Australian Government
Department of Health and Ageing

Barriers and Incentives to Treatment for Illicit Drug Users

Monograph Series
No. 53

National Drug Strategy

Barriers and Incentives to Treatment for Illicit Drug Users

Monograph Series No. 53

Carla Treloar[1]
Jeanne Abelson[1]
Wen Cao[1]
Loren Brener[1]
Susan Kippax[1]
Lance Schultz[2]
Meriel Schultz[2]
Nicky Bath[3].

1 National Centre in HIV Social Research, University of New South Wales.
2 LMS Consulting.
3 The Australian Injecting and Illicit Drug Users League.

April 2004

ISSN: 1322 5049

ISBN: 0 642 82555 6

Publication approval number: 3542

Contents

Tables

Preface

The Barriers and Incentives to Treatment for Illicit Drug Users research project was funded by the Australian Government Department of Health and Ageing. A consortium, comprising LMS Consulting, the National Centre in HIV Social Research (NCHSR) at the University of New South Wales and the Australian Injecting and Illicit Drug Users League (AIVL), conducted the research project.

A key feature of the study was the involvement of the AIVL as a full partner in the study and their involvement in all aspects of design, planning, implementation and the formulation of recommendations.[1]

There were two main purposes of the study:

- an investigation of barriers and incentives to treatment for substance use; and
- the development of recommendations regarding possible policy and program directions arising from the research findings.

The study involved:

- a review of the international and national literature;
- a drug user survey of users of heroin, amphetamines and cocaine, conducted in three Australian states;
- service provider interviews, conducted in the areas in which participants in the user survey were recruited;
- key informant interviews, conducted nationally;
- a 'negotiation workshop' with participants representing both drug user and service provider interests; and
- the development of policy and program recommendations.

Each of these arms of the study provided a different perspective to the problem.

Structure of the Monograph

The structure of the Monograph reflects its dual purpose:

- PART ONE: INTRODUCTION provides necessary background to the study and outlines the methods used;
- PART TWO: ARMS OF THE STUDY presents the methodology and findings of the various research and investigative arms of the study; and
- PART THREE: IMPLICATIONS FOR POLICY AND FUTURE PRACTICE presents the results of the 'negotiation workshop', and presents policy and program recommendations.

Part TWO contains the main points arising from the illicit drug users survey. The full report is at Appendix A.

---

1 As Single & Rohl commented in their 1997 Review of Australia's National Drug Strategy:

'When user organisations are present, the prevailing concept of an illicit drug user is less likely to be that of a person unable to control his or her actions and prone to criminal behaviour, and more likely to be that of an otherwise normal person who uses drugs and experiences a variety of consequent problems. It would seem reasonable to consult with the persons most affected by a particular social policy when developing such policies.' (Single & Rohl, 1997, p.55.)

Acknowledgements

The consortium members wish to thank a number of departments, agencies and individuals that made this research study possible:

Departments, agencies and non-government organisations

The Australian Government Department of Health and Ageing; for funding the project.

NSWHealth; for providing supplementary funding to increase the survey sample size for the illicit drug user survey in New South Wales.

The University of Queensland (QADREC); for support in fieldwork and data collection.

AIVL and its member organisations, the state and territory drug user organisations, particularly in New South Wales (NUAA), Queensland (DUNES) and Western Australia (WASUA); for assistance in recruiting survey participants and providing peer interviewers.

Family Drug Support; for providing and collating the written family stories examined in the study as an adjunct to the literature review.

Turning Point Alcohol and Drug Centre; for providing an advance copy of their related study on *Treatment utilisation by heroin dependent persons in Australia: Implication for treatment service systems* and for advice during the course of the project.

Individuals

Dr Stephanie Taplin (Whitfeld and Taplin Consultants); for providing the first cut of the literature review, and Dr Catherine Spooner (CJ Spooner: Planning Research and Evaluation) for her comments on the draft literature review.

Mr Matthew Toomey; for liaison with the AIVL and its member organisations.

Gratitude is also due to key informants, service provider interviewees and the participants in the negotiation workshop (listed in Appendix B) who gave freely of their time and provided insights to the study, and to all respondents in the illicit drug users' survey for their interest, time and the information and insights they provided.

We have also been ably advised and assisted by the following expert members of our project advisory committee:

Robert Ali, Judith Aulich, Paul Dietze, Sally-Anne Scott, Alex Wodak.

Executive Summary

This project investigated barriers and incentives to illicit drug users accessing, utilising and remaining in treatment.

Purpose

There were two main purposes of the study:

- an investigation of barriers and incentives to treatment for substance use; and
- the development of recommendations regarding possible policy and program directions arising from the research findings.

Method

The study involved:

- ***A review of International and National Literature*;**
- ***A Survey of Illicit Drug Users:*** Face-to-face interviews were conducted with 685 people who use heroin, cocaine, or amphetamines, recruited from New South Wales (one inner-Sydney, one outer-Sydney site and one rural site – Bathurst/ Orange); Queensland (Brisbane and Cairns); and Western Australia (Perth);
- ***Service Provider Interviews:*** Face-to-face interviews were conducted with 33 service providers and outreach referral services in areas in which participants in the illicit drug users survey were recruited to ascertain their views on real and perceived barriers (and incentives);
- ***Key Informant Interviews:*** Face-to-face and telephone interviews were conducted with 28 key informants to obtain their views on barriers and incentives to treatment for illicit drug users, and about the ways in which barriers and incentives relate to current and future national and state policies and programs;
- A one-day **negotiation workshop** with 45 participants, representing both customer and service provider interests, was held to review and discuss the findings of the research arms of the study, and to identify and discuss options for improved treatment service delivery for substance use.

The purpose for using a number of methods was to examine the drug treatment access and retention issue from a variety of perspectives to reflect the complexity of the issues, and to provide recommendations across the range of possibilities.

Framework

A model, based on the health psychology and public health model of Winett, King & Altman (1989), was used throughout the study to examine influences at four levels – personal, interpersonal, organisational/institutional and social – in order to explore a comprehensive, yet coherent, understanding of the problem.

Literature Review

The literature review identified a wide range of personal, interpersonal, organisational and social barriers to treatment; and few incentives. Few studies specifically addressed barriers (or incentives): in most cases, they had to be inferred from the literature.

For the general population of illicit drug users, the international and national literature indicated that the main barriers were:

- *Personal*: Individuals not being ready for treatment; being ill-informed about treatment; having negative attitudes towards orthodox medical treatment; and experiencing difficulties in making the necessary arrangements;
- *Interpersonal:* Opposition from a drug-using partner; and/or embededness in a sub-culture with drug using friends;
- *Organisational/Institutional*: Lack of treatment places; waiting times; costs; inappropriateness of the services offered; and onerous rules and regulations associated with drug use treatment access and retention; and
- *Societal:* Social stigma.

The main motivators and incentives identified at the various levels were:

- *Personal*: Individuals wishing to gain control over their lives/improving the quality of their lives;
- *Interpersonal:* Concern about the impact of drug use on others; support from family and friends;
- *Organisational*: Provision of non-threatening, low-threshold services; and product innovations, e.g. availability of buprenorphine prescriptions; the provision of vouchers as positive reinforcers; travel coupons; court diversion.
- *Social:* Change in community attitudes, and a reduction in stigma and discrimination.

A review of studies examining barriers specific to population groups, such as women and youth, rural and remote communities, people from cultural and linguistic diverse backgrounds and Aboriginal and Torres Strait communities, indicated that there are particular sets of problems relating to these populations in addition to the barriers illicit drug users face in general. The under-representation of ethnic communities in drug treatment services appears to reflect under-utilisation of the services by community members, rather than lower need; but the particular treatment needs of these groups are not well known or documented.

Research indicates that the incidence of dual diagnosis is high. Individuals who suffer coexisting drug use and mental health problems experience difficulties in accessing treatment, and are regarded as 'difficult to treat patients'. While there are effective treatments, their effectiveness is limited by inadequate communication between the agencies involved. More research is needed on barriers to treatment for people with dual diagnosis, particularly from a consumer perspective.

There is a tendency in the illicit drug use treatment literature to focus on the individual drug user and drug of choice in isolation, without considering the wider context of personal relationships and circumstances. Little attention is given to the impact of the various socio-economic determinants affecting health and wellbeing and drug use, such as poverty, social exclusion, level of education and training, living environments and unemployment on people from disadvantaged groups, and their ability to access treatment services and remain in treatment.

Illicit Drug User Survey

Demographics

A summary of the main characteristics of the sample is given below. The three sample groups are similar across most characteristics. However, some significant differences exist:

- participants who had never been in treatment were, on average, younger than those who had ever been in treatment;
- a greater proportion of participants who were currently in treatment were receiving government benefits as their main source of income, compared to those previously and those never in treatment; and
- a greater proportion of participants who had ever been in treatment identified opioids as their most frequently used drug (that is, a greater proportion of participants who had never been in treatment identified psychostimulants as the most frequently used drug).

Summary of the main characteristics of the sample recruited for the current study

Characteristic	In treatment	In/out treatment	Never in treatment	Total (N=685)
Recruitment	48%	24%	28%	100%
Mean age (years)	32.16	32.28	30.11	31.61
Gender (male)	64.7%	63.2%	73.1%	66.7%
Capital cities	62.9%	61.3%	61.1%	62%
Regional/rural	37.1%	38.7%	38.9%	38%
Australian born	83%	85.3%	88.6%	85.1%
ATSI	8.2%	15.3%	13.5%	11.4%
On benefit	81.8%	69.9%	54.9%	71.4%
Education < =Y10	61.1%	57.7%	54.9%	58.5%
Opioid user	59%	60.1%	36.3%	52.8%
Psychostimulant user	41%	39.9%	63.7%	47.2%

Drug use history

The study found:

- almost 60% of the sample indicated that they used drugs once or more a day and almost all (92%) injected drugs;
- on average, participants had started injecting drugs at 19.3 years of age and had been injecting for 12 years;
- the mean severity of dependence (SDS) scores for those in and out of treatment and those never in treatment were 7.59 and 5.84, respectively (higher scores indicate higher levels of dependency). The corresponding SF[2] health scores were 34.20 and 38.87. Those in treatment had a SF health score of 35.05 (higher score indicates better self-rated physical and emotional health).

Treatment history

The study found:

- almost three-quarters of the sample had taken steps previously to change drug use without professional help, such as 'cutting down' and 'stopped using';
- on average, participants had been in formal treatment 3.7 times; and
- most participants who had experience of treatment were aware of treatment via a professional. Other sources were family, friends, partners or the media. Most had referred themselves to treatment.

Motivation for help seeking

With regard to reasons for wanting to change, the study found that:

- about 60% indicated they were 'in crisis' or 'chaotic' at that time, of whom about 50% indicated that their financial state prior to treatment was 'debt ridden';
- the most frequently reported reasons for wanting to change drug use related to personal issues such as wanting to improve one's quality of life, to increase stability and being sick of the lifestyle. Other frequently reported reasons for wanting to change drug use included being concerned about the impact of drug use on others; and concerns about their physical and mental health. Reasons such as being diagnosed with hepatitis C or being worried about getting blood borne viruses were among the lowest frequency responses. Respondents not currently in treatment were more likely than those in treatment to want to change drug use because of problems with drug supply; and
- of the 685 participants, nearly one-third had been in trouble with the police in the last six months, of whom 76% reported that the charge was related to drug use, 17% of whom had been referred to a drug court.

2 The Short Form 12 (SF-12) is a standardised, internationally used instrument that provides a general measure of health status.

Barriers to treatment entry

The study found that:

- twenty-eight percent of participants (n=190) reported that they had tried to get treatment for their drug use and not been able to do so in the last 5 years;
- of these, 55% reported no service available in the area as the main barrier to treatment. Other significant barriers reported by participants were: waiting list was too long (52%), lack of support from health professionals (25%), inability to meet the criteria (22%), treatment offered was not the kind wanted (22%), treatment program did not suit needs (20%), travel problems (19%), cost of program (14%), lack of support from family/friends (14%), heard from others that the treatment was no good (13%), fear of disclosure (13%), fear of being stigmatised (13%), banned from the program (7%), fear of children being taken away (6%), treatment was unable to accommodate children (6%) and partner (6%), and fear of job loss (5%); and
- with regard to social stigma, more than half the participants in the sample reported that they had been discriminated against by family (63%), staff at pharmacies (63%), friends (62%), and doctors/nurses (54%), while a significant proportion mentioned discrimination by partners (37%), other health care workers (36%), landlords (36%) and workmates (34%).

Factors affecting retention in treatment

With regards to client treatment aims, the study found that:

- 56% of those currently in treatment and previously in treatment indicated that their treatment aim was abstinence, while 44% indicated that their aim was to control, reduce or have a break from drug use. Only about one-quarter of participants indicated that they were successful in achieving their treatment aims; and
- the most frequently endorsed reason for achieving treatment aims was 'self determination'.

With regard to *client satisfaction* with treatment and the range of services offered, the study found that about 60% of participants indicated that they were somewhat or very satisfied with their current or most recent treatment episode, while 22% reported being very or somewhat unsatisfied with their treatment.

With regard to treatment agencies providing *additional services* relating to users' health and wellbeing, the study found that the most frequently reported 'additional' services offered by treatment programs were medically related and included: information about blood-borne viruses (81%); individual counselling (79%); relapse prevention strategies (63%); mental health assessment and treatment (54%); and medical/dental treatment (54%). However, respondents in the current treatment group were more likely than those in the past treatment group to report that their current treatment provider offered other services, such as employment/skills training, housing assistance, family interventions, financial planning assistance, legal advice and referral to peer support programs.

With regard to after-treatment support programs, the study found that most participants were aware of support available from drug and alcohol counsellors.

Other programs reported by high proportions of participants included self-help groups, methadone maintenance, support from local doctor, long term therapy/counselling and naltrexone maintenance.

Perceptions of barriers and incentives by treatment experience

The study found that users' attitudes to treatment, their perceptions of barriers and incentives, and the presumed salience of these barriers and incentives in respect of them accessing or remaining in treatment, varied according to their drug use career and drug treatment career profiles.

In bivariate analyses, the following differences between 'never in treatment' and other groups were found:

- Those '*never in treatment'* were more likely than the other groups to report that: sooner or later most drug users will stop using and/or there was no appropriate treatment available for people like them. They were more likely than the other groups to indicate wanting to change drug use because of problems with drug supply. They were also more likely than the other groups to report that, when they had tried to get treatment in the past five years and had been unsuccessful, staff at drug treatment centers had tried to treat everything in their lives as though it was drug-related; and had treated them badly in front of other clients. They were more likely to have a view that treatment administrated by a doctor in a medical setting works best; and that detoxification is a successful treatment;
- The '*having ever been in treatment'* group were more likely than the other groups to disagree that drug users can stop using drugs without professional help and, conversely, to believe that most drug treatments fail. They were more likely to report that they 'kept using' while waiting for treatment. Respondents in this group were more likely than the current treatment group to report barriers to achieving their treatment aims, such as rules and regulations, lack of support from peers and/or staff, as well as their own lack of readiness to stop using. They were more likely than the other groups to report that staff at drug treatment centers looked down on them, did not respect their confidentiality, didn't know much about drugs and didn't respect their rights to continue drug using;
- The '*current treatment'* group were least likely than those in the other groups to report that anybody who wants to can get off drugs can do so without professional help. They were more likely than the 'ever in treatment' group to report that their treatment aim was total abstinence, to express satisfaction with the treatment being offered and to report that they received various types of support from staff, group sessions and individual counseling. They were more likely to report that residential programs are better than other programs:
  - the 'current treatment' group was more likely than those in the 'ever' and 'never in treatment' groups to report having experienced discrimination by staff at methadone clinics, by landlords, partners, family members, friends, flat-mates, bosses and/or workmates. However, they were more likely to report that staff at drug treatment centres did not make judgements, listened to what they said, were supportive, took time to make sure that they understood all the treatment options and implications and had realistic expectations about treatment.

Using a reduced model of multivariate analysis, the study found that:

- Compared with the 'in-out treatment' group, '*never being in treatment*' was independently related to:
  - less likely to be a current injector;
  - more likely to report using drugs to "party" (than for other reasons);
  - using a bigger mix of drugs (having higher polydrug use scores);
  - being in better health;
  - being less likely to report overdose;
  - having tried self-treatment; and
  - while in self-treatment, being more likely to aim to reduce or control drug use than abstain and use fewer other drugs:
- Compared with those who have 'never been in treatment', '*having ever been in treatment*' was independently related to:
  - using drugs more frequently;
  - using drugs for purposes other than recreation;
  - having blood-borne virus positive diagnosis/es;
  - being more likely to report overdose;
  - having tried self-treatment;
  - while in self-treatment, being more likely to aim to abstain;
  - having a better opinion of treatment staff;
  - denying that, if they want to, drug users can stop using without professional help; and
  - deny that treatments that allow continued injection of drugs are the most helpful:
- Compared with those who have 'been in treatment' previously, being in '*current treatment*' was found to be independently related to:
  - using drugs more frequently (before treatment);
  - not having disclosed drug use in the last six months;
  - not being a current drug user;
  - more involved with drug use networks;
  - more satisfied with treatment;
  - more likely to report requirements and conditions of treatment;
  - more likely to report abstinence as a requirement of treatment;
  - less likely to have asked to be referred to treatment; and
  - less likely to have found about treatment from professionals.

Differences between current and most recent experiences

With regard to the differences between their current treatment experience and their most recent treatment, 74% of the 'current treatment' respondents who answered this question reported that this time they were 'ready' and found a treatment 'suiting' their needs. Other factors receiving endorsement from more than 50% of respondents were: 'drug use more out of control this time'; 'life more in crisis'; 'more support from family and friends'; 'treatment affordable/free'; 'accepted into treatment immediately'; 'more information about benefits of treatment'; and 'child care facilities'.

It is difficult to know from the cross-sectional data if the differences noted in the treatment experiences between those 'currently in treatment' and those 'ever in treatment' will persist, or if they are a function of the current experience of the groups; that is, that those 'currently in treatment' may, some time after the conclusion of their current treatment episode, come to resemble the profile of the 'ever in treatment' group.

Geographical Location

The findings of the survey of illicit drug users indicated that differences in location were not significantly associated with the outcomes examined. Other location was examined for outcomes such as treatment completion, achieving treatment goal and plans for future treatment. Although recruitment location was not found to be significant in these data, the insights from other sections of the project (literature review, service providers and key informants) indicate significant barriers for rural and remote users in terms of the availability and accessibility of treatment services.

Service Provider Interviews

Service providers focused on barriers at the organisational and social levels, rather than at the personal and interpersonal levels. The main themes of the interviews included:

- in general, service providers focused on the individual as the sole cause of drug problems in society and individual personal factors as the main barrier to treatment, leading to a treatment approach described as 'fix it'. Service providers described community perception of drug use, drug users and drug treatment as highly intolerant and hostile, and indicated that the community expected abstinence (rather than anything else) as an outcome;
- service providers identified differing treatment philosophies and their related treatment goals as at the core of many barriers to treatment. This impacted on service providers' referral and networking, and was evident in the often competing interests of various agencies involved in the care/management of an individual, which worked to undermine the treatment progress of individual clients. Providers perceived that users' lack of fore-knowledge of the philosophical bases underpinning specific treatments led to users dropping out of treatments that did not match their philosophy of drug use;
- alternative models, such as consumer involvement, based on the rights of individuals within treatment, were not evident in the interviews. While national and state drug strategies state that drug treatment should be attractive to the user, service provider participants identified many aspects of current system as particularly unattractive and demeaning;
- service providers identified a number of specific practical barriers at the organisational level, such as costs, lack of places, waiting lists and confidentiality issues;
- workforce issues were perceived as critical for the success of the sector. The drug and alcohol workforce was portrayed as being in long term 'crisis management'. Jobs were described as stressful, salary rates in non-government agencies were low, career structures not apparent and training was piecemeal;

- respondents acknowledged that a wide range of groups (e.g. culturally and linguistically diverse, indigenous people, younger people, primary amphetamine users) were not currently being well served by existing services. Mental health care was described as a major failing within and between sectors;
- it was apparent from the interviews that respondents had an understanding of the complex, multiple needs of their customers, and efforts, with varying levels of success, were made to connect customers with services that could help to address these needs. However, continuity of care was being undermined by a pattern of linkages, based on ad-hoc connections to other services; and
- court diversion, which respondents regarded as a major incentive for treatment, was an emerging issue at the time the interviews were conducted. Concerns were expressed about a possible development of a two-tiered treatment system, with those referred from courts getting quicker and cheaper access to treatment.

Key Informant Interviews

Key informant views were sought on barriers and incentives to treatment for illicit drug users and about the ways in which barriers and incentives relate to current and future national and state policies and programs. Given the purpose of the interviews, it was expected that their comments would focus on public policy, societal and institutional and organisational barriers. The main themes included:

- key informants considered that Australia's performance in providing treatment for illicit drug users was good in what it offered (compared to other developed countries), but that what it offered was limited in innovation and scope;
- key informants generally adhered to an holistic view of treatment, with treatment aiming to improve health outcomes and quality of life. In order to be regarded as treatment, an intervention, in their view, has to be based on mutual agreement between the service and the client;
- key informants showed a keen appreciation of the way in which psychosocial problems compounded drug use and help seeking. They also noted that illicit drug users have difficulty in negotiating health outcomes and in being treated with the same degree of respect as other citizens. Overzealous rules and regulations meant that drug users accessing treatment spent more time 'sliding down snakes than climbing ladders'. They acknowledged the need for more services that recognise family and friends as supports for treatment;
- the views expressed by key informants on organisational/institutional barriers covered a wide field – insufficient funding, the erosion of services in the primary health field, the need for a wide range of treatment interventions, including early interventions, the need to address the multiple needs of drug users seeking treatment and the challenges of comorbidity and workforce issues;
- in their view, community attitudes and distrust of drug users and treatment services, fueled by the media, was the source of one of the biggest barriers to help seeking by illicit drug users. As a consequence, illicit drugs was the only public health policy area where politicians, policy makers and the media called the shots, rather than allowing for informed decisions between health professionals and patients in regard to their treatment;

- key informants considered that treatment services were culturally unsuited to many, and that illicit drug treatment agencies paid only lip service to meeting the needs of a wide range of non-mainstream customers.

Negotiation Workshop

In line with the participatory approach to the research study, the project management group sought input from key stakeholders in the analysis and application to policy of the outcomes of research arms of the study in a one-day negotiation workshop. The workshop included representation from the project advisory committee, drug user organisations, service providers and policy makers and researchers, most of whom had already contributed to one or more arms of the study.

The aims of the workshop were to:

- review and discuss the findings of the literature review, illicit drug users' survey, service provider interviews and key informant consultations;
- agree and analyse the main issues arising from the various arms of the study;
- identify and discuss options for improved treatment service delivery for illicit drug users; and
- indicate implications for future policy and program planning.

The one-day, facilitated workshop was held at the University of NSW in Sydney in August 2003. One half of the number of workshop participants were nominated by the Australian Injecting and Illicit Drug Users League (AIVL), while the service provider and other participants were selected on the basis of their knowledge and participation in the project, either as service provider participants, key informants or members of the project advisory or management committees.

The workshop participants identified an overarching theme arising from the study. This theme focused on *the barrier of illegality and the associated stigma surrounding access and retention in drug treatment for those people motivated to make changes to their drug using behaviour.*

Priorities for action, based around this overarching theme, were identified in five categories:

- strategic directions;
- quality practice;
- consumer involvement;
- workforce development; and
- continued research.

Recommendations

The following recommendations, grouped against the five priority areas for action identified at the workshop, were developed to reflect the discussion of these areas at the workshop and the priorities developed by workshop participants. Each of the recommendations is grounded in the findings of one or more arms of the study.

The recommendations are intended to provide directions for policy improvements at all levels of government. In some instances, the policy improvements suggested require the cooperation of all parties. They are intended to be applied to and build on current policy frameworks (such as the *National Drug Strategy*, the *National Illicit Drugs Strategy* and the various accompanying policies and strategies in place at State and Territory levels). These policy recommendations are accompanied by a number of suggested implementation strategies.

The premise underlining the recommendations is the *normalisation* of illicit drug treatment and drug treatment services. Study participants noted that: just as drug users are marginalised in community, so too are those who provide drug treatment. Participants also observed that the closer models of treatment are brought to other health treatments within the Australian health system: the more holistic the health approach; the better the community understanding of the purpose and function of drug treatment; and the greater is the prospect of quality of life outcomes for those accessing treatment. At the same time, the issue of legality (of drug use) and the associated stigma surrounding drug use dissipate as treatment is 'normalised'.

I: Recommendations for improving strategic directions

Expanding treatment definition

R 1: Develop and promote a nationally agreed, comprehensive and contemporary definition of 'drug treatment' for people who use illicit drugs.

Comment

This definition will acknowledge both clinical intervention and the social aspects of treatment and care that lie outside clinical interventions.

Suggested implementation strategy

As part of national drug strategy, this broader definition of drug treatment will require dissemination and application to policies and programs all levels of government.

Funding models

R.2: Commission the development of new funding models that acknowledge the broadened scope of treatment for illicit drug use and the continuing discrepancies between demand for treatment and the adequacy of response through service delivery.

Managing complexity of need

R 3: Governments at all levels work to reverse the current erosion (especially noticeable in the primary health care sector) of holistic and timely health care for clients with complex needs (e.g. those who use drugs illicitly/with mental health problems/with blood borne illnesses).

Suggested implementation strategies

Governments identify ways to restore resources to the primary health care sector.

Governments fund, develop and implement models of integrated service delivery that increase nationally the number and type of health and related services responding to the complex health needs experienced by people who use illicit drugs.

Governments at all levels recognise and fund the work of drug user organisations as an integral part of effective drug treatment service planning and delivery.

Managing comorbidity

R 4: Governments work together to improve the interrelationship between drug and alcohol and mental health disciplines and services.

Suggested implementation strategies

Increase nationally the availability of workforce development opportunities that address the management of comorbidity, especially in the rural sector.

Include comorbidity and its management as a significant element of medical, nurse and pharmacy undergraduate and postgraduate training programs; fund regional workshops as part of National Drug Strategy implementation and dissemination.

Acknowledge the need for, and increase and fund cross-discipline work placement and work experience programs for health and allied workers in drug and alcohol and mental health service delivery (across the continuum of training and ongoing work practice).

Investing in community education

R 5: Governments, together with the non-government sector and drug user organisations, fund, develop and sustain a community education strategy for delivery nationally.

Comment

This recommendation proposes a move away from traditional mass media campaign models to work within communities, outlining, in particular, the realities and benefits of different treatment modalities and emphasising (e.g. through story telling, practical examples and open days at treatment services) the way in which different treatment modalities work for different people at different stages of the drug use continuum.

Suggested implementation strategy

This strategy could expand and sustain the current Alcohol and Other Drugs Council of Australia *'Treatment Works'* annual program.

II: Recommendations for quality service provision

Mapping service location and type

R 6: Governments work together to improve national coverage of drug treatment service provision, recognising inconsistencies and gaps in availability and access.

Suggested implementation strategies

Commission a national mapping study that identifies (in relation to population groups) the scope, range, level (i.e. primary care, drug and alcohol specific, specialist) and location of treatment and support services on a regional basis. (NB this is not intended as a directory of services).

Using the mapping outcomes, identify the scope of current service delivery, and apply the results to future planning, mix and distribution of drug and alcohol treatment and support services, including the allocation of granted funds.

Improving infrastructure support

R 7: Governments work together to update and improve current infrastructure support for effective service delivery.

Suggested implementation strategies

Location: Utilise current Intergovernmental processes in place across Australia to build partnerships with those responsible for town and regional planning, encouraging the co- or proximal location of the range of services accessed by those with complex health and social issues and identifying associated transport requirements.

Funding: Governments at all levels continue work on effective funding models that encourage a range of services to work towards common goals that are in the interests of people with complex health needs (including mental health and drug issues) and to the inclusion of these people as part of their local communities.

Case management: Increase resources and training support for management and staff in both health and social service settings in the planning and delivery of contemporary joint, evidence-based case management systems.

Rules, regulations, protocols: Working in a partnership approach, governments, together with service providers and drug user organisations, review the current drug treatment service rules, regulations and protocols and simplify them to correspond with those applied in other sectors of the health treatment system.

Publicising service philosophies

R 8: Service providers improve the visibility and clarity of individual service philosophies, including the differences between different philosophies and the impact of these differences on those seeking treatment.

Suggested implementation strategies

All services providing treatment and support to people who use illicit drugs have an identified and publicly available philosophy statement.

The development, articulation and demonstrated application of both agency and program philosophies relevant to treatment of people who use illicit drugs be made a condition of government funding to the primary health care sector and drug and alcohol and related services.

Responding to diversity of need

R 9: Governments increase their investment in a range of diversified drug treatment services in order to meet the needs of different sub-population groups in the community.

Suggested strategy

A planned commitment in budget allocation to incrementally increase the funding available annually for planning and service delivery for drug treatment services suited to Aboriginal and Torres Strait Islander people, young people, women with children and people whose cultural and ethnic background may require specific approaches, specific locations for treatment or additional programs to mainstream services.

Improving 'on ramps' to treatment

R 10: Governments to promote partnership approaches to increase support to generalist health, social and community services in recognition of their role in assisting people who use illicit drugs to access and remain in treatment.

Suggested implementation strategies

Free up and fund positions in a range of services, specifically for work in the promotion of, and education about, drug treatment, and in the delivery of brief interventions and other evidence-based motivational interventions that may encourage entry into treatment.

Develop and fund a model (e.g. through the Council of Australian Governments) for the introduction of liaison workers within and across health and related services, with the aim of improving the pathways for access and retention in treatment for those who use illicit drugs. This model may usefully build on work in progress in Western Australia.

III: Recommendations for consumer involvement

Ensuring consumer participation

R 11: Governments at all levels ensure, as in mainstream health services, that consumer participation is included in service planning, delivery and evaluation.

Suggested implementation strategies

A consumer participation plan to form part of agency funding agreements.

A formal complaints mechanism to be included at the agency level as part of service agreements.

Integrating peer education into service delivery

R 12: Service providers include peer education and peer support as part of treatment service provision for people who use illicit drugs, noting the unique role these strategies provide in relation to access and retention in treatment for people who use illicit drugs.

Suggested implementation strategies

Development of a model for inclusion of peer workers and peer education in treatment service delivery, particularly in relation to treatment modality choices, referral processes, the practical experiences for drug users of different drug treatment modalities and in the provision of practical advice and support in negotiating and remaining in treatment.

Introduce peer workers as liaison officers to facilitate uptake and retention in treatment (i.e. in and between the range of health, financial, legal and other services that drug users may need to access during treatment).

Improving family support

R 13: Governments at all levels and service providers build on the relationships and strengths offered and recognise the needs of those families who seek to help family members through drug treatment.

Suggested implementation strategies

Governments work with professional organisations (e.g. the Australian Divisions of General Practice and the Chapter of Addictions Medicine) to promote family practice at the primary care level. This work will build on current models of family practice, acknowledging that a proportion of families will identify drug issues as part of their overall health needs.

Develop information for General Practitioners and other primary health care workers that promotes and provides examples of family-centred approaches to prevention and management of drug use, including pathways and referral processes for treatment, care and support within a family context.

Maintain and expand the number and the range of support groups and services for families and carers who are engaged in the treatment and lives of their drug using family members.

IV: Recommendations for workforce development

Reassessing the workforce

R 14: Within the broader definition of treatment described in Recommendation 1, Governments re-assess the composition of the drug treatment workforce, the range of skills required and those members of the workforce best placed to provide them.

Suggested implementation strategies

A needs-based and outcome focused national review of the drug treatment services workforce. (Recent reviews of the nursing profession may provide a useful framework for action).

Governments review and revise existing training programs that address drug treatment, ensuring that the levels of training and the competencies contained within them reflect the knowledge and skills mix required for an effective and holistic drug treatment workforce. This revision will require governments to work closely with professional bodies, training authorities and academic institutions and focus on maximising knowledge uptake and skills development in the use of holistic approaches when working with people who use illicit drugs.

Clarifying workforce roles and responsibilities in drug treatment

R 15: Service providers clarify and distinguish from each other the roles and responsibilities of different types and levels of practitioners responsible for drug treatment and service provision and ensure adequate training opportunities for each.

Suggested implementation strategies

Develop guidelines for practitioners, building on existing treatment guidelines, and detailing the roles and responsibilities and interrelationships between generalist primary health care practitioners (e.g. GPs), drug and alcohol service providers and a range of specialist services (e.g. those specialising in mental health, blood-borne infections, addictions, gastroenterology etc).

Investing in effective service management

R 16: Governments improve opportunities for training and ongoing staff development at the service management level.

Suggested implementation strategy

Increase funding at the program level for service management training and staff development, noting the need for upgrading skills and knowledge in the areas of service linkages, partnership approaches to service delivery and customer-centred service delivery.

Providing guidelines and referral protocols for case management of people with complex needs

R 17: Develop national guidelines, including referral protocols, for effective case management of people with complex needs, especially for those experiencing drug and alcohol and mental health problems.

Suggested implementation strategy

Develop guidelines and referral protocols that clarify and describe the roles, responsibilities, inter-relationships and optimal points for referral between each of the principal providers of health and allied care (e.g. differentiate but link the roles of general practitioners, general practitioners specialising in drug and alcohol, social workers, pharmacists, nurses working in general practice/nurses working in drug and alcohol services, specialist medical practitioners, community support services).

V: Recommendation for continued research

R 18: Government prioritise and allocate funding to the research of effective models of health service delivery for quality of life outcomes among those who use drugs illicitly.

Suggested implementation strategies

Develop benchmarks of care (similar to those in development for aged care) to correspond to quality of life outcomes.

Investigate and develop new funding models that focus on centralised funding (rather than multiple funding streams) and collaborative approaches focused on improved drug treatment outcomes.

Part 1:
Introduction

Chapter 1:
Background

This Chapter includes background on the study's rationale, its objectives and scope, the various arms of the study, the project terms and framework used in the study, and the social and political environmental context in which the study was undertaken.

1.1 Introduction

In recent years, there has been high level of government and public interest in treatment as a means of alleviating the individual and social problems associated with illicit drug use. Treatment was a key element of the Australian Government's 1997 National Illicit Drug Strategy, which comprises a range of measures aimed at reducing supply, demand and the harms associated with illicit drugs and the 1999 Illicit Drugs Diversion Initiative, which involves the diversion of non-violent illicit drug users from the criminal justice system into assessment with a view to treatment. Over the same period, State and Territory governments have increased funding for treatment, often in responses to recommendations from local drug summits involving legislators, key stakeholders and advocates.

However, it is widely acknowledged that only a proportion of estimated total population of people who use illicit drugs engage with treatment services (many do not seek treatment because they believe their use is non-problematic) and those in treatment at any one time are a minority of the estimated number of dependent users.

There is a growing body of evidence of the effectiveness of various illicit drugs treatment interventions and their relevance to Australian conditions. However, treatment can only be effective if users engage with service providers and actively participate in treatment. And, as this study will show, much more than effective clinical treatment is needed to engage and retain drug users in treatment.

1.1.1 Overall objectives of the study

The objectives of this research project were to:

- investigate barriers to illicit drug users accessing, utilising and remaining in treatment services;
- investigate factors which facilitate or act as incentives to illicit drug users accessing and remaining in treatment; and
- make recommendations regarding how the findings of these investigations might be addressed at both the policy and program levels.

There were, thus, two main components of the study:

- the investigation of barriers and incentives to treatment for people who use illicit drugs; and
- the development of recommendations regarding possible policy and program directions arising from the research findings.

1.1.2 Scope

The requirements for the project specified that the study would address barriers and incentives to a range of treatment services with a particular emphasis on opioid (e.g. heroin) and stimulant (e.g. amphetamines and cocaine) use. However, in recognition of the prevalence of polydrug use, the study also would take into account barriers and incentives to treatment for alcohol, cannabis and benzodiazepine use, where this is directly relevant to the primary drug of use (heroin, amphetamines, cocaine).

The study recognises that any examination of the barriers and incentives for people who use illicit drugs entering and remaining in treatment also needs to take into account a range of behavioural, social and cultural factors that:

- influence the wellbeing of illicit drug users;
- make it difficult for them to engage in treatment; and
- have implications for the provision of affordable, acceptable and culturally appropriate treatment.

The study also recognises that there are a number of groups with special needs whose individual circumstances and contexts influence their likelihood of accessing and remaining in treatment. While the study draws attention to the influence of such factors as polydrug use, existing comorbidities, age and gender, incarceration, culture and language background and indigenous status, it is beyond the scope of the study to investigate the impact of these factors in any great depth.

1.1.3 Terminology

1.1.3.1 Treatment interventions

The requirements for the project state that, for the purposes of the project, treatment services should be defined as 'any services that reduce or eliminate drug use'. This broad definition of treatment services encompasses the four main categories of treatment intervention identified by Gowing et al. in their *Evidence supporting treatment: the effectiveness of interventions for illicit drug use* (ANCD research paper No.3, 2001), which are examined in this study. Gowing et al.'s categories are: *making contact and engaging users, detoxification, pharmacological treatments* and *psychosocial treatments*.

According to their categorisation of treatment interventions:

- *Making contact and engaging users* refers to outreach interventions such as peer education, community outreach and needle and syringe programs that provide information about drug use and encourage behavioural change;
- *Detoxification* refers to the management of the process of withdrawal from chronic drug use. Withdrawal services include residential, home-based and outpatient services;
- *Pharmacological treatments* include symptom management (e.g. alleviation of withdrawal), substitution treatment (e.g. methadone maintenance) and treatments involving blocking and aversive agents (e.g. naltrexone);
- *Psychosocial treatments* include a range of psychosocial therapy approaches to support lifestyle adjustment and behavioural change and develop coping skills through individual and group counselling, residential rehabilitation and therapeutic communities.

Within the illicit drugs treatment literature, treatment usually refers to 'formal' or professional treatment provided by drug treatment modalities such as methadone maintenance, drug free outpatient counselling, therapeutic communities and medical detoxification. Walters (2000) defines 'formal intervention' as treatment received through an organisation such as medical, psychiatric, private and public rehabilitative and self-help channels, with the goal of relieving drug and alcohol problems. Assistance received through friends, family, and religious organisations do not constitute 'formal intervention' under this definition.

1.1.3.2 Project terms

The major project terms have been defined as follows:

Barrier: 'Anything that restrains or obstructs progress or access' (*Macquarie Encyclopedic Dictionary*, 1998)

Incentive: 'That which incites to action.' (*Macquarie Encyclopedic Dictionary*, 1998)

According to these definitions, barriers can be real or perceived, surmountable or insurmountable obstacles. Incentives can include motivators, provocations and positive reinforcers.

The term, 'substance misuse' is more problematic. In one sense, it can refer to a point on the continuum in individual patterns of drug use from occasional and recreational use, through frequent and problematic use to dependent use. This continuum is reflected in the use of the terms 'recreational use', 'misuse', 'abuse', 'addiction' and 'dependence' (Gowing et al, 2001 p.6).

The problem is, that in the literature, the term is used inconsistently. At times it is used as a trans-Atlantic or trans-Pacific transliteration of the American use of the term, 'substance abuse', which refers to a specific maladaptive pattern of substance use leading to significant impairment or distress as defined in the criteria for substance abuse in the widely used *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV (American Psychiatric Association, 1994*). However, in the United Kingdom drug strategy documents, 'drug misuse' is defined as the 'non-medical use of drugs that are intended for use in medical treatment, and the use of drugs that have no accepted medical purpose' (UK Government, 1994). Where the use of drugs is controlled by legislation, the term is synonymous with 'illicit drug use'. In practice, the term is used loosely in the examined literature to refer to illicit drug use at any point on the continuum of drug use.

For the study, the non-pejorative terms of 'illicit drug users' or 'people who use heroin, cocaine, or amphetamines', respectively, will be used, according to context. People who use illicit drugs and who are in treatment will be referred to simply as 'consumers' or 'clients' of treatment services, according to context.

1.1.4 Arms of the study

There were five arms of the study:

- ***A review of international and national literature*** on access, uptake and adherence to treatment by illicit drug users, which was undertaken to provide a summary of the evidence in relation to the aims of the study;

- ***A Drug User Survey*** of people who inject and non-injecting users of heroin, cocaine, amphetamines, recruited from three capital cities and two regional sites in three jurisdictions (New South Wales, Queensland and Western Australia) to:
  - examine barriers and incentives to treatment uptake and adherence to a range of available treatment options;
  - compare those people in treatment with those never in treatment and those in and out of treatment with respect to uptake and adherence to treatment;
  - assess the relationship between drug of choice and treatment uptake and adherence;
  - examine the relationship between geographical location and treatment uptake and adherence; and
  - investigate the impact of drug user networks and stage of drug career on uptake and adherence to treatment.
- ***Service Provider Interviews*** conducted with service providers in areas in which participants in the illicit drug users survey were recruited to ascertain their views on real and perceived barriers and incentives that prevent or facilitate illicit drug users negotiating current health systems and services.
- ***Key Informant Interviews*** conducted to
  - obtain views from both national and state-based informants on barriers and incentives to treatment for illicit drug users;
  - obtain information about the ways in which barriers and incentives relate to current and future national and state policies and programs; and
  - build on the information provided through the drug user survey and the service provider interviews.

Key informants included policy makers, researchers, clinicians and advocates with expertise and interest in national and state/territory drug strategies and treatment provision for illicit drug users.

- A one-day ***Negotiation Workshop*** (with participants representing both service provider and consumer interests) which was held to review and discuss the findings of the research arms of the study and to identify and discuss options for improved treatment service delivery for illicit drug users.

Details of the methodologies used in each of the arms of the study are outlined in the following Chapter (Chapter 2).

1.1.5 Framework

The model outlined in Box 1 was used throughout the study to examine the literature and interview data to identify various types of barriers and incentives. It is based on the health psychology and public health model of Winett, King & Altman (1989). By examining influences at four levels of influence: personal, interpersonal, organisational/institutional and social, the model provided a means of exploring a comprehensive yet coherent understanding of the problem.

Box 1.1: An outline of the model used to identify and explore various types of barriers and incentives to treatment

Level of analysis	Explanation of level	Relevant theories	Values	Specific aims of goals
Personal	This level of analysis is concerned with biological, cognitive and behavioural variables.	Psychobiology, social cognitive theory, health belief and communication models, behavioural analysis, social marketing	Health and illness primarily a result of personal lifestyle.	Individual change
Interpersonal	This level of analysis is concerned with the influence of peers, groups, families and other social factors.	Social support and network theory, communication theory, group dynamics, social marketing.	Health and illness is influenced by family, friends and other social groups.	Individual and group change
Organisational/ Institutional	This level of analysis emphasises influences at the organisational, public policy and institutional levels. Behavioural change is seen as highly influenced by settings, rules, organisational policy, and substance availability.	Organisational theory and environmental psychology. Public policy, political science, law, economic theory.	Health and illness is influenced by organisational factors and by the environment.	Organisational and program changes Legal, regulatory and policy changes.
Social	This level of analysis is concerned with influences at the social and community levels.	Social change theory, community organisational theory, social marketing, social etiology.	Health, illness and access to treatment is influenced by community norms.	Changes in community attitudes.

After Winett, King & Altman (1989)

1.2 Context

This Section provides context and necessary background to the issues considered in subsequent chapters of this report. Taken as a snapshot in July 2002 to coincide with the commencement of data collection for the illicit drug users survey, and *reflecting the prevailing situation at that time,* it includes estimates of the numbers of heroin, amphetamines and cocaine users in Australia; a brief description of the treatment service systems available in Australia for heroin, amphetamine and cocaine users; the numbers of heroin, amphetamine and cocaine clients of treatment service agencies, and brief comments on the impact of the 2001 'heroin drought' and the emergence of court diversion and drug court interventions. Reference is made to the situational context in the three states in which the illicit drug user survey and service provider interviews were conducted – New South Wales, Queensland and Western Australia – and to any salient metropolitan and non-metropolitan differences.

1.2.1 Prevalence of illicit drug use in Australia

Drawing on the results of the Australian Institute of Health and Welfare's *National Drug Strategy Household Survey* (1998). Higgins et al. (2000) reported that the prevalence of illicit drug use in the Australian population in the twelve months before the Survey as follows:

- marijuana was the most widely used illicit drug in Australia (reported by 17.9% of respondents);
- amphetamines were the second most widely used illicit substances (reported by 3.6% of respondents), followed by the use of:
- ecstasy/designer drugs (2.4% of respondents).
- cocaine (1.4% of respondents); and
- heroin (0.7% of respondents).

Drawing on the same survey data to investigate illicit drug use in regional Australia, Williams (2001) reported that the use of illicit drugs increased in regional Australia over the previous decade by 77% for heroin, 131% for amphetamines, 37% for cocaine and 47% for cannabis. Williams noted that, while the 1998 non-metropolitan levels were lower than in metropolitan Australia, they approximate rates observed in the cities a few years ago.

The major findings or the 2000 *Illicit Drug Reporting System (IDRS*) on Australian trends were as follows (Topp et al., 2001):

- heroin use increased in most Australian jurisdictions in 2000, as did fatal opioid overdoses. The price of a gram of heroin decreased in NSW for the third successive year. Heroin remained relatively available in all Australian jurisdictions except for Tasmania and the Northern Territory. Increases in the frequency and quantity of use among existing heroin users were reported in NSW, South Australia, Victoria and the ACT;

- amphetamine use increased in most Australian jurisdictions and remained relatively available in all jurisdictions except Victoria, where reports were mixed. The availability and use of more potent forms of methamphetamine increased in all jurisdictions;
- cocaine use remained uncommon in all jurisdictions except NSW (confined mainly to particular post code areas of metropolitan Sydney), where its use increased in late 1998 but then stabilized; and
- cannabis, readily available in all jurisdictions, remained by far the most widely used illicit drug in Australia.

1.2.2 Estimates of the number of heroin dependent users in Australia

Hall et al. (2000) used three methods to estimate the number of heroin dependent persons in Australia. Estimates varied between 67,000 and 92,000, with a median of 74,000 as the best estimate. This estimate represented a 25% increase since their earlier 1988-1993 estimates and an increase in the rate of heroin dependence from 3.7 per 1,000 in 1984-7 and 5.9 per 1,000 in 1988-93 to 6.9 per 1,000 in 1997.

The authors suggest that crude estimates of the number of heroin-dependent people in each of the Australian states and territories can be derived by allocating estimate for Australia as a whole to each jurisdiction according the proportion of overdose deaths in those jurisdictions (during the period, 1994-1998). On this basis, NSW in 2000 would have an estimated 35,400 heroin dependent persons, just under half (48%) of the national estimate. Victoria would have an estimated 19,600 (27%) heroin dependent people and the remaining states/territories would have 19,000 (25% of the national estimate).

Hall et al (2000) attribute the increase in the number of heroin dependent users to the increased availability of heroin in the past two decades, which may also have led to an increase in new users beginning heroin use via non-injecting routes and an increase amongst younger users who have psychosocial disorders. They suggest that the number of heroin dependent people in Australia is of the same order of magnitude as in Britain and other European societies.

1.2.3 Treatment services available in Australia for heroin, amphetamine and cocaine users

There is no published treatment services map covering the treatment services available throughout Australia for problematic heroin, amphetamine and cocaine users. The range of services differs from jurisdiction to jurisdiction and reflects both state/territory government policy emphasis and the way in which services have traditionally been provided locally by government, non-government and the private sectors.

In 2002, methadone was the main pharmacological treatment prescribed for heroin dependent users in all Australian states and territories, except the Northern Territory. The introduction of naltrexone maintenance treatment in Western Australia increased the options for heroin dependent users but the actual delivery of naltrexone treatment services in that state in 2002 was the subject of widespread public debate. Buprenorphine was being used with selected patients included in a national trial undertaken in conjunction with Turning Point Alcohol & Drug Centre, Victoria.

There is a lack of consensus, internationally and nationally, regarding effective pharmacological treatment for psychostimulant (amphetamine and cocaine) users (Gowing et al., 2001). The only available treatments in Australia in 2002 for amphetamine and cocaine users were non-pharmacological (e.g. cognitive behavioural therapy) or abstinence-based 12 step approaches, and not specific to those drugs.

Each of the states surveyed in this study had a range of residential, home-based and outpatient detoxification services. Typically, about 80% of these services were in metropolitan areas. Residential rehabilitation services, including abstinence based and therapeutic community based services, were provided predominantly by the non-government and charity sectors.

In 2002, drug user organisations and a wide range of non-government organisations (e.g. Needle and Syringe Programs, drop in centers, community outreach services), were involved in a range of outreach interventions aimed at making contact and engaging users. While treatment referral was not their primary role, they did play a role as 'on ramps' to treatment by providing referral and advice and, in some cases, providing 'off ramp' relapse prevention services. In NSW, the Government agreed to support an 18-month trial of a medically supervised injecting room in one Sydney site. The trial commenced in 2001.

1.2.4 Clients in treatment services

The May 2001 census findings of the *Clients Of Treatment Service Agencies (COTSA)* national survey (Shand & Mattick, 2001) found that the 507 agencies responding to the survey provided some form of treatment for drug and alcohol problems for a total of 5,304 clients on the day of the census. Over 40% of clients were seen in New South Wales service agencies, which was the state with the largest number of agencies, followed by Queensland, Victoria and Western Australia.

The services provided by these agencies in Australia as a whole and by the states involved in this study on the census day are shown in Table 1.1. As with previous censuses, non-residential (outpatient) services were more utilised than residential services (n=3,403: n=2,376). The outpatient service most used was counselling (n=1,842) while inpatient rehabilitation or therapeutic community services were received most by clients in a residential setting.

Table 1.1 Services utilized by clients by state/territory, May 2001

Service				
Non-residential	**NSW**	**Qld**	**WA**	**Total Australia**
Assessment and referral	162	129	83	589
Outpatient counselling	564	287	292	1,842
Methadone and counselling	248	39	17	404
Outpatient detoxification	58	15	13	135
Other non-residential services	177	60	53	433
TOTAL				**3,403**
Residential				
Rapid detoxification	10	1	0	14
Inpatient detoxification	164	24	15	346
Inpatient rehabilitation or therapeutic community	897	387	186	1,932
Other residential services	15	11	11	84
TOTAL				**2,376**

Source: Shand & Mattick, 2001

As the authors point out, the actual number of clients being treated on an outpatient basis could be five to ten times the number being treated on the census day (depending on the client's outpatient visits to the agency). By adding the number of methadone clients in Australia (only those who receive services like counselling in addition to receiving methadone are included in the census) and the clients seen by residential services, the total number of clients receiving face to face treatment at any one time ranged from 51,386 to 68,401 (Shand & Mattick, 2001). Even so, this estimate does not include clients seen by a GP, as GPs do not participate in the census.

1.2.4.1 Principal drug problems of clients in treatment services

The client's principal drug problems nominated by COTSA agencies are shown in Table 1.2. The figures include all nominated drug problems (i.e. for some clients more than one problem was nominated).

Table 1.2 Principal drug problem of clients of treatment services, 2001

Drug Problem	Percentage of substance users (n=4,953)
Alcohol	35.1%
Opiates	32.0%
Opiates/poly drug	7.1%
Amphetamines	8.3%
Amphetamine related substances	0.5%
Other drugs (e.g. incl. cocaine)	1.4%

The first report on the National Minimum Data Set (NMDS AIHW, 2002) reported that, during 2000-2001, reporting services registered a total of 83,529 clients for treatment. Over a third (34%) were self-referred. Alcohol was the most common drug of concern for clients (34%), followed by heroin (28%), cannabis (14%) and amphetamines (9%). The NMDS first report, however, does not include Queensland data, which was unavailable at the time.

1.2.4.2 Principal drug problems for non-metropolitan clients of treatment services

According to the COTSA census findings, non-metropolitan users accounted for 26.3% of alcohol and other drug users for whom a postcode was recorded. This is roughly equal to the percentage of the Australian population who live in non-metropolitan areas (27.4%), based on 1996 population figures (Shand & Mattick, (2001), p.22). They were more likely to present with alcohol, cannabis and polydrug use that excluded opiates problems and less likely to present with opiate, amphetamines and polydrug use that included opiates than their metropolitan counterparts.

1.2.5 Clients participating in methadone maintenance treatment programs

Data on clients participating in methadone maintenance programs provided by state health departments is shown in Table 1.3 (the figures on the breakdown between private and public sectors should be treated with caution as classifications vary from jurisdiction to jurisdiction).

Table 1.3 Number of methadone clients by state in April/May 2001

State	Public sector	Private sector	Prison program	Total
NSW	2,978	10,473	1,514	14,965
Qld	3,302	564		3,866
WA	683	1,512		2,195
Other states/territories	1,286	9,870	397	10,969
Total	**8,249**	**22,419**	**1,911**	**31,995**

Source: Shand & Mattick, (2001) p.10.

As can be seen from the table, NSW in 2001 had 46.8% of the total number of methadone clients in Australia and NSW, Qld and WA (the states in which this study was conducted) accounted for 65.4% of the total.

By adding the number of substance user clients of treatment services whose main problem was opiates (n=1,591) or polydrug including opiates (n=351) to the number of clients participating in methadone maintenance programs (n=31,995), it is possible to arrive at an estimate of the total number of people being treated for opioid problems on the day of the census. This figure, however, represents less than half (45.7%) of Hall et al.'s estimated number of heroin dependent people in Australia (as discussed in Section 1.2.2 above).

1.2.6 Recent changes in national and state drug strategies

1.2.6.1 National drug strategy

T*he National Drug Strategy* currently forms the basis of Australia's approach to drug problems. While maintaining the principles of previous phases of the National Drug Strategy (e.g. harm minimisation, evidence base, partnerships), it outlined a number of measures specifically aimed at reducing both the demand and supply of illicit drugs.

The National Illicit Drug Strategy launched by the Prime Minister in November 1997, focused on the interception of illicit drugs, while at the same time supporting prevention and treatment measures, training, skills development and research.

