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Appendix A: Review Advisory Committee members and 'critical friends'

Review Advisory Committee members

Membership	Representative
Chair	
First Assistant Secretary, Mental Health and Drug Treatment Division Commonwealth Department of Health and Ageing	Sue Campion
MHDAPC representation	
Western Australia	Neil Guard
New South Wales	David McGrath
Sector representation	
Australasian Therapeutic Communities Association	A/Professor Lynne Magor-Blatch
National Indigenous Drug and Alcohol Committee	Scott Wilson
Australian National Council on Drugs	Gino Vumbaca
Alcohol and other Drug Council of Australia	David Templeman
National Drug and Alcohol Research Centre	Professor Mike Farrell
Australian Medicare Local Alliance	Renee Williams
State and territory peak body representation	
Queensland	Rebecca MacBean
Tasmania	Jann Smith
Consumer representation	
Australian Injecting and Illicit Drug Users League (AIVL)	Annie Madden
Consumer Health Forum of Australia	Jeff Gavin
Homelessness representative nominated by the Prime Minister's Council on Homelessness	Ian Carter
Clinical representation	
Australasian Chapter of Addiction Medicine	A/ Professor Nick Lintzeris
Drug and Alcohol Nurses of Australasia	Jennifer Harland

"Critical friends"

Professor Margaret Hamilton, Australian National Council on Drugs (ANCD) member

Associate Professor Robert Ali, Director, Drug & Alcohol Service South Australia (DASSA) WHO Collaborating Centre for the Treatment of Drug and Alcohol Problems

Professor Steve Allsop, Director, National Drug Research Institute, Curtin University

Professor Robin Room, Director, Centre for Alcohol Policy Research, Turning Point Alcohol & Drug Centre, University of Melbourne

Associate Professor Adrian Dunlop, Area Director, NSW Health, Newcastle Area, Conjoint , School of Medicine and Public Health, Faculty of Health and Medicine, University of Newcastle

Appendix B: Illicit Drug Diversion Initiative (IDDI)

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January, 2014

(Prepared as part of the review of drug and alcohol prevention and treatment service sector)

Context

One project within the review of alcohol and other drug (AOD) treatment services is an analysis of all AOD related treatment funding, with a focus on the Commonwealth investments. The Illicit Drug Diversion initiative (IDDI) has been an important funding source for AOD interventions. This discussion paper provides details of IDDI funding, and the associated funding mechanisms, which have changed over time. The paper was informed by existing reports and analyses of the IDDI (eg Hughes & Ritter, 2008), and interviews with Commonwealth personnel involved in the IDDI.

History of the IDDI

The Illicit Drug Diversion Initiative (IDDI) was a substantial funding initiative launched by the Howard government as part of Tough on Drugs in 1999. Its purpose was to fund a 'nationally consistent approach to the diversion of minor drug offenders'.

The IDDI involves diversion of offenders by police or from the courts to appropriate drug education, or a diverse range of clinically acceptable drug treatment or counselling services, and waiving a criminal conviction for those who comply with these requirements. It targets those charged with drug offences for the first time or who have little or no involvement with the criminal justice system, and those apprehended for use or possession of small quantities of any illicit drug. The Council of Australian Governments (COAG) agreed to a National IDDI Framework (1999) which specified eligibility criteria (illicit drug use/possess; no history of violence; admit to the offence), compulsory assessment, non-compliance/expiation requirements, and education interventions. The Framework was sufficiently flexible such that programs across jurisdictions could be diverse.

It is important to note that diversion programs pre-dated the IDDI initiative. For example the Victorian Cannabis Cautioning program started in 1997 and the Victorian Drug Diversion program and CREDIT (Court Referral and Evaluation for Drug Intervention and Treatment) program commenced in 1998. Victoria signed the IDDI COAG agreement in August 2000 and these three programs then became part of IDDI. Likewise the ACT Simple Cannabis Offence Notice Scheme (SCON) program commenced in 1992, but became part of the IDDI in December 2001 (with receipt of IDDI funds).

The IDDI is effectively a sub-set of all diversion programs across Australia, even though it may not be exactly clear what programs are labelled as IDDI versus other diversion (or forensic[1]) programs (see below for further discussion of this).

If we turn to all diversion programs in the first instance, a review of all Australian diversion programs completed in 2008, found "51 programs operating for the diversion of drug and drug-related offenders throughout Australia". Diversion is provided across the full spectrum of the criminal justice system, via police, courts and specialist courts. The review found that 31% of programs were for police diversion; 22% for court diversion; and 18% drug courts (29% were multi-targeted). The review also noted that … "diversion expanded considerably since 2000, […] there was an expansion not only in the number, but also the type of programs" (p. 1)[2].

IDDI funded diversion vs non-IDDI funded diversion programs?

It is useful to try and distinguish between those diversion programs funded as part of IDDI, and those funded from other sources, as this relates to program 'ownership' and funding amounts. Data on whether a diversion program is or is not IDDI funded is not necessarily highly reliable, and may be dated.

In the 2008 review, Hughes and Ritter classified programs according to whether they were funded under IDDI or not. This information was derived from state/territory drug and alcohol offices; legislation and policy documents produced by police and magistrates; and program evaluations. All data were cross-checked and corrected with diversion providers in each state/territory at the time of the review.

Table B1: IDDI funded vs non-IDDI funded diversion programs as at 2008 (source: Hughes & Ritter, 2008)

Jurisdiction and program	**IDDI funded**	**Not IDDI funded**
ACT police diversion	ACT Policing Early Intervention and Diversion (PEID) program	SCONS (Simple Cannabis Offence Notice Scheme) Children & Young People Act 1999
ACT court diversion	CADAS (Court Alcohol and Drug Assessment Service) TRP (Treatment Referral Program)	
NSW police diversion	Adult Cannabis Cautioning Scheme	Young Offenders Act

[1] In Victoria, the diversion programs are referred to as "forensic" programs, eg "forensic education and training, cannabis" for the cannabis cautioning program.

[2] Hughes, C., & Ritter, A. (2008). DPMP Monograph No: 16. A summary of diversion programs for drug and drug-related offenders in Australia. *DPMP Monograph Series.* Sydney: National Drug and Alcohol Research Centre.

NSW court diversion	MERIT (Magistrates Early Referral Into Treatment) Rural Alcohol Diversion (RAD) Pilot Program Youth Drug and Alcohol Court	(Adult) Drug Court
NT police diversion	Northern Territory Illicit Drug Pre-Court Diversion Program	Cannabis expiation scheme Juvenile Pre-Court Diversion Scheme Youth Justice Act
NT court diversion	CREDIT NT (Court Referral and Evaluation for Drug Intervention and Treatment)	
QLD police diversion	Police Diversion Program for Minor Drug Offences	Juvenile Justice Act 1992
QLD court diversion	Illicit Drug Court Diversion Program	QMERIT (Queensland Magistrate's Early Referral into Treatment) Drug Court program
SA police diversion	(PDDI) SA Police Drug Diversion Initiative	Cannabis Expiation Notice Young Offenders Act 1993
SA court diversion	CARDS (Court Assessment and Referral Drug Scheme) Youth CARDS (Court Assessment and Referral Drug Scheme)	SA Drug Court
TAS police diversion	Police Drug Diversion	Youth Justice Act 1997
VIC police diversion	Cannabis cautioning program Drug diversion program Rural outreach diversion	Victoria Police Cautioning Program
VIC court diversion	CREDIT (Court Referral and Evaluation for Drug Intervention and Treatment) Koori Drug Diversion Deferred sentencing Children's court clinic drug program	Youth Justice Group Conferencing Drug Treatment Order - Drug Court
WA police diversion	CIN (Cannabis Infringement Notice) but	Young Offenders Act 1994

	only Cannabis Education Component) All Drug Diversion YPOP (Young Person's Opportunity Program)	
WA court diversion	POP (Pre-sentence Opportunity Program) IDP (Indigenous Diversion Program) STIR (Supervised Treatment Intervention Regime)	GASR (Geraldton Alternative Sentencing Regime)

The AIC report[3] published one year prior is indicative of funding changes: for example the Victorian deferred sentencing program was not IDDI funded in 2007 (whereas in 2008 it was listed as IDDI funded); the NT cannabis expiation scheme was IDDI funded in 2007 (but not listed as IDDI funded in 2008).

In addition to changes in funding status over time, some programs receive both IDDI and state government funding. For example, the Victorian CREDIT program is noted to be funded by both state government and commonwealth IDDI funds. Likewise the Queensland police diversion program and the NSW Youth Drug Court are other examples (see below). These points simply reinforce that the boundaries between what is and is not IDDI funded remain blurry and changeable.

IDDI funds can be used by police, courts and health departments (that is it is not specific to Health): "The IDDI provided funding to state and territory police services in partnership with their respective health departments to legislate diversion programmes" (p. 166)[4]. Program responsibility resides with the Commonwealth Department of Health.

For the purposes of tracking the funding, IDDI can be viewed in four stages:

1. $110m (1999 to 2002)
2. $215m (2003 to 2007)
3. $165m (2008 to 2010/11)
4. undisclosed amount[5]

[3] Wundersitz, J. (2007). Criminal justice responses to drug and drug-related offending: are they working? *Technical and Background Paper No. 25*. Canberra: Australian Institute of Criminology. Available at: http://www.aic.gov.au/documents/9/C/F/%7B9CFCC5DC-A6E3-4321-84AB-4B6210862954%7Dtbp025.pdf

[4] Australian Crime Commission. (2012) Illicit Drug Data Report 2011-12. Canberra: Australian Crime Commission. http://www.crimecommission.gov.au/publications/intelligence-products/illicit-drug-data-report/illicit-drug-data-report-2011-12

[5] The current Commonwealth per annum commitment is approximately the same amount as per annum grants from the NGOTGP.

Stages 1 and 2 (1999 to 2007)

Across these first two stages, the Department of Health was responsible for paying states/territories based on negotiated Funding Agreements to provide Special Purpose Payments. (These SPPs were not bundled with other SPP's). The Funding Agreements specified details such as establishment of a state reference group, nomination of preferred providers (who met national standards as specified in the IDDI Framework), and agreement to participate in data collections and evaluations. The Funding Agreements also specified the amount for each jurisdiction, and types of diversion programs, education and/or treatment to be provided. While the focus appeared to mainly be on police diversion at the initial stages of IDDI, court-based programs grew throughout this first stage (MERIT, CREDIT, CADAS).

The Funding Agreements (between the Commonwealth and states/territories) did not differentiate the amounts going to police, courts or AOD treatment services. This was determined by the states/territories, in line with their planning processes.

It appears that even in Stage 1 of IDDI, state governments were also contributing towards the IDDI programs. For example, the NSW Youth Drug Court was funded partly by IDDI and partly by a number of NSW government departments :"the Attorney General's Department (AGD), including the NSW Legal Aid Commission (LAC); the Department of Juvenile Justice (DJJ); the NSW Health Department (DoH); the Department of Education and Training (DET); the NSW Police Service (PS); and the Department of Community Services (DoCS) and its three contracted service agencies" (p. 159)[6]. This simple example demonstrates that even from the start of IDDI, there have been complex funding arrangements shared between state/territory and Commonwealth governments across various diversion programs.

Reporting/accountability

Police and courts reported to states/territories, which then reported to DoH. Schedule 5 was the IDDI return mechanism (and this was separate from other schedules completed by state/territories to report to DoH). Schedule 5 included a summary of the number of diversion programs, and for each program (eg police cannabis diversion) the total number of offenders (by age, sex), drug use, past history of diversion, expiation, and trends in numbers.

More specifically, Schedule 5 required the following data elements:

- Volume of diversions
- Offender demographics
- Expiation rates
- Principal drug of concern

Quarterly and annual reports were required. [7]

[6] Eardley et al Evaluation of the NSW Youth Drug Court. SPRC Report 8/04. Sydney: University of New South Wales https://www.sprc.unsw.edu.au/media/SPRCFile/Report8_04_YDC_Pilot_Program_Evaluation.pdf

[7] The Schedule 5 IDDI data were separate to the Alcohol and other Drug Treatment National Minimum DataSet (AODTS-NMDS) although it is possible that AOD treatment agencies reported the same episodes to both AODTS-NMDS and to the Schedule 5 IDDI system.

Stage 3 2008/09 to 2011/12

In 2008 the Australian Healthcare Agreements combined a range of payments to states/territories into a single payment (The National Healthcare Specific Purpose Payment, SPP). Thus in October 2008 COAG moved from 92 different SPP's down to 5-6 SPP's, one of which was the Healthcare SPP. IDDI funds became part of the Healthcare SPP from July 2009. This effectively meant that the individually negotiated Funding Agreements which included detail regarding actual diversion programs and reporting thereof were no longer in place. The healthcare SPP also shifted the processing of payments from the then CW Department of Health and Ageing to state/territory health departments to be from CW Department of Treasury to state/territory Treasuries.

It was known that the National HealthCare SPP was going to be part of a broader health reform and a new National Health Reform Agreement (assuming finalisation of the COAG agreement to health reform) would specify revised funding arrangements. In this context it could be argued that this meant less attention was paid to the National Healthcare SPP set up in 2008 and thus to the IDDI funds.

Technically, it was at this point that the funds became indistinguishable from other health funding to states/territories, although arguably the amounts could still be identified because they were transferred from the previous Funding Agreements.

Program details

Changes in the number and type of diversion programs funded by IDDI over these first three stages are not able to be determined. [8] There is an absence of data to inform whether the shift to a broadbanded SPP resulted in changes to the delivery of the IDDI within states/territories.

Reporting and accountability

Whereas previously the Schedule 5 returns were required as part of the individually negotiated funding agreements between each state/territory and the Commonwealth, under the Healthcare SPP, indicators were pooled. The Healthcare SPP, as with the other broadbanded SPP's was not intended to reduce accountability, rather a move to macro-level outcome reporting. "Reporting against an appropriate set of performance indicators is an essential feature of the new public accountability framework that underpins the Intergovernmental Agreement and the new National Healthcare Agreement".

The use of agreed indicators that form part of a National Minimum Data Set (NMDS) was the primary mechanism for reporting under the Healthcare SPP, however a specific NMDS for IDDI was not employed. Hence, continuation of the previous Schedule 5 was an interim measure until an IDDI-specific NMDS was established. It appears, however, that not all jurisdictions maintained Schedule 5 returns to DoHA in this period.

[8] Table 1 provides the state of play around 2008, but multiple changes before and since then, the absence of annual statistics regarding programs, and the lack of clarity about what is IDDI and what is state/territory funded make this impossible

Stage 4: Current arrangement 2012/2013 onwards

Stage 4 sees the introduction of the current arrangements, with the replacement of the Healthcare SPP (as detailed above) with new health funding agreements/mechanisms: the National Healthcare Agreement and the National Health Reform Agreement.

The National Healthcare Agreement 2012[9] covers the 'collective aspirations' of governments, and identifies respective roles and responsibilities (it has been referred to as an update and replacement of the 2008 National Healthcare SPP). The National Health Reform Agreement 2012[10] specifies the funding arrangements ('sets out the Parties commitments in relation to funding').

1. National Healthcare Agreement, 2012

The National Healthcare Agreement is effectively an updated version of the 2008 National Healthcare SPP.

It does not specify funding flows but outlines respective roles and responsibilities and commitments by the parties, including reporting requirements.

Schedule A2 of the National Healthcare Agreement 2012 identifies the variety of National Minimum Data Sets that all parties agree to continue to collect as part of the new healthcare funding arrangements. While this is an obtuse way of locating specific initiatives under the Agreement, it does specify the IDDI (page A-14) as one of a number of collections that have yet to have NMDS's developed. It notes that "jurisdictions will continue to collect and supply data annually pending these becoming NMDS".

2. National Health Reform Agreement (NHRA) 2012

The NHRA specifies the funding arrangements. Clause A 32 a) of the NHRA notes the transition arrangements from the Healthcare SPP to the NHRA:

> *A32. For 2012-13, the Commonwealth will provide funding equivalent to the amount that would otherwise have been payable through the National Healthcare SPP. This amount will be divided into the following funding streams:*
> *a. an amount for public health activities calculated as the sum of amounts identified under the NHA relating to national public health, youth health services and essential vaccines (service delivery) in 2008-09 ($244.0 million), indexed by the former National Healthcare SPP growth factor;*
>
> *b. a proportion of the total amount for hospital services to patients in public hospitals better funded through block grants and in respect of teaching, training and research functions funded by States undertaken in public hospitals, with the distribution of funds between these block funded elements based on State advice;*
> *c. the residual amount will be divided between the following interim ABF service categories based on State advice:*
>
> *i. acute admitted public patients;*

[9] Available at: http://www.federalfinancialrelations.gov.au/content/npa/healthcare/national-agreement.pdf
[10] Available at: http://www.federalfinancialrelations.gov.au/content/npa/health_reform/national-agreement.pdf

ii. eligible private patients;
iii. emergency department services; and
iv. eligible non-admitted patient services.

