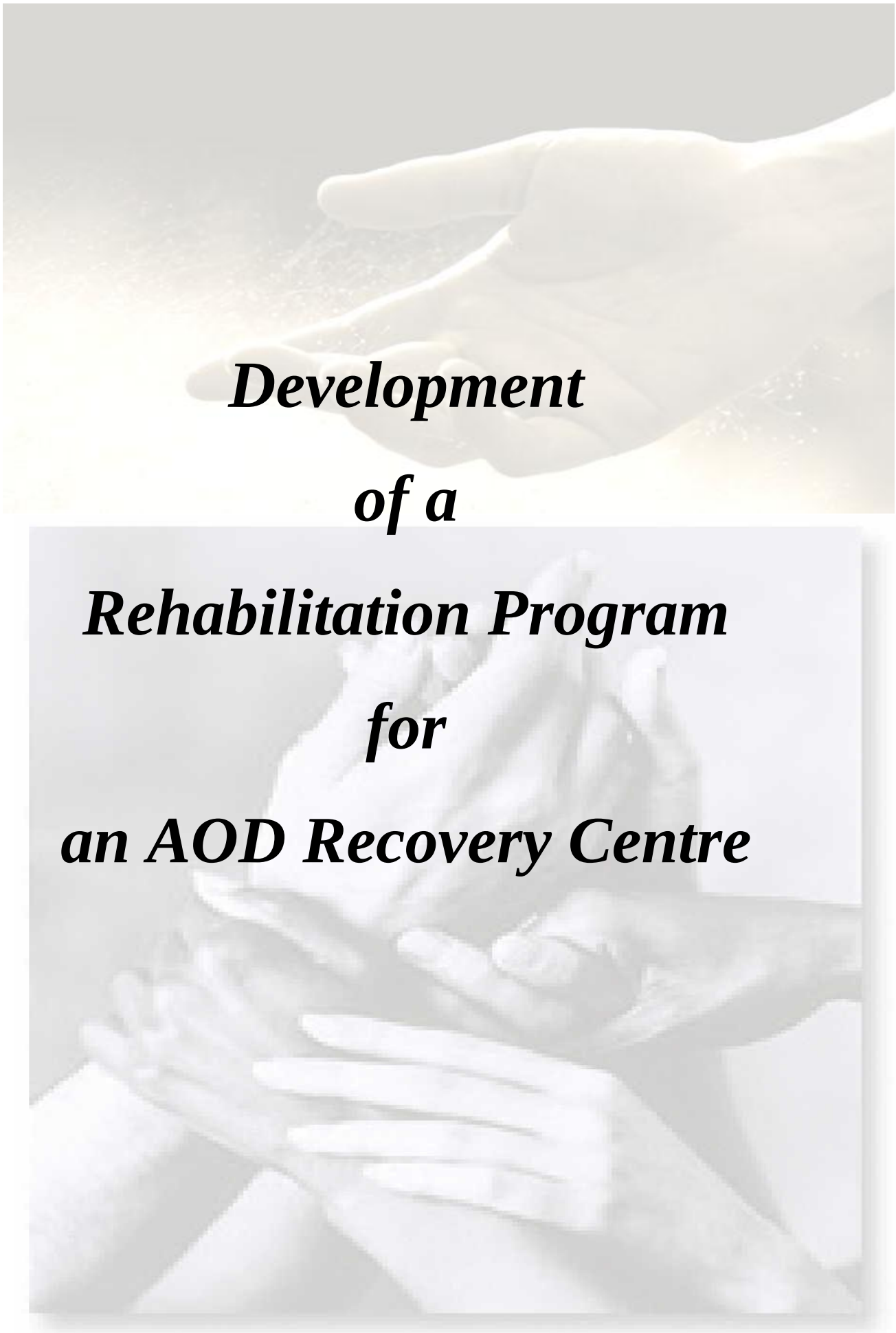

Development of a Rehabilitation Program for an AOD Recovery Centre

Canberra Institute of Technology

Faculty of Communications and Community Services

Department of Community Services

PROJ 159

WORK BASED PROJECT

ALCOHOL AND OTHER DRUG WORK

2006

Development of a Rehabilitation Program for an AOD Recovery Centre

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Researcher Profile

Brian Williamson is 60 years old and a product of the "baby-boomer" period of Australian history and custom. He is enrolled in the Diploma of Alcohol and Other Drugs Work at the Canberra Institute of Technology and is in his final year of study. His ambition in relation to the Diploma is to work in the AOD industry as a Caseworker.

Prior to his current studies Brian has had extensive experience in Personnel Management and Business Management. He has worked as a policy advisor to government agencies and private enterprise.

Brian is an admitted recovering addict and hopes that his experience and the knowledge gained through his studies will enable him to bring comfort and assistance to people currently suffering from their addictions and to assist the industry at large to enhance the style and type of recovery treatment/assistance that it offers.

Abbreviations

ABS ..... Australian Bureau of Statistics

AIHW ..... Australian Institute of Health and Welfare

AOD ..... Alcohol and Other Drugs

CIT ..... Canberra Institute of Technology

IT ..... Information Technology

NIDA ..... National Institute on Drug Abuse (USA)

NHMRC ..... National Health and Medical Research Council

NMDS ..... National Minimum Data Set

PM ..... Project Management

PMBOK® ..... Project Management Body of Knowledge
(reg. trademark of the Project Management Institute)

SAMHSA ..... Substance Abuse and Mental Health Services Administration, USA

SWOT ..... Strengths-Weaknesses-Opportunities-Threats

UNIDCP ..... United Nations International Drug Control Programme

UNODC ..... United Nations Office on Drugs and Crime

Project Abstract /Synopsis

This Research Project has developed out of a perception that while many services are provided to assist people with alcohol and other drugs related issues there is a very low success rate in these people maintaining a sense of recovery from their issues and that treatment practitioners appear unaware, and perhaps unwilling, to look at the reasons why.

In a launch promo for the book *Addiction Counselling: Content & Process* by Ali Marsh & Ali Dale (IP Communications, 2006), Craig Carmichael of the Western Australian Drug and Alcohol Office (Personal communication, October 20, 2006) quotes from the book: "For many counsellors and therapists, clients who have alcohol and other drug problems present a particular challenge. High drop-out rates, irregular attendance at sessions, on-going drug use, suicidal ideation and attempts, difficulties forming a solid therapeutic relationship, slow progress, and co-occurring psychological disorders, are just some of the difficulties counsellors face."

The objective of this Project is to highlight these challenges and to provide some help in obtaining a practical solution both for practitioners and clients.

In his famous book "Man's Search for Meaning Viktor Frankl suggested that *The meaning of our existence is not invented by ourselves, but rather detected* (1963, p 157).

There seems to be an innate desire in all of us to detect that meaning. Frankl also talks about the tension between "actualisation" and "gratification" (see also Fromm, 1947; Maslow, 1954; and others) and that appears to be the psychological issue surrounding drug use and the underlying determinant of whether recovery programs will or will not work. Of course there are also the biological/genetic issues and the socio/cultural issues to be considered.

The aims of this Project were to:

- Examine the reasons why people who have completed a rehabilitation program tend to relapse into addiction;
- Develop a position on the availability of "best practice" methodologies for the treatment and rehabilitation of people addicted to alcohol and other drugs (AOD); and
- Draw together a methodology by which AOD workers may provide the best environment for the recovery of AOD addicts.

The research strategy undertook the following steps:

- A literary review;
- An exploration of the industry;
- Analysis of the data from the exploration against information discovered from the literary review; and
- Development of an argument for change in program methodology.

The research discovered a plethora of activity across the globe in relation to establishing evidenced-based, best practice methodologies for the treatment and recovery of AOD addicts. This activity has taken place, and is on-going, over more than twenty years.

However, the adoption of best practice models on an industry wide basis has not occurred at the same pace. The evidence suggests that this is because most practitioners are too busy with clients to have time to devote to appreciating the progression in knowledge and changing ideas within the disciplines of the industry.

The research suggests the *necessity* for practitioners to take time out to look at what is evolving in treatment methodologies and to adopt strategies which will enable them to:

- Review their current practices in the light of new thinking;
- Grow networks to share new ideas and methodologies; and
- Put in place systems which will enable them to maintain their practices in line with developing thought and industry changes.

The outcome of this Project is the development of a Best Practices in Addiction Treatment Workshop as a first step in this process.

Chapter 1. Project Planning

In approaching this research it became abundantly clear that the scope was going to be quite large and diverse. Simply gathering a few figures together and drawing up a conclusion would not be enough. It was, therefore, necessary to approach the research in a systematic way and to develop it as a major project requiring a formal project management approach.

The Project Management Institute's "*A Guide to the Project Management Body of Knowledge*" (2004, p 5) defines a project as "a temporary endeavour undertaken to create a unique product, service or result" and prescribes a protocol of "good practice" which will provide for a systematic approach to project management. (p 3)

The Project Management Body of Knowledge (PMBOK®) has been accepted by the Australian Institute of Project Management and Standards Australia (Hutchings, 2006).