Since its launch, the Australian Government has allocated more than $1 billion to the Strategy for a range of supply reduction, demand reduction and harm reduction measures. Treatment related activities included:

- the National Evaluation of Pharmacotherapies for Opioid Dependence (NEPOD) project, which evaluated 13 treatment outcome studies with a total of 1500 participants. The evaluated pharmacotherapies included buprenorphine, methadone, LAAM and naltrexone;
- Funding to continue the Non Government Organisation Treatment Grants Programme, and ensure that treatment resources reach those who need them, and for a range of specific new treatment and prevention services;
- funding a range of research activities, such as:
  - Monitoring, evaluation and dissemination of the outcomes of alternative treatment trials;
  - Dissemination of best practice in treatment of illicit drug dependence
  - Enhanced activities in evaluation, quality assurance and outcome monitoring; and
  - The Training of front line workers initiative.

1.2.6.2 State Drug Summits

Each of the Australian states participating in this survey held a local drug summit within three years before the fieldwork commenced in July 2002:

- The May 1999 NSW Drug Summit put forward over 170 recommendations for future action, many of which focused on treatment issues. Following the Summit, the NSW Government allocated more than $120 million over four years to enhance the range, quality and availability of drug treatment services in NSW;
- The 1999 Queensland Drug Summit focused on youth issues and led to a commitment to ongoing consultation with young people about what constitutes effective drug strategies and service. In 1999, the *'Beyond a Quick Fix – Queensland Drug Strategic Framework, 1999/2000 – 2003/04* was launched to provide a means to develop cooperative approaches on a range of issues relating to 'harmful' drug use and a Second Youth Drug Summit was held in October 2001;

- The Western Australian Community Drug Summit was held in June 2001. The Summit produced a number of recommendations on the treatment of drug users and their integration in the community. These included the development of current services, with particular attention on meeting the needs of Aboriginal, CALD people, people with disabilities and rural, regional and remote people, meeting gaps in the existing network, continuous improvement of specialist alcohol and drug agencies, broadening service provision and cultural change.

1.2.7. Key issues impacting on the illicit drug use patterns in Australia in 2001

1.2.7.1 The 'heroin drought'

Around December 2000 a sudden change was noted in the drug market in Australia signifying the beginning of a period that become known as the 'heroin drought'. Heroin availability decreased substantially and its price and purity increased (Weatherburn et al, 2003). This change in the heroin market was sustained throughout 2001 in all jurisdictions in Australia where heroin had previously been relatively easy to obtain (Day et al, 2003).

Data from the Illicit Drug Reporting System for NSW for the first five months of 2001 revealed that 'since 2000, there has been a dramatic increase in the proportion of subjects reporting cocaine as their drug of choice, and a corresponding decline in the proportion nominating heroin as their drug of choice.' (Darke et al 2001). The authors attribute this change to the effects of a recent 'heroin drought'. They report that the proportion of respondents nominating heroin as their drug of choice decreased from 81% in 2000 to 61% in 2001 and the number of days using heroin also declined. Conversely, the use of cocaine increased: in 2000, 10% of respondents reported cocaine as their drug of choice, compared to 29% in 2001. Those reporting recent cocaine use also increased from 63% to 84%. Cocaine powder remained the predominant form of cocaine in NSW. The use of amphetamines also appeared to have increased amongst illicit drug users, particularly throughout 2001 in New South Wales (Darke et al 2001), with a continued trend towards the highly potent forms of methamphetamine. The proportion of substance users who used methamphetamine in the preceding six months increased from 40% in 2000 to 51% in 2001.

1.2.7.2 Court diversion and drug courts

There has been substantial interest in the diversion of drug-related offenders from the criminal justice system in recent years within Australia. The first Australian drug court was established in Sydney but have since been adopted in Queensland, Western Australia, South Australia and Victoria. The essential features of a drug court are a court dealing with a specific class of offenders, integration of drug-treatment services within a criminal case processing system, early intervention, the use of a non-adversarial approach, the dominant and continuing role of the drug court judge, frequent substance use testing, frequent contacts with the court, a comprehensive treatment and supervision program and a system of graduated awards and sanctions. (Frieberg, 2000).

Criminal justice system diversion schemes include the NSW Adult Drug Court, NSW Youth Drug Court, the NSW MERIT scheme (magistrate-based), Victorian CREDIT scheme, and Drug Courts established in Queensland, Western Australia, South Australia, and Victoria (Frieberg, 2000).

1.2.7.3 Family support groups

Family drug support groups consolidated their efforts in 2001. Family Drug Support (FDS) had become an established telephone support, information and referral service, which provided volunteer support for families and friends of drug users. Together with Families and Friends for Drug Law Reform (FFDLR) it organised the November 2000 'National Families and Community Conference on Drugs 'Voices to be Heard' in Sydney.

Chapter 2:
Methods

This Chapter outlines the methods used in respect of each of the five arms of the study:

- the literature review;
- the survey of illicit drug users;
- the service provider interviews;
- the key informant interviews; and
- the one-day 'negotiation workshop'.

2.1 Literature Review

2.1.1 Aim

The aim of the literature review was to summarise the published and unpublished evidence in relation to its terms of reference, which were to examine the international and national literature on barriers and incentives to treatment for illicit drug users, with particular regard to people dependent on heroin, cocaine and amphetamines in relation to:

- access, uptake and adherence in treatment for opioid and stimulant use;
- barriers to users of heroin, cocaine and amphetamines accessing, utilising and remaining in treatment; and
- social determinants of health and wellbeing (including physical, behavioural and social factors), which facilitate or act as barriers to people who use illicit drugs accessing and remaining in treatment.

2.1.2 Literature search

A number of methods were used to access literature relevant to the project:

- an initial literature search was undertaken for the years 1990 – 2001 by the Alcohol and Other Drugs Council of Australia (ADCA) of its electronic databases using treatment-orientated key search terms, such as illicit drugs and barriers to treatment, illicit drugs and incentives to treatment, drug abuse and treatment, drug misuse and treatment, substance abuse and treatment, addiction treatments, methadone maintenance, detoxification, therapeutic communities, drug use and help-seeking. Searches on each illicit substance category (e.g. heroin, cocaine, and amphetamines) with the term 'treatment') were also performed;
- these searches were supplemented by scanning the reference lists of the journal articles so identified for other relevant articles and published sources;

- websites of both Australian and international drug and alcohol research centers and departments of health were examined for current projects and reports relevant to the project topic, for example, the National Institute on Drug Abuse, USA, the National Drug and Alcohol Research Centre, the Australian Institute of Criminology and the Australian Government Department of Health and Ageing websites;
- researchers working in the field were contacted directly regarding any unpublished reports or work in progress;
- a request for information on the project topic was sent out on '*UPDATE',* an electronic mailroom for people working in the alcohol and other drugs field throughout Australia.

Approximately 200 articles and publications were found by these means.

The literature identified included analyses of general population surveys and national data sets, longitudinal studies, comparative studies of treated and untreated users, literature reviews, clinical studies, program-based evaluation studies, and a large number of individual studies. Given the main purpose of the review, which was to summarise the existing literature relevant to the project, review articles were relied upon whenever possible.

2.2 Illicit Drug Users Survey

2.2.1 Overview

A cross-sectional survey was conducted of illicit drug users in six sites in Australia. The overall sample was structured as shown in Table 2.1. Two main axes for recruitment were used:

1. Treatment status, comprising three groups:
   a. The 'in treatment' sample
   b. The 'not in treatment' sample
      i. Those not currently in treatment but who have been in treatment previously ('in-out')
      ii. Those 'never in treatment'
2. Drug of choice, comprising two groups
   a. Opioid users
   b. Psychostimulant users

For those 'in treatment', four treatment modalities were of interest, including:

- pharmacotherapies;
- detoxification;
- residential rehabilitation; and
- counselling

Table 2.1 Overall sample structure

	Drug of Choice			Drug of Choice	
Treatment	**Opioid**	**Stimulant**	**Not in Treatment**	**Opioid**	**Stimulant**
Residential rehabilitation			In and out of treatment (not in last 6 months)		
Detoxification			Never been in treatment		
Pharmacotherapies					
Counselling					

2.2.2 Questionnaire design

The questionnaire was developed, based on an extensive review of the drug treatment literature and existing national and international drug treatment questionnaires, and in consultation with the project's advisory and project management committees. Two quantitative questionnaires were devised: one for the 'not in treatment' sample and one for the 'in treatment' sample. Both questionnaires addressed a range of complex issues around barriers and incentives to drug treatment uptake. The 'in treatment' and 'not in treatment' questionnaires differed largely in the order and phrasing of questions. Both questionnaires focused on (1) demographics, (2) drug use history and networks, (3) health and social wellbeing, (4) past help seeking, treatment history and current treatment experiences, (5) problems or barriers to treatment and (6) experiences of, and attitudes towards, drug treatment and health care.

The summary measures and scales used in analyses are presented in relevant sections of the results in Chapter 4.

2.2.3 Pilot study

A final draft version of the questionnaire was administered to 30 participants, 22 in an urban and 8 in a rural setting in New South Wales (NSW). The questionnaire was then modified, based on problems identified during the piloting of the tool. Ambiguous items were identified and removed and the questionnaire was shortened.

2.2.4 Participants

Participants were recruited according to a number of behavioural and social variables. These included:

- age: participants were 18 years of age or older;
- current treatment status: comprising 'in treatment' participants and those 'not in treatment'. 'In treatment' refers to those who are currently in treatment or have completed a treatment program in the last six months, while the 'not in treatment' group consists of people who have been in and out of treatment in the past (their last treatment being more than six months previously) as well as those who have never been in treatment;

- geographic location – in order to encompass different patterns of drug use across different states in Australia and to compare urban and rural drug user practices;
- drug of choice – the study focused on people who use opioids and psychostimulants and compared differences in access to and availability of treatment and in their experiences of drug treatment;
- stage in drug use career – to compare differences in experiences of treatment depending on an individual's stage of drug use;
- type of treatment: participants in four categories of treatment were recruited (1) residential and non-residential detoxification, (2) pharmacotherapies (e.g. methadone, buprenorphine and naltrexone), (3) formal rehabilitation (in-patient residential treatment and outpatient services) and, (4) counselling facilities. These categories applied to those participants currently in treatment (within the last six months) and the most recent treatment of those who have been in and out of treatment. Sampling was designed to recruit participants who were in only one of these treatments. For example, clients enrolled in both pharmacotherapy and counselling treatments would not have been eligible for participation.

Participation was not restricted to people who inject, although, for the majority of the sample, injecting was the primary route of administration. Every effort was made to obtain an similar numbers of people who used opioids and stimulants to include a similar amount of participants in each of the treatment categories, and to have a similar number of participants in the 'in treatment' and 'not in treatment' groups as well as in the two different 'not in treatment' groups. Attempts were also made to ensure a ratio of at least 2:1 male to female participants in line with results of previous Australian studies of drug treatment and non-treatment samples (Dietze et al., 2003; MacDonald & Zhou, 2002).

2.2.5 Recruitment

Participants were recruited from New South Wales (NSW), Queensland (QLD) and Western Australia (WA) in six different geographical locations including four urban areas and two rural/regional sites. In NSW, two urban and one rural sites were chosen. In QLD, one urban and one regional site and, in WA, one urban site was chosen. In the QLD urban site the aim was to recruit 150 illicit drug users. The NSW sample was enlarged from 150 to approximately 230 with the receipt of additional funding from the NSW state health department. In the regional QLD, rural NSW and urban WA sites, around 100 illicit drug users were to be recruited. Within each geographical location, the criteria for inclusion into the study were based on the participant's primary drug of choice and treatment status within the last six months. The following sample frame was used as the target in terms of recruitment for each site. Table 2.2 and Table 2.3 depict the breakdowns in terms of the larger two urban sites in NSW and QLD and Table 2.4 outlines the sample in the rural/regional sites in NSW and QLD and the smaller urban site in WA.

Table 2.2 Target sample in urban NSW sites (target N=220-230)

	Drug of Choice			Drug of Choice	
In Treatment (n=115)	**Opioid**	**Stimulant**	**Not in Treatment (n=115)**	**Opioid**	**Stimulant**
Residential rehab.	15	15	In and out of treatment (not in last 6 months)	27	27
Detoxification	15	15	Never been in treatment	27	27
Pharmacotherapies	20				
Counselling	15	15			
TOTAL	**65**	**45**		**54**	**54**

Table 2.3 Target sample in urban Queensland sites (target N= 150-160)

	Drug of Choice			Drug of Choice	
In Treatment (n=80)	**Opioid**	**Stimulant**	**Not in Treatment (n=80)**	**Opioid**	**Stimulant**
Residential rehabilitation	10	10	In and out of treatment (not in last 6 months)	20	20
Detoxification	10	10	Never been in treatment	20	20
Pharmacotherapies	20				
Counselling	10	10			
TOTAL	**40**	**40**		**40**	**40**

Table 2.4 Target sample for Rural NSW, Regional Queensland, Urban WA (n=100 in each site)

	Drug of Choice			Drug of Choice	
In Treatment (n=80)	**Opioid**	**Stimulant**	**Not in Treatment (n=80)**	**Opioid**	**Stimulant**
Residential rehab.	6	6	In and out of treatment (not in last 6 months)	12	12
Detoxification	6	6	Never been in treatment	12	12
Pharmacotherapies	12				
Counselling	6	6			
TOTAL	**24**	**24**		**24**	**24**

2.2.5.1 Recruitment in Inner Sydney (urban)

Given the complexity of the sample breakdown, it was felt that the data collection should focus on two central and closely related area health services in Sydney. Central and South Eastern Sydney were chosen as primary sites to recruit illicit drug users. Approval was obtained from both area health services and from the Human Research Ethics Committee at the University of New South Wales.

A list of drug treatment services and needle and syringe exchange programs (NSPs) available in Central and South Eastern Sydney was obtained from the NSW Health website. This list was extensive and, in consultation with the Australian Injecting and Illicit Drug Users League (AIVL), the New South Wales Users and AIDS

Association (NUAA) and the Project Management Committee, a decision was made about which services to target as key recruitment sites. Sites were chosen, based on the type of client group who accessed the services (primarily opiate and psychostimulant users rather than other substance users),and whether the service was well known and well frequented by clients. Contact was then made with managers of these key services, who were informed of the project and their participation in recruitment for the study requested. Four detoxification facilities, three residential rehabilitation services, two clinics offering methadone or buprenorphine and two counselling services were chosen (see Appendix B for list of services). To recruit the 'in treatment' sample, fliers advertising the study were placed in services, either with a telephone number for those interested to contact or advertising a date and time that interviewers would be present at the service. In recruiting the 'not in treatment' sample, an advertisement outlining the study with a contact number was placed in the local drug user organisation magazine. 'Not in treatment' participants were also recruited through two central and well-frequented NSPs.

Two peer interviewers and the AIVL project liaison worker were trained to conduct interviews. A peer interviewer manual, based on the peer worker manual used in the Vietnamese Harm Reduction Study conducted by the Macfarlane Burnet Centre for Medical Research and Western Region AIDS Prevention, was modified for this study by the AIVL project liaison worker. Peer interviewers were also instructed to recruit participants through their peer networks. The three peer interviewers and one researcher conducted interviews. Participants were interviewed either in the NSP or the treatment facility (especially those in residential rehabilitation or residential detoxification), or at a coffee shop near to the service agency.

2.2.5.2 Recruitment in Outer Sydney (urban)

Towards the end of the original Sydney data collection phase, additional funding was obtained from NSWHealth to increase the Sydney sample by approximately 80 participants. Apart from collecting more data in the Central and South Eastern Sydney Areas, this additional funding allowed the research team to increase the diversity of the Sydney sample and collect data in a different geographical location. The Wentworth Area was chosen and an ethics application submitted to the relevant area health service. Contact was made with services in this area, managers informed of the study and the participation of the service in recruitment requested. A decision was made to focus only on counselling, residential rehabilitation and detoxification treatments and to omit pharmacotherapies. One of each of these services was targeted in this area. (Pharmacotherapy participants had been over-sampled in the other sites).

A peer interviewer from the area was trained to conduct interviews. Her brief was to focus on the 'not in treatment' sample through her personal networks and by recruiting through the mobile primary and fixed site secondary NSPs in the area. The AIVL liaison project worker worked alongside the peer interviewer to collect 'not in treatment' data. Two peer interviewers who had already collected the 'in treatment' data in the rural NSW site were asked to continue their work in the Wentworth Area. Hence, they were familiar with the process of approaching treatment facilities, advertising the study through fliers and arranging access to the treatment population.

2.2.5.3 Recruitment in Rural NSW

The rural NSW site was chosen, based on the size of the population, the availability of drug and alcohol treatment services and NSPs, and the enthusiasm of services and organisations to be involved in the research. Approval was obtained for the study from the relevant Area Health Service. The Coordinator of the Alcohol and Other Drugs Program in the area provided a list of drug treatment agencies in the area. The key services providing pharmacotherapies, detoxification, counselling and residential rehabilitation were contacted and informed of the study. All sites were visited by researchers prior to commencement of the study. Recruitment was simplified, due to there being only one detoxification facility (residential) and one residential rehabilitation in this area. People on pharmacotherapies were recruited from three methadone clinics in three separate towns (two larger and one smaller one) within the Area Health Service. The 'not in treatment' participants were recruited through NSPs in various sites throughout the area.

Two peer interviewers from the area and five people working in the local NSPs were trained to conduct interviews. The peer interviewers were primarily responsible for the 'in treatment' sample and the NSP workers for the 'not in treatment' sample. On-going contact with the interviewers and monitoring of the data collection occurred regularly. Initially, weekly visits were held with peer interviewers and then weekly teleconferences. Teleconferences were also conducted weekly with the NSP workers. During meetings and teleconferences with both sets of interviewers, feedback was provided about the questionnaire administration and completion, and interviewers were afforded the opportunity to raise issues around data collection. Difficulties were encountered in obtaining the required number of 'not in treatment' participants and the peer recruiter used personal networks to recruit additional participants. Unfortunately, despite adopting numerous different strategies, difficulties were encountered in recruiting participants in counselling. Hence there were only two people in counselling recruited from this area.

2.2.5.4 Recruitment in Brisbane (urban)

Given the large sample required in Brisbane and the difficulty in coordinating it from afar, the Queensland Drug and Alcohol Research Centre (QADREC) was approached to coordinate the study. A Queensland Directory of Drug and Alcohol Agencies, 2000-2001, was obtained from the Alcohol and Drug Foundation. In consultation with AIVL, the Project Management Committee, the Queensland drug user organisation, DUNES, and various key services providers, services were selected to be targeted as key recruitment sites. Contact was made with these services and managers were visited by researchers and informed of the study. Ethics approval for the project was obtained from the University of Queensland and from site-specific ethics committees.

Nine interviewers, comprising two peers and seven others who worked in the local drug user organisation or in drug and alcohol and related fields were chosen by QADREC. These interviewers had worked on previous projects for QADREC and were familiar with the population and service organisations. Staff from the NCHSR trained interviewers. A research officer at QADREC coordinated the project. Weekly teleconferences were held with the coordinator in order to monitor the data collection, and address, obtain feedback and address any problems.

The 'in treatment' sample was recruited through two residential rehabilitation facilities, two detoxification facilities and two opioid pharmacotherapy services. In this area, counselling participants were recruited through a range of facilities, NSPs, the drug user organisation and through peer networks. Two drug user organisations and two well-known NSPs were used as target sites for the 'not in treatment' group.

For both the 'in treatment' and 'not in treatment' samples, individuals were approached at various services regarding participation in the study. Fliers were placed in some facilities describing the study and requesting participation. Staff also informed service users that the study was occurring and, if they wanted to participate, they could see the interviewer, who was present at the service on particular days. At the two residential rehabilitation services, prospective participants were approached by staff regarding their willingness to take part in the study. Participants were also recruited through the personal networks of peer interviewers and through using snowballing techniques. Interviews either took place at the treatment service, at the NSPs or at the local drug user organisation.

2.2.5.5 Recruitment in Regional Queensland

The regional site in Queensland was chosen, based on the size of the population, availability of drug and alcohol treatment and NSP services, which could provide recruitment sites and support for the project from the major regional drug and alcohol service organisation. Approval for the study was sought through the relevant ethics committee office. The regional Alcohol, Tobacco and Other Drug Office (ATODS) provided a list of services in the area. Service managers or key personnel were contacted, visited and informed of the study. Treatment service and NSP staff were also invited to a meeting in which a presentation of the study was provided. Their participation in assisting recruitment was requested.

Five interviewers comprising both peer and non-peers were trained to conduct interviews. One person was appointed to coordinate the data collection so as to ensure that approximately the correct number of participants was obtained in each category. Weekly teleconferences were held with the interviewers in order to monitor the sample, to provide input on questionnaire administration and completion and to generally obtain feedback from the interviewers about the data collection process. Interviewers recruited the 'in treatment' sample through one detoxification facility, one residential rehabilitation facility, two methadone clinics and one counselling service. The 'not in treatment' sample was recruited through NSPs, youth specific services, a police remand centre, fliers in key nightclubs and an advertisement placed in a free newspaper circulated in nightspots in the area.

A difficulty was encountered at this site in recruiting people in residential rehabilitation. In this area, there is only a very small residential rehabilitation service consisting of two beds (due to be expanded to a twenty bed facility in 2003). Hence, a limited number of people were recruited from residential rehabilitation in this area (n=3). Additionally, the detoxification facility was male only and, therefore, the detoxification sub-sample from this area did not contain any females.

2.2.5.6 Recruitment in Perth (urban)

The Western Australian Substance Users Association (WASUA) was approached to coordinate the study in Perth. A list of treatment facilities was obtained, which contained contacts for both government and non-government organisations. The peak non-government drug and alcohol organisation in WA invited all NGOs to attend a presentation by the NCHSR to inform them of the study. A similar presentation was conducted at the government agency coordinating drug and alcohol services in Perth. Managers in key services were also contacted individually, briefed about the study and their participation in recruitment requested. Site-specific ethics clearance was obtained for the study.

WASUA recruited four peer interviewers to be involved in the process of data collection, and one peer interviewer was selected to coordinate the complex recruitment and data monitoring. Interviewers were trained to conduct interviews by NCHSR staff. Recruitment in Perth for the 'not in treatment' sample occurred through personal networks of the peer interviewers, as well as at NSPs and through WASUA. Treatment facilities were contacted by the project coordinator in Perth, and visits to conduct interviews scheduled. Fliers were sent to treatment services and NSPs, advertising the study and outlining the relevant criteria for entry into the study.

One detoxification facility and three residential rehabilitation facilities were used to recruit these target groups. Although numerous counselling agencies were approached, participants in counselling were obtained through the personal networks of the peer interviewers, as were those in pharmacotherapy programs. The 'not in treatment' sample was also recruited through peer interviewer networks.

Weekly teleconferences were held with the interviewers in order to monitor the sample, to provide input on questionnaire administration and completion, and to generally obtain feedback from the interviewers about the data collection process.

2.2.6 Procedure

Participants were interviewed at the treatment facility (especially if they were in-patient treatments), at coffee shops near to the treatment service, at NSPs or at the local drug user organisation. For appointments made by telephone in response to advertising, interviews were conducted in areas frequented by illicit drug users so that both the interviewer and the interviewee would be familiar with the meeting place. Respondents were informed that participation in the study was voluntary and all information obtained was confidential. An information sheet about the study was given to participants to read prior to the administration of the questionnaire. Important points from the information sheet were reiterated to participants by the interviewer, especially in cases where there was concern about the literacy level of participants. All participants were also informed that they could terminate the interview at any time.

The questionnaire was interviewer administered. Interviews lasted approximately 45 minutes to 1 hour. Participants were reimbursed AUD$20 as an acknowledgement of their time and costs.

2.2.7 Interviewers

At each site, a combination of peer interviewers and researchers were used to administer the questionnaire. Face-to-face training was provided to ensure that peer interviewers felt confident in conducting interviews, and that interviewing procedures and techniques were kept standard. As the NCHSR is based in Sydney, one person at each of the other sites was chosen to coordinate the research. On-going monitoring through weekly meetings or teleconferences with the site coordinator and/or interviewers was conducted at all sites.

2.2.8 Statistical analysis of questionnaire data

Data from the questionnaire were subjected to contingency table analysis (χ^2) for individual variables and to multiple logistic regression analysis in order to identify those variables which were independently associated with the dependent variables of interest.

Missing values were excluded when analysing both contingency tables and in multivariate analyses. Where required, multiple comparisons were carried out using the Bonferroni argument[3].

In the multivariate analyses, model reduction was done using a form of backwards elimination, which considered variables in families, using a hierarchical model. A family-wise type-I error rate of 0.10 was used to decide on elimination of the family, and a type-I error rate of 0.05 was used for elimination of individual variables.

2.3 Service Provider Interviews

2.3.1 Aim

Interviews with service providers were conducted to ascertain their views on real and perceived barriers and incentives that prevent or facilitate illicit drugs users accessing or remaining in treatment.

2.3.2 Sampling rationale

Services were selected to reflect the sampling used for illicit drug users' survey – and tailored to suit each location. The five main categories of services sampled were:

- residential rehabilitation;
- detoxification;
- pharmacotherapy;
- counselling; and
- outreach services making contact with users and involved in treatment advice and referral (e.g. NSPs, youth outreach, drug user organisations).

3 The Bonferroni argument is a method for deciding whether the result of a statistical test is significant (in the statistical sense) taking into account the number of such tests which are relevant. It is applied in this study, for example, when there is a finding that the three groups being compared are significantly different, and then subsequently three supplementary tests (examining each pair of differences) need to be carried out in order to reveal which pairs differ significantly from one another.

2.3.3 Recruitment

For the illicit drug users' survey, a number of services assisted with the recruitment of participants. These services were approached to be involved in the service provider interviews. A letter was sent to each service explaining the study. A follow-up telephone call ascertained the interest of each service in participating and the identity of the individual who would participate. A time and date for interview was made. In most cases, the interviews were conducted face-to-face. In some cases, interviews were conducted by telephone. All interviews were audiotape recorded with the participant's consent. Interviews lasted from 25 minutes to 2 hours, with a typical length of 30 minutes. Participants were also asked to indicate key informants in their area for consideration as key informant interviewees.

Ethics approval for conducting this study was obtained from the University of New South Wales Human Research Ethics Committee and all relevant area health services ethics committees.

2.3.4 Interview schedule

The interview schedule was developed in consultation with the Project Management Group. As it was not possible to cover the range of issues in each interview, interviews concentrated on the service provider's perceptions of barriers and incentives and descriptions of the services they provided.

2.3.5 Data management and analysis

All audio recordings of interviews were transcribed and de-identified prior to analysis.

Consistent with the approach taken for the study as a whole, a variation of the Winett, King and Altman (1989) model was used to examine the interview data. This model examines influences on the target issue at four levels: personal, interpersonal, organisational/institutional and social.

Members of the project management committee read the interviews closely, and participated in a daylong analysis workshop. The workshop aimed to elaborate the issues raised by interview participants at each level of the analytical framework and to identify key themes emerging from the data. To preserve anonymity of participants and services, attributions for quotes are given in the results section in Chapter 5 with information sufficient for context, but not for identification.

2.4 Key Informant Interviews

2.4.1 Aims

The key informant consultations built on the previous information collected for this study (i.e. through the literature review, the drug user survey and the service provider interviews). The questions put to key informants represented a shift from a 'service provision' focus to include information relevant to policy and program issues.

The aims of conducting interviews with key informant were to:

- obtain views from both national and state-based informants on barriers and incentives to treatment for illicit drug users;

- obtain information about the ways in which barriers and incentives relate to current and future national and state policies and programs; and
- build on the information provided through the illicit drug users survey and the service provider interviews.

2.4.2 Selection of key informants

Key informants were selected for interview from names that had come to the attention of the research team during the course of the study to reflect the experiences of policy makers, researchers, clinicians and advocates with expertise and interest in national and state/territory drug strategies and treatment provision for illicit drug users. They were chosen both for their expertise in their field of work and for their ability to offer an over-view of the issues. A list of 28 names was submitted to the Department of Health and Ageing for approval.

2.4.3 Recruitment

The Australian Government Department of Health and Ageing sent a letter to each candidate explaining the study and seeking his/her input into this consultation process. A follow-up telephone call ascertained their interest, and a time and date for interview was made. In most cases, the interviews were conducted by telephone but, in some instances, (i.e. those available for interview in Canberra) the interviews were conducted face-to-face. All interviews were audiotape recorded with the participant's consent. Interviews lasted from 25 minutes to one hour, with a typical length of 40 minutes.

Ethics approval for conducting this study was obtained from the University of New South Wales Human Research Ethics Committee.

2.4.4 Interview schedule

The interview schedule was developed in consultation with the Project Management Committee. Key informants were provided with a sample list of questions that would guide the interview. As it was not possible to cover the range of issues in each interview, the interviews focused on the key informant's perceptions of barriers and incentives in relation to the broad areas of treatment definition, barriers and incentives to treatment and treatment retention, stigma, diversity of need, service delivery, alignment of research, policy and practice and workforce issues.

2.4.5 Data management and analysis

All audio recordings of interviews were played back and notes made of the main points raised in the consultations. The notes were then de-identified prior to analysis.

Consistent with the approach taken for the study as a whole, a variation of the Winett, King and Altman (1989) model was used to examine and analyse the interview data.

To preserve anonymity of participants and services, attributions for quotes are given with information sufficient for context, but not for identification.

2.5 Negotiation Workshop

2.5.1 Aims

The aims of the workshop were to:

- review and discuss the findings of the literature review, illicit drug user survey, service provider interviews and key informant consultations;
- agree and analyse the main issues arising from the study;
- identify and discuss options for improved treatment service delivery for illicit drug users; and
- indicate implications for future policy and program planning.

2.5.2 Purpose of the workshop

The purpose of the workshop was to:

- bring together people who have contributed to the study;
- share preliminary findings from the literature review, the illicit drug users survey, and the service provider and key informant interviews; and
- draw on the information to identify actions that may improve the match between treatment services and support systems and the needs of illicit drug users.

2.5.3 Expected outcomes

By the end of the day, it was expected that participants would have:

- shared information about the study and the preliminary findings;
- gained a first impression of the issues arising from the study;
- discussed the implications of the findings for future service delivery and support systems; and
- discussed and agreed on a number of priority issues that require action, if the match between services, support systems and the needs of those seeking changes in their illicit drug use is to be met.

2.5.4 Processes

2.5.4.1 Selection of Participants

One half of workshop participants were nominated by the Australian Injecting and Illicit Drug Users League (AIVL), while the service provider and other participants were selected on the basis of their knowledge and participation in the project, either as service provider participants, key informants or members of the project advisory or management committees. The Australian Government Department of Health and Ageing was invited to comment on/add to the resulting representative mix of participants. Many of the participants nominated by their organisations had previously been involved in the fieldwork for the study. The workshop, therefore, also provided them with feedback from those processes, enabled the project management group to acknowledge their contributions to the project overall and for drug user organisation representatives, service providers, policy makers and researchers to share face-to-face the commonalities and differing experiences of their work in continuous improvement of access and retention in treatment for illicit drug users.

2.5.4.2 Recruitment and Participation

LMS Consulting sent a letter to each nominee, explaining the study, providing background materials and seeking input to this negotiation process. The Australian Government Department of Health and Ageing agreed to meet the costs of up to 28 participants from the non-government sector and the overnight accommodation costs for workshop participants travelling from Western Australia and the Northern Territory. This made it possible for participants from non-government organisations with limited travel budgets to attend.

Workshop participants were allocated a place at tables of 9-10. This allocation ensured a mix of service providers/drug user organisation representatives and key informants on each table. The morning session consisted of presentations about each of the arms of the study with opportunity for questions between each. Participants were given a handout of the presentations. The afternoon session provided an opportunity for participants to work out a number of priority issues, and to consider how they might be addressed. Each table had a facilitator and participants were asked to:

- self select a scribe and a rapporteur for their group;
- discuss briefly what they heard in the morning;
- individually identify five top issues they think essential to address if improvements between service provision and client needs are to be made;
- share their views, collate issues and rank them; and
- feed back top 5 issues and suggested options with rationale in plenary.

Part 2:
Research Results

Chapter 3:
Literature Review

3.1 Overview

This Chapter presents the findings of the international and national literature on barriers and incentives to treatment for illicit drug users, with particular regard to users of heroin, cocaine and amphetamines.

The review of the literature on help seeking, access to and engagement with treatment services and retention in treatment revealed a wide range of barriers to treatment (and few incentives) relating to access, uptake and adherence in treatment. The barriers and incentives discussed in this Chapter are not an exhaustive list of barriers or incentives, merely those encountered in the literature.

Few of the studies examined were devoted specifically to examining barriers or incentives to treatment. Within the context of help seeking, the most frequently cited barriers were specific barriers to accessing services, often described in the literature as 'service structural' barriers, such as the unavailability of treatment slots, waiting times, costs, program eligibility and transportation (e.g. Hser et al., 1998; Hartnoll & Power, 1989; Dietze et al., 2003). The most often cited social barrier was social stigma (e.g. Marlatt et al.,1997; Cunningham et al., 1993; Copeland, 1997). Even so, the impact of stigma and the stigmatizing effects of current treatments were not discussed in any great detail.

More recently, there has been a focus on the specific barriers facing sub-populations of users, for example, women who self-managed change (Copeland, 1997; Swift & Copeland, 1996), women completers of residential treatment (Knight et al., 2001), youth (Howard, 1994; Spooner et al., 1996) and services for ethnic communities (Reid et al., 2001).

Research specifically on incentives tends to focus on the use of voucher-based incentives to treat cocaine and other substance use (Higgins et al., 2002), free treatment for methadone maintenance (Kwaitawski et al., 2000), or staff facilitation, including small monetary incentives and payments for public transport (Friedman et al., 2003; Booth et al., 1996).

Studies on health care utilisation/non-utilisation generally suggest that access, uptake and adherence in treatment result from an interplay of individual, interpersonal, structural and social factors. Simpson (2000), for example, draws attention to the interactions between individual needs, motivation factors, social pressures and aspects of treatment programs that influence individuals in their decisions to access and remain in treatment. The present study uses a model, based on the Winett et al. (1989) model, which proposes four levels of influence (personal, interpersonal, organisational/institutional and social) to identify various types of barriers, and to explore a comprehensive and coherent understanding of the problem.

3.2 Access, Uptake and Adherence in Treatment

The literature establishes that the majority of drug and alcohol users do not seek formal treatment (Carroll & Rounsaville, 1992). Individual patterns of illicit drug use cover a continuum from recreational use and occasional use, to frequent, problematic and dependent use. By far the largest group of illicit drug users surveyed in Australia in the 1998 *National Drug Strategy Household Survey* (86% of heroin users, 59% of amphetamine users, and 75% of cocaine users) said they used the drug less than once a year (Higgins et al., 2000).

3.2.1 Self-help options

Dietze et al., (2002) in their survey of 933 heroin dependent persons in three Australian states found that 86% had attempted non-medicated withdrawal or 'cold turkey' a median of five times in the past, 72% had attempted a self-medicated withdrawal using benzodiazepines or tranquillisers and 61% had attempted a health trip (e.g. geographic relocation). Ninety-one percent of the sample had tried to reduce use without any help, citing lifestyle, financial or family reasons as reasons for attempting to reduce drug use. Around half the sample reported seeking assistance from friends or self-help groups such as Narcotics Anonymous.

With regard to amphetamine users, Hando et al., (1997 found that more than three quarters (79%, n=158) of their sample of amphetamine users in Sydney, Australia, had attempted to moderate their amphetamine use without professional assistance, with many subjects having done so on their own (73%, n=115) or with support from family or friends (38%, n=60). Techniques used to reduce amphetamine use included: 'just stopping', using 'will power' or 'inner strength', removing oneself from the environment associated with the drug and substituting other drugs for amphetamines (e.g. cannabis, heroin).

Noble et al., (2002), in their study of self-detoxification attempts among methadone maintenance patients, found that 61% of their sample had attempted self-detoxification with the help of drugs or alcohol. They concluded that heroin dependent people who feel that their drug use is under their control and are motivated to change their drug use *may* be able to do so without treatment.

3.2.2 Spontaneous remission

Walters' (2000) review of the literature on spontaneous remission from alcohol, tobacco, and other drugs concluded that spontaneous remission is a relatively common event and has been observed across cultures. He found that there were few meaningful differences on measures of prior drug involvement between spontaneous remitters and people who either continue problematic use or remit through treatment.

3.2.3 Maturing out

Waldorf (1983) suggest 'maturing out' is an important factor in stopping drug abuse, whereby the heroin user becomes abstinent when 'pushed' by the 'undesirable' aspects of a heroin-using lifestyle and simultaneously 'pulled' by the 'desirable' aspects of conventional life. Hando also describes a 'maturation' effect whereby young, recreational users grow out of their amphetamine use phase (Hando et al., 1997).

3.2.4 Drug use careers and treatment careers

Studies examining the course of drug use and treatment experience have shown that drug users generally do not seek formal treatment until they are well into a lifestyle of drug use. Hser et al., (1997) posit the concept of a drug use career, dependence or addiction career whereby an individual's drug use, once initiated, often escalates to more severe levels, with repeated cycles of cessation and resumption over an extended period. An individual's use of drug treatment follows a similar pattern – a cyclical process of treatment, abstinence and relapse that can be characterized as a 'treatment career', which, nevertheless, may vary widely among individuals. They suggest that, given the chronic, relapsing course of drug dependence, multiple treatment episodes are better understood as parts of a cyclical process of recovery and remission, rather than as failed efforts.

While clinicians, researchers, and government policy-makers have long recognised the value in conceiving treatment in terms of episodes, episodes of treatment have received little attention in the research/evaluation treatment outcomes literature (Luchansky et al., 2000).

3.2.5 Patterns of treatment uptake and dropping out

Seeking treatment does not necessarily imply that an individual will successfully engage in treatment, and many drop out after a very brief period. In addition, some individuals continue to use illicit drugs while in treatment, and relapse is common.

Whilst there is little consistency across studies and treatment settings in terms of characteristics of patients who drop out of treatment, there is a good deal of consistency across studies suggesting that most attrition occurs early, with the majority of the drop-outs usually occurring during the first month of treatment (Carroll, 1997).

Hser et al.'s (1998) study of 276 drug users who were seeking treatment and were provided with referrals to local drug treatment programs found, through follow-up interviews, that 38% did not enter treatment at any time during the 6-month follow-up period. It has also been estimated that about half the patients in the United States seeking treatment for cocaine use are lost between first contact and the initial assessment interview (Agosti et al., 1991; Kang et al., 1991; Kirby et al., 1997; Higgins & Wong, 1998; Proudfoot & Teesson, 2000) and, between intake and treatment, the risk of dropout is high (the research shows that 29% to 42% of admitted clients fail to return to begin treatment (Weisner et al., 2001; Baekeland & Lundwall, 1975).

In their review of treatment outcomes of a sample of ex-residents of an Australian therapeutic community, Toumbourou et al. (1998) found, as with other studies, that drop-out was common in the early stages of treatment: 19% reached induction only, 45% reached pre-treatment, 10% reached level one and only 5% graduated from the program.

Stark's (1992:102) review of the literature on substance use treatment dropouts concluded that: *'the fact that clients who use more drugs have higher attrition rates is true almost by definition and is overwhelmingly confirmed by the evidence'*. He noted, however, that while the rates of dropping out of substance use treatment is high,

it is only somewhat higher than that of clients undergoing a range of medical and psychiatric treatments.

3.2.6 On ramps to treatment

A number of services are involved in making contact with users and encouraging behavioural change and, where appropriate, entry into formal treatment.

3.2.6.1 General Practitioners

General medical practitioners are more often than not the first point of contact for people with substance use problems or dependence (Penrose-Wall et al., 2000). Dietze et al. (2002) report that GPs were the major professional group that 71.1% of their Australian sample of heroin users contacted in relation to controlling their drug use.

However, a number of studies suggest that many GPs do not feel confident about their ability to deal with drug users, are concerned about safety and cost issues and experience difficulties in slotting the drug user into a typical patient's role (Abouyanni et al., 2002; Reid et al., 2000; Wong et al., 2003).

Proudfoot & Teesson (2000) note that amphetamine users present to primary care facilities rather than other treatment services, and suggest that it is important that problematic amphetamine use be identified at this point. Many agencies are pursuing a strategy of involving GPs in a system of shared care (e.g. GP liaison workers), which, it has been argued, may be the most appropriate system of care for amphetamine users (Kamieniecki et al., 1998).

3.2.6.2 Outreach services

Adolescents' drug problems are more likely to emerge in a social setting (in seeking help from an adult friend, rather than a parent) or in a legal setting (e.g. criminal justice system) than in a health care setting (Marlatt et al., 1997). Booth et al. (1996) found that illicit drug-using subjects intervened with by community outreach workers were more likely to have entered treatment than participants lacking interventions by community outreach workers.

3.2.6.3 Needle and Syringe Programs (NSPs)

NSPs have been identified as an important point of referral to facilitate drug users entering drug treatment programs (Shah et al., 2000; Hagan et al., 2000). A survey of US needle and syringe exchange providers illustrated that many have agreements with treatment facilities to which they refer clients and help access these facilities (Paone et al., 1999). Bluthenthal et al. (2001) found high readiness to change among people who inject attending NSPs. They argue that these findings represent an opportunity for NSPs to offer assistance for those who request information and access to appropriate drug treatment programs. Kuo et al.'s (2003) study supports other research demonstrating that NSPs can act as an important facilitator into treatment. (They found a 70% entry rate among clients referred from an NSP into a LAAM detoxification treatment program).

3.2.6.4 Medically supervised injecting centres

The evaluation of the recently established Medically Supervised Injecting Centre (MSIC) in Sydney indicated that 11% of clients attending the MSIC were referred

to treatment. Additionally, more frequent attendees of the MSIC were more likely to be referred to treatment and to become involved in the treatment process (MSIC Evaluation Committee, 2003).

3.2.6.5 Drug and alcohol help lines

Telephone help lines represent an immediate avenue for help seeking, combating the barrier of delayed access to treatment. Help lines can make users aware of the range of drug treatment options that may be available to them (Hughes et al., 2001).

3.3 Identification of Barriers to Access, Uptake and Adherence in Treatment

3.3.1 Personal Level Influences

3.3.1.1 Demographic characteristics

Individual demographic variables such as age, gender, race, and educational status, do not appear to predict treatment seeking, and entry and research findings on demographic variables as treatment entry predictors has been inconsistent (Booth et al., 1996, Hser et al., 1998; Siegal et al., 2002). Marlatt et al. (1997:47) note: '*the lack of robust demographic differences in help seeking for substance use is consistent with the broader health-related literature on help-seeking*'.

3.3.1.2 Personal motivation

The failure of 'fixed' characteristics, like demographic variables, to predict treatment uptake and retention has led to a focus on the role that 'dynamic' characteristics, like motivation play in treatment retention. Motivation is described in the literature in terms of a 'state of eagerness or readiness to change' following problem recognition (Miller & Rollnick, 1991). Motivation has been found to be associated with access to and retention in treatment across a range of treatment modalities (Joe et al., 1998). Its role in treatment retention has been firmly established (De Leon, 2001).

Conversely, the concept of denial is the most commonly cited reason in the literature for failure to seek treatment (Hser et al., 1997). For example, Grant (1997), reporting on an extensive study involving interviews with just under 43,000 respondents who were asked why they failed to seek help with their alcohol problems when they perceived a need for it, found that the most common reasons were beliefs that they thought they should be strong enough to handle their problem by themselves; that the problem would get better by itself; that the problem was not serious enough to get help; and that they were not convinced treatment would be effective or that it would be necessary. In her view, these reasons could all be considered as various expressions of denial. Denial may serve not only to impede the treatment process, but also to impede the perception of the problem altogether. Wright et al. (1999) express the view that primary amphetamine users who report no problems; do not classify themselves as 'drug addicts'; and consider themselves in control; are in denial.

3.3.1.3 Stages of change

In Prochaska and DiClemente's often cited 'stages of change' model (Prochaska & DiClemente, 1997) various factors are thought to move a person from the

contemplation to the action stage, including believing that the 'cons' of the behaviour (negative consequences) outweigh the 'pros' of the behaviour (positive consequences) and that one has the power to change his or her behaviour. This perspective suggests that, when the negative consequences begin to outweigh the positive consequences, continuation of the behaviour becomes disadvantageous and problematic. Once the problem is recognised, reduction or elimination of the negative consequences is achieved through modification of the behaviour during the action stage.

However, various studies have shown that a substantial number of untreated heroin dependent persons do not want to give up the intoxication experience (Rounsaville & Kleber, 1985). Likewise, amphetamines are valued by the young for socialising and dancing and by women because they keep weight down and provides them with energy to cope with children and domestic chores (Klee 1993, 1997; Morgan & Beck, 1997).

3.3.1.4 Discounting of delayed and probabilistic outcomes

Marlatt et al. (1997) suggest that the behavioural-economic literature on discounting of delayed and probabilistic outcomes may be relevant to understanding why only a small minority of people, whose use is problematic, seek treatment. According to Marlatt, treatment entry places a user in the position where he/she must forego a highly valued commodity (the used substance) that is immediately available in order to obtain a probable and delayed outcome (the benefits of treatment). Given the value of the used substance to the user and the probabilistic and/or delay discounting of treatment benefits, Marlatt suggest it is, perhaps, understandable why most substance users do not seek treatment.

3.3.1.5 Knowledge about treatment options

Illicit substance users appear to be ill informed about their available treatment options (Copeland, 1997; Dietze et al., 2003). Reid et al. (2000) found that many of their study participants had scant knowledge of the various drug treatment services available in their local area. Hartnoll & Power (1989) commented that one important difference between their 'agency' (in treatment) help seeking group and 'non-agency' (not in treatment) group was that the agency group had a better knowledge and understanding of treatment services; and, conversely, drug users who did not seek help were less well placed to know where and how to find it. Oppenheimer et al., (1988) also found that those with greater treatment experience were more aware of treatment options. Word of mouth (and the treatment experience of peers) is regarded as an important source of information for drug users about treatment (Power et al., 1992; Dietze et al., 2003).

3.3.1.6 Attitudes to treatment

Reid et al. (2000:1) state: '*while illicit drug users have many health problems, they often view orthodox medical services as forbidding, judgmental, inaccessible, costly or otherwise inappropriate for their needs'*. Hartnoll (1992: 434) comment: '*It is possible that the image of a service, as well as the substance of the actual service offered, plays an important part in influencing who uses it and when'*. On the other hand, prior history of treatment has been associated with treatment entry (Booth et al., 1996; Siegal et al., 2002).

3.3.1.7 Psychosocial problems

Positive associations between help-seeking and psychosocial problems related to dependent substance use have been found across studies of treated and untreated opiate, cocaine and polydrug users (Carroll & Rounsaville, 1992; Power et al., 1992). Marlatt et al. (1997: 48) note that the association between help seeking and psychosocial problems appears to be robust across drug types, and that the pattern is similar to that found for other medical and psychological problems. In their view, the factors influencing help seeking for substance use are not substantially different from those involved in help seeking for other health problems.

3.3.1.8 Personality factors

There is a strong suggestion in the literature that personality factors may be an important mediator of help seeking, principally through neuroticism and depression. (Hartnoll, 1992, Rounsaville & Kleber, 1985). Loss of control, mental health and relationship problems were reported to be the strongest motivators for seeking treatment in Wright & Klee's (1999) profile of amphetamine users who present to treatment and do not return. Amphetamine users frequently mention psychological problems, particularly paranoia and aggression and physical problems being out of control as reasons for help seeking (Kamieniecki et al., 1998). However, high levels of psychological distress may also undermine motivation to remain in treatment (Hser, et al., 1998).

3.3.1.9 Hope

Jackson et al. (2003) identified hope as an important predictor of entering substance abuse treatment. In their study of incarcerated drug users, they found that people reporting less hope were more likely to enter drug treatment. They hypothesize that people with greater hope may be able to use alternative strategies to reduce drug use, especially as formal treatment is often seen as a last resort that is employed after all other strategies have failed.

3.3.1.10 Individual circumstances

Hser et al. (1998) found that 18% of their respondents reported not entering treatment because they had difficulty making the necessary arrangements to go to treatment (e.g. accommodation for family needs or housing security). Concerns about childcare have been reported as barriers to treatment in a number of studies on women and treatment (Battjes et al., 1999; Copeland, 1997; Sterk et al., 2000). Lifestyle issues and individual financial concerns appear to be a factor motivating treatment-seeking behaviour. Dietze et al. (2002) found that between 18-41% of their sample cited financial problems as a major reason for entering treatment.

3.3.1.11 Homelessness

Homelessness is a particular problem for many drug users requiring treatment as it is 'virtually impossible' to address drug problems for those who are sleeping rough (Neale, 2000). Fountain et al. (2003), in their study of homeless people in inner London, found that drug use was high among this population and uptake of drug treatment services low. Bessant et al. (2003), in their survey of the accommodation needs of heroin users in a range of settings in Melbourne and Sydney, found that absence of secure accommodation, combined with rigorous enforcement of registration requirements relating to residence, was a significant barrier for accessing

and remaining on methadone maintenance for homeless and transient users. Further, some services aimed at reducing drug use, such as home detoxification, by definition, were not available. Kelinman et al. (2002), on the other hand, found homelessness to be a predictor of treatment utilisation.

3.3.1.12 Employment status

Kleyn & Lake (1990), in their study of people who inject, found that those who received income from employment were significantly less willing to enter treatment because, among other difficulties, treatment is time-consuming and can limit job-related travel. Also, they feared their employment might be terminated if their employers discovered their drug use. However, having a job is considered a positive incentive, especially for professionals. Job seeking counselling and training has been found to be an incentive for remaining in treatment, when provided as an ancillary service to drug treatment (Smith & Marsh, 2002).

3.3.1.13 Legal involvement and criminal activity

Research suggests that legal involvement and criminal activity are factors related to treatment seeking, although this relationship is complex (Sheehan et al., 1986; Dietze et al., 2003; Siegal et al., 2002). Being mandated to treatment acts as a predictor of treatment entry and retention (Hall, 1997). Kleinman et al. (2002), in their study predicting long-term treatment utilisation patterns, found that those on parole were more likely to be in treatment.

Weatherburn & Lind's (2001) Australian study of 511 heroin users found that a majority of respondents currently or previously in treatment rated 'avoiding more trouble with police/courts' as an important or very important reason for entering treatment. In an earlier study, they found that 30% of their sample of 247 methadone users in Sydney cited having been in trouble with the police as reasons for stopping using heroin (Weatherburn & Lind, 1995). Legal reasons were also significantly higher amongst the treatment-entry subjects in the research undertaken by Hser et al. (1998). Wright & Klee (2000) reported that fear of being gaoled is a major prompt for men and women to seek treatment for amphetamine use. Ferri et al. (2002) found that involvement in crime was a deterrent to treatment entry among first-time treatment seeking, but those who sought treatment re-entry often had higher rates of criminal involvement. However, Dietze et al.'s (2002) Australian study of heroin dependent persons found that legal reasons were given by only a small minority of respondents for seeking help during their last course of treatment.

3.3.1.14 Health-Related Issues

Various authors have found that physical health concerns are important factors in treatment seeking (Wright et al., 1999; Sterk et al., 2000). Despite this, in the study by Dietze et al. (2002) concerns around health related issues, such as overdose and blood borne virus infection, were not regarded as motivators for treatment seeking.

Bessant et al. (2003) notes that a drug dependent person, who may be unwell from other conditions such as hepatitis C, undernourishment, tiredness, nausea and general poor health, may find undertaking tasks, such as daily visits to a methadone dispenser and making a doctor's appointment and keeping it, too much to cope with.

3.3.1.15 Drug related events as prompts to help seeking

The most frequently cited reasons in the literature for wishing to cease illicit drug use provided by those already in treatment are tiring of the drug-related 'hustle'; 'hitting bottom'; fear of being gaoled; and family responsibilities and pressures (Cunningham et al., 1994; Varney et al., 1995; Joe et al., 1998; Dietze et al., 2003). Dietze et al. (2002) found that 55-60% of their sample sought treatment because they were tired of the drug using lifestyle. Problems with drug supply were cited by a number of their participants as a factor in seeking treatment.

Studies, which have surveyed both untreated and regular drug-using peers (Rounsaville & Kleber, 1985; Dietze et al., 2003) suggest that the level of drug use *per se* (and thus the likely level of dependence) does not reliably differentiate help seekers from non-help seekers. Neither do broad measures of wellbeing in other areas of life (e.g. health, relationships or criminal activities) show significant differences. Hartnoll (1992: 432) suggest that it was '*largely the successive, often rapid occurrence of several drug-related events leading to increased anxiety about drug use and other life areas (notably emotional state, health, means of support and living situation) and to a perceived need for help that prompted help seeking'*. In a separate account of their London study, Power, Hartnoll & Chambers (1992) reported that the main 'concerns' and 'need for help' that differentiated the treatment seekers from their non-treatment seeking peers were (in order of importance) drug use, finance/means of support, psychological health, physical health and partner relationship.

It is unclear from the literature whether discrete and (sometimes extraordinary) events related to substance problems precede help seeking or whether an accumulation of drug related problems over time is more typical (Marlatt et al., 1997: 53).

3.3.2 Interpersonal Level Influences

3.3.2.1. Pressure from families and friends

Room's (1989) US national survey of the US household population found (in relation to adult drinking and help seeking) that few people enter treatment without encountering informal pressures from their family, friends and acquaintances. Walters (2000) found that, in respect of spontaneous remitters, pressure from friends and family, along with health concerns and extraordinary events were instrumental in initiating spontaneous remission, while social support, non-drug using friendships, willpower, and identity transformation were pivotal in maintaining change.

Family related issues such as gaining custody of a child and the desire to be a good parent were often cited in the literature as triggers, particularly for women, for stopping and maintaining the decision to stop using (Weatherburn, 2001).

