients with small children, or need to travel long distances can find it difficult to attend appointments. They may be suitable for home-based withdrawal. Clients who are employed may be suitable for an outpatient service. At one service, the OPWS will often admit more complex clients such as those with psychological issues or aggressive behaviour, because of staff training and skills. This is also a safety precaution, as HBWS staff do not feel comfortable going into these people's homes. At another service, a client did not meet the inclusion criteria of the HBWS because of their psychiatric history, but was accepted into the OPWS because of prior contact between the outpatient withdrawal worker and the client.

In practice, though not necessarily included in formal inclusion/exclusion criteria, the characteristics of the client's substance use may also be used to guide decisions. For example, outpatient services may accept people with slower reductions over longer periods, such as benzodiazepine and methadone withdrawals; non-medicated cannabis withdrawals; binge drinkers or people who wish to reduce their drinking rather than give up alcohol; people whose life is not dominated by their substance use and those who can continue to work and undertake daily living tasks while using.

A number of clients of OPWSs commented that they would have preferred to have begun their withdrawal with visits at home and then they would have been happy to have visited the OPWS after the first couple of days, or the first two or three visits.

All these examples show that although there may be differences in the clients of outpatient and home-based services, there may also be many similarities. If these differences are founded on social rather than medical characteristics, then there may be little justification for one service type to be delivered by nursing trained staff and the other by non-nursing trained staff. The original *Services for Alcohol and Drug Withdrawal* project on which much of the services redevelopment planning was founded made no distinction when discussing decisions about which settings were most appropriate for which clients. (Frank and Pead, 1995: 31) They simply distinguished three settings of home-based, community residential and inpatient hospital.

It should be remembered that this service type is still in its infancy. The people who have implemented it have been doing an excellent job in establishing these services and providing a significant community-based, non-residential withdrawal option to alcohol and drug users. This service type may 'take off' once it becomes better known. Further consideration of the questions raised here would be useful in for the continued development of non-residential withdrawal options. In summary these questions include:

- Should there be an emphasis on closer integration of OPWSs and HBWSs, so that clients can move smoothly between service types as the course of their withdrawal requires, or their social circumstances dictate?
- Would integrating HBWSs and OPWSs mean a loss of emphasis on home-based withdrawal, a service type which tends to be more costly and time consuming to deliver, and would this diminish the availability of this option to clients?
- Would an integrated system with combined budgets and staffing be more capable of providing a weekend service and is this desirable?
- Should a term other than outpatient be used, to avoid confusion and to emphasise the supportive but non-home-based aspect of the withdrawal support that can be offered?
- Should there be service collaboration around the development of clearer guidelines about what should be covered in outpatient sessions? This would assist services to ensure outpatient withdrawal counselling was simply that, and not de facto alcohol and drug counselling sessions. An example of such guidelines can be found at CDAS, where they are currently in the process of documenting an outline of a standard eight outpatient sessions.

### **3.5 Summary**

The redevelopment of alcohol and drug services in Victoria saw the establishment of four types of withdrawal services: rural support, community residential, home-based and outpatient withdrawal. These services were designed to provide a range of treatment options to people requiring withdrawal support and to meet diverse client needs in terms of complexity of the withdrawal process and individual social circumstances. The evaluation was not asked to compare the service types, nor would it be appropriate to do so. A number of issues, however, were identified in the course of the evaluation that are common across service types.

All four service types are governed by PSPs that contain standard measures such as:

- The number of episodes of care to be provided.
- Completion rates.
- The proportion of clients with Individual Treatment Plans (ITPs).
- The proportion of women accessing the service..
- In the case of CRWSs, occupancy rates and length of stay.

Variation exists, however, within the PSPs as to rates of client satisfaction, average hours of intensive counselling and proportion of clients achieving short term goals in their ITPs. Funding levels are also not consistent within each of the four service types, although each service is contracted to meet the same targets. The Department of Human Services reports that this is not Departmental policy and may be a transitional artifact of the redevelopment.

All services types generally comply with the target or performance measures set out in the PSPs, although a number of issues have been identified. Firstly, RWSSs and HBWSs are funded at the same rate to provide the same number of treatment episodes. Given the differences in geographic areas covered by the two service types, it would appear the RWSSs are under-funded. Secondly, the episode of care targets for OPWS need to be reconsidered, given current staffing levels and profiles, and practice methods. Thirdly, the 100 per cent occupancy rate for CRWSs is considered unrealistic, given the reality of managing unpredictable vacancies. Fourthly, as the concepts of “episode” and “completion” have been interpreted differently across all four withdrawal service types, comparison of individual services across service types is difficult. There is a need for further clarification and application of these concepts across all service types. Finally, there is also a need for consideration to be given to the most appropriate way in which the Department recognises the health promotion and case management work conducted by withdrawal services.

On the whole, the guidelines for withdrawal services are seen to be appropriate for the four service types. There is a concern that both HBWSs and RWSSs are working outside the guidelines in the provision of home-based withdrawal, where clients do not have home environments that are suitable for withdrawal. There are also a number of legal implications associated with the provision of home-based withdrawal support that need to be addressed. The requirement that both HBWSs and RWSSs provide 24 hour, 7 day on-call service for support and advice translates generally as staff being available to clients on a telephone basis outside of normal office hours. Within the reality of current staffing levels, weekend service coverage for both service types is minimal.