It is assumed that the IDDI funds are covered within section a): public health activities.

As to how the funds are transferred, under the NHRA, funds move from treasury to treasury and are located within the National Health Funding Pool. "All payments are made by the Commonwealth Treasury directly to State Treasuries which are responsible for distributing funding to their line departments" (Commonwealth website, Federal Relations[11]).

The NHRA and NHA note that existing fund amounts are retained and indexation is applied. However, we understand that these funds are not separately identified within the public health activities (or possibly within the entire National Health Funding Pool).

Program details

In theory, the previous funding agreements from stages 1 through 3 have not changed. That is, what is being purchased now should not have changed from previous funding agreements. While the mechanisms for payment have changed over time, the commitment to provide the IDDI services has not changed (formally).

Despite this, some jurisdictions have apparently ceased providing IDDI services. For example, the ANCD Communique Feb 2013 notes the "dismay" at the cessation of Queensland diversion programs. The NSW Youth Drug Court ceased operation in July 2012, arguably another example where IDDI funds had been expended which has now ceased. But, as noted earlier, it is actually not clear whether the programs that have been closed were solely IDDI funded, or even in receipt of IDDI funds (for example the Qld MERIT was not IDDI funded, see above Table). Given that state/territories also contributed to IDDI programs, it can be argued that it is their prerogative to close programs (that they co-fund). That point notwithstanding, the closure of any diversion programs given the level of need is worrying.

Reporting and accountability

In theory, the performance indicators agreed to as part of the NHA provide accountability for the IDDI funds which sit in the National Health Funding Pool. As noted on the Commonwealth website (Federal Relations), "States have considerable flexibility as to how these funds may be spent, provided agreed outcomes are achieved"[12]. This then links the importance of agreed outcomes associated performance indicators and the NMDS for recording IDDI activity. However there is currently no agreed NMDS for IDDI and Schedule 5 returns are inconsistently reported to Commonwealth Department of Health. There may also be some confusion about the regularity of reporting requirements.

[11] http://www.federalfinancialrelations.gov.au
[12] http://www.federalfinancialrelations.gov.au

Some diversion episodes are recorded in the AODTS-NMDS[13]. There is a lack of clarity about whether this is representative of IDDI or not (whether it covers none, some, most or all of IDDI episodes of care). And, it would not account for the police or court interventions provided under IDDI (only those with an AOD treatment service that completes the AODTS-NMDS).

Reflections

Both Commonwealth and state/territory governments invest in and fund diversion programs. It is not possible to clearly differentiate which programs (or parts of programs) are Commonwealth IDDI funded and which are state/territory funded.

Since its inception in 1999, there have been a number of changes to the machinery of government and federal-state funding arrangements that have had the potential to substantially impact on the IDDI.

Identifying the amount and type of diversion services funded via IDDI is not possible at present. While some activity is recorded in the AODTS-NMDS, there is no way of assessing its representativeness, nor even whether indeed it is IDDI funded or otherwise funded. In addition, the Schedule 5 returns (a remaining interim measure) cannot provide an analysis of the amount and type of diversion services.

It would be difficult for the Commonwealth to hold states/territories to account for program closures when: 1. it is not necessarily clear whether a diversion program is or is not IDDI funded; 2. many programs are co-funded; and 3. data returns/accountability are not closely monitored.

In theory, the AOD sector receives annual funding for IDDI through the National Health Reform Agreement with some of this amount expended by police through the various police diversion initiatives and other amounts through the court system. There is not a way of determining the amount that is provided to AOD treatment services.

In theory, accountability for IDDI funds (Treasury to Treasury) occurs through the agreed NHRA and NHA outcomes. However there is not a specific NMDS for IDDI (although as noted above, this has been flagged in the NHA (page A-14).

It is not clear whether the AOD sector has noticed a specific reduction in IDDI funding.

One framing of the Commonwealth IDDI investment is that it provides generic support for diversion programs across Australia, rather than specific or particular diversion programs per se – in this sense it is capacity-building/support funds, and is consistent with a Commonwealth mandate.

[13] The AODTS-NMDS collects information from government and NGO AOD treatment services, and includes "source of referral". 'Police' and 'Courts' are possible sources of referral – but it is not clear that these are solely IDDI episodes (and no doubt other IDDI episodes are not reported to the AODTS-NMDS).

Appendix C: Projected Demand for Treatment

Summary of literature

The estimation of need and demand for treatment is one of the important elements in planning for alcohol and other drug (AOD) treatment services.[14] There is an extensive literature on quantitative planning for alcohol and other drug treatment, which is briefly summarised here. The key concepts are 'need', 'demand', 'diagnosis', 'social indicators' , and prevalence.

Defining some key terms

'need' = the number of people who meet diagnostic criteria for substance use disorder, and where that disorder is known to respond to effective interventions.

'demand' = the number of people who are seeking treatment

'unmet need' = the proportion of people with alcohol and other drug problems who are not in receipt of treatment.

'unmet demand' = the proportion of people who could seek treatment but do not receive it (there may be many reasons why treatment is not received, factors both arising from the individual, and from the treatment system).

'diagnosis' = the number of people who meet formal diagnostic criteria.

'social indicators' = the use of social indicators, such as alcohol sales data, mortality rates and so on to predict the extent of potential need for treatment services in any one location.

'prevalence' = the proportion of the population who meet formal diagnostic criteria of the condition.

Need for treatment

The most common techniques to estimate need for treatment are epidemiological, and rely on surveys of self-reported symptoms (which lead to diagnoses) which then define the size of the potential population in need of treatment. Researchers have used epidemiological models to plan for services (see for example (McAuliffe et al., 2003). A number of papers describe epidemiological estimates of need for treatment. For example (Rush and Urbanoski, 2007) for cannabis users in Canada; (Schultz et al., 2003) for older substance abuse clients; (Mojtabai and Crum, 2013) for substance use treatment in the USA; (Kip et al., 2002)on the limitations of national epidemiologic data for needs assessment. (Clemens and Ritter, 2008) used a multiplier technique to estimate the need for alcohol treatment in Victoria.

In Australia, there is really only one national general population survey that can be used to estimate need: the NSMHWB and the associated secondary analyses from that survey (eg AUSBOD). [15] This is the data source for DA-CCP. There are lags in the prevalence data. For example, the latest National Survey of Mental Health and Well Being (NSMHWB) was undertaken in 2007. However, the

[14] There is, however, a much broader set of considerations in undertaking planning for AOD treatment that extend beyond a simple quantification of numbers – these issues are taken up in Chapter 6.

[15] The NDS Household Survey does not measure substance use disorder and therefore is not suitable for the kinds of estimations which rely on diagnosis to define treatment need.

population may have changed since 2007. This is one limitation of using this survey to estimate Australian treatment need. Another limitation is the inherent under-representation of low prevalence disorders in general population surveys. This is true for heroin and methamphetamine use. More sophisticated epidemiological methods, such as back-projection, capture-recapture, multiplier methods, or a combination of two or three methods (Frischer et al., 2001; Smit et al., 2006), can assist in establishing more accurate population prevalence for these drug classes. Put simply, these methods use indicators from multiple sources, such as mortality databases, arrest statistics and emergency department presentations to calculate the size of the total population. Because the methods use indicators that are likely to be associated with need for treatment, the prevalence estimation derived from these may be most fit for purpose in estimating need. Nonetheless, there are a variety of technical issues associated with these epidemiological methods see(Degenhardt et al., 2004), and they are time consuming and require specialist epidemiological expertise.

There are problems with the notion of 'need' for treatment as defined by formal diagnosis (alcohol abuse/dependence; cannabis abuse/dependence and so on). The inclusion of both the abuse and dependence categories of the diagnostic system raises questions about the match between the formal diagnostic system and the notion of need for treatment. It is not clear that all people who meet criteria for abuse would appropriately need treatment. At the same time, there may be people who do not meet the formal diagnostic criteria (so-called sub threshold cases) who may be appropriate for treatment (Druss et al., 2007). Thus one assumption behind the definition and measurement of unmet need for AOD treatment is that substance use diagnosis is an accurate reflection of those who need treatment in the population. This may be the case for medical diseases and mental health disorders (although see (Sareen et al., 2013) but may be less applicable for AOD. "Many experts have argued that diagnosis alone is not a good proxy for treatment need" (Sareen et al., 2013).

In addition, diagnostic criteria are arbitrary. This has most recently been demonstrated in the changes introduced between DSM-IV and DSM-V. As shown by (Mewton et al., 2011; Mewton et al., 2013) changing the diagnostic criteria results in changes to the prevalence estimate (for example the prevalence of cannabis use disorder decreased from DSM-IV (6.2%) to DSM-5 (5.4%)(Mewton et al., 2013). For establishing need for treatment, this means that the estimate will depend on which diagnostic system is used to provide the population prevalence figure.

One alternative to formal diagnosis is the use of harmful consumption measures(Fischer et al., 2012). General population surveys of alcohol and drug use, such as the National Household Survey, could then be used to assist in estimating the proportion of the population in need of treatment. However general population surveys tend to underestimate consumption (largely because of the sampling frame for such surveys) (Degenhardt, et al., 2011). On the other hand, there is concern that harmful consumption rates will substantially overestimate the population in need of treatment. Not everyone who consumes alcohol or drugs to predefined 'harmful' levels is likely to benefit from or requires formal treatment.

Another approach explored widely is to use social indicator measures, rather than or in addition to prevalence rates. Combining need projections with other indicators (such as hospitalisation rate, total population size, mortality and arrest rate) can facilitate prediction of bed capacity (at a state level). These forecasting models can be used to "compare a present system with a normative experience…[and] demonstrate areas of shortage or oversupply" (Ford, 1985)p. 250). (Beshai, 1984), the Alcohol Epidemiologic Data System (AEDS, 1982), (Gregoire, 2002), (Sherman et al., 1996), and (Mammo and French, 1998) are all examples of research which has used social indicators to predict the need for alcohol and/or drug treatment services at the local level. In

(Beshai, 1984)'s work, for example, the indicators included number of alcohol outlets, mortality rates, alcohol-related traffic offences and measure of housing cost and overcrowding. In (Mammo and French, 1998) the indicators were driving while intoxicated arrests, alcohol-related mortality, domestic violence arrests and alcohol retail outlets. More recently (McAuliffe and Dunn, 2004) have used a social indicators approach to develop alcohol and drug need indexes for each USA state; and (McAuliffe et al., 2002) for specific towns.

In early work from Australia, (Crook and Oei, 1998) reviewed potential planning approaches for alcohol treatment services. Their paper discussed the variety of ways of estimating need and demand (social indicators, epidemiology). They concluded that a variety of methods can be used, but the work did not entail the application of any methods to Australia. (Dietze et al., 2000) show how indirect measure of alcohol harm such as mortality rates, alcohol-related hospitalisations and motor vehicle accidents, coupled with other social indicators such as employment and housing can generate estimates for need for alcohols services. In the case of this work by (Dietze et al., 2000) the focus was on Local Government Area, rather than national or state-based planning, which enables a finer grained analysis of need. In a similar approach, (Dietze et al., 2003) demonstrate how this can also be applied to need for harm reduction services through local government area analysis of the patterns of non-fatal; heroin overdoses.

The challenge for all the above measures of 'need' is the difference between need for treatment and demand for treatment. At a superficial level, it could be argued that anyone who meets substance use disorder criteria is in need of and should receive treatment services (tailored to level of severity). However, the reality of patient demand for services is considerably different. In addition, formal treatment services are not necessarily always required for remission of AOD problems; the role of maturation and spontaneous remission are important to acknowledge (Walters, 2000). Indeed, (Sareen et al., 2013) have shown that people with a substance use disorder (and hence counted as 'in need') who have not received treatment are more likely to remit than those with a substance use disorder who received treatment. This demonstrates how measurement of unmet need based on diagnosis may substantially overestimate need for treatment. This then takes us to consideration of 'demand' measures for treatment planning.

Demand for treatment

In a series of early papers Ford and colleagues (Ford, 1985, 1997; Ford and Luckey, 1983; Ford and Schmittdiel, 1983) describe a variety of treatment planning approaches which they term "demand-based projections". The approaches all start with existing treatment utilisation (hence 'demand-based') with the underlying assumption that past demand predicts future demand and that past demand reflects client needs[16].

Population surveys include questions about whether the respondents sought treatment. Thus, one can derive an estimate of met demand by self-reported service utilisation. For example, amongst young people (12 to 17 year olds) in the USA, the National Survey on Drug Use and Health (USDHHS, 2006) found that 7% of those who met diagnostic criteria for alcohol use disorder received treatment; and 9% of those who met diagnostic criteria for drug use disorder received treatment.

An alternative to using actual treatment to predict demand is to estimate demand by expert consensus. This is effectively what DA-CCP does – DA-CCP starts as an epidemiological model (that is with the potential need for treatment defined by the numbers meeting diagnostic criteria). It then moves to estimate demand by taking out of the 'need' number the proportion who will not seek treatment (the "treatment rate").

[16] Ford notes that both of these underlying assumptions are open to criticism.

The work led by Brian Rush (Rush et al., 2012)is a demand-based model for the Canadian provinces. The model is predicated on different categories of problem severity, reflecting tiers of a population health pyramid, such that the need for more intensive treatment and support increased for people in the higher compared to lower tiers. The estimates of rates of help-seeking varied by the tiers and the model developers made extensive use of Delphi procedures to derive demand estimates for the model. In a similar way to DA-CCP the model includes a variety of treatment types, including withdrawal management, community and residential services as well as screening, brief intervention and referral to treatment from generalist services.

Rather than relying on expert judgement to ascertain demand, some researchers have used multiple datasets to derive a demand estimate. For example, Spence (2003) estimated demand for treatment based on a measure that included diagnosis (DSM-IV) by severity, but then also quantified relapse potential (eg, # previous treatments) plus environmental risk (marital status, employment status, living arrangements and so on) – already this kind of measure is much more sophisticated than simply 'need' based on diagnosis, and moves beyond 'demand' based on expert judgement. This measure accommodates factors consistent with notion of demand for treatment, such as the individual's circumstances. In addition, they included preference-based need, obtained from a survey (what they said they wanted). Thus a composite measure of demand for treatment is created that not only accommodates context but preferences for service types. (They then go on to compare the results to actual service provision in Texas, USA).

Another alternative method is to survey people about their intention to seek treatment, or their perceived need for treatment. In population surveys, the majority of respondents report that they do not need treatment. For example, the US National Survey on Drug Use and Health, 2010 data (United States Department of Health and Human Services)(SAMHSA, 2010) showed that of the 6,384 people who demonstrated a need for treatment (as defined by meeting diagnostic criteria and not being in receipt of treatment in the last 12 months), only 392 felt the need for treatment (6%) and 193 "made the effort to seek treatment" (unsuccessfully) (3%). In the US National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), only 8.5% of those respondents with a substance use disorder perceived the need for treatment (Mojtabai and Crum, 2013). Perceptions about one's own need for treatment can also change over time (Munson et al., 2012). In the youth survey mentioned above, "very few of the youths who had not received treatment perceived an unmet need for treatment" [17] (U.S. Department of Health and Human Services(USDHHS, 2006). Thus it is likely that perceived need for treatment may represent a lower estimate of unmet demand.

Finally, an estimate of demand could be derived, in theory, from examination of waiting to enter treatment. This intuitively appealing idea is that those who are waiting for treatment represent the true 'demand' population and one that health planners should be most concerned with (hence the focus on things like hospital waiting lists). Waiting is therefore seen to be a proxy measure of unmet demand. In most instances, waiting focusses on 'waiting lists' (rather than self-reported experiences of waiting). The assumption is that those who want and actively seek treatment will be counted within any waiting list system – and it is these people, who have to wait for treatment, that demonstrate a real unmet demand for treatment. There are a number of issues with waiting list data and their use as measures of demand – see Working paper # 1. In summary there are a number of reasons why the quantification of numbers of people waiting to enter treatment cannot be used as a simple measure of unmet demand: the very knowledge that there is a waiting period may discourage initiation of service contact (Hadland et al., 2009; Milloy et al., 2010; Peterson et al., 2010; Redko et al., 2006); a proportion of people on waiting lists never enter treatment; prospective clients may find treatment elsewhere but remain on a list; some agencies may prioritise certain clients (eg pregnant women) hence influencing the demographic profile of waiting clients resulting in

[17] The figures were 2.2% for alcohol and 3.5% for illicit drugs.

misinterpretation of unmet demand; a waiting list only exists if there is an actual service – there may be areas of demand where there are no services and hence no waiting lists; the measurement of waiting times is somewhat arbitrary – at what point does someone 'count' as being in a period of waiting?; and waiting time is not independent from individual, agency and system characteristics. The notion of 'waiting' is highly individualised, dynamic and driven as much by service capacity as by extraneous factors such as the attractiveness of treatment and the perceived likelihood of treatment entry.