3.3.2.2 Family and social support

Support from family and friends has been important for those users wishing to moderate their drug use without seeking professional help (Shearer et al., 1999; Dietze et al., 2003) and in the treatment seeking process (Hartnoll, 1992).

Stanton (1997) in a review of studies on the topic of the role of the family and significant others in the engagement and retention of drug-dependent individuals point out that, whether or not drug dependents actually live with their parents,

the accumulated evidence suggests that most are closely tied to their families at many points, with communication often routed through siblings, relatives and spouses and they tend to use a given household as a constant reference point in their lives.

Families play an important role in identifying the need for treatment, facilitating entry into treatment and in providing support during the treatment process (Mitchell et al., 2001). However, research has also shown that women are less likely than men to receive support from family members and may experience opposition to treatment from their family (Knight et al., 2001).

Research has shown that family involvement in treatment has a positive impact in adolescent treatment involvement. Family involvement can be difficult to achieve, and is even less likely if it is not actively recruited. Approaches employing active engagement of the family have been trialed with positive effect, although they might need some modification with different cultural groups (Spooner et al., 1996).

Findings as to the role of social support and functioning has been mixed with some findings indicating that lower levels of social support encourage people to seek treatment, while other studies have found the opposite (Hartnoll, 1992; Hser, et al., 1998). In terms of outcomes, having a drug using partner is associated with less days abstinent from heroin (Riehman et al., 2003), while being part of a social network of drug users is also related to continued heroin use while in treatment (Gogineni et al., 2001) and increased criminality (Best et al., 2003). The impact of social support on reduced drug use while on opioid maintenance treatment has also been found to vary both by the type of support given and by the class of drug used (Wasserman et al., 2001).

3.3.2.3 Insights from Family and User Stories

As an adjunct to the study, the research team reviewed available written family and user stories for any insights they may offer on barriers and incentives to treatment. Family and Drug Support (FDS) and the AIVL network were approached and together provided over a hundred accounts of personal experiences, mainly from stories printed in the records of national conferences (e.g. the National Families and Community Conference on Drugs 'Voices to be Heard' FDS and FFDLR, 2000) and from FDS and Drug User Organisation newsletters. These were then coded according to broad categories and analysed according to main themes.

Family and user stories soon proved to be a rich mine of information on personal experience with drug treatment services, which was beyond the scope and mandate of the study to study in any great detail. The findings in Box 3:1 are, therefore, presented as cameos of these personal experiences.

Box 3.1 Main themes from an examination of available family and user written stories

Demographics: The experiences show that dependent drug use/addiction can happen to anyone, irrespective of education, economic status, employment or locality.

Family types: The families of drug users in these stories could be grouped into three broad categories: those who did not want to know, those who helped and those who wanted to help but did not know how to. In either case, the impact on the family of the drug user was significant, described as '*a life of hell*'.

'*Hitting rock bottom*': Families had a strong aversion to agencies waiting until a user reached rock bottom before offering treatment: '*She hit rock bottom alright, but now she's dead and what can you do once you're dead*'.

Treatment episodes: After the initial hope and search for a quick fix, families became resigned to view treatment as a '*long and bumpy journey*' and encouraged to '*not give up on your kids*'.

Family support: Families would go to considerable lengths to help, even to the extent of providing funds or even procuring drugs for their child.

Treatment works: Families had mixed views on whether 'treatment works' and some considerable reservations about methadone maintenance. This, however, could be a reflection of their earlier search for a 'quick fix'.

Inclusion in treatment: On the whole families felt excluded from treatment, although individual drug advisers and counsellors were found to be useful.

User contact with family members: Whether or not users with problematic drug use were actually living with their parents or not, those included in this sample were closely tied with their families. Even when not living at home or on the street, users either regularly or periodically made contact with a family member.

Eligibility: There were many examples of users and their families experiencing knock backs when seeking treatment. For example, users were turned away because they were too young, 'didn't look like an addict', their dole cheque was too low or they had dual diagnosis problems.

Treatment staff and treatment philosophies: In general there were two types – those who sought to empower and those who sought to straighten and punish the user.

Inappropriate treatments: There were many examples, e.g. an 18-year-old girl placed in a detoxification service with middle-aged male dependent drinkers.

Social stigma: Social stigma was widely encountered e.g. '*we live in a country town so everyone knows her and her addiction. We have to put up with all the glares, gossips, police courts and embarrassment to us all in our family*'.

A plea for normalisation: '*As a society, we need to look closely at our values regarding those in the country who need our help and try not to judge them*'.

3.3.2.4 Self Help Groups

Self help groups are viewed in the literature as an important social support for people who attempt to stop using drugs, and play a significant role in treatment outcomes. A range of evaluation studies have found that self help groups have been associated with sustained reductions in alcohol and drug use (Toumbourou, 2002). Additionally, attendees of self help groups were more likely to maintain abstinence than non-attendees (Miller et al, 1997). Long-term and more stable abstinence from drug use has been associated with greater frequency of attendance at a Twelve-Step program (Siegal et al, 2002).

3.3.3 Organisational/Institutional Level Influences

3.3.3.1 Treatment availability

Estimates in the literature of the treatment gap between dependent users who would benefit from treatment and those in treatment vary considerably. In 1999, only 36% of the estimated 74,000 dependent heroin users in Australia were in methadone maintenance treatment, the main and the preferred treatment modality available to them (Hall, et al., 2000). In the United States, Judd (1998) reported that a smaller percentage (19%) of the estimated 600,000 dependent heroin users in that country were on methadone maintenance treatment. Rounsaville & Kosten (2000) estimated that current methadone maintenance delivery in specially licensed, centralised programs in the United States reach only about 14% of opioid dependent users in that country because of limited treatment slots and geographic constraints.

Farabee at al.'s (1998) survey of 2,613 out-of-treatment drug injectors (street users) in the US in the past year found that the most common reason for not entering drug treatment was that the treatment program did not have room (45.7%); and Dietze et al.'s (2002) study on treatment utilisation by heroin-dependent people in Australia found that the most commonly cited reason for not accessing treatment related to a lack of availability of treatment places across all jurisdictions. Dietze et al.'s (2002) estimates of dependent heroin users indicate that there is a significant shortfall in available methadone maintenance places in Victoria.

Lack of services specifically for amphetamine users has been cited as one of the major barriers to treatment for amphetamine users. Wright et al. (1999) consider there is a significant under-estimation of the need for treatment in this population, with many trying to self-medicate until a crisis occurs which prompts them to approach treatment out of necessity.

3.3.3.2 Treatment accessibility

Wenger & Rosenbaum (1994) point out that analyses of drug-user treatment experiences in urban areas have well documented that availability of services does not necessarily translate to accessibility and acceptability of those services. These studies have indicated many barriers to accessibility of treatment services, including lack of transportation. Hser et al. (1998) found that, in terms of service structure barriers, lack of transport (12%) was the second most common reason (after program eligibility) offered for not going to treatment. Travelling times have been sited as reasons for leaving methadone maintenance programs (Taplin, 2000). The lack of public transportation and distance from health care facilities in rural areas complicate availability of care and influence treatment choices (Dunn, 1998).

3.3.3.3 Treatment affordability

Costs appear as significant barrier to treatment, in particular in United States studies. For example, Farabee at al.'s (1998) survey of 2,613 out-of-treatment people (street users) in the USA who reported that they tried unsuccessfully to enter treatment (short-term detoxification and methadone maintenance) in the past year found that not having enough money was the second most common reason for not entering drug treatment (after the treatment program not having room). However, Dietze et al.'s (2002) study of Australian heroin dependent persons concluded that costs associated with treatment did not present as a major barrier to

treatment service entry. Nevertheless, their findings in respect of methadone maintenance treatment suggest that costs of this form of treatment were important for clients, and that a small proportion of the sample cited costs as a reason for ceasing their last course of treatment.

3.3.3.4 Treatment appropriateness

Marlatt et al. (1997) comment that the traditional view that the client needs to be motivated to change has led many agencies to be reactive, waiting for the person who uses illicit drugs to approach them for care. To reduce barriers, there needs to be changes to the types of services available and how and where they are offered, and provision of a broad range of options (Oppenheimer et al., 1988; Cunningham, 1993). An important factor in facilitating help-seeking and reducing attrition rates is the provision of low threshold, easily accessible, non-threatening services that have no attached stigma (Stark, 1992; Marlatt et al., 1997).

3.3.3.4.1 Treatment for stimulant users

Klee & Morris's (1994) survey of amphetamine users in the UK found that, while half their sample wanted to reduce their use of amphetamines, two-thirds of the sample believed that treatment was inappropriate for them and biased towards opiate users. Wright et al. (1999) also found from matched case control interviews with amphetamine users in, and not involved in treatment, that the perceived opioid orientation of treatment services acts as a considerable deterrent to amphetamine users.

The increase of psychostimulant users, especially people who inject methamphetamine, poses new challenges for Australian drug treatment facilities (Topp et al., 2003). Conventional treatments appear to have limited effect, and show high drop out rates for methamphetamine users (Copeland & Sorenson, 2001). Rawson et al. (2002) in a review of treatment of methamphetamine disorders, state that current treatment programs in the US are unprepared for the requirements of treating methamphetamine users.

In a study of drug injectors not in treatment who use stimulants only, opiates only, or both, John et al. (2001) found that the stimulant use was highly prohibitive to entering treatment. The stimulant only group were 24-25 times less likely than the other two groups to enter treatment, despite being offered immediate, free treatment after participating in the study. Stimulant only users were slightly younger, had a shorter history of drug use and spent less on drugs than the other two groups. These differences, nevertheless, did not explain the huge differential in treatment initiation between the three groups. They suggest that their finding that the stimulant only group had the highest paranoia, hostility and psychoticism scores may explain some of this difference in that these psychological difficulties may form barriers to the development of adequate trust in treatment establishments and rapport with staff and counsellors. The authors conclude that the health care system must better understand and address the needs of stimulant users in order to provide more appropriate treatment.

3.3.3.5 Program related problems

Farabee et al.'s (1998) examination of the data of a sample of 2,613 out-of-treatment people in 21 United States cities who inject and who tried, but were unable, to enter treatment, revealed that, apart from availability, program-based reasons (e.g., waiting lists, too costly, or stringent admission criteria) were the most commonly cited barriers to drug treatment.

3.3.3.5.1 Waiting lists

Brown et al. (1989) found that long waits appear to be associated with decreased interest in entering treatment. Kirby et al.'s (1997) study of cocaine users in the United States found that many clients were lost by delays as short as 24 hours, with the percentage of clients attending the initial appointment falling from 83% to 57% in the first 24-hour period following the initial contact. Wright et al. (1999), in researching amphetamine users, found that the time between the initial approach and the first interview was the point at which clients often disappeared. Waiting periods for appointments were seen as a problem, especially when the only treatment on offer was counselling. Dietze et al.'s (2002) study of heroin dependent persons found that waiting lists was a major reason for respondents not obtaining treatment in the past.

The provision of 'rapid intake' or treatment 'on demand', compared to procedures that involve a delay in intake or the use of waiting lists, has been demonstrated to be effective in increasing the number of illicit drug users who enter and remain in treatment (Woody et al., 1975; Dennis et al., 1994; Festinger et al., 1996; Higgins & Wong, 1998). Festinger et al. (2002) found that participants in their study who were offered intake to drug treatment twenty four hours after initial contact were four times more likely to attend the intake appointment than those with a longer wait. Several studies have shown that by cutting down the time between application for treatment and first contact, retention can be improved significantly (Baekeland & Lundwall, 1975; Stark et al., 1990). Stark (1992) found that clients are also likely to continue in treatment longer when they received a rapid initial response and individual attention, and when they were seen in smaller groups in friendly, comfortable environments. Inexpensive techniques, such as reminder phone calls and personal letters, can be employed in the absence of other resources.

3.3.3.5.2 Eligibility

Hser et al. (1998) found that, in terms of service structure barriers, reasons offered for not going to treatment were program eligibility problems (16%), lack of transportation (12%), not wanting to be on a waiting list or being on a waiting list too long (14%), financial difficulty (16%), and/or scheduling conflicts (1%). Eligibility requirements, of course, vary from treatment modality to treatment modality.

3.3.3.5.3 Matching clients to particular treatments

Research has identified that no single treatment approach is effective for all clients, and that a range of alternatives needs to be designed to suit individual needs (Hser et al., 1997: 550). Treatment matching involves selecting the treatment that will have the best outcome for that person at that time. However, most treatments are not highly individualised, and tend to offer the same general program for all who enter that treatment.

Current research highlights the significance of matching clients with treatment types (Reiber et al. 2002). Research examining the importance of matching treatment services to client needs indicates that a disparity between these is a major source of dissatisfaction for clients (Dietze et al., 2003). Studies also suggest that matching clients to appropriate counselling services is associated with reduced substance use (Smith & Marsh, 2002).

3.3.3.5.4 Provision of ancillary services

Both Hartnoll & Power's (1989) London agency (treatment) and non-agency groups indicated that in seeking help, the most important factor they had taken into account (or would take into account) was what services were offered. Both groups rated help with practical issues like housing, health, means of support, skills training, legal problems and child care as being of equal importance to obtaining a methadone prescription or methadone maintenance treatment. In terms of methadone maintenance, many authors note that most clients who enter this treatment have multiple needs, and that the most effective programs provide comprehensive services to meet these needs (Anglin & Hser, 1990; Ball & Ross, 1991; Joe, et al., 1991).

Smith & Marsh (2002) found that matching clients to ancillary services, such as housing, job training and legal services increased clients' satisfaction with the service. However the number of services clients received in treatment had an even stronger relationship to treatment outcomes. The authors suggest that these findings point to the importance of having enough services to meet the needs of clients. Similarly data from a study by Walton et al. (2003) indicate that additional treatment and post-treatment services may be required to ensure better client outcomes.

Despite these findings, research suggests that drug treatment services often do not offer enough services to meet client needs. In a report assessing trends in comprehensive service availability in outpatient drug treatment, Friedmann et al. (2003) note little change in comprehensive service provision between 1990 and 2000. Despite research noting the benefits of increased service provision, especially medical and psychosocial services, no change in the availability of these services was noted. However, Ritter & Barends (2003) raise the point that it may not be feasible for treatment facilities to provide all services to all clients and that these needs may be better met by referring clients to agencies designed to address these specific needs.

3.3.3.5.5 Case management

Case management has been shown to increase treatment entry and retention (Metja et al., 1997). Bokos et al. (1992) found that 90% of their case-managed group entered treatment compared with 35% of controls. Taplin (2000) found that counselling helpfulness was one of five factors that predicted retention on methadone maintenance programs. Clients reported that they wanted advice, assistance and someone to talk to from their counselling.

3.3.3.5.6 Staff facilitation

Booth et al. (1996) found that out-of-treatment people who inject opiates were more likely to enroll in treatment within six months when staff helped clients schedule and arrange transportation to appointments, than when patients were given a list of aftercare programs in the community. Further, Chutuape et al. (2000) found that staff facilitation from detoxification to aftercare combined with small monetary incentives may be useful in improving transition from detoxification to aftercare.

3.3.3.6 Program financial incentives

3.3.3.6.1 Free treatment coupons

Studies in the United States have shown that the use of coupons for 'free substance abuse treatment' improves treatment entry rates by lowering the financial barriers (Sorenson et al., 1993; Wells et al., 1995). The most consistent findings across the studies of free treatment coupons are that free treatment is a significant motivator for drug users to enter treatment and that a substantial number of coupon redemptions come from subjects who have not previously participated in treatment (Sorenson et al., 1993; Wells et al., 1995). Kwiatkowski et al. (2000) comment that free treatment increases the likelihood of heroin users entering treatment.

3.3.3.6.2 Voucher incentives

Programs using vouchers that were exchangeable for retail items, job opportunities or housing as positive reinforcers for cocaine abstinence or program level advancement have been reported to be successful in ensuring continued abstinence across a range of drug classes (Higgins et al., 2002; Pollack, 2002). Voucher based incentive programs have also been found to be successful in transitioning clients to opiate agonist therapy or drug free treatment (Robles et al., 2002).

3.3.3.6.3 Life structure incentives

Friedmann et al.'s (2001) study of the use of transportation incentives to improve client retention in an outpatient treatment service in the United States (i.e. the provision of car, van or contracted transportation services for clients) and Schumacher et al.'s (2000) study on the provision of immediate rent free housing as an incentive for abstinence highlight the importance of the providing life-style structure incentives in the treatment seeking and recovery processes.

Katz et al. (2001) devised a reinforcement based outpatient treatment for opiate and cocaine users that offered a range of incentives for both treatment attendance and treatment abstinence. Attendance incentives included transportation assistance in the form of bus tokens and monetary vouchers; and abstinence incentives included vouchers for lunch, supported recreational activities and rent or utilities payments. They found higher rates of long-term drug free participation as a result of the reinforcement incentives schedule. However, they also note that the incentives did not prevent relapse or drop out for over half the participants.

In their analysis of data of over 1,000 clients in methadone maintenance and drug free programs in the US DATOS study, Friedman et al. (2001) found that the provision of car, van or contracted transportation services improved treatment retention, but individual vouchers or payments for public transport did not.

3.3.3.7 Legal coercion

Court ordered treatment has become more widespread in the countries examined in this review. While the essential role of motivation in treatment retention implies that 'coerced' clients are less likely succeed in treatment than 'voluntary' clients, studies that have compared treatment retention among coerced and voluntary clients found that coercion to treatment does not appear to be a barrier to the effectiveness of treatment (Spooner et al., 2001). However, while legal coercion increases the likelihood that criminal justice clients will stay in treatment longer, these clients are also less likely to complete program requirements. Criminal justice clients may be

meeting the minimal requirements necessary to remain in treatment, but often fall short of those necessary for successful completion (Knight et al., 2001).

3.3.4 Social Level Influences

3.3.4.1 Public attitudes/social stigma

Marlatt et al. (1997: 53), in their review of help-seeking for substance use, commented: *'the frequent reticence of substance abusers to seek help, especially from formal treatment programs, seems to be rooted not in denial of their substance-related problems, but in concerns about privacy, labeling, and the stigmatising effects of current treatments. Structural factors such as treatment cost and accessibility are less influential.'*

A number of authors report that there is considerable stigma associated with drug use and treatment participation (Cunningham et al., 1993; Copeland, 1997). This stigma takes the form of users being too embarrassed to discuss their drug use with anyone, and being afraid of what others would think (Grant, 1996). Knight et al. (1991) report that some women actively avoid seeking treatment when faced with the possibility of losing custody or of being penalised by correctional or child welfare systems for placing a child 'at risk' through exposure to a 'substance abusing lifestyle'.

Judd (1998: 168) conveying the findings of a United States independent 'consensus panel of experts on the development of effective medical treatment of opiate addiction' reported: *'Many of the barriers to effective use of MMT in the treatment of opiate dependence stem from misperceptions and stigmas attached to opiate dependence, the people who are addicted, those who treat them, and the settings in which services are provided. Persons dependent on opiates are often perceived not as individuals with a disease, but often as 'other' or 'different'. Many people believe that dependence is self-induced or is a failure of willpower and that efforts to treat it will inevitably fail. Vigorous and effective leadership is needed to inform the public that dependence is a medical disorder that can be effectively treated with significant benefits for the patient and society.'*

3.4 Retention in Treatment

3.4.1 Length of time in treatment

Studies on treatment retention have found that the longer a client remains in treatment, the better the chance that management of substance use and improvements in client functioning will be sustained over time (Simpson et al., 1997; Corsi et al., 2002; Gossop et al., 2002). In two large studies, Simpson (1984) found that length of time in treatment was an important predictor of outcome for the more than 6,000 clients in the Drug Abuse Reporting Program (DARP) follow up research, while Hubbard et al. (1989) also found that time in treatment was one of the most important predictors of successful drug abuse treatment in their Treatment Outcome Prospective Study (TOPS) of more than 1,500 clients. However, relapse rates post-treatment for those completing a course of treatment are still very high and treatment completion does not ensure success (Hubbard et al., 1989).

3.4.2 Program related factors

The factors increasing retention and outcome are different across different treatment modalities (Prendergast et al., 2000; Comfort et al., 2003). Consideration also needs

to be given to the time spent in treatment, ranging from 7-30 days for inpatient detoxification, to 6-18 months for long term residential programs, including therapeutic community programs, to years for many clients on methadone maintenance. The treatment program factors (and potential barriers) that affect retention in treatment that are specific to the various treatment modalities include:

Methadone maintenance programs

Some of the treatment factors that affect retention on methadone maintenance programs that are frequently mentioned in the literature are:

- *Level of methadone dose:* Reynolds & Magro (1975) and Reynolds et al. (1976) found higher doses resulted in better outcomes. Other researchers also found that higher doses resulted in greater retention (Hargreaves, 1983; Strain et al., 1993; Caplehorn et al., 1991; Taplin, 2000; Farre et al., 2002);
- *Flexible clinic philosophy:* Jaffe (1970) presented evidence suggesting that an aggressive clinic policy can overcome any dose effect and cause equally poor retention in both high and low dose groups. Caplehorn et al. (1991) found that, while allowing for patient descriptors and maximum dose of methadone, those subjects assigned to a strongly abstinence-oriented program were more likely to leave treatment in the first two years than those in a more laissez-faire program. Gaughwin et al. (1998) concluded from their study of retention on the South Australian methadone program, 1981-1991, that more humane approaches and higher doses increase retention. Taplin (2000) also found that more draconian clinic practices resulted in clients leaving programs sooner;
- *Counselling:* Dole & Nyswander (1967), in their original model for methadone maintenance, advocated the provision of counselling to aid in clients rehabilitation, primarily to assist them in practical ways to reintegrate into society. Ball & Ross (1991) and McLellan et al. (1993) have shown that programs that provide regular, frequent, structured, drug-focused counselling realise better outcomes than programs that provide little or no counselling. For some clients, specialised psychotherapy often helps to address some of the emotional and behavioural problems that interfere with treatment progress (Woody et al., 1983);
- *Staff attitudes:* Extensive research has been undertaken on the influence of staff attitudes on policies and practices in drug treatment services. In Australia, Caplehorn et al. (1998) found that, although staff working in methadone clinics in Sydney were relatively well informed about the benefits of methadone treatment, many were led by their personal beliefs to support more abstinence-oriented practices. The dose prescribed was found to be associated with the prescribers' attitude scores; and
- *Regimental structures*: Koester et al. (1999) comments that the regimented structure and requirements demanded by methadone clinics are contrary to the heroin user's own routine: they may have only known the heroin-using lifestyle. They may be used to being 'independent'. '*To obtain methadone requires the heroin user to re-enter the system, to seek treatment, to submit to counseling and random urinalysis, and to pay a fee on a scheduled basis.*' '*Long-term methadone maintenance, as well as drug treatment in general, represents and requires fundamental life changes for heroin users. It may entail the loss of one's social role and identity, one's economic strategy, and the loss of friends and acquaintances'*. (Koester et al., 1999: 2149).

Therapeutic communities

Therapeutic communities offer long-term residential rehabilitation programs. These programs emphasise behaviour, socialisation and lifestyle changes with a focus both on abstinence from drug use and the adoption of more socially acceptable behaviour. Clients often comprise people who have tried other treatments, and would prefer a more formal abstinence-based, long-term treatment to attempt to control their drug use. (Sindelar & Fiellin, 2001). De Weert-Van Oene et al. (2001: 254) comment: *'in general a picture emerges with the patient-therapist relationship being one of the most important in-treatment factors with respect to treatment retention and treatment outcome.' 'Among in-treatment factors, helping alliance is the most important' (across a range of treatments). 'Patients' perception of the quality of the therapeutic relationship is among the important factors in the prediction of treatment retention.'*

Counselling

Counselling appears to be important as a treatment in its own right or as an essential ancillary to other treatments, such as residential rehabilitation and methadone maintenance. Dietze at al. (2002) found that counselling was often the first type of treatment accessed by their sample. An additional advantage of counselling identified by Sindelar & Fiellin (2001) is that it is a treatment suitable for treating people using a range of different substances, not just heroin and, as such, may attract psychostimulant users. Nevertheless, some clients and would be clients are put off by the confrontational counselling models used by some treatment services.

Detoxification

Ghodse et al. (2002) found much better outcomes among those clients who completed detoxification and then spent at least 6 weeks in a recovery or residential rehabilitation program as compared to those who just completed the detoxification program. These authors conclude that detoxification alone does not offer long-term benefits, unless followed by a more substantial and ongoing treatment. However research suggests that, for many, completion of a detoxification program is not followed by entry into long-term treatment (Kleinman et al., 2002; Mark et al., 2002; Millery et al., 2002). Additionally episodes of detoxification, whether professional or self managed, appear to occur often over the course of an individual's drug using career (McCarty et al., 2000; Noble et al., 2002). Gandhi et al. (2003) argue that detoxification may have benefits for people who are not yet ready for long-term treatment but want to make changes to their drug use. Their study, which focused on outcomes of a brief outpatient detoxification program, found that the program had an important short-term benefit in aiding clients to reduce the frequency and intensity of their drug use. Further, Rysavy et al. (2001) found that leaving the program early did not appear to be associated with client dissatisfaction; rather, changing one's mind and personal commitments where the most commonly cited reasons for the not completing the detoxification program.

3.5 Population Groups with Different Experiences

3.5.1 Introduction

Gowing et al. (2001) point out that drug use treatment research is dominated by trials assessing efficacy, and tends to focus on groups that represent the majority of the population.

The population groups examined below encounter many of the same barriers as the general population of users, as well as barriers that appear to be specific to them. As the barriers facing each group can be a study in its own right, only a brief description to the specific barriers encountered is provided below.

3.5.1.1 Women

Women tend to underutilise drug treatment services compared to men, indicating that women may face unique barriers to drug treatment entry (Watkins et al., 1999). Beckman's (1994) review of the treatment needs of women with alcohol problems discussed intrinsic factors such as denial, fear of stigmatisation, guilt, shame and concern about leaving or losing their children. Findings from various studies have found that women entering drug treatment facilities have higher rates of medical and psychiatric complications, unemployment, family and social concerns and abuse (Chatham et al., 1999; Davis, 2002). The major barriers for women to entering treatment relate to interpersonal issues, including opposition from families and friends, the social costs of family and friends and structural barriers, such as inadequate training of health professionals to deal with substance use among women, and lack of women-only treatment care that also provides child care. Klee & Jackson (1997) noted that reluctance to be identified as an illicit drug user is particularly strong for women who fear that social services may be informed and check on the welfare of their children.

In Copeland's (1997) Australian study of barriers to treatment seeking among women users (alcohol, psychostimulants and heroin) who managed change without formal intervention, the reasons given for not seeking professional assistance included the social stigma attached to women with substance dependence, their preference to rely on available social support, their past experiences with general medical practitioners, and the notion of self-reliance. Seventy eight percent of respondents felt that women with alcohol and other drug problems were more looked down upon than men, with suggestions of a lack of moral and social restraint and overtones of promiscuity and poor maternal instincts. Some thought it was embarrassing for their family and children if they had to go away to 'dry out'.

3.5.1.2 Youth

Adolescents do not usually go into treatment voluntarily. More often, they are coerced by their family, schools, the legal system, or significant others. Treatment services are often viewed by youths, and specifically adolescents, as frightening and unapproachable (Brown, 1991; Howard, 1994,). Brown concluded (1991: 69): *'Young people who use illicit drugs seldom attend services. Of the few who do, most attend unwillingly and briefly, and even fewer still obtain any discernible benefit or satisfaction from the experience.'* (Spooner et al., 1996: 7-2). Howard (1994) notes many adolescent-specific programs are not 'adolescent-friendly'.

Donovan et al. (1991) found that conventionality is related not only to substance abuse but all health behaviours. Unconventionality is linked to less involvement in health-maintaining behaviour. This suggests that adolescents may avoid health-maintaining behaviour (or health promotion) as it is seen to be conventional (Spooner et al., 1996).

3.5.1.3 Rural/remote users

Economic and physical barriers frequently prevent rural populations from receiving adequate health care. The lack of public transportation, few local providers from which to choose and distance from health care facilities complicates availability of care and influences treatment choices. Furthermore, rural areas traditionally have difficulty in recruiting and retaining health care professionals (Howland, 1995). These areas also cannot sustain a range of specialist drug and alcohol services that may be available in larger urban areas (Donnermeyer et al., 2002)

Drug treatment acceptability may also be more of an issue in rural communities. The role of religion and the church, adherence to community norms, fear of lack of privacy, or stigmatised illness may be some of the barriers to treatment entry. Additionally, the rural work ethic which stresses the importance of being able to continue work and function in their usual productive roles, coupled with independence and self-reliance, may also deter people from seeking help for the substance-use associated problems (Metsch & McCoy, 1999). Often the only alternative for an individual in a rural area seeking drug treatment, is to leave the area. This may deprive them of other important social supports necessarily to help encourage and sustain changed drug use patterns (Donnermeyer et al., 2002).

3.5.1.4 Culturally and Linguistically Diverse (CALD) users

The report *Drugs in a Multicultural Community – An Assessment of Involvement* (2000) suggested that little is known about illicit drug use amongst ethnic groups in Australia. It found that, in addition to language and cultural barriers to treatment, many CALD users were not aware of the services available; were concerned about confidentiality issues; and were suspicious of counselling and self-disclosure. Young CALD people may hide their drug use from their family for fear of being ostracised.

Reid, Crofts & Beyer (2001) suggest that the under-representation of ethnic minorities in drug treatment services represents underutilisation rather than a lower need. Intense shame and loss of face linked with acknowledgement of illicit drug use was common and, as a consequence, help seeking was fraught with difficulties. Lack of knowledge of available assistance was widespread. Even when treatment services were accessed, key informants consulted for the study viewed them as culturally insensitive, inflexible, and having language barriers.

3.5.1.4 Aboriginal and Torres Strait Islander People

The 1998 National Drug Strategy Household Survey found that around 59% of Indigenous people surveyed had tried at least one illicit drug, with almost a quarter having used at least one illicit substance during the past twelve months. However, given the small sample (n=200) the estimates should be treated with caution (Higgins et al., 2000).

Spooner et al., (2001) address in their literature review some of the barriers to treatment for Aboriginal and Torres Strait Islander illicit substance users. They comment that there are arguments both for and against providing Indigenous Australian-specific services. However, most present to mainstream services for help. One of the main barriers to Aboriginal and Torres Strait Islander users accessing treatment was seen to be the lack of culturally appropriate treatment options.

3.6 Summary and Discussion

The review has identified a wide range of personal, interpersonal, organisational and societal barriers.

Many of the barriers (and incentives) identified at the problem identification, help seeking, treatment access and engagement stages are also relevant at the treatment retention and post-treatment stages. For example, predisposing factors, such as personal motivation and attitudes and beliefs about treatment are just as important at the engagement with services, and retention in treatment, stages. Social stigma is manifested at all stages (though many clients in treatment report that they are satisfied with the treatment given) and family and social support are important at the problem recognition, access, and retention in treatment, stages.

Whereas individual factors, such as personal motivation, knowledge and attitudes to treatment, are more often than not discussed in the literature in terms of associated barriers (e.g. in relation to denial, lack of knowledge of treatment options, and lack of available treatment places), interpersonal influences such as family, social, and employment are presented as enabling factors, i.e. in providing prompts and incentives for help-seeking (Hser et al., 1997). Social forces, ranging from family, peer and community influences, drug availability, policy activities, and the treatment service system (financing, eligibility, adequacy of services) provide pressure or support for treatment utilisation. Although external factors such as legal pressures and sanctions can be useful in keeping clients in treatment, intrinsic factors are commonly considered more fundamental to the recovery process (Cunningham et al., 1994). Studies also suggest that the predictors of entry, retention and outcome may be different for people choosing different treatment modalities and what the client brings to the treatment process may strongly determine the treatment outcomes (Comfort et al., 2003; Gossop et al., 2003).

Studies examining barriers specific to population groups, such as women and youth, rural and remote communities, cultural and linguistic diverse background people and Aboriginal and Torres Strait communities, indicate that there are particular sets of problems relating to these populations in addition to the barriers illicit drug users face in general. Reid et al.'s (2001) conclusion that the under-representation of ethnic communities in drug treatment services reflects under-utilisation of the services by community members, rather than lower need applies equally to all the identified sub-populations. Addressing the needs of these communities and sub-populations requires further consultation and the provision of culturally appropriate interventions and services.

Research indicates that the incidence of dual diagnosis, an overlap between drug dependency and psychiatric/psychological morbidity, is high. Individuals who suffer coexisting drug use and mental health problems experience difficulties in accessing

treatment, and are regarded as 'difficult to treat clients'. While there are many effective treatments, their effectiveness is limited by inadequate communication between the agencies involved. Barriers to treatment for people with dual diagnosis is an area where more research is needed, particularly from a consumer perspective.

Few incentives, other than the use of coupons or transportation assistance to encourage treatment entry and retention in treatment, were identified in the literature. However, if the focus shifts from the drug use problem and treatment focused on this problem to the individual as a whole person, many other incentives to engaging in treatment can be identified. For example, court diversion can be regarded as an incentive to treatment when viewed as an alternative to incarceration, employment and skills training and coping strategies associated with treatment can assist an individual's integration into society and improving family and other relationships can be an important motivator for entering treatment. Also, policy and program innovations such as the availability of new pharmacotherapies (e.g. buprenorphine), low threshold and safe treatment settings, novel counselling methods (e.g. contingency management) and new maintenance therapies for chaotic drug users (e.g. heroin maintenance) can provide incentives to treatment entry (Sindelar et al., 2001).

Evidence from studies on retention in treatment suggest that aspects of the treatment experience, such as flexible clinic philosophy, the quality of the therapeutic relationship, matching clients to particular treatments, case management, client-centred communication and consumer satisfaction, lead to better adherence in treatment and better client outcomes.

There is a tendency in the drug use treatment literature to focus on the individual drug user in isolation, without considering the wider context of their personal relationships and circumstances. Little attention is given in the literature to the impact of the various socio-economic determinants affecting health and wellbeing and drug use, such as poverty, social exclusion and inclusion, level of education and training, living environments and work and unemployment on people from disadvantaged groups, and their ability to access treatment services and remain in treatment.

Chapter 4:
Main Points from the Survey of Illicit Drug Users

This Chapter summarises the main points arising from the survey of illicit drug users. The full report can be found at Appendix A.

4.1 Sample Characteristics

Overall, this sample comprised about two-thirds males, had a mean age of 31.6 years, were mostly born in Australia, and included 11% of people identifying as Aboriginal or Torres Strait Islander. About 60% had an education level of Year 10 or less, and about three-quarters of the sample reported an annual income of less than $20,000; and about the same proportion reported government benefits as their main source of income.

Demographics

A summary of the main characteristics of the sample is given below. The three sample groups are similar across most characteristics. However, some significant differences exist. Later analyses will examine if these are independently related to treatment status:

- participants who had never been in treatment were, on average, younger than those who had ever been in treatment;
- a greater proportion of participants who were currently in treatment were receiving government benefits as their main source of income, compared to those previously and those never in treatment; and
- a greater proportion of participants who had ever been in treatment identified opioids as their most frequently used drug (that is, a greater proportion of participants who had never been in treatment identified psychostimulants as the most frequently used drug).

The main characteristics of the sub-group of this sample in current treatment (including demographic and other variables) were compared against those of a recent sample of people in treatment for heroin dependency (Dietze et al., 2003) and the routine data collected in a one-day snapshot of attendees in Australian treatment services (Shand & Mattick, 2002).

On main demographic variables, this sample was similar to those of other recent Australian studies in terms of age, gender, ethnicity and socioeconomic indicators, as shown in Table 4.2.

Table 4.1 Summary of the main characteristics of the sample recruited for the current study

Characteristic	In treatment	In/out treatment	Never in treatment	Total (N=685)
Recruitment	48%	24%	28%	100%
Mean age (years)	32.16	32.28	30.11	31.61
Gender (male)	64.7%	63.2%	73.1%	66.7%
Capital cities	62.9%	61.3%	61.1%	62%
Regional/rural	37.1%	38.7%	38.9%	38%
Australian born	83%	85.3%	88.6%	85.1%
ATSI	8.2%	15.3%	13.5%	11.4%
On benefit	81.8%	69.9%	54.9%	71.4%
Education < =Y10	61.1%	57.7%	54.9%	58.5%
Opioid user	59%	60.1%	36.3%	52.8%
Psychostimulant user	41%	39.9%	63.7%	47.2%

Table 4.2: Main demographic and drug use indicators for the current study sample compared to two recent Australian studies

	Barriers In Treatment Sample)	Dietze et al. (2003)	Shand & Mattick (2002)
Sex, males	65%	64%	64.8%
Age (mean)	32	30.2	32.8
Country of Birth, Australia	83%		89.3%
ATSI	8%		11%
On benefit	82%, (employed 12%)		(employed 16.5%)
Age at first injection	20	(first heroin injection) 20.4	
Drug related arrest last 6 months	32%	(last 12 months) 21%	
Served sentence last 6/12 mths	11%	(ever) 52%	
Ever overdose	62%	(involving naltexone, past 12 months) 21%	
Tried self-treatment	75%	91%	
Number times tried self-treatment (mean)	4	5	

4.1.1 Geographic location

The findings of the survey of illicit drug users indicated that differences in location were not significantly associated with the outcomes examined. We would not expect recruitment location to be associated with treatment group – as individuals 'in treatment', 'in-out of treatment' and 'never in treatment' were recruited from each site. However, other location was examined for additional outcomes, such as treatment completion, achieving treatment goal and plans for future treatment. Although recruitment location was not found to be significant in these data, the insights from other sections of the project (service providers and key informants) should be used to examine this issue in greater detail.

4.2 Drug Use History

The study found:

- almost 60% of the sample indicated that they used drugs once or more a day, and almost all (92%) injected drugs;
- on average, participants had started injecting drugs at 19.3 years of age, and had been injecting for 12 years; and
- the mean severity of dependence (SDS) scores for those in and out of treatment and those never in treatment were 7.59 and 5.84, respectively (higher scores indicate higher levels of dependency). The corresponding SF health scores were 34.20 and 38.87. Those in treatment had a SF health score of 35.05 (higher score indicates better self-rated physical and emotional health);

4.2.1 Treatment status and drug most frequently used

Since there is no widely accepted pharmacotherapy for stimulant dependence, there are fewer treatment options for stimulant than for opioid users. The sampling of participants for this study was adjusted to accommodate this (that is, additional stimulant users were sought in other non-pharmacological categories of treatment). Consequently, the fact that stimulant users were mainly in the 'never in treatment' group is probably due to relatively low need or desire for treatment among stimulant users.

4.2.2 Use of drugs during treatment

Those 'in treatment' tended to have the lowest rates of use (or injecting) of any of the drugs listed. This may be a true treatment effect, or it may be magnified by the context in which the questionnaire was completed, that is, within a treatment centre.

In general, the 'never in treatment' group tended to have similar or lower rates of use of drugs compared to the 'in-out treatment' group. The exceptions to this were alcohol, cocaine use (not injecting), ecstasy use and injecting and MDA use. In particular, ecstasy use and ecstasy injecting by the 'never in treatment' group was two and three times that of the 'in-out treatment' group, respectively. This may indicate that the 'never in treatment' group has a wider range of drug use but lower dependency on any one particular drug.

When considering reports of high abstinence during treatments, it should be borne in mind that relapse rates were not documented in this study and that self-report is fallible.

4.3 Social Networks

4.3.1 Family member uses drugs

Fifty-three percent of respondents reported that one or more immediate family members used drugs. However, the survey question did not specify illicit drugs. Consequently, the very high rates of drug use among immediate family members may indicate alcohol and cannabis use in particular. Lifetime prevalence of other illicit drug use is much lower in the general population, particularly for injecting drug use (Australian Institute of Health and Welfare, 2002). However, other recent studies have shown very high rates of injecting among family members of participants (up to 50%) (Sheaves et al., 2001). The relationship between family members' drug use and individual use is not well understood.

4.4 Law Enforcement

4.4.1 Trouble with police

About one-third of participants indicated that they had been in trouble with police in the last six months. Of those participants, 75% indicated that the charge was related to drug use. Of those who indicated that the charge was related to drug use, 17% were referred to a drug court. Of the 57 people who served a sentence, 44% were not offered drug treatment in prison.

4.5 Health and Wellbeing

4.5.1 Blood Borne Virus (BBV) testing

The sample showed a high rate of testing, with over 80% of the sample being tested for hepatitis C, hepatitis B and HIV. However, the rate of testing was significantly lower in the never in treatment group, and testing for hepatitis B was lower than for other BBV. Rates of hepatitis B vaccination were also low (around 18%). This indicates that programs to introduce hepatitis B screening and vaccination as a priority for injecting drug users have had only partial success. In addition, strategies are required to encourage BBV testing for people who use drugs, and who have not been in drug treatment.

4.5.2 Compulsory testing and pre/post test counselling

Only one quarter of participants reported having received BBV testing as a compulsory part of drug treatment. This finding is alarming, as it may suggest that treatment centres fail to communicate that testing is strongly recommended, although optional. Although participants may have interpreted testing offers at treatment facilities as compulsory, their finding that only about one-third of participants responding to the question indicated that they had received pre/post test counselling is concerning. Pre/post test counselling offers a prevention education opportunity for this high-risk group and should be provided routinely for all BBV tests.

4.5.3 Having felt suicidal in the last 4 weeks

About one-third of the sample, fewer in the 'never in treatment' group, indicated that they had felt suicidal in the previous 4 weeks (lower in the 'never in treatment' group). This could be interpreted as a significant indicator of underlying mental ill health.

A recent Australian study (Darke, 2003) also indicated a high proportion of suicidal feelings in the sample of treatment clients. Together, these results indicate a significant issue for providers of drug treatment services: that mental health input into treatment and care is warranted for a sizeable minority of drug treatment clients.

4.5.4 Physical and emotional health indicators

The 'never in treatment' group reported significantly better physical and emotional health on all scores used, compared to the 'in-out' and 'in treatment' groups. The mean SF health scores for those 'in treatment', 'in and out' of treatment and those 'never in treatment' were 35.05, 34.20 and 38.87, respectively (higher scores indicate better self-rated physical and emotional health).

The scores of the 'in treatment'group are difficult to interpret – it could be hypothesised that those in treatment should show better physical and emotional health scores than the 'in-out treatment' group. However, the effect of current treatment on these scores is not clear: for example, does treatment bring into focus the effects of drug use on physical and emotional health? After treatment, do the physical and emotional health scores improve to be comparable to scores of the never in treatment group? If so, what is the timeframe of this change?

4.6 Treatment History and Current Treatment

4.6.1 Awareness of treatment and referral to treatment

Professional sources of information were the most frequent means by which participants were made aware of treatment services. However, personal contacts (family, friends and partner) and media were reported by a significant proportion of participants.

Most participants referred themselves to treatment indicating significant personal incentives to undertake treatment (rather than imposed conditions to attend treatment).

4.6.2 Entry into treatment

Most participants indicated that they had to meet requirements before being admitted to treatment. Typically, these requirements were to see a professional and, to a lesser extent, abstinence or urine testing. Overall, the majority of participants were able to meet these requirements, and were accepted into treatment, although most continued to use drugs while waiting for treatment. The average wait for entering treatment was two days.

4.6.3 Barriers and incentives in relation to achieving treatment aims

With regards to client *treatment aims*, the study found that 56% of those currently in treatment and previously in treatment indicated that their treatment aim was abstinence, while 44% indicated that their aim was to control, reduce or have a break from drug use. Only about one-quarter of participants indicated that they were successful in achieving their treatment aims.

The most frequently endorsed reason for achieving treatment aims was 'self determination'. Also frequently reported were 'support from staff and support from peers'.

In general, the most frequently reported barriers to achieving aims were the inter-related issues of not being ready to stop using and a preference to keep using drugs.

These results indicate that clients of drug treatments see their own individual motivations as paramount to their success in treatment. Interpersonal or organisational supports were perceived as secondary facilitators.

With regard to *client satisfaction* with treatment and the range of services offered, the study found that about 60% of participants indicated that they were somewhat or very satisfied with their current or most recent treatment episode, while 22% reported being very or somewhat unsatisfied with their treatment.

With regard to treatment agencies providing *additional services* relating to users' health and wellbeing, the study found that the most frequently reported 'additional' services offered by treatment programs were medically related and included: information about blood-borne viruses (81%); individual counselling (79%); relapse prevention strategies (63%); mental health assessment and treatment (54%); and medical/dental treatment (54%). However, respondents in the current treatment group were more likely than those in the past treatment group to report that their current treatment provider offered other services such as employment/skills training, housing assistance, family interventions, financial planning assistance, legal advice and referral to peer support programs.

With regard to post treatment support programs, the study found that most participants were aware of support available from drug and alcohol counsellors. Other programs reported by high proportions of participants included self-help groups, methadone maintenance, support from a local GP, long term therapy/counselling and naltrexone maintenance.

4.6.4 Reasons for wanting to change drug use

With regard to reasons for wanting to change, the study found that about 60% indicated they were 'in crisis' or 'chaotic' at that time, of whom about 50% indicated that their financial state prior to treatment was 'debt ridden'.

The most frequently reported reasons for wanting to change drug use related to personal issues, such as wanting to improve one's quality of life, to increase stability and being sick of the lifestyle. Other frequently reported reasons for wanting to change drug use included being concerned about the impact of drug use on others and concerns about their physical and mental health. Reasons, such as being diagnosed with hepatitis C or being worried about getting blood borne viruses, were among the lowest frequency responses. Respondents not currently in treatment were more likely than those in treatment to want to change drug use because of problems with drug supply.

4.6.5 Previous drug treatments

Participants had previously sought professional treatment on an average of four times. The treatments most frequently sought included visiting a GP for medication, drug counselling and methadone maintenance.

4.7 Attempts to Change Drug Use Without Professional Help

4.7.1 Self treatment attempts

Participants had attempted self-treatment on an average of four times. Strategies most frequently used included cutting down and stopping using. The aims of self-treatment were reported as 'to stop using' by 42% of participants (lower among those 'never in treatment').

Over half of the participants reported using cannabis and benzodiazepines to assist them in their self-treatment attempts.

About 40% of participants felt they were not at all successful in their last attempt at reducing drug use by self-treatment.

About 30-40% of participants relied on support from a current partner, family members and friends in their last self treatment attempt, with all supports accessed reported as being helpful by most participants.

4.8 Barriers to Treatment

4.8.1 Past treatment seeking

The study found that:

- twenty-eight percent of participants (n=190) reported that they had tried to get treatment for their drug use and had not been able to do so in the last 5 years;
- of these, 55% reported 'no service available in the area' as the main barrier to treatment. Other significant barriers reported by participants were: waiting list was too long (52%); lack of support from health professionals (25%); inability to meet the criteria (22%); treatment offered was not the kind wanted (22%); treatment program did not suit needs (20%); travel problems (19%); cost of program (14%); lack of support from family/friends (14%); heard from others that the treatment was no good (13%); fear of disclosure (13%); fear of being stigmatised (13%); banned from the program (7%); fear of children being taken away (6%); treatment was unable to accommodate children (6%), and partner (6%); and fear of job loss (5%): and
- with regard to social stigma, more than half the participants in the sample reported that they had been discriminated against by family (63%), staff at pharmacies (63%), friends (62%), and doctors/nurses (54%), while a significant proportion mentioned discrimination by partners (37%), other health care workers (36%), landlords (36%) and workmates (34%).

4.8.2 Differences between current and previous treatment (for 'in treatment' participants only)

The most frequently endorsed difference between participants' perceptions of their current and previous treatment attempts was "this time you were ready". This finding indicates that participants primarily see themselves as responsible for success in treatment. 'Treatment orientation' and 'support from others' were reported as important but less frequent reasons for the difference.

4.9 Attitudes

4.9.1 Experience of discrimination

More than half of participants reported experiencing discrimination. The most frequently reported sources of discrimination included family and friends, but also included doctors/nurses and pharmacy staff.

Experience of discrimination was more frequently reported by those currently 'in treatment' (including from staff at methadone clinics). However, participants in the 'current' and 'past treatment' groups were more likely than those in the 'never in treatment' group to report having experienced discrimination by doctors/nurses and staff at pharmacies.

4.9.2 Attitudes towards drug treatment staff

Participants currently in treatment reported more positive ratings in attitudes towards drug treatment staff than other participants. This may indicate that attitudes towards drug treatment staff are not sufficient barriers to entering treatment. Alternatively, the responses given by those currently in treatment may have been influenced by the setting in which they completed the questionnaire (i.e. typically within the treatment service).

4.9.3 Attitudes to drug treatment

Overall, those who had never been in treatment were more likely to report that people who use drugs can stop using without professional help, and that sooner or later most people will stop using drugs. Those with treatment experience indicated their beliefs that professional help was required to stop using. This may be related to a higher level of dependency among those with treatment experience, or a result of interactions with treatment services and an understanding of what drug treatments can offer.

However, both this point and the one above indicate that contact with drug treatment services is associated with a positive attitude to treatment services and their staff.

4.10 'In-out' versus 'Never In Treatment'

Overall, the results indicate those 'never in treatment' have better health and less drug dependence indicators. This suggests that the incentives to seek treatment reported by the majority of participants (lifestyle, stability and quality of life) have not been sufficiently negatively affected by drug use to prompt this group to seek treatment.

Results of multivariate analyses indicate the following profile of those 'never in treatment':

- more likely to have better health;
- more likely to use a bigger mix of drugs;
- less likely to inject drugs;
- less likely to have overdosed;
- more likely to use drugs to party (rather than for other reasons);

- less likely to have tried self-treatment: Besides not having engaged with professional treatment, the 'never in treatment' group also has had fewer experiences of self-treatment attempts. Again, this suggests that their level of drug use has not reached sufficient levels to impact negatively on main life indicators and direct individuals to attempts to change their drug use;
- more likely to have used fewer other drugs in self treatment attempts; and
- more likely to have aimed to reduce or control drug use than abstain in self-treatment attempts. This finding indicates that those 'never in treatment' have not reached an experience with drug use which leads them to seek abstinence, and that their attempts to change their drug use have been aimed at modifying their level of drug use.

4.11 'Ever' versus 'Never In Treatment'

The results indicate that those who have 'ever been in treatment' can be characterised as having more problematic drug use, lower health indicators and a different attitude to treatment (i.e., a more favourable attitude to treatment, as well as a greater commitment to abstinence) than those 'never in treatment'. With regards to the latter point, those with experience of treatment appear to believe that successful treatments involve abstinence aims and professional intervention. This could suggest that those with experience of treatment have come to this opinion after repeated unsuccessful attempts to control their drug use.

Results of multivariate analyses indicate the following profile of those who have 'ever been in treatment':

- have a better opinion of treatment staff;
- are more frequent users;
- have more experience of overdose;
- have positive BBV diagnosis/ses;
- use drugs for purposes other than recreation;
- use self-treatment;
- aim for abstinence in self-treatment;
- deny that, if you want to, you can stop using drugs without professional help; and
- deny that treatments that allow continued injection of a substance are the most helpful.

4.12 'In Treatment' versus 'In-out'

It is difficult to know from the cross-sectional data if the differences between those currently in treatment and those with previous treatment experience will persist, or if they are a function of the current experience of the groups: that is, that those currently in treatment will some time after the conclusion of that treatment come to resemble the profile of those not currently in treatment.

For example, those currently in treatment scored higher on drug dependency indicators in the period prior to treatment than those who were not currently in

treatment. The drug use of those not currently in treatment may also escalate some time in the future to the point where they decide to seek treatment.

Results of multivariate analyses indicate the following profile of those in current treatment:

- being more satisfied with treatment: This result may be a function of timing, that is, that clients report being more satisfied with treatment while currently in treatment. After treatment concludes, satisfaction with treatment may decline, particularly if drug use increases;
- using drugs more frequently in 6 months before treatment (heavier user);
- being more involved with drug use networks;
- not having disclosed in last 6 months before treatment;
- more likely to report requirements and conditions of treatment. This result indicates a structural difference in treatment experience between people who were currently in treatment and those who had been in treatment previously. The interpretation of this finding is unclear;
- more likely to report abstinence as a condition of treatment;
- less likely to have asked to be referred to treatment. This result may indicate the operation of the court diversion system at the time of the study, whereby clients are directed to treatment as part of sentencing;
- less likely to have found out about treatment from professionals;
- less likely to be using drugs while in treatment; and
- less likely to believe that sooner or later most drug users will stop using drugs without professional help. This result may be a function of timing and the experience of currently being in treatment.

4.13 'Treatment Completer' versus 'Non-Completers'

The variables which distinguished those who previously completed treatment versus 'non completers' were primarily those which could be considered aspects of treatment, such as better attitude to treatment, lower poly drug use, and greater achievement of treatment goals. The one antecedent variable found to be significant was method of referral. Those participants who were referred by the corrections system were more likely to complete treatment than those who were referred by other means. Although this finding indicates that referral by the corrections system was a facilitator of treatment completion, findings from the service provider interviews indicated conflicting views of treatment success by corrections and health agencies, and should be taken into account when interpreting these survey findings.

Results of multivariate analyses indicate the following profile of those who have completed treatment:

- achievement of treatment aims. This finding would appear to be directly related to completing treatment. However, the direction of the relationship is not known, that is, whether completing treatment enhanced perception that aims were achieved or whether achieving aims facilitated completion of treatment;

- being referred by police/parole officer/court. Referral from these sources may carry greater incentives than those "self-imposed" (such as improving quality of life), particularly if the referral carried a risk of a jail sentence if treatment was not completed;
- having relatively low polydrug use. Those treatment clients with lower poly drug use scores may have found it easier to complete treatment because treatment is less complicated by polydrug use factors; and
- belief that 'it is easy to obtain good treatment'. The direction and interpretation of this result is unclear (that is, those who complete treatment may come to believe that it is easy to obtain good treatment, conversely, those who believe good treatment is easy to obtain may be motivated to complete treatment).