Given the standard rates of funding, it is interesting to note that staffing levels vary across all four withdrawal service types. Both HBWSs and RWSSs have low EFT staffing levels, with implications for the worker’s ability to provide 24 hour, 7 day coverage, participate in ongoing professional development, take sick, annual or study leave, access peer support and offer a client sensitive service. Some further consideration needs to be given to appropriate staffing levels in RWSSs. It is suggested that greater integration of HBWSs and OPWSs may overcome some of these issues.

RWSSs report difficulties with recruiting and maintaining suitably qualified and experienced staff. Access to professional and clinical supervision is identified as being of particular concern across all service types, but particularly for RWSSs, where geographic distances impact on workers' ability to participate in metropolitan-based training and network development. The demands on staff in CRWSs are also seen to be considerable and additional effort needs to be directed towards providing adequate support, supervision, debriefing and training.

Most withdrawal service types (with the exception of some OPWSs and some CRWSs night shifts) are staffed by nurses who can provide clients with medical support and advice. Access to GPs for additional medical support is more problematic, especially for non-residential services. Considerable resources have been directed to inform and support GPs regarding their role in the withdrawal process, particularly by RWSSs and HBWSs. However, non-residential services still experience difficulty in working with doctors who have low levels of alcohol and drug knowledge, are reluctant to work with alcohol and drug clients, and prescribe inappropriate medications for withdrawal. In many instances, these services are reliant on one or two GPs for medical support. This is clearly unsatisfactory and requires further consideration. CRWSs access GP support in a variety of ways, including the use of hospital doctors, sessional GPs, and through a shared care model with community-based GPs. There exist some unresolved tensions regarding the medico-legal responsibility for clients with the shared care model that need to be addressed.

Access to local hospitals is a critical component of rural withdrawal support, due to the absence of locally available community residential withdrawal services. Although most RWSSs have developed protocols with hospitals, the degree to which they can (and do) utilise hospital beds for withdrawal varies considerably across Victoria. The ratio of home-based and inpatient care varies across RWSSs. Some RWSSs balance the provision of home-based and inpatient care well. Other services concentrate on the provision of inpatient care, to the detriment of home-based options. Yet other services are unable to access hospital beds and therefore have restricted withdrawal options. The ability to balance these options is influenced by a number of factors including relationships with local hospitals, GP support, and worker confidence.

Despite the concerted efforts of most RWSSs in providing support and training to hospitals, there exist concerns regarding low levels of understanding about the withdrawal process within the hospital environment, the appropriateness of hospitals as a suitable environment for withdrawal care and support, and the lack of guaranteed access to hospital beds. Access to CRWSs by rural residents is also of concern with waiting lists, geographic distance and client reluctance presenting barriers to their optimal utilisation. The level of regional spending on metropolitan community residential beds could be reconsidered in light of this, including the possible diversion of these funds into rural services.

The SAW model suggests that hospitals be part of the continuum of care that is also available to metropolitan services. Access to inpatient care for clients who require maximum support due to very complicated withdrawal is problematic.

Accessibility of services is seen to be a concern for RWSSs where geographic distance may prevent clients from entering treatment. In the metropolitan area, waiting lists for CRWSs are seen as hindering client access. Issues around services' capacity to be sensitive to the needs of a range of client characteristics are also raised. All service types report difficulties in accessing post-withdrawal treatment options. This has serious implications for the capacity of withdrawal services to provide case management and continuity of care.

Withdrawal services are generally working at, or near to, capacity levels. Increased demand will place withdrawal services under greater pressure to establish, or see a growth in, waiting lists—thereby needing to ration service delivery.

## 4. The Model from the Perspective of Its Objectives

The 28 Phase 1 services were evaluated within the framework set by the four Department of Human Services objectives for withdrawal (*Withdrawal Services Evaluation Plan 1998*). This framework was used to consider the extent to which individual services are operating within the Department's specifications and guidelines. The information from this process is now taken to enable a consideration of the model of community drug withdrawal as a whole and to comment on the strengths and limitations of its current operations.

### 4.1 Objective 1: Completion of the Withdrawal Syndrome

The first objective of withdrawal services is to "ensure that the person in withdrawal satisfactorily completes the withdrawal syndrome with *safety* and *comfort* at an affordable cost. Effective treatment of drug withdrawal involves tailoring interventions to the assessed importance of neuroadaptation reversal, illness and psychosocial factors" (Original emphases Department of Health and Community Services, Sept. 1994: 3).

#### 4.1.1 Episode and Completion Data

Access to episode and completion data has been problematic as described above, but services are generally, in so far as it is possible to judge from the available data, working at expected levels in terms of client numbers. The exception is the outpatient service type, where there is wide variability in target achievement.

There is some variety in how services have been interpreting an episode of withdrawal and a completion of that episode. An episode of care in all service types is "a completed course of treatment undertaken by a client under the care of an alcohol and drug worker which achieves significant agreed treatment goals." This allows for flexibility, but has resulted in a level of confusion across the sector. This may resolve itself over time, when services become more confident and comfortable with the new terminology.