These protocols are used in the development of this Research Project.

Section 1.01 The Importance of Project Management Skills

In any project of this magnitude, where the outcomes may affect the well-being of a significant number of people, proper management of the project is essential.

Microsoft Corporation (2004) summarises project management as a complex series of non-routine tasks directed to meet a specific one-time goal. The project manager works to balance project scope, the time available to carry out the project, and the budget available for the project (p 1)

The PMBOK® Guide divides Project Management (PM) into five process groups:

- Initiation, planning, execution, control, and closing (p 38);

and nine knowledge areas:

- integration, scope, time, cost, quality, risk, human resources, procurement, and communications. (p 11)

Managing a project includes:

- Identifying requirements;
- Establishing clear and achievable objectives;
- Balancing the competing demands for quality, scope, time and cost; and

- Adapting the specifications, plans, and approach to the different concerns and expectations of the various stakeholders. (p 8)

The following table shows how these processes work together. (The numbers in the table refer to Chapters in the PMBOK®)

Process Groups / Knowledge Area	Initiating	Planning	Executing	Controlling	Closing
4. Project Integration Management		4.1 Project Plan Development	4.2 Project Plan Execution	4.3 Integrated Change Control	
5. Project Scope Management	5.1 Initiation	5.2 Scope Planning 5.3 Scope Definition		5.4 Scope Verification 5.5 Scope Change Control	
6. Project Time Management		6.1 Activity Definition 6.2 Activity Sequencing 6.3 Activity Duration Estimating 6.4 Schedule Development		6.5 Schedule Control	
7. Project Cost Management		7.1 Resource Planning 7.2 Cost Estimating 7.3 Cost Budgeting		7.4 Cost Control	
8. Project Quality Management		8.1 Quality Planning	8.2 Quality Assurance	8.3 Quality Control	
9. Project Human Resource Management		9.1 Organizational Planning 9.2 Staff Acquisition	9.3 Team Development		
10. Project Communications Management		10.1 Communications Planning	10.2 Information Distribution	10.3 Performance Reporting	10.4 Administrative Closure
11. Risk Project Management		11.1 Risk Management Planning 11.2 Risk Identification 11.3 Qualitative Risk Analysis 11.4 Quantitative Risk Analysis 11.5 Risk Response Planning		11.6 Risk Monitoring and Control	
12. Project Procurement Management		12.1 Procurement Planning 12.2 Solicitation Planning	12.3 Solicitation 12.4 Source Selection 12.5 Contract Administration		12.6 Contract Closeout

In order to achieve proper outcomes, the project manager must have a skill-set that provides discernment, planning, time management and financial management. He/she also needs to be able to adapt to changing circumstances, be a good communicator and show empathy with the stakeholder group, while, at all times, making sure that the project objectives are met.

These skills are particularly important here because we are dealing with methodologies that will affect people's lives and well-being. Not only that, but there may well be ramifications on a wider scale affecting AOD policy within major institutions and government bodies.

Section 1.02 The Theoretical Base Applied to Project Management

The PMBOK® Guide not withstanding, PM as a discipline is not universally defined. There are many attitudes as to how to approach systematically the management of a

project. The Australian Institute of Project Management (AIPM) lists no less than 26 English-speaking bodies around the world offering advice on protocols for PM (2005).

In a report prepared for the Project Management Institute, Koskela and Howell (2002) made an interesting observation:

> *In their analysis of project management research, spanning forty years, Kloppenborg and Opfer (2000) have nothing to report on the theory of project management. This extraordinary silence on the theoretical is puzzling; it is either conceded that there is no theory of project management, or it reflects the opinion that the theoretical is not significant from the point of view of project management* (p 1).

In looking back over thirty years experience in PM, this seems especially true within large organisations and bureaucracies. The constraints of being seen to get things done, irrespective of how well they are done, seem to cause many projects to be run on an ad hoc basis with little thought to any theoretical approach. That is not to say that this type of PM is haphazard; most of the projects that this Researcher has been involved with have been coordinated systematically. But they have had little or no recourse to expert opinion and their success has relied upon the accumulated skills and what the PMBOK® calls "product-oriented knowledge" of the project team.

As the saying goes, projects run in this manner are successful more by good luck than good management. The greatest dangers they face are time and cost overruns with outcome rollouts that require constant reassessment and modification.

This AOD Project cannot afford such mishaps. It is a single opportunity to explore significant features of a major societal structure and to produce effective outcomes for the health and welfare industries. Evidenced based protocols are required to ensure that mistakes are minimised.

The PMBOK® Guide contains these protocols and is accepted world-wide as the common standard on which project management should be based.

Section 1.03 Innovative Project Management Approaches

> *Many people and organizations today have a new or renewed interest in project management. Until the 1980s, project management primarily focused on providing schedule and resource data to top management in the military and construction industries. Today's project management involves much more, and people in every industry and every country manage projects. New technologies have become a significant factor in many businesses. Computer hardware, software, networks, and the use of interdisciplinary and global work teams have radically changed the work environment* (Schwalbe, 2005).

PM, it seems, has become the "flavour of the month" in a number of industries. Most, if not all, businesses have defined and agreed outcomes which require solid management if they are to be successful. PM principles, particularly those set out in PMBOK®, are evidenced-based in their success and solidity.

Change and innovation are also backbones to success. Hospitality Management Specialist, Tony Eldred, in his essay "*Staying ahead of the market*" (2006) suggests that,

> *For a business to remain healthy, it must be in a state of constant evolution. If you freeze your system, your business will stagnate and eventually die. … There are three 'states of change' a business can be in. They are: no change, sometimes called stagnation; unplanned or uncoordinated change, or chaos, which is just as bad as stagnation because it leads to extremely inconsistent quality and service; and planned and coordinated change which we call 'progress'. It is part of the proper responsibility of an owner or manager to ensure that their business is progressing — by constantly evolving and moving with the times* (p 1).

That change requires innovation is a given. The world has changed over the centuries because of innovation which means thinking outside the square. The greatest change in the contemporary world is that of technology, particularly in information technology (IT). PTG-Global, a world respected IT consultant group incorporated in Australia, writes on its web page that … *the appropriate use of information technology is critical to success for every organisation. It's an area in which there are frequent innovations, providing the opportunity to improve business efficiency or to create completely new businesses* (2006).

How PM relates to IT (and *vice-versa*) can be seen from the following observation in the Ezine, *Information Week*:

> *Utilities are investing in technology to make sure they remain competitive in the new environment, where deregulation and competition make it even more important to keep customers happy. …*
>
> *Utilities are also attempting to be innovative when it comes to organizational structure and project management, to better focus IT resources on profitable endeavors. In addition, utilities are beginning to embrace the Internet and plan to have an industrywide procurement consortium up and running by year's end. …*
>
> *That has forced some utilities to adopt innovative project-management approaches to handle the demand for IT resources* (Garvey, 2000).

This Project uses IT innovations and the PMBOK® standards to successfully draw its conclusions and develop outcomes.

Chapter 2. Processes Used To Identify the Need

This Research Project has come out of a concern that clients of alcohol and other drugs (AOD) recovery services relapse on a regular basis. In 2003-04 of nearly 130,000 clients only 69,000 (53%) completed treatment. Also many people graduating from such programs relapse into addictive behaviour (Australian Institute of Health and Welfare, 2005).

It may be that treatment options as they are currently offered in Australia, have some flaws which are factors in relapse indicators, and that different approaches, particularly for long-term residential treatment should be examined. This Research Project aims to look at these areas.

(i) Research Purpose:

The purpose of this Research Project is to ascertain whether a methodology exists or can be developed, in the terms of "best practice" (see definition at Section 3.01), by which an AOD recovery/treatment program can ensure, all other things being equal, that the client/patient is given the opportunity to self-actualise, and to ascertain whether such a program will give the client/patient a high degree of maintaining recovery from his/her addiction.

(ii) Hypothesis:

Do rehabilitation practices exist that allow significant success in recovery for the participants?

(iii) Aims and objectives of the research:

This research aims to:

- Examine the reasons why people who have completed a rehabilitation program tend to relapse into addiction;
- Develop a position on the availability of "best practice" methodologies for the treatment and rehabilitation of people addicted to alcohol and other drugs; and
- Draw together a methodology by which AOD workers may provide the best environment for the recovery of AOD addicts.

Section 2.02 Research Strategy:

The strategy undertook the following steps:

1. A literary review which aimed to discover –
    - The types of long-term rehabilitation programs used across the industry;
    - The underlying theories of rehabilitation used by such programs;
    - The statistical success rate of the more predominant programs;
    - Evaluation methods;
    - Feedback/comments, if any, from graduates of such programs regarding their success; and
    - Bio-psycho-social models of successful change to human behaviour;
2. An exploration of the industry in the Canberra region to discover the types and success rates of programs used in the region. This exploration will include surveys of both professionals and their clients;
3. Analysis of the data from the exploration against information discovered from the literary review;
4. Development of an argument for change in program methodology;
5. Development of a "best practice" program, based on the research, which may be incorporated by rehabilitation agencies in the Canberra region.