Conclusions

Planning the amount and type of AOD treatment requires either need or demand estimation. Need estimation, from epidemiological studies of prevalence of disorders has been used extensively but is also criticised because the accuracy of the diagnostic rate can be variable, and it presumes that those identified in the underlying prevalence are by default in need of treatment. This can be contested. There is also debate about the application of national epidemiologic data to state or county based needs assessment (Gfroerer et al., 2004; McAuliffe and Dunn, 2004; McAuliffe et al., 1999). Arguably, demand is a more important measure for treatment planning, because it only includes those who seek or intend to seek treatment. However the measurement of demand (from self-report surveys, waiting lists, or expert judgement) is difficult.

The advantage of the epidemiological methods is that they rely on estimating the actual number of people with alcohol or drug problems. The advantage of the demand-based projections is that they take into account treatment seeking behaviour. The advantage of social indicator methods is that they rely on existing administrative datasets (See(Dewit and Rush, 1996) for a comprehensive review of various ways of assessing need and demand for treatment, including epidemiological and social indicator models). Debate continues about the extent to which epidemiological models, social indicator approaches or demand-based projections are preferred (Gfroerer et al., 2004; McAuliffe and Dunn, 2004; Simeone et al., 1993). It is likely that combinations of these approaches, coupled with qualitative data and dialogue processes will produce the most robust planning estimates.

The simple quantum of need or demand is limited in its usefulness unless it is matched with different treatment types and their relative intensity. Not everyone with a substance use disorder requires the full array of treatment interventions – withdrawal, counselling and residential rehabilitation. Some people respond to brief interventions. In addition, unmet need or demand will vary by population characteristics such as age and gender (Fischer et al., 2012). Thus estimates of unmet need or demand need to accommodate the specific drug type, plus the specific treatment type, plus population characteristics. Health planners need more sophisticated planning approaches that can accommodate variations in client severity, treatment types and client characteristics. This moves us beyond simple estimates of need and demand, and considers need and demand for whom and for what type of treatment.

DA-CCP Expert Reference Group

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DA-CCP care packages and resource distribution

For four of the five drug types (alcohol, benzodiazepines, cannabis and amphetamines), a series of care packages were developed for the mild, moderate and severe presentations. Heroin included care packages for moderate and severe presentations. A care package represented the typical care that a person should receive over the course of a year, given the person's age and primary drug use disorder. Where possible, all the details in the care packages were based on available research evidence regarding efficacy, effectiveness and cost-effectiveness. For example for the mild presentations the care package covered screening and brief interventions (Bertholet, 2005; Kaner, 2009). For heroin dependence, one of the severe care packages was for pharmacotherapy maintenance, a demonstrably efficacious and effective treatment (Belenko et al., 2005; Connock et al., 2007; Zarkin et al., 2005). However, for other care packages, the evidence-base was less readily available. For example the essential components within drug withdrawal (detoxification) have not been comprehensively researched for each drug type. Likewise the number of counselling sessions for alcohol dependence or cannabis dependence has not been definitively established in the literature (Copeland et al., 2001; Marijuana Treatment Project Group, 2004; Stephens et al., 2000). This is where the Expert Reference Group was essential in making judgements about inclusions in the care packages. Substantial discussions took place over many months to distil both the evidence and the expertise of the reference group members. Care packages were drafted and then revised in light of more expert judgement. Overall, the process of developing the 100 or so care packages took more than two years. The list of care packages for 18 to 64 years for alcohol use disorders is provided in Table C1. The care packages for the other drugs are provided in Tables C2 to C5.

Table C1: Alcohol care packages, 18 to 64 year olds

Care Package name
Screening and brief intervention
Mild care package
Moderate care package
Severe - Psychosocial interventions without relapse prevention pharmacotherapies – standard
Severe - Psychosocial interventions - with relapse prevention pharmacotherapies – standard
Severe – Psychosocial interventions– without relapse prevention pharmacotherapies – complex
Severe – Psychosocial interventions– with relapse prevention pharmacotherapies – complex
Severe – Withdrawal management - home based - without relapse prevention pharmacotherapies – standard
Severe - Withdrawal management - daily outpatient - without relapse prevention pharmacotherapies – standard
Severe - Withdrawal management - daily outpatient - with relapse prevention pharmacotherapies – standard
Severe – Withdrawal management - daily outpatient – with relapse prevention pharmacotherapies – complex
Severe - Withdrawal management - residential – with relapse prevention pharmacotherapies – standard
Severe – Withdrawal - management – residential - with relapse prevention pharmacotherapies - complex
Severe - Withdrawal management – drug and alcohol hospital bed – with relapse prevention pharmacotherapies
Severe - Rehabilitation day program – 25 days – standard
Severe - Residential rehabilitation - 8 week stay

Severe - Residential rehabilitation – 13 week stay, 13 weeks aftercare and 13 weeks outclient program
Severe - Residential rehabilitation – 26 week stay, 13 weeks of aftercare/transition/re-entry and 10 weeks outclient program

Table C2: Cannabis care packages, 18 to 64 year olds

Care Package name
Screening and brief intervention
Mild care package
Moderate care package
Severe - Psychosocial interventions - standard
Severe - Psychosocial interventions - complex
Severe - Withdrawal management – Daily outpatient - standard
Severe - Withdrawal management – Drug and Alcohol hospital bed - standard
Severe – Residential rehabilitation – 13 week stay (8 weeks stage 1 treatment as a resident, 5 weeks stage 2 treatment + 13 weeks after care/transition/re-entry)+ 13 weeks outclient program

Table C3: Benzodiazepines care packages, 18 to 64 year olds

Care Package name
Screening and brief intervention
Mild care package
Moderate care package
Severe - Benzodiazepine long term patient care package – complex – outpatient stabalisation by 6 months
Severe – Benzodiazepine long term patient care package – complex – outpatient stabilisation after 6 months
Severe - Benzodiazepine long term patient care package – complex – inpatient stabalisation by 6 months
Severe – Benzodiazepine long term patient care package – complex – inpatient stabilisation after 6 months

Table C4: Amphetamines care packages, 18 to 64 year olds

Care Package name
Screening and brief intervention
Mild care package
Moderate care package
Severe - Psychosocial interventions – without relapse prevention pharmacotherapies – complex
Severe – Withdrawal Management – Daily outpatient – standard with relapse prevention pharmacotherapies
Severe - Withdrawal Management – Drug and Alcohol Bed – Standard
Severe – Residential rehabilitation – 13 week stay (8 weeks stage 1 treatment as a resident, 5 weeks stage 2 treatment + 13 weeks outclient program after care/transition/re-entry) + 13 weeks outclient program.

Table C5: Illicit Opioids care packages, 18 to 64 year olds

Care Package name
Patients registered in illicit opioids treatment programs – illicit opioids substitution treatments – standard
Patients registered in illicit opioids treatment programs – illicit opioids substitution treatments – complex
Psychosocial interventions - standard
Psychosocial interventions - complex
Withdrawal management – Daily outpatient - standard
Withdrawal management – Daily outpatient - complex
Withdrawal management – Residential - standard
Withdrawal management – Residential - complex
Withdrawal management – Drug and alcohol hospital bed - standard
Rehabilitation – day program – 25 days - standard
Residential rehabilitation 8 week stay
Residential rehabilitation – 13 week stay, 13 weeks aftercare and 13 weeks outclient program
Residential rehabilitation – 26 week stay, 13 weeks of aftercare/transition/re-entry/and 10 weeks outclient program
Residential rehabilitation – 16 week stay, 12 weeks of aftercare/transition/re-entry/transition/re-entry, 13 week of exit program/outclient in the community – methadone to abstinence residential (MTAR)
Residential rehabilitation – 16 week stay, 12 weeks of aftercare/transition/re-entry, 16 weeks of exit program/outclient in a residential rehabilitation bed, 7 weeks of exit program in the community – residential treatment for heroin dependence stabilisation program (RTOD)

As can be seen from the above Tables, DA-CCP distinguishes between standard and complex care packages to accommodate co-morbidities. The complex care packages take into consideration comorbid presentations, including comorbid mental health, physical health and social circumstances such as homelessness.

The care packages aimed to be comprehensive and to cover all possible evidence-based AOD service types. The full range of settings was included: primary care, specialist residential, outpatient, and day-patient. There are also other types of care that people receive that were not specified in care packages but were dispersed across the whole model, including emergency department presentations, needle exchange programs and hospital admissions.

Having established the care packages, a further task was to distribute the people between the care packages. In some cases this was straightforward. For mild, there was only one care package (SBIRT) and hence all were allocated into that care package. For severe it becomes more complex: for the 18 to 65 year olds, alcohol use disorder, there were 14 different possible care packages. Again, a combination of existing data and expert judgement was used. Existing data covered the current distribution of people between service types from administrative data {Australian Institute of Health and Welfare (AIHW), 2007 #89}. The Expert Reference Group then reviewed those allocations and adjusted according to their expert judgement. For example, few people in Australia receive withdrawal (mainly due to access difficulties), whereas evidence and expert wisdom suggests that greater numbers should receive withdrawal, especially in the case of alcohol dependence.

Resource estimation

The resources counted within the model included: staffing time – which comprised direct contact time with patients, clinical administration, supervision and training; doses by medication type;

number of beds and bed days; and number of diagnostic tests. Unit costs were used to specify the actual costs associated with each resource output. For example for medication doses, a unit cost per dose was established and used to derive the total costs associated with the model. This means that unit costs can be varied depending on the individual planning region circumstance (for example differences in average nurse salaries) without changing the quantum of the resource. Clearly the bulk of the resources are taken up with staff time (approximately 70%). The model specifies three different types of clinicians: medical doctors, nurses/allied health workers, and alcohol and drug counsellors. All direct patient care specified in the care packages was assigned to one of these three staff types. Thus the model output predicts the numbers of doctors working in either general practice or as addiction medicine specialists, nurses and allied health and alcohol and other drug counsellors that would be required to meet the needs of Australians with substance use disorders. The model does not specify who funds the services – its purpose is to predict resource requirements not to determine the funding bodies.

Australian research estimating the proportion of people with substance use disorders who receive treatment

Authors	Year	Drug type	Method Estimating population in need/demand	Method Estimating treatment utilisation	% met demand
Andrews et al (also Corry et al, 2004)	2004	AUD	NSMHWB, 1997 general population prevalence of substance use disorder	Self-reported treatment seeking rate	8.1% Alcohol harmful 13.6% Alcohol dependence
Slade et al	2009	SUD	National Survey of Mental Health and Wellbeing, 2007	Self-reported treatment rate	15.5% Alcohol harmful use 35.5% Alcohol dependence 24.1% Any drug harmful use 52.4% Any drug dependence 24% Any substance use disorder
Teesson et al	2010	AUD	National Survey of Mental Health and Wellbeing, 2007	Self-reported treatment rate	22.4% alcohol use disorders (effectively the average of the Slade et al report of 15.5% for harmful alcohol and 35.5% for alcohol dependence)
Teesson et al	2012	CUD	NSMHWB 2007 cannabis use disorder rates	Self-reported health service use "for mental health problems" in last 12 months	36.2% cannabis use disorders
Clemens et al	2003	AOD	Prevalence data for alcohol – problematic use; QF method; opioids – Hall et al., 200; cannabis &	Alcohol and Drug Information System (ADIS) for numbers in treatment – self-report	2.6 to 6.4% (alcohol) 35 to 62% (opioids) 22 to 39% (MMT clients) 4 to 7% (cannabis)

Authors	Year	Drug type	Method Estimating population in need/demand	Method Estimating treatment utilisation	% met demand
			stimulants – NSMHWB 1997 plus Hall et al., 1999; 1999		4 to 17% (stimulants) 6 to 11% (tranquillisers)

International met demand estimates: study methods and results

Authors	Year	Drug type	Country/ region	Method Estimating Population in need/demand	Method Estimating treatment utilisation	% met demand
Becker et al	2008	Opioids	USA	National Survey on Drug Use and Health	National Survey on Drug Use and Health – self report	15.2%
Best et al	2007	Drug (PDU)	UK	Local data on prevalence or treatment patterns.	Data source: national monitoring systems for drug treatment (admin treatment data)	55.8%
Busch	2013	SUD	USA	National Survey on Drug Use and Health	National Survey on Drug Use and Health – questions on treatment use	12.8% to 30.7%
Charter & Caetano	2011	alcohol	USA	Data from 2 household surveys: National Longitudinal Alcohol Epi Survey and National Epi Survey on Alcohol and Related Conditions (2001-2002)	Survey question: *Ever sought help* Included: alcohol or drug program; mental health service; health professional; emergency room; mutual aid; human service.	White: 14.01% Black: 17.14% Hispanic: 16.17%
Cohen	2007	alcohol	USA	National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) for need.	Self-reported treatment rate amongst positive diagnoses	14.6% AUD lifetime; 7.5% alcohol abuse 4.8% alc dependence 27.9% both alcohol abuse and dependence (lifetime)
Drummond et al	2004	alcohol	England	A study of available data on the prevalence of alcohol use disorders in England	The national survey of the provision of alcohol treatment service in England	5.6%
Drummond et al	2009	alcohol	Scotland	Combination of two surveys: Scottish health Survey and Psychiatric morbidity survey – AUDIT and CAGE scores	Survey of specialist alcohol treatment agencies to estimate no. of individuals accessing treatment.	8.2%
Edlund et al	2012	Alcohol	USA	Two surveys: National Survey on Drug use and Health, National Epi Survey on Alcohol and	Survey questions re: treatment for AUD.	8%

Authors	Year	Drug type	Country/ region	Method Estimating Population in need/demand	Method Estimating treatment utilisation	% met demand
				Related Conditions		
Luckey & Ford (see also Ford & Luckey, 1983; Ford 1985)	1976	Alcohol	USA	Demand-based bed projections systems using admissions to inpatient alcohol treatment facilities.	The identified target population was then multiplied by the number of "beds per contact" to give an indication of the number of beds of a given type need to serve the target population.	20%
Kohn	2004	AUD	global	Need = Psychiatric epidemiology surveys;	Studies with information on service utilisation treatment rate	21.9%
McAuliffe et al	1991	Drug abuse	USA – Rhode Island	Need= population prevalence of drug abuse Demand= 20% of population prevalence	Actual admissions & self-report survey.	79% "met demand" 15.8% "met need"
McCollister, K.E. M. and French, M.T.	2002	SUD	USA	Prison population		13%
Mojtabai & Crum	2013	SUD	USA	National Epi Survey on Alcohol and Related Conditions (2001-2002) – Wave I – self-reported perceived need for treatment	National Epi Survey on Alcohol and Related Conditions (2004-2005) – Wave II – subsequent use of treatment.	14.8%
Popova et al	2006	Opioid use	Canada	Statistical data and key informant data through surveys	Key informant data through surveys.	26% in Methadone Maintenance Treatment. 6% received other outpatient treatment. 5% received inpatient abstinence-oriented treatment (eg.

Authors	Year	Drug type	Country/ region	Method Estimating Population in need/demand	Method Estimating treatment utilisation	% met demand
						Detox, withdrawal mgmt.)
Sareen et al	2013	SUD	USA	National Epi Survey of Alcohol and Related Conditions (NESARC)	Survey questions re: treatment for AUD.	31.4%
Spence	2003	SUD	USA - Texas	Modelled (based on severity, risk environment, and nominated preferences)		33%
Sung et al	2011	SUD	USA	a: Adapted from "Drug use and dependence, state and federal prisoners" b:Analysis of the 2006 National Survey on Drug Use and Health	Survey questions related to treatment need and utilisation	17% (Federal prison inmates[a]) 15% (State prison inmates[a]) 12% (General Public[b]) 30% (Parolees[b])
United States Department of Health and Human Services. SAMHSA,	2010	Illicit drugs	USA	National Survey on Drug Use and Health	National Survey on Drug Use and Health	19.1%

DA-CCP sensitivity analysis

Changes in prevalence rates for substance use disorders

The first sensitivity analysis involved altering prevalence rates to see what effect these changes have on treatment numbers and costs. We used the prevalence rate in DA-CCP as the starting point or base for our analysis, for example, in DA-CCP the prevalence rate for alcohol disorder in the 18-64 year age group is 6,355 per 100,000. We then increased and decreased prevalence rates in this age group by 25%, and kept the severity distribution as well as treatment rates constant. We also conducted a sensitivity analysis by altering the prevalence rate to 7,380 per 100,000 in the 18-64 year age group (as this was the original 1997 National Survey of Mental Health and Wellbeing finding, rather than the adjusted AUSBoD prevalence used in DA-CCP). In the DA-CCP model the treatment resource cost for alcohol disorders (18-64 year age group) was $912.16 million and the total number of people treated was 2,250 per population of 100,000.