#### 4.1.2 Safety and Comfort

A broad definition of withdrawal has been adopted across the board, encompassing reduction, controlled use, short, medium or long term cessation of use. The focus of withdrawal workers on clients and their goals is evident here, as is a view of withdrawal within a harm minimisation context. Including the family and friends of the client in the withdrawal is often an important aspect of ensuring safety and comfort, especially in rural and home-based services.

Withdrawal workers have an extensive range of skills, experience and knowledge which help to make withdrawal safe and comfortable for clients. This is particularly important in the context of the variable level of knowledge and co-operation of hospitals and general practitioners. There is still a reluctance among some hospitals and some medical practitioners to see alcohol and drug affected people in withdrawal as their business. Rural services in particular have played a key role in educating hospital staff and rural medical practitioners. The non-residential and some of the residential, metropolitan services too have put considerable effort into educating GPs, but have far less contact with hospitals.

The pharmacotherapy knowledge of many withdrawal workers is impressive, and their role in informing GPs of appropriate medication regimes is vital, if at times delicate because of the reluctance of many medical professionals to be advised by a nurse. Nursing skills are an important element in the safety and comfort of people withdrawing from alcohol and drugs. The Drug and Alcohol Clinical Advisory Service (DACAS) plays a role in providing clinical advice, but a lack of professional supervision for staff in relation to both pharmacotherapy and psychosocial issues was noted by a number of services. In many non-residential services workers hold, supply as required and dispose of unused medication. Not all services have signed agreements with clients formalising this, which may leave them open to potential legal repercussions should an incident occur.

Worker dedication to clients is evident around the state. In most of the non-residential services, workers go considerably out of their way to meet the needs of their clients. In doing so, they sometimes go beyond the service guidelines and take calculated risks in order to accommodate clients' needs. Examples include rural and home-based services consenting to work with clients who do not have stable or drug free accommodation, a telephone, or a support person. Clients whose medical condition may suggest the need for a residential withdrawal are also sometimes taken on in the face of a refusal to accept a residential option, or in the absence of such an option. On the one hand, this willingness bespeaks courage and a commitment to clients and to a harm minimisation approach. On the other hand, it places strain on workers and poses a potential risk to clients. To date few serious incidents have occurred, but the potential remains and workers and agencies remain unclear about their legal position should this happen.

To ensure safety and comfort for withdrawal clients the Department's specifications and guidelines require rural withdrawal support services and home-based services to provide 24 hour 7 day a week cover. This is implemented in a number of ways. Examples include regional on-call networks of withdrawal workers, two part-time workers spreading their hours in such a way that they provide half day cover over Saturday and Sunday and public holidays, or sole workers being continuously on-call. Clients are also directed to call Direct Line for support, and GPs and hospital emergency departments for acute medical problems. Details on how to use the Drug and Alcohol Clinical Advisory Service are also given to medical practitioners. However, in practical terms the 'hands on' nature of the on-call requirement places considerable stress on sole or unsupported workers. This suggests that this requirement needs to be met by collaborative arrangements, or some kind of group response, rather than relying on individual commitment. It also highlights the value of alcohol and drug services being closely linked so as to facilitate these sorts of arrangements. Greater integration of outpatient and home-based services as described above could alleviate some of the strain on individual workers and facilitate the provision of weekend services.

### **4.1.3 Affordability**

Withdrawal services are free, or in the case of some of the CRWSs, there is a small fee of around \$20 for medication, massage, herbal remedies and activities. In the

non-residential services, clients have to pay for medication, though some services have developed ways of assisting clients with this cost. Rural residents are financially disadvantaged in some areas by the absence of GPs who will bulk bill and by the lack of methadone prescribers and/or dispensers. Travel costs to the withdrawal service or to methadone services for rural clients can be considerable. Some agencies make a small fund available to assist clients. More broadly applied, such an initiative could play a useful role in increasing the affordability of services for clients.

#### **4.1.4 Accessibility**

Services are working diligently and generally very effectively to be accessible to their clients, to maximise their response capacity and to minimise waiting lists. Few non-residential services have waiting lists, but residential services have waits of between two days and three weeks. Outpatient services, despite the intention that they should be an option which (among other things) can suit people who are employed or who do not wish to involve family members, are not providing a weekend service or extensive after-hours operations. Immediacy of response is generally seen to be important, though in some of the debates around management of assessment and waiting lists in CRWSs there still remains a trace of the attitude that making services too accessible means clients may not be 'serious' about withdrawing. Waiting for a service can be seen to test a person's motivation.

Physical accessibility of withdrawal services is generally good, though distance and lack of public transport is a problem in many rural areas, adding to client costs and, in some cases risk, as some clients are described as having to hitch-hike to reach services. In some rural regions and in some metropolitan ones also, there are pockets which are distant from services and outreach options have been attempted, with mixed success. Access can be increased, but service delivery costs also increase and there are considerable logistical challenges for sole worker services trying to be available in two places at once. Many rural withdrawal workers travel excessive distances and feel that the time this takes and the strain it engenders are not recognised in the expectations of their role. The siting and layout of some services have been criticised by clients and staff alike, and can be a drawback in terms of accessibility.