Key variables, which did not reach significance, were:

- treatment type: Treatments were classified as either (1) rehabilitation/detoxification or (2) pharmacotherapy/counselling on the assumption that treatment aims differed between these treatment modalities. This variable was not significantly associated with treatment completion (in univariate or multivariate analyses). This indicates that the achievement of treatment aims, whatever those aims may be, is more important to completion of treatment than the type of treatment entered into; and
- client focused treatment. It could be hypothesised that clients who enroll in treatment that is client-focused would record higher completion rates than those in treatment which is not described as client focused. This was not found (in either univariate or multivariate results). Other factors appear to be more important in determining the completion of treatment.

4.14 'Treatment Goal Achievers' versus 'Non-Achievers'

A number of these results may be interpreted as the outcomes of treatment, in which case, these variables do not have a primary role as barriers or incentives to treatment. For example, not injecting, feeling good, satisfaction and completion of treatment can all be construed as outcomes of treatment, rather than as factors which differentiate those who achieve, and do not achieve treatment goals.

Results of multivariate analyses indicate the following profile of those who achieved treatment goals:

- current abstinence from injection;
- disagreement with idea that legally prescribed heroin is a successful form of treatment;
- having felt good in last 4 weeks;
- having been in treatment for longer;
- having been satisfied with treatment;
- having completed the last treatment; and
- if stopped from getting treatment in last 5 years, this was because they heard the treatment was no good. This result may indicate that people who achieved treatment goals had made an informed choice about treatment options and had chosen a treatment which best suited their needs.

Key variables, which did not reach significance, were:

- drug use or demographic variables. Demographic or drug use variables did not differentiate in this sample those who would achieve and not achieve treatment goals; and
- treatment type and treatment goals. The type of treatment and type of aims (abstinence versus reduce/cut down) was not related to goal achievement.

4.15 Plans for Future Treatment

Those who are planning to go into treatment in the next six months can be characterized as having poorer health measures and higher drug dependency indicators. In addition, they report previous attempts to obtain professional treatment. In this way, they appear similar in profile to those who have been in treatment, or currently are in treatment (compared to the profile of those never in treatment). Also, those who plan to go into treatment have a good opinion of treatment, and aim to be abstinent. These are also the characteristics of those with treatment experience.

Results of multivariate analyses indicate the following profile of those who plan to go into treatment in the future:

- they have relatively poor overall health (compared with those who do not plan to go into treatment);
- they use drugs to avoid withdrawal or because they are sad (rather than for recreation);
- their aim in self treatment is likely to be abstinence, i.e., to stop drug use;
- they are likely to have a relatively good opinion of treatment staff; and
- they are likely to have tried and failed to get into treatment in the last five years; and/or to have kept using drugs while waiting for treatment.

4.16 Opioid versus Stimulant Users

Opioid users appear to have more negative outcomes in terms of withdrawal needs and BBV diagnoses. It is logical that those who most frequently use opioids would be in pharmacological treatment (there being no widely accepted pharmacological treatment for stimulant dependency), and that they would agree with an attitudinal statement, which particularly relates to treatment for opioid addiction.

Results of multivariate analyses indicate the following profile of those who most frequently report using opioids:

- they use drugs to avoid withdrawal or pain relief (rather than to party). This result suggests a higher level of dependency among opioid users than stimulant users. This result may also reflect the physiological action of opioids in creating a withdrawal syndrome;
- they have one or more positive BBV diagnoses;
- they are on pharmacological treatment; and
- they agreeing with statement that ‘legally prescribed heroin would be a better treatment than methadone maintenance’.

The results draw attention to the association between opiate use and generally poorer outcomes or status on a number of measures, such as greater dependency scores, higher drug use, poorer health status and greater attempts at treatments of various kinds. These results suggest that a wider variety of options is required to meet the treatment needs of very entrenched drug users.

Chapter 5:
Findings of the Service Provider Interviews

5.1 Aim

Interviews with service providers were conducted to ascertain their views on real and perceived barriers and incentives that prevent or facilitate illicit drugs users accessing or remaining in treatment.

5.2 Results

5.2.1 Interviews conducted

A total of 34 interviews were conducted, 33 of which could be categorised by the treatment of interest (see Table 5.1).

Table 5.1 Sample of service provider interviewees

Treatment Type	Areas Represented	N
Residential Rehabilitation	Inner Sydney, Western Sydney, Rural NSW, SE Qld, WA	5
Detoxification	Inner Sydney, Rural NSW, SE Qld, 2 Rural Qld, WA	6
Pharmacotherapies	Inner Sydney, 2 Rural NSW, SE Qld, Rural Qld, WA	6
Counselling	Inner Sydney, Western Sydney, Rural NSW, 2 SE Qld, Rural Qld, WA	7
Services engaging or making contact with users	2 Inner Sydney, Western Sydney, 2 Rural NSW, 2 SE Qld, Rural Qld, 2 WA	9
Total		**33**

5.3 Levels of Influence

5.3.1 Personal Level

Many participants commented on the individual barriers or incentives to entry into drug treatment. Typically, clients were described as being without skills, in crisis or at 'rock bottom' when seeking treatment.

For example, barriers attributed to individuals included their own state of mind, denial, or *'their own personality being their own worst enemies'* (rural treatment provider) and that '*they are so used to what they are doing, they don't know it can be different'* (rural treatment provider).

In describing people seeking treatment, participants spoke about people who have '*no living skills*' (urban treatment provider) and not knowing '*how to do the most basic things; shop, cook, use the telephone*' (rural treatment provider). In terms of barriers to treatment or relapse, this meant that services tried to provide these skills, as well as building up the client's self esteem.

Some services configured treatment as trying to '*attach people to the shame of who've they've become…becoming aware of the failure of their life*' (urban treatment provider).

Referral services perceived that treatment services tend to focus on an individual's negative life events and to perceive individuals as being without skills. They were critical about this attitude to treatment:

> '*It's also about the punitive nature of some of those [treatments], it's not about the implementation of effective treatment practice, it's 'we're going to deconstruct your nasty drug using personality and we'll give you a bright shiny new one and if you can't hack it then there's something wrong with you and you better piss off'. So it's not a lot about engaging people in a therapeutic process*' (urban, outreach service).

Participants from some treatment services made comments that identified clients as possessing skills and knowledge, which are useful in everyday life:

> '*We work on the basis that everybody has got strengths and skills. And that they don't have to learn new ones, they've already got things that they can do themselves. So it's about uncovering those or alerting people to the fact that they do have the skills and how can they use those in the dilemma that they've got at the moment*' (rural treatment provider).

In addition, participants from some agencies perceived that there was an over-focus on drug use in the client's life: *'[within] treatment services there is a focus on drug use, but assume drug use is paramount'* (urban treatment provider).

In response to this individual level focus, the services themselves appeared to be oriented to focusing on the individual to the exclusion of almost all other impacts on their wellbeing. This was described as a 'fix-it' model of drug treatment.

This was echoed in participants' statements about the lack of community support for, and knowledge about, drug treatment. If the individual is seen as solely responsible for drug problems and the source of barriers to successful treatment, then they also are vulnerable to stigmatising community perceptions.

Participants from referral agencies also recognised structural issues, such as 'poverty traps' and a 'historical mistrust of health services' as generating significant barriers at the individual level.

5.3.2 Interpersonal level

Service provider participants, typically, portrayed the same interpersonal issues as acting as both barriers and facilitators to treatment. The key actors in this level included the individual's peer group and family. Drug using peers were viewed as both barriers and facilitators to treatment uptake and retention in treatment. A peer group constituted entirely of drug using peers could perpetuate the individual remaining embedded in a drug using culture (this perception is linked with the descriptions of clients having '*no skills*' etc.). In addition, individual users contemplating treatment were also described as being actively pressured away from treatment by peers: '*I suppose there'd be some peer group pressure for people not to get well because then it would highlight other people's own failings*' (rural treatment provider). In terms of treatment retention, still being in touch with that peer group was seen as a '*huge part of their problem*' (urban, treatment provider). Alternatively, isolating

clients from peers was also seen as a barrier to treatment retention, and may work to '*drag them back to drug use'* (urban, treatment provider).

In the same way, family relationships were perceived as both positive and negative influences. Unsupportive families or those with 'unrealistic' expectations of the individual were described as posing barriers to treatment uptake, retention and success. Various external and internal pressures on the family unit (such as threat of Departments of Community Services (DoCS) interventions or demands by partners) were seen as prompts to treatment. However, treatments which necessitated isolation from families (particularly children) or which did not cater for dealing with the family as a unit were perceived to carry risks of treatment non-completion.

5.3.3. Organisational/Institutional level

5.3.3.1 Workforce

Participants generally described working in this sector as demanding and not readily accepted or acknowledged by the wider health workforce or the general community. The personal stresses of working in sector were acknowledged with claims that staff need to be 'emotionally healthy' to work with difficult clients.

Besides demanding work roles, there were other structural influences on the ability of the sector to attract and retain staff. Many participants described salary rates within the sector as low and, in some jurisdictions, the salary rates for non-government agencies were described as significantly below government rates:

> '*I believe we're about seven to ten thousand dollars behind the government services. Our own experience is that we tend to hire people straight from uni, spend a year or two training them up and then they go to a more lucrative job. There's a bit of sparring we have amongst the NGOs about stealing people from each other, but in fact its probably we all experience that we take graduates, you know, then they disappear with all our experience*.' (urban treatment provider).

Other participants spoke about lack of a career structure within the sector, lack of job security and the piecemeal nature of training at various levels:

> '*The trainings are piecemeal. The TAFE course, the advanced certificate in drug and alcohol, waxes and wanes. There's no real coherence to university training so there's no real drug and alcohol strand in social work or psychology and there's no specialist medical organisation that focuses on drug and alcohol…there's no nationally consistent or articulated drug and alcohol course for medical undergraduate students*' (urban treatment provider).

In small centers, where the workforce was small, participants described difficulties in getting a balance of skills across the team. This was compounded in sites where funding was on a limited term (e.g. project-based) and contracts of employment could only be offered for short periods (i.e. until the end of the current round of funding).

5.3.3.2 Links between services/continuity of care

Participants generally identified that clients presented with many needs that any one service could not address. All participants spoke of the need to work with other agencies to meet clients' needs. However, the extent to which this had been achieved was perceived as variable, and there was a general view among participants that this was a difficult aspect of their work requiring on-going effort. Further, participants

nominated barriers to effective inter-agency work originating in many factors, including differing philosophies between agencies, knowledge of external practitioners and agencies and 'prejudicial staff' in other agencies.

'Case management' was a term used to describe treatment services' approach to service delivery. Typically this involved referral of the client to external services and facilitation of the client's attendance at that service. However, this came at a price. Some agencies believed linking clients to outside services increased the risk of '*actually [dropping] them through the cracks*' (urban treatment provider), that is, participants perceived significant distance between the operation of their service and outside services which could pose a threat to the continuity of care of an individual.

The particular issues pertaining to links between drug treatment and mental health services will be discussed below.

5.3.4 Social level

5.3.4.1 Community attitudes and stigma

There was a view among participants that community attitudes towards drug use and drug treatment were barriers for people seeking, entering and remaining in drug treatment. No participant stated that community attitudes would be an incentive for drug treatment.

Participants described community attitudes in strong terms: that is, it was *'widely accepted as OK to discriminate against drug users'* (urban outreach service); that drug users see themselves as *'outside of mainstream society'* (urban treatment provider); and that drug users are effectively *'demonized'* in our society (rural outreach service). These perceptions were described as originating in media reports of drug use, in a lack of understanding of drug use in society and from perceiving illicit drug use from the perspective of alcohol use (rural outreach service).

Participants raised the issue of discrepancy between drug use as a norm within society and the community's lack of understanding of illicit drug use. In this context, the issue of perceiving drug use as an individual's failure to cope with social pressure was questioned:

> '*And so we're a drug taking society. We're taught to take drugs as a way to fix ourselves up. Whether that be mentally, emotionally or physically. And everyone wonders why as adults there's all these people choosing to take these drugs. Its like 'wow, where did that come from?'* (rural referral).
>
> *'Some people would say drug use is not an unreasonable choice given the sort of society you may find yourself living in. There was a really nice piece of graffiti saying 'I would rather have a bottle in front of me than a frontal lobotomy' and it makes sense. If you are living in a shitty society and are somewhat despairing about finding employment or a meaningful lifestyle, drug use makes a lot of sense to some extent…. If drug use was seen as a functional/dysfunctional response to the daily grind, maybe we got to do something about the daily grind.*' (urban treatment provider).

The positioning of drug users within society was construed by participants as a barrier to drug treatment. Drug users' experience in society was described in broad cultural terms: living outside of '*mainstream society'* (urban treatment provider) as a '*deviant underclass*' (urban referral) and that entering drug treatment requires

crossing a '*cultural line*' (urban treatment provider). A further implication of negative community attitudes is the pervasive effect of '*internalised self worth*':

> '*And the portrayal of drug users in the media is another reason why people would feel excluded from mainstream services and so its funny, when you talk to people who've been using for a long time their first contact with a drug treatment service, they're saying 'wow I never knew these places existed. And I never imagined society would provide them'* (urban treatment provider).

Participants identified the connection between accessing drug treatment and stigma:

> '*Just the perception by users that they are going to be stigmatized if the do actually access treatment'* (urban treatment provider).
>
> '*The only barrier is society, the stigma attached to methadone'* (rural treatment provider).
>
> '*I guess there is such an ugly connotation attached to drug use so therefore anyone who seeks treatment is one of these people. Which I think the government and the media continually spit at us. And so I guess again people don't see themselves as one of those people so they'll separate and go 'well, that's not me'* (rural referral).

Participants described a '*pecking order*' (urban treatment provider) or hierarchy of attitudes to users of certain drugs within society and also within treatment services. Heroin users tend to be those at the lowest place in the order and '*ostracised*' by others receiving treatment (urban treatment provider):

> '*And unfortunately its like, there's a saying in the AA and NA that the alcoholic looks down on the glue sniffer and the glue sniffer looks down on such and such, its like that's how it is. Within society. I suppose the perception still is mainly that heroin is the bad one. It causes the most trouble*' (rural outreach).

The perception of heroin as the worst of the worst was also found in interviews with outreach agency participants. Building on a lack of community understanding of drug use generally was the perception that heroin was *'incredibly foreign'* to the general community (rural outreach agency), and that the 'media and government' see heroin as '*such a more harsh and scarier drug*' (rural outreach agency):

> '*Everyone places their own experience into the colour of the subject matter. So they are coming at opiate issues from an alcohol point of view'* (rural no-treatment service provider).

The participants called for education of the community on a number of counts: to redress the perception that drug users are '*always people in the gutter*' (urban no-treatment provider), the contribution of media portrayal to the perception that adverse incidents involving drug use are the norm (urban no-treatment provider) and to build awareness among the general public of the drug treatment services available:

> '*We need as a community to be more proactive in getting the message out there that there are [alcohol and other drug] services available so that its known in the general population, so there's an all-of-community approach'* (urban treatment provider).

Negative community attitudes to drug use and users was further demonstrated in participants' statements about remarks made to them personally, some of which implicate the worker as part of a stigmatised group, because of the assistance they provided within a harm minimisation framework.

'*People say to me 'oh I don't know how you can work in drug and alcohol. I don't know how you can stand working with the druggies' or the junkies or whatever other names they put to them*' (rural no-treatment service provider).

'*So many people so often say 'there's no way I could do your job'. And I don't fully get it other than, I guess it depends on your expectations. It's seen as a failure, you're not curing people, then you're not fixing the problem. Then why get involved with it? I know I just keep on harping on about the discrimination and demonisation of injecting drug users. As a worker who works with injecting drug users, I'm also often, not necessarily demonized, but put in the same category of someone, I'm a bit distasteful. Yeah. You don't want to be helping them'* (urban no-treatment service provider).

5.3.4.2 Policy influences

A number of barriers at the policy level were noted by participants in direct ways, as well as feeding negative community attitudes about drug use, people who use drugs and drug treatment.

In some jurisdictions, people accessing methadone treatment are placed on a 'drug addicts register'. This was seen to immediately threaten confidentiality and to raise concerns about stigma. The use of the term 'tough on drugs' was also cited as one frequently picked up in a negative way by the media. The use of the term was seen to emphasise criminal aspects of illicit drug use and to affect community attitudes towards drug treatment for those who use drugs illicitly. This in turn influences the willingness of illicit drug users to engage with treatment services.

Questions were also raised about the link between drug treatment and Christianity and the effect of this link on retention in treatment:

'*I don't know why it has to be linked with Christianity. Like in that way. No other treatments are. I suppose that's a barrier for some people. Those sort of treatment centres are often, I mean, you could go to a treatment centre and sort of feel as though the people who are running it, I don't know, haven't really thought the issues through or that you weren't being given the sort of care that you think you deserve. And I wouldn't be surprised if the people wouldn't stay'* (urban treatment provider).

A further reflection on government policy was aimed at the three-pronged harm minimisation policy adopted in Australia – addressing supply, demand and harm reduction issues of drug use. This participant saw barriers to treatment linked to greater focus on supply and demand issues:

'*In terms of policy issues probably the greatest concern I've had is the watering down, what I see as the watering down of the harm reduction. Harm minimisation prevention policy. Because I think they are watering down the harm reduction and focusing more on the supply and demand. And putting all the money there. When we actually need the money put in other places'* (urban treatment provider).

5.4 Multi-Level Influences

5.4.1 Treatment philosophies

5.4.1.1 Individual

Overall, the philosophy underpinning the organisation of drug treatments in general, and in specific services, was an area widely discussed by the participants. The sample of participants included providers of services based on philosophies ranging from user-organised harm reduction models to Christian-based abstinence 12-step models, and also across a range of treatment options (methadone maintenance treatment, detoxification and rehabilitation programs and drug counselling). The implications of the treatment philosophy were noted at each level – personal, interpersonal, organisational and social. This generated interesting relationships and tensions between the statements of participants.

Participants identified a lack of knowledge about the range of available treatment, as well as the underlying philosophies. A lack of understanding and knowledge of the implications of the philosophy of the treatment was identified as a barrier to remaining in treatment:

> '*I guess what they aren't aware of [is] the philosophical underpinnings of some of the treatment agencies. I guess the classic one is 'do they get involved with NA or AA?' and 'what's bloody 12 steps about?' and this sort of thing and 'does that mean I've got to get religious now and get God on my side?' and uh…and 'are they all like that?' and 'is it a Christian-based organisation or is it research driven?'. All those sort of things come into play and often the differences or the philosophical differences between agencies doesn't really come into part of the decision making process for people. They generally just go somewhere and get shaped by their…by whatever program they go into. The problem with that is many people usually have some idea about what their problem is and research tends to say you should find a program that is not at odds with that, so there is some kind of consistency. If you see it as a disease, then seek a disease model program, otherwise you're just not going to hit it off. So that becomes an internal barrier once you're in treatment so to speak*' (urban treatment provider).

Lack of users' understanding of treatment philosophy was a focus of an outreach agency program aiming to '*empower [users] to be better health consumers, let them know what to think about before they accept the treatment so they don't access the wrong one or misunderstand what they've got themselves into*'.

The issue of the language of drug treatment as 'treatment' has implications on all levels. Some participants rejected or questioned the language of drug 'treatment', which implies that sick people are suffering an illness that requires treatment intervention. Participants described this as a barrier to those who reject such labels, or perceive their drug use as not problematic in such a way:

> '*Even the word treatment you know has got 'well shit I don't think it's an illness, I just think it's a lifestyle choice, you know'. So the language can be repelling…in that kind of way like 'treatment' implies a very medical way of viewing what many people would say is more of a social problem or a lifestyle decision that has a down side eventually*' (urban treatment provider).

Some participants addressed the issue of language barriers around 'treatment' by trying to 're-market' themselves:

> '*We've looked at how to re-market ourselves. So trying to, yeah, put more information to people about who we are, but more about what we do rather than seeking because you've got a problem. So trying to phrase things in different sorts of ways*' (urban treatment provider).

Language around drug use was raised as a controversial issue in relation to 'chroming' (sniffing paint). Although outside the remit of this study, this is an interesting point as the definition of drug use in this context has direct and significant implications for the 'treatments' available for those who use drugs in this way:

> '*There's a lot of controversy over [whether] to call it drug use. Some people like to call it self-harm and where do you actually put that? Whether those people gain support and how do they access that support?*' (urban outreach service).

5.4.1.2 Organisational

The way in which treatment philosophies play out in social structures – including other systems involved in the care and 'management' of those in treatment, the wider community, the drug treatment workforce and the friends and families of those in treatment – were discussed by the participants.

For example, a major difference in philosophy was identified between the drug treatment system as a whole and the judicial/corrections system. Incompatibility in philosophy and focus, means that these agencies are often working at odds with each other and, in turn, undermining the progress of the individual:

> '*So I suppose there are some structural/social kind of issues, ….in regards to the criminal justice system…. A lot of the criminal justice system has a completely different focus. Its not focused on health. It's focused on preventing crime. And the health of the individual is not so really looked at too much. That's not their primary issues. So they wouldn't come from that point of view. And that sort of stops a lot of access to treatment'* (urban treatment provider).

During the data collection for this project the NSW Magistrate's Early Referral Into Treatment (MERIT) program, a court diversion program for people receiving drug-related sentences, was in the early stages of implementation. The clash of philosophy between outcomes viewed as successes by the drug treatment arm of this program and those viewed as successes by the court and police were discussed:

> '*Actually statewide we're working on what we define as outcomes. Our outcomes at the moment, because the evaluation is essentially done by the Attorney General's [office], the outcomes focus on recidivism rates. Which isn't particularly a good outcome measure. Because they could be offending and not being caught. Alternatively there's lots of other benefits and lots of other successful outcomes…. We do a lot of outcome-focused stuff with goal setting. So its about setting up a plan with goals and then reviewing those. And if towards the end they've met some or all of those, then we would consider that as significant success…So we view lots of little things I guess, in inverted commas, as successes, but the court, the difficulty is that the court and the police don't view the same success…Because we are so closely linked with the court system, we might have somebody who's been using quite significantly with major health risks and has really benefited.*

He's using more harm minimisation strategies and his use might have reduced and he's using safer, and not using with children. All those sorts of things we try and reinforce, but to actually present those to the court as success is really difficult. Because at the end of the day they want to see somebody who's clean. Because they're still committing crime in the court's eyes. So that's really difficult. And I think it undermines the work that the clients are doing because they don't get credit from the people that they're working so hard to get credit from' (rural treatment provider).

The same issue of differing views of success or goals was noted in other agencies such as Centrelink and DoCS (NSW).

The issue of relapse was raised by other participants in a number of ways relating to philosophies of treatment. Programs, which are '*commitment focused*', do not allow for second chances: '*if you blow it, that's it*' (rural outreach). In other programs, where the philosophy permits those who '*relapse*' to re-enter the program, there may be a culture of expectation that works against the user achieving the set goals, as they are known to treatment workers. This was particularly relevant in rural or regional areas:

'*Quite a lot of our clients have extensive track records with entering and exiting treatment options. They might have been kicked out, whatever… because they go back to somewhere who's already got expectations of them. And not necessarily positive expectations…. But some [clients] get really frustrated because they don't feel like they're getting a fair go. They feel like they've been judged before they arrive'*
(rural treatment provider).

Treatment philosophy was also described as important in recruiting, training and maintaining a drug treatment workforce. A mismatch between the philosophies of a worker and those of the program may mean that the worker is unsuitable for the work. The large numbers of former drug users involved in the drug treatment workforce should be acknowledged at this point:

'*Even when you do find people that do do the work, we have a certain program and philosophy and they can certainly do it from another philosophy. We've had people start here and not work out because their philosophy's been quite different. And it just hasn't worked out. They haven't been able to encompass where we're coming from*'
(urban treatment provider).

Networks between services was a major theme emerging from the data. Participants described one-way communication between services as related to treatment philosophy with abstinence-based programs unwilling to refer to harm-reduction based agencies:

'*It's interesting because we can work closely with people with very different philosophical backgrounds,…but people seeking a strong, clear anti-drugs abstinence program, then we'll refer those people on to abstinence based services. But I'm pretty sure they won't do the same back…*' (urban outreach service).

5.4.1.3 Community norms

Participants described society's view of the goals of drug treatment as the obtaining and maintaining of abstinence. This attitude or assumption was seen as important in shaping the wider social perception of people who gain access to drug treatment, those who relapse and those who chose to continue some level of illicit drug use:

> '*So there's this culture out there that [drug users are] going to steal your car, break into your house and do whatever. That they're going to be horrible. I think there also this big push that is driven by somebody abstaining. I mean it's a beautiful goal but its very unrealistic a lot of the time as well*' (urban treatment provider).

For the following participant, the assumption of abstinence also highlighted significant gaps in treatment programs' responses to retention and maintenance:

> '*I think part of the problem is that there is a real lack of incentive for retention. I think that its always assumed by most people from the top down from funders, policy makers, down to the individual providers, that its natural and normal not to take drugs, therefore the incentive will be inherent. That most people, particularly once [a user has] sought treatment, [he/she believes that] drugs are bad, not taking drugs is good and therefore that is enough of an incentive and missing the fact that there are also a lot of incentives to taking drugs…there would just be an assumption that not taking drugs is enough of an incentive and you don't need to build it into any particular service or any model of service delivery*' (urban no-treatment provider).

5.4.2 Awareness of treatment services

Individual, interpersonal and organisational level barriers existed around knowledge of available services, and also referrals between services. Service providers described gaps in knowledge of users about available services and the structure or philosophy of those services, particularly those outside of the residential sector:

> '*Some service providers stated that they rely on the 'grapevine' or 'word of mouth' for publicising their service or others do not promote their service 'to avoid the mass hysteria that goes around*' (rural treatment provider).

For those working in the outreach services sector, difficulty was noted in attempts to *'tap into networks or people who aren't already receiving treatment to say this is what it's like'* (urban outreach service). For users trying to find out about treatment options difficulties were also noted:

> '*How do people know they can access services? Like, they might not feel comfortable going to see a doctor or something. Or maybe they think [that is] the only person they could see*' (urban outreach service).

The efforts of agencies in educating clients about availability of services was linked to funding and to philosophy underpinning services. The result of these influences was described as a very limited promotion of information about available services:

> '*I mean part of the problem now is that people go to service X and they'll sell service X, but they might not stand back and say 'this is what we do, however, you can also look at the following other options'…its not so much they'll sell themselves because they want the client or they want the business, its more a case of failing to understand what other services are and because treatment providers are so busy in their own services they just don't have the opportunity to see what's going on elsewhere and to learn more about other options, particularly those which don't fall within their services' philosophical background*' (urban outreach service).

5.4.3 Access and capacity

Typically participants spoke of the limited access to specific treatment places, or a general lack of places. This was particularly highlighted in non-metropolitan areas where individuals might be forced to travel interstate to find suitable treatment programs.

A paucity of treatment places was related to costs associated with treatment: participants advocated for 'free' treatment as an incentive to entering treatment. Different treatments place different costs on clients. Although the methadone prescription was free to those on treatment, dispensing of methadone carries a daily fee. Also, daily transport to access methadone dosing was another cost associated with this treatment. Examples of costs associated with other services were described as 'up-front' fees for rehabilitation places or costs of giving up employment or accommodation or finding long-term childcare whilst in detoxification or rehabilitation treatment.

In addition, waiting lists were described as significant barriers to services in and of themselves, as well as in relation to the types of clients trying to access these services. Services with waiting lists often required potential clients to ring at certain times to ascertain the availability of a place. This system was described as difficult for homeless or chaotic users who could not organise or access telephones at the required times.

Besides the limited availability of treatment places overall, participants also called for a greater diversity of services to meet '*everyone's needs*' (urban outreach service). The call for diversity was compounded with the pervasive difficulty of dealing with mental health issues. Some service providers described being pressured to take '*complex clients*' but receiving no extra funding for dealing with mental health issues (urban treatment provider).

To counter negative community attitudes towards drug use, people who use drugs and drug treatment services, some participants described resources re-directed to do '*positive media*' (rural treatment provider).

Lack of access to immediate assistance on a 24-hour basis was seen as a barrier to effective drug treatment:

> '*If they're really concerned about their drug use, getting to the decision to do something about it takes a lot of energy and you get to that point and you really just want to do something about it right now, not next week or the week after, you want it there and then. And if there isn't something there and then, then the opportunity may be missed and [they] wander off again and keep using for a while and that just keeps going and going and going*' (urban outreach service).

In a non-treatment service agency, 'intensive police activity' was seen as a barrier to accessing information about treatment (as well as other harm reduction services):

> '*We've noticed that .. our numbers .. have dropped dramatically because of the intensive police activity…A lot of our clients (who have warrants out for them), for example, no longer come to us*' (urban outreach service).

Finally, the project-based funding of some services hindered access to services. This arrangement took practitioners away from direct client work to focus on grant writing to apply for continued or enhanced funding.

5.5 Issues specific to Service Types, Drug Types or Special Needs Groups

5.5.1 Rehabilitation

Rehabilitation services were described as a complex arrangement requiring a great deal of direct as well as emotional commitment from clients. In addition, there are significant structural and access issues, which could pose barriers to rehabilitation treatment. Rehabilitation services will only accept clients who have completed a recognised detoxification (detox) program. For those without a place to detox (either a detox bed or no suitable place to home detox), they cannot enter rehabilitation. For those who have undertaken detox but cannot immediately access a rehabilitation place, a number of barriers (such as housing, relapse, financial pressures) exist for the continuance of their treatment.

Residential rehabilitation programs are typically lengthy – programs can be up to 12 months in duration. This means that clients need to 'give up' numbers of things to enter the program: housing, contact with family, money.

A structured program and community living are the typical hallmarks of a residential rehabilitation program. All clients do not accommodate to this type of arrangement equally well. This is of particular concern if clients are not well informed of the structure and philosophy of the program before entering it.

5.5.2 Detoxification

Participants stated that clients can be fearful of a detoxification program, particularly those that do not offer medicated withdrawal. Limitations for in-hospital detoxification beds places restrictions on how many, if any, illicit drug use clients can be detoxed with this support. In supported in-patient detoxification services, a mixture of clients is often housed in the same area. This was described as unsuitable, and the need for separate places for alcohol and for illicit drug clients was described.

5.5.3 Methadone maintenance therapy

Descriptions of methadone as 'liquid handcuffs' were noted. Restrictions on methadone clients (such as limited dosing times, transport difficulties, cost, stigma) have been noted in previous studies.

5.5.4 Services for stimulant users

Previously, the community's perception of heroin as the '*bad one'* was described. Amphetamine users seeking treatment face a range of other barriers. Unlike the range of available pharmacotherapy treatments for opiate dependence (e.g., methadone, buprenorphine, naltrexone), participants indicated that there is no well-accepted pharmacotherapy treatment for amphetamine dependence. Further, participants described gaps in the drug treatment workforce training and skill level in dealing with amphetamine clients:

> '*A lot of counselors were trained during a time when speed use wasn't prevalent here and the only experience they have built up has been around opiate use*' (urban outreach service).

Further the effects of amphetamine use make it difficult for those seeking counselling to '*sit still'* for counselling sessions (urban outreach service).

5.5.5 Exclusion and disadvantage

It was frequently noted across the interviews that some groups are less well served by treatment options. The lists generated by participants included barriers for groups based on ethnicity, culture, language, indigenous status, gender, disability, sexual identity, education, age, accommodation, relationship status and geographic location. Besides all participants acknowledging the exclusion of these people and groups from treatment services, one participant went further to question the existing knowledge of needs of these groups:

> '*I'm not sure we even know what the needs of those groups are in terms of treatment… But I don't think we've studied those enough to say whether that's a socially responsible thing to do*' (urban outreach service).

5.5.6 Mental health

Again, mental health was a pervasive theme of participants' comments. Issues about mental health in drug treatment were multi-faceted, and covered workforce training and skills, funding incentives, cross-sectoral work and philosophies of treatments. Significant levels of drug use and mental health comorbidity were readily identified among participants' client groups. However, the degree to which services were equipped (in terms of appropriately trained staff and sustainable links to specialist mental health services) were variable.

In some cases, mental health and drug use comorbidity was seen as difficult by both sectors, and one service had countered this by developing expertise in dealing with this client group:

> '*We tend to get the clients that other facilities reject, so we have high levels of comorbidity so I guess in the past five years or so we've developed expertise in dealing with that sort of client. If you like, it's become something of a passion with me that I see this as a particularly disenfranchised group who present for AOD services and are sent away because you've got mental health problem, and present at mental health services and are sent away because you've got an AOD problem*' (urban treatment provider).

5.6 Summary and Discussion

Many participants commented on individual barriers to treatment. Typically, clients were generally described as being without skills and in crisis, embedded in the drug using culture and attracted to treatment only after hitting rock bottom.

In general, service providers focused on the individual as the sole cause of drug problems in society and individual personal factors as the main barrier to treatment, leading to a treatment approach described as 'fix it'. Service providers described the community perception of drug use, drug users and drug treatment as highly intolerant and hostile, and indicated that the community expected abstinence (rather than anything else) as an outcome of treatment.

Service providers identified differing treatment philosophies and their related treatment goals as at the core of many barriers to treatment. This impacted on service providers' referral and networking and was evident in the often competing interests of various agencies involved in the care/management of the individual which worked to undermine the treatment progress of individual clients.

Providers perceived that users' lack of fore-knowledge of the philosophical bases underpinning specific treatments led to users dropping out of treatments which did not match their philosophy of drug use.

Alternative models, such as consumer involvement, based on rights of individuals within treatment, were not evident in the interview comments. While national and state drug strategies state that drug treatment should be attractive to the user, service provider participants identified many aspects of current system as particularly unattractive and demeaning.

Some specific barriers, such as cost, lack of places, waiting lists and confidentiality issues were identified.

Workforce issues were critical for the success of the sector. Workforce was portrayed as being in long term 'crisis management'. Jobs were stressful, salary rates in non-government agencies were low, career structures not apparent and training was piecemeal.

Participants acknowledged that a raft of other barriers exist (e.g. ethnicity, age, drug of choice, geography) and that clients from these backgrounds were not currently well served by existing services. Mental health care was described as major failing within and between sectors.

It was apparent from the interviews that participants had an understanding of the complex needs of clients and efforts, with varying levels of success, were made to connect clients with services which can help address these needs. However, a system of linkages based on ad-hoc connections to other services has implications for continuity of care.

Court diversion, regarded by participants, as a major incentive for treatment, was an emerging issue at the time the interviews were conducted. Concerns were expressed about a possible development of a two-tiered treatment system, with those referred from courts getter quicker and cheaper access to treatment.

This section reports participants' perceptions of the influences on drug treatment uptake and retention. In some cases, the issues raised by some providers were critically discussed by others, and we have attempted to include a balance in reporting of these perceptions. The methodology of this interview study did not allow for a "check" process, whereby participants could comment on the detailed findings. This meant that some issues raised by service providers did not receive critical attention by other participants. For example, with regard to services for stimulant users, other groups may perceive that, rather than accepting the gap in services for these clients, services need to develop alternate ways of meeting the needs of these clients, for example, walking with a client who is restless and energetic. In making this point, the authors of this report do not endorse any particular viewpoint, but encourage critical, on-going discussion across the drug treatment sector to bring to light points of difference in perceptions, strategies and service delivery.

Chapter 6:
Findings of the Key Informant Interviews

6.1 Aims

The key informant consultations build on the previous information collected for this study (i.e. through the literature review, the drug user survey and the service provider interviews). The questions put to key informants represented a shift from a 'service provision' focus to include information relevant to policy and program issues.

The aims of conducting interviews with key informant were to:

- obtain views from both national and state-based informants on barriers and incentives to treatment for illicit drug users;
- obtain information about the ways in which barriers and incentives relate to current and future national and state policies and programs; and
- build on the information provided through the drug user survey and the service provider interviews.

6.2 Results

6.2.1 Interviews conducted

A total of 28 interviews were conducted. All the invited key informants or, in a small number of cases, their nominees participated in the consultation process.

Informants were representative of one or more of the following groups:

- Policy Makers
  - Health
- Justice (law reform, judiciary, court diversion)
- Social Policy
- Researchers
- Drug and Alcohol
- Social Research
- Clinicians
- Alcohol and Drug Specialists
- Primary Health Care (including GPs)
- Advocates
  - Peak non-government organisations/committees
  - Drug user networks
  - Family support
  - Youth
  - CALD people
  - Indigenous

A list of key informants is at Appendix B.

Table 6.1 shows the sample of key informants achieved.

Table 6. 1 Sample of key informant interviewees

Expertise Represented	Number
Health policy	5
Justice; Law reform	2
Research	4
Clinicians, including GPs	5
Peak organisations (IGCD, ANCD, DAMEC, NACCHO, AIVL, FDS)	12
Total	**28**

6.2.2 Definition of treatment

Key informants, as a whole, held a broad view of treatment, as indicated in the following responses:

'*Treatment aims to improve health outcomes and quality of life.*'

'*A continuum of responses that change over time and are based on mutually identified needs.*'

'*Anywhere that someone can get help and assessment of their current problems.*'

'*A response to a request for intervention.*'

'*Treatment starts when people listen to a drug user and takes their issues seriously.*'

'*Treatment does not have to be provided by health professionals.*'

'*Need whole of government approaches.*'

Some service provider informants added that, in order to be regarded as 'treatment', an intervention had to be based on mutual agreement between the service and the client. Treatment was, therefore:

'*An intervention, based on mutual agreement between the service and the client.*'

'*An agreed intervention linked to effective treatment and support services.*'

6.2.3 Treatment goals

Key informants noted a dichotomy between policy (and community) goals and clinical goals. Policy goals '*are seeking shorter response times than can be met at client/service level*', whereas treating drug dependence as a chronic lapsing condition involved *'matching goals to small steps at a time, some of which may be retrograde'*.

Consistent with their broad definition of treatment, key informants considered that treatment goals may be about life management as much as they are about drug dependency. While the aim of treatment '*must be to reduce the harms associated with the current situation/drug use*', treatment goals '*may relate to the toxicity of a drug, criminality, family neglect, work issues and viral diseases*' and should '*recognise underlying issues that precede drug use*'.

Recognising that '*clinical goals are often very different from client goals'*, the informants stressed the importance of negotiating health outcomes with the client, which involves faith and trust on both sides.

> *'Treatment is about negotiated outcomes.'*
>
> *'Engagement is the key. Engagement requires faith and trust on both sides in order to build the confidence for a person to return again to the treating service.'*
>
> *'What I do in practice – act as a facilitator: help identify goals, let patient set goals, help work out strategies to work towards goals.'*

Treatment will work '*when the service provider is able to hear what the user has to say and speak their language'* and *'when it is seen as a reconciliation between the evidence of what works and when there is acceptance by the other party'*. One cannot *'aim' treatment at someone – it must be accepted'*. While the 'stages of change' model provides a framework for intervention, there is '*no need to hit rock bottom before treatment offered or accepted'*. Treatment may be provided '*as early intervention in managing health hazards and in managing dependency'*.

While *'ethically, treatment should be offered to all people who use drugs'*, some clinicians noted that not every drug user seeks/requires treatment at all stages of their drug using career.

6.3 Barriers and Incentives to Treatment

Given that the questions put to key informants represented a shift from the hitherto identification of personal barriers and a 'service provision' focus to include information relevant to policy and program issues, it was to be expected that their comments would focus mainly on these issues. Nevertheless, some interesting comments by the key informants on personal and interpersonal barriers were noted.

6.3.1 Personal Level Influences

Key informants showed an appreciation of the way in which psychosocial problems compound help seeking. Drug problems are '*compounded by double and triple jeopardies (e.g. paying off debts, homelessness, communicable diseases, other physical health problems, depression, anxiety'. 'Sometimes people have no means with which to move forward, once they give up their illegal income – cheap loans through Community Banks is one way to go'*. One informant commented that there should have more programs for women that help with mothering, such as *'children's development, nutrition, immunisation, pregnancy, housing and employment at the same time as offering a pharmacotherapy'*.

Costs could be a significant barrier for the most disadvantaged (e.g. Aboriginal drug users) where *'co-payments, dispensing and transport costs (especially in rural areas) can come to $100 or more per week'*.

In respect of help seeking, key informants noted illicit drug users are at a particular disadvantage in negotiating favourable health outcomes, since '*illicit drug users have difficulty being treated with the same degree of respect as other citizens'*. '*We expect drug users to jump through multiple hoops on multiple occasions. We don't ask this of other health care clients'*. For users within treatment, '*overzealous rules and regulations means there is more time spent sliding down snakes than climbing ladders'*.

One GP sought to introduce a sense of normalcy about a drug user's ambivalence towards treatment: *'No-one likes treatment – of any kind – not just drug treatment'*.

With regard to information about treatment, illicit drug users are given *'little explanation of what each treatment modality means in practice'* and so *'myths, moral and religious positions get in the way of help seeking'*.

6.3.2 Interpersonal Level Influences

One informant noted that, in engaging in treatment, *'people are isolated from the only peer group they have. They don't have rich (or any) families to fall back on'* and another commented:

> *'We desperately need more services that recognise family and friends as supports in treatment. This is as much about social inclusion as it is about including families in the treatment process'*.

It was noted that families and peers may be at different stages of change to the user and interpersonal conflict over treatment could present a barrier:

> *'For example: in the first instance, families seeking treatment for/with a user tend to want fast treatments that result in abstinence. The person seeking treatment may have stabilisation more in mind'*.

6.3.3 Organisational/Institutional Level Influences

This was the level that received the most comments from the key informants. Their responses can be grouped according to the following main themes.

Erosion of services

A number of informants commented that *'systematic formal treatment approaches are currently contaminated by the erosion of services, especially in the primary health care field'* and that *'government services, especially primary health care are so pared back they cannot respond'*. Further, because demand for treatment services outstrips supply, this *'encourages the use of a vetting system for treatment entry'*.

Treatment interventions

Respondents noted that, currently, *'pharmacotherapies override every other type of treatment'*, leading one respondent to comment that *'methadone is just a strategy; it should be a last resort but may be considered as a treatment for those who have failed other treatment options and are not drug free*'. However, in the view of one other respondent, '*methadone is the biggest barrier to treatment in Australia today'*.

It was noted that *'treatment is currently opiate and Western Anglo Saxon Protestant-centric'* and that' *treatment for amphetamine users is in the early stages'*. In general, however, there was a need for *'clear criteria about who benefits from which treatment/type of service'*.

Key informants gave considerable support to more early treatment interventions in order to '*move back from treatment delivery at crisis or near crisis intervention levels'*. Court diversion was considered to be an early intervention, with one respondent describing it as a *'reverse incentive'*.

As a further incentive to encourage users into treatment, one respondent advocated *'funding a range of evaluated options – home based detox, for example'*.

One respondent noted that engaging users in formal treatment was not easy: *'Service providers are very functional: the drug user (and those around him/her) may be very dysfunctional. Match is difficult to make in a realistic way.'* Further, early interventions of engaging the user had to take place in low threshold settings in which the user felt comfortable, since *'hospitals, clinics and institutional settings put people off'*. In this sense, a lack of outreach from treatment *'– all medical and center based –'* could be seen as a barrier. Also, at present, '*there is no first point of call to discuss treatment and treatment options. Its straight into a formal assessment or nothing*'.

Multiple needs

Key informants recognised multiple issues, multiple needs and the complex social and health issues that affect people who use illicit drugs. However, there was a concern that '*social health needs are seen as non-essentials by treatment services'*.

While key informants strongly supported case management, for example, in statements such as *'good case management is the key'* and '*introduce well-funded case management systems across Australia'*, a number of informants noted that in many services caseloads are too large and the services needed to meet the multiple needs of clients were not available. Concern was expressed that other non-health service providers (e.g. social security, housing) are not trained to understand the complexity of needs of drug users as health professionals are.

On backup support, the alcohol and drug sector was considered to be at a disadvantage when compared with the management of other complex health issues:

> *'Other complex health issues have back up support for primary health care, e.g. specialist centers, information lines etc. This is not systematically the case for AOD.'*
>
> *'GPs need better guidelines and linkages to specialist and backup support in treating alcohol and other drug problems.'*

Some respondents drew attention to a greater need for follow-up on referrals and follow-up on users who failed to attend sessions. Agencies would refer people on but would provide '*no help with getting to the next step'* with referral. Another commented that AOD services:

> '*Need more follow-up if non-presenters expected to be totally self-motivated. Mental health is more generous on this*.'

The different philosophies underpinning treatment presented problems for inter-agency referrals. One respondent noted that there are referrals from services that have a harm reduction philosophy to services that are abstinence based or provide different types of treatment options, but that this referral process is not reciprocal. Another commented that some religious services denigrate treatment options that differ from their own.

As incentives, one respondent suggested greater links between treatment, employment/traineeships, while another suggested providing heroin prescription as part of a one-stop shop program. While there was general support for the one-stop shop concept, it was also noted that *'one stop shop centers or service groups are great but expensive'*.

Mental health

The way comorbidity problems are handled by the system presents barriers for those dual diagnosis clients. It was felt that *'co-morbidity is poorly handled'*, generates a '*revolving door'* approach to service provision and the *'mental health field generally does not understand addiction.'* Also, some clients '*may have fragile mental health but not be at a diagnosable or certifiable level – they still need support'*.

Workforce issues

While there were '*some highly professional organisations'*, '*we [the AOD sector] have a ragbag of workers that are patchily trained and skilled'* and are at *'the bottom of the pile*. In general, the respondents considered that AOD sector has a mix of staff with high turnover as most want to move on to other better recognised, better supported or better paid work. Those that stay were highly motivated.

Respondents considered that a major investment is needed in higher education, on the job training and in raising the profile of work in drug and alcohol treatment. They also considered there was a need for 'new' types of workers, for example, treatment services officers, who act as a middle person between client and the range of treatment options available, to improve treatment matching, access and retention.

Respondents also considered there is a desperate need for alcohol and other drug issues to be integrated into normal medical, nursing and allied health practices as part of usual code of practice. In this context, the new Chapter of Addiction Medicine was referred to as a positive move.

Quality assurance

A number of informants considered that the drug and alcohol industry need better benchmarks and indicators for quality of life and quality of care for people who use drugs illicitly i.e., '*Common benchmarks and indicators for QOL and QOC are needed'*.

6.3.4 Policy Level Influences

In this subsection, a distinction was made in the coding of responses between 'policy' which is understood to refer to a course of action adopted by a government, for example, in pursuing national and state drug strategies, while 'politics' refers to power politics or to the behaviour of 'belonging to, or taking sides, in politics'.

Drug policy

As a general statement about Australia's performance in providing treatment for illicit drug users, key informants considered that Australia was good in what it offers (in comparison with other developed countries) but limited in its innovation and scope. There were, however, a number of qualifications. One informant commented that *'there is an assumption that one size fits all'*. Another commented that: *'policies are confused, convoluted – messages are inconsistent and actions on evidence are selective – not all-embracing'*.

Respondents noted a shift in emphasis in national drug policy whereby '*Australia focuses on demand and supply with very little real effort directed to harm reduction'*. However, the countervailing view was also represented: '*The Strategic framework needs to clearly state that primary goal is to be drug free. However, there may be harm*

reduction strategies needed along the way'. The partnership with law enforcement was considered to be useful, but '*we are too dependent upon this single partnership – a much wider range is needed'*

The comment was made that Australia has lost the original focus on an interactive public health model that looks at people, their drug use and the environment in which drug use occurs and concentrates heavily on the 'drug'. One informant considered that *'treatment should be a state matter with a national focus, supported by Commonwealth funding'*.

Politics

Some informants bemoaned the way politics and policies rule what service providers can do, say and prescribe. Illicit drugs is the '*only issue where politicians, policy makers and the media call the shots, rather than allowing an informed decision for treatment between health professional and patient, based on what works'*. The views of a number of informants are encapsulated in the statement, *'the biggest barriers to effective treatment are politics and ill-informed 'shock jock' media'*.

Drug legislation

Service provider informants complained about the increasing 'legalisation' of the treatment field, the influence of mandatory requirements and rules about how, when and what to report, which detract from time spent face to face with clients. For example:

> '*Service providers are so bound up with red tape that it's hard to treat drug users with the same degree of attention as other clients.*'
>
> *'At the service policy levels the rail gauges all vary (e.g. takeaway provisions).'*

Funding

Many informants considered that drug treatment remains under-funded. Also that funding is *'patchy'* (the view shared by a number of respondents) and *'still allocated to services and programs we know don't work'*. Further, in their view, funding is *'poorly coordinated'* or *'not not well joined up: 'Departments still work from separate cost centres'*.

In their view, more funding is needed to increase capacity and to improve quality. More funding results in increased capacity, more people in treatment (of various kinds) and to better outcomes for illicit drug users, their families and the community, whereas improved quality requires better trained staff, better accommodation etc.

Legality

The view was strongly put by some informants that the illegal status of drugs makes *'equitable treatment and equitable access to health care near impossible'*. Greater access to treatment would come as a result of the 'decriminalisation' and 'demystification' of illicit drug use. One informant warned that '*increased penalties make situations worse, don't ban, hand out'*.

'The way drug treatment is normalized in the Netherlands' was proposed as an incentive to accessing treatment, but *'what's the catalyst to acceptance in a country like Australia?'*

6.3.5 Social Level Influences

Key informants considered that stigma *'is alive (and well-fueled by the media)'*, and noted that stigma at the community and family level deters people from seeking treatment. For example:

> '*One of the biggest barriers is the wide appeal of the 'shock jock' media and the associated community distrust of drug users and treatment services.*'

The handling of drug issues in the media resulted in a '*cyclical process where the media needs to raise the emotional interest of its audience, which responds with emotion-fuelling emotive rather than factual debate.*'

As a result, *'AOD services as well as clients are 'low status' – the whole field is 'disadvantaged'* and had been assigned a *'completely different set of values and principles from other health care issues'* and the public is ill informed and inconsistent in their perceptions about treatment. Consequently, there was a *'need to change belief systems so that drug users are no longer put in the 'bad/criminal' basket'*. One respondent advocated *'more initiatives like 'Treatment Works' week',* and another asked: *'Why don't we celebrate the successes of treatment more?'*

6.3.6 Barriers Relating to Specific Populations

A number of informants considered that the current treatment services were *'culturally not suited to many*' and that '*we pay lip service only to population groups/sub population groups like CALD and Indigenous people and youth.*' One informant noted that, if people from different cultural backgrounds get a bad reception from a treatment service, they *'never go again'*.

Informants noted that Aboriginal specific services i.e. services that are local, understand the importance of 'family' and have good follow up support are '*practically non existent'*.

Further, the view was expressed that '*the criteria set for entry and retention in treatment exclude most Aboriginal drug users'*, and that '*most Indigenous services are 12-step and 12-step is actually not where most of the Indigenous population is at. So match is poor'*. One informant suggested that we *'need something like an Indigenous AIVL so that people have safe peers to relate to'*.

6.4 Summary

Key informants generally adhered to an holistic view of treatment, with treatment aiming to improve health outcomes and quality of life. In order to be regarded as treatment, treatment has to be based on mutual agreement between the service and the client.

Key informants showed a keen appreciation of the way in which psychosocial problems compounded drug use and help seeking. The also noted that drug users have difficulty in negotiating health outcomes and being treated with the same degree of respect as other citizens. Overzealous rules and regulations meant that drug users accessing treatment spent more time '*sliding down snakes than climbing ladders'*. The need for more services that recognise family and friends as supports for treatment was acknowledged.

The views expressed by key informants on organisational issues and barriers covered a wide field – increased funding, the erosion of services, the need for a wide range of treatment interventions (including early interventions), the multiple needs of drug users seeking treatment and the challenges of comorbidity and workforce issues.

Community attitudes and distrust of drug users and treatment services, fueled by the media, was the source of one of the biggest barriers to help seeking by illicit drug users.

While key informants considered that Australia's performance in providing treatment for illicit drug users was good in what it offered (compared to other developed countries), but what it offered was limited in innovation and scope. However, illicit drugs was the only public policy area where politicians, policy makers and the media called the shots, rather than allowing for informed decisions between health professionals and patients in treatment.

Treatment services were considered to be culturally unsuited to many, and that illicit drug treatment agencies paid only lip service to meeting the needs of a wide range of non-mainstream clients.

Chapter 7:
Overall Discussion

7.1 Introduction

The study comprises a number of arms – a literature review, an illicit drug user survey, service provider interviews and key informant interviews – each of which offered its own perspective on barriers and incentives to treatment. The model used in this study, which examines influences on the target issue at four levels, personal, interpersonal, organisational/institutional and social was used to (a) to identify a wide range of barriers and incentives to treatment and (b) arrive at a comprehensive, yet coherent, understanding of the problem by examining the inter-relationships between the various levels. Following the Winett et al. (1989) conceptual and strategic framework on which the model is based, this Chapter takes the analysis in the study one stage further by seeking to integrate the findings from each individual level with the other levels with a view to arriving at a number of overarching themes for consideration in Part 2: *Implications for Policy and Future Practice*.

7.2 Identification of Barriers and Incentives

Table 7.1 presents a summative list of the more frequently cited types of barriers and incentives identified by the various methods used in the study at the personal, interpersonal, organisational/institutional and social levels. While this approach resulted in the identification of a wide range of barriers and incentives, there were consistent findings across all arms of the study.

The points we can draw into the discussion are, of course, limited by the original framework of the study and specifics of data collection. For example, although treatment philosophies emerged as a strong theme in service provider interviews, we did not ask illicit drug user survey participants to directly comment on this issue. Hence, the discussion of this point is limited, as not all components of the overall study will contain relevant data.