The results are presented in Table C6. According to our analysis, when population prevalence was reduced by 25%, the numbers treated were identically reduced by 25% (for alcohol, 18-64 years): ie the original prevalence (6355 per 100,000)) predicted a total of 2,250 people being treated. The reduced prevalence (at 4,766) predicted 1,687 people (per 100,000) being treated; likewise the increase by 25% of population prevalence (to 2,812 people per 100,000 with alcohol use disorders) produced a modelled result of treating 2,812 people per 1000,000 (a 25% increase).

We have also modelled the resource use, for information. A 25% reduction in prevalence (4,766 per 100,000) reduced treatment resource costs for alcohol disorders to $698.7 million, which is a 23% reduction of alcohol treatment costs when compared to the treatment costs in the DA-CCP model. Changing the prevalence rate to 7,380 per 100,000 resulted in an increase in treatment resource costs for alcohol disorders to $1.049 billion. This 16% increase in prevalence rate resulted in a 15% increase of alcohol treatment costs when compared to the treatment costs in the DA-CCP model. Similarly, a 25% increase in prevalence (7,944 per 100,000) increased treatment resource costs for alcohol disorders to $1.125 billion, which is a 23% increase in treatment costs when compared to the DA-CCP model.

Table C6: Effect of changes in alcohol disorder prevalence rates (for 18-64 yrs) on treatment numbers and associated costs

Prevalence rates (per 100,000 of population):	**,6,355***	**4,766**	**7,380**	**7,944**
Total number of people treated (per 100,000)	2,250	1,687	2,613	2,812
Percentage change of numbers treated (alcohol disorder)	-	-25%	16%	25%
Treatment Resource Cost (alcohol) for selected Pop. $ millions	$912.1	$698.7	$1,049.8	$1,125.6
Percentage change of alcohol cost compared to DA-CCP estimates	-	-23%	15%	23%

*Prevalence rates from DA-CCP model

Adjusting prevalence rates for other substance use disorders (cannabis, benzodiazepines, amphetamines and opioids) had similar results and these can be seen in the tables below.

Table C7: Effect of changes in cannabis disorder prevalence rates (for 18-64 years) on treatment numbers and associated costs

Prevalence rates (per 100,000 of population):	**1,765***	**1,324**	**1,980**	**2,206**
Total number of people treated (per 100,000)	625	469	701	782
Percentage change of numbers treated (cannabis disorder)		-25%	12%	25%
Treatment Resource Cost (cannabis) for selected Pop. $ millions	$179.99	$142,84	$198.28	$217.57
Percentage change of cannabis cost compared to DA-CCP estimates		-21%	10%	21%

*Prevalence rates from DA-CCP model

Table C8: Effect of changes in benzodiazepine disorder prevalence rates (for 18-64 years) on treatment numbers and associated costs

Prevalence rates (per 100,000 of population):	**376***	**282**	**380**	**470**
Total number of people treated (per 100,000)	169	126	171	212
Percentage change of numbers treated (benzodiazepines disorder)		-25%	1%	25%
Treatment Resource Cost (benzodiazepines) for selected Pop. $ millions	$94.52	$71.22	$95.51	$117.90
Percentage change of benzodiazepines cost compared to DA-CCP estimates		-25%	1%	25%

*Prevalence rates from DA-CCP model

Table C9: Effect of changes in amphetamine disorder prevalence rates (for 18-64 years) on treatment numbers and associated costs

Prevalence rates (per 100,000 of population):	**511***	**383**	**639**
Total number of people treated (per 100,000)	187	140	233
Percentage change of numbers treated (amphetamine disorder)		-25%	25%
Treatment Resource Cost (amphetamines) for selected Pop. $ millions	$131.57	$99.88	$163.41
Percentage change of amphetamines cost compared to DA-CCP estimates		-24%	24%

*Prevalence rates from DA-CCP model

Table C10: Effect of changes in opioid disorder prevalence rates (for 18-64 years) on treatment numbers and associated costs

Prevalence rates (per 100,000 of population):	**655***	**491**	**819**
Total number of people treated (per 100,000)	655	491	819
Percentage change of numbers treated (opioid disorder)		-25%	25%

Treatment Resource Cost (opioids) for selected Pop. $ millions	$731.66	$549.47	$913.05
Percentage change of opioids cost compared to DA-CCP estimates		-25%	25%

*Prevalence rates from DA-CCP model

This illustrates the direct and linear relationship between population prevalence and the resulting modelled/predicted numbers being treated. This suggests that in using DA-CCP, any change to population prevalence will produce an identical proportionate change to the numbers being treated.

Changes to distribution of mild, moderate and severe prevalence for substance use disorders

The second sensitivity analysis involved altering the distribution of mild, moderate and severe (severity distribution) to see what effect this had on treatment numbers and associated costs. In this analysis the prevalence rate (6,355 per 100,000) for alcohol disorder (18-64 years) and the treatment rates: 20% of the mild cases, 50% of the moderate cases, and 100% of the severe cases were not changed and were kept the same as in the DA-CCP model. We altered the mild, moderate and severe distribution (which in the DA-CCP model for alcohol disorder is 67% mild, 22% moderate and 11% severe). We tested four different scenarios.

The first scenario involved decreasing mild distribution by 10%, increasing moderate distribution by 10% and not altering the severe distribution. These changes resulted in an 8% increase in number of people treated (2,440 per 100,000 compared to 2,250 per 100,000) and alcohol treatment costs also increased by 6.6% compared to the treatment costs in the DA-CCP model. The second scenario involved increasing mild distribution by 10% and decreasing moderate distribution by 10% and not altering the severe distribution. As expected, the results were the reverse of the first scenario with an 8% decrease in the number of people treated and a 6.6% decrease in alcohol treatment costs compared to the DA-CCP model.

The third scenario involved not altering mild distribution, increasing moderate distribution by 10% and decreasing severe distribution by 10%. These changes resulted in a 14% reduction in number of people treated (1,933 per 100,000) and a 63% reduction in alcohol treatment costs compared to the DA-CCP model. The fourth scenario involved no change to mild distribution, decreasing moderate distribution by 10% and increasing severe distribution by 10%. These changes resulted in a 14% increase in number of people treated (2,568 per 100,000) and a 63% increase in alcohol treatment costs.

This sensitivity analysis illustrates that changes to severity distribution for alcohol disorders, specifically the severe prevalence, has a major impact on treatment costs. Table C11 below summarises the results of this sensitivity analysis.

Table C11: Effect of changes in alcohol disorder distribution of prevalence (severity distribution) for 18-64 years on treatment numbers and associated costs

Prevalence rates (per 100,000 of population):	**6,355**	**6,355**	**6,355**	**6,355**	**6,355**
Severity Distribution	*Mild 67% Mod 22% Severe	Mild 57% Mod 32% Severe	Mild 77% Mod 12% Severe	Mild 67% Mod 32% Severe 1%	Mild 67% Mod 12% Severe

	11%	11%	11%		21%
Total number of people treated (per 100,000)	2,250	2,440	2,059	1,933	2,568
Percentage change of numbers treated (alcohol disorder)		8%	-8%	-14%	14%
Treatment Resource Cost (alcohol) for selected Pop. $ millions	$912.1	$972.61	$851.71	$334.82	$1,489.51
Percentage change of alcohol cost compared to DA-CCP estimates		6.6%	-6.6%	-63%	63%

*prevalence distribution from DA-CCP model

Adjusting severity distribution for cannabis disorder had similar results to alcohol as the severity distribution for cannabis is the same as for alcohol in the DA-CCP model (see Table C12 below).

Table C12: Effect of changes in cannabis disorder distribution of prevalence (severity distribution) for 18-64 years on treatment numbers and associated costs

Prevalence rates (per 100,000 of population):	**1765***	**1765**	**1765**	**1765**	**1765**
Severity Distribution	*Mild 67% Mod 22% Severe 11%	Mild 57% Mod 32% Severe 11%	Mild 77% Mod 12% Severe 11%	Mild 67% Mod 32% Severe 1%	Mild 67% Mod 12% Severe 21%
Total number of people treated (per 100,000)	625	677	572	537	714
Percentage change of numbers treated (cannabis disorder)		8%	-8%	-14%	14%
Treatment Resource Cost (cannabis) for selected Pop. $ millions	$179.99	$188.29	$171.69	$70.84	$289.13
Percentage change of cannabis cost compared to DA-CCP estimates		5%	5%	-61%	61%

*prevalence distribution from DA-CCP model

However, when we changed the severity distribution for amphetamines, benzodiazepines and opioids the results were different to those seen for alcohol and cannabis.

Table C13 below summarises the results of this sensitivity analysis for amphetamines. For amphetamines, the prevalence rate (511 per 100,000) and the treatment rates (mild 0%, moderate 50% and severe 35%) were not changed and were kept the same as in the DA-CCP model. We altered the mild, moderate and severe distribution (which in the DA-CCP model for amphetamines disorder is 0% mild, 10% moderate and 90% severe). We tested four different scenarios.

The first scenario involved keeping mild distribution at 0%, increasing moderate distribution by 10% and decreasing severe distribution by 10%. These changes resulted in a 4% increase in number of people treated (194 per 100,000 compared to 187 per 100,000) and amphetamine treatment costs decreased by 9% compared to treatment costs in the DA-CCP model. The second scenario involved no change to mild distribution, decreasing moderate distribution by 10% and increasing severe distribution by 10%. These changes resulted in a 4% decrease in people treated (179 per 100,000) and increased treatment costs by 9% compared to the DA-CCP model.

The third scenario involved not altering mild distribution, increasing moderate distribution by 20% and decreasing severe distribution by 20%. These changes resulted in an 8% increase in number of people treated (202 per 100,000) and a 17% reduction in amphetamine treatment costs compared to the DA-CCP model. The fourth scenario involved no change to mild distribution, increasing moderate distribution by 30% and decreasing severe distribution by 30%. These changes resulted in a 12% increase in number of people treated (209 per 100,000) and a 9% decrease in amphetamine treatment costs. This sensitivity analysis illustrates that changes to severity distribution when applied to amphetamines does not have the same effect as changes to severity distribution in alcohol disorder.

Table C13: Effect of changes in amphetamine disorder distribution of prevalence (severity distribution) for 18-64 years on treatment numbers and associated costs

Prevalence rates (per 100,000 of population):	**511**	**511**	**511**	**511**	**511**
Severity Distribution	*Mild 0% Mod10% Severe 90%	Mild 0% Mod 20% Severe 80%	Mild 0% Mod 0% Severe 100%	Mild 0% Mod 30% Severe 70%	Mild 0% Mod 40% Severe 60%
Total number of people treated (per 100,000)	187	194	179	202	209
Percentage change of numbers treated (amphetamine disorder)		4%	-4%	8%	12%
Treatment Resource Cost (amphetamine) for selected Pop. $ millions	$131.57	$120.20	$142.94	$108.83	$120.20
Percentage change of amphetamine cost compared to DA-CCP estimates		-9%	9%	-17%	-9%

*prevalence distribution from DA-CCP model

As can be seen from the above analyses, varying the severity distribution produces changes in the final modelled/predicted treatment numbers, and this varies depending on the drug class. For alcohol, a 10% increase in the proportion in moderate disability and a 10% decrease in the proportion in severe disability results in a 14% decrease in the number of people treated (and reduces the cost of treatment by 63%). The impact is not as powerful for amphetamines where the same change in severity distribution (10% increase in moderate distribution and a 10% decrease in severe distribution) increases the number of people treated by only 4% (and reduces costs by 9%). In the case of benzodiazepines and

opioids, changes in severity distribution had an impact on the number of people treated as well as costs but the effect was not as powerful as the changes in severity distribution had on alcohol and cannabis. See Tables C14 and C15 below.

Table C14: Effect of changes in benzodiazepines disorder distribution of prevalence (severity distribution) for 18-64 years on treatment numbers and associated costs

Prevalence rates (per 100,000 of population):	**376***	**376**	**376**	**376**	**376**
Severity Distribution	*Mild 50% Mod 30% Severe 20%	Mild 40% Mod 40% Severe 20%	Mild 60% Mod 20% Severe 20%	Mild 50% Mod 40% Severe 10%	Mild 50% Mod 20% Severe 30%
Total number of people treated (per 100,000)	169	180	158	150	189
Percentage change of numbers treated (benzodiazepines)		7%	-7%	-11%	12%
Treatment Resource Cost (benzodiazepines) for selected Pop. $ millions	$94.52	$96.56	$92.48	$59.44	$129.60
Percentage change of benzodiazepines cost compared to DA-CCP estimates		2%	-2%	-37%	37%

*prevalence distribution from DA-CCP model

Table C15: Effect of changes in opioid disorder distribution of prevalence (severity distribution) for 18-64 years on treatment numbers and associated costs

Prevalence rates (per 100,000 of population):	**655***	**655**	**655**	**655**
Severity Distribution	*Mild 0% Mod 0% Severe 100%	Mild 0% Mod 10% Severe 100%	Mild 0% Mod 20% Severe 80%	Mild 0% Mod 30% Severe 80%
Total number of people treated (per 100,000)	655	590	524	459
Percentage change of numbers treated (opioids)		-10%	-20%	-30%
Treatment Resource Cost (opioids) for selected Pop. $ millions	$731.66	$658.89	$586.13	$513.36
Percentage change of opioid cost compared to DA-CCP estimates		-10%	-20%	-30%

*prevalence distribution from DA-CCP model

Changes to treatment rates for substance use disorders

The third sensitivity analysis involved altering the treatment rates between mild, moderate and severe to see what effect this had on treatment numbers and associated costs. In this analysis the prevalence rate (6,355 per 100,000) for alcohol disorder (18-64 years) and the severity distribution (mild 67%, moderate 22% and severe 11%) were not changed and kept the same as in the DA-CCP model. We altered the mild, moderate and severe treatment rates (20% mild, 50% moderate and 100% severe in the DA-CCP model).

Table C16 below summarises the results of this sensitivity analysis. A number of different scenarios were tested and these included increasing mild treatment to 50%, and keeping moderate and severe treatment constant, that is, 50% and 100% respectively. These changes resulted in a 57% increase in number of people treated (3,527 per 100,000 compared to 2,250 per 100,000) and alcohol treatment costs increased by only 2% when compared to treatment costs in the DA-CCP model. Another scenario involved decreasing mild treatment to 10%, moderate treatment to 10% and keeping severe treatment at 100%. These changes resulted in a 38% decrease in number of people treated (1,405 per 100,000 compared to 2,250 per 100,000) and alcohol treatment costs decreased by 10% when compared to treatment costs in the DA-CCP model.

A third scenario involved keeping mild and moderate treatment rates the same as the DA-CCP model (20% and 50% respectively) and decreasing the severe treatment rate to 90%. This change resulted in a 3% decrease in number of people treated (2,180 per 100,000) and an 8% decrease in treatment costs compared to DA-CCP. The fourth scenario involved keeping mild treatment rate at 20%, decreasing moderate treatment rate to 30% and decreasing severe treatment rate to 90%. These changes resulted in a 16% decrease in number of people treated (1,900 per 100,000) and a 14% reduction in alcohol treatment costs compared to the DA-CCP model. This sensitivity analysis illustrates that changes to severity treatment distribution for alcohol disorders is not as sensitive as severity distribution.

Table C16: Effect of changes in alcohol disorder treatment rates for 18-64 years on treatment numbers and associated costs

Prevalence rates (per 100,000 of population):	**6,355**	**6,355**	**6,355**	**6,355**	**6,355**
Treatment Distribution	*Mild 20% Mod 50% Severe 100%	Mild 50% Mod 50% Severe 100%	Mild 10% Mod 10% Severe 100%	Mild 20% Mod 50% Severe 90%	Mild 20% Mod 30% Severe 90%
Total number of people treated (per 100,000)	2,250	3,527	1,405	2,180	1,900
Percentage change of numbers treated (alcohol disorder)		57%	-38%	-3%	-16%
Treatment Resource Cost (alcohol) for selected Pop. $ millions	$912,1	$933.83	$822.30	$841.77	$786.68

Percentage change of amphetamine cost compared to DA-CCP estimates		2%	-10%	-8%	-14%

Adjusting severity treatment rates for cannabis disorder had similar results to alcohol as the severity treatment rates for cannabis are the same as for alcohol in the DA-CCP model. This can be seen in Table C17 below.