Marketing services has been a critical issue in many areas, where informing the service system, especially the medical field, of the existence and role of the withdrawal service has been seen to be a vital first step, especially in the face of the complete reorganisation of the alcohol and drug service system. Informing the general public has sometimes come second in this, and needs to come further to the fore. However, many services are already working at or near capacity and increased marketing may result in pressure on services to establish waiting lists and/or ration services.

The accessibility for rural clients to metropolitan residential units remains a problem, as discussed in the service type sections above. Services acknowledge difficulties in meeting the needs of a number of other client groups including:

- People from a non-English speaking background.
- Parents, predominantly women, with dependent children.
- People with a mental illness in conjunction with a substance abuse issue.
- People who are homeless and/or itinerant.

Very few services have materials on their service in languages other than English, although some do use published material on withdrawal. Developing service specific resources is seen by withdrawal services to be beyond their skills and budgets. Only two services have specifically employed bilingual workers.

Some agencies have made efforts to address these difficulties, but a good deal more can and needs to be done. Universally, withdrawal workers and Koori alcohol and drug workers express the view that working with Koori people is best done through, or in close collaboration with, Koori-specific agencies. Some services have developed considerable expertise in working with particular groups, others have projects to address specific client needs, others are taking some innovative steps to develop greater expertise and to build networks with relevant allied service providers. Services need more opportunities to share ideas and experiences. A number of recent projects auspiced by the Department of Human Services may assist in building up awareness and expertise. These projects include the Best Practice Drug and Alcohol Treatment and Support Service Models for Young People of Cambodian, Laotian and Vietnamese Origin; the Cultural and Linguistic Diversity Project; Community Residential Withdrawal Services: the Report on the Best Practice; Youth Outreach Services: Report on Best Practice; the Pilot Dual Diagnosis: Drug Problems and Mental Health Project; and the Young People and Drugs Needs Analysis. It is vital that the findings from these pieces of work are widely disseminated throughout the field.

## 4.2 Objective 2: Health Promotion and Harm Reduction

The second objective emphasises the importance of a health education and harm minimisation approach to withdrawal. "Other outcomes that can be achieved in the same settings are health promotion and *behaviour change* directed at managing psychosocial crises and encouraging harm reduction. Intensive behaviour change interventions directed at relapse prevention undertaken during withdrawal may be counterproductive" (Original emphasis the Department of Health and Community Services, Sept. 1994: 3).

All services embrace this objective in their philosophy and interpret it broadly. However, the extent to which services can put it into practice varies by service type. Health promotion work occurs in three contexts:

- With clients and their family and/or carers.
- In secondary consultation with service providers in health and welfare.
- With the general community at large.

In rural areas, withdrawal workers, together with their colleagues in alcohol and drug counselling and youth outreach services, often play a very broad role in all three contexts. In metropolitan non-residential services the focus tends to be on working with clients, their support people, and with service providers. In

metropolitan residential services (apart from one Unit where the shared care arrangements include extensive work with medical practitioners) clients tend to be the focus, sometimes with very little inclusion of family and friends. It is an ongoing concern that CRWSs are hard pressed to undertake a great deal of harm reduction education with clients within the constraints of the short stay, potentially complex medical process of the withdrawal and pressure on staff to undertake numerous administrative and clinical tasks. Even fewer opportunities can be found to work with family members.

There are times in withdrawal work when a tension is experienced by workers between placing a focus on cessation of substance use, while providing information on safe using. Whilst most services negotiate this well, residential services have the most difficulty, perhaps because of the emphasis on a drug free environment in the units, the relatively short time clients spend there, and the limited time workers have to spend with each individual. In some services split kits are provided to clients, however, this is problematic in that not all services are accredited needle and syringe exchanges.

There is a range of useful harm minimisation pamphlets, brochures and information sheets that services use or have developed themselves to inform clients and their carers of the way to manage withdrawal and post-withdrawal. Again greater sharing of these would prevent duplication. Tight budgetary constraints were mentioned by a number of services as inhibiting the purchase of harm minimisation publications and the production of in-house material, particularly translated material.

The extensive work undertaken by services to meet this objective goes relatively unrecorded by current reporting and monitoring processes. There are times when services feel a tension between on the one hand, direct work with clients which is clearly part of the mandatory and measured performance of the service, and on the other hand, health education work with service providers and the general public, which is not measured or recorded in any way and not part of the monitoring framework. Ways of ensuring the latter area is recognised in performance measures would better reflect the breadth of the work of withdrawal services. This would also draw greater attention to this important role.

### **4.3 Objective 3: Case Management**

The third objective emphasises the importance of a case management approach, which includes “supportive counselling and advice to ensure that following treatment of withdrawal services are available, accessible and coordinated to meet each individual’s need” (Department of Health and Community Services, Sept. 1994: 3).