Table 7.1: The more frequently cited barriers and incentives by arms of the study

Level of analysis	Barrier/Incentive	LR	IDU	SP	KI
Personal					
Barriers	Not being ready to stop using	X	X	X	X
	Lack of information about treatment options/not understanding what treatment means	X	X	X	X
	Difficulties in making the necessary arrangements (e.g. transport, child care)	X	X		
	Existence of comorbidities	X	X	X	X
Incentives	Regain control of one's life	X	X	X	
	Improve one's quality of life	X	X	X	X
	Avoid trouble with police/courts	X			
	Incentive and transport vouchers	X			
Interpersonal					
Barriers	Drug using friends/family	X	X	X	
Incentives	Pressure from family/friends	X			
	Support from family/friends	X	X		X
	Concern about impact on others	X	X		
Organisational/ institutional					
Barriers	Availability, e.g. treatment slots, waiting times	X	X	X	X
	Accessibility, e.g. travel times	X		X	
	Affordability, e.g. costs	X	X	X	X
	Appropriateness, e.g. 'one size fits all', lack of services for amphetamine users	X	X	X	X
	Attractiveness	X			X
	Treatment philosophies			X	X
	Rules and regulations, e.g. eligibility requirements	X	X	X	X
	Workforce issues	X	X	X	X
	Politics			X	X
Incentives	Provision of low threshold services	X		X	X
	Innovations in product delivery e.g. buprenorphine	X		X	X
	Drug courts/Court diversion	X	X	X	X
Social					
Barrier	Social stigma/community attitudes	X	X	X	X
	Media representations			X	X

(Key: LR = Literature review, IDU = IDU survey, SP = Service provider interviews and KI = Key Informant Interviews).

7.2.1 Personal Level Influences

The illicit drug users survey highlighted the importance of personal motivation, defined in terms of an eagerness or readiness to change (Miller and Rollnick, 1991) in relation to access and retention in treatment, particularly for the 'in-treatment' group. Most participants referred themselves to treatment, indicating significant personal incentives, rather than imposed conditions, to undertake treatment. In general, users most commonly endorsed 'self determination' (followed by 'support from staff' and 'support from peers') as the main reason for achieving their treatment aims and considered the inter-related issues of 'not being ready to stop using' and a preference to 'keep using drugs' as barriers to achieving their aims.

The most frequently endorsed difference between 'in-treatment' survey participants' perceptions of their current and previous treatment attempts was 'this time you were ready'. This finding indicates that participants primarily see themselves as responsible for success in treatment. Treatment orientation and support from others were reported as important, but less frequent reasons for the difference.

It should be pointed out, however, that self-determination, or being ready, is a necessary, but not sufficient condition, for achieving the aims of treatment. That is, if a user does not want to abstain or control their drug use, there is little chance of abstaining or controlling his/her drug use. Wanting to stop and self-determination does not work in and of itself. The present study demonstrates that the availability of treatment slots and support from family, friends, medical, public health and appropriate health services are essential to ensure that such self-determination achieves its aim.

The most frequently mentioned reasons or motivators for wanting to change drug use by the 'in-treatment' group in the illicit drug users survey were personal issues, such as wanting to improve quality of life, to increase stability, being sick of the life style and to reduce stress. In assessing their own psychological state prior to their current or prior treatment episodes, about 60% indicated they were 'in crisis' or 'chaotic' at the time, and about 50% indicated that their financial state prior to treatment was 'debt-ridden'.

While many of the often-cited service structural barriers, such as transport, travelling time and lack of child care facilities did not figure prominently in the overall illicit drug users survey, they are, as key informants pointed out, significant for particular disadvantaged groups, such as those on low incomes, women and rural and remote users. Treatment costs were cited as barriers to treatment by 20% of both the 'in-out treatment' group and those 'never in treatment' who had been unsuccessful in their treatment seeking efforts in the previous five years. 30% of those 'never in treatment' and 21% of the 'in-out treatment' group mentioned travel problems, while 6.3% of respondents answering this question reported that the program was unable to accommodate their children.

Significant minorities of those who reported that they had tried and failed to obtain treatment in the previous five years to the survey reported that, from a consumer's point of view, the treatment offered was not the kind they wanted (22%), the treatment program did not suit their needs (20%) or they heard from others that the treatment was no good (13%). 25% reported lack of support from health professionals as a reason for the failed attempt/s.

Respondents overall agreed with the statement that: 'Treatment programs designed by people who have been users themselves are the most successful'.

Typically, clients of the treatment agencies interviewed in this study were described as in crisis or at 'rock bottom' when seeking treatment and having poor living skills. Participants in the 'current treatment' group in the survey reported that the treatment program offered additional services such as information about blood borne viruses (81%), individual counselling (81%) relapse prevention strategies (63%), mental health assessment and treatment (54%) and medical/dental treatment (54%) and found these services helpful. Other less frequently reported additional services included employment/skills training, housing assistance, ante and post-natal support, family interventions, financial planning assistance, legal advice and referral to peer support groups. The literature review found that found that matching clients to ancillary services such as housing, job training and legal services increased clients' satisfaction with the service (Smith & Marsh, 2002) and that, in seeking help, the most important factor those 'currently in treatment' and those 'never in treatment' had taken into account (or would take into account) was what services were offered (Hartnoll & Power, 1989). However, key informants commented that treatment services in Australia had become too drug-centred and inter-service linkages and case-management needed to be improved and become more widespread.

About one third of the sample in the illicit drug users' survey (but fewer in the 'never in treatment' group) indicated that they had felt suicidal in the previous four weeks. This could be interpreted as a significant indicator of underlying mental ill health. The Brief Treatment Outcomes Measure study (NDARC, 2003) also indicated a high proportion of suicidal feelings in their sample of treatment clients. Together, these results indicate a significant issue for providers of drug treatment services, namely, that mental health input into illicit drug treatment and care is warranted for a sizeable minority of drug treatment seeking clients. However, service providers and key informants reported that the way comorbidity problems were being handled by the system presented barriers for dual diagnosis clients. It was felt that 'co-morbidity was ' *poorly handled',* generating a '*revolving door'* approach to service provision.

7.2.2 Interpersonal Level Influences

While research, including the illicit drug users' survey, showed that families and friends play an important role in identifying the need for treatment, facilitating entry into treatment and providing support during the treatment process (Mitchell et al, 2001), service provider participants typically portrayed the same interpersonal issues as acting both as barriers and facilitators to treatment. For example, in terms of treatment retention, they considered user contact with drug using peers to be part of the problem; however, they also considered isolating clients from peers as a barrier to treatment retention. While they considered having unsupportive families, or families with unrealistic expectations of the individual, could present barriers, they considered having receptive families to fall back on to be an enabling factor. Service providers considered treatments which necessitated isolation from families (particularly children) or which did not cater for dealing with the family as a unit to carry risks of treatment non-completion.

7.2.3 Organisational/Institutional Level Influences

7.2.3.1 Organisational Level

In the illicit drug user survey, the most frequently cited barriers among the 30% of participants who indicated that they had sought help in the previous five years and had not been able to access that help were lack of places and waiting lists being too long. The most frequently mentioned inaccessible treatment modality was residential rehabilitation.

The availability of treatment places and appropriate treatment options (and individual awareness that ready and available treatment may not be available), can have a direct bearing on failure to seek help and lead to an underestimation of need in the same way that unemployment statistics fail to account for the so-called 'discouraged workers' who have ceased to seek employment (Metsch & McCoy, 1999). Further, as one key informant pointed out, because demand for treatment services outstrips supply, this encourages the use of a vetting system for treatment entry, thereby raising additional barriers to entry.

The literature review and the illicit drug users' survey also identified barriers in relation to *accessibility* (e.g. lack of transportation, traveling times), *affordability* (e.g. up front treatment fees and ongoing dispensing costs), *appropriateness* (e.g. treatments biased towards opiate users being inappropriate for amphetamine users, culturally inappropriate service for CALD and Aboriginal people and *attractiveness* (e.g. the lack of low threshold, non-threatening services).

For the service providers, the main barriers at the organisational level were either workforce related (e.g. demanding work roles, difficulties in attracting and retaining staff, lack of career structure) or interagency (e.g. differing philosophies between agencies, lack of follow up with referrals). Key informants commented that, while drug and alcohol place numbers had generally increased (but still not sufficient to meet demand), this had been accompanied by an on the erosion of primary health care services, a lack of services for amphetamine users and clients with comorbidities and a lack of the services required to address the multiple, complex needs of clients. While giving strong support for case management, informants also noted that many service caseloads are too large and services required to meet the multiple needs of clients were not available.

Service providers considered that differing treatment philosophies and their related treatment goals were at the core of many barriers to treatment at the organisational level. This impacted on service providers' referral and networking, and was evident in the often competing interests of various agencies involved in the care/management of individuals, which worked to undermine the treatment progress of individual clients. Also, users' lack of fore-knowledge of the philosophical bases underpinning specific treatments led to users dropping out of treatments which did not match their philosophy of drug use.

Contrary to expectations, the illicit drug users survey did not find (in univariate or multivariate analyses) that treatments considered by clients to be client-focused had higher rates of completion than those not so described. However, the large proportion of participants who did not complete this question may indicate that they did not understand the concept of client input into treatment, or were not offered this.

Further, alternative models of treatment, such as consumer involvement, based on the rights of individuals, were not evident in the service provider interview comments.

7.2.3.2 Policy and Institutional Level Influences

Key informants considered that Australia was good in what it offered in comparison with other developing countries, but that what it offered was limited in innovation and scope, thus reducing the opportunity of drug treatment innovations acting as motivators and incentives to treatment. Drug treatment provision was patchy, poorly coordinated and still allocated to some treatments that are not evidence based. Illicit drugs was the only issue in public policy in which the politicians, policy makers and the media called the shots, rather than allowing treatment to be an issue between the health professional and the patient. Further, the illegal status of the drugs examined in this study made equitable treatment and equitable access for users near impossible.

7.2.3.2.1 Drug courts and court diversion

The main variable found in the user survey multivariate analyses distinguishing those who completed and those who did not complete treatment was related to the method of referral – those referred by the corrections system were more likely to complete treatment than those who were not. Although this indicates that referral by corrections system is a facilitator of treatment retention, findings from the service provider interviews also drew attention to differing and sometimes conflicting views on success or goals between the drug treatment and the judicial/corrections systems.

7.2.4 Social Level Influences

Each of the methods used in the study identified considerable stigma associated with drug use, treatment participation and working in the drug treatment industry. This stigma resulted in barriers related to user concerns about privacy, labeling and the stigmatizing affects of current treatments, including staff attitudes and impacted on the status staff working in treatment services. Key informants commented on the negative effect of talkback radio on community distrust of drug users and treatment services.

In respect of help seeking, the literature review, drug users, service providers and key informants noted that illicit drug users were at a particular disadvantage in negotiating favourable health outcomes, since they have difficulty being treated with the same degree of respect as other citizens. They were expected to '*jump through multiple hoops on multiple occasions*'. For users within treatment, '*overzealous rules and regulations*' meant that clients spent more time '*sliding down snakes than climbing ladders'*. In other words, they encountered a system that was more harsh and punitive than other treatment services offered for other health issues.

More than half the participants in the illicit drug users sample reported that they had been discriminated by the following: family (63%), staff at pharmacies (63%), friends (62%) or doctors/nurses (54%). While clients 'currently in treatment' were more likely than the other participants to report that staff at drug treatment centers did not make judgements and listened to what they said, those 'in and out of treatment' were more likely to report that staff tried to treat everything in their life as if it were drug-related and treated them badly in front of others. Those 'never in treatment' were more likely than the other groups to report that staff at treatment centers had treated them without respect, and had tried to make them feel guilty about their drug use.

7.3 Multilevel interventions

The above multilevel analysis suggests that multilevel interventions would be appropriate in the following domains. (These are discussed in the following Chapter):

- improved individual and community understanding of treatment;
- legality and social stigma;
- treatment services meeting the needs of a diverse group of clients;
- the provision of ancillary services and case management;
- better handling of clients or potential clients with existing comorbidities;
- better utilisation of family and peer supports;
- workforce development and ongoing support; and
- consumer-centered services.

Part 3:
Implications

Chapter 8:
Implications for Policy and Future Practice

8.1 Negotiation workshop

In line with the participatory approach to the research study, the project management group sought input from key stakeholders in the analysis and application to policy of the outcomes of the literature review, the illicit drug users survey, service provider interviews and key informant consultations. The project management group organised a one-day negotiation workshop with representation from the project advisory committee, drug user organisations, service providers and policy makers and researchers, most of whom had already contributed to one or more arms of the study. The one-day, facilitated workshop was held at the University of NSW in Sydney in August 2003.

8.1.1 Aims of the negotiation workshop

The aims of the workshop were to:

- review and discuss the findings of the literature review, illicit drug user survey, service provider interviews and key informant consultations;
- agree and analyse the main issues arising from the study;
- identify and discuss options for improved treatment service delivery for illicit drug users;
- indicate implications for future policy and program planning.

8.1.2 Workshop participation

45 participants attended the workshop. A list of participants is at Appendix B.

Table 8.1 shows the representation of participants achieved.

Table 8.1 Workshop representation

Areas Represented	Number
Service providers	15
Drug user organisations	19
Policy	3
Advisory Committee	3
Research team	5
Total	**45**

8.2 Negotiation Workshop Outcomes

An important observation from the day was the harmonious, motivated and respectful approach established early in the day between all participants, based on the premise that all parties present represented essential and integral parts of illicit drug treatment service provision and support services, and all had a similar intention to improve and maintain the quality of life of people using illicit drugs, through provision of adequate, accessible, relevant and quality treatment and support services.

8.2.1 Overarching theme

The workshop participants identified an overarching theme arising from the study. This theme focused on:

> *The barrier of illegality and the associated stigma surrounding access and retention in drug treatment for those people motivated to make changes to their drug using behaviour.*

The illegal status of opiates, psychostimulants and other relevant drugs and the stigma associated with their use was recognised as an issue for:

- the drug user;
- treatment service providers;
- families and friends; and
- communities.

Participants noted that illegality and stigma were strongly represented as barriers in all arms of the study.

Workshop participants indicated the need for action to reduce the stigma and myths surrounding use of illicit drugs. Participants did not address the legality issue directly within the current Australian legislative framework but chose to focus on improvements in treatment that would in turn influence both issues of legality and the different aspects of stigma associated with drug use and drug related harm. The participants identified areas for action that would benefit all concerned, based on the premise that the common outcome sought was that of quality of life – a decent life – for those seeking treatment. To address the issue of stigma, actions formulated reflect the need for better education and understanding of drug use, treatment and lifestyle needs at all the levels of the model, but particularly at the social/community level.

In general, workshop participants noted that, just as drug users are marginalised in the community, so too are those who provide drug treatment. Participants also observed that the closer models of treatment are brought to other health treatments within the Australian health system, the more holistic the health approach, the better the community understanding of the purpose and function of drug treatment, the greater the prospect of quality of life outcomes for those accessing treatment. At the same time, the issue of legality (of drug use) and the associated stigma surrounding drug use dissipate as treatment is 'normalised'. The recommendations that follow are based on this premise.

8.2.2 Identified priorities

Priorities for action, based around this overarching theme, were identified in five categories:

- strategic directions;
- quality practice;
- consumer involvement;
- workforce development; and
- continued research.

8.3 Priorities for Action and Recommendations

This Section discusses the workshop outcomes against the above five priority areas for action.

The recommendations are intended to provide directions for policy and program improvements at all levels of government. In some instances, the recommendations require the cooperation of all parties.

The recommendations are intended to be applied to, and build on, current Commonwealth and State and Territory policy frameworks, such as the National Drug Strategy, the National Illicit Drugs Strategy and the various accompanying policies and strategies in place at State and Territory levels. The recommendations are accompanied by a number of suggested implementation strategies.

8.3.1 Improving Strategic Directions for Future Provision of Drug Treatment

Strategic directions, discussed at the workshop, that have implications for policy and program improvement included:

- The development of much clearer **definitions of 'treatment'**, broadening definitions to emphasise treatment as a continuum of options/modalities that allow for a range of goals (including abstinence) that change for individuals over time, depending on their stage of drug use and on current needs;
- The importance of **broadening the scope of treatment** from clinical intervention/pharmacotherapy to include 'on ramps' or lead up to drug treatment (i.e. safe injecting rooms. NSPs, primary health care services) and 'off ramps' or times of community readjustment (i.e., on-going support after detoxification, on completing a rehabilitation program, during stressful life events, during pregnancy, during legal proceedings, on release from gaol) as part of both definitions and delivery of 'treatment';
- The development and implementation of **new funding models** that acknowledge the broadened scope of treatment described above. In particular, funding models will need to address the ongoing gap between demand for treatment and adequate response through service delivery that still exists in many locations throughout Australia;

- **Recognition of the complexities and multiple health and social needs** that are frequently profiled by people using drugs illicitly. The issue of **comorbidity** was noted as an important and only partially resolved issue for many people seeking drug and alcohol treatment. Improved systems of joint case management, rather than the current duality of drug and alcohol and mental health treatment services, were identified as vital to improved outcomes for those with drug and mental health comorbidities. The silo approach to training and employing health professionals and allied workers in one or other of these fields of treatment was seen as limiting in terms of streamlined service provision and effective case management processes;
- Development of **a sustainable approach to broad community/public education**, using a variety of mediums to reach the community and to educate them about dependence as a medical disorder that can be effectively treated with significant benefits to the individual and society, the purpose, types and realities of 'treatment'; the way in which treatment is offered; and to include information about the ways in which treatment needs for individuals are often long-term and need to respond to change over time (e.g. build on the ADCA *Treatment Works* approach); and
- Clarification and dissemination of **plain English information at the community level** of the types of treatment available; the purpose of different treatment modalities; the contexts in, and the drug use for which they are most likely to be effective; and the linkages between different forms of treatment.

8.3.1.1 Recommendations for improving strategic directions

Recommendations relevant to strategic direction in drug treatment service provision for people who use drugs illicitly are as follows:

Expanding treatment definition

R 1: Develop and promote a nationally agreed, comprehensive and contemporary definition of 'drug treatment' for people who use illicit drugs.

Comment

This definition will acknowledge both clinical intervention and the social aspects of treatment and care that lie outside clinical interventions.

Suggested implementation strategy

As part of national drug strategy, this broader definition of drug treatment will require dissemination and application to policies and programs at the Commonwealth, State, Territory and Local Government levels.

Funding models

R.2: Commission the development of new funding models that acknowledge the broadened scope of treatment for illicit drug use and the continuing discrepancies between demand for treatment and the adequacy of response through service delivery.

Managing complexity of need

R 3: Governments at all levels work to reverse the current erosion (especially noticeable in the primary health care sector) of holistic and timely health care for clients with complex needs (e.g. those who use drugs illicitly/with mental health problems/with blood borne illnesses).

Suggested implementation strategies

Identify ways to restore resources to the primary health care sector.

Governments fund, develop and implement models of integrated service delivery that increase nationally the number and type of health and related services responding to the complex health needs experienced by people who use illicit drugs.

Governments at all levels recognise and fund the work of drug user organisations as an integral part of effective drug treatment service planning and delivery.

Managing comorbidity

R 4: Governments work together to improve the interrelationship between drug and alcohol and mental health disciplines and services.

Suggested implementation strategies

Increase nationally the availability of workforce development opportunities that address the management of comorbidity, especially for the rural sector.

Include comorbidity and its management as a significant element of medical, nurse and pharmacy undergraduate and postgraduate training programs; fund regional workshops.

Acknowledge the need for, increase and fund cross-discipline work placement and work experience programs for health and allied workers in drug and alcohol and mental health service delivery (across the continuum of training and ongoing work practice).

Investing in community education

R 5: Governments, together with the non-government sector and drug user organisations, fund, develop and sustain a community education strategy for delivery nationally.

Comment

This recommendation proposes a move away from traditional mass media campaign models to work within communities, outlining, in particular, the realities and benefits of different treatment modalities and emphasising (e.g. through story telling, practical examples and open days at treatment services) the way in which different treatment modalities work for different people at different stages of the drug use continuum.

Suggested implementation strategy

This strategy could expand and sustain the current ADCA *'Treatment Works'* annual program.

8.3.2 Quality Improvement in Drug Treatment Service Delivery

The issues and priorities for action discussed at the workshop included:

- **The need for treatment services to clearly state their philosophy and service delivery principles 'up front',** so that both clients and staff have a common understanding of what to expect from accessing/working in particular treatment organisations and services;
- **Continuous improvements in service delivery that recognise diversity of need**. Improvement is particularly needed in relation to the needs and culture of young people, to women (particularly those with responsibilities for children) and to those for whom ethnic and cultural considerations may influence their own and their communities' particular beliefs, attitudes and historical response to the use of the drugs that are currently classified as 'illicit' in Australia. Continuous improvement includes appropriate matching of customers with services and staff who are appropriately skilled to work with them;
- **National mapping of treatment services** at the regional level so that the mix, location and scope of services can be identified and any patchy distribution or gaps in services addressed as part of future service planning;
- **Service availability and equity of access.** Despite recent increases in the number of treatment places available, there is still insufficient ready access to many drug treatment and mental health services. This issue requires consideration as part of the mapping exercise;
- **Pathways and 'on ramps' to treatment**. Greater recognition is required of the ways in which people who are using illicit drugs may come into treatment. This needs to be accompanied by increased provision of support, information and funding for service providers (e.g. those engaged in community based social welfare services, needle and syringe programs, hepatitis/AIDS/services, youth services) that are in frequent contact with people using illicit drugs in these 'on ramp' periods of time. The greatest need is identified as the ability to 'free up' service providers to spend time on education, brief intervention and other practical assistance that promotes, motivates and enables entry into treatment for those seeking a change to their drug using behaviour;
- **Liaison Workers**. Greater use of a 'middle' person, to encourage and provide practical and acceptable support to people negotiating the plethora of social, health, legal and other services that come into play in day to day life management issues and in meeting the requirements of drug treatment;
- **Service location.** There is a need for improved town and regional planning that encourages future co-location of health and social services or, at least, transport availability between social, medical and other health services;
- **Service funding**. Drug treatment services continue to be funded using a 'silo' and sometimes 'historical' approach to budget allocation. This is particularly apparent where funding is allocated under specific program budgets or for particular levels of health care. There is an urgent need to move from this silo approach to a funding model that identifies a common source of funding – at least at the State and Territory level – to cover the mix of services and supports needed. Mix is likely to follow the broader 'treatment' definitions described above;

- **Brokerage of treatment and case management.** While excellent models for case management approaches to service provision are available, these are not as widely applied as they could be. Promotion of effective case management models of care and associated training and support in their use are needed; and
- **Rules, guidelines and protocols.** The rules and regulations for clients accessing and remaining in treatment are viewed as excessively onerous and in some instances discriminatory in comparison with access and retention in other health treatment. Urgent review is required, including identification of opportunities to reduce the hoops, hurdles and onerous service protocols, rules and regulations that currently face both those negotiating drug treatment and those providing it. The expectation of such a review would be to bring the requirements into line with other treatments in the health system.

8.3.2.1 Recommendations for quality service provision

Recommendations for quality service provision are as follows:

Mapping service location and type

R 6: Governments work together to improve national coverage of drug treatment service provision, recognising inconsistencies and gaps in availability and access.

Suggested strategies

Commission a national mapping study that identifies (in relation to population groups) the scope, range, level (i.e. primary care, drug and alcohol specific, specialist) and location of treatment and support services on a regional basis. (NB this is not intended as a directory of services).

Using the mapping outcomes, Governments identify the scope of current service delivery, and apply results to future planning, mix and distribution of drug and alcohol treatment and support services.

Improving infrastructure support

R 7: Governments work together to update and improve current infrastructure support for effective service delivery.

Suggested implementation strategies

Location: Utilise current Inter-governmental processes in place across Australia to build partnerships with those responsible for town and regional planning, encouraging the co- or proximal location of the range of services accessed by those with complex health and social issues and identifying associated transport requirements.

Funding: Governments at all levels continue work on effective funding models that encourage a range of services to work towards common goals that are in the interests of people with complex health needs (including mental health and drug issues) and to the inclusion of these people as part of their local communities.

Case management: Increase resources and training support for management and staff in both health and social service settings in the planning and delivery of contemporary joint, evidence-based case management systems.

Rules, regulations, protocols: Working in a partnership approach, Governments, together with service providers and the Australian Injecting and Illicit Drug Users League (AIVL), review the current drug treatment service rules, regulations and protocols and simplify to correspond with those applied in other sectors of the health treatment system.

Publicising service philosophies

R 8: Service providers improve the visibility and clarity of individual service philosophies, including the differences between different philosophies and the impact of these differences on those seeking treatment.

Suggested implementation strategies

All services providing treatment and support to people who use illicit drugs have an identified and publicly available philosophy statement.

The development, articulation and demonstrated application of both agency and program philosophies relevant to treatment of people who use illicit drugs be made a condition of Government funding to the primary health care sector and drug and alcohol and related services.

Responding to diversity of need

R 9: Governments increase their investment in a range of diversified drug treatment services in order to meet the needs of different sub-population groups in the community.

Suggested strategy

A planned commitment in budget allocation to incrementally increase the funding available annually for planning and service delivery for drug treatment services suited to Aboriginal and Torres Strait Islander people, young people, women with children and people whose cultural and ethnic background may require specific approaches, specific locations for treatment or additional programs to mainstream services.

Improving 'on ramps' to treatment

R 10: Governments promote partnership approaches to increase support to generalist health, social and community services in recognition of their role in assisting people who use illicit drugs to access and remain in treatment.

Suggested implementation strategies

Free up and fund positions in a range of services, specifically for work in the promotion of, and education about, drug treatment, and in the delivery of brief interventions and other evidence-based motivational interventions that may encourage entry into treatment.

Develop and fund a model (e.g. through COAG) for the introduction of liaison workers within and across health and related services, with the aim of improving the pathways for access and retention in treatment for those who use illicit drugs. This model may usefully build on work in progress in Western Australia.

8.3.3 Consumer Involvement

The issues and priorities for action discussed at the workshop included:

- **Consumer input** to planning, training and delivery and evaluation of services and support systems. Many parts of the health system have useful models for consumer participation in health service planning, delivery and evaluation. Application of these models and the strategies used within them is needed for those people accessing drug treatment. The research study identified few references to consumer participation, and workshop participants noted the need to bring practice in the drug treatment field (in relation to consumer participation) in line with other parts of the health system;
- Development of a **formal complaints mechanisms for clients of drug treatment services.** A specific issue, related to consumer input was the benefit perceived from an established, formal complaints mechanism for clients of treatment services, providing clients with a legitimate mechanism to be heard;
- **Peer education.** There is potential to integrate peer education much more strongly into drug treatment service delivery and to engage **peer workers** in the processes of treatment referral, treatment linkages, access and uptake of service and support services;
- **Funded peer advocacy.** This study has clearly demonstrated the invaluable contribution of drug user organisations as research partners in the identification and practical application of enabling factors for entry and retention in drug treatment. The facilitating role of peer educators in awareness raising, entry, and retention in treatment requires greater recognition, including the funding of peer educators to work within and across drug treatment services providing practical peer support for clients as they work through different stages of their drug treatment;
- **Family-centred medical practice**. Within the context of family-centred general practice, drug users and their families require and deserve holistic health treatment and care in the same way as any other family presenting to general practice; and
- **Family support**. Families and carers of those experiencing drug related problems require ongoing options for support. Family drug support groups and associated telephone, information, advisory and support services provide an important adjunct service to drug treatment. These services require expansion to ensure national coverage and funding to maintain both the quality of support offered and the range of services available to families and carers.

8.3.3.1 Recommendations for consumer involvement

Ensuring consumer participation

R 11: Governments at all levels ensure, as in mainstream health services, that consumer participation is included in service planning, delivery and evaluation.

Suggested implementation strategies

A consumer participation plan to form part of agency funding agreements.

A formal complaints mechanism to be included at the agency level as part of service agreements.

Integrating peer education into service delivery

R 12: Service providers include peer education and peer support as part of treatment service provision for people who use illicit drugs, noting the unique role these strategies provide in relation to access and retention in treatment for people who use illicit drugs.

Suggested implementation strategies

Development of a model for inclusion of peer workers and peer education in treatment service delivery, particularly in relation to treatment modality choices, referral processes, the practical experiences for drug users of different drug treatment modalities and in the provision of practical advice and support in negotiating and remaining in treatment.

Introduce peer workers as liaison officers to facilitate uptake and retention in treatment (i.e. in and between the range of health, financial, legal and other services that drug users may need to access during treatment).

Improving family support

R 13: Governments at all levels and service providers build on the relationships and strengths offered and recognise the needs of those families who seek to help family members through drug treatment.

Suggested implementation strategies

Governments work with professional organisations (e.g. the Australian Divisions of General Practice and the Chapter of Addictions Medicine) to promote family practice at the primary care level. This work will build on current models of family practice, acknowledging that a proportion of families will identify drug issues as part of their overall health needs.

Develop information for General Practitioners and other primary health care workers that promotes and provides examples of family-centred approaches to prevention and management of drug use, including pathways and referral processes for treatment, care and support within a family context.

Maintain and expand the number and the range of support groups and services for families and carers who are engaged in the treatment and lives of their drug using family members.

8.3.4 Workforce Development

Key informants and service providers acknowledged that workforce issues within all the human and social services are overwhelming and that there is an urgent need for the Governments of Australia to review the systems that infrastructure surrounding workforce pay, conditions, training and development and recruitment and retention processes. Consideration of these issues lies outside the scope of this study.

Issues raised in the workshop that were specific to drug treatment and with implications for policy included:

- **Matching workers to treatment** (using the new broader definitions of treatment indicated above). There is an unmet need in provision and recruitment

of a mix of staff for drug treatment agencies that can meet the differing needs of clients. Currently staffing occurs more on the basis of professional mix and hierarchic levels of staffing rather than skills mix and culturally appropriateness;

- **Broaden the knowledge base about the complex needs of people using drugs and the linkages between different types of service provision**. (e.g. time spent working in mental health, alcohol and other drugs, communicable diseases services as part of workforce development and training programs) and increased education and information dissemination to both drug and alcohol services and other services who come in contact with people who use drugs (i.e., mental health services, social security, housing officers, pharmacies);
- Increased opportunities for **service management training,** taking into account the complexities of service provision and service linkages necessary within the drug treatment field;
- **Salary review and development of a salary structure for alcohol and other drug professionals and allied workers** e.g. use nursing review as a model;
- **Training and career development** (attitudes, knowledge, population group specific, increased use of peer workers) – ongoing and linked to review;
- **Leadership for the drug treatment field** from peak health care workers and public health experts. The identification of 'champions' and the provision of support and encouragement for them to speak out; and
- **Clarification and regulation of workers' roles and responsibilities**, especially in relation to the primary care sector and specialist service providers. This should include the delineation of generalist from specialist roles and the creation of a national system of linkages between the two, so that adequate support is available to the generalist.

8.3.4.1 Recommendations for workforce development

Recommendations for workforce development are as follows:

Reassessing the workforce

R 14: Within the broader definition of treatment described in Recommendation 1, Governments re-assess the composition of the drug treatment workforce, the range of skills required and those members of the workforce best placed to provide them.

Suggested implementation strategies

A needs-based and outcome focused national review of the drug treatment services workforce. (Recent reviews of the nursing profession may provide a useful framework for action).

Review and revise existing training programs that address drug treatment ensuring the levels of training and the competencies contained within them reflect the knowledge and skills mix required for an effective and holistic drug treatment workforce. This revision will require governments to work closely with professional bodies, training authorities and academic institutions and focus on maximising knowledge uptake and skills development in the use of holistic approaches when working with people who use illicit drugs.

Clarifying workforce roles and responsibilities in drug treatment

R 15: Service providers clarify and distinguish from each other the roles and responsibilities of different types and levels of practitioners responsible for drug treatment and service provision and ensure adequate training opportunities for each.

Suggested implementation strategy

Develop guidelines for practitioners, building on existing treatment guidelines and detailing the roles and responsibilities and interrelationships between generalist primary health care practitioners (e.g. GPs) drug and alcohol service providers and a range of specialist services (e.g. those specialising in mental health, blood borne infections, addictions, gastroenterology etc).

Investing in effective service management

R 16: Improve opportunities for training and ongoing staff development at the service management level.

Suggested implementation strategy

Increase funding at the program level for service management training and staff development, noting the need for upgrading skills and knowledge in the areas of service linkages, partnership approaches to service delivery and customer-centred service delivery.

Providing guidelines and referral protocols for case management of people with complex needs

R 17: Develop national guidelines, including referral protocols, for effective case management of people with complex needs, especially for those experiencing drug and alcohol and mental health problems.

Suggested implementation strategy

Develop guidelines and referral protocols that clarify and describe the roles, responsibilities, inter-relationships and optimal points for referral between each of the principal providers of health and allied care. (e.g. differentiate but link the roles of general practitioners, general practitioners specialising in drug and alcohol, social workers, pharmacists, nurses working in general practice/nurses working in drug and alcohol services, specialist medical practitioners, community support services).

8.3.5 Continued Research

Issues and priorities for action discussed at the workshop that have policy implications included:

- the maintenance in Australia of evidence-based and outcome-focused treatment, with improved quality of life and social inclusion for people using drugs as the primary outcome;
- the increased use of action and participatory research to determine good practice and improvements for drug treatment service provision within the community context;
- continued research to determine the most efficacious treatment options and modes of delivery. Increased emphasis on continuum of treatment and improved mechanisms for service linkages and delivery; and
- core criteria for funding drug and alcohol treatment services research to include demonstrated ability to include and build partnerships with drug users/drug user organisations, primary health carers and, where relevant, families and carers in all aspects of the research process.

8.3.5.1 Recommendation for continued research effort

The recommendation for continued research effort is as follows:

R 18: Prioritise and allocate funding into the research of effective models of health service delivery for quality of life outcomes among those who use drugs illicitly.

Suggested implementation strategies

Develop benchmarks of care (similar to those in development for aged care) to correspond to quality of life outcomes.

Investigate and develop new funding models at both Commonwealth and State levels that focus on centralised funding (rather than multiple funding streams) and collaborative approaches focused on improved drug treatment outcomes.

Appendices

Appendix A:
Findings of the Illicit Drug Users Survey – Detailed Results

SECTION 1 Sample Characteristics

Sample Breakdown Summary (Table 1)

The sample, consisting of 685 participants, was divided into 3 groups depending on participants' experience of professional treatment: a group who were currently in professional treatment (329 participants), a group who were not currently in professional treatment but who had been in professional treatment in the last 6 months (163 participants), and a group who had never undertaken professional treatment (193 participants).

Table 1 Sample breakdown

	In treatment		In-out treatment		Never in treatment		Total	
	N	%	N	%	N	%	N	%
Number recruited	329	48	163	24	192	28	684	100

Age Summary (Tables 2-3)

The mean age of the sample was 31.6 years (range 18-64 years, with 21.6% of the overall sample aged 24 years or less.

Participants in the 'current treatment' group and participants who had been in treatment in the past ('in-out' group) were older than participants who had never been in treatment.

Table 2 Current age, by treatment status

	In treatment		In-out treatment		Never in treatment		Total	
	N	mean	N	mean	N	mean	N	mean
Current age [a] [b]**	329	32.16	163	32.28	192	30.11	684	31.61
NR	0	—	0	—	1	—	1	—

**p<. 01

Table 3 Age distribution, by treatment status

	In treatment		In-out treatment		Never in treatment		Total	
	N	%	N	%	N	%	N	%
Age								
<20	7	2.1	4	2.5	18	9.3	29	4.2
20-24	58	17.6	23	14.1	38	19.7	119	17.4
25-29	80	24.3	31	19.0	42	21.8	153	22.3
30-34	66	20.1	46	28.2	41	21.2	153	22.3
35-39	52	15.8	28	17.2	22	11.4	102	14.9
40-44	37	11.2	20	12.3	21	10.9	78	11.4
45-49	23	7.0	10	6.1	7	3.6	40	5.8
50+	6	1.8	1	0.6	3	1.6	10	1.5
NR	0	0	0	0	1	0.5	1	0.1

Demographics Summary (Table 4)

Two hundred and twenty-nine participants or 33.4% of the sample were from the two sites in Sydney. The inner Sydney site consisted of 168 participants (24.5% of the total sample) of whom: 87 (52%) were currently in treatment, 36 (21%) had been in treatment in the past and 45 (27%) had never been in treatment. The outer Sydney site consisted of 61 participants (8.9% of the total sample): 32 (52%) in treatment, 10 (16%) in and out of treatment and 19 (31%) who had never been in treatment.

In Brisbane, 161 participants were recruited comprising 23.5% of the total sample: 75 (47%) were currently in treatment, 42 (26%) been in treatment in the past and 44 (27%) had never been in treatment.

Ninety-six participants or 14% of the total sample were from Perth: 45 (47%) were currently in treatment, 22 (23%) had been in treatment in the past and 28 (29%) had never been in treatment.

The sample size from the regional Queensland site was 94 comprising 13.7% of the total sample: 35 (37%) currently in treatment, 31 (33%) in treatment in the past and 28 (30%) had never been in treatment.

The rural NSW site consisted of 105 participants, 15.3% of the total sample: 55 (52%) were currently in treatment, 22 (21%) had been in treatment in the past and 28 (27%) had never been in treatment.

Two-thirds of the sample (n=457) were male. Most participants were born in Australia (85%, n=583) and spoke English at home (97%, n=663).

Seventy eight participants or 11% of the total sample identified as Aboriginal or Torres Straight Islanders (ATSI), 552 or 81% as of other Australian ethnicity and 50 participants, 7% of the sample, identified as anything other than these two categories. Five people did not respond to this question.

Over half of the participants (59%, n=401) had an education level of up to and including Year 10 and most participants were not currently involved in study (90%, n=615). About three-quarters of the sample reported an annual of less than $20,000 (76%, n=522) and about the sample proportion indicated their main source of income as government benefits (71%, n=489). Almost all participants (92%, n=627) reported that they did not hold private health insurance.

Forty percent of the sample (n=281) reported living in unstable accommodation, including 11% (n=79) indicating they were homeless. Almost 80% (n=533) of the sample reported living with others.

Participants in the 'never in treatment' group and 'past treatment' group were more likely than those in the 'current treatment' group to have an income above $20,000 per year.

They were also more likely to obtain their main income from work or crime/dealing, rather than from benefits. And they were more likely to live in a rental property, or in their own property, and to live alone.

Table 4 Demographic variables, by treatment status

	In treatment		In-out treatment		Never in treatment		Total	
	N	%	N	%	N	%	N	%
Recruitment location								
Sydney	87	26.4	36	22.1	45	23.3	168	24.5
Regional Queensland	35	10.6	31	19.0	28	14.5	94	13.7
Rural NSW	55	16.7	22	13.5	28	14.5	105	15.3
Western Sydney	32	9.7	10	6.1	19	9.8	61	8.9
Perth	45	13.7	22	13.5	29	15.0	96	14.0
Brisbane	75	22.8	42	25.8	44	22.8	161	23.5
Recruitment location by states								
NSW	174	52.9	68	41.7	92	47.7	334	48.8
QLD	110	33.4	73	44.8	72	37.3	256	37.2
WA	45	13.7	22	13.5	29	15.0	96	14.0
Recruitment location by city								
Capital cities	207	62.9	100	61.3	118	61.1	425	62.0
Other sites	122	37.1	63	38.7	75	38.9	260	38.0
Gender								
Female	115	35.0	59	36.2	50	25.9	224	32.7
Male	213	64.7	103	63.2	141	73.1	457	66.7
Transgender	1	0.3	1	0.6	2	1.0	4	0.6
Country of birth								
Australian	273	83.0	139	85.3	171	88.6	583	85.1
Other	56	17.0	24	14.7	22	11.4	102	14.9

Table 4 Demographic variables, by treatment status *(continued)*

	In treatment		In-out treatment		Never in treatment		Total	
	N	%	N	%	N	%	N	%
Ethnicity								
Aboriginal/Torres Strait Islander	27	8.2	25	15.3	26	13.5	78	11.4
Australian	274	83.3	123	75.5	155	80.3	552	80.6
Other	26	7.9	14	8.6	10	5.2	50	7.3
NR	2	0.6	1	0.6	2	1.0	5	0.7
Language spoken at home								
English	318	96.7	158	96.9	187	96.9	663	96.8
Other	9	2.7	4	2.5	6	3.1	19	2.8
NR	2	0.6	1	0.6	0	0	3	0.4
Highest level of education								
Up to & incl. Year 10	201	61.1	94	57.7	106	54.9	401	58.5
Over Year 10	126	38.3	67	41.1	86	44.6	279	40.7
NR	2	0.6	2	1.2	1	0.5	5	0.7
Involve in study currently								
Not in any study currently	301	91.5	145	89	169	87.6	615	89.8
Involved in study	26	7.9	17	10.4	21	10.9	64	9.3
NR	2	0.6	1	0.6	3	1.6	6	0.9
Income ***								
Less than $10,000	170	51.7	67	41.1	69	35.8	306	44.7
Between $10,001–$20,000	103	31.3	56	34.4	57	29.5	216	31.5
Between $20,001–$30,000	19	5.8	14	8.6	27	14.0	60	8.8
Between $30,001–$40,000	13	4.0	8	4.9	18	9.3	39	5.7
Between $40,001–$50,000	8	2.4	0	0	6	3.1	14	2.0
Between $50,001–$60,000	1	0.3	5	3.1	4	2.1	10	1.5
Over $60,001	7	2.1	2	1.2	3	1.6	12	1.8
Other	8	2.4	11	6.7	9	4.7	28	4.1
Income***								
Less than $ 20,000	273	83.0	123	75.5	126	65.3	522	76.2
Over $ 20,000	56	17.0	40	24.5	67	34.7	163	23.8
Main source of income***								
Work	38	11.6	25	15.3	50	25.9	113	16.5
On benefit	269	81.8	114	69.9	106	54.9	489	71.4
Crime/dealer/sex worker	20	6.1	21	12.9	31	16.1	72	10.5
NR	2	0.6	3	1.8	6	3.1	11	1.6
Current accommodation***								
Rent/own property	152	46.2	117	71.8	134	69.4	403	58.8
Boarding/rehab/refuge/park	152	46.2	23	14.1	27	14.0	202	29.5
Homeless	25	7.6	23	14.1	31	16.1	79	11.5
NR	0	0	0	0	1	0.5	1	0.1

Table 4 Demographic variables, by treatment status *(continued)*

	In treatment		In-out treatment		Never in treatment		Total	
	N	%	N	%	N	%	N	%
Live with*								
Alone	51	15.5	35	21.5	40	20.7	126	18.4
With others	270	82.1	123	75.5	140	72.5	533	77.8
NR	8	2.4	5	3.1	13	6.7	26	3.8
Private health cover								
Without private health cover	300	91.2	155	95.1	172	89.1	627	91.5
With private health cover	29	8.8	8	4.9	21	10.9	58	8.5

***p<.05 **p<.01 ***p<.001**

SECTION 2 Drug Use History

Definitions

1. Drug most frequently used timeframe (Table 5):
   - For 'in-out' and 'never in treatment' groups, questions refer to last 6 months.
   - For 'in treatment' group, questions refer to 6 months *prior to treatment*.
2. Drug most frequently used classification (Table 5):
   - opioid users – those who most frequently injected heroin or methadone, or combinations of drugs including heroin or methadone. Participants using both heroin/methadone and (meth)amphetamine were classified as opioid users.
   - stimulant users – those who most frequently injected (meth)amphetamine, cocaine, or combinations of drugs including (meth)amphetamine, but excluding heroin and methadone.
3. Can't meet bills because of drug use (Table 6)
   - on a scale from 0 (never) to 3 (always)
4. After scoring, I use as soon as I can (Table 6)
   - on a scale from 0 (never) to 4 (all the time)
5. Reasons for drug use (Table 8)
   - participants were restricted to choosing 3 items from total list of 18 items

Drug Use History Summary (Table 5)

The total sample comprised of 362 participants (53%) who chose opioids as their primary drug and 323 (47%) who chose stimulants. Fifteen participants had not used any drug in the last six months. However 7 nominated heroin and 8 stimulants as the drug they had used most often when they were using.

Almost 60% of the sample (n=400) indicated that they used drugs once or more a day and almost all (92%, n=628) injected drugs.

Of the 595 participants who indicated they injected, almost 60% had not injected any other drug before the current drug of choice (or drug most frequently injected). Of those who had injected another drug, about two-thirds indicated that the other drug injected was a stimulant.

Of the 470 providing a response to the issue of when drug use occurs after acquiring drugs, 78% indicated that they use drugs as soon as they can most or all of the time.

Opioid users were more likely to be in the 'in treatment' or 'past treatment' groups than in the 'never in treatment' group. Stimulant users were more likely to be in the 'never in treatment' group than in 'past' or 'current treatment' groups.

Frequent users, i.e. users who normally inject drugs once or more times a day, were more likely to be in the 'current treatment' group than in the 'past' or 'never in treatment' groups.

Participants who use drugs by *injection* were more likely to be in the 'current' or 'past treatment' groups than in the 'never in treatment' group. Those who do not inject drugs were more likely to be in the 'never in treatment' group.

Participants who had injected another drug before injection of their current drug, were more likely to be in the 'current' or 'past treatment' groups than in the 'never in treatment' group. Participants whose current injection drug was their first injection drug were more likely to be in the 'never in treatment' group.

Participants who previously used opioids were more likely to have accessed treatment than participants who previously used mainly stimulants.

Participants who reported that, most of the time or all the time, they used their drug as soon as possible after scoring were more likely to be in the 'past treatment' group than in the 'never in treatment' group.

Table 5 Drug use history, by treatment status

	In treatment		In-out treatment		Never in treatment		Total	
	N	%	N	%	N	%	N	%
Drug most frequently used (6 mths)* **								
Opioids	194	59.0	98	60.1	70	36.3	362	52.8
Stimulant	135	41.0	65	39.9	123	63.7	323	47.2
Drug use frequency (6 mths)* **								
Do not use drugs	0	0	6	3.7	9	4.7	15	2.2
Less than once per day	68	20.7	82	50.3	120	62.2	270	39.4
One or more times per day	261	79.3	75	46.0	64	33.2	400	58.4
How drug is used* **								
Injected	306	93.0	159	97.5	136	84.5	628	91.7
Not injected	23	7.0	4	2.5	30	15.5	57	8.3
Injected any drug before current drug* **								
No	165	50.2	83	50.9	108	56.0	356	52.0
Yes	132	40.1	64	39.3	43	22.3	239	34.9
Not injecting	29	8.8	12	7.4	38	19.7	79	11.5
NR	3	0.9	4	2.5	4	2.1	11	1.6
Drug injected before current drug **								
Stimulant	89	27.2	41	25.2	26	13.5	156	22.8
Opioids	41	12.5	23	14.1	17	8.8	81	11.9
Not injecting or no other drug injected before current one	194	59.3	95	58.3	145	75.1	434	63.5
NR	3	0.9	4	2.5	5	2.6	12	1.8
After scoring I use as soon as I can*								
Never	[1	0.3]	2	1.2	7	3.6	10	1.5
Rarely	[4	1.2]	5	3.1	15	7.8	24	3.5
Sometimes	[26	7.9]	14	8.6	29	15.0	69	10.1
Most of the time	[34	10.3]	56	34.4	54	28.0	144	21.0
All the time	[59	17.9]	82	50.3	82	42.5	223	32.6
NR	[205	62.3]	4	2.5	6	3.1	215	31.4

*** p<.05 ** p<.01 *** p<.001**

Drug Use History Summary (Table 6)

On average, participants had started injecting drugs at 19.3 years of age and had been injecting for 12 years. There was only a short average time (less than one year) between age of first use of current drug (19.6 years) and age started injecting current drug (20.4 years).

The questions concerning financial bills because of drug use and relative timing of drug acquiring to use were converted to a score. Overall, participants recorded a relatively low mean score of 1.43 (on a scale from 0 being 'never' to 3 being 'always') for financial difficulties because of drug use. In terms of when drugs are used after acquisition, participants scored a mean score of 3.16 (on a scale from 0 being 'never' to 4 being 'all the time') indicating a relatively high urgency to drug use.

Participants who had bill-paying problems due to drug use were more likely to be in the 'current treatment' group than in the 'past' or 'never in treatment' groups.

Participants who had a long history of injecting were more likely to be in the 'current' or 'past treatment' groups than in the 'never in treatment' group.

Table 6 Drug use history, by treatment status

	In treatment		In-out treatment		Never in treatment		Total	
	N	**Mean**	**N**	**Mean**	**N**	**Mean**	**N**	**Mean**
Can't meet the bills because of drug use****	326	1.77	162	1.25	193	1.02	681	1.43
NR	3	—	1	—	0	—	4	—
Age when first used drug	48	19.33	12	20.33	46	19.76	106	19.63
Age started injecting current drug	297	20.45	149	20.31	149	20.40	595	20.40
NR	32	—	14	—	44	—	90	—
Age first started to inject	297	19.07	149	19.26	151	19.79	597	19.30
NR	32	—	14	—	42	—	88	—
Years of injecting drug**	294	13	146	13	147	10	587	12
NR	35	—	17	—	46	—	98	—
After scoring, I use drug as soon as I can... *	[124	3.18]	159	3.33	187	3.01	470	3.16

***p<.05 **p<.01 ***p<.001**

Current Drug Use Summary (Table 7)

About 70% of the total sample indicated that they continued to use or inject drugs. Alcohol, cannabis, 'speed' (injected) and heroin (injected), were the drugs most frequently reported by the sample overall.

The great majority of participants who claimed to be non-drug users were in the 'current treatment' group. Only 18 non-users were in the 'past' or 'never in treatment' groups.

A large proportion (more than half) of all participants currently used alcohol and/or cannabis/'pot'. However, more participants in the 'never in treatment' group than in either of the other groups reported current use of alcohol, and more participants in the 'past' and 'never in treatment' groups than in the 'current treatment' group reported current use of cannabis.

Stimulants, cocaine, and ecstasy were used by the 'never in treatment' group more than by the 'past' or 'current treatment' groups.

Benzodiazepine was used by the 'past treatment' group more than by either the 'current' or 'never in treatment' groups.

At least 50% of participants currently in treatment, were still injecting opioids or stimulants.

Table 7 Still use or inject drugs, by treatment status

	In treatment		In-out treatment		Never in treatment		Total (N=685)	
	N	%	N	%	N	%	N	%
Do you still use or inject drugs* **								
No	193	58.7	8	4.9	10	5.2	211	30.8
Yes	136	41.3	155	95.1	183	94.8	474	69.2
Use or inject following drugs:							**(N=474)**	
Alcohol * **								
Use	72	52.9	104	67.1	147	80.3	323	68.1
Pot * **								
Use	85	62.5	128	82.6	161	88.0	374	78.9
Inhalants								
Use	8	5.9	15	9.7	23	12.6	46	9.7
Speed/crystal/ice/ meth/base * **								
Use	4	2.9	2	1.3	30	16.4	36	7.6
Inject	68	50.0	108	69.7	122	66.7	298	62.9
**Cocaine ** **								
Use	4	2.9	7	4.5	19	10.4	30	6.3
Inject	21	15.4	37	23.9	48	26.4	106	22.4
Heroin * **								
Use	3	2.2	4	2.6	8	4.4	15	3.2
Inject	68	50.0	106	68.4	82	44.8	256	54.0
Methadone *								
Use	3	2.2	7	4.5	12	6.6	22	4.6
Inject	10	7.4	29	18.7	20	10.9	59	12.4
Naltrexone								
Use	0	0	3	1.9	1	0.5	4	0.8
Inject	0	0	0	0	1	0.5	1	0.2

Table 7 Still use or inject drugs, by treatment status *(continued)*

	In treatment		In-out treatment		Never in treatment		Total (N=474)	
	N	%	N	%	N	%	N	%
Buprenorphine								
Use	1	0.7	4	2.6	2	1.1	7	1.5
Inject	5	3.7	19	12.3	18	9.8	42	8.9
Other opioids **								
Use	4	2.9	13	8.4	10	5.5	27	5.7
Inject	22	16.2	48	31.0	36	19.7	106	22.4
Ecstasy ***								
Use	16	11.8	27	17.4	66	36.1	109	23.0
Inject	7	5.1	6	3.9	18	9.8	31	6.5
Benzos ***								
Use	43	31.6	73	47.1	64	35.0	180	38.0
Inject	8	5.9	21	13.5	11	6.0	40	8.4
Ketamine								
Use	3	2.2	3	1.9	11	6.0	17	3.6
Inject	1	0.7	2	1.3	4	2.2	7	1.5
GHB								
Used	1	0.7	2	1.3	5	2.7	8	1.7
Inject	0	0	0	0	1	0.5	1	0.2
MDA								
Used	4	2.9	7	4.5	17	9.3	28	5.9
Inject	2	1.5	7	4.5	7	3.8	16	3.4
Steroids								
Used	1	0.7	1	0.6	2	1.1	4	0.8
Inject	1	0.7	2	1.3	4	2.2	7	1.5

Reasons for Drug Use Summary (Table 8)

Overall, the most frequently endorsed reasons for using drugs included issues of 'fun' and 'party' as well as issues of 'need' and 'avoiding withdrawal'. For greater clarity, it is important to consider the endorsement of these reasons by treatment status.

Participants who reported recreational reasons for drug use – 'use to party', 'use recreationally', 'use for sex', 'use because want to', 'use at dance party' and 'use on special occasions' – were more likely to be in the 'never in treatment' group.

Participants who reported 'habitual', 'withdrawal' or 'pain relief' reasons for drug use were more likely to be in the 'current' or 'past treatment' groups.

Participants who reported their reason of drug use was 'because I like it' were more likely to be in the 'past' than the 'current treatment' group.