Table C17: Effect of changes in cannabis disorder treatment rates for 18-64 years on treatment numbers and associated costs

Prevalence rates (per 100,000 of population):	**1,765***	**1,765**	**1,765**	**1,765**	**1,765**
Treatment Distribution	*Mild 20% Mod 50% Severe 100%	Mild 50% Mod 50% Severe 100%	Mild 30% Mod 60% Severe 100%	Mild 20% Mod 30% Severe 90%	Mild 30% Mod 60% Severe 90%
Total number of people treated (per 100,000)	625	979	782	528	763
Percentage change of numbers treated (cannabis disorder)		57%	3%	-12%	-4%
Treatment Resource Cost (cannabis) for selected Pop. $ millions	$179.99	$186.01	$185.91	$159.18	$172.92
Percentage change of cannabis cost compared to DA-CCP estimates		3%	3%	-12%	-4%

*prevalence distribution from DA-CCP model

However, when we changed the severity treatment rates for amphetamines, benzodiazepines and opioids the results were different to those seen for alcohol and cannabis, see Tables C18, C19 and C20 below.

For example, for amphetamines, the prevalence rate (511 per 100,000) and the severity distribution (mild 0%, moderate 10% and severe 90%) were not changed and were kept the same as in the DA-CCP model. We altered the mild, moderate and severe treatment rates (which in the DA-CCP model for amphetamines disorder is 0% mild, 50% moderate and 35% severe). We tested four different scenarios.

The first scenario involved keeping mild treatment rate at 0%, increasing moderate treatment rate by 10% and increasing severe treatment rate by 10%. These changes resulted in a 27% increase in the number of people treated (238 per 100,000 compared to 187 per 100,000) and amphetamine treatment costs increased by 28% compared to treatment costs in the DA-CCP model. The second scenario involved no change to mild treatment rate, increasing moderate treatment rate by 10% and decreasing severe treatment rate by 10%. These changes resulted in a 28% decrease in the number of people

treated (135 per 100,000) and decreased treatment costs by 28% compared to the DA-CCP model.

A third scenario involved keeping mild treatment rate at 0%, increasing moderate treatment by 20% and increasing severe treatment rate by 20%. These changes resulted in a 55% increase in the number of people treated (289 per 100,000 compared to 187 per 100,000) and amphetamine treatment costs increased by 55% compared to treatment costs in the DA-CCP model. The fourth scenario involved no change to mild treatment rate at 0%, decreasing moderate treatment by 20% and decreasing severe treatment rate by 20%. As expected, the results were the reverse of the third scenario with a 55% decrease in the number of people treated (84 per 100,000 compared to 187 per 100,000) and amphetamine treatment costs decreased by 55% compared to treatment costs in the DA-CCP model. Table C18 below summarises the results of this sensitivity analysis.

Table C18: Effect of changes in amphetamine disorder treatment rates for 18-64 yrs on treatment numbers and associated costs

Prevalence rates (per 100,000 of population):	**511**	**511**	**511**	**511**	**511**
Treatment rate	*Mild 0% Mod 50% Severe 35%	Mild 0% Mod 60% Severe 45%	Mild 0% Mod 40% Severe 25%	Mild 0% Mod 70% Severe 55%	Mild 0% Mod 30% Severe 15%
Total number of people treated (per 100,000)	187	238	135	289	84
Percentage change of numbers treated (amphetamine disorder)		27%	-28%	55%	-55%
Treatment Resource Cost (amphetamine) for selected Pop. $ millions	$131.57	$120.20	$142.94	$108.83	$120.20
Percentage change of amphetamine cost compared to DA-CCP estimates		28%	-28%	55%	-55%

*prevalence distribution from DA-CCP model

These results illustrate that changes to treatment rate have different effects on alcohol treatment rates compared to amphetamine treatment rates. For example, a 30% increase in mild treatment (keeping moderate and severe treatment constant) resulted in a 57% increase in the number of people treated (but only a 2% increase in costs). For amphetamines, a 10% increase in moderate treatment rates and a 10% increase in severe treatment rates resulted in a 27% increase in treatment numbers and a 28% increase in treatment costs.

Tables C19 and C20 below illustrate the effect that changes in benzodiazepine disorder and opioid disorder treatment rates have on treatment numbers and associated costs.

Table C19: Effect of changes in benzodiazepine disorder treatment rates for 18-64 years on treatment numbers and associated costs

Prevalence rates (per 100,000 of population):	**376***	**376**	**376**	**376**	**376**
Treatment Distribution	*Mild 20% Mod 50% Severe 100%	Mild 50% Mod 50% Severe 100%	Mild 10% Mod 10% Severe 100%	Mild 10% Mod 40% Severe 90%	Mild 0% Mod 30% Severe 90%
Total number of people treated (per 100,000)	169	225	105	132	102
Percentage change of numbers treated (benzodiazepine)		33%	-38%	-22%	-40%
Treatment Resource Cost (benzodiazepine) for selected Pop. $ millions	$94.52	$104.72	$82.96	$81.38	$75.94
Percentage change of benzodiazepine cost compared to DA-CCP estimates		11%	-12%	-14%	-20%

*prevalence distribution from DA-CCP model

Table C20: Effect of changes in opioid disorder treatment rates for 18-64 years on treatment numbers and associated costs

Prevalence rates (per 100,000 of population):	**655***	**655**	**655**	**655**
Treatment Distribution	*Mild 0% Mod 0% Severe 100%	Mild 0% Mod 0% Severe 90%	Mild 0% Mod 0% Severe 80%	Mild 0% Mod 0% Severe 70%
Total number of people treated (per 100,000)	655	590	524	459
Percentage change of numbers treated (opioids)		-10%	-20%	-30%
Treatment Resource Cost (opioids) for selected Pop. $ millions	$731.66	$658.89	$586.13	$513.36
Percentage change of opioids cost compared to DA-CCP estimates		-10%	-20%	-30%

*prevalence distribution from DA-CCP model

Sensitivity analysis – combined variations

The final sensitivity analysis that we conducted involved looking at the effect of multiple changes in the three variables of interest (prevalence, severity distribution and treatment rate) on treatment numbers and treatment costs. In this analysis the prevalence rate (6,355 per 100,000) for alcohol disorder (18-64 years) and the severity distribution (mild 67%, moderate 22%, and severe 11%) were changed whilst the treatment rate (20% of mild, 50% of moderate and 100% of severe) was kept the same as in the original DA-CCP model. Table C21 below summarises the results of this sensitivity analysis.

The first scenario involved decreasing the prevalence rate by 25% to 4,766 per 100,000, we then decreased the proportion in mild disability by 10%, increased moderate disability by 10% and did not change the proportion in severe disability. These changes resulted in a 19% decrease in number of people treated (1,830 per 100,000 compared to 2,250 per 100,000) and alcohol treatment costs decreased by 18% compared to the treatment costs in the original DA-CCP model. The second scenario involved changing the prevalence rate to 7,380 per 100,000, and increasing the proportion in mild disability by 10%, decreasing moderate disability by 10% and not changing severe disability. These changes resulted in a 6% increase in number of people treated (2,392 per 100,000 compared to 2,250 per 100,000) and alcohol treatment costs decreased by 7%.

A third scenario involved increasing the prevalence rate by 25% to 7,944 per 100,000 and keeping mild disability the same as the DA-CCP model and increasing moderate disability by 10% and decreasing severe by 10%. This resulted in a 7% increase in number of people treated (2,414 per 100,000) and alcohol treatment costs decreased by 56%. The fourth scenario involved changing the prevalence rate to 7,380 per 100,000, we then decreased moderate disability by 10% and increased severe disability by 10% and did not change mild disability proportion. This resulted in a 33% increase in number of people treated (2,982 per 100,000) and alcohol treatment costs increased by 89%.

Table C21: Effect of changes of alcohol prevalence rates and severity distribution (for 18-64 years) on treatment numbers and associated costs

Prevalence rates (per 100,000 of population):	**6,355**	**4,766**	**7,380**	**7,944**	**7,380**
Severity Distribution	*Mild 67% Mod 22% Severe 11%	Mild 57% Mod 32% Severe 11%	Mild 77% Mod 12% Severe 11%	Mild 67% Mod 32% Severe 1%	Mild 67% Mod 12% Severe 21%
Total number of people treated (per 100,000)	2,250	1,830	2392	2414	2982
Percentage change of numbers treated (alcohol disorder)		-19%	6%	7%	33%
Treatment Resource Cost (alcohol) for selected Pop. $ millions	$912.1	$744.05	$979.65	$403.91	$1,720.31
Percentage change of alcohol cost compared to DA-CCP estimates		-18%	7%	-56%	89%

The tables below illustrate the effect of changes to prevalence rates and severity distribution on treatment numbers and associated costs for cannabis, amphetamines, opioids and benzodiazepines.

Table C22: Effect of changes of cannabis prevalence rates and severity distribution (for 18-64 years) on treatment numbers and associated costs

Prevalence rates (per 100,000 of population):	**1,765***	**1,324**	**1,980**	**2,206**	**1,980**
Severity Distribution	*Mild 67% Mod 22% Severe 11%	Mild 57% Mod 32% Severe 11%	Mild 77% Mod 12% Severe 11%	Mild 67% Mod 32% Severe 1%	Mild 67% Mod 12% Severe 21%
Total number of people treated (per 100,000)	625	509	642	561	800
Percentage change of numbers treated (cannabis disorder)		-19%	3%	-10%	28%
Treatment Resource Cost (cannabis) for selected Pop. $ millions	$179.99	$149.06	$188.97	$70.04	$320.72
Percentage change of cannabis cost compared to DA-CCP estimates		-17%	5%	-61%	78%

*prevalence distribution from DA-CCP model

Table C23: Effect of changes of amphetamine treatment rates and severity distribution (for 18-64 years) on treatment numbers and associated costs

Prevalence rates (per 100,000 of population):	**511***	**511**	**511**	**511**	**511**
Severity Distribution	*Mild 0% Mod 50% Severe 35%	Mild 0% Mod 60% Severe 45%	Mild 0% Mod 40% Severe 45%	Mild 0% Mod 70% Severe 55%	Mild 0% Mod 30% Severe 15%
Total number of people treated (per 100,000)	76	92	59	110	42
Percentage change of numbers treated (amphetamine disorder)		21%	-22%	45%	-45%
Treatment Resource Cost (amphetamine) for selected Pop. $ millions	$24.50	$30.02	$18.99	$35.53	$13.47
Percentage change of amphetamine cost compared to DA-CCP estimates		23%	-22%	45%	-45%

*prevalence distribution from DA-CCP model

Table C24: Effect of changes of opioid prevalence rates and severity distribution (for 18-64 years) on treatment numbers and associated costs

Prevalence rates (per 100,000 of population):	**376***	**282**	**380**	**470**	**376**
Severity Distribution	*Mild 50% Mod 30% Severe 20%	Mild 40% Mod 40% Severe 20%	Mild 60% Mod 40% Severe 10%	Mild 50% Mod 40% Severe 10%	Mild 50% Mod 20% Severe 10%
Total number of people treated (per 100,000)	169	135	160	188	189
Percentage change of numbers treated (opioid disorder)		-20%	5%	11%	12%
Treatment Resource Cost (opioid) for selected Pop. $ millions	$94.52	$72.75	$93.45	$74.05	S129.60
Percentage change of opioid cost compared to DA-CCP estimates		-23%	-1%	-22%	37%

*prevalence distribution from DA-CCP model

Table C25: Effect of changes of benzodiazepine prevalence rates and severity distribution (for 18-64 years) on treatment numbers and associated costs

Prevalence rates (per 100,000 of population):	**376***	**282**	**380**	**470**	**376**
Severity Distribution	*Mild 50% Mod 30% Severe 20%	Mild 40% Mod 40% Severe 20%	Mild 60% Mod 40% Severe 10%	Mild 50% Mod 40% Severe 10%	Mild 50% Mod 20% Severe 10%
Total number of people treated (per 100,000)	169	135	160	188	189
Percentage change of numbers treated (benzodiazepine disorder)		-20%	5%	11%	12%
Treatment Resource Cost (benzodiazepines) for selected Pop. $ millions	$94.52	$72.75	$93.45	$74.05	S129.60
Percentage change of benzodiazepine cost compared to DA-CCP estimates		-23%	-1%	-22%	37%

*prevalence distribution from DA-CCP model

These results reinforce that the distributions between mild, moderate and severe disability are important drivers for the final modelled outputs. They appear more sensitive than the prevalence rates alone.

Appendix D: DVA Tender for Treatment of Alcohol and Other Substance Use Disorder - Advisory Services

Core Service Standards Checklist: Questions to assist decision-making about treatment service quality[18]

Service Accessibility

1. Does the service offer a service information pack (or similar) to help clients to make informed choices about attending services, give them details on all aspects of the treatment program, and reduce the risk of drop-out?
Rationale: Treatment effectiveness is enhanced and better treatment outcomes are achieved when clients are provided with information that allows them to make informed decisions about their treatment (Eliany & Rush, 1992; Marsh & Dale, 2006). A variety of benefits ensue from the active participation of clients in the making of decisions about treatment, including increased satisfaction with treatment and decreased symptom burden (Adams & Drake, 2006).
Indicators: The service provides printed (including website) information on the type and style of services(s) offered; for whom the service is appropriate; for whom the service is inappropriate; and referral procedure.

2. If the service has a waiting list for access, what mechanisms are in place to keep clients engaged while they wait?
Rationale: Reminders (letters and telephone calls) to clients help to improve retention, particularly before the first treatment session. Where a client has to wait to enter treatment, keeping in touch through personal and encouraging reminders has been shown to increase treatment engagement and retention. Effectiveness of the reminder is enhanced by making it personal, motivating and encouraging (National Treatment Agency on Substance Abuse, 2005). Contact with clients while they are waiting for structured treatment, providing information and updates on the length of the wait in the form of regular phone calls or text messages has also been found to enhance treatment engagement and retention. During this time, the service should also offer advice and information on other support services such as. drop-in services, induction/preparation, group support, referral to wraparound services such as housing, assistance with finances (National Treatment Agency on Substance Abuse, 2005).
Indicators: The service has a system of regular contact with clients on the wait-list, which may include telephone or web-based communication, outreach services, delivery of wait-list groups, and regular updates regarding progress on the wait-list. In addition, the service

[18] Reproduced from Attachment B of Request for Tender No. [AOD01/2014] publically available at: https://www.tenders.gov.au/?event=public.ATM.viewDocuments&atmuuid=A2009520-D679-48A1-515BA2FB264B26FE (access date: 14 March 2014)

should provide wait-list clients with alternative options for treatment and support services.

Evidence-based Practice and Governance

3. Is this service accredited with an authoritative accrediting body? Is this accreditation current? Does the service have established links with credible professional organisations and/or research centres? Does the service subscribe to a recognised Code of Practice/Ethics Code?

Rationale: Meeting accreditation standards provides assurance to consumers and health service management that services meet a set of agreed healthcare standards (Australian Commission on Quality and Safety in Healthcare, 2013).

Organisational and professional isolation from the broader AOD and healthcare sector is incompatible with high quality service delivery. The establishment and maintenance of professional networks and alliances is a vital component of professional development and an indicator of organisational performance, as they can provide a forum for professional debate and review, access to new research, benchmarking opportunities and enhanced accountability through exposure to external/independent scrutiny (Brinkerhoff, 2003).

People working in the AOD field come from diverse backgrounds and professions. While individuals may bring their own personal and professional ethics to their work in the AOD field, clients have a right to expect high ethical standards and a consistent approach to identifying and responding to ethical dilemmas across different services and workers (Fry, 2007)

Indicators: The service holds current accreditation with either:

a. *Quality Improvement Council (QIC) Health and Community Service Standards.*
b. *International Organization for Standardization (ISO) 9001:2008 Quality Management Systems.*
c. *EQuIP Australian Council of Healthcare Standards (ACHS).*

The service is linked with the broader AOD sector through structured professional relationships or strategic alliances (with, for instance, University-based research centres, peak body memberships, sector networks).
The service has explicitly incorporated the Alcohol and Other Drugs Code of Ethics (2007) into its policies and practices. Other profession-based Codes (such as the Australian Psychological Society Code of Ethics 2007 or the Code of Ethics for Nurses 2008) may also apply. The service ensures clients are aware of the Codes.

4. What professional qualifications do clinical staff hold? Are clinical staff registered with a recognised registration board (e.g. AHPRA, AASW)? Are they a member of a professional body within the Australian AOD sector? How much experience do clinical staff have in providing AOD treatment? Is the staff composition appropriate for the service undertaken?

Rationale: The need for clinical staff to have relevant professional qualifications is vital. An appropriately skilled and qualified workforce is critical to achieving and sustaining effective

responses to drug use. A consistent level of sector-specific skills and knowledge base amongst AOD clinicians not only contributes to the quality of client care but also enhances the credibility of AOD clinicians as sector professionals and experts particularly by those in related health and welfare fields who call upon them for specialist support, consultancy and auxiliary care (Victoria Department of Human Services, 2006; Australian Government Department of Health and Ageing, 2010a).
Multi-disciplinary staff composition contributes to the quality and effectiveness of AOD treatment services and is a defined quality standard for quality assurance (Uchtenhagen & Schaub, 2011).