All services identify that they operate with a case management approach, but the extent to which this occurs in a broad sense is mixed. In many instances, this goes no further than ensuring that post-withdrawal options are identified and some referrals are made. Follow up is rare. The relationship between client and withdrawal service is relatively brief, especially in the CRWSs, and the capacity for

case management to be put in place in the full sense of the concept is inevitably limited. As interpreted by services, case management is put into practice via assessment, the development of individual treatment plans, and discharge planning/post-withdrawal referral. All of these are conducted in collaboration with the client and other service providers as appropriate. Discharge processes range from the formal, where discharge summaries are given to the client and/or are sent to referral sources or post-withdrawal services, to the relatively informal, where discharge is simply the cessation of contact between client and service. There are some examples in the field of excellent policies which detail these processes. Sharing of these can only enhance practice.

The Office of the Public Advocate (OPA) defines case management as involving “on-going contact between the client and the case manager, to ensure that services are available, accessible and co-ordinated to meet each individual’s needs” (OPA, 1992: 2). Case management is described as being put into operation by means of involvement, planning, linking and monitoring. If this is accepted as what case management involves, then services cannot completely achieve this. Firstly, their role is often limited to referral, rather than extending to the coordination of services. Secondly, services have little or no capacity to monitor the situation of their clients once they have completed withdrawal. Thirdly, some withdrawal workers have described their role as one of the services being coordinated by a case manager in another agency, for example Child Protection or COATS.

However, it would be useful to articulate what is expected of services with regard to case management and to develop a clear definition of case management in alcohol and drug work. This could include a recognition of the limitations faced by short term services in working with clients with long term issues, as well as an acknowledgment of the extreme lengths some services have gone to in order to assist clients with a range of associated, but non-substance abuse, issues. These include organising material aid, helping clients to find accommodation and move house, paying for medication, food, travel, bailing them out from Police stations, arranging solicitor’s advice, appearing in court on a client’s behalf for Child Protection hearings, advocating with Police and psychiatric teams in favour of, or against, compulsory committal to psychiatric hospital and so on.

#### **4.3.1 Linkages with Other Services**

Services have generally done an excellent job in liaising and linking with other services. This is particularly noticeable in rural areas where service networks tend to rely on personal contact rather than formal protocols. Despite the Department’s stated preference for formal protocols between the withdrawal services and other key agencies, these have been relatively slow to develop. This is perhaps not surprising, in what has essentially been the establishment phase of these withdrawal services. Also, a number of health and welfare agencies have been reluctant to enter into formal agreements, believing them to be unnecessary. Now that withdrawal services are becoming accepted and have established their credentials with other agencies, recognition is growing of the benefits of formal agreements. However, some organisations still believe that reciprocal protocols are not necessary. It remains difficult to reach formal agreements with GPs.

In summary, a number of issues stand out as barriers to effective case management and the provision of withdrawal and post-withdrawal support. These include:

- The limitation imposed by the very short period of time clients spend in residential units, especially relevant with clients who have complex needs.
- A lack of knowledgeable and supportive GPs with whom to work in the community.
- The reluctance of a number of country hospitals to provide inpatient support.
- The importance of continued support to rural hospitals which do accept withdrawal clients.
- The lack, apart from three beds at Western Hospital, of hospital beds designated for withdrawal.
- The lack of community residential withdrawal options outside the metropolitan area.
- The issues surrounding the limited use of metropolitan residential withdrawal units by rural residents, including the reluctance of clients to leave their family supports and local environment, the delays in accessing beds, and the problems people in withdrawal face in travelling across Victoria.
- The difficulties encountered in working with psychiatric services around clients with a mental illness.
- The need to provide training on an ongoing basis to service providers generally, and hospital and medical staff in particular, especially where staff turnover is regular or rapid.
- Lack of bridging programs to support clients while waiting to enter withdrawal or post-withdrawal programs.
- Relatively restricted access to post-withdrawal alcohol and drug counselling and a general lack of group counselling opportunities.
- A lack of local, crisis, medium and long term supported accommodation.
- Extremely restricted options for post-withdrawal residential rehabilitation.

#### **4.4 Objective 4: Client Rights and Dignity, Monitoring and Evaluation**

This fourth objective was not originally articulated as an objective per se in the Department's 1994 and 1997 documents. It was however, inherent in the service indicators, core features and service specifications described therein. It was therefore labelled 'an objective' for the purposes of the evaluation and incorporates the requirement that services maintain a commitment to the rights and dignity of clients and engage in monitoring and evaluation activities, to ensure high standards of service and outcome.

There is no doubt that withdrawal services generally are extremely well served in terms of commitment to client rights and dignity. Withdrawal workers are almost without exception strongly committed to their client group. This is in contrast to the more negative attitudes towards alcohol and drug clients of some staff in generalist health and welfare agencies, including the agencies where withdrawal services may be situated. Not all services however, have formal statements of clients' rights nor clear directions as to how to make a complaint about the service. These need to be developed.

In general terms, despite some commitment, monitoring and evaluation is poorly carried out by services. Very few agencies have formal processes for review and evaluation of their withdrawal service such as regular case conferences, structured staff meetings with an evaluative component, formal report writing or annual review or planning days. Few have mechanisms to support review and evaluation processes such as:

- Regular staff performance appraisals.
- Data collection and collation systems around the different aspects of running a withdrawal service (direct client work, health education work, work with other service providers).
- Community education around alcohol and drugs.
- Specific mechanisms for ensuring clients and allied services can provide feedback.