Table 8 Reasons of using drugs, by treatment status

	In treatment (N=329)		In-out treatment (N=163)		Never in treatment (N=193)		Total (N=685)	
	N	%	N	%	N	%	N	%
Use drugs to party* **								
Yes	48	14.6	23	14.1	51	26.4	122	17.8
Most important	12	3.6	3	1.8	19	9.8	34	5.0
Use because need to								
Yes	68	20.7	26	16.0	25	13.0	119	17.4
Most important	43	13.1	15	9.2	19	9.8	77	11.2
Use recreationally* **								
Yes	22	6.7	21	12.9	43	22.3	86	12.6
Most important	3	0.9	4	2.5	16	8.3	23	3.4
Use to bond with partner								
Yes	23	7.0	7	4.3	10	5.2	40	5.8
Most important	7	2.1	0	0	5	2.6	12	1.8
Used to bond with friends								
Yes	16	4.9	6	3.7	16	8.3	38	5.5
Most important	11	3.3	3	1.8	2	1.0	16	2.3
Use for sex*								
Yes	14	4.3	5	3.1	20	10.4	39	5.7
Most important	3	0.9	4	2.5	3	1.6	10	1.5
Use when unhappy								
Yes	66	20.1	33	20.2	32	16.6	131	19.1
Most important	41	12.5	14	8.6	12	6.2	67	9.8
**Use because want to ** **								
Yes	53	16.1	27	16.6	37	19.2	117	17.1
Most important	11	3.3	14	8.6	24	12.4	49	7.2
Use because the drug is there								
Yes	39	11.9	17	10.4	23	11.9	79	11.5
Most important	16	4.9	2	1.2	6	3.1	24	3.5
Use because of peer pressure								
Yes	12	3.6	5	3.1	7	3.6	24	3.5
Most important	1	0.3	2	1.2	4	2.1	7	1.0
Use at dance party/raves/ events*								
Yes	12	3.6	4	2.5	14	7.3	30	4.4
Most important	2	0.6	0	0	4	2.1	6	0.9
Use on special occasions**								
Yes	8	2.4	0	0	12	6.2	20	2.9
Most important	2	0.6	0	0	3	1.6	5	0.7

Table 8 Reasons of using drugs, by treatment status *(continued)*

	In treatment (N=329)		In-out treatment (N=163)		Never in treatment (N=193)		Total (N=685)	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Reasons of using drugs, by treatment status								
Use because could afford it								
Yes	23	7.0	14	8.6	11	5.7	48	7.0
Most important	1	0.3	0	0	4	2.1	5	0.7
Use out of habit* **								
Yes	99	30.1	36	22.1	26	13.5	161	23.5
Most important	46	14.0	15	9.2	18	9.3	79	11.5
Use to avoid withdrawal* **								
Yes	72	21.9	31	19.0	28	14.5	131	19.1
Most important	67	20.4	25	15.3	11	5.7	103	15.0
Used when had a few drinks								
Yes	15	4.6	5	3.1	14	7.3	34	5.0
Most important	1	0.3	0	0	1	0.5	2	0.3
Use because like it **								
Yes	71	21.6	40	24.5	44	22.8	155	22.6
Most important	36	10.9	39	23.9	32	16.6	107	15.6
Use of pain relief*								
Yes	38	11.6	20	12.3	16	8.3	74	10.8
Most important	24	7.3	22	13.5	9	4.7	55	8.0

*** p<0.05 ** p<0.01 *** p<0.001**

SECTION 3 Social Networks

Definitions

1. Partner uses drugs (Table 9)
   - for 'current treatment' group: in the 6 months before treatment
   - for others: partner uses drugs currently
2. Family members use drugs (Table 9)
   - for 'current treatment' group: in the 6 months before treatment
   - for others: family members uses drugs currently
3. Live with people who use drugs (Table 9)
   - for 'current treatment' group: in the 6 months before treatment
   - for others: anyone where you currently live
4. Time spent with people who use drugs (Table 10)
   - for 'current treatment' group: in the 6 months before treatment
   - for others: currently
5. Extent of friends' drug use (Table 10)
   - on a scale from 0 (none) to 4 (all)
6. Disclosure of drug use (Table 10)
   - for 'current treatment' group: in the 6 months before treatment
   - for others: ever

Network Variables Summary (Table 9)

The proportion of participants with partner, family members and cohabitants using drugs was re-calculated by considering only those who gave positive or negative answers (that is, the 'not applicable', 'don't know' and 'no response' options were excluded). Of these, almost half of the participants indicated that their partner used drugs, 67% indicated that immediate family and 11% extended family used drugs and that 74% of those they lived with used drugs.

There was no association between treatment status and drug use of partner, family members, or cohabitants.

Table 9 Network variables, by treatment status

	In treatment		In-out treatment		Never in treatment		Total	
	N	%	N	%	N	%	N	%
Partner uses drugs								
No	137	41.6	51	31.3	70	36.3	258	37.7
Yes	126	38.3	58	35.6	65	33.7	249	36.4
NA/DK/NR	66	20.1	54	33.1	58	30.1	178	26.0
Family member uses drugs								
No	60	18.2	29	17.8	29	15.0	118	17.2
Yes, extended only	27	8.2	14	8.6	18	9.3	59	8.6
Yes, immediate	165	50.2	88	54.0	107	55.4	360	52.6
NA/DK/NR	77	23.4	32	19.6	39	20.2	148	21.6
Live with people who use drugs								
No	72	21.9	42	25.8	51	26.4	165	24.1
Yes	239	72.6	100	61.3	119	61.7	458	66.9
NA/DK/NR	18	5.5	21	12.9	23	11.9	62	9.1

Network Variables Summary (Table 10)

When extent of friends' drug use was examined on a scale from 0 ('none') to 4 ('all'), the sample overall recorded a moderate mean score of 2.69.

Participants in the 'current treatment' group scored higher on a scale of drug use among friends than participants in the 'past treatment' and 'never in treatment' groups.

Participants in the 'current treatment' group scored higher on a scale of time spent with people who use drugs than participants in the 'past treatment' and 'never in treatment' groups.

Participants in the 'past treatment' group had disclosed their drug use to a greater number of people in the last 6 months than other participants.

Table 10 Network variables, by treatment status

	In treatment		In-out treatment		Never in treatment		Total	
	N	mean	N	mean	N	mean	N	mean
Extent of friends' drug use ***	328	2.88	162	2.53	191	2.51	681	2.69
Time spent with people who use drugs ***	329	2.85	162	2.45	190	2.32	681	2.61
Disclosure of drug use ***	329	3.82	163	4.79	193	4.20	685	4.16

***** p<.001**

SECTION 4 Law Enforcement

Definitions

1. Trouble with police (Table 11)
   - refers to last 6 months

Note: Presentation of results is 'filtered', i.e., only those who report trouble with police in last 6 months are included in the later sections of the table.

Law Enforcement Summary (Table 11)

Of the 685 participants, nearly one-third (n=223) had been in trouble with police in the last six months.

Participants who reported having trouble with police in the last six months were more likely to be in the 'current' or 'past treatment' group than in the 'never in treatment' group.

Of the 223 participants who reported having trouble with police: 85% reported being arrested in the last six months, 76% reported that the charge was related to drug use, and 26% reported having served a sentence.

Participants who reported that the charge was related to drug use were more likely to be in the 'current' or 'past treatment' groups than in the 'never in treatment' group.

Of the 169 participants who reported that the charge was related to drug use, 17% reported having been referred to a drug court.

Of the 57 participants who reported having served a sentence in the last 6 months, 44% reported having not been offered treatment in prison. There was no difference in terms of the treatment status (current, past or never) of those offered vs not offered treatment in prison. However, numbers are small.

Of the 57 participants who reported having served a sentence in the last 6 months, 11% reported continued drug use.

Table 11 Law enforcement, by treatment status

	In treatment		In-out treatment		Never in treatment		Total	
	N	%	N	%	N	%	N	%
Trouble with police**								
No	206	62.6	109	66.9	146	75.6	461	67.3
Yes	123	37.4	53	32.5	47	24.4	223	32.6
NR	0	0	1	0.6	0	0	1	0.1
Were you arrested?(N=223)								
No	17	13.8	5	9.4	9	19.1	31	13.9
Yes	104	84.6	48	90.6	38	80.9	190	85.2
NR	2	1.6	0	0	0	0	2	0.9

Table 11 Law enforcement, by treatment status *(continued)*

	In treatment		In-out treatment		Never in treatment		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Served a sentence?(N=223)								
No	85	69.1	35	66.1	40	85.1	160	71.7
Yes	35	28.5	16	30.1	6	12.8	57	25.6
NR	3	2.4	2	3.8	1	2.1	6	2.7
Was the charge related to drug use?* (N=223)								
No	24	19.5	9	17.0	18	38.3	51	22.8
Yes	96	78.1	44	83.0	29	61.7	169	75.8
NR	3	2.4	0	0	0	0	3	1.4
Referred to a drug court? (N=169)								
No	75	78.1	38	86.4	26	89.7	139	82.2
Yes	19	19.8	6	13.6	3	10.3	28	16.6
NR	2	2.1	0	0	0	0	2	1.2
Offered treatment in prison? (N=57)								
No	13	37.1	8	50.0	4	66.7	25	43.9
Drug counseling	7	20.0	3	18.8	0	0	10	17.5
GP for medication/ medical detox	4	11.4	3	18.8	0	0	7	12.3
Self help groups	1	2.9	0	0	0	0	1	1.8
Methadone	7	20.0	0	0	0	0	7	12.3
buprenorphine	1	2.9	0	0	0	0	1	1.8
NR	2	5.7	2	12.6	2	33.4	6	10.4
Manage drug use in prison? (N=57)								
Continue use	2	5.7	3	18.8	1	16.7	6	10.5
Enforced withdrawal	9	25.7	6	37.5	3	50.5	18	31.6
Self detox	5	14.3	3	18.8	0	0	8	14.0
Controlled use	5	14.3	1	6.3	0	0	6	10.5
Prison is a chance for some down	0	0	0	0	1	16.7	1	1.8
Used certain drugs to cope with prison life	4	11.4	1	6.3	0	0	5	8.8
Other	10	28.6	1	6.3	0	0	11	19.3
NR	0	0	1	6.3	1	16.7	2	3.5

***p<.05 **p<.01**

SECTION 5 Health and Wellbeing

Definitions

1. Emotional experience
   - timeframe: in last 4 weeks
   - individual items examined by 'ever' vs 'never', as well as on a scale from 0 (never) to 3 (often)
   - negative emotion items used to construct a negative emotion scale
   - positive emotion items used to construct a positive emotion scale.
2. Physical problems
   - timeframe: ever experienced
   - scale generated by count of number of physical problems reported.
3. SF scores
   - derived from SF12 (Short-Form Health Survey; Ware et al., 1996). This is a general measure of health and wellbeing.
4. Severity of Dependence Scale (SDS; Gossop et al., 1995)
   - because of the standardised nature of this scale, data cannot be recorded retrospectively (i.e., 6 months prior to treatment). Consequently, for the 'current treatment' group, SDS scores are only available for respondents who continued to use drugs while in treatment.

Blood-Borne Virus Tests Summary (Table 12)

Over 80% of the total sample reported being tested for hepatitis C, hepatitis B or HIV. Self-reported hepatitis C positive status was reported by 44% of the sample, whereas 8% reported being positive for hepatitis B and 2% reported being HIV positive. In addition, 18% reported having had vaccinations for hepatitis B.

Participants who reported hepatitis C positive status were more likely to be in the 'current' or 'past treatment' groups than in the 'never in treatment' group.

Participants who reported HIV positive status were more likely to be in the 'past' or 'never in treatment' groups than in the 'current treatment' group.

About one-quarter of the sample indicated that they had been tested for blood-borne viruses as a compulsory part of treatment. Those who had had a compulsory BBV test were more likely to be in the 'current' or 'past treatment' groups than in the 'never in treatment' group.

Of these, about two-thirds reported that they had not received pre/post test counselling as part of these tests. There were no treatment status differences between those that had, and those that had not received counselling.

Table 12 Blood borne virus tests, by treatment status

	In treatment		In-out treatment		Never in treatment		Total	
	N	%	N	%	N	%	N	%
Have ever been tested for hepatitis C* **								
Never	17	5.2	6	3.7	48	24.9	71	10.4
Ever	310	94.2	156	95.7	142	73.6	608	88.8
Do not know	2	0.6	1	0.6	3	1.6	6	0.9
Hepatitis C test result**								
Negative	121	36.8	66	40.5	79	40.9	266	38.8
Positive	167	50.8	82	50.3	53	27.5	302	44.1
NR	41	12.4	15	9.2	61	31.6	117	17.1
Have ever been tested for hepatitis B* **								
Never	30	9.1	12	7.4	57	29.5	99	14.5
Ever	285	86.6	144	88.3	123	63.7	552	80.6
Do not know	14	4.3	7	4.3	13	6.7	33	4.9
Hepatitis B test result								
Negative	177	53.8	90	55.2	81	42.0	348	50.8
Being vaccinated	60	18.2	33	20.2	27	14.0	120	17.5
Positive	34	10.3	14	8.6	4	2.1	52	7.6
NR	58	17.7	26	16	81	41.9	165	24.1
Have ever been tested for HIV * **								
Never	17	5.2	7	4.3	56	29.0	80	11.7
Ever	307	93.3	153	93.9	135	69.9	595	86.9
Do not know	5	1.5	3	1.8	2	1.0	8	1.5
HIV test result* **								
Negative	291	88.4	145	89.0	119	61.7	555	81.0
Positive	0	0	6	3.7	8	4.1	14	2.0
NR	38	11.6	12	7.4	66	34.2	116	17.0
Compulsory test as part of treatment* **								
No	220	66.9	104	63.8	183	94.8	507	74.0
Yes	103	31.3	51	31.3	8	4.1	162	23.6
NR	6	1.8	8	4.9	2	1.0	16	2.3
Received pre/post test counselling?								
No	66	20.1	28	17.2	7	3.6	101	14.7
Yes	33	10.	18	11.0	4	2.1	55	8.0
NR	230	69.9	117	71.8	182	94.3	529	77.2

***p<.05 **p<.01 ***p<.001**

Emotions in the last 4 weeks Summary (Tables 13 and 14)

In terms of emotional health high proportions (over 90%) of participants in the total sample reported a range of positive and negative emotions in the previous four weeks, such as feelings of calm, anger, joy, anxiety, sadness and happiness. Lower proportions of participants reported feeling ecstatic, desperate, enraged, jealous and paranoid. Overall, about one-third of the sample reported feeling suicidal in the previous four weeks.

Participants in the 'current treatment' group were more likely than those in the 'past' or 'never in treatment' groups to have ever felt: sad in last 4 weeks.

Participants in the 'current' and 'past treatment 'groups were more likely than those in the 'never in treatment' group to have (ever) felt: suicidal in the last 4 weeks.

Participants in the 'past' and 'never in treatment' groups were more likely than participants in the 'current treatment' group to have (ever) felt: enraged in the last 4 weeks.

Similar overall patterns when emotional experience was examined as a score (from 0 being 'never' and 3 being 'often') (Table 14) . Participants in the 'never in treatment' group reported feeling calm, and also feeling ecstatic, more often than participants in the 'current treatment' group.

Participants in the 'never in treatment' group reported feeling happy more often than participants in the 'past treatment' group.

Participants in the 'current' and 'past treatment' groups reported feeling more anger, anxiety, and sadness than participants in the 'never in treatment' group.

Participants in the 'past treatment' group reported feeling depressed, and suicidal more often than participants in the 'never in treatment' group.

Overall, participants in the 'never in treatment' group reported more positive feelings, and those in the 'past' and 'current treatment' groups more negative feelings, in the last 4 weeks.

Table 13 Emotions in the last 4 weeks, by treatment status

	In treatment		In-out treatment		Never in treatment		Total	
	N	%	N	%	N	%	N	%
Calm								
Never	22	6.7	6	3.7	5	2.6	33	4.8
Ever	307	93.3	157	96.3	187	96.9	651	95.0
NR	0	0	0	0	1	0.5	1	0.1
Angry								
Never	13	4.0	12	7.4	17	8.8	42	6.1
Ever	316	96.0	151	92.6	175	90.7	642	93.7
NR	0	0	0	0	1	0.5	1	0.1
Joyful								
Never	32	9.7	11	19.3	14	7.3	57	8.3
Ever	297	90.3	151	92.6	177	91.7	625	91.2
NR	0	0	1	0.6	2	1.0	3	0.4
Anxious								
Never	16	4.9	9	5.5	16	8.3	41	6.0
Ever	313	95.1	154	94.5	176	91.2	643	93.9
NR	0	0	0	0	1	0.5	1	0.1
Depressed								
Never	28	8.5	14	8.6	23	11.9	65	9.5
Ever	301	91.5	149	91.4	169	87.6	619	90.4
NR	0	0	0	0	1	0.5	1	0.1
Sad*								
Never	16	4.9	14	8.6	20	10.4	50	7.3
Ever	313	95.1	149	91.4	172	89.1	634	92.6
NR	0	0	0	0	1	0.5	1	0.1
Ecstatic								
Never	117	25.6	51	31.3	53	27.5	221	32.3
Ever	212	64.4	111	68.1	138	71.5	461	67.3
NR	0	0	1	0.6	2	1.0	3	0.4
Desperate								
Never	96	29.2	40	24.5	66	34.2	202	29.5
Ever	232	70.5	123	75.5	126	65.3	481	70.2
NR	1	0.3	0	0	1	0.5	2	0.3
Suicidal*								
Never	214	65.0	101	62.0	143	74.1	458	66.9
Ever	114	34.7	61	37.4	48	24.9	223	32.6
NR	1	0.3	1	0.6	2	1.0	4	0.6
Happy								
Never	12	3.6	5	3.1	4	2.1	21	3.1
Ever	317	96.4	158	96.9	188	97.4	663	96.8
NR	0	0	0	0	1	0.5	1	0.1

Table 13 Emotions in the last 4 weeks, by treatment status

	In treatment		In-out treatment		Never in treatment		Total	
	N	%	N	%	N	%	N	%
Enraged**								
Never	133	40.4	43	26.4	66	34.2	242	35.3
Ever	194	59.0	120	73.6	126	65.3	440	64.2
NR	2	0.6	0	0	1	0.5	3	0.4
Jealous								
Never	168	51.1	84	51.1	100	51.8	352	51.4
Ever	160	48.6	79	48.5	92	47.7	331	48.3
NR	1	0.3	0	0	1	0.5	2	0.3
Paranoid								
Never	110	33.4	53	32.5	59	30.6	222	32.4
Ever	218	66.3	110	67.5	133	68.9	461	67.3
NR	1	0.3	0	0	1	0.5	2	0.3

*p<.05 **p<.01 ***p<.001

Table 14 Emotions in the last 4 weeks, by treatment status

	In treatment (N=329)		In-out treatment (N=163)		Never in treatment (N=193)		Total (N=685)	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Calm *	1.97	0.84	2.03	0.78	2.16	0.74	2.04	0.80
Angry **	1.95	0.82	1.88	0.89	1.66	0.85	1.85	0.85
Joyful	1.76	0.90	1.70	0.78	1.87	0.89	1.77	0.87
Anxious **	2.13	0.88	2.18	0.85	1.82	0.91	2.05	0.89
Depressed *	1.89	0.92	1.99	0.95	1.72	0.96	1.87	0.94
Sad ***	1.93	0.86	1.95	0.93	1.60	0.90	1.84	0.90
Ecstatic *	0.98	0.89	0.98	0.82	1.19	0.93	1.04	0.89
Desperate	1.35	1.10	1.39	1.00	1.17	1.04	1.01	1.06
Suicidal *	0.56	0.86	0.65	0.94	0.42	0.81	0.54	0.86
Happy *	2.10	0.78	2.06	0.73	2.26	0.70	2.14	0.75
Enraged	1.09	0.07	1.26	1.00	1.02	0.94	1.11	1.02
Jealous	0.84	1.00	0.80	0.96	0.76	0.92	0.81	0.97
Paranoid	1.31	1.11	1.33	1.09	1.24	1.01	1.30	1.07

*p<.05 **p<.01 ***p<.001

Physical Problems Summary (Table 15)

Overall the mean number of physical problems reported by participants was 11.4 (on a scale from 0-17). Over 70% of the sample reported ever experiencing bruising, scarring, nausea, sleep deprivation, paranoia, constipation and fluctuations in weight. Moderate proportions of participants (30%-70%) reported the following physical problems: overdose, headache, abscess, dirty hit, collapsed veins, nasal problems, violence, diarrhoea, dental problems, chest problems, cracked lips.
A small proportion of participants reported anal problems (18%).

Participants in the 'current' and 'past treatment' groups were more likely than those in the 'never in treatment' group to report having: overdosed due to drug use, and to report having headache, diarrhoea (dirty hit), scarring, collapsed veins, nausea, dental problems due to drug use.

Participants in the 'current treatment' group were more likely than those in the 'never in treatment' group to report having: abscess, bruising, paranoia, experience of violence, constipation, fluctuations in bodyweight because of drug use.

Participants in the 'current treatment' group were more likely than participants in the 'past' and the 'never in treatment' groups to report having: chest problems, and/or cracked lips due to drug use.

Table 15 Physical problems related to drug use, by treatment status

	In treatment		In-out treatment		Never in treatment		Total	
	N	%	N	%	N	%	N	%
Overdose ***								
Never	124	37.7	54	33.1	117	60.6	295	390
Ever	205	62.3	109	66.9	76	39.4	43.1	56.9
Headache***								
Never	76	23.1	45	27.6	92	47.7	213	31.3
Ever	252	76.6	118	72.4	100	51.8	470	68.6
NR	1	0.3	0	0	1	0.5	2	0.3
Abscess**								
Never	178	54.1	97	59.5	131	67.9	406	59.3
Ever	151	45.9	66	40.5	61	31.6	278	40.6
NR	0	0	0	0	1	0.5	1	0.1
Dirty hit ***								
Never	108	32.8	56	34.4	111	57.5	275	40.1
Ever	22	66.9	107	65.6	82	42.5	409	59.7
NR	1	0.3	0	0	0	0	1	0.1
Bruising **								
Never	56	17.0	34	20.9	60	31.1	150	21.9
Ever	272	82.7	129	79.1	133	68.9	534	78.0
NR	1	0.3	0	0	0	0	1	0.1

Table 15 Physical problems related to drug use, by treatment status *(continued)*

	In treatment		In-out treatment		Never in treatment		Total	
	N	%	N	%	N	%	N	%
Scarring* **								
Never	42	12.8	16	9.8	58	30.1	116	16.9
Ever	286	86.9	147	90.2	134	69.4	567	82.8
NR	1	0.3	0	0	1	0.5	2	0.3
Collapsed Veins * **								
Never	162	49.2	75	46.0	135	69.9	372	54.3
Ever	165	50.2	88	54.0	57	29.5	310	45.3
NR	2	0.6	0	0	1	0.5	3	0.4
Nausea * **								
Never	37	11.2	20	12.3	67	34.7	124	18.1
Ever	292	88.8	143	87.7	126	65.3	561	81.9
Nasal problem								
Never	196	59.6	111	68.1	129	66.8	436	63.6
Ever	133	40.4	52	31.9	63	32.6	248	36.2
NR	0	0	0	0	1	0.5	1	0.1
Anal problem								
Never	265	80.5	131	80.4	167	86.5	563	82.2
Ever	64	19.5	32	19.6	24	12.4	120	17.5
NR	0	0	0	0	2	1.0	2	0.3
Sleep deprivation								
Never	26	7.9	14	8.6	26	13.5	66	9.6
Ever	303	92.1	149	91.4	166	86.0	618	90.2
NR	0	0	0	0	1	0.5	1	0.1
Paranoia* **								
Never	75	22.8	47	28.8	77	39.9	199	29.1
Ever	254	77.2	116	71.2	115	59.6	485	70.8
NR	0	0	0	0	1	0.1	1	0.1
Violence* **								
Never	128	38.9	81	49.7	131	67.9	340	49.6
Ever	200	60.8	81	49.7	60	31.1	341	49.8
NR	1	0.3	1	0.6	2	1.0	4	0.6
Diarrhoea* **								
Never	110	33.4	64	39.3	100	51.8	274	40.0
Ever	219	66.6	99	60.7	92	47.7	410	59.9
NR	0	0	0	0	1	0.5	1	0.1
Constipation* **								
Never	67	20.4	44	27.0	83	43.0	194	28.3
Ever	262	79.6	119	73.0	109	56.5	490	71.5
NR	0	0	0	0	1	0.5	1	0.1

Table 15 Physical problems related to drug use, by treatment status *(continued)*

	In treatment		In-out treatment		Never in treatment		Total	
	N	%	N	%	N	%	N	%
Fluctuations in weight* **								
Never	38	11.6	36	22.1	72	37.3	146	21.3
Ever	291	88.4	126	77.3	119	61.7	536	78.2
NR	0	0	1	0.6	2	1.0	3	0.4
Dental problems* **								
Never	96	29.2	44	17.0	98	50.8	238	34.7
Ever	232	70.5	119	73.0	94	48.7	445	65.0
NR	1	0.3	0	0	1	0.5	2	0.3
Chest problem*								
Never	185	56.2	107	65.6	130	67.4	422	61.6
Ever	142	43.2	55	33.7	62	32.1	259	37.8
NR	2	0.6	1	0.6	1	0.5	4	0.6
Cracked lip**								
Never	148	45.0	92	56.4	115	59.6	355	51.8
Ever	180	54.7	71	43.6	76	39.4	327	47.7
NR	1	0.3	0	0	2	1.0	3	0.4

***p<.05 **p<.01 ***p<.001**

Summary Health and Wellbeing Scores Summary (Table 16)

SF health scores (range 0-36): Participants with the best health and wellbeing were likely to be in the 'never in treatment' group rather than the 'past' or 'current treatment' groups.

Negative emotion scores (range 0-21): Participants who reported feeling the most negative emotion were likely to be in the 'current' or 'past treatment' groups rather than the 'never in treatment' group.

Positive emotions scores (range 0-12): Participants who reported feeling the most positive emotion were likely to be in the 'never in treatment' group rather than the 'current' or 'past treatment' groups.

Physical problem scores (range 0-17): Participants who reported having many physical problems were more likely to be in the 'current' or 'past treatment' groups than in the 'never in treatment' group.

Severity of dependency scale (range 0-23): Participants who reported high drug dependency were more likely to be in the 'past treatment' group than in the 'never in treatment' group.

Table 16 Summary health and wellbeing scores, by treatment status

	In treatment		In-out treatment		Never in treatment		Total	
	N	mean	N	mean	N	mean	N	mean
SF health scores* **	329	35.05	163	34.20	192	38.87	685	35.93
Negative emotion scores**	329	12.19	163	12.64	193	10.67	685	11.87
Positive emotion scores**	329	6.81	163	6.77	193	7.48	685	6.99
Physical problem scores* **	329	12.53	163	11.82	193	9.06	685	11.38
SDS scores * **	[124	7.06]	157	7.59	182	5.84	463	6.76

** p<.01 ***p<.001

SECTION 6 Treatment History and Current Treatment Experiences

Definition

1. Length of time waiting for treatment
    - 0 was seen immediately, 1 within one day, 2 waited more than one but less than two days, 3 waited more than two but less than three days, 4 waited between three and six days, 5 waited one to two weeks, 6 waited more than two weeks.

Treatment Referral and First Appointment Summary (Tables 17 and 18)

Most participants who had experience of treatment were aware of treatment via a professional. About equal proportions were made aware of treatment by family, friends or their partner as by the media. Most frequently, those who had treatment experience had referred themselves to treatment. Less frequent referrals were made by professionals and fewer still by family, friends and partners as well as the corrective services.

About two-thirds of participants asked to be referred, most consented to be referred and most attended their first appointment. About 60% of participants reported that they had to satisfy entry requirements for treatment. About 70% reported that the requirement involved attending appointments with counsellors or doctors. The remaining 30% indicated that the requirements involved abstinence from drug use or urine testing to ascertain drug use. Most participants indicated that they could meet the requirements imposed by the treatment agency and were accepted into treatment.

Participants in the 'past treatment' group were more likely than those in the 'current treatment' group to have 'consented' to be referred (at last treatment). They were also more likely to report having 'kept using' drugs while waiting for treatment.

Participants who reported abstinence/urine test requirements for treatment entry were more likely to be in the 'current treatment' group than in the 'past treatment' group.

On average, participants waited for 2-3 days for the first appointment for treatment. Most indicated that they kept using drugs while waiting for treatment. Very few participants indicated that they undertook any detoxification while waiting for treatment.

In assessing their own psychological state prior to treatment about 60% indicated they were "in crisis" or " chaotic" at that time. Conversely, about one-third indicated they were "level headed". About half indicated that their financial state prior to treatment was "debt ridden".

Table 17 Treatment referral and first appointment, by treatment status

	In treatment		In-out treatment		Total	
	N	%	N	%	N	%
How found out about treatment						
Family/friends/partner	69	21.0	25	15.3	94	13.7
Media	88	26.7	20	12.3	108	15.8
Professional referral	116	35.3	109	66.9	225	32.8
Never in treatment/NR	56	17.0	9	5.5	258	37.7
Who referred you to treatment						
Self	184	55.9	78	47.9	262	38.2
Friend/partner/family/user/ex-user	39	11.9	22	13.5	61	8.9
Court/parole officer/police/ corrective service/prison hospital	24	7.3	10	6.1	34	5.0
Other professional/DK	82	24.9	53	32.5	135	19.7
Never in treatment	—	—	—	—	193	28.2
Asked to be referred						
No	51	15.5	43	26.4	94	19.1
Yes	103	31.3	81	49.7	184	37.4
NR/Skip	175	53.2	39	23.9	214	43.5
Consented to be referred*						
No	6	1.8	12	7.4	18	3.7
Yes	75	22.8	41	25.2	116	23.6
NR/Skip	248	75.4	110	67.4	358	72.8
Attended first appointment						
No	19	5.8	11	6.7	30	6.1
Yes	304	92.4	113	69.3	417	84.8
NR/Skip	6	1.8	39	23.9	45	9.1
Requirement/s for entry						
No	131	39.8	40	24.5	171	34.8
Yes	195	59.3	73	44.8	268	54.5
NR/Skip	3	0.9	50	30.6	53	10.8

Table 17 Treatment referral and first appointment, by treatment status *(continued)*

	In treatment		In-out treatment		Total (N=492)	
	N	**%**	**N**	**%**	**N**	**%**
Nature of treatment requirements* **						
None	127	38.6	40	24.5	167	33.9
Abstinence/urine	73	22.2	6	3.7	79	16.1
Counseling/doctor/other	121	36.8	67	41.1	188	38.2
NR/skip	8	2.4	50	30.7	58	11.8
Impact of such requirements?						
Couldn't meet, didn't go	2	1.0	4	5.3	6	2.2
Couldn't meet, was not accepted	1	0.5	4	5.3	5	1.8
Couldn't meet some of them, but was accepted anyway	25	12.7	19	25.3	45	16.5
Could meet all and was accepted	159	80.7	42	56.0	201	73.9
No response	10	5.0	6	8.0	16	5.9
Management of drug use while waiting for treatment* **						
No waiting	77	15.7	21	12.9	98	19.9
Self/home detox	19	3.9	5	3.1	24	4.9
Kept using	228	46.3	86	52.8	314	63.8
NR	5	1.0	51	31.3	56	11.4
Personal situation prior to accessing treatment						
Level headed						
No	220	44.7	103	63.2	323	65.7
Yes	108	22.0	55	33.7	163	33.1
NR	1	0.2	5	3.1	6	1.2
Chaotic						
No	134	27.2	68	41.7	202	41.1
Yes	193	39.2	88	54.0	281	57.1
NR	2	0.4	7	4.3	9	1.8
In crisis						
No	126	25.6	58	35.6	184	37.4
Yes	201	40.9	99	60.7	300	61.0
NR	2	0.4	6	3.7	8	1.6
Debt ridden						
No	173	35.2	79	48.5	252	51.2
Yes	153	31.1	76	46.6	229	46.5
NR	3	0.6	8	4.9	11	2.2

Table 18 Time waiting for first appointment, by treatment status

	In treatment		In-out treatment		Total	
	N	mean	N	mean	N	mean
Length of time waiting	329	3.0	163	3.2	492	3.1

Treatment History Summary (Table 19)

Overall, a slightly higher proportion of participants indicated that the aim of their treatment was abstinence (versus to control, reduce or have a break from drug use). Participants were reasonably evenly split over the range of options of achievement of treatment aim. That is, just over one-third of participants indicated that they did not achieve their aims, or achieved their aims at a reasonable level. About one-quarter of participants indicated that they were successful in achieving their treatment aims.

The most frequently endorsed support in achieving treatment aims was "self determination". Less frequently endorsed sources of supports included "staff", "peers", "individual counselling" and "abstinence".

In terms of barriers to achieving treatment aims, the most frequently reported barriers were "not being ready to stop using" and "prefer to keep using".

Participants in the 'current treatment' group were more likely than those in the 'past treatment' group to report their treatment aim as being "total abstinence" (rather than reduction, control, etc., of drug use).

Participants in the 'current treatment' group were also more likely than those in the 'past treatment' group to report having received various kinds of support for the achievement of their treatment aims, including support from "staff", "group sessions", "individual counselling", and from "abstinence".

Participants from the 'past treatment' group were more likely than those in the 'current treatment' group to report support from "naltrexone".

Participants in the 'past treatment' group were also more likely than those in the 'current treatment' group to report various factors preventing the achievement of their treatment aims, including, "rules and regulations", "lack of support from peers" and/or "staff", "lack of own readiness to stop using".

Table 19 Treatment history, by treatment status

	In treatment		In-out treatment		Total (N=492)	
	N	%	N	%	N	%
Treatment aim* **						
Abstinence	206	62.6	70	42.9	276	56.1
Control/reduce/have break	123	37.4	93	57.1	216	43.9
Achievement of aim* **						
Not at all/to small extent	93	28.3	85	52.1	178	36.2
To reasonable/large extent	148	45.0	41	25.2	189	38.4
Almost completed/completed	88	26.7	37	22.7	125	25.4
Supports to achievement/ near achievement of treatment aim					**(N=314)**	
Support from peers	124	52.5	41	52.6	165	52.5
Support from staff**	161	68.2	39	50.0	200	63.7
Group sessions**	108	45.8	19	24.4	127	40.4
Threat of incarceration	59	25.0	18	23.1	77	24.5
Self determination	206	87.3	63	80.8	269	85.7
Individual counseling*	120	50.8	29	37.2	149	47.5
Psychiatrist	34	14.4	8	10.3	42	13.4
Methadone	65	27.5	21	26.9	86	27.4
Buprenorphine	22	9.3	4	5.1	26	8.3
Naltrexone*	2	0.8	4	5.1	6	1.9
Financial counseling	15	6.4	2	2.6	17	5.4
Abstinence**	123	52.1	25	32.1	148	47.1
Prevented from achieving treatment aims					**(N=178)**	
Abstinence	28	30.1	29	34.1	57	32.0
Rules and regulations*	15	16.1	28	32.9	43	24.2
Group sessions	7	7.5	5	5.9	12	6.7
A particular staff person	4	4.3	8	9.4	12	6.7
Lack of support from peers*	12	12.9	25	29.4	37	20.8
Lack of support from staff*	10	10.8	20	23.5	30	16.9
Was not ready to stop using**	39	41.9	58	68.2	97	54.5
Was not intolerant of the situation	13	14.0	23	27.1	36	20.2
Did not want to be in there	14	15.1	21	24.7	35	19.7
Prefer to keep using	33	35.5	43	50.6	76	42.7

*** p<0.05 ** p< 0.01**

Client –Focused Treatment Summary (Table 20)

Most participants were not offered a choice of worker in their last treatment. Around half of the participants were offered flexible appointment times and had a plan for their last treatment.

Of those who answered the question, the majority reported that they had input into their treatment plan. However, the large proportion of participants who did not complete this question may indicate that they did not understand the concept of client input into treatment plan, or were not offered this.

About one-third of participants had taken part in a review of a treatment provider and most reported that they knew they had rights as a consumer of health services. However, most had not seen a copy of the treatment provider complaints procedure.

Overall, about 60% of participants indicated that they were somewhat or very satisfied with their current or most recent treatment compared to 22% who reported being very or somewhat unsatisfied with this treatment.

Participants in the 'current treatment' group were more likely than those in the 'past treatment' group to report that they were offered flexible appointment times, and to report being satisfied with their treatment.

Table 20 Client-focused treatment, by treatment status

	In treatment		In-out treatment		Total (N=492)	
	N	%	N	%	N	%
Offered choice of treatment worker in last treatment						
No	261	79.3	133	81.6	394	80.1
Yes	66	20.1	23	14.1	89	18.1
Skip/NR	2	0.6	7	4.3	9	1.8
Offered flexible appointment times in last treatment**						
No	121	36.8	79	48.5	200	40.6
Yes	192	58.4	74	45.4	266	54.1
Skip/NR	16	4.9	10	6.1	26	5.3
Had a treatment plan						
No	146	44.4	84	51.5	230	46.8
Yes	181	55.0	74	45.4	255	51.8
Skip/NR	2	0.6	5	3.1	7	1.4
Had input in last treatment						
No	30	9.1	17	10.4	47	9.6
Yes	161	48.9	58	35.6	219	44.5
Skip/NR	138	41.9	88	54.0	226	45.9

Table 20 Client-focused treatment, by treatment status *(continued)*

	In treatment		In-out treatment		Total (N=492)	
	N	%	N	%	N	%
Took part in a review of treatment provider						
No	212	64.4	107	65.6	319	64.8
Yes	113	34.3	53	32.5	166	33.7
Skip/NR	4	1.2	3	1.8	7	1.5
Knew that had rights as a consumer of health services						
No	61	18.5	34	20.9	95	19.3
Yes	267	81.2	128	78.5	395	80.3
Skip/NR	1	0.3	1	0.6	2	0.4
Seen copy of treatment provider complaints procedure?						
No	256	77.8	126	77.3	382	77.7
Yes	70	21.3	35	21.5	105	21.3
Skip/NR	3	0.9	2	1.2	5	1
Satisfied with current/most recent treatment?* **						
Very unsatisfied	28	8.5	35	21.5	63	12.8
Somewhat unsatisfied	19	5.8	27	16.6	46	9.3
In the middle	46	14.0	31	19.0	77	15.7
Somewhat satisfied	101	30.7	33	20.2	134	27.2
Very satisfied	132	40.1	31	19.0	163	33.1
NR	3	0.9	6	3.7	9	1.8

Reasons for Wanting to Change Drug Use Summary (Table 21)

The most frequently reported reasons for wanting to change drug use, with high endorsement, related to personal issues such as "wanting to improve one's quality of life", to "increase stability" and "being sick of the lifestyle". Still frequent, but less common, reasons for wanting to change drug use included "being worried about the impact of drug use on others" and worries about "physical and mental health".

Reasons such as being "diagnosed with hepatitis C" or being "worried about getting blood borne viruses" were among the lowest frequency responses.

Participants currently in treatment were more likely than those not in current treatment to endorse the following reasons for wanting to change their drug use: "to increase stability in life"; "being sick of the lifestyle"; "to improve quality of life", and "to reduce stress".

Participants not in current treatment were more likely than those in treatment to want to change drug use because of "problems with the drug supply".

Table 21 Reasons for wanting to change drug use, by treatment status

	In treatment		In-out treatment		Total (N=492)	
	N	%	N	%	N	%
Why did you want to change your drug use?						
Diagnosed with HCV	27	8.2	22	13.5	49	10.0
Worried about getting HCV, HIV or other BBV	78	23.7	31	19.0	109	22.2
Worried about physical health	212	64.4	104	63.8	316	64.2
Worried about mental health	228	69.3	109	66.9	337	68.5
Increase stability in my life*	291	88.4	129	79.1	420	85.4
Sick of the lifestyle*	295	89.7	131	80.4	426	86.6
Reached crisis point	247	75.1	111	68.1	358	72.8
Problems with drug supply***	59	17.9	51	31.3	110	22.4
Stop committing crime	139	42.2	58	35.6	197	40.0
Harassed by the police/arrested	126	38.3	61	37.4	187	38.0
Stopped enjoying drug use	190	57.8	80	49.1	270	54.9
Wanted to gain control over drug use	259	78.7	127	77.9	386	78.5
Pressure from parent/family/friend	140	42.6	69	42.3	209	42.5
Pressure from boss	14	4.3	6	3.7	20	4.1
Directed by the courts	43	13.1	19	11.7	62	12.6
Fear of losing job	30	9.1	19	11.7	49	10.0
Worried about the impact of drug use on those close to me	231	70.2	113	69.3	344	69.9
Worried about children being taken away	73	22.2	26	16.0	99	20.1
To be a better partner	123	37.4	53	32.5	176	35.8
To improve my quality of life*	306	93.0	138	84.7	444	90.2
To reduce stress*	269	81.8	117	71.8	386	78.5

*** p<0.05 *** p< 0.001**

Services Provided and Helpfulness of Service (Table 22 and 23)

A range of services were offered by treatment agencies. The most frequently reported 'additional' services offered by treatment programs, included: information about blood-borne viruses (81%); individual counselling (79%); relapse prevention strategies (63%); mental health assessment and treatment (54%); and medical/dental treatment (54%).

Participants in the 'current treatment' group were more likely than those in the 'past treatment' group to report that their treatment provider offers: employment/ skills training; housing assistance; mental health assessment and treatment; medical/dental treatment; ante and post natal support; relapse prevention strategies; therapeutic groups; individual counselling; family interventions; financial planning assistance; legal advice; referral to peer support programs.

The helpfulness of the services offered by treatment agencies was rated relatively highly. Participants in the 'current treatment' group were more likely than those in the 'past treatment' group to perceive their service provider as offering relapse prevention strategies and therapeutic groups.

Table 22 Services Offered, by Treatment Status

	In treatment		In-out treatment		Total (N=492)	
	N	%	N	%	N	%
Information about HCV, HIV or other BBVs	271	82.4	126	77.3	397	80.7
Employment/skills training***	103	31.3	23	14.1	126	25.6
Housing assistance***	120	36.5	32	19.6	152	30.9
Post prison re-integration	39	11.9	12	7.4	51	10.4
Mental health assessment and treatment***	196	59.6	67	41.1	263	53.5
Medical/dental treatment ***	198	60.2	66	40.5	264	53.7
Antenatal/postnatal support*	35	10.6	9	5.5	44	8.9
Relapse prevention strategies***	223	67.8	84	51.5	307	62.4
Therapeutic groups***	195	59.3	62	38.0	257	52.2
Individual counselling***	281	85.4	107	65.6	388	78.9
Family interventions***	103	31.3	26	16.0	129	26.2
Financial planning assistance***	112	34.0	20	12.3	132	26.8
Legal advice**	91	27.7	24	14.7	115	23.4
Referral to peer support program***	148	45.0	45	27.6	193	39.2
User magazines (users news)	95	28.9	60	36.8	155	31.5
Harm reduction strategies if still using	154	46.8	67	41.1	221	44.9

*** p<0.05 *** p<0.001**

Table 23 Perceptions of service provider helpfulness, by treatment status

	In treatment		In-out treatment		Total	
	N	%	N	%	N	%
Was the service helpful?						
Information about HCV, HIV or other BBV exposure	215	79.3	99	78.6	314	79.1
Employment/skills training	72	69.9	18	78.3	90	71.4
Housing assistance	90	75.0	25	78.1	115	75.7
Post prison re-integration	28	71.8	6	50.0	34	66.7
Mental health assessment and treatment	143	73.0	43	64.2	186	70.7
Medical/dental treatment	161	81.3	52	78.8	213	80.7
Antenatal/postnatal support	17	48.6	7	77.8	24	54.5
Relapse prevention strategies*	186	83.4	59	70.2	245	79.8
Therapeutic groups**	159	81.5	38	61.3	197	76.7
Individual counseling	231	82.2	86	80.4	317	81.7
Family interventions	68	66.0	16	61.5	84	65.1
Financial planning assistance	75	67.0	12	60.0	87	65.9
Legal advice	61	67.0	19	79.2	80	69.6
Referral to peer support program	100	67.6	24	53.3	124	64.2
User magazines (users news)	77	81.1	51	85.0	128	82.6
Harm reduction strategies if still using	123	79.9	56	83.6	179	81.0

After-Treatment Support Programs Summary (Table 24)

In terms of after-treatment support programs, most participants were aware of support available from drug and alcohol counsellors. Other programs reported by a high proportion of participants included self-help groups, methadone maintenance, support from local doctor, long term therapy/counselling and naltrexone maintenance.

Participants in the 'past treatment' group were more likely than those in the 'current treatment' group to report having heard of: drug user programs.

Participants in the 'current treatment' group were more likely than those in the 'past treatment' group to report having heard of: support from drug and alcohol counselling, long term therapy/counselling, naltrexone maintenance.

Table 24 After-treatment support programs, by treatment status

	In treatment		In-out treatment		Total (N=492)	
	N	%	N	%	N	%
Have you heard of any of these after-treatment support programs?						
Drug user organisations**	192	58.4	115	70.6	307	62.4
Peer network	145	44.1	77	47.2	222	45.1
Support from your local doctor	232	70.5	126	77.3	358	72.8
Support from a drug and alcohol counsellor**	310	94.2	140	85.9	450	91.5
Long term therapy/counselling**	253	76.9	100	61.3	353	71.7
Alternative/natural therapies	188	57.1	81	49.7	269	54.7
Self help groups	286	86.9	133	81.6	419	85.2
Methadone maintenance	280	85.1	132	81.0	412	83.7
Buprenorphine maintenance	218	66.3	96	58.9	314	63.8
Naltrexone maintenance*	245	74.5	104	63.8	349	70.9
Prison release support	131	39.8	58	35.6	189	38.4

Treatment Supports and Helpfulness of Supports (Table 25)

The most frequently reported sources of support during participants' most recent or current treatment was from counsellors and health care workers. Also frequently reported was family members. The helpfulness of the supports was rated relatively highly across all categories.

Table 25 Treatment supports, by treatment status

	In treatment		In-out treatment		Total (N=492)	
	N	%	N	%	N	%
Do/did you have support during the current/most recent treatment? From:						
Current partner	129	39.2	70	42.9	199	40.4
Family members	211	64.1	86	52.8	297	60.4
Your friends	181	55.0	86	52.8	267	54.3
Workmates	29	8.8	17	10.4	46	9.3
Boss	20	6.1	12	7.4	32	6.5
Self-help group**	131	39.8	37	22.7	168	34.1
Counsellor***	239	72.6	87	53.4	326	66.3
Doctor/nurse/health care worker	212	64.4	113	69.3	325	66.1
Drug user organisation	68	20.7	44	27.0	112	22.8
Current user**	75	22.8	54	33.1	129	26.2
Non-user*	163	49.5	62	38.0	225	45.7
Telephone help lines	27	8.2	15	9.2	42	8.5
Support helpful? From:						
Current partner	121	93.8	61	87.1	182	91.5
Family members	192	91.0	77	89.5	269	90.6
Your friends	162	89.5	74	86.0	236	88.4
Workmates	24	82.8	14	82.4	38	82.6
Boss	17	85.0	8	66.7	25	78.1
Self help group	109	83.2	30	81.1	139	82.7
Counsellor	216	90.4	74	85.1	290	89.0
Doctor/nurse/health care worker	183	86.3	100	88.5	283	87.1
Drug user organisation	60	88.2	33	75.0	93	83.0
Current user*	63	84.0	36	66.7	99	76.7
Non-user	145	89.0	50	80.6	195	86.7

Treatment Frequency and Treatment Sought in the Past (Table 26)

On average, participants had been in treatment 3.7 times. The most frequently sought treatments in the past were GP, for medication, and drug counselling.

Participants in the 'current treatment' group were more likely than those in the 'past treatment' group to report having sought in the past: psychiatric treatment, self-help groups, residential detoxification and residential rehabilitation.

Table 26: Treatment frequency and type of treatment sought in past, by treatment status

	In treatment		In-out treatment		Total (N=492)	
	N	**Mean**	**N**	**Mean**	**N**	**Mean**
Times in treatment	309	3.7	136	3.6	445	3.7
NR	20	—	27	—	47	—
					(N=389)	
	N	**%**	**N**	**%**	**N**	**%**
Kinds of treatment sought in past ?						
Drug counselling	156	47.4	101	62.0	257	66.1
GP for medication	158	48.0	116	71.2	274	70.4
Psychiatrist**	92	28.0	44	27.0	136	35.0
Self-help groups (NA, etc.)	119	36.2	63	38.9	182	46.8
Residential detoxification	138	41.9	60	36.8	198	50.9
Outpatient detoxification	68	20.7	42	25.8	110	28.3
Home detoxification	109	33.1	69	42.3	178	45.8
Community based treatment	54	16.4	36	22.1	90	23.1
Residential rehabilitation	113	34.3	44	27.0	157	40.4
Methadone	121	36.8	94	57.7	215	55.3
Buprenorphine	44	13.4	18	11	62	15.9
Naltrexone	23	7.0	20	12.3	43	11.1

*** p<0.05 ** p<0.01 *** p<0.001**

SECTION 7 Attempts to Change Drug Use Without Professional Help (Self-Treatment)

Definition

1. How long ago did you most recently attempt to reduce your drug use (Table 29):

   1, within the last 3 months; 2, 3-6 months ago; 3, 6-12 months ago;
   4, 1 year – 2 years; 5, 2 – 3 years; 6, 3 year – 4 years; 7, 4 year – 5 years;
   8, more than 5 years.

Reduction of Drug Use Without Professional Help Summary (Table 27)

Almost three-quarters of the sample had taken steps to change drug use without professional help. Overall, the most frequently reported strategies to change drug use were "cutting down" and " stopped using", although all strategies were reported by over half of the sample. The most frequently reported strategies used in participants' most recent attempt to change drug use were also "cutting down" and "stopped using".

Substantial proportions of the sample used a variety of other drugs to assist in self-treatment attempts to change drug use. Almost two-thirds of the sample reported using cannabis in the most recent attempt at self-treatment and 57% reported use of benzodiazepines. Fifty-eight percent of the sample indicated that they aimed to reduce using in their attempts at self-treatment and 43% indicated they aimed to stop using drugs.

Table 27: Reduction of drug use without professional help, by treatment status

	In treatment		In-out treatment		Never in treatment		Total (N=495)	
	N	%	N	%	N	%	N	%
Have you ever done anything to reduce drug use without professional help?								
Yes	245	74.5	132	81.0	118	61.1	495	72.3
No	83	25.2	30	18.4	75	38.9	188	27.4
Can't remember	1	0.3	1	0.6	0	0	2	0.3
Steps had taken without anyone else's help?								
Cutting down	219	89.4	113	85.6	100	84.7	432	87.3
Stopped using	185	75.8	92	69.7	77	65.3	354	71.7
Self medication (licit)***	179	73.4	95	72.0	46	39.0	320	64.8
Self medication (illicit)***	174	71.3	82	63.1	57	48.3	313	63.6
Geographical ***	166	68.0	68	52.3	55	47.0	289	58.9
Isolation ***	174	71.3	81	61.4	48	41.0	303	61.5
Steps were taken in most recent attempt?								
Cutting down	148	60.7	84	64.1	73	62.4	305	62.0
Stopped using	133	54.5	59	45.0	50	42.4	242	49.1
Self-medication (licit)**	110	45.3	66	50.0	36	30.8	212	43.1
Self-medication (illicit)	93	38.3	58	44.6	39	33.3	190	38.8
Geographical *	73	30.0	24	18.6	36	30.8	133	27.2
Isolation	82	33.7	42	32.3	34	29.1	158	32.2
If you used other drugs the last time you tried reducing your drug use without help, what did you use?								
Pot	144	60.0	91	71.7	67	60.9	302	63.3
Benzos*	144	60.0	76	60.3	49	44.5	269	56.5
Methadone	35	14.6	23	18.5	13	11.9	71	15.0
Herbal remedies **	39	16.3	7	5.6	10	9.2	56	11.8
Other prescription drugs***	132	55.0	54	42.9	29	26.6	215	45.3
Over-the counter painkillers	81	33.8	47	37.0	31	28.7	159	33.5
Other illicit	65	27.3	33	26.2	20	18.7	118	25.1
What did you want to get out of reducing your drug use * **								
Stopping using	127	51.8	54	40.9	29	24.6	210	42.4
Reduce using and other	118	48.2	78	59.1	89	75.4	285	57.6

*** p<0.05 ** p<0.01 *** p<0.001**

Success and Supports in Reducing Drug Use Without Professional Help Summary (Table 28)

Participants' opinions of their success in the most recent self-treatment were varied. About 40% of the sample indicated that they were not at all successful, 36% indicated they were somewhat successful and 23% indicated they were very successful.

Reports of supports available to participants in attempting self-treatment were generally lower than the reports received during professional treatment attempts. However, the most frequently reported supports were drawn from partners, family and friends. Regardless of the source, of support was generally regarded as positive with over 70% of the sample indicating all supports as helpful.

Participants in the 'current treatment' group reported less success in self-treatment than participants in the 'never in treatment' group.

Participants in both the 'current' and 'past treatment' groups reported more support in their self-treatment from current partner, family, self-help groups and counsellors than participants in the 'never in treatment' group.