Indicators: Staff in clinical service delivery roles are University qualified in one of the health/social/behavioural sciences. Professions with registration requirements (i.e. psychologists, social workers, nurses, pharmacists, medical practitioners, etc) hold current registration.

Membership of professional bodies such as the Australasian Professional Society on Alcohol and other Drugs (APSAD) or the Drug and Alcohol Nurses Australasia (DANA) is well-regarded as it indicates connection with peers in the AOD field.

Clinical staff are adequately experienced in the provision of AOD treatment (DVA to determine what is 'adequate'). There is a clear definition of staff roles and responsibilities.

Staff composition across the service is multidisciplinary, composed of at least three professions.

5. Does the service/clinician follow particular clinical guidelines or other evidence-based standards?

Rationale: The purpose of guidelines is to help clinicians and patients make appropriate decisions about health care. Guidelines attempt to do this by:

- *Describing a range of generally accepted approaches for the diagnosis, management, or prevention of specific diseases or conditions.*
- *Defining practices that meet the needs of most patients in most circumstances.*

(Australian Government Department of Health & Ageing, 2010b)

The use of clinical guidelines and other evidence-based standards improves clinical effectiveness (Feder, Eccles, Grol, Griffiths, Grimshaw, 1999).

Indicators: The service/clinician has formally incorporated clinical guidelines or other evidence-based standards into routine practice. As a minimum standard, treatment is consistent with:

a. *Guidelines for the Treatment of Alcohol Problems, 2009 (Australian Government Department of Health & Ageing)*
b. *Guidelines on the Management of Co-occurring AOD and Mental Health Conditions in AOD Treatment Settings,2009 (National Drug and Alcohol Research*

Centre, UNSW)

c. *Management of Cannabis Use Disorder and Related Issues: A clinician's guide, 2009 (National Cannabis Prevention and Information Centre, UNSW)*
d. *Relevant clinical practice guidelines issued by State Health Departments (e.g. NSW Drug and Alcohol Treatment Guidelines for Residential Settings 2007; Qld Clinical Protocols for Detoxification in Hospitals and Detoxification Facilities 2002; Victoria Clinical Treatment Guidelines for Co-occurring ABI/Cognitive Impairment and Alcohol and Other Drug Use Disorders 2006)*

6. Does the service have a demonstrated commitment to clinical staff training, clinical supervision and regular auditing of staff training needs?

Rationale: Well-managed supervision and professional development programs improve the quality of client service, improve staff confidence, skills, and peer relationships and provide opportunity for positive feedback and enhanced career opportunities (Graham, 2004; Griffiths, 1999). Clinical supervision and professional development are important aspects of any treatment service as they assist the maintenance and improvement of clinicians' standard of practice (Marsh, Dale & Willis, 2007).

Indicators: The service has in place a framework for clinical training and supervision that promotes access for all staff, is consistent with professional and industrial obligations and supports clinical governance. Policies and procedures outline the models and processes of clinical training and supervision in the service. The service has in place evaluation processes to regularly monitor the implementation of clinical supervision and the impact on consumer and service outcomes.

7. What is the philosophy of the service with regard to AOD treatment (for example, does the service work within an abstinence-only framework or does it recognise controlled use approaches)? Is this consistent with the needs, philosophy and goals of the client?

Rationale: Treatment varies depending on the type of drug and the characteristics of the patients. Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society (National Institute on Drug Abuse, 2012).

Indicators: The philosophy of the service is clearly articulated and there is a common understanding of the service's philosophy, aims and objectives, and therapeutic approach. The client understands the approach, and treatment provision is compatible with the needs, philosophy and goals of the client.

8. Is the treatment approach determined on a case-by-case basis or is there a formulaic approach? Will practical and achievable goals be negotiated with the client? Will progress be measured against a regularly-reviewed treatment plan?

Rationale: Individual treatment plans ensure treatment covers the particular concerns relevant to the client and also provide clients with a sense of hope by highlighting the fact that many of their seemingly insurmountable practical difficulties can be overcome (Marsh, Dale & Willis, 2007). Detailed individual treatment plans as the basis for intervention with clients are particularly necessary in the AOD field given the complex and multidimensional nature of the problems many clients tend to present with (Gossop, 2003). Research indicates individualised treatment plans, consistent with client goals, enhance treatment effectiveness and are associated with better therapeutic outcomes (Marsh & Dale, 2006; National Treatment Agency for Substance Misuse, 2006).
Indicators: Individual treatment plans are devised for each client and documented in case notes. Treatment plans: *a. Are jointly negotiated between clinician and client;* *b. Are directly derived from the results of assessment, goal setting and client choice;* *c. Contain practical, realistic goals and the strategies for achieving these goals;* *d. Where appropriate, include parents, partners, families and friends.*

9. Does the service/clinician routinely include a client risk assessment which is regularly reviewed throughout treatment? In the event of unplanned exit from the service is a risk assessment carried out to help other community services keep the client safe and to encourage treatment re-engagement?
Rationale: Targeted risk assessments are required in order to comply with Guidelines for the Treatment of Alcohol Problems (Australian Government Department of Health & Ageing, 2009); the Guidelines on the Management of Co-occurring AOD and Mental Health Conditions in AOD Treatment Settings (National Drug and Alcohol Research Centre – UNSW, 2009); and the Management of Cannabis Use Disorder and Related Issues: Clinician's Guide (National Cannabis Prevention and Information Centre – UNSW, 2009).
Indicators: A client's risk assessment is continually reviewed throughout treatment, alongside the treatment plan. Particular attention is paid to co-occurring disorders, medications, history of violence, child protection issues, risk of the client committing a serious offence, engaging in self harm, or putting other people's lives and well-being at risk. *Various policies are in place to manage unplanned exit. These include making re-engagement attempts, giving harm reduction advice, and arranging transport back home, all underpinned by a risk assessment.* *When a departure is unplanned, the service notifies the referring agency. The risk assessment is shared, along with any details of the client's intentions.*

10. Are clinical staff trained to use formal assessment and outcome measurement instruments? Are systematic protocols in place to ensure assessments are standardised, formal, written and relevant?
Rationale: Conducting a comprehensive assessment is an essential requirement of determining the most appropriate and potentially effective treatment intervention for the

client (National Cannabis Prevention and Information Centre, 2009; Australian Government Department of Health and Ageing, 2009). Evaluation of outcomes using standardised tools to gather data are an integral part of the treatment system (Dale & Marsh, 2000). Key domains of client functioning for standardised outcome measurement include: AOD use, quantity, frequency and level of dependence; BBV risk exposure and behaviour; general health; social functioning; psychological functioning; criminality; engagement in treatment and treatment completion; and client satisfaction with treatment (Marsden et al, 1998).

Indicators: Clearly articulated policies exist to ensure clients undergo a semi-structured assessment interview and standardised assessment on entry into the treatment program. Clinical staff have received training in the use and interpretation of formal assessment instruments. Clients are provided with a rationale for assessment procedures and results of all assessment procedures are provided (in summary form) to the client. Standardised assessment is completed upon entry and exit from the treatment program, as well as at follow-up (1 and 3 months post-treatment where possible).
A summary of the assessment is included in the treatment plan. The summarised assessment incorporates: presenting problems; predisposing factors; precipitating factors; perpetuating factors; and protective factors.

11. How will co-occurring conditions (such as mental health problems) be addressed by the service/clinician? Does the service/clinician provide multi-disciplinary services or work collaboratively with other organisations?

Rationale: 'No wrong door' refers to formal recognition by a service system that individuals with co-occurring disorders may enter a range of community service sites; that they are a high priority for engagement in treatment; and that proactive efforts are necessary to welcome them into treatment and prevent them from falling through the cracks. AOD services and clinicians are encouraged to identify individuals with co-occurring disorders, welcome them into the service system, and initiate proactive efforts to help them access appropriate treatment in the system, regardless of their initial site of presentation. (Substance Abuse and Mental Health Services Administration, 2006).
Because substance use disorders and other mental health problems frequently co-occur, clients presenting with one condition should be routinely assessed for the other(s), and treatment should address both (or all) conditions (NIDA, 2012)

Indicators: The service has adopted a 'no wrong door' policy. Staff of the service have engaged in ongoing professional development in relation to identification and management of common co-occurring conditions.
The service routinely screens clients for co-occurring conditions, and conducts ongoing monitoring of symptoms and assessment of client outcomes.
The service has a structured approach to working collaboratively with other health care services (including GPs) to ensure the most effective multi-disciplinary approach to addressing complex co-occurring conditions.

12. Are there protocols for concluding treatment plans and to assist exit from treatment?

Rationale: Exit planning is integral to the treatment process and is conducted in close consultation with the client to ensure exit occurs in a planned, collaborative manner. Clearly established and effective exit procedures protect the safety and integrity of the service, staff, and clients (National Treatment Agency on Substance Abuse, 2009).
Indicators: Clients are prepared ahead of time for cessation of treatment and actively involved in exit planning (in particular, relapse prevention and other strategies to manage high-risk situations are addressed). A structured process for referral to further treatment or support is followed, and the exit plan is documented in the client's record.

Systems

13. How does the service take account of client feedback for the purposes of continual improvement?
Rationale: Systems that ensure clients are meaningfully engaged in the planning, implementation, delivery, review and evaluation of interventions and services contribute to a dynamic and responsive AOD treatment sector (Victoria Department of Human Services, 2008). A program of continual improvement that incorporates client feedback contributes to high quality AOD service standards (Marsh, Dale & Willis, 2007).
Indicators: As part of continuous quality review mechanisms, the service has systems that solicit and make appropriate use of client feedback, suggestions and complaints. Clients are used in agency review and planning activities where possible. Client participation in decisions about their own care and treatment is encouraged and enabled. Clients are fully informed about service options and encouraged to provide feedback and make complaints about the quality of services at any time without prejudice or obstruction. At the commencement of treatment, clients are given verbal and written information about treatment options, their rights, responsibilities and formal agency complaints mechanisms. The service systematically plans and implements client surveys or other mechanisms, analysing these and developing strategies to address client concerns. The service has developed and implemented a comprehensive set of policies, procedures and practices that support client involvement.

14. What systems exist to remedy client complaints about inappropriate, poor or unacceptable service?
Rationale: There is a large body of evidence about the benefits of consumer participation in health services (NSW Department of Health, 2005). In summary, the rationale for involving consumers is that: • *Globally, participation is largely considered to be an ethical and democratic right for health service consumers.* • *Involving consumers assists in ensuring that health services:* – *are appropriate and accessible* – *are responsive to the needs of consumers* – *have consumer input into quality improvement processes* • *There is increasing evidence that the process of participation itself improves health outcomes for participants.* • *Consumer participation is a requirement of health service accreditation*

<u>Indicators:</u> The process for making a complaint is routinely provided to clients and widely promoted in public access areas. Support is available to clients to assist them to make an effective complaint and clients are made aware of this support. The organisational culture supports complaints handling, for example, complaints are positively received, they are genuinely taken seriously, staff see complaints as useful and as part of ongoing quality improvement. Issues related to client safety to make a complaint have been appropriately considered and incorporated into complaints procedures.

15. How does the service/clinician keep up to date with current trends and evidence in the AOD field? How is this used to improve outcomes for clients?
<u>Rationale:</u> Evidence based treatment involves integrating clinical expertise with the best available clinical evidence derived from systematic research (Strauss & Sackett, 1998). Translating research findings into practice promotes improvements in the quality of treatment (Reimer, Sawka & James, 2005; Sterling & Weisner, 2006).
<u>Indicators:</u> The service and its clinical staff maintain professional networks and strategic relationships with the broader AOD field. There is a structured process for incorporating new research into policy, practice and service development. The service and its clinical staff have ready access to key professional journals and other publications (e.g. those from the National Research Centres).

16. How and where will client records be stored? Who will have access to client files? What safeguards exist to maintain privacy, confidentiality and security of personal information?
<u>Rationale:</u> Safe storage of, and restricted access to, client records is a core quality standard for AOD treatment services and a requirement of service accreditation (Marsh, Dale & Willis, 2007; Uchtenhagen & Schaub, 2011; Victoria Department of Human Services, 2008). Clinicians have an obligation to refrain from disclosing information received in confidence unless there is a sufficient and compelling reason to do so. Sufficient and compelling reasons include: *a. if the client threatens to harm him or her self or someone else;* *b. if a child is currently at risk of abuse or neglect; and* *c. if the clinician or case notes are subpoenaed to court.* *(Marsh, Dale & Willis, 2007)*
<u>Indicators:</u> Client records include assessment results, treatment plans, goals, case notes, outcome measures, referral and reporting documentation. Client records are marked confidential and securely stored. Access to client records is strictly limited to the treatment team (or as required by law).

17. How frequently does the service routinely review the program, using a variety of different sources of information, including service user feedback, the evidence base, incident reports, clinical audit and peer reviews?
Rationale: Quality improvement programs involve continuous process development, review, implementation and modification of policies and procedures to improve clinical practices. Quality improvement programs contribute to ensuring service quality. All AOD agencies should be involved in a quality improvement program which involves wide consultation throughout the service, and with external agencies and stakeholders, including consumers (Marsh, Dale & Willis, 2007).
Indicators: Service review is conducted at least every 18 months. A quality improvement process is in place at the service, in which staff are involved, and includes review and revision of: intake and referral procedures; evidence-based treatment; client focussed practice; staff development, support and supervision; client records; risk management; organisational governance and management; and agency and client rights and responsibilities.

Appendix E: Evaluation of AOD peak bodies role in capacity building: Interim report

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EVALUATION OF AOD PEAK BODIES' ROLES IN BUILDING CAPACITY IN THE NON-GOVERNMENT ALCOHOL AND OTHER DRUGS SECTOR

PROGRESS REPORT FEBRUARY 2014

Prepared by David McDonald
Consultant in Social Research & Evaluation

05 February 2014

In brief

All of Australia's eight states and territories have peak bodies representing the alcohol and other drug (AOD) sector within their respective jurisdictions. Some have been operating for many years whereas others (particularly ATDC, ATODA and AADANT) have commenced operations more recently. Since their inception, the peaks have had sector capacity building as a major focus of activity. This has been strengthened, in recent years, by funding from the Australia Government Department of Health, particularly funding under the Substance Misuse Service Delivery Grants Fund (SMSDGF) with an emphasis on improving capacity in the area of AOD/mental health comorbidity.

The Peaks Capacity Building Network resolved that the work that they undertake with the aim of building the capacity of the non-government AOD sector would be evaluated. The evaluation commenced in December 2012 and will conclude in November 2014. This is the mid-term Progress Report of the evaluation.

The purpose of this project is:

> To evaluate the role of the peak bodies for the NGO AOD sector in building sector organisational capacity, particularly each peak body's ability to support the NGO AOD treatment services to deliver measurable and sustainable results in treatment outcomes, including improvement of services to people experiencing co-occurring mental illness and substance misuse…The evaluation is not designed to result in a comparison of each state and territory, but rather assesses the role of peak bodies overall.

The evaluation applies the Utilisation-focused Evaluation model which emphasises producing evaluation findings that have been identified as being useful to a range of stakeholders. The evaluation strategy entails undertaking conceptual work and data collection that enables answers to be provided to eight evaluation-specific questions that have been endorsed by the Evaluation Reference Group (ERG).

A key task for the first half of the evaluation has been to identify, through discussions with the peak bodies, the underlying program theory for their capacity building activities. This has been done and is documented in this Progress Report. The statement of program theory draws attention to the four key strategies for capacity building that are applied, and the six levels that are focused upon.

This Progress Report presents interim findings with respect to the first three evaluation questions:

Evaluation question 1: In what ways have the NGO AOD peak bodies engaged in sector capacity building activities focusing on AOD treatment and related supportive activities?

Answer: Descriptive information is provided on 73 capacity building activities that seven of the peak bodies have identified as being the most important of those they conducted during the 2012-13 year. These activities are highly diverse. The most frequently used capacity building strategy was building sustainable linkages and strategic partnerships, followed by (in descending order of frequency) developing and promoting information and resources, assisting services to undertake service improvement, and identifying and facilitating training opportunities.

The level of activity, or focus, most frequently applied was with respect to organisations as entities (rather than individual workers within organisations), other than the peak bodies themselves. This was closely followed by (in descending order) a focus on networks, individual workers within other organisations, the external environment, the peak organisations themselves, and individual workers within the peak organisations.

Evaluation question 2: How much of the peaks' effort is capacity building relating to AOD treatment and related supportive activities?

Answer: Approximately two-thirds of the efforts of the seven peak bodies participating in the evaluation, as shown through their allocation of staff resources, went to capacity building activities. This varied from peak to peak, with the proportions of staff times ranging from a low of 42% to a high of 85%. This means that capacity building is the dominant activity of the state and territory peaks across the nation, with their other activities absorbing just one-third of the peaks' staff resources nationally

Evaluation question 3: How sound is the rationale underpinning, and design of, the peaks capacity building activities?