Client feedback is only one mechanism for evaluating service provision and services have been required by the Department to report on levels of client satisfaction. Most services, have developed a client feedback sheet, but unless this is incorporated as an integral part of the service, for example as part of the discharge process, then response rates are very low. Where services receive feedback from clients and from other service providers, it is essentially via informal means. Overall, (but not exclusively) formal feedback mechanisms at agency and service level are under-developed, or variably applied. Some services have been innovative in their efforts to acquire client and service provider feedback. Some have developed agency-based statistical systems to assist them with performance monitoring requirements and service review and planning. Other services have no such system in place and are often without the capacity to undertake analysis themselves.

Service level monitoring and evaluation seem to work best where:

- Efforts to tap client and service provider feedback are built into everyday practice and not seen as just an extra (and sometimes an annoying extra) imposed by external forces.
- Both the agency *and* the withdrawal service are committed to monitoring and evaluation, and energy and resources are put into developing systems and mechanisms to ensure that they occur.
- Training and support is given to withdrawal workers to develop expertise and to support the development of evaluation mechanisms, or else expertise in the agency is made available to them.
- Both personal support as well as professional supervision are available to withdrawal workers. The absence of the latter is a significant gap in the non-residential services.
- Departmental staff at the regional and central level are viewed by withdrawal services as responsive and willing to listen to the issues they face in producing quarterly monitoring data and ADIS requirements.

In addition to the failure of most agencies to support monitoring and evaluation activities, there have been a number of problems with external systems, including the performance monitoring requirements and the ADIS system.

The negative climate that has built up around ADIS is discussed in the environment section above. Even with the introduction of a more 'user-friendly' system in the form of Interim ADIS, a significant effort is required to facilitate a collaborative enterprise between government and funded agencies to develop a useful and properly functioning monitoring system.

## **4.5 Summary**

The vision inherent in the four objectives framework remains entirely appropriate, focusing as it does on safe and comfortable withdrawal, a harm minimisation approach, coordinated care and service linkages within a case management model of practice, a commitment to clients' rights and dignity and on the importance of monitoring, evaluation and quality assurance.

As illustrated above, services are largely operating in such a way as to meet the four objectives. As a basic conceptual framework for the model of community drug withdrawal, these objectives are considered appropriate overall. However, a number of ways in which the model could be improved are identified. These would be of benefit to both purchasers and providers in clarifying exactly what is expected of withdrawal services, and would also provide a clearer framework for ongoing monitoring and evaluation both by the Department and at the service level.

The three seminal documents for the redevelopment of alcohol and drug services (Department of Health and Community Services, March 1994, Department of Health and Community Services, Sept 1994, Department of Human Services, 1996) played an important role but did result in somewhat over-elaborate, and at times inconsistent, statements about what services should look like, what they should do and on what bases they should be monitored.

A re-statement is needed of the model, including the overall aim and the specific objectives for withdrawal services. Collaboration between purchasers and providers would assist in the development of a clearer and shared definition of some of the concepts inherent in the objectives, such as 'case management', 'satisfactorily complete', and 'episode'. The underlying framework of requirements, measures and targets which facilitates monitoring and evaluation activities needs to be much more closely linked to the aim and objectives of withdrawal. It also needs to be incorporated into the centralised data system. Ideally such a system would have the capacity to generate target data as well as broad service use data, so as to avoid the current necessity of having dual data collection systems.

Performance measures and targets need to reflect the full range of the work of withdrawal services including harm reduction and health education activities, and establishment and maintenance of networks and relationships with other health and welfare services, especially the medical profession. Again, collaboration between purchasers and providers could result in a more useable and informative framework.

The suggestions here focus on greater collaboration between practitioners and the Department of Human Services to clarify and articulate the model and to ensure that the aim, objectives, performance measures and evaluation processes for withdrawal services are all consistent, coherent and closely linked.

## **5. Conclusion: An Overview of the Model**

Victoria is in the process of building up an excellent alcohol and drug service network, providing a range of options to those who wish to reduce or cease their substance use. The services are staffed by a body of workers whose skills and knowledge about withdrawal are extensive. Major strengths are the range of withdrawal options, the harm minimisation focus, a treatment approach which pays particular attention to detailed assessment, the development of individual treatment plans and identifying post-withdrawal needs, in addition to an overall commitment to clients by a skilled and dedicated workforce. Limitations lie largely in the agency, community and bureaucratic environment within which the services operate, problems with monitoring and evaluation frameworks, and barriers which services face in accessing post-withdrawal treatment and support options.

This concluding section takes an overview of the issues which have emerged during this evaluation and can be seen to have an influence on the overall effectiveness of withdrawal services for clients. This section is written in such a way as to link these issues to the principles (Department of Human Services, Sept. 1997: 9–13) which are to underpin the provision of the redeveloped alcohol and drug services.

### **5.1 Valuing and Supporting Withdrawal Workers**

This evaluation stresses the vital importance of the workers to the withdrawal service system. Without them, the services could not be as effective as they are. However, there are a number of areas which are essential for the continuing support, development and retention of these workers, all of which could be improved. These include the need for more opportunities for training and professional development, personal and organisational support, professional and clinical supervision, structures for networking and sharing information amongst workers in similar service types, and opportunities for communicating with and being heard by the Department of Human Services at regional and central levels.