Section 2.03 Risk Analysis

(a) SWOT Analysis (*Strengths, Weaknesses, Opportunities, Threats*)

Strengths and Weaknesses: Strengths and weaknesses which can contribute to or detract from the Project's success.

Strengths	**Weaknesses**
▪ Experience in the industry	▪ Lack of experience depth
▪ Based on evidence	▪ Evidence is haphazard
▪ Affinity with Stakeholders	▪ Survey sample is small
▪ Belief in outcomes	▪ Lack of acceptance within industry
▪ Background support from agencies	

Strengths

Experience in the industry: With over two years experience in residential treatment methods, the Researcher has a firm base on which to develop the Project.

Based on evidence: The outcomes and recommendations of the Project are based on empirical evidence gathered through the Literary Review and stakeholder Surveys.

Affinity with Stakeholders: This is a major strength in the success of the Project, because the Researcher has lived in addiction and understands, first hand, the processes of recovery and long-term sobriety.

Belief in outcomes: The Researcher has a strong belief that long-term recovery through residential treatment for addictions is both possible and desirable.

Background support from agencies: Treatment agencies have responded enthusiastically to approaches in relation to the Project as a whole and the Survey of Needs.

Weaknesses

Lack of experience depth: The Researcher is still gaining knowledge of the depths of the addiction/recovery process and may stumble in naiveté when it comes to producing strong support for the hypothesis.

Evidence is haphazard: Confidentiality agreements and a general reluctance by agencies to give out information may create some difficulties in collating and corroborating evidence of treatment outcomes.

Survey sample is small: Logistical constraints in gathering data through the Survey of Needs may result in too narrow a base for the evidence to be considered statistically viable.

Lack of acceptance within industry: There is some evidence that the AOD Treatment industry as a whole is closed to accepting the need for methodological change.

Opportunities and Threats: While analysing the Project's strengths and weaknesses informs the Project in its current state, the analysis of opportunities and threats should determine future possibilities for the outcomes of the Project. Opportunities and threats form part of the external environment of the Project, while the strengths and weaknesses determine the unique aspects of it.

Opportunities	**Threats**
▪ Bring new approaches to treatment methods	▪ Industry not ready for change
▪ Involvement of Government and NGOs	▪ Inability to secure funding to provide training
▪ Public support for outcomes	▪ Lack of interest from industry and Government
▪ Empowering professionals and clients	▪ Burnout
▪ Strengthening of Program validity	

Opportunities

Bring new approaches to treatment methods: The data analysis and resultant conclusions lead to an opportunity for a fresh approach to treatment methodologies which work.

Involvement of Government and NGOs: This freshness in approach should bring the policy makers and treatment professionals to work together for consistent outcomes.

Public support for outcomes: The reflection of the general community through media reports indicates that success in recovery from drug use would be beneficial as a societal principle.

Empowering professionals and clients: Treatment professionals and their clients would welcome methodologies offering evidenced-based positive outcomes.

Strengthening of Program validity: The flow-on effects of successful treatment methods will produce positive outcomes for the overall strategies in dealing with alcohol and other drug use and treatment.

Threats

Industry not ready for change: The data suggest that there is some strong reluctance by professionals to change their methodologies.

Inability to secure funding to provide training: Funding for on-going development of the recommendations is necessary, but may not be readily forthcoming.

Lack of interest from industry and Government: This Research Project has no automatic acceptability by the major policy stakeholders.

Burnout: The possibility exists of over enthusiasm and resultant burnout.

(b) Risk Analysis

The risks related to the Project arise directly from the identified weaknesses and threats. Analysis of the risks is required so that contingencies may be put in place to eliminate or greatly reduce the chances of the risks sabotaging the Project's outcomes. The table on the following page shows estimated risk factors and strategies to overcome/minimise them.

Section 2.04 Needs Analysis

(a) The Australian Government Perspective

> *The National Drug Strategy, and its forerunner, the National Campaign Against Drug Abuse, were created to minimise the harmful effects of drug use in Australian society. The Strategy adopts a comprehensive approach to drugs, which encompasses the misuse of licit drugs such as alcohol, tobacco and pharmaceuticals, as well as illicit drugs. This approach stresses the promotion of partnerships between health, law enforcement, education, non-government organisations, and private industry, and attempts to address drug issues in a balanced fashion* (Dept. Health and Ageing, 2004).

As part of the National Drug Strategy, the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS) conduct a number of surveys on the use and abuse of alcohol and other drugs. Many of the statistics quoted below are taken from the results of these surveys.

The AIHW report *Alcohol and other drug treatment services in Australia 2004–05* indicates an increase of 4% in the number of people admitted to AOD treatment services in 2004-05 compared to the previous year. This is a progressive increase of 17% since the 2001-02 report.

The following graph gives an indication of the gradual increase in high-risk alcohol consumption in Australia in the ten-year period 1995-2005. The indicative increase is around 7% of the total (adult) population, which, although small in percentage terms, shows a significant increase in population growth of people consuming health-risk levels of alcohol (ABS, 2006).

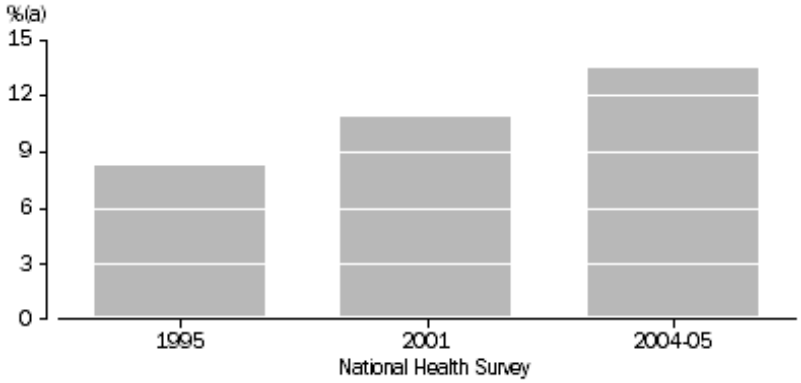
Risk Analysis Table

Score for Likelihood and Impact: High = 3, Medium = 2, Low = 1

Risk Factors: 6 – 9 Extreme; 2 – 4 Heavy; 0 – 1 Light

Nature of Risk or Uncertainty	Likelihood High/ Medium/ Low	Impact High/ Medium/ Low	Risk Factor [Likelihood x Impact]	Actions required to manage the risk
▪ Burnout of Researcher resulting in poor input/output	L	H	3	▪ Systematic approach to each phase of the research and development with accountability to supervisor
▪ Inability to secure funding to provide training	L	H	3	▪ Development of appropriate approach methods using successful lobbyists
▪ Insufficient expertise to carry Project	L	H	3	▪ Development of strategies to bring other expertise into the development phases
▪ Lack of acceptance within industry	M	H	6	▪ Strategic development of workshops and pilot studies
▪ Survey sample is too small for validity	H	M	6	▪ Broaden the sample base as necessary – gather data from other sources
▪ Haphazard/ unsustained evidence	M	H	6	▪ Ensure evidence has empirical standing
▪ Industry not ready for change	M	H	6	▪ Base outcomes and recommendations on strong evidence
▪ Lack of interest from industry and Government	M	H	6	▪ Base outcomes and recommendations on strong evidence

Risky/high risk alcohol consumption



(a) Age-standardised percentage.
Source: ABS National Health Survey: Summary of Results, Australia, 2004-05 (4364.0)

The AIHW Report *Statistics on drug use in Australia 2004*, makes the following observations regarding drug use and mental health

> *In 2004, approximately two in three people aged 18 years and over had low levels of reported psychological distress (71% of males and 66% of females) (Table 7.1). Overall, females (11%) were more likely than males (9%) males to have high or very high levels of psychological distress.*
>
> *Among males and females, smokers were approximately twice more likely than non-smokers to report high or very high levels of psychological distress.*
>
> *Males and females that consumed alcohol at risky and high risk levels for long-term harm were more likely to report high or very high levels of psychological distress than abstainers or persons who drank at low risk levels. Female risky and high-risk drinkers (18%) were more likely than male risky and high-risk drinkers (12%) to experience high or very high levels of psychological distress.*
>
> *Use of marijuana/cannabis in the last month and use of any illicit drug except marijuana/ cannabis in the last month were both correlated with high or very high levels of psychological distress for both males and females. For example, approximately one in five males and one in four females who had used an illicit drug other than marijuana/cannabis in the last month reported high or very high levels of psychological distress. The corresponding percentages for males and females who had not used an illicit drug other than marijuana/ cannabis in the last month were 8% and 10%.*

What is significant in this research and analysis is the clear indication that drug use is associated with deterioration in the health and well-being of the drug-using population.

(b) Other Perspectives

The following table is taken from the ACOSS Community Sector Survey for 2004-05. It clearly indicates that AOD services were in high demand and also backs up assertions that the prevalence of health issues related to AOD use/abuse are increasing progressively.

