



# Population planning for alcohol and other drug services: the national Drug and Alcohol Clinical Care & Prevention (DA-CCP) project

Medicine

National Drug and Alcohol Research Centre

Drug Policy Modelling Program

A project commissioned by the Ministerial Council on Drug Strategy through the Cost Shared Funding Model

Funding: NSW Ministry of Health and Australian Government Department of Health and Ageing

Presented by: Alison Ritter, Chair, Expert Reference Group, DA-CCP

Project team: NSW MHDAO - Sue Hailstone, Judith Burgess, Gavin Stewart, Meredith Sims, Brian Woods

# History and context

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Service planning poorly done

- How many services do we need?
- What types do we need?
- Where do we need them?

Past & current attempts to plan for treatment

- Often based on historical funding (supply = demand)
- Little research on ‘unmet demand’
- No systematic agreement about treatment types and best practice standards
- No estimates of potential resources required

# Drug and Alcohol Clinical Care & Prevention (DA-CCP)

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- DA-CCP – an endeavour to overcome this
  - Build a national planning model
  - Develop standard types of care and identify their components
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- DA-CCP based on an earlier NSW mental health planning model (Pirkis et al., 2007)

# DA-CCP Aims and Objectives

- To build the first national population based model for drug and alcohol service planning
- To estimate the need and demand for services
- To use clinical evidence and expert consensus to specify the care packages required by individuals and groups
- To calculate the resources needed to provide these care packages
- To provide a tool for jurisdictions: the development of a national model that can be adapted for use within each Australian jurisdiction (transparency and consistency in service planning)
- Work in progress – model outputs not yet available.

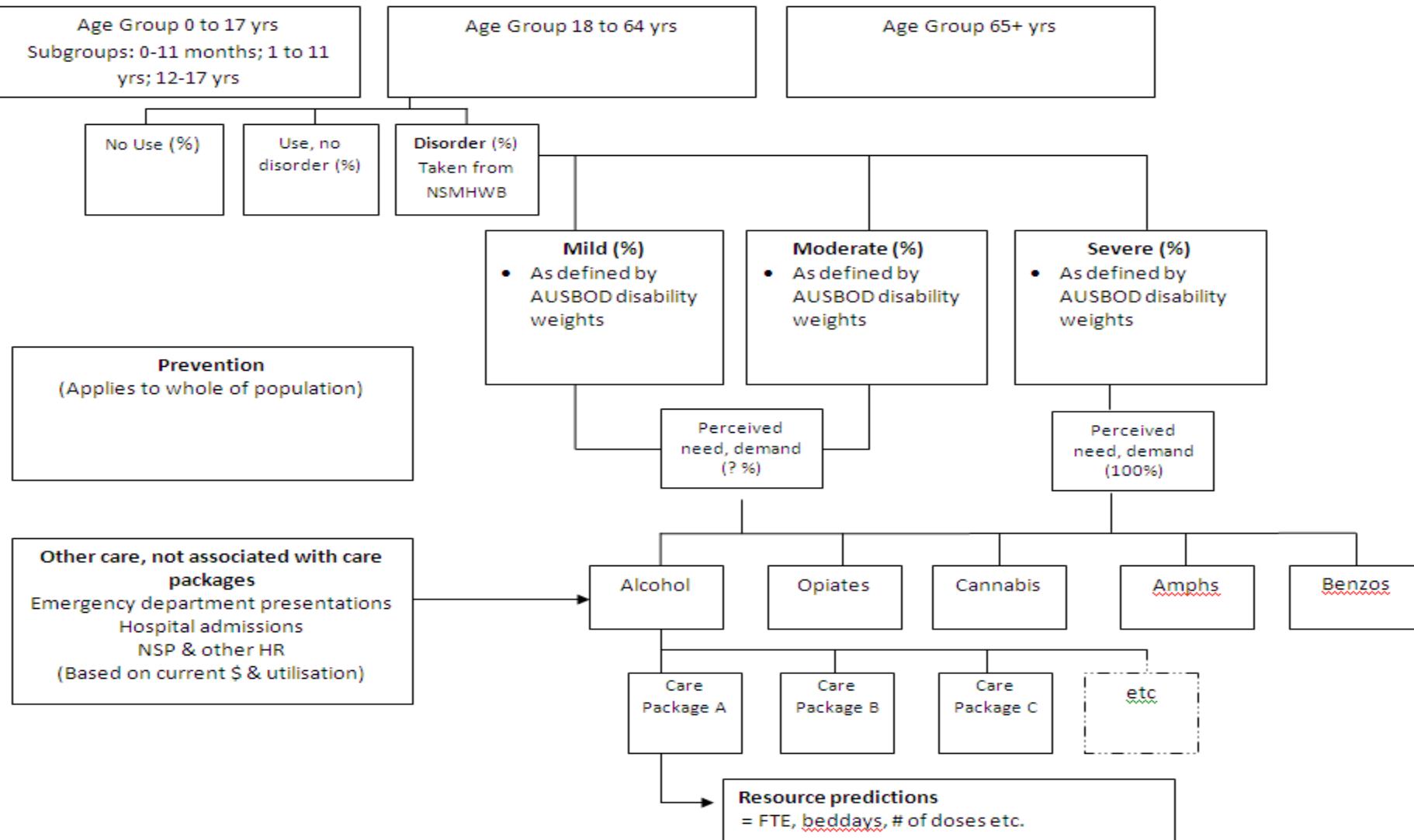
# The DA-CCP model

- The model is about what '**should be**', not what currently is
- Five drug classes (alcohol, opiates, cannabis, methamph & benzos)
- Five age groups (0-11mnths; 1-11 yrs; 12-17 yrs; 18-64 yrs; 65+)
- Care packages: range of service types:
  - Outpatient, community based treatments
  - Residential rehabilitation services
  - Inpatient, hospital based treatments
  - Inpatient, community based treatments
  - Primary care services (eg. GPs)
- Care packages are evidence based. In the absence of evidence, then care packages are based on expert consensus
- 'Where' not included: not a geographical resource distribution formula