### **5.2 A Range of Service Options**

The fact that there is now a range of residential and non-residential withdrawal options open to clients has emerged as a strength of the current service system. Rural services do an impressive job in often difficult circumstances, facing large geographic areas, receiving at times reluctant and inexperienced alcohol and drug withdrawal support from GPs and rural hospitals (and sometimes no support at all), and having limited local services to call on to support clients post-withdrawal. Community residential units play an important role for many clients, but they face difficulties in managing a demand which is greater than their capacity to meet. In addition, short lengths of stay inhibit their efforts to implement harm minimisation and case management approaches. Home-based and outpatient services creatively provide an important range of urban, non-residential options. A number of suggestions are made in this report about the potential value of greater integration of these two service types.

### **5.3 Standardisation and Regionalisation versus Choice and Diversity**

The redevelopment of alcohol and drug services in Victoria has resulted in the establishment of considerably more withdrawal options than were previously available across the State. This is an important achievement, but at the same time some aspects of client choice have been restricted by the processes of standardisation and regionalisation. This is particularly evident in relation to the six community residential services. It is suggested in this report that the redistribution of the alcohol and drug budget using a regional population based funding formula has resulted in an over-emphasis on standardisation of service provision, to the detriment of the development of specialist expertise. Clients now *have* to use the service in their region, or the service which supplies their rural region with residential services. All CRWSs are supposed to be sensitive to the needs of all client types. In reality, given the small size of residential units and the complexity of client needs, all services cannot be sensitive to all client needs. Greater recognition could be given to the specialist skills of the residential units, together with more flexibility for cross-regional referrals. Units could be charged with an explicit training role in relation to their area of specialty.

### **5.4 Matching Clients to Service Types**

The SAW guidelines (Frank and Pead, 1995) suggest that decisions about who is suitable for which type of withdrawal service should be made on the basis of an assessment along three dimensions—neuroadaptation reversal, physical and psychiatric illness and psychosocial factors. In practice, this evaluation has found that at least two other dimensions are in play when decisions are made. These are the availability of a particular service and the preferences of the client. Thus, a client may be assessed on neuroadaptation, illness and psychosocial grounds as suitable for a home-based withdrawal, but the client, or their family, may refuse to contemplate this and insist on using a residential unit. Another client may be assessed as suitable for a residential withdrawal on neuroadaptation, illness and/or psychosocial grounds, however, a place in a unit may not be available for two weeks. This client may then insist that they want to stop using immediately and they want immediate support. In reality, these clients may then be offered outpatient or home-based withdrawal support. A further factor complicating the picture is that the client may decline to go to the service in their region, or vacancies in a residential unit may only be available outside of their region and so the client is not eligible to access them. Withdrawal services face these sorts of dilemmas every day and the complexity and consequences of this situation need to be acknowledged when alcohol and drug services are being further developed.

### **5.5 Access and Sensitivity to Client Needs**

The intention of the redevelopment was that all services would be accessible to clients geographically, physically and in terms of sensitivity to parenting, age, gender and cultural issues. The evaluation identifies that the capacity of services staffed at a 1 to 1.5 EFT level to achieve this is inevitably limited. Some

suggestions have been made about the potential for services to increase service sensitivity by means of service integration. Also relevant are the comments regarding the role of CRWSs in building up and disseminating expertise. Other service types could also discuss ways in which individual services could take up a 'portfolio' role in relation to particular issues or skills and then use this to disseminate learning to the field more broadly.

## **5.6 Continuity of Care**

An important feature of the redevelopment of the alcohol and drug service system is the requirement that services provide continuity of care. It was believed that case management would facilitate this. There are, however, some significant barriers to the achievement of continuity inherent in two areas: the environment within which these services work, and in the lack of available post-withdrawal services in general (and alcohol and drug supported accommodation options in particular). A critical component in the environment within which withdrawal support is provided is the role of medical input. Given the relevance of this, it is discussed under a separate heading below. Another critical aspect is access to residential withdrawal beds. This remains a major problem which requires ongoing consideration and action to resolve. Demand is high, beds are limited, waiting lists are long and diversity is restricted.

Community drug withdrawal services ideally play a role in facilitating long term changes in drug using habits. The barriers to post-withdrawal support make this very difficult. Counselling is available but usually only after a waiting period, residential post-withdrawal rehabilitation beds are very scarce, and many people are forced to return, post-withdrawal, to residential settings which remain antithetical to changed drug use habits. More crisis, short, medium and long term supported accommodation options are needed, as are specific 'dry house' options.

## **5.7 Access to Medical Services**

The capacity of withdrawal services to provide continuity of care is constantly impeded by the reluctance of hospitals and general practitioners to provide withdrawal support, and by the lack of specific alcohol and drug skills and negative attitudes of many medical personnel. This is particularly, but not exclusively, evident in some rural areas. The literature also identifies that medical practitioners can be unsupportive (Walsh, 1995; Deehan, Taylor and Strang, 1997), although Saunders and Roche (1991) claim this is not necessarily reflected in poor clinical performance. Other factors, such as pessimism about effective interventions, a lack of knowledge, a lack of resources, lack of time and a lack of incentives and financial rewards, have been identified as key factors in poor performance by medical professionals. All of these are part of the picture in Victoria, and despite the important role that the Drug and Alcohol Clinical Advisory Service plays in supporting medical practitioners, and the range of existing training initiatives, there remains a great deal to be done to bring the medical profession into a partnership with withdrawal services.