Client need by service type 2004-5

N=514

Service type	Rank	Score[1]
Health care (including mental health and drug and alcohol services)	1	100.0
Long term housing	2	99.8
Income support	3	82.1
Crisis and supported accommodation	4	77.2
Family relationship services	5	60.6
Aged and disability services	6	59.1
Employment, education and training programs	7	53.8
Transport	8	40.9
Legal services	9	28.6
Child care	10	27.5
Cultural, arts, recreation, sport, information and social activities	11	25.2
Child welfare services	12	23.4
Assistance with the cost of energy, water, telecommunications	13	22.6

[1] Derived by adding the number of times respondents marked a service type as the most important (1), second most important (2) and third most important (3) and weighting according to priority. The value is expressed on a scale of 1 to 100

Drug Related Harm

> *Alcohol is the world's favourite psychoactive drug. It brings pleasure to many people and plays a key role in many societies – as an aid to celebration, sociability and relaxation. Although alcohol is mainly consumed in a responsible manner, in all societies where it is consumed there is a variety of alcohol-related harms. These include physical harms and dependence, and acute harms associated with intoxication* (International Harm Reduction Association, 2006).
>
> *The alcohol and other drugs sector is at a crossroad. While there has been a significant injection of new funds into supply reduction, demand reduction and treatment under the National Illicit Drugs Strategy and a number of State and Territory Governments have in recent years launched major new drug initiatives, demand for illicit drugs continues to increase and the harm arising from illicit drugs – most particularly, the number of deaths - continues to increase. In a similar manner, the harm arising from the use of licit drugs – alcohol, tobacco and prescription drugs – continues to rise significantly* (Alcohol and Drug Council of Australia, 2000).

(c) Addressing the Issues

Why is it that people find it difficult to stop using drugs, despite the evidence of harm from prolonged misuse?

Is it because rehabilitation/recovery programs don't touch the real issues of why people take drugs (including alcohol and nicotine) in the first place? Is it because addicts cannot overcome/manage their addiction? Is it because drugs are readily available and they are the easy way to change unwanted circumstances?

Clearly there is a need to address these issues. The question that this Research Project asks is "what is the best method of assisting people to reduce drug-related harm to themselves?"

As the following analysis shows, there is no one method which is agreed by the therapeutic specialists as being the "best." However, there are methodologies that have similarities of approach and which also have evidence-based consistency in outcomes sufficient to suggest that they can be called "best practice."

This Research Project examines these methodologies with a view to extracting those practices which are demonstrably consistent and using them to develop a program suitable for the Australian/Canberra environment.

Section 2.05 Methodology and approaches Used

Social Action Research (SAR) involves, among other things, researching the needs and aspirations of the targeted community group. To be successful the research should ensure that the target group becomes involved in developing outcomes. This is called Participatory Action Research (PAR) and is integral to this Project. Participants to the research (stakeholders) have been involved in surveys and focus groups to allow them to give their views and to discuss options for the delivery of the Project outcomes.

> *Action research combines twin aims in a single process. Action researchers wish to improve some aspect of professional practice or social process, while generating new knowledge at the same time. Action research is not action for research (doing something to increase understanding), nor research for action (increasing knowledge to be applied later). These two purposes come together in a single project* (Hughes, 2004).

A number of AOD agencies and their clients have been asked to provide information on their treatments and the efficacy of such treatments. From this information a database has been established to provide some indication of what works and what doesn't. Details of the data analysis are at Chapter 3.

Section 2.06 Literature Review

The literary review for this Project commenced with a search for reports and evidenced-based methodologies showing alleged "best practice" in AOD treatments leading to long-term recovery for addicts.

There are a number of definitions of "best practice." The following summarise the Researcher's understanding of the term:

> *'An industry accepted way of doing something, that works.' Aidan Lawes, CEO itSMF.*
>
> *Best Practice is the best identified approach to a situation based upon observation from effective organisations in similar business circumstances.*

> *A Best Practice approach means seeking out ideas and experiences from those who have undertaken similar activities in the past, determining which of these practices are relevant to your situation, testing them out to see if they work, before incorporating the proven practices in your own documented processes.*
>
> *Best Practice is all about not "re-inventing the wheel", but learning from others and implementing what has been shown to work.*
>
> *Best Practice techniques can be applied in all walks of life* (IT Service Management Forum, Australia, 2003).
>
> *A Best Practice in Community Action is any program, project, process, procedure, or strategy that has produced a positive change in one or more of the agency's core operations, and which:*
>
> *1. Measurably improves the efficiency or effectiveness of customer service or support systems;*
>
> *2. Is replicable with modification in other community action agencies; and*
>
> *3. Is an innovative or creative solution to the problem addressed by the practice* (Ohio Association of Community Action Agencies, n.d.).

Another useful definition of "best practice" comes from the Community Youth Training Scheme in Western Australia: "…the best way of doing things which includes quality, timeliness of delivery and outcomes achieved" (1997).

The following quote from the North Carolina branch of the National Alliance on Mental Illness probably sums up what the literary review has discovered, namely, "the local business plan must show compliance with models of best practice determined by the state. The state, however, has not officially released its list of best practice models. What we do know is that the state intends to adopt nationally recognized, evidenced-based models as its best practices" (2002).

Section 2.07 Underlying Theories and Success Rates

At this point, some discussion of expert opinion on best-practice and evidence-based methodologies is necessary.

The following are key findings from the English National Treatment Outcomes Research Study (2000). The study was conducted under the auspices of the National Treatment Agency for Substance Misuse in England and focused primarily on opiate users.

- *The full engagement of clients and their retention in treatment is key to achieving more positive treatment outcomes*
- *Rapid treatment intake after first contact with a service can lead to fewer early dropouts and does not jeopardise longer-term retention*

- *Services have a crucial role in promoting the full engagement of the client. Using screening or assessment as part of a motivational process aimed at encouraging the uptake of treatment is effective where motivation is the barrier. However, intensive, ongoing help is needed to promote treatment uptake when the problems are due to instability and lack of personal resources*
- *Reminder telephone calls or letters before scheduled sessions improve attendance rates personal approaches incorporating motivational elements (e.g. 'we are looking forward to seeing you') have the best results*
- *Once clients attend for the first time, specific activities and sessions designed to clarify the treatment process and to deal with concerns and misconceptions mean clients engage more fully. An empathic and positive style works best at this stage as well as throughout the treatment process*
- *The service provider agency's ethos has an impact on retention and outcome. The research evidence suggests that more positive outcomes occur within services that target the overall development of clients, are responsive to their needs as rounded individuals and that show flexibility and encourage client participation within clearly communicated and coherent treatment programmes*
- *In addition to achieving an adequate methadone dose, the relationship between client and key worker is important to effective engagement. Service users tend to engage more fully and do better when they feel they are understood and are given helpful and positive responses to their concerns*
- *Organisations and key workers who prioritise engagement have been shown to retain clients in treatment and achieve positive outcomes with service users considered to have a poor prognosis (due to the severity of their problems or their lack of motivation to enter treatment).*

The conclusions reached by this study are common to a number of other studies conducted along similar lines (cf. Neal, 2002; McKeganey, et. al., 2004)

The Australian National Council on Drugs report *Evidence supporting treatment: the effectiveness of interventions for illicit drug use* (2001) concluded among other things that, … for drug dependence to be successfully overcome, it is usually necessary to address both physical and psychosocial dimensions. This typically requires a long period of time (Gowing et al., p 11). However, rates of drop-out from treatment tend to be high, particularly in the early stages. For those who complete treatment, outcomes are good in terms of reduced drug use, reduced criminal behaviour and increased employment (p 9).

The UK *Drugscope* organisation, responding to service users, commented that, "A proper responsiveness to users of drug and medical services is about hearing what they say and want as part of a process of discussion and negotiation, that should be framed by the evidence base and the professional competencies of service providers and informed by the stated goals and desires of service users, which are indispensable data but not unassailable prognoses" (Roberts, 2005).

Section 2.08 Survey of Stakeholders

As part of establishing the need for a best practice approach to AOD treatment, this Project undertook a survey of both AOD treatment Professionals and addicts who have gone through a treatment program (See Appendix II).

The survey was sent to a number of treatment agencies in Canberra and was also made available on the World Wide Web to electronic AOD user groups around the world.

As shown in the following tables, analysis of the responses to the surveys indicate that there is a wide disparity regarding the particularities of treatment methods. There is, however, some consistency in attraction to holistic approaches rather than simply detoxing/withdrawing from the substance.