# What will DA-CCP tell us...

- Nationally shared descriptions of units of service (care packages)
- Estimates of:
  - The # of people 'needing' treatment (by drug type and by age range)
  - The # of staff (FTE) required (medical, allied health/nursing, AOD workers)
  - The # of beds; treatment places required
  - The amount of other care (doses of meds, medical investigations etc)
- A tool for each jurisdiction to use in planning for AOD services

## DA-CCP SCHEMA



# The epidemiology

Derived from National Survey of Mental Health and Wellbeing (1997)

- Nationally representative, face-to-face survey of 10,641 individuals, 18-85 yrs
- DSM-IV and ICD-10 diagnoses

Those who meet diagnostic criteria for abuse or dependence

- Separated into mild, moderate and severe
- Based on disability weights from Burden of Disease work (Begg et al., 2007)

Perceived need/demand - treatment rate for mild, moderate and severe

- Mild 20-25%
- Moderate 65-75%
- Severe 100%

Based on overall 'best' treatment prevalence of 51% (Tolkien report)

# Care packages

The care for a person for a year is defined in terms of:

- the drug type
- the age group
- the severity of presentation (mild, moderate, severe)

And for each of these:

- frequency & duration of sessions (outpatient treatments)
- type of clinician (FTE time)
- number of bed days & occupancy rate

The level of care that is specified for an “average” person is adequate, anything less would be unsatisfactory.

# What are the alcohol 'care packages'?

1. Psychosocial interventions - without RP meds - standard
2. Psychosocial interventions - with RP meds - standard
3. Psychosocial interventions - without RP meds - complex
4. Psychosocial interventions - with RP meds - complex
5. Withdrawal - home based - standard - without RP meds
6. Withdrawal - daily outpatient - standard without RP meds
7. Withdrawal - daily outpatient - standard with RP meds
8. Withdrawal - daily outpatient - complex - with RP meds
9. Withdrawal - residential - standard - with RP meds
10. Withdrawal - residential - complex - with RP meds
11. Rehabilitation - day program - 25 days - standard
12. Residential rehabilitation - 8 week stay
13. Residential rehabilitation - 13 week stay
14. Residential rehabilitation - 26 week stay

# What are the opioid ‘care packages’?

1. Opioid maintenance treatment - standard
2. Opioid maintenance treatment - complex
3. Psychosocial interventions - standard
4. Psychosocial interventions - complex
5. Withdrawal - daily outpatient - standard
6. Withdrawal - daily outpatient - complex
7. Withdrawal - residential - standard
8. Withdrawal - residential - complex
9. Rehabilitation - day program - 25 days - standard
10. Residential rehabilitation - 8 week stay
11. Residential rehabilitation - 13 week stay
12. Residential rehabilitation - 26 week stay
13. Residential rehabilitation - methadone to abstinence
14. Residential rehabilitation - stabilisation program

# Example: Opioid care package, maintenance treatment

## Induction

- 1x 60 mins assessment by doctor
- 1x 60 min assessment by case manager
- 1x 30 min diagnostic testing (inc routine bloods FBC, U & E, LFT, BBV)
- 1x 20 min UDS
- 2 x 15 min referral (pharmacy, clinical psychology, counselling)
- 1x 30 min case conference
- 1x 30 min medical review (first week)
- 3 x 30 min medical review (week 2 to 4)
- 3 x 30 min case management (week 2 to 4)

## Maintenance

- 12 x 30 minutes medical reviews
- 12 x 30 minute Case Management
- 1 x 30 minute Referral
- 1 x 30 minute bloods per year
- 6 x 20 minute UDS per year
- 2 x 30 min case conferencing

## Individual psychosocial interventions

- 1x 15 min intake
- 1x 60 min assessment
- 6 x 60 min 1:1 psychosocial intervention/family/supporter
- 1x 15 min case conference
- 2 x 30 min transfer of care/ discharge / care coordination

## Dosing, tobacco intervention, assertive follow-up

# Additional ‘care’ that we spread across the model

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- Consultation/liaison services in hospitals (ED and acute)
- Harm reduction services (eg Needle Syringe programs)
- Services for pregnant woman with AOD disorders
- Early and brief interventions
- Telephone services
- Prevention activities & programs

# Challenges

## 1. Epidemiology

- Epidemiology is dated (and inaccurate for low prevalence, eg opioid dependence)
- Treated prevalence – expert judgment, plus disability weights
- Allocation to care packages – expert consensus plus existing utilisation

## 2. Care components

- High quality evidence for some care packages is lacking
- Evidence for prevention is lacking

## 3. Other issues

- Co-morbidity
- Not all drugs covered (eg pharmaceutical opioids)
- Indigenous module

# Conclusions

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- Progressive approximations towards a sensible model
- First endeavour – will be built on in subsequent iterations
- Internationally cutting edge – only one other nation attempting work in this area (Canada)
- Capacity to transform Australian planning of AOD services

# Thank-you

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Professor Alison Ritter  
Drug Policy Modelling Program, Director  
National Drug and Alcohol Research Centre  
UNSW, Sydney, NSW, 2052, Australia

E: [alison.ritter@unsw.edu.au](mailto:alison.ritter@unsw.edu.au)  
T: + 61 (2) 9385 0236

DPMP Website:

<http://www.dpmp.unsw.edu.au>

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