## 5.8 Linkages with Other Service Providers

Another aspect which is critical to a managed care focus is the collaboration of alcohol and drug services with other human services. Withdrawal services have, by and large, developed a wide range of links with other services, especially in rural areas. However, there are some specific service areas where linkages have been slower to build, most notably with the Office of Corrections and COATS, with mental health and psychiatric services, and with ethnospecific agencies. Although services have been instructed by the Department of Human Services to develop formal protocols with other agencies, this has been relatively slow to occur. This is partly because of reluctance by these agencies to enter into formal agreements and a belief that they are unnecessary. Now that withdrawal services are becoming accepted and have established their credentials with other agencies, recognition is growing of the benefits of formal agreements. However, some organisations still believe that reciprocal protocols are not necessary. It remains difficult to reach formal agreements with GPs. As this is still essentially the establishment phase of most withdrawal services, it is expected that the development of formal protocols will increase.

## 5.9 Monitoring, Evaluation and Quality Assurance

This evaluation has identified the lack of agency level development of monitoring and evaluation processes and of mechanisms to support these. In addition, it has highlighted the importance of a well functioning, well resourced, and well understood centralised data system to underpin further development of withdrawal services. Ideally, such a system would be capable of generating information which can be put to a range of uses, for example it could provide information which would contribute to the following:

- Accountability and ongoing monitoring.
- Short term planning by the auspice agency and the withdrawal service.
- Medium and long term planning at the regional and central level.
- Evaluation at all these levels.
- Research at all these levels and for all these purposes.

## 5.10 Community Oriented Service Delivery

The redevelopment of alcohol and drug services is based on the principle that people with alcohol and drug issues can be effectively treated in community-based settings. All withdrawal services were to be located in community-based settings. All of them are, in the sense that they are not delivered by a government agency. However, whether people actually consider major metropolitan or rural hospitals to be community agencies is debatable.

There is no particular evidence about whether one setting is more or less effective than another, or more or less acceptable to clients. Rather the presence or absence of certain critical elements appear to be more important than whether the service is delivered through a hospital, a community health centre or a non-government, not-for-profit agency. These are the quality of the staff running the service, the culture and practices of the host agency, and the attitude and culture of the community within which the service operates.

Firstly, it is important that the workers in the service have particular skills and attitudes. Listing these serves to illustrate the extremely high standards currently expected of withdrawal workers. They include: commitment, knowledge, experience, compassion, a range of skills in nursing, pharmacotherapy,

counselling, community development, outreach, marketing, training, development of resource material, report writing, evaluation, public speaking, group work, and the ability to communicate with a wide range of people including clients and their families, GPs, nurses, youth workers, management, and the bureaucracy.

Secondly, it is important that the host agency (irrespective of whether it is a hospital, a community health centre or a non-government agency) is characterised by:

- A positive and empathic attitude to alcohol and drug users.
- Prior experience in alcohol and drug work, or a strong commitment to developing the expertise of those working with alcohol and drug issues.
- A culture focused around client rights and dignity, health education and harm reduction.
- Personal support mechanisms for withdrawal staff.
- Professional supervision processes for withdrawal staff.
- A capacity for the replacement of staff taking leave.
- Integrated structures for ongoing monitoring, evaluation and review.
- Close links with 'like' services, such as counselling, other addiction workers and domestic violence support services.
- A community focus, that is outward looking and places an emphasis on developing links with other community agencies.

Finally, there is the importance of the surrounding environment within which the withdrawal service operates. A service is enhanced when the local community is prepared to 'own' alcohol and drug issues and to see the relevance to the whole community of trying to address them. In addition, the community needs to be flexible and innovative and willing to develop coalitions to tackle service user and service provider needs, and finally be prepared to accept community development approaches.

## **5.11 Restating the Model**

Suggestions have been made about the advantages of restating the model of community drug withdrawal. This would best be based on a collaborative process to refine a number of concepts and to ensure linkage between all levels of the model, that is the overall aim, the four objectives, the general and specific key service requirements, the performance measures and targets, and processes for monitoring and evaluation.

## **5.12 The Future**

This evaluation took a snapshot at a particular moment<sup>6</sup> in the development of these withdrawal services. They are still essentially in the early stages of establishment. As services become more established and well known it is clear that demand will grow and pressure on services will mount. Future resource decisions need to be based on a clear recognition of this.

This evaluation covered a broad spectrum of the work of withdrawal services. There are, however, a number of areas warranting more in-depth exploration. These areas could include:

- Dealing with demand: assessment and waiting lists in CRWSs.
- Utilisation of metropolitan residential services by rural residents.
- Working with mental health services.

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<sup>6</sup> Early 1998

- Models of medical input in CRWSs.
- The role of hospitals and GPs in withdrawal.
- Working with homeless and itinerant clients.
- Defining case management in alcohol and drug services.

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