Answer: The rationale underpinning, and the design of, the peaks' capacity building activities are sound. This conclusion is based on four criteria: the validity of key underpinning assumptions (diagnostic, prescriptive, transformational and external), the fidelity of program implementation, the extent of implementation and the availability of resources.

The evaluation will continue through 2014 with key activities for the year including collecting data to answer the five remaining evaluation questions, as well as updating the interim answers to the first three evaluation questions, given above. It will entail interviews with key informants and the deployment of questionnaires to the peak bodies' member organisations, among other things.

A final report on the evaluation will be presented by 30 November 2014.

INTRODUCTION

Project context

All of Australia's eight states and territories have peak bodies representing the alcohol and other drug (AOD) sector within their respective jurisdictions. Some of the state and territory peaks have among their members (generally as associate members or similar) governmental AOD organisations, although in the majority of the peaks bodies the focus is on the non-government (NGO) sector. The peak bodies are as follows:

- Alcohol, Tobacco and other Drugs Association ACT (ATODA)
- Alcohol, Tobacco and other Drugs Council (Tasmania: ATDC)
- Association of Alcohol and other Drug Agencies NT (auspiced by the Northern Territory Council of Social Services) (AADANT)
- Network of Alcohol and other Drugs Agencies (NSW: NADA)
- Queensland Network of Alcohol and other Drugs Agencies (QNADA)
- South Australian Network of Drug and Alcohol Services (SANDAS)
- Victorian Alcohol and Drug Association (VAADA)
- Western Australian Network of Alcohol and other Drug Agencies (WANADA).

All but AADANT have been fully involved in commissioning, oversighting and contributing data and information to the evaluation. The low level of involvement by AADANT reflects the early stage of development of the association.

Some of the state and territory peaks have been operating for decades whereas others, particularly those in Tasmania, the ACT and the Northern Territory, have been established more recently. Having a peak body in each state and territory has allowed them to work together to an increasing degree. While all have their individual constitutions, strategies, challenges and opportunities, one thing they have in common is a commitment to building the capacity of the NGO AOD agencies within their respective jurisdictions to deliver evidence-informed, cost-effective, high quality AOD treatment and related supportive services.

Each of the state and territory peaks has been funded by the Australian Government Department of Health, under the Substance Misuse Service Delivery Grants Fund (SMSDGF), to increase the capacity of the NGO AOD sector to provide high quality treatment and related services. The peak bodies have a number of other sources of support for capacity building activities, including the state and territory governments, donors and organisations in related sectors. This fact, combined with the broad scope of the peak organisations' capacity building activities, means that the evaluation focuses on both the activities directly funded under the SMSDGF and also on related activities funded from other sources.

Jointly, the state and territory peak bodies, through their national Network, resolved that the work that they undertake with the aim of building the capacity of the non-government AOD sector,

including improving capacity in the area of AOD/mental health comorbidity, would be evaluated. This is the mid-term Progress Report of the evaluation.

Key concepts: capacity, capability and capacity building

'Capacity building' is a complex construct. It implies both a set of processes (e.g. organisational development) and the attainment of valued outcomes (e.g. improved drug treatment services).

'*Capacity'* and '*capability'* are related concepts. In the context of capacity building, 'capacity' is a skill, a faculty, a state of competence attained by an individual or an organisation. In contrast, 'capability' means being able to use one's capacity to achieve the desired outcome. It entails turning one's capacity into practice. So, for example, a psychologist may have the *capacity* to undertake long-term psychotherapy with drug dependent people (because they have advanced training in that type of intervention) but, because the demand on their services is so great, they only have the *capability* of providing brief psychological interventions. An implication of this differentiation is that capacity building can usefully focus on both (a) building the capacity of people and organisations to provide quality services and (b) building the capability of organisations to make the optimal use of the capacity of their staff.

A useful definition of *capacity building*, developed with particular reference to the public health field, is as follows:[19]

> *If capacity is defined as 'the ability to carry out stated objectives', then capacity building is a process that improves the ability of a person, group, organization or system to meet its objectives or to perform better. Capacity building interventions therefore work to improve the input and processes within the health system as a whole (seeking to improve the way it functions); organizations within the health system (to improve the way they function); health personnel (to improve their ability to perform work functions); and clients of the system and their communities (to improve their ability to engage productively with the health system through accessing services and influencing resource management, and improving their own health). Capacity building is further defined by the following five characteristics.*
>
> *Capacity building in the health sector:*
>
> - *Is a dynamic and continuous process*
> - *Can occur and be measured on four mutually dependent levels of society: health system, organization, health personnel and individual/community*
> - *Should lead to an improvement in performance*
> - *Is influenced by the external environment*
> - *Contributes to the sustainability of the health system, health-related organizations, and health personnel and individual/community behaviour.*

As discussed below, the emphasis in this definition of how capacity building operates at the levels of the health system, individual AOD (treatment) organisations, the staff of those organisations and the clients/communities that interrelate with them, provides part of the conceptual framework underpinning this evaluation.

[19] LaFond, AK, Brown, L & Macintyre, K 2002, 'Mapping capacity in the health sector: a conceptual framework', *The International Journal of Health Planning and Management*, vol. 17, no. 1, p. 10.

Evaluation strategy

Purpose of the evaluation

The purpose of the evaluation, as documented in the consultant briefing paper, is as follows:

> *The aim of this project is to evaluate the role of peak bodies for the NGO AOD sector in building sector organisational capacity, particularly each peak body's ability to support the NGO AOD treatment services to deliver measurable and sustainable results in treatment outcomes, including improvement of services to people experiencing co-occurring mental illness and substance misuse.*
>
> *The outcome measures will need to be flexible enough to take into account the varying existing levels of capacity within each state and territory and the diverse range of key activities to be undertaken.*
>
> *The evaluation is not designed to result in a comparison of each state and territory, but rather assesses the role of peak bodies overall. However, some jurisdictions may request details of the data and information collected in their jurisdiction.*

Evaluation questions

Eight evaluation questions have been endorsed by the Evaluation Reference Group, as follows:

1. In what ways have the NGO AOD peak bodies engaged in sector capacity building activities focusing on AOD treatment and related supportive activities?
2. How much of the peaks' effort is capacity building related to AOD treatment and related supportive activities?
3. How sound is the rationale underpinning, and the design of, the peaks' capacity building activities?
4. How well have the peaks' capacity building strategies and activities been implemented?
5. How valuable are the outcomes at the levels of the system, organisation, worker and client/community?
6. To what extent have the capacity building strategies and activities represented good use of the available resources to achieve valued outcomes (value for money)?
7. What challenges have been experienced? How and to what extent have they been overcome (barriers and enablers) ?
8. What are the implications of the evaluation's findings for the future of the peaks' capacity building functions?

This Progress Report provides preliminary findings relating to the first three of these evaluation questions. The final report, to be delivered towards the end of 2014, will update findings in those areas and also provide findings relating to the remaining questions.

The evaluation model

This evaluation applies the Utilisation-focused Evaluation model. Utilisation-focused Evaluation is defined as follows:

> *Program evaluation is the systematic collection of information about the activities, characteristics, and results of programs to make judgements about the program, improve or further develop program effectiveness, inform*

> *decisions about future programming, and/or increase understanding. Utilization-focused program evaluation is evaluation done for and with specific intended primary users for specific, intended uses.*[20]

The key users of the findings of the evaluation are the Peaks Capacity Building Network members (representatives of the eight state and territory NGO AOD peak bodies), and the individual peak bodies themselves. Other users with whom the Network intends to share the evaluation's findings include their member organisations and current and potential funding bodies. High level policy committees, such as those managing the state and territory and national drug strategies, may also be identified as potential users of the evaluation's findings.

The evaluation focuses on both the processes and outcomes of the peak organisations' capacity building activities. It includes identifying any unintended consequences of the initiative and attends to both *what* has been achieved and *how* this has come about.

An important part of any program evaluation is attending to the assumptions that underpin its development and implementation, and to the context within which it operates. The context is particularly important for this national capacity building initiative. The national AOD system is dynamic, having to respond to changing patterns of drug use and drug-related harms, changing availability of financial and human resources, and changing economic and political contexts. These all have potential to be powerful influences on the implementation and achievements of the peaks' capacity building activities. As one authority explains, the importance of context should not be underestimated:

> *Fifty years of evaluation findings point over and over again to the fact that the degree of effectiveness of programs and projects depends to a great extent to the larger system dynamics of which they are a part and which either limit or support their effectiveness.*[21]

Evaluation activities to date

This evaluation project commenced in December 2012. After being briefed about the background and expectations of the evaluation, the evaluator prepared a draft evaluation protocol for consideration by members of the Peaks Capacity Building Network (the Evaluation Reference Group). The protocol was modified to reflect comments provided by the ERG members and was finalised on 25 March 2013.

During the first half of 2013 the evaluator visited all but two of the peak organisations to discuss the evaluation, and its context. (The seventh peak was visited towards the end of 2013; AADANT has expressed its interest in the evaluation but is not actively participating owing to the early stage of development of its activities.) During these visits, the evaluator and the personnel of the state and territory peaks discussed the evaluation in depth. Particular attention was paid to the contents and scope of evaluation data collection to ensure that it is realistic, taking into account the ability of the individual peak organisations to contribute in this way.

In July 2013 a draft template for collecting data on the peaks capacity building activities undertaken during the 2012-13 financial year was distributed. The framework was endorsed in August 2013 and the seven participating peak organisations provided activity data in the agreed-upon format during

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[20] Patton, MQ 2008, *Utilization-focused evaluation*, 4th edn, Sage Publications, Thousand Oaks, p. 39.
[21] Patton, MQ 2013, 'The future of evaluation in society: top ten trends plus one', in SI Donaldson (ed.), *The future of evaluation in society: a tribute to Michael Scriven*, Information Age Publishing, Charlotte, NC, p. 58.

the August-December 2013 period. These data inform some of the interim evaluation findings presented below.

The program theory

A key component of this evaluation is to make explicit the program theory underlying the capacity building work of the state and territory NGO AOD peak bodies, with an emphasis on treatment capacity building. Program theory has been defined as

> *...an explicit theory or model of how an intervention, such as a project, a program, a strategy, an initiative, or a policy, contributes to a chain of intermediate results and finally to the intended or observed outcomes. A program theory ideally has two components: a theory of change and a theory of action. The theory of change is about the central processes or drivers by which change comes about…The theory of action explains how programs or other interventions are constructed to activate these theories of change.*[22]

Documenting the program theory is one of the tasks of this evaluation. It is important because the primary sources of program failure (obverse: program success) are generally taken to be (1) faulty program theory, (2) the difficulty of transferring program theory into programs that have high efficacy, and (3) inadequate fidelity of program implementation in the real world.[23] One way of developing a statement of program theory is to ask 'What are the active ingredients that make this program work?'

Following discussions with the peak bodies, the evaluator drafted a preliminary statement of the program theory. This was subsequently discussed with the individual peaks and modified based on their feedback and on data collected, through the evaluation, on their capacity building activities conducted across the nation during the 2012-13 year.

The interim statement of the program theory that underpins the national and state/territory capacity building activities is as follows:

The theory of change

The state/territory NGO AOD peak bodies, in consultation and collaboration with member organisations and other stakeholders, conduct or facilitate the conducting of a range of activities that assist member organisations to better attain their goals of providing high-quality treatment and related services to clients and, through doing so, to attain positive treatment outcomes. These capacity building activities and outcomes are seen at the levels of the broad system within which the AOD sector is embedded, individual AOD organisations, AOD organisations' staff performance, and the interactions of clients and the community with the organisations and the broader AOD sector. A key to success is the engagement of the peak bodies with their members. This engagement is both formal (through contracts) and organic, with the latter seen as genuine bonds that reflect shared values and commitments. The peak bodies have observably different roles from those of their members and other organisations, and operate in such a manner as to add value to the work of their members.

[22] Funnell, SC & Rogers, PJ 2011, *Purposeful program theory: effective use of theories of change and logic models*, Jossey-Bass, San Francisco, CA, p. xix.

[23] Adapted from Wholey, JS, Hatry, HP & Newcomer, KE (eds) 2004, *Handbook of practical program evaluation*, 2nd edn, Jossey-Bass, San Francisco.

The theory of action

The state/territory peak bodies work with member organisations and other stakeholders to identify areas within which increased capacity needs to be built to produce better client outcomes in a cost-effective manner. The peak bodies develop strategies, and harness and deploy funding and other resources, to assist member organisations to meet the needs identified. The priorities of funding bodies are often powerful influences on the peak bodies' priority-setting. The capacity building strategies include, but are not limited to:

- Building sustainable linkages and strategic partnerships
- Assisting services to undertake service improvement
- Identifying and facilitating training opportunities
- Developing and promoting relevant information and resources.

The capacity building activities have three foci:

- The peak bodies developing their own capacity to operate effectively and efficiently
- The peak bodies developing their own capacity to develop capacity in other organisations
- The peak bodies directly developing capacity in other organisations.

These three foci are operationalised through activities that can be seen at one or more of these six levels:

- Individual workers within the state/territory peak bodies
- Individual workers within other organisations
- State/territory peak bodies themselves
- Other organisations
- Networks (both formal and informal)
- The external enabling (or impeding) environment.

When the strategies are implemented well, the operation of the sector as a whole is more effective; individual member organisations have improved governance and operational capacity; individual workers within member organisations are more highly skilled and motivated to provide screening, assessment, treatment and referral interventions to clients; and clients and the community contribute more effectively to member organisations' operations. Furthermore, member organisations are more effective in lobbying and advocacy work that aims to improve AOD policy and resource allocation both nationally and within their individual state/territories and regions, although such advocacy, even when effective, provides no guarantee of continued funding of the peak body itself.

This statement of the theory of change and theory of action helped to make explicit the assumptions underpinning the peaks' capacity building activities. It demonstrates how a hierarchy of outcomes exists that turns resourcing into activities, activities into outputs, outputs into immediate outcomes and immediate outcomes into longer term outcomes and impacts. It helps crystallise thinking about the importance of context and guides data collection along the outcomes hierarchy. One of the evaluation questions, dealt with below, concerns the soundness of the rationale underpinning the capacity building activities, i.e. the validity of this program theory statement.

Interim evaluation findings

This report presents interim findings covering three of the eight evaluation questions detailed above, namely

1. In what ways have the NGO AOD peak bodies engaged in sector capacity building activities focusing on AOD treatment and related supportive activities?
2. How much of the peaks' effort is capacity building related to AOD treatment and related supportive activities?
3. How sound is the rationale underpinning, and design of, the peaks' capacity building activities?

Updated findings relating to these evaluation questions, and the findings relating to the others, will be presented in the final report.

Evaluation question 1: In what ways have the NGO AOD peak bodies engaged in sector capacity building activities focusing on AOD treatment and related supportive activities?

As part of the evaluation, each of the seven participating peak bodies identified the ten or so activities (range 9–12) that they had undertaken during the 2012-13 year. Of course, this is not exhaustive of all the capacity building activities undertaken by the peaks. The aim of this part of the evaluation is to provide descriptive information about the national capacity building activities, thus operationalising or making concrete capacity building as it is actually undertaken.

The activities reported upon

In all, 73 activities have been reported upon; they are listed in the Appendix. The criteria that were suggested for identifying activities that could be classified as 'the most important or significant' during the year were as follows:

- The *size* of the activity in terms of resources of time, expertise funds, etc. employed
- The *significance* in terms of creating important changes or having a real potential for doing so in the future
- The *number of organisations or people likely to benefit* from the activity
- Addressing an *urgent challenge* that, if it is not dealt with reasonably well, could create adverse outcomes
- Addressing a *serious challenge* that, if not dealt with reasonably well, could create adverse outcomes
- The degree to which the approach is *likely to be successful* based on empirical evidence and/or a strong program logic
- The *feasibility* of implementing the activity and of producing good outcomes, taking into account the available resources
- The likely impacts on *equity*
- *Value for money*
- Other
- Combinations of the above.

SMSDGF-supported activities

Although the evaluation has a particular focus on capacity building activities that are funded under the Australian Government Department of Health's SMSDGF initiatives, it is clear that the peaks engage in many capacity building activities that are not funded from these sources. Furthermore, some activities are funded partly from these sources and partly from funds obtained from elsewhere. Of the 73 projects reported upon, 59 were identified as being funded under the SMSDGF and 14 as being funded from other sources. This highlights the important contributions of the SMSDGF to the state and territory peaks' initiatives in building capacity within the AOD sector nationally.