Table 28 Success and support in reducing drug use without professional help, by treatment status

	In treatment		In-out treatment		Never in treatment		Total	
	N	%	N	%	N	%	N	%
How successful do you think your last attempt at reducing your drug use was?* **								
Not successful at all	132	53.9	42	31.8	29	24.8	203	41.1
Somewhat successful	75	30.6	56	42.4	48	41.0	179	36.2
Very successful	38	15.5	34	25.8	40	34.2	112	22.7
Support received during the last attempt to reduce drug use								
Current partner*	98	40.3	52	40.9	31	26.5	181	37.2
Family members**	93	38.1	41	32.3	27	23.1	161	33.0
Friends	88	36.1	52	40.6	48	41.0	188	38.4
Workmates	12	5.0	9	7.1	8	6.8	29	6.0
Boss	6	2.5	5	4.0	3	2.6	14	2.9
Self-help group **	32	13.3	16	12.2	7	5.9	55	11.2
Counsellor ***	62	25.6	25	19.5	8	6.8	95	19.5
Doctor/health worker	73	30.0	38	29.7	24	20.5	135	27.7
Drug user organisation	22	9.0	16	12.5	11	9.4	49	10.0
Current user	55	22.6	29	22.7	19	16.2	103	21.1
Non-user	58	23.9	28	21.9	28	23.9	114	23.4
Telephone help lines	9	3.7	5	3.9	3	2.6	17	3.5
Support helpful								
Current partner	91	92.9	47	90.4	28	90.3	166	91.7
Family members	83	89.2	37	90.2	23	85.2	143	88.8

Table 28 Success and support in reducing drug use without professional help, by treatment status *(continued)*

	In treatment		In-out treatment		Never in treatment		Total	
	N	%	N	%	N	%	N	%
Support helpful								
Friends	74	84.1	47	90.4	43	89.6	164	87.2
Workmates	11	91.7	9	100.0	6	75.0	26	89.7
Boss	6	100.0	4	80.0	2	66.7	12	85.7
Self-help group	26	81.3	10	62.5	4	57.1	40	72.7
Counsellor	52	83.9	21	84.0	6	75.0	79	83.2
Doctor/health worker	63	86.3	30	78.9	20	83.3	113	83.7
Drug user organisation	19	86.4	11	68.8	10	90.9	40	81.6
Current user	44	80.0	23	79.3	14	73.7	81	78.6
Non-user	49	84.5	24	85.7	22	78.6	95	83.3
Telephone help lines	9	100.0	4	80.0	2	66.7	15	88.2

p<.05, **p<.01, p<0.001.**

Drug Reduction Attempts Without Professional Help Summary (Table 29)

Participants were asked how many times they had attempted self-treatment with one response option being "too many times to count". The average number of self-treatment attempts was calculated in two ones (1) those answers "too many times to count" were assigned the mean number of attempts as reported by the rest of the sample (2) those answers "too many times to count" were assigned the highest number reported (100 attempts). The number of self-treatment attempts as calculated in the first way indicate that participants had attempted self-treatment between 4 and 5 times on average. When calculated using the second method, the average number of self-treatment attempts is 66. We would estimate that the average number of self-treatment attempts of this sample could be higher than 4-5 but much less than 66.

On average, the most recent self-treatment attempt occurred within the 6-12 months prior to the interview.

Participants in both the 'current' and 'past treatment' groups reported more self-help attempts than the 'never in treatment' group.

Table 29 Drug reduction attempts without professional help, by treatment status

	In treatment		In-out treatment		Never in treatment		Total	
	N	mean	N	mean	N	mean	N	mean
Drug reduction attempts without professional help. 'Too many' = mean.	68	4.85	39	4.05	65	4.17	172	4.41
Too many to count =100 ***	241	73.2	129	71	115	45.8	485	66.1
How long ago was most recent attempt?	245	3.78	130	2.64	118	2.44	493	3.16

SECTION 8 Barriers to treatment

Barriers to Treatment Summary (Table 30)

Twenty-eight percent of participants reported that they had tried to get treatment for drug use and not been able to do so in the last 5 years. Participants in the 'current' and 'past treatment' groups were more likely to report having tried and failed to obtain treatment for drug use than participants in the 'never in treatment' group.

Of the total 190 participants who reported that they had tried and failed to get treatment for drug use in the last 5 years, 40% reported having sought residential detoxification. Other kinds of help that participants tried but failed to obtain, included: medication from GP (32%), drug counselling (27%), residential rehabilitation (21%), methadone treatment (20%), home detoxification (15%), psychiatric help (14%), AIDS information (13%), outpatient detoxification (11%), community based treatment (8%), self-help groups (7%), treatment for dual diagnosis (8%), buprenorphine treatment (6%), naltrexone treatment (3%), and natural therapies treatment (5%).

Participants in the 'never in treatment' group were more likely than those in the 'past' or 'current treatment' groups to report having tried to obtain help from natural therapies.

Of the total 190 participants who reported that they had tried and failed to obtain treatment for drug use in the last 5 years, 55% reported no service available in the area as the top barrier to treatment. Other barriers reported by participants were: waiting list was too long (52%), lack of support from health professionals (25%), inability to meet the criteria (22%), treatment offered was not the kind wanted (22%), treatment program did not suit needs (20%), travel problems (19%), cost of program (14%), lack of support from family/friends (14%), heard from others that the treatment was no good (13%), fear of disclosure (13%), fear of being stigmatised (13%), banned from the program (7%), fear of children being taken away (6%), treatment was unable to accommodate children (6%) and partner (6%), and fear of job loss (5%).

The 'in-out' and 'never in treatment' groups reported more barriers to treatment than the 'current treatment' group, in particular: inability to meet criteria, lack of support from family and friends, fear of children being taken away, treatment offered was not the kind wanted, and program did not suit personal needs.

Table 30 Barriers to treatment, by treatment status

	In treatment		In-out treatment		Never in treatment		Total (N=190)	
	N	%	N	%	N	%	N	%
Have you ever tried get treatment for your drug use and not been able to in the last 5 years?* **								
Yes	109	33.1	56	34.4	25	13.0	190	27.7
No	219	66.6	107	65.6	168	87.0	494	72.1
NR	1	0.3	0	0	0	0	1	0.1
What sort of help were you trying to get?								
Natural therapies**	4	3.7	1	1.8	5	20.0	10	5.3
Information (AIDS)	13	11.9	6	10.7	6	24.0	25	13.2
Drug counseling	31	28.4	13	23.2	7	28.0	51	26.8
GP for medication	34	31.2	20	35.7	7	28.0	61	32.1
Psychiatrist	15	13.8	8	14.3	4	16.0	27	14.2
Self help groups	4	3.7	7	12.5	3	12.0	14	7.4
Outpatient detoxification	9	8.3	7	12.5	4	16.0	20	10.5
Residential detoxification	47	43.1	18	32.1	11	44.0	76	40.0
Home detoxification	15	13.8	8	14.3	6	24.0	29	15.3
Community based treatment	7	6.4	4	7.1	4	16.0	15	7.9
Residential rehabilitation	25	22.9	10	17.9	5	20.0	40	21.1
Treatment for dual diagnosis	6	5.5	6	10.7	4	16.0	16	8.4
Methadone	19	17.4	14	25.0	5	20.0	38	20.0
Buprenorphine	6	5.5	5	8.9	0	0	11	5.8
Naltrexone	5	4.6	0	0	1	4.0	6	3.2
What stopped you from getting help?								
Cost of the program	10	9.2	11	20.0	5	20.0	26	13.8
Waiting list too long	59	54.1	26	46.4	14	56.0	99	52.1
No places available	64	58.7	28	50.0	13	52.0	105	55.3
Travel problems	16	14.7	12	21.4	8	32.0	36	18.9
Unable to meet entry criteria*	17	15.6	16	28.6	9	36.0	42	22.1
Heard it was no good	10	9.2	11	19.6	4	16.0	25	13.2
Lack of support from health professionals	23	21.1	14	25.0	10	40.0	47	24.7
Lack of support from family/friends**	8	7.3	13	23.2	6	24.0	27	14.2
Treatment offered was not what you wanted*	18	16.5	15	26.8	9	36.0	42	22.1
Fear of job loss	4	3.7	2	3.6	3	12.0	9	4.7
Fear of children being taken away*	3	2.8	6	10.7	3	12.0	12	6.3

Table 30 Barriers to treatment, by treatment status *(continued)*

	In treatment		In-out treatment		Never in treatment		Total (N=190)	
	N	%	N	%	N	%	N	%
What stopped you from getting help?								
Treatment was unable to accommodate my children	7	6.4	4	7.1	1	4.0	12	6.3
Unable to accommodate my partner	5	4.6	4	7.1	2	8.0	11	5.8
Fear of disclosing drug use to others	10	9.2	9	16.1	6	24.0	25	13.2
Program did not suit needs*	14	12.8	14	25.0	9	36.0	37	19.5
Banned from the program	7	6.4	5	8.9	1	4.0	13	6.8
Fear of being stigmatised	10	9.2	10	17.9	4	16.0	24	12.6

p<0.05 ** p<0.01 *** p<0.001

Differences Between Current and Most Recent Treatments Summary (Table 31)

Over 60% of the participants in the 'current treatment' group who answered the above question, concerning factors differentiating their current treatment from past treatments, endorsed being 'ready', and having found a treatment service 'that suits' this time. Other factors receiving frequent endorsement – from more than 50% of respondents – were: drug use more out of control this time, life more in crisis, more support from family and friends, treatment affordable/free, accepted into treatment immediately, more information about benefits of treatment, child care facilities.

Table 31 Treatment group only: Difference between current and past treatment

	In treatment	
	N=229	%
This time you were ready	170	74.2
This time you were in crisis	119	52.0
Drug use was getting more out of control	131	57.2
The treatment was affordable/free	118	51.5
Accepted into treatment immediately	135	59.0
Found a treatment service suiting your needs	157	68.6
Had more information about the benefits of treatment	118	51.5
Had support from GP/nurse/health care worker	95	41.5
Had support from family/friends	126	55.0
Most of your friends had stopped using	23	10.0
The next time you got arrested would be serious	82	35.8
Moved to a new area/interstate	61	26.6
Easy to travel to the treatment service	108	47.2
Can take time off work to attend treatment	21	9.2
Child care facilities available at the treatment	121	52.8

SECTION 9 Attitudes

Definitions

1. For scale scores: attitude to treatment staff (Table 33); General attitudes to treatment (Table 35); and, Specific attitudes to treatment (Table 36)
   - 1: disagree strongly; 2: disagree, 3: agree, 4: agree strongly.

Experience of Discrimination Summary (Table 32)

More than half the participants in the sample reported that they had been discriminated against by the following: family (63%), staff at pharmacies (63%), friends (62%), doctors/nurses (54%).

Participants in the 'current treatment' group were more likely those in the 'past' and 'never in treatment' groups to report having experienced discrimination by staff at methadone clinics, by landlord, partner, family, friends, flatmates, boss and/or workmates. Participants in the 'current' and 'past treatment' groups were more likely than those in the 'never in treatment' group to report having experienced discrimination by doctors/nurses, staff at pharmacies.

Table 32 Experience of discrimination, by treatment status

	In treatment		In-out treatment		Never in treatment		Total	
	N	%	N	%	N	%	N	%
Felt having ever been discriminated against by any of the following because of drug use								
Doctor/nurse***	189	58.2	98	60.5	72	40.0	359	53.8
Staff at methadone clinics*	80	36.9	37	30.3	18	21.4	135	31.9
Staff at pharmacies *	206	64.2	107	68.6	95	55.6	408	63.0
Staff at residential rehabilitation	57	23.1	25	25.5	14	18.2	96	22.7
Staff at out-patient rehabilitation	28	14.9	17	18.1	10	13.5	55	15.4
Other health care workers	121	38.5	60	38.7	47	29.4	228	36.2
A landlord ***	129	42.6	55	36.2	41	23.8	225	35.9
Partner *	125	41.9	49	35.0	46	28.6	220	36.7
Family **	216	67.1	103	65.5	96	53.6	415	63.1
Friends ***	222	69.4	99	62.3	93	49.2	414	62.0
Flatmate **	99	36.9	32	26.2	35	23.5	166	30.8
Boss **	77	35.8	27	26.5	23	18.4	127	28.7
Workmates *	83	39.0	36	34.3	30	23.6	149	33.5

*** p<0.05 ** p<0.01 *** p<0.001**

Attitudes to Treatment Staff Summary (Table 33)

Participants who were in current treatment were more likely than other participants to report that staff at drug treatment centres: did not make judgements, listened to what they said, were supportive, took time to make sure that they understood all the treatment options and implications, had realistic expectations about treatment.

Participants in the 'current treatment' group were less likely than other participants to report that staff at drug treatment centres: looked down on them, did not respect their confidentiality, didn't know much about drugs, didn't respect their rights to continue drug using.

Participants in the 'in-out of treatment' group were more likely than other participants to report that staff at drug treatment centres: tried to treat everything in their lives as though it was drug related, and treated them badly in front of other clients.

Participants in the 'never in treatment' group were more likely than those in the 'past' or 'current treatment' groups to report that staff at drug treatment centres: had treated them without respect, and had tried to make them feel guilty about their drug use.

Table 33 Attitudes to treatment staff, by treatment status

	In treatment		In-out treatment		Never in treatment		Total	
	N	Mean	N	Mean	N	Mean	N	Mean
Staff at drug treatment programs...								
Do not treat me with any respect***	317	1.97	162	2.10	171	2.27	650	2.08
Make me feel guilty and ashamed***	319	2.04	161	2.24	172	2.37	652	2.18
Do not judge me***	319	2.74	162	2.56	171	2.40	652	2.60
Look down on me***	321	2.13	160	2.41	175	2.33	656	2.25
Do not respect my confidentiality**	316	2.05	159	2.28	175	2.24	650	2.16
Ask me what I want out of treatment	318	2.87	161	2.79	171	2.82	650	2.84
Listen to what I say**	314	2.92	158	2.77	175	2.75	647	2.84
Push me into doing stuff that I don't want to	317	2.32	161	2.43	174	2.46	652	2.38
Are very supportive of me ***	313	2.97	159	2.74	174	2.72	646	2.85
Try to treat everything in my life as though it is drug related ***	319	2.53	160	2.83	172	2.60	651	2.62
Take the time to make sure that I understand all the treatment options and implications *	319	2.75	161	2.60	170	2.69	650	2.70

Table 33 Attitudes to treatment staff, by treatment status *(continued)*

	In treatment		In-out treatment		Never in treatment		Total	
	N	Mean	N	Mean	N	Mean	N	Mean
Staff at drug treatment programs...								
Treat me badly in front of other clients *	319	1.97	161	2.12	168	2.07	648	2.04
Don't know much about drugs *	315	2.35	158	2.54	168	2.56	641	2.45
Have realistic expectations about treatment ***	309	2.75	157	2.49	161	2.56	627	2.64
Do not respect my right to continue to use drugs ***	305	2.42	155	2.71	163	2.74	623	2.58

*** p<0.05 ** p<0.01 *** p<0.001**

Discrimination and Opinion of Staff Summary (Table 34)

Good opinion of staff scale (range 0-37): Participants with a very good opinion of treatment staff were more likely to be in the 'current treatment' group than in the 'in-out' or 'never in treatment' groups.

Discrimination scale (range 0-14): Participants who felt that they had been discriminated against because of their drug use were more likely to be in the 'current treatment' or 'in-out of treatment' groups than in the 'never in treatment' group.

Table 34 Summary discrimination and opinion of staff scores by treatment status

	In treatment		In-out treatment		Never in treatment		Total	
	N	mean	N	mean	N	mean	N	mean
Discrimination scale* **	329	5.04	163	4.65	193	3.30	685	4.46
Good opinion of staff scale* **	329	21.84	163	19.52	193	19.60	685	20.66

**** p<.01 ***p<.001**

General Attitudes to Drug Treatment (Table 35)

Participants in the 'current treatment' group were less likely than those in the 'past' or 'never in treatment' groups to report that: anybody who wants to can get off drugs without professional help.

Participants in the 'current' and 'past treatment' groups were less likely than those in the 'never in treatment' group to report that: there is no appropriate treatment available for people like me.

Participants in the 'never in treatment' group were more likely than other participants to report that sooner or later most drug users will stop using.

Participants in the 'past treatment' group were more likely than those in the 'current treatment' group to report that most drug treatments fail.

Table 35 General attitudes to treatment, by treatment status

	In treatment		In-out treatment		Never in treatment		Total	
	N	Mean	N	Mean	N	Mean	N	Mean
Anybody who wants to can get off drugs without professional help***	322	2.05	160	2.23	190	2.39	672	2.19
Sooner of later most drug users stop using **	317	2.17	159	2.30	190	2.36	666	2.25
People usually need to try more than one kind of treatment before they succeed	317	3.00	158	3.06	181	3.02	656	3.02
Most drug treatments fails *	305	2.48	155	2.65	175	2.62	635	2.56
It is easy for most of people to access good treatment	321	2.34	160	2.29	186	2.26	667	2.30
It is hard to understand why anyone would want to give up taking drugs *	314	2.08	159	2.03	186	2.22	659	2.10
There is no appropriate treatment available for people like me***	322	2.06	161	2.32	178	2.53	661	2.25

*<.05**<.01***<.001

Specific Attitudes To Drug Treatment (Table 36)

Participants in the 'current treatment' group were more likely than those in the 'past treatment' group to report that residential treatment programs are best.

Participants in the 'current treatment' group were less likely than those in the 'past' and 'never in treatment' groups to report that: self-help programs are useful, treatments involving continued use of small amounts of a drug are the most successful, home-based detoxification is most successful.

Participants in the 'never in treatment' group were more likely that those in the 'current treatment' group to report that: treatment administrated by a doctor in a medical setting works best, detoxification is a successful treatment.

Table 36 Specific attitudes to treatment, by treatment status

	In treatment		In-out treatment		Never in treatment		Total	
	N	Mean	N	Mean	N	Mean	N	Mean
Methadone maintenance as the substitute for heroin use is the most successful treatment program	296	2.11	159	2.04	174	2.21	629	2.12
Legally prescribed injectable heroin would be a better treatment than methadone maintenance	296	2.99	162	3.07	180	3.02	638	3.02
Residential treatment programs are better than other programs *	287	2.67	145	2.50	161	2.58	593	2.60
Self help programs like narcotics anonymous are useful for only a few people ***	311	2.67	160	2.91	181	2.85	652	2.78
A treatment which allows people to continue using smaller amounts of drug will be more successful than one which insists on total abstinence ***	309	2.46	160	2.79	182	2.80	651	2.64
Treatment programs designed by people who have been users themselves are the most successful	308	3.14	161	3.15	184	3.08	653	3.13
A treatment for injecting users will be more successful if it involves injecting another substance ***	303	2.11	155	2.32	178	2.37	636	2.23
Treatment programs administered by doctors in medical setting work best *	302	2.14	151	2.18	172	2.30	625	2.19
I would rather go to prison than be directed to go drug treatment	323	1.65	162	1.71	185	1.69	670	1.67
Home based detoxification programs are better than residential ones ***	281	2.23	149	2.58	158	2.58	588	2.41
Detoxification by itself is a successful treatment***	309	2.11	156	2.27	166	2.37	631	2.22

*<.05**<.01***<.001

SECTION 10 'In-Out of Treatment' vs 'Never in Treatment'

This section summarises the results of the bivariate and multivariate analyses with the 'in-out of treatment' group vs 'never in treatment' group as the dependent variable.

Bivariate results

There were statistically significant differences between the 'in-out' and the 'never in treatment' group on a number of dimensions (see Table 37 for details).

Compared with those who had been in treatment in the past, those who had never been in treatment can be characterised as:

- younger
- male
- working, not on benefits
- stimulant users, rather than opioid users
- being more likely to use drugs by non-injection routes than by injection
- having injected drugs for a shorter period of time
- using a smaller mix of drugs
- being less dependent on drugs
- used drugs for "fun" reasons rather than for "pain relief" or "to avoid withdrawal"
- not having experienced financial difficulties because of drug use
- being healthier (physically and emotionally)
- having fewer or no BBV diagnoses
- not having experienced overdose
- not having experienced discrimination because of drug use
- not having told as many people about their drug use in the last 6 months
- not having tried self-treatment, having tried fewer self-treatments, or fewer types of self-treatment
- having used fewer other drugs in self-treatment
- having aimed to reduce rather than stop drug use in self-treatment
- not having tried (and failed) to seek treatment in the past
- not having encountered barriers to treatment in the past, particularly, waiting lists, or others' negative reports about treatments
- not having plans to seek treatment in the future.

Table 37 'In-Out of Treatment' vs 'Never in Treatment' (NIT), Summary of Significant Bivariate Results

	NIT	NIT (n=193)	In-out (n=163)	p
Demographics				
– Current age	Younger	30 yrs (18-64)	32 yrs	<.01
– Male gender	more	74%	64%	<.05
– Employment status	More working, fewer on dole	W: 28%	W: 18%	<.05
Drug Use History				
– Length of injecting career	Shorter	7 yrs (0-34)	11 yrs	<.001
– Disclosed drug use	Less	4 (0-10)	5	<.01
– Drug used most frequently	More stimulant users	64%	40%	<.001
– Current injectors	Less	81%	93%	<.001
Reasons for Drug Use				
– For partying	More	36%	16%	<.001
– For recreation	More	31%	15%	<.001
– For dances/raves	More	9%	3%	<.01
– For sex	More	12%	6%	<.05
– For special occasions	More	8%	0%	<.001
– To avoid withdrawal	Less	20%	34%	<.01
– For pain relief	Less	13%	26%	<.01
Finance				
– Can't meet bills because of drug use[4]	Less	1 (0-3)	2	<.05
Self-treatment History				
– Do self treatment	Less	61%	81%	<.001
– Number of self treatments	Less	8 times	15 times	<.001
– Number of types of self-treatments	Less	2 types	3 types	<.001
– Number of other drugs used during last self treatment	Less	1	3	<.001
– Aimed to stop using	Less	15%	33%	<.001
Health and Wellbeing				
– Severity of dependency	Lower	6 (0-15)	7	<.001
– SF12 (general health)	Better	21 (0-36)	17	<.001
– Physical problems	Less	8 (0-17)	10	<.001
– Felt good last 4 weeks	Better	8 (0-12)	7	<.01
– Felt bad last 4 weeks	Less	10 (0-21)	12	<.001
– Felt suicidal last 4 weeks[2]	Less	0.4 (0-3)	0.6	<.05
– BBV positive	Less	28%	53%	<.001
– Experienced overdose	Less	39%	67%	<.001

4 0 Never, 1 sometimes, 2 often, 3 always.
2 0 Never, 1 rarely, 2 sometimes, 3 often.

Table 37 'In-Out of Treatment' vs 'Never in Treatment' (NIT), Summary of Significant Bivariate Results *(continued)*

	NIT	NIT (n=193)	In-out (n=163)	p
Discrimination/Opinion				
– Felt discriminated against because of drug use	Less	3 (0-14)	5	<.001
Treatment History/Future				
– Unable to get treatment when wanted in last 5 years	Less	13%	34%	<.001
– Barrier: waiting list too long	Less	9%	22%	<.001
– Barrier: heard no good	Less	2%	7%	<.05
– Seek treatment in future	Less	15%	29%	<.01

Multiple Regression Analysis Summary

Study factors which were significantly, or nearly significantly, associated with the dependent variable were included in the logistic regression. Backward stepwise analysis was used to reduce the regression model. Variables, which had a p value of more than 0.05 were excluded from further analysis. The reduced model explained 35% of the variance in the dependent variable.

By comparison with the 'in-out of treatment' group, never having been in treatment was independently related to:

- not being a current injector (OR=0.2, CI. 0.1-0.7, p=0.01)
- using drugs to "party", rather than for other purposes (OR=2.1, CI 1.1-4.0, p=0.02)
- using a bigger mix of drugs (i.e., having higher polydrug scores) (OR=1.3, CI 1.1-1.6, p=0.006)
- being in better health (OR=1.1, CI 1.0-1.1, p=0.003)
- not having experienced overdose (OR=0.3, CI 0.2-0.6, p=<0.001)
- having tried self-treatment (OR=3.2, CI 1.4-7.1, p=0.005)
- while in self-treatment, having aimed to reduce or control drug use rather than to abstain (OR=0.4, CI 0.2-0.7, p=0.004), and having used more non-injection drugs (OR=0.5, CI 0.4-0.6, p<0.001).

SECTION 11 'Ever' versus 'Never in Treatment'

This section summarises the results of the bivariate and multivariate analyses with 'ever in treatment' versus 'never in treatment' as the dependent variable.

Bivariate results

There were statistically significant differences between the 'ever in treatment' group and the 'never in treatment' group on a number of dimensions (see Table 38 for details).

Compared with the 'never in treatment' group, those who had ever been in treatment can be characterised as:

- older
- female
- having lower income
- being on benefits/pension, not working
- having injected for longer
- using drugs more frequently
- having higher polydrug scores
- being opioid, rather than stimulant, users
- using drugs to "avoid withdrawal", rather than for fun reasons
- having greater involvement with IDU social networks
- having experienced financial problems due to drug use
- being less healthy (physically and emotionally)
- having one or more BBV diagnosis
- having experienced overdose
- having been in more trouble with the police
- having experienced more discrimination because of drug use
- having tried self-treatment, having tried more self-treatments or more types of self-treatment, having used more other drugs in the last self-treatment
- having aimed to stop rather than reduce drug use in self-treatment
- having failed to achieve self-treatment aims
- having a better opinion of treatment staff
- denying that drug users can stop using if they want to, that users will stop using sooner or later, that treatments which involve continued drug use are best, that self-help groups are unsuccessful, and that doctor-only treatments are best
- perceiving more barriers to treatment, particularly, waiting lists
- planning to seek treatment in the future.

Table 38 'Ever' vs 'Never in treatment', Summary of Significant Bivariate Results

	NIT	NIT (n=193)	Ever (n=492)	p
Demographics				
– Current age	Younger	30 yrs (18-64)	32 yrs	<.01
– Male gender	More	74%	65%	<.05
– Income[1]	More	2.2	1.9	.001
– Employment status	More work & crime, less dole	W: 28%	W: 15%	<.001
Drug Use History				
– Length of injecting career	Shorter	7 yrs (0-35)	11 yrs	<.001
– Frequency of drug use[2]	Less	3	5	<.001
– Drug most frequently used: Stimulant	More	64%	41%	<.001
– Poly drug use	Less	4 (0-9)	5	<.05
Reasons for Drug Use				
– For partying	More	36%	18%	<.001
– For recreation	More	31%	10%	<.001
– For dances/raves	More	9%	4%	<.01
– For sex	More	12%	5%	<.01
– For special occasions	More	8%	2%	<.001
– Because I want to	More	32%	21%	<.01
– To avoid withdrawal	Less	20%	40%	<.001
– For pain relief	Less	13%	21%	<.05
– Because I need to	Less	23%	31%	<.05
– Out of habit	Less	23%	40%	<.001
– When sad	Less	23%	31%	<.05
Drug using Network				
– Social network with drug users	Less	5 (0-8)	6	<.001
Finance				
– Can't meet bills because of drug use[3]	Less	1 (0-3)	2	<.001
Self-treatment History				
– Do self treatment	Less	61%	77%	<.001
– Number of self treatments	Less	8 (0-26)	15	<.001
– Number of types of self-treatments	Less	2 (0-7)	3.4	<.001
– Number of other drugs used during last self treatment	Less	1	3	<.001
– Achieved self treatment goals[4]	More	1.0 (0-2)	0.7	<.001
– Aimed to stop using	Less	15%	37%	<.001

1 Less than $10,000, 2 10,000-20,000...
2 ...3 more than once a week but not everyday, 4 once a day, 5 once or twice a day...
3 0 Never, 1 sometimes, 2 often, 3 always.
4 0 No, 1 To some extent, 2 Yes.

Table 38 'Ever' vs 'Never in treatment', Summary of Significant Bivariate Results *(continued)*

	NIT	NIT (n=193)	Ever (n=492)	p
Health and Wellbeing				
– SF12 (general health)	Better	22 (0-26)	18	<.001
– Physical problems	Less	8 (0-17)	11	<.001
– Felt good last 4 weeks	Better	7.5 (0-12)	6.8	.001
– Felt Bad last 4 weeks	Less	10.3 (0-21)	11.8	.001
– Felt suicidal last 4 weeks[5]	Less	0.4	0.6	<.05
– BBV positive	Less	28%	53%	<.001
– Experienced overdose	Less	39%	64%	<.001
Law Enforcement				
– Been in trouble with the police	Less	24%	36%	<.01
Discrimination/Opinion				
– Felt discriminated against because of drug use	Less	3 (0-14)	5	>.001
– Good opinion of treatment staff	Less	19 (0-37)	21	<.01
– Users can stop if they want to	Agree	45%	29%	<.001
– Sooner or later most users stop	Agree	42%	31%	<.01
– NA and other self-help not usually successful	Agree	77%	68%	<.05
– Treatment that allows small amount of drug use is best	Agree	67%	50%	<.001
– Treatment that allows injecting drugs is best	Agree	39%	26%	.001
– Treatment by doctor in medical setting is best	Agree	32%	23%	<.05
– Treatment involving home detox best	Agree	50%	32%	<.001
– Treatment that involves only detox is best	Agree	42%	28%	.001
Treatment History/Future				
– Unable to get treatment when wanted in last 5 years	Less	13%	34%	<.001
– Barrier: waiting list too long	Less	9%	22%	<.001
– Seek treatment in future	Less	15%	29%	<.01
– Count of barriers to treatment	Less	0.6 (0-15)	1.1	<.05

5 0 Never, 1 rarely, 2 sometimes, 3 often.

Multiple Regression Analysis Summary

Study factors which were significantly, or nearly significantly, associated with the dependent variable were included in the logistic regression model. Backward stepwise analysis was used to reduce the model. Variables which had a p value of more than 0.05 were excluded from further analysis. The reduced model explained 35% of the variance in the outcome variable.

Compared with the 'never in treatment' group, having ever been in treatment was independently related to:

- using drugs more frequently
  (OR=0.7, CI 0.7-0.8, p=<0.001)
- using drugs for non-recreational purposes (e.g., to avoid withdrawal)
  (OR=2.5, CI 1.4-4.5, p=<0.001)
- having one or more positive BBV diagnosis
  (OR=0.4, CI 0.3-0.7, p=0.001)
- having experienced overdose
  (OR=0.5, CI 0.3-0.8, p=0.003)
- not having tried self-treatment
  (OR=3.9, CI 2.1-7.1, p=<0.001)
- having aimed to abstain during self-treatment
  (OR=0.3, CI 0.2-0.6, p=<0.001),
- having used more non-injection drugs during self-treatment
  (OR=0.4, CI 0.3-0.5, p=<0.001)
- having a better opinion of treatment staff
  (OR=0.9, CI 0.9-1.0, p=0.005)
- denying that if drug users want to they can stop using drugs without professional help
  (OR=2.4, CI 1.5-3.7, p=<0.001)
- denying that treatments that allow continued injection of drugs are the most helpful
  (OR=2.5, CI 1.6-4.1, p=<0.001)

SECTION 12 'In Treatment' vs 'In-Out of Treatment'

This section summarises the results of the bivariate and multivariate analyses with the 'in treatment' versus 'in-out of treatment' groups as the dependent variable.

Bivariate results

There were statistically significant differences between the 'in treatment' group and the 'in-out of treatment' group on a number of dimensions (see Table 39).

Compared with the 'in-out of treatment' group, those who were currently in treatment can be characterised as:

- less likely to identify as an Aboriginal or Torres Strait Islander
- more likely to be on benefits
- having used drugs more frequently (prior to treatment)
- less likely to be using drugs currently
- less likely to be currently injecting
- having more contact with other illicit drug users
- using drugs "out of habit", and not for "recreation"
- having poorer health
- having financial problems due to drug use
- not having disclosed drug use in the last 6 months (before treatment)
- having failed to achieve self-treatment aims
- having aimed to stop (rather than reduce) drug use in self-treatment
- being more likely to be in client-focused treatment
- having achieved treatment aims to a greater extent
- being more satisfied with treatment
- reporting entry requirements, in particular, the abstinence requirement
- having been in rehabilitation or detoxification, rather than counselling or pharmacotherapy
- not having asked to be referred
- having obtained information about treatment from media or friends rather than professionals
- not having experienced barriers to treatment, in particular, lack of family support
- having a good opinion of treatment staff
- denying all of the following: that users can stop using if they want to, that sooner or later most users will stop, that most drug treatments fail, that legal heroin would be the most successful treatment, that self-help groups are unsuccessful.

Table 39 'In Treatment' vs 'In-Out of Treatment', Summary of Significant Bivariate Analyses

	In-Treatment	In-Treat (n=329)	In-out (n=163)	p
Demographics				
– Aboriginal/Torres Strait Islander	Less	8%	15%	<.05
– Employment status	More on benefits (B)	B: 81%	B: 69%	<.01
Drug Use History				
– Drug use frequency (before tr)	Less	5 (0-8)	4	<.001
– Disclosure of drug use (before tr)	Less	4 (0-10)	5	<.001
– Currently using (even if tr)	Less	41%	96%	<.001
– Currently injecting	Less	40%	93%	<.001
Drug Using Network				
– Social network with drug users	More	6 (0-8)	5	<.001
Reasons for Drug Use				
– For recreation	Less	8%	15%	<.01
– For special occasions	More	3%	0%	<.05
– Because I like to	Less	33%	49%	.001
– Out of habit	More	44%	31%	<.01
Self-Treatment				
– Achieved self-treatment aims[1]	Less	0.7	1.0	<.001
Finance				
– Can't meet bills because of drug use[2]	More	1.8	1.3	<.001
Discrimination/Opinion				
– Belief treatment staff are good	More	22 (1-37)	20	<.001
– Users can stop if they want to	Disagree	25%	37%	<.01
– Sooner or later most users stop	Disagree	27%	38%	.01
– Most drug treatments fail	Disagree	45%	55%	<.05
– Legally prescribed heroin is most successful treatment	Disagree	66%	77%	<.01
– Self-help not usually successful	Disagree	61%	81%	<.001
Health				
– Physical problems	More	11 (1-17)	10	<.05

1 0 No, 1 to some extent, 2 yes, completely/almost completely.
2 0 Never, 1 sometimes, 2 often, 3 always.

Table 39 'In Treatment' vs 'In-Out of Treatment', Summary of Significant Bivariate Analyses *(continued)*

	In-Treatment	In-Treat (n=329)	In-out (n=163)	p
Treatment History				
– Client-focused treatment[3]	More	1.3 (0-3)	1.0	<.001
– Achieved treatment aims[4]	More	1.0 (0-2)	0.7	<.001
– Satisfied with treatment[5]	More	3.9 (1-5)	3.0	<.001
– Treatment aim is to stop using drugs	More	63%	43%	<.001
– Length of wait for treatment[6]	More	3.0 (0-6)	2.3	<.01
– Kept using while waiting for treatment	More	69%	53%	<.001
– Treatment entry requirements	More	60%	45%	<.01
– Abstinence condition of treatment	More	23%	5%	<.001
– Treatment type	More rehab/ detox (RD); Less counselling/ pharmacotherapy (CP)	RD: 51% CP: 49%	RD: 29% CP: 71%	<.001
– Asked to be referred	Less	31%	50%	<.001
– Where obtained information about treatment	Less professional (P); more media/ friends	P: 35%	P: 67%	<.001
– Barrier: lacked family support	Less	2%	8%	<.01

3 0 Not client focused, 3 very client focused.
4 0 No, 1 to some extent, 2 yes, completely/almost completely.
5 0 No, 1 neither satisfied nor dissatisfied, 2 satisfied completely/almost completely.
6 2 More than one, but less than two days; 3 more than two, but less than three days…

Multiple Regression Analysis Summary

Study factors that were significantly, or nearly significantly, associated with the dependent variable were included in the logistic regression model. Backward stepwise analysis was used to reduce the model. Variables which had a p value of more than 0.05 were excluded from further step analysis. The reduced model explained 53% of the variance in the dependent variable.

Compared with the 'in-out' group, being currently in treatment was independently related to:

- having used drugs more frequently before treatment (OR=0.7, CI 0.6-0.8, p=<0.001)
- not having disclosed drug use in the last 6 months (OR=1.6, CI 1.3-1.9, p=<0.001)
- not currently using drugs (OR=40.7, CI 10.1-163.6, p=<0.001)
- being more involved with drug using networks (OR=0.7, CI 0.5-0.8, p=<0.001)
- being more satisfied with treatment (OR=0.6, CI 0.5-0.8, p=<0.001)
- being more likely to report requirements and conditions of treatment (OR=0.01, CI 0.01-0.08, p=<0.001)
- being more likely to report abstinence as a requirement of treatment (OR=0.02, CI 0.01-0.08, p=<0.001)
- being less likely to have asked to be referred to treatment (OR=5.1, CI 2.4-10.5, p=<0.001)
- being less likely to have found out about current treatment from professionals (OR=2.6, CI 1.3-5.2, p=0.009)
- being less likely to endorse that "sooner or later most drug users will stop using drugs without professional help" (OR=2.9, CI 1.4-6.3, p=0.006).

SECTION 13 Treatment Completion versus Non-Completion

This section summarises the results of the bivariate and multivariate analyses with treatment completion versus non-completion as the dependent variable.

Bivariate results

Within the 'in-out' group, there were statistically significant differences between those who completed their last treatment, versus those who did not, on a number of dimensions (see Table 40).

Compared with those who did not complete their last treatment, those who did complete, can be characterised as:

- having higher education
- using drugs less frequently
- having lower polydrug scores
- having lower drug dependency scores
- using drugs because they "like it" or for "recreation", and
- not "out of habit", "because drugs are there", to "bond with friends"
- having fewer financial problems due to drug use
- having better health (physical and emotional)
- having had less difficulty obtaining treatment in the past
- having come closer to achieving personal aims in the last treatment
- having been satisfied with treatment
- having been referred to treatment by court or correctional services
- having obtained information about treatment from professionals, not family or friends.

Table 40 Completion vs Non-Completion of Last Treatment Among In-Out group, Summary of Significant Bivariate Analyses

	Completed	Completed (n=75)	Did not complete (n=83)	p
Demographics				
– Education level completed[1]	Higher	3 (1-7)	2	<.05
Drug Use History				
– Frequency of drug use[2]	Less	3 (0-8)	4	<.001
– Poly drug use	Less	4 (0-9)	5	<.001
Reasons for Drug Use				
– For recreation	More	21%	8%	<.05
– To bond with friends	Fewer	0%	8%	.01
– Because they are there	Fewer	4%	17%	<.01
– Because can afford to	More	15%	4%	<.05
– Because I like to	More	60%	39%	<.01
– Out of habit	Fewer	23%	41%	<.05
Finance				
– Can't meet bills because of drugs[3]	Fewer	1 (0-3)	2	<.01
Discrimination/opinion				
– Easy to access good treatment	Agree	47%	31%	<.05
Health				
– Severity of Dependency Score	Lower	7 (0-20)	8	<.05
– Felt good last 4 weeks	More	7 (1-12)	6	<.05
– SF12	Better	19 (0-35)	16	<.01
Treatment History				
– Unable to get treatment when wanted	Fewer	25%	42%	<.05
– Achieved treatment aims[4]	More	1 (0-2)	0.33	<.001
– Satisfied with treatment	More	55%	25%	<.001
– Obtained treatment info from family/friends	Fewer	9%	22%	<.05
– Referred by court/police/ parole	More	11%	3%	<.05
– Referred by other professional	Fewer	23%	40%	<.05

1 ...2 Year 10, 3 Year 12...
2 3 more than once a week but not everyday, 4 once a day, 5 once or twice a day...
3 0 Never, 1 sometimes, 2 often, 3 always.
4 0 No, 1 to some extent, 2 yes, completely/almost completely

Multiple Regression Analysis Summary

Study factors which were significantly, or nearly significantly, associated with completion versus non-completion of last treatment, were included in the logistic regression analysis. Backward stepwise method was used to reduce the model. Variables which had a p value of more than 0.05 were excluded from further step analysis. The reduced model explained 33% of the variance in the outcome variable.

Among the 'in-out treatment' group, treatment completion, as against non-completion, was independently related to:

- having relatively low polydrug scores (OR=0.6, CI 0.5-0.8, p=0.001)
- having more closely achieved treatment aims (OR=4.8, CI 2.7-8.6, p=<0.001)
- having been referred to treatment by police/parole officer/court (OR=12.0, CI 1.7-75.5, p=0.01)
- endorsing the statement: "it is easy to access good treatment" (OR=0.6, CI 1.2-6.5, p=0.02).

SECTION 14 Treatment Goal Achievement versus Non-Achievement

Participants were asked to estimate the extent to which they felt they had achieved their treatment goals: in their current treatment, for those currently in treatment, or in their most recent treatment, for those who had been in treatment in the past but were no longer in treatment.

Of those currently in treatment, 63% (n=206/329) reported that they aimed to abstain, while 37% (123/329) reported that they had another aim, e.g., to reduce or control drug use. Seventy-four percent (n=65) of those aiming to abstain reported success in their aim. Of those in the 'in-out' group, 43% (70/163) reported that they aimed to abstain, while 57% (93/163) did not answer or reported another aim. Forty-three percent (n=16) of those aiming to abstain reported success in their aim. See Table 41.

Table 41 Self-reported success by treatment status and treatment aim

Self-reported success	In Treatment Group				Total		In-Out Group				Total	
	Aim to abstain		Other aim				Aim to abstain		Other aim			
	n	%	n	%	n	%	n	%	n	%	n	%
Achieved goal	65	31.6*	23	18.7*	88	26.7	16	22.9	21	22.6	37	22.7*
Did not achieve goal	141	68.4	100	81.3	241	73.3	54	77.1	72	77.4	126	77.3
Total	206		123		329		70		93		163	

*p=<.01

There was no relationship between treatment status and achievement of treatment goal. More or less the same percentage (about 25%) of those in the 'in treatment' and 'in-out' groups reported having achieved their goal. However, treatment aim and goal achievement were related in the 'in treatment' group. In the 'in treatment' group, but not the 'in-out' group, a higher percentage of persons aiming to abstain than to control/reduce their drug use reported success (32% vs 19%, p=<.01).

In relation to treatment type, a higher percentage of those in detox/rehab than in counselling/pharmacological treatment achieved their goal (36% vs 18%, p=<.001). See Table 42

Table 42 Self-reported success by treatment type and treatment aim

Self-reported success	Detox/Rehab				Total		Counsel/Pharm				Total	
	Aim to abstain		Other aim				Aim to abstain		Other aim			
	n	%	n	%	n	%	n	%	n	%	n	%
Achieved goal	57	37.5	15	31.3	72	36.0*	20	18.9	24	16.9	44	17.7*
Did not achieve goal	95	62.5	33	68.8	128	64.0	86	81.1	118	83.1	204	82.3
Total	152		48		200		106		142		248	

*p=<.001

Treatment type and treatment aim were also related. More of those in detox/rehab than in counselling/pharmacological treatment aimed for abstinence (76% vs 43%, p=<.001). In the 'in treatment' group, choice of treatment aligned fairly well with stated treatment goal. A majority of those currently in detox/rehabilitation reported that they aimed to abstain entirely from drugs while only a minority of those in counselling/pharmacological treatment had this aim (81% vs 44%, p=<.001). In the 'in-out' group, on the other hand, there was no relationship between treatment type and stated treatment goal. See Table 43. In interpreting these findings, it should be borne in mind that subsequent to treatment, the stated aims of treatment may undergo adjustment depending on treatment outcome, relapse, etc.

Table 43 Self-reported treatment aim by treatment status and treatment type

Self-reported aim	Treatment group				Total		In-out group				Total	
	Detox/ Rehab		Counsel/ Pharm				Detox/ Rehab		Counsel/ Pharm			
	n	%	n	%	n	%	n	%	n	%	n	%
Aim to abstain	134	80.7*	72	44.2*	206	62.6	34	40.0	18	52.9	52	43.7
Other aim (reduce..)	91	55.8	32	19.3	123	37.4	51	60.0	16	47.1	67	56.3
Total	163		166		329		85		34		119†	

*p=<.001
† Data missing for Treatment type in In-out Treatment group.

Bivariate results

There were statistically significant differences between those who more nearly achieved, or failed to achieve, their treatment goals on a number of dimensions (see Table 44 for details).

In contrast to the less successful, those who more nearly achieved their treatment goal can be characterised as:

- being non-English speaking
- studying
- living in detox/rehab, rather than other stable accommodation
- relying on crime, dealing, or sex work as main source of income
- not currently using illicit drugs or injecting drugs (as much)
- having had a relatively short drug using career
- having lower severity of dependency scores
- using drugs for recreation, because of peer pressure, and because they can afford to
- being healthier (physically and emotionally)
- not having BBV diagnoses
- not having felt suicidal in the last 4 weeks
- not having experienced discrimination due to drug use
- not having had trouble with the police
- having a positive opinion of treatment staff
- favouring residential treatment
- not favouring legally prescribed heroin, self-help groups, or drug use during treatment

- reporting that their treatment goal was abstinence, as opposed to reduction or control of drug use
- having been in rehabilitation/detox rather than counselling or pharmacotherapy
- condition of treatment entry more likely to have been abstinence
- barrier to treatment was less likely to have been lack of medical support
- treatment satisfaction was higher
- length of time in treatment longer
- length of time waiting for treatment longer
- number of attempted self-treatments fewer.

Table 44 Treatment Goal Achieved (completely/almost completely) vs Not Achieved. Treatment & In-out groups only (492). Bivariate analyses: significant differences

	Goal Achieved	Goal Achieved (n=125)	Goal not achieved (n=367)	p
Demographics				
– Non-English speakers	More	6%	2%	<.05
– Studying	More	14%	7%	<.05
– In detox/rehab accommodation	More	34%	21%	<.01
– In stable accommodation	Less	57%	69%	<.05
– Income source: crime, dealing, sexwk	Less	2%	11%	<.01
Drug Use History				
– Currently using illicit drugs	Less	41%	66%	<.001
– Currently injecting drugs	Less	39%	63%	<.001
– Length of illicit drug career	Shorter	8.4 (1-35)	11.6 yrs	<.001
Reasons for Drug Use				
– For recreation	More	15%	8%	<.05
– Because of peer pressure	More	7%	2%	<.001
– Because can afford to	More	13%	6%	<.05
Opinion				
– Residential is most successful	More	62%	49%	<.05
– Positive opinion of treatment staff	More	22.7	20.5	<.001
– Legally prescribed heroin best	Less	57%	74%	<.001
– Self-help groups not usually successful	Less	56%	72%	.001
– Treatment that allows drug use best	Less	37%	55%	.001
– Treatment that allows injection best	Less	19%	28%	<.05

Table 44 Treatment Goal Achieved (completely/almost completely) vs Not Achieved. Treatment & In-out groups only (492). Bivariate analyses: significant differences *(continued)*

	Goal Achieved	Goal Achieved (n=125)	Goal not achieved (n=367)	p
Health/Wellbeing				
– Severity of dependency	Lower	5.1 (0-20)	7.5	<.001
– Felt good last 4 weeks	Higher	7.9 (0-12)	6.4	<.001
– Felt bad last 4 weeks	Lower	10.1 (0-21)	12.3	<.001
– Felt suicidal last 4 weeks	Lower	0.4 (0-3)	0.6	<.01
– SF12 health score	Higher	21.4 (0-35)	16.6	<.001
– Positive BBV diagnosis	Less	46%	56%	<.05
– Feel been discriminated against	Less	4.2 (0-14)	5.2	.001
– Been in trouble with police	Less	28%	38%	<.05
Treatment history				
– Aim is/was abstinence	More	65%	53%	<.05
– Aim is/was control/reduce…	Less	35%	47%	
– Use/d while in treatment	Less	41%	66%	<.001
– Type of treatment: Counselling	Less	10%	21%	<.01
– Type of treatment: Pharmacological	Less	25%	34%	<.05
– Type of treatment: Rehabilitation	More	34%	16%	<.001
– Condition of treatment: abstinence	More	26%	13%	<.001
– Bar to treatment: Lack med support	Less	3%	9%	<.05
– Treatment satisfaction	More	4.1 (1-5)	3.4	<.001
– Treatment length	Longer	4.8 (1-8)	4.3	<.05
– Length of wait for treatment	Longer	3.1 (0-6)	2.6	<.05
– Number of self-treatments attempted	Fewer	12.9 (0-26)	15.5	<.05

Multiple Regression Analysis Summary

Study factors which were significantly, or nearly significantly, associated with treatment goal achievement in the current and past treatment groups, were included in the regression model. Backward stepwise analysis was used to reduce the model. Variables which had a p value of more than 0.05 were excluded from further step analysis. The reduced model explained 28% of the variance in the outcome variable.

Among those with previous and current experience of treatment, a higher (rather than lower) level of achievement of treatment goal was independently related to:

- current abstinence from injection (beta coef. –0.36, p=<0.001)
- having felt good in the last four weeks (beta coef. 0.07, p=<0.001)
- having been satisfied with treatment (beta coef. 0.1, p=<0.001)

- having been in treatment for longer (beta coef. 0.06, p=<0.001)
- having completed the last treatment (beta coef. 0.2, p=0.001)
- not having participated in treatments that others described as not good (beta coef. 0.4, p=0.005)
- disagreement that "legally prescribed heroin would be a more successful form of treatment" (beta coef. 0.3, p=<0.001)

SECTION 15 Having Plans versus No Plans for Future Treatment

This section summarises the results of bivariate and multivariate analyses among participants not currently in treatment, with future treatment plans versus no plans as the dependent variable.

Bivariate results

There were statistically significant differences between those who planned future treatment in the next 6 months versus those who did not on a number of dimensions (see Table 45).

By contrast with those who had no plans for future treatment, those who intended to go into treatment in the next six months can be characterised as:

- on benefits and not working
- currently injecting drugs
- using drugs frequently
- using drugs to "avoid withdrawal", not for "recreation"
- opioid users rather than stimulant users
- having more involvement in IDU networks
- having family members who use drugs
- having financial problems due to drug use
- having attempted self-treatments
- aimed for abstinence in self-treatments
- attempted more types of self-treatment
- having experienced failure/low success with self-treatments
- having had poorer health (physical and emotional)
- greater severity of dependency
- having had more trouble with the police
- having experienced more discrimination because of drug use
- favouring "treatment by a doctor in a medical setting"
- having tried professional treatment before (i.e., being in the In-out group)
- have tried and failed to get treatment in the past
- reporting treatment entry requirements

- having kept using while waiting for treatment
- having asked to be referred to treatment
- reporting a higher number of barriers to treatment
- having more reasons for wanting to change drug use
- wanting to change drug use for the following reasons: more stability in life, sick of the lifestyle, stopped enjoying drug use, wanting to improve quality of life, being worried about the impact of drug use on others, wanting to gain control over drug use, having reached crisis point
- having experienced various barriers to treatment in the past, namely, waiting lists too long, too far to travel, worry about disclosure.

Table 45 Plan to seek treatment in next 6 months: 'Never' and 'In-out' groups only (356 cases), Bivariate analyses: significant differences

	Plan treatment	Plan treatment (n=76)	No plans/ NR (n=280)	p
Demographics				
– Employment status	More benefits/ pension	75%	56%	<.01
Drug use history				
– Inject drugs	More	93%	84%	<.05
– Frequency of drug use[1]	Higher	4 (0-8)	3	<.001
– Drug most frequently used	More opioids	66%	42%	<.001
Reasons for drug use				
– For partying	Fewer	15%	30%	<.01
– For recreation	Fewer	8%	28%	<.001
– For dances/raves	Fewer	1%	8%	<.05
– For special occasions	Fewer	0%	5%	<.05
– Because I want to	Fewer	17%	32%	<.05
– Because I like it	Fewer	29%	48%	<.01
– To avoid withdrawal	More	49%	21%	<.001
– Because I need to	More	33%	21%	<.05
– Out of habit	More	36%	24$	<.05
– When sad	More	43%	21%	<.001
Drug using network				
– Social network with drug users	Larger	5.3 (0-8)	4.8	<.05
– Family use drugs[2]	Lower	0.95 (0-2)	1.25	<.05
Finance				
– Can't meet bills because of drug use[3]	Higher	1.43	1.04	.001

1 3 more than once a week but not everyday, 4 once a day, 5 once or twice a day...
2 0 no family use, 1 extended family only use, 2 immediate family use
3 0 Never, 1 sometimes, 2 often, 3 always.

Table 45 Plan to seek treatment in next 6 months: 'Never' and 'In-out' groups only (356 cases), Bivariate analyses: significant differences *(continued)*

	Plan treatment	Plan treatment (n=76)	No plans/ NR (n=280)	p
Self-treatment history				
– Do self treatment	More	83%	67%	<.01
– Self treatment aim is abstinence	More	45%	18%	<.001
– Number of types of self-treatments	Higher	3 (0-6)	2	<.01
– Achieved self-treatment goals[4]	Lower	0.72 (0-2)	1.02	<.001
Health and wellbeing				
– SF12 (general health)	Lower	15 (0-36)	21	<.001
– Severity of dependence	Higher	9 (0-23)	6	<.001
– Physical problems	Higher	10 (0-17)	9	<.05
– Felt good last 4 weeks	Lower	6 (0-12)	7	<.001
– Felt Bad last 4 weeks	Higher	13 (0-21)	10	<.001
– Felt suicidal last 4 weeks[5]	Higher	0.8	0.5	<.01
Law enforcement				
– Been in trouble with the police	More	38%	25%	<.05
Discrimination/opinion				
– Felt discriminated against because of drug use	Higher	5 (0-14)	4	<.01
– Treatment by doctor in medical setting is best	Agree	42%	26%	<.01
Treatment history/future				
– Treatment status: in-out	More	62%	41%	<.01
– Treatment status: never	Fewer	38%	59%	
– Unable to get treatment when wanted it in last 5 years	More	43%	17%	<.001
– Treatment entry requirements	More	36%	21%	<.01
– Kept using while waiting for treatment	More	38%	20%	.001
– Asked to be referred	More	45%	22%	<.001
– Barriers: count of what stopped me getting help	Higher	1.4 (0-15)	0.8	<.05
– Reasons for change: count of reasons	Higher	7 (0-22)	4	<.001
– Want stability in my life	More	52%	32%	<.01
– Sick of the lifestyle	More	53%	33%	.001
– Stopped enjoying drug use	More	38%	18%	<.001
– To reduce stress	More	49%	29%	.001

4 0 No, 1 to some extent, 2 yes, completely/almost completely
5 0 Never, 1 rarely, 2 sometimes, 3 often.