Main Factors in Recovery				
Self-Awareness	43%		Issues Management	29%
Emotional Awareness	43%		After-care Services	21%
Abstinence Programs	36%		Change Management	21%
Self-Control	36%		Support Groups	21%
Self-Esteem	36%		Prevention Education	21%
Drug Education	29%		Spiritual Concepts	14%
Harm Minimisation	29%		Safe Houses	7%
Enhancing Relationships	29%		Other	7%

1 Survey of Professionals: Main Factors in Recovery

Currently on Treatment	*75%*
Not in a Program but drug free	*10%*
Treatment Types Undertaken	**Percentage of Respondents**
Individual Counselling	55%
Home (Self-help)	50%
Residential: 12 Step	48%
Residential: Not 12-Step	48%
Non Res. 12 Steps (AA, NA, etc)	38%
Treatment in Gaol	25%
GP Support	25%
In-patient / Out-patient	23%
Other Types of Treatment	8%

2 Survey of Clients: Program Types Undertaken at Any Time

Reasons for not stopping (initial use)	
Authority Figures	0%
Not Doing a Program	0%
Religion Issues	0%
Unemployment Issues	0%
Other Crises	0%
Resentments	0%
Illness	0%
Need for More	0%
Problems with Significant Others	0%
"Higher Power" Issues	0%
Lack of Support	3%
Finance Issues	3%
Let down	3%
Own Attitude	3%
Criminal Activity	3%
People, Places & Things	3%
Other Relapse Issues	3%
Depression	8%
Cravings	13%

Reasons for Relapse	
Authority Figures	3%
Not Doing a Program	13%
Religion Issues	5%
Unemployment Issues	5%
Other Crises	5%
Resentments	15%
Illness	0%
Need for More	10%
Problems with Significant Others	3%
"Higher Power" Issues	3%
Lack of Support	8%
Finance Issues	3%
Let down	8%
Own Attitude	8%
Criminal Activity	5%
People, Places & Things	25%
Other Relapse Issues	15%
Depression	30%
Cravings	15%

3 Survey of Clients: Reasons for Substance Use

Note: The percentage disparities in the above table are a direct result of first-time program clients not understanding why they used the substance

Revenge	3%
Spirituality	5%
Problems with Authority Figures	5%
Crime	8%
Blaming others for situations	8%
Sex issues	8%
Physical or Emotional Disability	8%
Relationship issues	10%
Wanting to be in Control	10%
Resentments	10%
Making Excuses	13%
Fear	13%
Self-esteem	18%
Anger	23%
Childhood Issues (including abuse)	23%

4 Survey of Clients: Underlying Life Issues Surrounding Substance Use

Chapter 3. Issues Identified and Analysed

The Literary Review and Needs Analysis have combined to produce a number of interesting themes.

Major issues identified by these processes include:

- Most First-World countries have an AOD policy/strategy (Levine, 2002; Drug Policy Alliance, 2006);
- Most of these countries have similar views to Australia about AOD issues (Levine);
- Most countries would like to have zero drug issues, but know that is not practical (UNODC, 2006);
- Most countries have an approach to drugs under a Harm Minimisation umbrella (The International Task Force on Strategic Drug Policy, 2006);
- Statistics recognise that there is a high probability of relapse for recovering addicts (Tims & Leukefeld, 1998; NIDA 2006);
- Reasons for relapse are many and varied (NIDA);
- Treatment methodologies based on an holistic approach towards the client's needs, are more successful than detoxification and/or controlled use programs (UNIDCP, 2003);
- "Best practice" in treatment methodologies is evaluated through evidenced-based results/outcomes (Substance Abuse and Mental Health Services Administration (SAMHSA), 2006);
- There are some fundamental philosophies that need to be included in all "best practice" programs (SAMHSA).

A discussion of these philosophies, and how they may be incorporated into treatment programs, ought to lead to the development of a program methodology suitable for incorporating into any particular demographic.

Section 3.01 Philosophies of Recovery

(a) Desire for Change

> *When it comes to drug abuse, people within a community can be seen as belonging to three different zones. The three zones can be best compared to a*

> *traffic light. People in the green zone are those who do not use drugs presently. Those in the amber zone are the early users, who run a great risk of developing problems. Those in the red zone are persons who are addicted. People in the red zone need treatment that is expensive and requires a lot of effort, and relapses are frequent. Therefore, red zone strategies include detoxification and rehabilitation. Green zone strategies, which include awareness and education, reach a lot of people in the community. Amber zone strategies, including early identification and referral to treatment centers, are very effective, especially when the person is willing to work towards behavioral change* (UNODC, 2006).

"Motivation for change is a key component in addressing substance abuse" (SAMHSA/CSAT, 1999).

World-wide evidenced-based research suggests that the best way to engender change is to create an environment within which the client will *want* to change. Creating an environment for change involves using principles of behavioural psychology such as Cognitive Behavioural Therapy (CBT), Solution-Focussed Brief Therapy (SFBT), Motivational Interviewing (MI) and models of Emotional Intelligence (EQ) therapy. These therapies/models are included in the development of an AOD Professionals Workshop which is an outcome of this Research Project (see Chapter 7).

(b) Detoxification

The SAMHSA/CSAT Treatment Improvement Protocol (TIP) on detoxification (1995) explains that detoxification is not just the physiological removal of toxins but an holistic procedure involving psychological readjustment as well.

> *The term detoxification implies a clearing of toxins (Alling, 1992). For many AOD-dependent people, removal of drugs from their bodies is indeed part of the detoxification process. In the context of treating patients who are physically dependent on alcohol or other drugs, detoxification also includes the period of time during which the body's physiology is adjusting to the absence of drugs. However, as Gerstein and Harwood wrote, "Detoxification . . . is not a treatment for drug-seeking behavior. Rather, it is a family of procedures for alleviating the short-term symptoms of withdrawal from drug dependence" (Gerstein and Harwood, 1990). It must also include "a period of psychological readjustment designed to prepare the patient to take the next step in ongoing treatment" (Czechowicz, 1979)* (1995, p 2).

Whether the physiological change takes place at the rehabilitation centre or at a specialised medical centre, professional AOD staff need to take account of the psychological requirements as they plan their treatment methodologies.

(c) Individual Assessments

Data from the Literary Review and the Surveys conducted under this Research Project indicate that patient-matching (Condelli, 1993) is very desirable from both the professional and patient/client viewpoint. 71% of professional respondents to the Survey provided individual case management of clients while 55% of AOD clients had received such management as part of their treatment process.

The SAMHSA/CSAT TIP on patient matching agrees that "… matching is a participatory activity that involves both the clinician and the patient. Also important is the patient's motivation as well as the level of support available to the patient to achieve and maintain a life-style free of AOD abuse" (1995, p 2) and the United Nations treatment protocols agree that "treatment services must offer a range of approaches that should as far as possible be adapted to individual need" (UNIDCP, p. III.5).

(d) Other Philosophies

The protocols for other philosophies depend on the individual assessments discussed in the previous sub-section. There are, however, common threads that need to be taken into account at the individual level. These include:

- **Assessment/diagnosis to ascertain service requirements** – detox, medical services, recovery services, rehabilitation services, etc.

  For people with dual disorders, the attempt to obtain professional help can be bewildering and confusing. They may have problems arising within themselves as a result of their psychiatric and AOD use disorders as well as problems of external origin that derive from the conflicts, limitations, and clashing philosophies of the mental health and addiction treatment systems (SAMHSA/CSAT TIP #9, 1995).

- **Flexible case management**
  When implemented to its fullest, case management will enhance the scope of addictions treatment and the recovery continuum. A treatment professional utilizing case management will
  - *Provide the client a single point of contact for multiple health and social services systems;*
  - *Advocate for the client;*
  - *Be flexible, community-based, and client-oriented;*
  - *Assist the client with needs generally thought to be outside the realm of substance abuse treatment* (SAMHSA/CSAT TIP #27, 1998).

- **Intervention Types** – as mentioned above when talking about behavioural change, the type of intervention given to the client will impinge upon the desired outcome (Survey data, 2006; SAMHSA, 2006; UNODC, 2006). There are so many different

types of interventions and each practitioner, naturally, believes that their type is best. However, survey data and the literary review have shown that "no size fits all." For example, the Treatment Improvement Protocols of SAMHSA/CSAT comprise at least twenty different treatment protocols depending upon the client/patient condition at the time of assessment.

- **Bio-psycho-social models**
  For more than 200 years, America has vacillated over the question of whether excessive drug use is a disease, an illness, a sickness, a malady, an affliction, a condition, a behavior, a problem, a habit, a vice, a sin, a crime or some combination of these …The fact that neither group speaks with one voice demands considerable care in our synthesis of the prevailing themes within the pro-disease and anti-disease camps (White, 2001).