Capacity building the primary, or a secondary goal of the activities

Many activities undertaken by the peaks have multiple goals. For some of them, capacity building was identified as the primary goal. Examples include NADA's Personality Spectrum Disorders Workshop, ATODA's 6th Annual ACT Alcohol, Tobacco and Other Drug Conference, ATDC's Consumer Engagement and Participation initiative and WANADA's development and implementation support for the Standard on Culturally Secure Practice (AOD Sector).

For other activities, capacity building was identified a secondary (albeit important) goal. Examples include QNADA's website redevelopment project, SANDAS' serving as a member of the SA Justice Reinvestment Group, and VAADA's work in promoting and maintaining effective collaboration with the Peaks Capacity Building Network.

Capacity building was identified as being the primary goal in 56 of the 73 activities reported upon. In the remaining 17 cases, capacity building was reported to be a secondary goal.

Key capacity building strategies used

The Peaks Capacity Building Network has identified four main strategies into which their capacity building activities can be classified. These are:

- Building sustainable linkages and strategic partnerships (e.g. ATDC's Biennial Comorbidity Symposium, and Drug Action Week projects in most jurisdictions)
- Assisting services to undertake service improvement (e.g. NADA's Applied Suicide Intervention Skills Training (ASIST) Trainers Network and VAADA's promotion and distribution of the Capacity Building and Change Management manual)
- Identifying and facilitating training opportunities (e.g. SANDAS' Gambling and Comorbidity Workshop and ATODA's ACT-specific ATOD training packages)
- Developing and promoting information and resources (e.g. QNADA's monthly newsletter 'Focus' and WANADA's development and launch of a Stigma and Discrimination Position Paper).

The most frequently used strategy was building sustainable linkages and strategic partnerships (employed in 33% of the activities). This was followed by developing and promoting information and resources (23%), assisting services to undertake service improvement (22%) and identifying and facilitating training opportunities (22%).

The level at which the activities are focused

The capacity building activities can be classified under three key foci:

- The peak bodies developing their own capacity to operate effectively and efficiently
- The peak bodies developing their own capacity to develop capacity in other organisations
- The peak bodies directly developing capacity in other organisations.

These three foci are operationalised through activities that can be seen at one or more of six levels, namely, focusing upon

- Individual workers within the state/territory peak bodies (e.g. QNADA's participation in the ADCA Policy Council)
- Individual workers within other organisations (e.g. ATODA's monthly research eBulletin)
- State/territory peak bodies themselves (e.g. NADA's Community Mental Health Drug and Alcohol Research Network Forums)
- Other organisations (e.g. ATDC's comorbidity bus tours)
- Networks (both formal and informal) (e.g. SANDAS' collaboration with SA Health (DASSA) on workforce development and government and NGO comorbidity service issues)
- The external enabling (or impeding) environment (e.g. WANADA's collaborating with all WA universities and the WA Clinical Training Network in implementing the WANADA student placement program).

It should be noted that any particular activity could have a focus at a number of different levels concurrently. Overall, the most frequently identified level of focus was 'other organisations' (21%) The other organisations were mainly the peaks' own members plus non-member organisations in the broader AOD, mental health and related sectors. This was closely followed by a focus on networks (19%), individual workers within other organisations (18%), the external environment (15%), the peak organisations themselves (14%) and individual workers within the peak organisations (13%). This demonstrates a fairly even spread of foci, demonstrating the breadth and depth of the peaks' capacity building activities.

Table 1, below, presents data on the 73 capacity building activities that the peaks have identified as being the most important or significant during the 2012-13 year. It cross-tabulates the four capacity building strategies with the six primary levels of focus. Please note that multiple responses could be provided so the totals do not sum to 73.

TABLE 1
CAPACITY BUILDING STRATEGY BY LEVEL AT WHICH IT TAKES PLACE

Level of focus	***Capacity building strategy***					
	Linkages/ partnerships	**Service improvement**	**Training**	**Info./ resources**	***Total***	***Row percent***
Workers in own org.	**21**	13	10	14	*58*	*13%*
Workers in other orgs	**24**	18	19	**22**	*83*	*18%*
Peak org.	**25**	12	13	12	*62*	*14%*
Other orgs	**28**	**23**	**22**	**24**	*97*	*21%*
Networks	**27**	17	20	20	*84*	*19%*
External environment	**24**	16	14	14	*68*	*15%*
Total	*149*	*99*	*98*	*106*	*452*	*100%*
Column percent	*33%*	*22%*	*22%*	*23%*	*100%*	

The cells that contain more than 20 responses are highlighted. As noted above, the most frequently employed strategy was building sustainable linkages and strategic partnerships. Within that category, the activities were targeted fairly evenly among the six levels.

Turning to the six levels at which the initiatives were focused, it will be observed that focusing on organisations (rather than individual workers within organisations) other than the peak bodies themselves was the most frequently reported. The numbers of activities within each type of strategy focus at this level were similar.

Evaluation question 2: How much of the peaks' effort is capacity building related to AOD treatment and related supportive activities?

Overall, during the 2012-13 year, some two-thirds of the efforts of the seven participating peaks, as shown through the allocation of personnel resources, went to capacity building activities. As per the terms of reference of the evaluation, comparisons of data relating to the individual peaks are not presented. It is noted, however, that the estimated proportions of the organisations' staff resources that were used for capacity building activities ranged from 42% to 85%, with a mean of 66% and median of 70%.

These data were provided by the peaks themselves, along with supporting evidence. Some key features of these personnel resource allocations included the following:

- Staff resources supported under the SMSDGF were used for both direct, instrumental capacity building activities such as brokering training courses, and for essential infrastructure activities such as staff supervision and back-office support.
- All the peaks have a number of other functions in addition to capacity building; these are funded from other sources. Examples include representation and advocacy.
- All the peak bodies employ some staff all of whose work is capacity building.
- One of the peak bodies pointed out that the effectiveness of the staff resources funded under the SMSDGF is enhanced through activities that are not directly quantifiable in terms of staff time. This includes the 'Goodwill and in-kind contributions of high-level expertise we can garner which may not otherwise be forthcoming…Access to the intellectual knowledge capital of the total collective of the AOD and related peaks—a synergy effect—e.g. the "swap meet" of capacity building activities that occurs as a result of individual peak funding'.

It is concluded that capacity building is the dominant activity of the state and territory peaks around the nation, with their other activities absorbing just one third of the peaks' staff resources nationally.

Evaluation question 3: How sound is the rationale underpinning, and the design of, the peaks' capacity building activities?

An interim statement of the program theory (theory of change and theory of action) underpinning the peaks' capacity building initiatives has been presented above. It was developed collaboratively between the evaluator and the members of the ERG. This evaluation question invites an exploration of the soundness of the program theory. It applies the 'clarificative' form of evaluation.[24]

The overall assessment of the evaluation, at this mid-point in its implementation, is that the rationale underpinning, and the design of, the peaks' capacity building activities, are sound. This conclusion is

[24] Owen, JM 2006, *Program evaluation: forms and approaches*, 3rd edn, Allen & Unwin, Crows Nest, N.S.W.

based on this definition of plausibility (how plausible is the underlying rationale?): 'The existence of necessary and sufficient conditions for a program to succeed'.[25]

The soundness of the rationale is evidenced by four factors:

- the validity of key underpinning assumptions
- the fidelity of program implementation
- the extent of implementation
- the availability of resources.

Each of these is discussed in turn.

Assumptions

Four categories of assumptions underpinning the capacity building work are identified in the evaluation literature: diagnostic assumptions, prescriptive assumptions, transformational assumptions and external assumptions.[26]

Diagnostic assumptions: '…stakeholders' expectations or beliefs of the major and minor causes of core problems'.

In this context, the 'core problem' that has been identified, nationally, is a need for continuing quality improvement in the operation of AOD organisations, including the attainment of a sufficient quantity of, and appropriate quality of, positive client outcomes. At both the organisational and workforce level agencies need to improve their capacity and capability so as to continue to meet needs.

These assumptions about the needs and the causes of contemporary challenges are sound.

Prescriptive assumptions: '…relate to the intervention or strategy devised for the problem or to reach a stated objective, which represents stakeholders' beliefs of what could be the best ways to address the problem or need'.

All of the peak bodies have mechanisms in place for undertaking needs assessment and identifying a range of options available to improve the capacity of member organisations and, where appropriate, other organisation in the AOD and/or related sectors. All now have a body of knowledge and skills derived from their experience in designing and implementing capacity building activities that meet the needs of organisations within their individual jurisdictions. Partly through the work of the Peaks Capacity Building Network they have been active in sharing knowledge and experiences, providing a sound basis to their beliefs about what are the best ways to build capacity across the sector.

Transformational assumptions: '…relate to how the immediate results of a strategy, program or intervention (outputs) are expected to lead to long term desired changes'.

This is always a difficult challenge for people designing programs that are relatively small but that address problems that are large and/or serious. The program theory statement spells out the underpinning

[25] *Op. cit.*, p. 202.
[26] The source of the quotations in this section is American Evaluation Association 2013, 'Apollo M Nkwake on working with assumptions in program evaluation', *AEA365: A Tip-a-Day by and for Evaluators*, http://aea365.org/blog/apollo-m-nkwake-on-working-with-assumptions-in-program-evaluation. Further details are available in Nkwake, AM 2013, *Working with assumptions in international development program evaluation*, Springer, New York.

assumptions about the relationship between the capacity building activities, their products, their immediate outcomes and the attainment of longer and deeper goals. This was touched upon in the discussion of evaluation question 1 (above) and will be further explored in the evaluation's final report.

Because capacity building activities have been undertaken in a number of the peaks over some years, and many of the activities have been subject to evaluations that have produced significant findings about their processes and outcomes, it is fair to conclude that the transformational assumptions underpinning the current capacity building activities are relatively sound.

External assumptions: assumptions about the 'preconditions for program success that are beyond the control of program stakeholders'.

These are assumptions about the context within which capacity building activities take place. Core assumptions are that the needs for quality NGO AOD services will continue well into the future but that the nature of the needs will change over time, with a concomitant need for services to be able to adapt. Despite the absence of a national AOD workforce strategy (although one is currently under development) a clear trend exists for the up-skilling of the workforce. It is probable that we are entering an era of greater financial restraint in the AOD sector, meaning that organisations will need to continue to improve their capability to deliver quality services with potentially less resources in the future.

These assumptions about factors that are beyond the control of the peaks' capacity building programs are sound and provide significant rationale for undertaking and, indeed expanding, NGO AOD capacity building activities.

Fidelity and extent of implementation of capacity building activities given the available resources

A criterion for assessing the soundness of the program theory—the rationale underpinning the capacity building activities— is the degree to which the activities are implemented as intended and have a significant enough reach to produce valued outcomes.

The activity data collected to date and discussed under evaluation question 1, above, indicates a high degree of fidelity of implementation of the capacity building projects (i.e. the programs have been implemented as intended, using strategies and modalities that have been demonstrated to be effective). Furthermore, the amount of capacity development work undertaken by the peaks within the limited amount of funds available is impressive. The question of value for money will be considered in the final report of the evaluation.

Evaluation activities during 2014

The evaluation will continue to be conducted during 2014, culminating in a final report which is to be presented by 30 November 2014.

Key evaluation activities that will be conducted during the 2014 year include (but are not necessarily limited to) the following:

- Providing regular reports to the ERG on progress with the evaluation.
- Updating the evaluation protocol, as required, with the endorsement of the ERG.
- Collecting data from each of the peak bodies on their capacity building activities and resources used for this purpose, covering the 2013-14 year.

- Further identifying, in the activities data collection, the extent to which the activities have a focus on AOD/mental health comorbidity.
- Collecting data on evaluation questions 4, 5, 6, 7 & 8, as well as updating and expanding upon the findings about the first three evaluation questions that are presented in this Progress Report. This will include conducting interviews with key informants and the deployment of questionnaires to the peaks' member organisations.
- It is intended that data collection will conclude at the end of September 2014, allowing sufficient time for data collation, data cleaning and data analysis prior to completing the final report.
- Analysing the outputs and outcomes of the capacity building activities undertaken during the 2012-13 and 2013-14 years, as well as the other data collected over the two years of the evaluation.
- Preparing a draft final report that will be presented in early November 2014 in time to be finalised by the target date for concluding the evaluation, 30 November 2014.

Appendix: the 73 capacity building activities discussed at evaluation question 1

These are the capacity building activities that were identified by each of the peak bodies as being the most important or significant among those that they have conducted during the 2012-13 year.

PEAK BODY	ACTIVITY
ATDC	Comorbidity Bus Tours
	ATDC/UTAS Research Symposium
	Consumer Engagement and Participation
	Communication Activities
	Biennial Comorbidity Symposium
	Comorbidity Workplace Exchange Project
	Drug Action Week
	Information Sessions
	Peaks Capacity Building Network
ATODA	Comorbidity Bus Tour
	ACT Training and Professional Development Calendar
	6th Annual ACT Alcohol, Tobacco and Other Drug Conference
	ACT Alcohol, Tobacco and Other Drug Services Directory
	ACT eASSIST Stage 1 Pilot
	ACT Alcohol, Tobacco and Other Drug Minimum Qualification Strategy
	Free NRT for ATOD, mental health and youth workers
	Partnership with the mental health and youth peak bodies in the ACT
	Peaks Capacity Building Network
	The monthly Research eBulletin
	Reconciliation Working Group
	ACT Specific ATOD Training packages
NADA	Capacity Building Communication
	Partnerships and stakeholders
	Member networks
	Peaks Capacity Building Network
	ACHS EQuIP5 Resource Tool

PEAK BODY	ACTIVITY
	Direct member support
	Personality Spectrum Disorders Workshop
	Cases Notes training for Managers and frontline workers
	ASIST Trainers Network
	Outcomes & mental health capability forum
	Community Mental Health Drug and Alcohol Research Network Forums
QNADA	Assistance to members to identify and apply appropriate accreditation framework
	ADCA Policy Council
	Scholarships to attend the Complex Needs Conference – April 2013
	Joint Members forum with the Queensland Alliance for Mental Health
	Medicare Locals (MLs) and Hospital and Health Services (HHSs) – membership and participation in planning activities
	Members Forum – August 2012
	QNADA Focus (monthly newsletter)
	Peaks Capacity Building Network
	Informing and influencing the establishment of the Qld Mental Health Commission
	QNADA website redevelopment
SANDAS	Being Comorbid in Victoria – Capacity Building Network Forum
	Sitting Member of the SA Justice Reinvestment Group
	Cultural and Linguistic Diversity (CALD) Reference Group
	Sitting Member of Child and Adolescent Mental Health (CAHMS) State Reference Group
	Gambling and Comorbidity Workshop involving providers from the AOD, MH and Gambling services sectors, both government and non-government.
	Comorbidity Action in the North (CAN) Project – as one of the Chief Investigators of this ARC Linkage Grant funded 3 year projects.
	VET sector training – Supporting the development of a Comorbidity Diploma and the design of an existing worker Cert IV AOD with MH including evaluation
	Advancing QI in funded organisations through direct onsite support, help desk functions, consultation on approaches and barriers and access to products that help improve systems.
	Sector Communications E-Bulletin, The Connector News Letter and SANDAS Website
	Collaboration with SA Health (DASSA) on Workforce Development and Government and NGO Comorbidity service issues
	EO Network; Peaks Policy Network; Peaks Capacity Building Network
VAADA	Delivery of personality disorders workshops - 21 May and 5 June 2013
	Promote and maintain effective collaboration with PCBN - ongoing
	ISI (SMSDGF)/VDDI conference organisation – 7-8 August 2012
	Coordination of SMSDGF network meetings - ongoing
	VAADA conference 2013 'Broadening The Focus' – 14-15 February 2013
	Trauma informed care sector survey – March-April 2013
	Development of related Trauma Informed Care (TIC) training program – May-June 2013
	Dissemination of alcohol and other drugs (AOD) and mental health (MH) prompt cards and provision of related training state-wide - ongoing
	Promotion and distribution of Capacity Building and Change Management manual
	Development of Trauma Informed Care prompt cards

PEAK BODY	ACTIVITY
	Participation in capacity building networks - ongoing
WANADA	Key Strategic Meetings
	Collaborating with all WA Universities (UWA, ECU, Notre Dame, Curtin and Murdoch) and the WA Clinical Training Network in implementing the WANADA student placement program
	Peaks Capacity Building Network
	Development and implementation support of the Standard on Culturally Secure Practice (AOD Sector), an Interpretive Guide and the AOD Knowledgebase and links with the Dual Diagnosis Capability in Addictions Treatment (DDCAT)
	The collective administration and support for member agencies for various programs
	Research and strategies to support capacity building.
	Communication with key stakeholders (weekly newsletter FYI, partnership with DAO on Drugspeak a quarterly newsletter, regular Managers Updates to AOD service managers and CEO's.
	Development and launch of a Stigma and Discrimination Position Paper
	Host and administer an AOD service directory and secured funding to develop the 'Green Book' to be a joint service directory of WA AOD and MH services