Table 45 Plan to seek treatment in next 6 months: 'Never' and 'In-out' groups only (356 cases), Bivariate analyses: significant differences *(continued)*

	Plan treatment	Plan treatment (n=76)	No plans/ NR (n=280)	p
Treatment history/future				
– To improve quality of life	More	57%	34%	<.001
— Worried about impact on those closest to me	More	53%	26%	<.001
– To gain control over drug use	More	54%	31%	<.001
– Reached crisis point	More	45%	28%	<.01
– Barrier: waiting list too long	More	22%	8%	<.001
– Barrier: too far to travel	More	11%	4%	<.05
– Barrier: worried about disclosure	More	9%	3%	<.05

Multiple Regression Analysis Summary

Study factors which were significantly, or nearly significantly, associated with having plans versus no plans for future treatment were included in the logistic regression model. Backward stepwise analysis was used to reduce the model. Variables which had a p value of more than 0.05 were excluded from further step analysis. The reduced model explained 24% of the variance in the outcome variable.

Having plans to go into treatment in the next six months, as against having no such plans, was independently related to:

- using drugs to avoid withdrawal (OR=3.5, CI 1.9-6.4, p=<0.001) or relieve sadness (OR=2.3, CI 1.2-4.3, p=<0.01), rather than for fun purposes
- having poorer health (OR=0.9, CI 0.9-1.0, p=<0.001)
- having tried and failed to get into treatment in the last 5 years (OR=2.5, CI 1.3-4.9, p=0.005)
- having kept using drugs in the past while waiting for treatment (OR=2.0, CI 1.0-3.8, p=0.04)
- having aimed for abstinence, rather than drug reduction, in self-treatment attempts (OR=2.6, CI 1.4-4.9, p=0.002)
- having a good opinion of treatment staff (OR=1.1, CI 1.0-1.1, p=0.008).

SECTION 16 Opioid Versus Stimulant Use

Opioid and stimulant use is defined above (p.7). As seen above, 53% (n=362) of the sample had used opioids more frequently in the last 6 months, while 47% (n=323) had used stimulants more frequently in the last 6 months. Opioid users (who might or might not also use stimulants) were more likely to be in the 'current' or 'past treatment' groups. They were less likely to be in the 'never in treatment' group. This is probably because opioids tend to be at the top of the drug ladder, with experienced drug users adding opioids to their repertoire, rather than inexperienced drug users starting out with this drug (Robins, 1980). The 'current' and 'past treatment' groups both appear to comprise heavier, more experienced drug users, than the 'never in treatment' group (see sections 10-12 above). At least 50% of participants currently in treatment were still injecting either opioids or stimulants while in treatment.

Bivariate results

There were statistically significant differences between opioid and stimulant users on a number of dimensions (see Table 46).

Those who used opioids, as against stimulants, as their primary drug in the past 6 months, can be characterised as:

- older at interview
- identifying as Aboriginal or Torres Strait Islander
- being on benefits; not working or studying
- being a more frequent user
- being a polydrug user
- having used drugs for longer
- having a higher dependency score
- using drugs to avoid withdrawal, out of need, or habit, for pain relief
- not for recreational reasons/partying/sex/drinking, etc.
- having relatively poor health (physical and emotional)
- having one or more positive BBV diagnoses
- having experienced overdose
- having more financial problems due to drug use
- having experienced more discrimination as a result of drug use
- having been in trouble with the police
- having attempted self-treatment
- having attempted more self-treatments (14 on average)
- having attempted more types of self-treatment
- having used more other drugs during self-treatment
- having aimed for abstinence in self-treatment
- believing that methadone and/or prescribed heroin treatment is the most successful form of treatment

- having a less positive opinion of treatment staff
- having had longer treatments
- having waited longer for treatment
- having been in a worse state before treatment (in a problematic/chaotic state, in crisis, debt ridden, not level headed)
- having been in professional treatment more often
- having asked to be referred/having referred self
- having obtained information about treatment from family, friends or media
- being currently in treatment or having been in treatment in the past
- having continued to use drugs during treatment
- having faced more treatment entry requirements
- having had counselling as a condition of treatment
- being in pharmacological treatment
- planning to seek treatment in the next 6 months (in-out and never groups only)
- having more reasons for wanting to change drug use
- wanting to change drug use for the following reasons: wanting more stability in life, being sick of the lifestyle, wanting to reduce stress, to improve quality of life, to gain control over drug use, worried about the impact of drug use on significant others, reached crisis point
- having experienced barrier to treatment, in particular, waiting list too long.

Table 46 Opioid users vs stimulant users. Full sample – 685 cases. Bivariate analyses: significant differences

	Opioid users	Opioid users (n=362) M/%	Stimulant users (n=323) M/%	p
Demographics				
– Age at interview	More	M=32.6 (18-64)	M=30.5 yrs	.001
– Aboriginal or Torres Strait Islander	More	15%	8%	<.01
– Employment status	More benefits	73%	66%	<.05
	Less work/ study	15%	22%	<.05
Drug use history				
– Frequency of drug use[1]	More	4.8 (0-8)	3.7	<.001
– Polydrug use	More	4.5 (0-9)	4.2	<.05
– Length of drug using career	More	11.3 (0-35)	8.1	<.001
– Severity of dependency	More	7.3 (0-15)	5.6	<.001

1 3 more than once a week but not everyday, 4 = once a day, 5 = once or twice a day...
2 0 Never, 1 sometimes, 2 often, 3 always.

Table 46 Opioid users vs stimulant users. Full sample – 685 cases. Bivariate analyses: significant differences *(continued)*

	Opioid users	Opioid users (n=362) M/%	Stimulant users (n=323) M/%	p
Adverse experiences due to drug use				
– Can't meet bills because of drug use[3]	Higher	1.5 (0-3)	1.3	.01
– Experienced discrimination due to drug use	More	5.0 (0-14)	3.9	<.001
– Been in trouble with the police	More	38%	26%	.001
Reasons for drug use				
– For partying	Fewer	12%	34%	<.001
– For recreation	Fewer	12%	21%	.001
– For dances/raves	Fewer	2%	9%	<.001
– Because I have cash	Fewer	6%	10%	<.05
– For sex	Fewer	4%	11%	<.001
– For drinks	Fewer	3%	7%	<.05
– To avoid withdrawal	More	51%	15%	<.001
– Because I need to	More	35%	21%	<.001
– Out of habit	More	39%	31%	<.05
– For pain relief	More	28%	9%	<.001
Self-treatment (s.t.) history				
– Number of self-treatments attempted	More	14.5 (0-26)	11.2	<.001
– Number of types of self-treatment	More	3.4 (0-7)	2.5	<.001
– Number of other drugs used in s.t.	More	2.7 (0-8)	1.8	<.001
– Do self treatment	More	78%	66%	<.001
– Self treatment aim is abstinence	More	37%	24%	<.001
Health and wellbeing				
– SF12 (general health)	Lower	17.8 (0-36)	20.2	<.001
– Positive BBV diagnoses	Higher	0.7 (0-3)	0.4	<.001
– Physical problems	Higher	10.7 (0-17)	9.5	<.001
– Felt good last 4 weeks	Lower	6.8 (0-12)	7.2	<.01
– Have overdosed	More	66%	47%	<.001
Opinions				
– Methadone maintenance is best tr.	More	33%	25%	<.05
– Legally prescribed heroin is best	More	78%	61%	<.001
– Positive opinion of treatment staff	Less	20.2 (0-37)	21.2	<.05

Table 46 Opioid users vs stimulant users. Full sample – 685 cases. Bivariate analyses: significant differences *(continued)*

	Opioid users	Opioid users (n=362) M/%	Stimulant users (n=323) M/%	p
Treatment history/future				
– Length of treatment	More	3.9 (0-8)	2.5	<.001
– Length of wait for treatment	More	2.2 (0-6)	1.7	<.05
– Treatment entry requirements	More	1.5 (0-7)	1.1	<.01
– State before treatment	Worse	2.1 (0-4)	2.5	<.01
– Number of past treatments	Greater	3.5 (0-50)	2.1	<.001
– Number of treatment entry requirements	More	1.5 (0-7)	1.1	<.01
– Asked to be referred	More	33%	24%	<.01
– Referred by self	More	47%	28%	<.001
– Treatment info: from family/friends	More	17%	11%	<.05
– Treatment info: from media	More	19%	12%	<.05
– Treatment status: in treatment	More	54%	42%	<.001
– Treatment status: never in	Fewer	19%	38%	<.001
– Use/d while in treatment	More	64%	53%	<.01
– Unable to get treatment when wanted it in last 5 years	More	32%	24%	<.05
– Kept using while waiting for treatment	More	52%	39%	.001
– Faced treatment entry requirements	More	46%	35%	<.01
– Condition of treatment: counsellg/other	More	34%	24%	<.01
– Treatment type: pharmacological	More	37%	7%	<.001
– Will seek treatment next 6 months	More	30%	14%	<.001
– Count of reasons for wanting change in drug use	Higher	8.2 (0-22)	6.6	<.001
– Reasons: Want stability in my life	More	68%	54%	<.001
– Sick of the lifestyle	More	71%	53%	<.001
– To reduce stress	More	61%	51%	<.01
– To improve quality of life	More	72%	56%	<.001
– Worried about impact on those closest to me	More	56%	44%	.001
– To gain control over drug use	More	62%	50%	.001
– Reached crisis point	More	58%	46%	<.01
– Barrier to tr.: waiting list too long	More	21.5%	14.6%	<.05

Multiple Regression Analysis

Study factors which were significantly, or nearly significantly, associated with opioid versus stimulant use, were included in the logistic regression model. Backward stepwise analysis was used to reduce the model. Variables which had a p value of more than 0.05 were excluded from further step analysis. The reduced model explained 34% of the variance in the outcome variable.

Using opioids most frequently, as against stimulants, was independently related to:

- being an Aboriginal or a Torres Strait Islander (OR=0.4, CI 0.2-0.8, p=0.002)
- using drugs more frequently (OR=0.8, CI 0.8-0.9, p=0.002)
- using drugs to avoid withdrawal (OR=0.2, CI 0.1-0.4, p=<0.001), and/or for pain relief (OR=0.2, CI 0.1-0.4, p=<0.001), not for partying (OR=2.4, CI 1.5-4.0, p=<0.001)
- having one or more positive diagnoses for blood-borne viruses (OR=0.6, CI 0.4-0.8, p=<0.001)
- being on pharmacological rather than other kinds of treatment (OR=0.1, CI 0.1-0.2, p=<0.001)
- agreeing that "legally prescribed heroin would be a better treatment than methadone maintenance" (OR=0.4, CI 0.2-0.6, p=<0.001).

SECTION 17 Peers and Family

In this section, information contained in the report that relates to peers and family is gathered together.

Drug use is known to be, on the whole, a social activity involving the peer group. There was some evidence to this effect in the present sample. Also glimpsed in the report are the possible roles of peers and family in both encouraging and discouraging drug use and drug treatment (i.e., as both barriers and incentives to these activities).

Seventy-eight percent (n = 533) of participants in the full sample of 685 respondents were living with other persons. Only 18% (n =126) were living alone. Presumably, in many instances, cohabitants were peers or family.

Many participants gave social reasons among their three 'most significant' reasons for drug use, saying that they use drugs: to party (18%, n = 122), for recreation (13%, n = 86), to bond with a partner (6%, n = 40), or with friends (6%, n = 38), for sex (6%, n = 39), for parties/raves etc (4%, n = 30), with drinks (5%, n = 34), because of peer pressure (4%, n = 24).

Respondents reported extensive contact with other drug users. On average they reported that 'most', rather than 'some', of their friends used drugs (M = 2.7, where 2 = some and 3 = most). Sixty-seven percent (n = 458) reported that they live with person(s) who use drugs. Fifty-three percent (n = 360) had immediate family (mother, father, child, stepmother/father, stepchild, brother, sister) who use drugs, and 9% (n = 59) had extended family (aunt/uncle, cousin), but not immediate family, who use drugs. Thirty-six percent (n = 249) had a partner who uses drugs.

On average, respondents spent close to 'most' of their time with people who use drugs (M = 2.6, where 2 = some and 3 = most, of the time).

Also, on average, respondents had disclosed their drug use to slightly over 4 categories of persons (partner/spouse, ex-partner, family members, friends, workmates, boss, acquaintances, healthcare workers/doctor, teacher/lecturer/school or university counsellor).

On the other hand, over half the respondents in the sample felt that they had been discriminated against by family or peer group because of their drug use. Sixty-one percent (n = 415) believed that they had experienced discrimination by family, 60% (n = 414) by friends, 32% (n = 220) by a partner, 24% (n = 166) by flatmates and 22% (n = 149) by workmates. Fourteen percent (n = 94) had found out about treatment through family, friends or a partner, and 9% (n = 61) had been referred to treatment by family, friends, or a partner.

Further, among those who were, or had been, in treatment *and* who claimed to have achieved their treatment aims to a reasonable or large extent (314 persons, 46% of the sample), more than half (53%, n = 165) said that they had been 'supported' in their efforts by their peers.

Overall, among those who had been in treatment, or were currently in treatment (492 persons), family and friends were important factors contributing to the desire to reduce/change drug use and were often supports during treatment. Nearly 70% of respondents (n = 344) said that they wished to change their drug use because they were worried about the impact of their drug use on those close to them. Forty-three percent (n = 209) reported pressure to change their drug use from family, friends or partner, and 20% (n = 97) reported worry that their children might be taken away from them. In addition, 36% (n = 176) said that they would like to be a better partner and that this motivated them to change their drug use.

In relation to support during the most recent treatment, 60% (n = 297) reported receiving support from family members, 54% (n = 267) from friends, 40% (n = 199) from a current partner, and 9% (n=46) from workmates. Forty-six percent (n = 225) said they received support from a non-user and 26% (n = 129) from a current user. Over 75% of those who received support from these various categories of persons, described the support given as helpful, especially support from partner and family – over 90% of those receiving this kind of support described it as helpful. Among the 'current treatment' group (329 participants), current treatment was said to be facilitated by support from family and friends (55%, n = 126), or because friends had stopped using (10%, n = 23), or because childcare was available (53%, n = 121).

Less often, family or peers featured among barriers to treatment or to the disclosure involved in seeking treatment. Twenty-eight percent of the sample (n = 190) said that, in the last five years, they had wanted treatment but been unable to obtain it for reasons connected with family or friends. Fourteen percent of this group (n = 27) had been unable to obtain treatment due to lack of support from family or friends, 6% (n = 12) due to fear of children being taken away, or because the treatment facility was unable to accommodate children or partners.

Appendix B:
Lists of Study Participants

Appendix B contains lists of service provider, key informant and workshop participants in the study. Their valuable contribution to the study is acknowledged in the *Acknowledgements* at the beginning of the Report.

1. Service Provider Interviews – Participants

Site	Service	Name of Service
Sydney (inner)	Residential Rehabilitation	Catherine Booth House
	Detoxification	Gorman House, St Vincent's
	Pharmacotherapy	Kirketon Road Centre
	Counseling	Langton Centre
	No Treatment	NUAA
	No Treatment	REPIDU
Sydney (west)	Residential Rehabilitation	West Mount
	Counseling	Wentworth AHS
	No Treatment	Sexual Health
Rural NSW	Residential Rehabilitation	Lyndon Therapeutic Community
	Detoxification	Lyndon Detoxification Unit
	Pharmacotherapy	Chiefley Cottage
	Pharmacotherapy	Hogan's Pharmacy
	Counseling	MERIT
	No Treatment	Speadilink
	No Treatment	Sexual Health
Brisbane	Residential Rehabilitation	The Haven
	Detoxification	QUIVAA
	Pharmacotherapy	BIALA
	Counseling	Hot House/DUNES
	No Treatment	DUNES
	No Treatment	Brisbane Youth Centre
Rural Qld	Residential Rehabilitation	St Vincent's
	Detoxification	ATODS
	Pharmacotherapy	ATODS Methadone
	Counseling	Addiction Help Agency
	No Treatment	Youthlink
Perth	Residential Rehabilitation	Palmerston Farm
	Detoxification	Bridge House
	Pharmacotherapy	Next Step
	Counseling	North Metro CDST
	No Treatment	WASUA
		WASUA (treatment referral worker)

2. List of Key Informants

Dr Robert Ali, Drug and Alcohol Services Council, SA

Dr Andrew Byrne, General Practitioner, Sydney

Ms Bridget Carrick, Substance Misuse Program, National Aboriginal Community Controlled Organisation

Mr Kelvin Chambers, Drug and Alcohol Multicultural Centre, Sydney.

Dr Jan Copeland, National Drug and Alcohol Research Centre, Sydney

Dr Paul Dietze, Turning Point, Melbourne

Ms Jenny Hefford, Drug Strategy Branch, Australian Government Department of Health and Ageing

Dr David Helliwell, Nimbin Medical Centre, NSW

Mr Peter Kay, Department of Human Services, SA

Dr Kevin Lambkin, Alcohol and Other Drugs, Queensland Health Department

Associate Professor Wendy Loxley, National Drug Research Institute, Curtin University

Ms Annie Madden, The Australian Injecting and Illicit Drug Users League (AIVL)

Dr Denzil McCotter, Western Australia Department of Health

Dr David McGrath, Clinical Services Policy, Drug Programs Bureau, NSW Health

Dr Rod McQueen, Alcohol and other Drug Services, Mid West Area Health Service, NSW

Dr James Pitts, Odyssey House, Sydney

Mr Richard Refshauge, Director of Public Prosecutions, Canberra

Professor Anne Roche, National Centre in Education and Training for Drug and Alcohol, Flinders University. SA

Professor John Saunders, Queensland Health and University of Queensland

Ms Marion Simmonds, Drug Court Program, Department of Human Services, Victoria

Mr Tony Trimingham, Family Drug Support

Dr Ingrid Van Beek, Kirkton Road Centre, Sydney

Major Brian Watters, The Australian National Council on Drugs.

Professor Ian Webster, Alcohol Education and Research Foundation.

Ms Cheryl Wilson, Alcohol and other Drugs Council of Australia

Mr Scott Wilson, The Australian National Council on Drugs

Dr Alex Wodak, St Vincent's Hospital, Sydney

3. 'Negotiation Workshop' – Participants (Listed by working groups)

Ms Nicky Bath (Facilitator)	AIVL, Canberra.
Ms Anne Lawrence	Clinical Services Policy, NSW Health Dept.
Ms Margaret Hughes	Wentworth Area Health Service, NSW
Ms Jan Parr	ATODS, Cairns.
Michael Thompson	Mid-West Area Health Service, NSW
Mr Ian West	CAHMA, Canberra
Ms Jacklyn DuDayle	DUNES, Queensland.
Dr Wen Cao	National Centre in HIV Social Research, UNSW.
Mr Lance Schultz (Facilitator)	LMS Consulting
Dr Paul Dietze	Turning Point, Melbourne
Ms Sandra Lines	Family Drug Support, Sydney
Dr David Helliwell	Nimbin Medical Centre, NSW
Ms Jo Northey	Kirkton Road Centre, Sydney
Ms Maureen Steele	NUAA, Sydney
Mr Joe Kim	VIVAIDS, Melbourne
Ms Di Flint	DUNES, Queensland
Ms Jo Lancaster	NUAA, Coffs Harbour
Ms Kate Jorgenson (Facilitator)	Dept Health and Ageing, Canberra
Prof Sue Kippax	National Centre in HIV Social Research. UNSW.
Ms Sally Ann Scott	WASUA, Perth
Ms Bruna Paci	Family Drug Support, Sydney
Ms Susan Cordeiro	Odyssey House, Sydney
Dr Allan Quigley	Next Step, Perth
Ms Di Forsyth	Addictions Help Agency, Queensland
Ms Kim Moran	CAHMA, Canberra
Ms Susan McGuckin	NUAA, Sydney
Mr Michael Lodge (Facilitator)	NUAA, NSW
Dr Carla Treloar	National Centre in HIV Social Research, UNSW
Dr Robert Ali	Drug and Alcohol Services Council, SA
Ms Didi Killen	Mid West Area Health Service, NSW
Ms Felicity Sheares	Wentworth Area Health Service, NSW
Ms Nicole Wiggens	CAHMA, Canberra
Mr Kevin Folks	DUNES, Queensland.
Mr John Martin	WASUA, Perth.
Mr Damon Brogan	VIVAIDS, Melbourne
Ms Annie Madden (Facilitator)	AIVL, Canberra
Dr Jeanne Abelson	National Centre in HIV Social Research, UNSW
Mr Rob Wilkins	Workforce Development Project, NSWHealth
Mr Noel Taloni	Dept of Health and Ageing, Canberra
Dr Rod McQueen	Mid West Area Health Service, NSW
Ms Sarah Lord	VIVAIDS, Melbourne
Mr Mathew Rourke	TUF, Northern Territory
Mr John Hewitt	WASUA, Perth
Ms Nicole Skelley	SAVIVE, SA

References

Abouyanni, G., Stevens, L.J., Harris, M.F., Wickes, W.A., Ramakrishna, S.S., Ta, E., & Knowlden, S.M. (2000). GP attitudes to managing drug- and alcohol–dependent patients: a reluctant role. *Drug and Alcohol Review*, 19, 165-170.

Agosti, V., Nunes, E., Stewart, J.W., & Quitkin, F.M. (1991). Patient factors related to early attrition from an outpatient cocaine research clinic: a preliminary report. *International Journal of the Addictions*, 26, 327-334.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders*. (4th ed.). Washington, DC: APA.

Australian Institute of Health and Welfare. (2002). *2001 National Drug Strategy Household Survey: First Results*. Canberra: Australian Institute of Health and Welfare.

Australian Institute of Health and Welfare. (2002). Alcohol and other drug treatment services in Australia 2000-01: First report on the National Minimum Data Set. Canberra: AIHW.

Baekeland, F., & Lundwall, L. (1975). Dropping out of treatment: a critical review. *Psychological Bulletin*, 82, 738-83.

Ball, J.C., & Ross, A. (1991). *The Effectiveness of Methadone Maintenance Treatment,* New York: Springer-Verlag.

Battjes, R.J., Onken, L.S., & Delany, P.J. (1999). Drug abuse treatment entry and engagement: Report of a meeting on treatment readiness. *Journal of Clinical Psychology*, 55(5), 643-657.

Beckman, L.J. (1994). Treatment needs of women with alcohol problems. *Alcohol Health & Research World*. 18(3), 206-11.

Bessant, J., Coupland, H., Dalton, T., Maher, L., Rowe, J., & Watts, R. (2003). Heroin users, housing and social participation: attacking social exclusion through better housing. Melbourne: AHURI.

Best, D., Hernando, R., Gossop, M., Sidwell, C., & Strang, J. (2003). Getting by with a little help from your friends: the impact of peer networks on criminality in a cohort of treatment-seeking drug users. *Addictive Behaviors*, 28, 597-603.

Bokos, P.J., Mejita, C.L., Mickenberg, J.H., & Monks, R.L. (1992). Case management: An alternative approach to working with intravenous drug users. In R.S. Ashery (Ed), *Progress and Issues in Case Management*. National Institute on Drug Abuse Research Monograph No. 127. US Department of Health and Human Services.

Booth, R.E., Crowley, T.J., & Zhang, Y. (1996). Substance abuse treatment entry, retention and effectiveness: out-of-treatment opiate injection drug-users. *Drug & Alcohol Dependence*, 42, 11-20.

Brown, H. (1991*). Report on services required for adolescents with drug-related problems*. Prahran: Victoria: Taskforce Community Involvement Centre.

Brown, B.S., Hickey, J.E., Chung, A.S., Craig, R.D., & Jaffe, J.H. (1989). The functioning of individuals on a drug abuse waiting list. *American Journal of Drug & Alcohol Abuse*, 15, 261-74.

Caplehorn, J.R.M., & Bell, J. (1991). Methadone dosage and retention of patients in maintenance treatment. *Medical Journal of Australia*. 154, 195-199.

Caplehorn, J.R.M., Lumley, T.S., & Irwig, L. (1998). Staff attitudes and retention of patients in methadone maintenance programs. *Drug & Alcohol Dependence*, 52(1), 57-61.

Carroll, K.M. (1997). Enhancing retention in clinical trials of psychosocial treatments: practical strategies. In L.S. Onken, J.D. Blaine & J.J. Boren. *Beyond the Therapeutic Alliance: Keeping the Drug Dependent Individual in Treatment*. NIDA Research Monograph 165. US Department of Health & Human Services.

Carroll, K.M., & Rounsaville, B.J. (1992). Contrast of treatment-seeking and untreated cocaine abusers. *Archives of General Psychiatry*, 49, 464-471.

Chatham, L.R., Hiller, M.L., Rowan-Szal, G.A., Joe, G.W., & Simpson, D.D. (1999). Gender differences at admission and follow-up in a sample of methadone maintenance clients. *Substance Use and Misuse*, 34(8), 1137-1165.

Chutuape, M.A., Katz, E.C., & Stitzer, M.L. (2001). Methods for enhancing transition of substance dependent patients form inpatient to outpatient treatment. *Drug & Alcohol Dependence*, 61(2), 137-143.

Comfort, M., Sockloff, A., Loverro, J., & Kaltenback, K. (2003). Multiple predictors of substance–abusing women's treatment and life outcomes. A prospective longitudinal study. *Addictive Behaviors*, 28, 199-224.

Copeland, J. (1997). A qualitative study of barriers to formal treatment among women who self-managed change in addictive behaviours. *Journal of Substance Abuse Treatment*, 14 (2), 183-190.

Copeland, A.L. and Sorenson, J.L. (2001). Differences between methamphetamine users and cocaine users in treatment. *Drug and Alcohol Dependence*, 62, 91-95.

Corsi, K.F., Kwiatkowski, C.F., & Booth, R.E. (2002). Predictors of positive outcomes for out-of-treatment opiate injectors recruited into methadone maintenance through street outreach. *Journal of Drug Issues*, 32(3), 999-1016.

Cunningham, J.A., Sobell, L.C., Sobell, M.C., Agrawal, S., & Toneatto, T. (1993). Barriers to treatment: why alcohol and drug abusers delay or never seek treatment. *Addictive Behaviours*, 18, 347-53.

Cunningham, J.S., Sobell, L.C., Sobell, M.B., & Gaskin, J. (1994). Alcohol and drug abusers' reasons for seeking treatment. *Addictive Behaviors, 19*(6), 691-696.

Darke, S. (2003). *Suicide among entrants to treatment for heroin dependence.* Paper presented at the 2003 NDARC Annual Symposium, Sydney.

Darke, S., Topp, L., & Kaye, S. (2001). *NSW Drug Trends 2001: Findings from the Illicit Drug Reporting System (IDRS)*. Sydney: NDARC.

Davis, T.M., Carpenter, K.M., Malte, C.A., Carney, M., Chambers, S., & Saxon, A.J. (2002). Women in addictions treatment: comparing VA and community samples. *Journal of Substance Abuse Treatment,* 23, 41-48.

Day, C., Topp, L., Rouen, D., Darke, S., Hall, W., & Dolan, K. (2003). Decrease heroin availability in Sydney in early 2001. *Addiction*, 98, 93-95.

De Leon, G. (2001). A commentary on 'retention in substance dependence treatment: the relevance of in-treatment factors'. *Journal of Substance Abuse Treatment*, 20, 263-264.

De Weert-Van Oene, G., Schippers, G.M., De Jong, C.A.J., & Schrijvers, G.J.P. (2001). Retention in substance dependence treatment: the relevance of in-treatment factors. *Journal of Substance Abuse Treatment*, 20, 253-261.

Dennis, M.L., Ingram, P.W., Burks, M.E., & Rachal, J.V. (1994). Effectiveness of streamlined admissions to methadone maintenance treatment: a simplified time series analysis. *Journal of Psychoactive Drugs*, 26, 207-16.

Dietze, P., Richards, J., Rumbold, G., Aitken, C., Day, C., McGregor, C., & Ritter, A. (2003). *Treatment utilisation by heroin-dependent persons in Australia: Implications for treatment service systems.* Fitroy, Victoria: Turning Point Alcohol and Drug Centre.

Dole, V.P., & Nyswander, M.E. (1967). Heroin addiction – a metabolic disease. *Archives of Internal Medicine*, 120, 19-24.

Donnermeyer, J.F., Barclay, E.M., & Jobes, P.C. (2002). Drug-related offenses and the structure of communities in rural Australia. *Substance Use and Misuse*, 37(5-7), 631-661.

Donovan J., Jessor, R., & Costa, F. (1991). Adolescent health behaviour and conventionality-unconventionality: an extension of problem-behaviour theory. *Health Psychology*, 10, 52-61.

Dunn, P. (1998). Introduction – Rural health and drug and alcohol dependence: Double jeopardy. In *Drug & Alcohol Services in Rural and Remote Australia*, (pp 1-6). Wagga Wagga: The Gilmour Centre.

Farabee, D., Leukefeld, C.G., & Hays, L. (1998). Accessing Drug-Abuse Treatment: Perceptions of Out-of-Treatment Injectors. *Journal of Drug Issues*, 28(2) 381-394

Farre, M., Mas, A., Torrens, M., Moreno, V., & Cami, J. (2002). Retention rate and illicit opioid use during methadone maintenance interventions: a meta-analysis. *Drug and Alcohol Dependence*, 65, 283-290.

Ferri, C.P., Gossop, M., Rabe-Hesketh, S., & Laranjeira, R.R.(2002). Differences in factors associated with first treatment entry and treatment re-entry among cocaine users. *Addiction*, 97, 825-832.

Festinger, D.S., Lamb, R.J., Kirby, K.C., & Marlowe, D.B. (1996). The accelerated intake: a method for increasing initial attendance to outpatient cocaine treatment. *Journal of Applied Behavioural Analysis*, 29, 387-9.

Fountain, J., Howes, S., & Strang, J. (2003). Unmet drug and alcohol service needs of homeless people in London: A complex issue. *Substance Use and Misuse*, 38(3-6), 377-393.

Frieberg, A. (2000). Australian Drug Courts. *Criminal Law Journal*, 24(4), 213-35.

Friedmann, P.D., Lemon, S.C., Durkin, E.M., & D'Aunno, T.A. (2003). Trends in comprehensive service availability in outpatient drug abuse treatment. *Journal of Substance Abuse Treatment,* 24, 81-88.

Gandhi, D.H., Jaffe, J.H., McNary, S., Kavanagh, G.J., Hayes, M., & Currens, M. (2003). Short-term outcomes after brief ambulatory opioid detoxification with buprenorphine in young heroin users. *Addiction*, 98, 453-462.

Ghodse, A.H., Reynolds, M., Baldacchino, A.M., Dunmore, E., Byrne, S., Oyefeso, A., Clancy, C., & Crawford, V. (2002). Treating an opiate-dependent population: A one-year follow-up study of treatment completers and noncompleters. *Addictive Behaviors*, 27, 765-778.

Gogineni, A., Stein, M.D., Friedman, P.D. (2001). Social relationships and intravenous drug use among methadone maintenance patients. *Drug and Alcohol Dependence*, 64, 47-53.

Gossop, M., Stewart, D., Browne, N., & Marsden, J. (2002). Factors associated with abstinence, lapse or relapse to heroin use after residential treatment: protective effect of coping responses. *Addiction*, 1259-1267

Gowing L., Proudfoot, H., Henry-Edwards, S., & Teesson, M. (2001). *Evidence Supporting Treatment: The Effectiveness of Interventions for Illicit Drug Use*. Canberra: Australian National Council on Drugs.

Grant, B.F. (1996). Barriers to alcoholism treatment: reasons for not seeking treatment in a general population sample. *Journal of Studies on Alcohol*, 58 (4), 366-371.

Hagan, H., McGough, J.P., Thiede, H., Hopkins, S., Duchin, J., & Alexander, R. (2000). Reduced injection frequency associated with increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors. *Journal of Substance Abuse Treatment*, 19, 247-252.

Hall, W. (1997). *The role of legal coercion in the treatment of offenders with alcohol and heroin problems* (Technical Report 44). Sydney: National Drug and Alcohol Research Centre, University of New South Wales.

Hando, J., Topp, L., & Hall, W. (1997). Amphetamine-related harms and treatment preferences of regular amphetamine users in Sydney, Australia. *Drug and Alcohol Dependence*, 46, 105-113.

Hartnoll, R. (1992). Research and the help-seeking process. *British Journal of Addiction,* 87, 429-437.

Hartnoll, R., & Power, R (1989). Why most of Britain's drug users are not looking for help. *Druglink*, 2, 8-9.

Higgins, S.T., Alessi, S.M., & Dantona, R.L. (2002). Voucher-based incentives. A substance abuse treatment innovation. *Addictive Behaviors*, 27, 887-910.

Higgins, K., Cooper-Stanbury, M., & Williams, P/ (2000*) Statistics on drug use in Australia 1998*. AIHW cat. No. PHE 16. Canberra: AIHW (Drug Statistics Series).

Higgins, S.T., & Wong, C.J. (1998). Treating cocaine abuse: what does research tell us. In S.T. Higgins & J.L. Katz (Eds.), *Cocaine Abuse: Behaviour, Pharmacology, and Clinical Applications.* (pp 343-361). San Diego: Academic Press.

Horvath, A.O., & Symonds, B.D. (1991). Relation between working alliance and outcome in psychotherapy: a meta-analysis. *Journal of Counselling Psychology*, 38, 139-49.

Howard, J. (1994). Irrelevant, unapproachable or boring: Treatment issues for drug-using youth. In: J. Ross (Ed), *Health for all? Social justice issues in the alcohol and other drug field.* Proceedings from the Sixth National Drug & Alcohol Research Centre Annual Symposium, Sydney, December 1993. (NDARC Monograph No. 21).

Howland, R.H. (1995). The treatment of persons with dual diagnoses in a rural community. *Psychiatric Quarterly*, 66(1), 33-49.

Hughes, J.R., Riggs, R.L., & Carpenter, M.J. (2001). How helpful are drug abuse help lines? *Drug and Alcohol Dependence*, 62, 191-194.

Hser, Y.I., Grella, M.D., Anglin, D., Longshore, D., & Prendergast, M.L.(1997). Drug treatment careers: A conceptual framework and existing research findings. *Journal of Substance Abuse Treatment*, 14(6), 543-558.

Hser, Y.I., Maglione, M., Polinsky, M.L., Anglin, M.D. (1998). Predicting Drug Treatment Entry among Treatment-Seeking Individuals. *Journal of Substance Abuse Treatment*, 15(3), 213-220.

Hubbard RL, Marsden ME, Rachal JV, Harwood HJ, Cavanaugh ER & Ginsburg HM (1989) *Drug abuse treatment: A national study of effectiveness*. Chapel Hill, NC. University of North Carolina Press.

Jackson, R., Wernicke, R.,& Haaga, D.A.F. (2003). Hope as a predictor of entering substance abuse treatment. Addictive Behaviors, 28, 13-28.

Joe, G.W., Simpson D.D., & Broome, K.M. (1998). Effects of readiness for drug abuse treatment on client retention and assessment of process. *Addiction,* 93(8), 1177-1190.

Joe, G.W., Simpson D.D., Hubbard, R.L. (1991). Treatment predictors of tenure in methadone maintenance. *Journal of Substance Abuse*, 3, 73-84.

John, D., Kwiatkowski, C.F., & Booth, R.E.(2001). Differences among out-of-treatment drug injectors who use stimulants only, opiates only or both: implications for treatment entry. *Drug and Alcohol Dependence*, 64, 165-172.

Judd, L.L. (Chair): National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. (1998). Effective medical treatment of opiate addiction. *Journal of the American Medical Association*, 280(22), 1936-1943.

Kamieniecki, G., Vincent, N., Allsop, S., & Lintzeris, N. (1998) *Models of intervention and care for psychostimulant users*. (Monograph Series No 32) Canberra, ACT: National Centre for Education and Training on Addiction.

Kang, S., Kleinman, P.H., Woody, G.E., Millman, R.B., Todd, T.C., Kemp, J., & Lipton, D.S. (1991). Outcomes for cocaine abusers after once-a-week psychosocial therapy. *American Journal of Psychiatry*, 148, 630-35.

Katz, E.C., Gruber, K., Chutuape, M.A., & Stitzer, M. (2001). Reinforcement-based outpatient treatment for opiate and cocaine abusers. *Journal of Substance Abuse Treatment*, 20, 93-98.

Kirby, K.C., Marlowe, D.B., Lamb, R.J., & Platt, J.J. (1997). Behavioral Treatments of Cocaine Addiction: Assessing Patient Needs and Improving Treatment Entry and Outcome. *Journal of Drug Issues*, 27(2), 417-429.

Klee, H. (1993). HIV risks for women injectors: heroin and amphetamine users compared. *Addiction*, 88, 1055-62.

Klee, H. (ed.) (1997) *Amphetamine Misuse: international perspectives on current trends.* Amsterdam: Harwood Academic Publishers.

Klee, H., & Jackson, M. (1997). *Illicit Drug Use, Pregnancy and Early Motherhood: an analysis of impediments to effective service delivery*. Report to the Department of Health Taskforce to Review Services for Drug Users.

Klee, H., & Morris, J. (1994). Factors that lead young amphetamine users to seek help: implications for drug prevention and harm reduction. *Drugs – Education Prevention & Policy,* 1(3), 289-297.

Kleinman, B.P., Millery, M., Scimeca, M., & Polissar, N.L. (2002). Predicting long term utilisation among addicts entering detoxification: the contribution of help seeking models. *Journal of Drug Issues*, 32(1), 209-230.

Kleyn, J., & Lake, E.S. (1990). Factors associated with willingness to enter drug treatment. Some implications for policy. *AIDS & Public Policy Journal*, 5(3), 112-6.

Knight, D.K., Logan, S.M., & Simpson, D.D. (2001) Predictors of program completion for women in residential substance abuse treatment. *American Journal of Drug & Alcohol Abuse*. 27(1), 1-18.

Koester, S., Anderson, K., Hoffer, L. (1999) Active heroin injectors' perceptions and use of methadone maintenance treatment: cynical performance or self-prescribed risk reduction? *Substance Use & Misuse*. 34(14):2135-53.

Kuo, I., Brady, J., Butler, C., Schwartz, R., Brooner, R., Vlahov, D., & Strathdee, S.A. (2003). Feasibility of referring drug users from a needle exchange program into an addiction treatment program. Experience with a mobile treatment van and LAAM maintenance. *Journal of Substance Abuse Treatment*, 24, 67-74.

Kwiatkowski, C.F., Booth, R.E., & Lloyd, L.V. (2000). The effects of offering free treatment to street-recruited opioid injectors. *Addiction*, 95(5), 697-704.

Luchansky, B., He, L., Krupski, A., & Stark, K.D. (2000). Predicting readmission to substance abuse treatment using state information systems. The impact of client and treatment characteristics. *Journal of Substance Abuse*, 12, 255-270.

MacDonald, M., & Zhou, J. (2002). *Prevalence of HIV, HCV and injecting and sexual behaviour among IDU at Needle and Syringe Programs: Australian NSP Survey: National Data Report 1995-2001*. Sydney: National Centre in HIV Epidemiology and Clinical Research.
McCarty, D., Caspi, Y., Panas, L., Krakow, M., & Mulligan, D. (2002). Detoxification centers: who is in the revolving door? *Journal of Behavioral Health Services Research*, 27, 245-256.

McCoy, C.B., Metsch, L.R., Chitwood, D.D., & Miles, C. (2001). Drug Use and Barriers to use of Health Care Services. *Substance Use & Misuse*, 36(6&7), 789-806.

McLellan, A.T., Arndt, I.O., Metzger, D.S., Woody, G.E., & O'Brien, C.P. (1993). The effects of psychosocial services in substance abuse treatment. *Journal of the American Medical Association*, 269, 1953-9.

Marlatt, G.A., Tucker, J.A., Donovan, D.M. & Vuchinich, R.E. (1997). Help-seeking by substance–abusers: the role of harm reduction and behavioural-economic approaches to facilitate treatment entry and retention. In L.S. Onken, J.D. Blaine & J.J. Boren, *Beyond the Therapeutic Alliance: Keeping the Drug Dependent Individual in Treatment*. NIDA Research Monograph 165. US Department of Health & Human Services.

Mark, T.L., Dilonardo, J.D., Chalk, M., & Coffey, R.M. (2002). Trends in inpatient detoxification services, 1992-1997. *Journal of Substance Abuse Treatment,* 23, 253-260.

Metsch, L.R., & McCoy, C.B. (1999). Drug Treatment Experiences: Rural and Urban Comparisons. *Substance Use & Misuse*, 34(4&5), 763-784.

Mejta, C.L., Bokos, P.J., Mickenberg, J., Maslar, M.E., & Senay, E. (1997). Improving Substance Abuse Treatment Access and Retention Using a Case Management Approach. *Journal of Drug Issues*, 27(2) 329-340.

Miller, W.R., & Rollnick, S. (Eds.) (1991). *Motivational Interviewing: Preparing People to Change Addictive Behaviour*. New York: Guildford.

Millery, M., Kleinman, B.P., Polissar, N.L., Millman, R.B., & Scimeca, M. (2002). Detoxification as a gateway to long-term treatment: assessing two interventions. *Journal of Substance Abuse Treatment,* 23, 183-190.

Mitchell, P., Spooner, C., Copeland, J., Vimpani, G., Toumbourou, J., Howard, J., & Sanson, A. (2001). *The Role of Families in the Development, Identification, Prevention and Treatment of Illicit Drug Problems.* A Literature Review prepared for the National Illicit Drug Strategy Working Committee and the National Health and Medical Research Council. Canberra: NHMRC.

Morgan, P., Beck, J., Joe, K., McDonnell, D., & Guiterrez, R. (1994). *Ice and other methamphetamine use*. Final report to the National Institute on Drug Abuse. Rockville. MD: National Institute of Health.

Morgan, P., & Beck, J. (1997). The legacy and the paradox: hidden contexts of methamphetamine use in the United States. In H. Klee (ed.), *Amphetamine Misuse: international perspectives on current trends*. Amsterdam: Harwood Academic Publishers.

MSIC Evaluation Committee. (2003). Final report on the evaluation of the Sydney Medically Supervised Injecting Centre. Sydney: authors.

Noble, A., Best, D., Man, L.. Gossop, M., & Strang, J. (2002). Self-detoxification attempts among methadone maintenance patients. What methods and what success? *Addictive Behaviors*, 27, 575-584.

Oppenheimer, E., Sheehan, M., & Taylor, C. (1988). Letting the client speak: Drug misusers and the process of seeking help. *British Journal of Addiction,* 83, 635-647.

Poane, D., Clark, J., Shi, Q., Purchase, D., & Des Jarlais, D.C. (1999). Syringe exchange programs in the United States, 1996: a national profile. *American Journal of Public Health*, 89, 43-46.

Pollack, M..H., Penava, S.A., Bolton, E., Worthington, J.J., Allen, G.L., Farach, F.J., & Otto, M.W. (2002). A novel cognitive-behavioral approach for treatment-resistant drug dependence. *Journal of Substance Abuse Treatment*, 23, 335-342.

Power, R., Hartnoll, R., & Chalmers, C. (1992). Help-seeking among illicit drug users: some differences between treatment and non-treatment sample. *The International Journal of the Addictions*, 27(8), 887-904.

Penrose-Wall, J., Copeland, J., & Harris, M. (2000). *Shared Care of Illicit Drug Problems by General Practitioners & Primary Health Care Providers: A Literature Review*. Canberra: Commonwealth Department of Health & Aged Care.

Prendergast, M.L., Podus, D., & Chang, E. (2000). Program factors and treatment outcomes in drug dependence treatment: An examination using meta-analysis. *Substance Use and Misuse*, 35(12-24), 1931-1965.

Prochaska, J.O., & DiClemente, C.C. (1986). Toward a comprehensive model of change. In W.R. Miller & N. Heather (Eds.), *Treating Addictive Behaviours* (pp 3-27). New York: Plenum Press.

Prochaska, J.O., DiClimente, C.C., & Norcross, J.C. (1992). In search of how people change: applications to addictive behaviours. *American Psychologist,* 47(9) 1102-1114.

Proudfoot, H., & Teesson, M. (2000). *Investing in Drug & Alcohol Treatment*. NDARC Technical Report No. 91. Sydney: NDARC.

Rawson, R.A., Gonzales, R., & Brethen, P. (2002). Treatment of methamphetamine use disorders: an update. *Journal of Substance Abuse Treatment*, 23, 145-150.

Reid, G., Crofts, N., & Hocking, J. (2000). *Needs Analysis for Primary Health Care among the Street Drug-using Community in Footscray*. Melbourne: The Centre for Harm Reduction, Macfarlane Burnet Centre for Medical Research.

Reid, G., Crofts, N., & Beyer, L. (2001). Drug Treatment Services for Ethnic Communities in Victoria, Australia: an examination of cultural and institutional barriers. *Ethnicity & Health*, 6(1), 13-26.

Riehman, K.S., Iguchi, M.Y., Zeller, M., & Morral, A.R. (2003). The influence of partner drug use and relationship power on treatment engagement. *Drug and Alcohol Dependence,* 70, 1-10.

Ritter, A. & Berends, L. (2003). Service System Review. Discussion paper no 1. Defining the Victorian Drug and Alcohol Treatment Service System. Melbourne: Turning Point Alcohol and Drug Centre

Robles, E., Stitzer, M.L., Strain, E.C., Bigelow, G.E., & Silverman, (2002). Voucher-based reinforcement of opiate abstinence during methadone detoxification. *Drug and Alcohol Dependence*, 65, 179-189.

Rounsaville, B., & Kleber, H. (1985). Untreated opiate addicts: How do they differ from those seeking treatment? *Archives of General Psychiatry*, 42, 1072-77.

Rounsaville, B.J., & Kosten, T.R. (2000). Treatment of opioid dependence: quality and access. *Journal of the American Medical Association*, 283(10),1337-1339.

Shah, N.G., Celentano, D.D., Vlahov, D., Stambolis, V., Johnson, L., Nelson, K.E., & Strathdee, S.A. (2000). Correlates of enrollment in methadone maintenance treatment programs differ by HIV-serostatus. *AIDS*, 14, 2035-2043.

Shand, L., & Mattick, R.P. (2001). *Clients of treatment service agencies: May 2001 census findings*. Sydney: NDARC.

Shand, F., & Mattick, R. P. (2002). Results from the 4th National Clients of Treatment Service Agencies census: changes in clients' substance use and other characteristics. *Australian & New Zealand Journal of Public Health, 26*, 352-357.

Sheaves, F., Preston, P., O'Neil, E., Klein, G., & Hart, K. (2001). That's SIC: mobilising youth for hepatitis C prevention. *Health Promotion Journal of Australia,* 12, 217-222.

Shearer, J., Wodak, A., Mattick, R.P., van Beek, I., Lewis, J., Hall, W., & Dolan, K. (1999). *A randomised controlled trial of the feasibility of monitoring controlled prescribing of dexamphetamine*. Technical Report No. 75. National Drug & Alcohol Research Centre. Sydney: NDARC.

Siegal, H.A., Falck, R.S., Wang, J., & Carlson, R.G. (2002). Predictors of drug abuse treatment entry among crack-cocaine smokers. *Drug and Alcohol Dependence*, 68, 159-166.

Single, E., & Rohl, T. (1997). *The National Drug Strategy: Mapping the future. An evaluation of the National Drug Strategy 1993-1997: A report commissioned by the Ministerial Council in Drug Strategy*. Canberra: Australian Government Publishing Service.

Simpson, D.D., Joe, G.W., Rowan-Szal, G.A., & Greener, J.M. (1997). Drug abuse treatment process components that improve retention. *Journal of Substance Abuse Treatment*, 14, 565-72.

Simpson, D.D. (2000). *TCU Model of Treatment Process and Outcomes.* Research Summary: Focus on treatment process and outcomes. Institute of Behavioural Research, Texas Christian University. Available from: www.ibr.tcu.edu

Sindelar, J.L., & Fiellin, D.A. (2001). Innovations in treatment for drug abuse: solutions to a public health problem. *Annual Review of Public Health*, 22, 249-72.

Smith, B.D., & Marsh, J.C. (2002). Client service marching in substance abuse treatment for women with children. *Journal of Substance Abuse Treatment*, 22, 161-168.

Spooner, C., Mattick, R., Howard, J. (1996). *The nature and treatment of adolescent substance abuse*. National Drug & Alcohol Research Centre, Monograph Number 26. Sydney: NDARC.

Spooner, C., Hall, W., & Mattick, R. (2001). An overview of diversion strategies for Australian drug-related offenders. *Drug & Alcohol Review,* 20(3), 281-94.

Sorenson, J.L., Costantini, M.F., Wall, T.L., & Gibson, D.R. (1993). Coupons attract high-risk untreated heroin users into detoxification. *Drug & Alcohol Dependence*, 31, 247-52.

Stanton, D. (1997). The role of Family and Significant Others in the Engagement and Retention of Drug-Dependent Individuals. In L.S. Onken, J.D. Blaine & J.J. Boren. *Beyond the Therapeutic Alliance: Keeping the Drug Dependent Individual in Treatment*. USA:NIDA.

Stark, M.J., Campbell, B.K., & Brinkerhoff, C.V. (1990) 'Hello, may we help you?' A study of attrition prevention at the time of the first phone contact with substance-abusing clients. *American Journal of Drug & Alcohol Abuse*,16, 67-76

Stark, M.J. (1992) Dropping out of substance abuse treatment: a clinically oriented review. *Clinical Psychology Review*, 12, 93-116.

Swift, W., & Copeland, J. (1996). Treatment and Experiences of Australian Women with Alcohol and Other Drug Problems. *Drug & Alcohol Dependence*, 40(3), 211-219.

Taplin, S.A. (2000) *Factors affecting retention on methadone maintenance programs.* Doctoral dissertation. Sydney: Department of Public Health & Community Medicine, University of Sydney.

Topp, et al., (2001*) Australian Drug Trends 2000: Findings of the Illicit Drug Reporting System* (IDRS) NDARC Monograph No. 47. Sydney: NDARC.

Topp, L., Day, C., & Degenhardt, L. (2003). Changes in patterns of drug injection concurrent with a sustained reduction in the availability of heroin in Australia. *Drug & Alcohol Dependence,* 70(3), 275-286.

Toumbourou, J.W., Hamilton, M., U'Ren, A., Steven-Jone, P., & Storey, G. (2002). Narcotics Anonymous participation and changes in substance use and social support. *Journal of Substance Abuse Treatment*, 23, 61-66.

Toumbourou, J., Hamilton, M., & Fallon, B. (1998). Treatment level progress and time spent in treatment in the prediction of outcomes following drug-free therapeutic community treatment. *Addiction*, 93(7), 1051-1064.

United Kingdom Government. (1998). *Tackling Drugs to Build a Better Britain*. London: HMSO (Cm.3945).

Varney, S.M., Rohsenow, D.J., Dey, A.N., Myers, M.G., Zwick, W.R., & Monti, P.M. (1995). Factors Associated with Help Seeking and Perceived Dependence among Cocaine Users. *American Journal of Drug & Alcohol Abuse*, 21(1), 81-91.

Victorian Government. (2000). *Drugs in a Multicultural Community – An Assessment of Involvement*. Melbourne: Victorian Government Publishing Service.

Weatherburn, D., & Lind, B. (2001). Street-level drug law enforcement and entry into methadone maintenance treatment. *Addiction,* 96(4), 577-87.

Waldorf, D. (1983). Natural recovery from opiate addiction: some social-psychological processes of untreated recovery. *Journal of Drug Issues*, 13, 237-80.

Walters, G.D. (2000). Spontaneous remission from alcohol, tobacco, and other drug abuse: seeking quantitative answers to qualitative questions. *American Journal of Drug & Alcohol Abuse*, 26(3), 443-60.

Walton, M.A., Blow, F.C., Bingham, R., & Chermack, S.T. (2003). Individual and social/environmental predictors of alcohol and drug use 2 years following substance abuse treatment. Addictive Behaviors, 28, 627-642.

Wells, E.A., Fleming, C., Calsyn, D.A., Jackson, T.R., & Saxon, A.J. (1995). Users of free treatment slots at a community-based methadone maintenance clinic. *Journal of Substance Abuse Treatment*, 12, 13-18.

Wasserman, D.A., Stewart, A.L., & Delucchi, K.L. (2001). Social support and abstinence from opiates and cocaine during opioid maintenance treatment. *Drug and Alcohol Dependence,* 65, 65-75.

Watkins, K.E., Shaner, A., & Sullivan, G. (1999). Addictions services: the role of gender in engaging the dually diagnosed in treatment. Commu*nity Mental Health Journal*, 35, 115-126.

Weatherburn, D., Jones, C., Freeman, K., & Makkai, T. (2003). Supply control and harm reduction: lessons from the Australian heroin 'drought'. *Addiction*, 98, 83-91.

Weisner, C., Mertens, J., Tam, T., & Moore, C. (2001). Factors affecting the initiation of substance abuse treatment in managed care. *Addiction*, 96(5), 705-16.

Wenger, L.D., & Rosenbaum, M. (1994). Drug treatment on demand – not. *Journal of Psychoactive Drugs*, 26 (1), 1-11.

Williams, P. (2001). Illicit drug use in regional Australia, 1988-1998. *Trends and Issues*, No 192. Canberra: Australian Institute of Criminology.

Winett, T., King, A., & Altman, D. (1989). *Health psychology and public health: An integrative approach*. Elmsford, NY: Pergamon.

Woody, G., O'Hare, K., Mintz, J., & O'Brien, C. (1975). Rapid intake: a method for increasing retention rate of heroin addicts seeking methadone treatment. *Comparative Psychiatry*, 16, 165-9.

Woody, G.E., Luborsky, L., McLellan, A.T., O'Brien, C.P., Beck, A.T., Blaine, J., Herman, I., & Hole, A. (1983). Psychotherapy for opiate addicts. Does it help? *Archives of General Psychiatry*, 40, 639-653.

Wong, J.G., Kraus, M.L., Feinberg, M.A., & Fiellin, D.A. (2003). Providing opioid agonist maintenance therapy in a generalist's office: the physician's perspective. Substance Abuse, 24(1), 1-3.

Wright, S., Klee, H.,. & Reid, P. (1999). Attitudes of amphetamine users towards treatment services. *Drugs: Education, Prevention & Policy*, 6(1), 71-86.