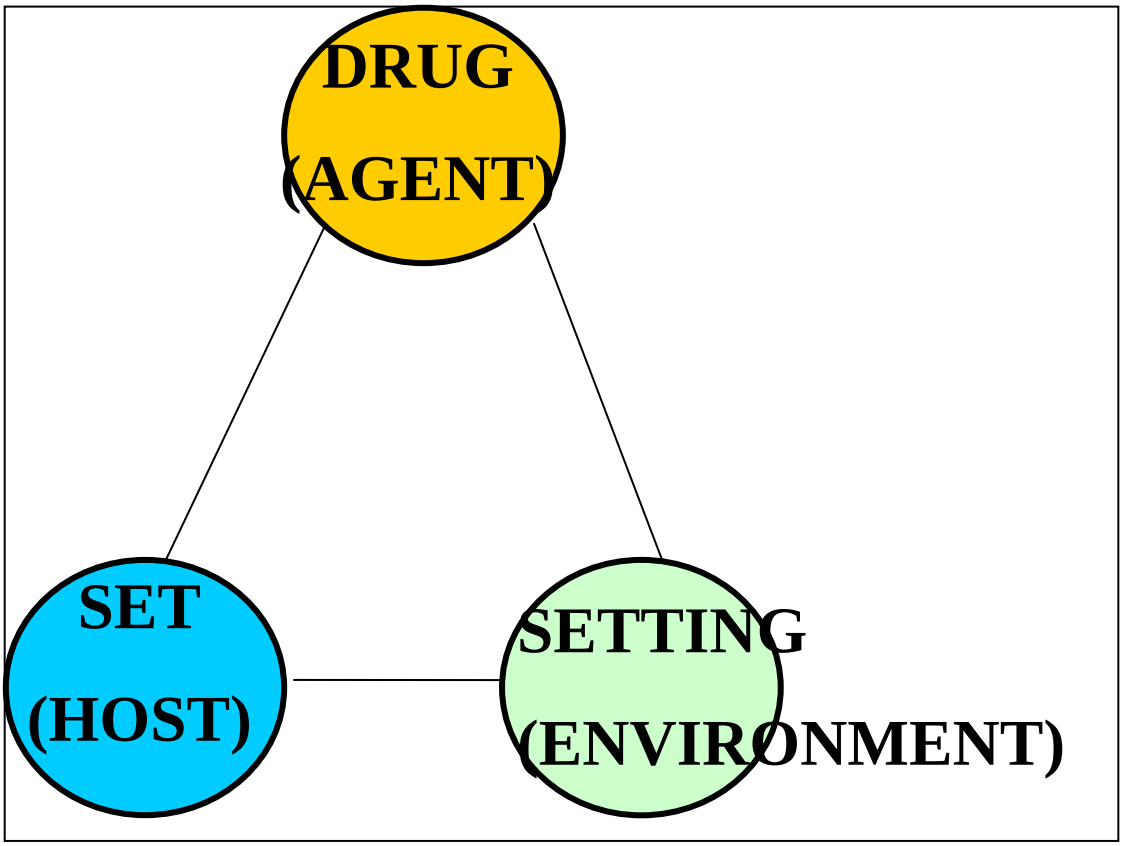
  There are, basically, two agreed models related to substance addiction/abuse/ misuse – The Disease model and the Habit model (Marlatt, et al., 1978; White, et al., 2001-2).

  Both models start out with the premise of misuse leading to major problems. However, the Habit model suggests that once the habit is controlled then the major problems cease. Most international experts currently dismiss this model as too simplistic in favour of the Disease model.

(e) The Impact of the Zinberg Model

The Zinberg public health model related to the use of drugs (1984) has been widely accepted within the AOD professional community (Peele, 1987; Ashley & Rankin, 1988; Hester & Miller, 1989) as probably the best therapeutic model for extrapolating the reasons why people use drugs, the effect those drugs have on individuals and the best type of treatment to assist users who want to minimise the harmful effects of the drugs . A basic diagram of the model is shown below.

Why is this important? Because if we don't understand why drugs are problematic, we will approach the subject of dealing with the "drug problem" in uncertainty and probably in a misguided manner. An example of this is given by Hester and Miller who suggest that the dominant treatment paradigm (in the 1980s, and not much changed since) has little or no scientific basis and there is much evidence that its most important product is failure. They suggest that, if someone set out to design a system to be as ineffective as possible, it would closely resemble what we have today.



Drug, Set and Setting – The Zinberg Model of Controlled Intoxicant Use

Briefly, Zinberg suggests that there is a cause and effect dynamic set up among the drug, the person taking the drug, and the environment in which the drug is taken which maybe different for each individual and may be different each time the drug is taken by the same individual.

The cumulative effect of this dynamic over time reinforces the need to treat each client separately and holistically.

Section 3.02 Holistic Treatment

The holistic approach to healing was brought to prominence as an evidenced-based methodology by Sigmund Freud (1856-1939) who is generally considered the Father of Psychoanalytic Therapy (cf. http://en.wikipedia.org/wiki/Sigmund_Freud). Other experts (Jung, Rogers, Maslow, Coon, Kohlberg, Herzberg, etc., etc.) have progressed and enhanced these theories.

“Holistic” comes from the noun “holism” which means that “entities, as fundamental components of reality, have an existence other than as the mere sum of their parts” (Dictionary.com, 2006). In relation to people, it encompasses every person's intellectual, emotional, social, physical, artistic, creative and spiritual potential – the whole person.

Evidenced-based treatment outcomes which are based on healing the whole person are statistically the most successful in terms of on-going recovery from addiction (NIAAA, 2000).

Section 3.03 Current Treatment Philosophies

Near the end of the 1980's, it was apparent to consumers and insurers alike that more facilities and treatment philosophies did not equal more effective care for the chronically addicted (Compass House, 2006).

There are many and varied treatment assessments and philosophies (Thomas, 2005), for example, some assessment protocols are:

- Addiction Severity Index (ASI),
- A Semi-Structured Interview for Selecting Treatment (ASSIST);
- Substance Abuse Subtle Screening Inventory (SASSI);
- Alcohol Dependence Scale (ADS);
- Michigan Alcoholism Screening Test (MAST);
- Substance Use Disorder Diagnostic Schedule (SUDDS);
- Substance Abuse/Life Circumstance Evaluation (SALCE);
- Medical Triggers Screening Tool (MTST);
- Alcohol Use Disorders Identification Test (AUDIT);
- Drug Abuse Screening Test (DAST); and
- Substance Abuse Questionnaire (SAQ)

In addition, there are a number of unstructured assessment protocols.

> *This spread of secondary presenting problems indicates that there is a useful differentiation of services. However, it may also indicate that the staff in agencies have particular skill sets and are more likely to identify secondary issues that fit with their specialisation.*
>
> *This emphasizes the need for a coherent pattern of assessment across the sector. This does not mean that there should be a completely uniform assessment procedure, rather that any assessment that is done needs to fit into an agreed pattern of assessment that will comprehensively identify client needs so appropriate referrals can be made* (The Nucleus Group, 2005, p6)

Conclusions and outcomes of this analysis are taken up in the next Chapter.

Chapter 4. Project Outcomes and Evaluation

Section 4.01 Research Conclusions

In a launch promo for the book *Addiction Counselling: Content & Process* by Ali Marsh & Ali Dale (IP Communications, 2006), Craig Carmichael of the Western Australian Drug and Alcohol Office (personal communication, October 20, 2006) quotes from the book: "For many counsellors and therapists, clients who have alcohol and other drug problems present a particular challenge. High drop-out rates, irregular attendance at sessions, on-going drug use, suicidal ideation and attempts, difficulties forming a solid therapeutic relationship, slow progress, and co-occurring psychological disorders, are just some of the difficulties counsellors face."

The hypothesis determined for this research is

- Do rehabilitation practices exist that allow significant success in recovery for the participants?

The research strategy undertook the following steps:

- A literary review;
- An exploration of the industry;
- Analysis of the data from the exploration against information discovered from the literary review; and
- Development of an argument for change in program methodology.

It seems fairly clear from the arguments put forward thus far that:

- Addiction and relapse are closely allied to life-issues and emotional conflicts;
- Practices do exist which will assist AOD users to come to grips with these issues but they are inconsistently applied and not well adapted by clients;
- Governments and policy makers are genuine in their attempts to minimise harm in relation to drug use.

This Research Project thus concludes that current service delivery may need reappraisal in the light of accumulated knowledge and evidence across the international industry. New insight has been brought to bear on treatment protocols which does not appear to have been applied across the industry.

The research lends itself to the promotion of a workshop facilitation whereby industry professionals have the opportunity to appraise their service delivery and to make changes in line with best practice protocols.

A "Best Practices in Addiction Treatment Workshop" has been designed by the Addiction Technology Transfer Centre Network in USA (ATTC, 2003). It would be readily adaptable to the Australian/Canberra environment and Australian best practice protocols.

A outline of an adapted Workshop is at Appendix III

Section 4.02 Models of successful change

The theoretical approach to group interaction in this Research Project is informed by the Gestalt concept towards human behaviour (Kirkegaard, Kant, Perls, et al.). It has an holistic approach to behavioural interventions and the freedom for individuals to explore alternatives to their current thinking.

Under these theories, groups should develop identity within the framework of objectives.

Tuckerman's stages of group development (1965) – forming, storming, norming, and performing – are relevant to all groups. Theoretically these stages are inherent in every group and it is the leader's role to get them through to the performing stage as soon as possible, and using Gestalt models for instance, allow them to develop at their own pace.

These models are also emphasised when introducing best practice changes within the AOD industry (SAMHSA). Thus they are incorporated as an integral part of the Workshop.

Section 4.03 Evaluation report

(a) Objective and Activities

The objective of the Workshop is to assist a group of AOD professionals to develop an awareness in "best practice" methodologies for the rehabilitation of alcohol and other drug users.

All of the activities of the Workshop are targeted to achieve this objective in that they:

- Allow participants to form a homogenous group;
- The knowledge and experience of group members is used to generate group discussion and focus;
- Q&A techniques draw out desired conclusions;

- Supplementary and critical knowledge to the requirements of the objective are integrated into the learning process; and
- The group will self-assess its progress.

(b) Activity Relationships

Each of the sessions has been designed so that the group will progress through from discussion of fundamental material to focussing on the relevant issues to final development of the outlines of a useful model.

The Workshop requires an assessment of knowledge and understanding intake from the participants so that this building process may be achieved.

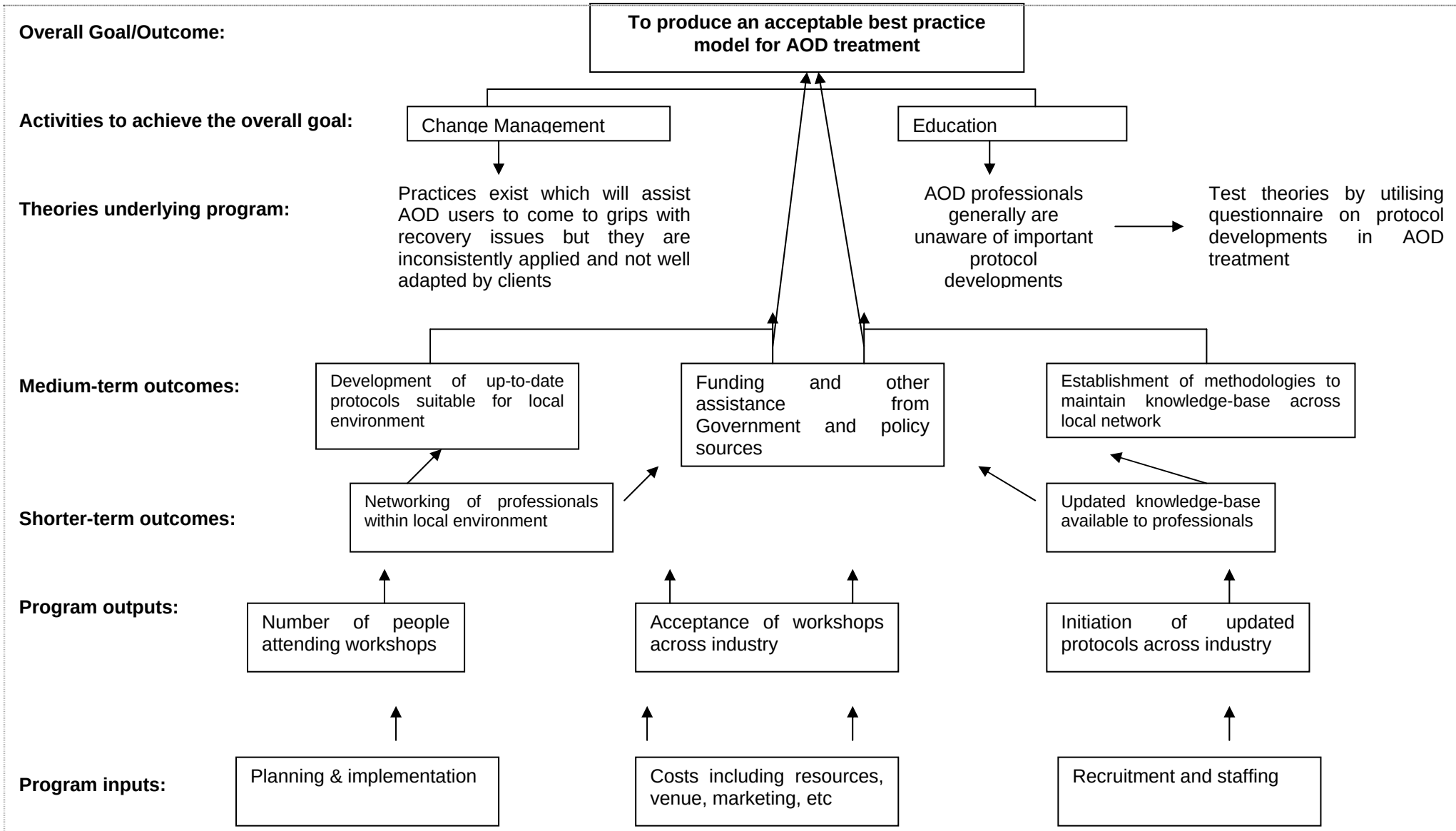
(c) Evaluation of the Process

A well-designed evaluation will help to:

- set clear aims and objectives for the program;
- ascertain the progress of the program;
- develop and improve the program;
- guard against the program becoming stagnant;
- test theories about why the program should work;
- identify problems and generate solutions during the life of the program;
- develop a scientific basis for decision-making;
- gather credible evidence about the program's effects;
- assess if the program has the intended impact; and
- set future directions (Zipparo, 2001).

In evaluating the "Best Practices in Addiction Treatment Workshop" as an outcome of this Project the model on the following page will be used. The model is adapted from Zipparo's outputs and outcomes model (p 7).

Policy impacts of the Workshop in relation to the industry are discussed in Chapter 7, and the model put forward by Pidd, et. al. (2004) for assessing workplace change is put forward.



Model of outputs and outcomes for a Best Practice in Addiction Treatment Workshop

Chapter 5. Impact of the Project

Section 5.01 Client group

The reasons why people take drugs, the effect of that drug taking and the ultimate desire for well-being innate in all humans (cf. Maslow, et al.; Zinberg) will be the deciding factors relating to the impact of this Project on the client group.

In his famous book "*Man's Search for Meaning*" Viktor Frankl suggested that … *the meaning of our existence is not invented by ourselves, but rather detected* (1963, p 157). There seems to be an innate desire in all of us to detect that meaning.

Frankl also talks about the tension between "actualisation" and "gratification" (see also Fromm, 1947; Maslow, 1954; et al.) and that appears to be the psychological issue surrounding drug use and the underlying determinant of whether recovery programs will work or not work. Of course there are also the biological/genetic issues and the socio/cultural issues to be considered.

There seem to be two principles of change that impact on individual clients and their ability to recovery from addiction:

1. You can't change what you don't acknowledge (McGraw, nd);
2. If nothing changes, then nothing changes (Alcoholics Anonymous, nd).

The ability of the treatment program to provide an environment in which positive outcomes from these principles occur will ultimately determine its success. The Workshop aims to provide information that allows for change to take place at all levels of the industry.

Section 5.02 Organisation/Agency/Workplace

Agencies are basically in the same situation as their clients in relation to the impact of change on the outcomes of their programs.

The literary review leading into this Project showed up ample evidence of treatment philosophies that were not efficacious. It also showed up modern, innovative, evidence-based protocols that do work.

The Workshop will provide an environment in which organisations may rethink their strategies in line with best practice protocols and thus enhance their *raison d'être* from their own perspective as well as from the perspectives of their major stakeholders.

Section 5.03 Workers and Volunteers

Satisfying outcomes are what workers generally and workers in the AOD industry importantly desire from their work (cf. Maslow and others). If they know that they have ownership of the methodologies used by their employer and that the agreed outcomes are seen to be successful, then they will want to continue working in the industry and will be better and more willingly prepared to input to the efficacious growth of the treatment modalities.

Section 5.04 Agency networks

One of the most important outcomes of the Workshop will be to enhance agency networks within both the local environment and the wider industry. As agencies prepare to acknowledge a cooperative spirit to achieve common outcomes, so will the importance of networks increase and be effective.

Section 5.05 Community

The community as a whole and individuals, particularly addicts and their significant others, will greatly benefit from successful treatment outcomes in holistic societal ways.

Further discussion of the policy impacts of the Project occurs in Chapter 7.

Chapter 6. Barriers

There are no known barriers to the implementation of the Project outcomes, as they are seen at this stage as theoretical models. However, should the Project be picked up by relevant agencies then some restrictive influences (barriers) are likely to occur from time to time and from agency to agency. The types of issues which may develop are:

- Funding

  The NHMRC funding policy (2006) allows for funding, made through eligible institutions, which are registered as Administering Institutions, under the following headings:

  - Centres of Clinical Research Excellence
  - Development Grants
  - Enabling Grants
  - Program Grants
  - Project Grants and
  - Strategic Awards

  The guidelines for funding may be prohibitive and some specialist/peak-body advice would be needed to advance a funding proposal.

- Resources and Staffing

  Resources, including staffing, are dependent upon funding so the question, at this stage is mute. However, there is no reason why the philosophies presented by the research cannot be utilised under current resource arrangements. They require a shift in thinking rather than any shift in resources.

- Organisational/systems Issues

  The current international trend is to produce evidence-based outcomes in relation to treatment and recovery. Naturally, these requirements will impinge upon the systems in place in an agency to show that such outcomes are being achieved.

  Some agencies may find that these requirements are daunting or even outside their expertise. Such issues need to be considered as part of any funding arrangements.

- Structural Issues

  The structural issues of each Agency in implementing the outcomes of this Research are in the end agency specific and may be constrained by budgetary and other requirements. However, each agency will need to consider its aims and objectives in the light of this research and restructure accordingly.

  As mentioned earlier in this report, the Nucleus Group's review of case management in the ACT (2005) indicated that there is a spread of secondary presenting problems [indicating] that there is a useful differentiation of services… However, it may also indicate that the staff in agencies have particular skill sets and are more likely to identify secondary issues that fit with their specialisation. This emphasises the need for a coherent pattern of assessment across the sector (p 6).

Chapter 7. Policy Development Issues

Section 7.01 Current Practice

> *Continued research to refine therapies for alcoholism will have widespread benefits for alcohol-dependent people, for their families, and for society as a whole, which bears the weight of the enormous economic and social costs of problem drinking* (NIAAA, 2000).

These comments are easily aligned to the AOD environment as a whole.

Much has been spoken of in this report and its references regarding the need for change. "*Even if you are on the right track, if you don't keep moving you will eventually get run over*" (probably Will Rogers, 1934) and it seems emphatically true in all stages of life.

In Australia, and particularly in the Australian Capital Territory, current practice reviews indicate that case management is generally not well defined, understood or practiced (Heather, et al., 1989; The Nucleus Group, 2005).

Section 7.02 Models

There are a number of international and Australian models that can be utilised in forming an agreed methodology for service provision. These include (but are not limited to):

- The Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health;
- United Nations Office on Drugs and Crime – Drug Abuse Treatment Toolkit;
- *Milliya Rumurra* Alcohol and Drug Rehabilitation Centre, Broome, Western Australia;
- Adolescent Drug and Alcohol Withdrawal Service, South Brisbane;
- "Putting People First" – Western Australia Model for Drug and Alcohol Treatment;
- *Beyondblue* – The National Depression Initiative: Integrated Service Model For Young People With Substance Use And Mental Health Needs;
- The Iowa Consortium for Substance Abuse Research and Evaluation.

These models are used as part of the resources for group discussion in the Workshop.

Section 7.03 Policy Impacts

The impact of the outcomes of this Project are difficult to measure at this early stage.

What this Project recommends is that the evaluation processes designed by the National Centre for Education on Training and Addiction (NCETA) be implemented as part of the on-going measurement of the Workshop in terms of its efficacy and impact on the AOD treatment industry in Canberra and beyond.

> *One of the 12 recommendations for priority action in a national strategic approach to AOD education and training was for the development of guidelines, methodologies and instruments to evaluate the impact of education and training initiatives. This recommendation was driven by the recognition that significant improvements were required in the assessment and measurement of the impact of AOD-related education and training on professionals' work practice* (Pidd, et al., 2004, p 1).

Again, the fragmentation of the industry's practices are highlighted and, as previously discussed, the challenge of this Project is to focus AOD professionals on the need for coordination with respect to education, change, and ongoing methodology development. Should that focus occur through the Workshop, the impact on policies and practices within the field will be significant.

A number of related issues were highlighted at the recent "*A Fair Go For All? - Policy Responses to Alcohol, Drug and Gambling Issues*" Conference held in Adelaide last September. At this stage it is too early to judge the outcomes of the conference, however, the impetus demands follow-up and this will be a further project for this researcher.

Chapter 8. Ethical Practice

According to the Australian Institute of Welfare and Community Workers (AIWCW),

> *…The welfare and community worker is a person who, through professional training and field education, has the requisite values, attitudes, knowledge, and skills to work autonomously, or with a team, in a social welfare agency or program intended to promote, relieve or restore the social functioning of individuals, families, social groups or larger communities* (2005, Introduction).

Canberra Institute of Technology (CIT) Research Handbook states:

> *Ensuring that research is ethical means that all those involved in the research will be protected from being harmed by the research… Ensuring that research is ethical also means that you will be able to undertake research within the laws concerning copyright, intellectual property and privacy* (2005, p 12).

As part of the process of the Project it is important that ethical considerations are taken into account at all times. The research used the following model, based on the AIWCW and CIT codes:

1. Identification of any ethical problems
   Ethical situations exist in all aspects of AOD policy development and service delivery. In relation to the Research Project the area of most concern was the gathering of information related to the Needs Analysis.
2. Identification of potential issues involved
   Potential issues involved the collection of very personal information from both industry professionals and AOD addicts.
3. Application of the AIWCW Code of Ethics and CIT "Research Ethics"
   These codes require that personal identification data be kept strictly confidential and that the desires of the participants in relation to the release of such data are strictly observed. Care was taken to ensure that such data was collected in accordance with the principles of the codes and participants were made aware of how the data was to be used.
4. If necessary seek legal counsel
5. Consideration of possible and probable courses of action
6. Exploration of the consequences of various decisions
7. Deciding on the best course of action
   Because of the strict adherence to the codes of ethics, items 4-6 above did not require any action. The ethical methodology used within the Project was submitted to supervision accountability for endorsement.

Section 8.01 Confidentiality and Privacy

All survey information was stored on an appropriate removable medium and all participants in the research were assured that personal identification data was not collected. Following analysis of the data, all survey returns were destroyed.

Nothing in this Report identifies personal information related to industry professionals, clients or research participants.

Chapter 9. Critical Reflection

This critical reflection has been difficult to write due to the amount of work required to keep up with the curriculum and my innate reluctance to examine my motives and attitudes.

Generally I did not have any difficulty with the research theory, as I have been involved with research and policy development for a number of years.

Discovering more about Social Action as a discipline has been exciting for me. I have a value system which says that people who hold heavy burdens in their lives need help with those burdens. While there is a lot of work being done in all sorts of areas in this regard, I am often surprised at the lack of positive coordination and the politics involved in providing the necessary support structures.

I have learned that Social Action Research is about advocating and effecting change, particularly where gaps are seen in service provision. We have also spoken about various models and structures. It seems to me, however, that the adage of "what goes around comes around" is inherent in the social welfare system. What I mean is that we are recycling theories and methodologies, catering for the few, while the many – including the most difficult – appear to slip through the cracks a lot of the time.

The theories appear to be sound, but the methods of delivery leave something to be desired.

This Project has developed with these thoughts in mind. I think that, if I can find practices that work in AOD rehabilitation, I can incorporate them in a program that I can present to AOD Workers in Canberra, and this just might have an impact on service delivery to halt the chronic relapse statistics of addicts.

Our subject co-ordinators have taken us on a journey to examine the way research in Social Action should be conducted. The methodologies are clear and logical and I can see that using them effectively would put me in a position to prove my research hypothesis.

I am happy with the way the class work progressed and that my research and reflection on these aspects led me in the right direction.

At one stage we were given a paper on "Critical Reflection". I was impressed by the quotation from Kierkegaard at the top of the paper: "All deep thought begins and ends in the attempt to grasp whatever touches one most immediately".

I had to be careful about being too narrow in my approach to the research. As Kierkegaard intimates, there is a possibility of me trying to justify my attitude towards service delivery. The danger in this is that I will overlook the positives and focus only on the negatives. I know that there are many positives and that everyone within the service delivery arena is doing what they think is in the interests of the clients. I had to be careful in developing my program that I didn't dismiss local processes out of hand.

The literary research has been overwhelming in its results. There is a lot of work being done in the AOD industry to critically examine methodologies and to pursue evidence-based best practice in service delivery. I was continually surprised as I delved into various aspects of AOD treatment practices at the depth of many of the initiatives. My bibliography has become gigantic!! However, this has been very pleasing, because , at the initial stages, I was very sceptical regarding "best practice" in the industry.

Tying everything together has been an absolute nightmare and I have be plagued by my personal demons and frustrations. At one stage I found myself in a depressed state which I thought was going to thwart the whole Project. I knew I had to start work but I couldn't; I was lethargic and depressed; time became "of the essence" and yet still I couldn't get into the Report.

Fortunately, I have professional help, personal support and the appreciation of my research supervisor to thank for getting me through that crisis.

As I now look back on what I have done, I am satisfied that it is professional enough for submission. I could spend more time on it, but there has to come a point where enough is enough. I think I have reached that stage.

I am not completely satisfied with the result, however there is opportunity for me to develop the program further should I want to and, at the end of the day, passion needs to be balanced with pragmatism.

Thank God it's OVER!!

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Appendices

- Appendix I - Action Plan
- Appendix II – Surveys
  - Professionals
  - AOD Recovering Addicts
- Appendix III –
  - Workshop in Best Practice Methodologies for the Rehabilitation of Alcohol and Other Drug (AOD) Users – Session Outline
  - ATTC Facilitators' Manual