

# Clinical Care Packages in a Nationally Agreed Drug and Alcohol Health Services Planning Model

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# What are Care Packages?

- The development of care packages can be seen across sectors. For example -
  - Community Aged Care Packages (CACPs) are individually planned and coordinated packages of care tailored to help older Australians remain living in their own homes.
  - Mental health - flexible care packages for patients with severe mental illnesses, implemented as part of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Program.
  - Mental Health Clinical Care and Prevention (MH-CCP) is designed to calculate the resources required (full time equivalent staff, beds) to provide an agreed level of mental health care for a population.

# What are AOD Care Packages?

- Search of the internet for alcohol care packages revealed 



 There was no drug care package, although you can get a nice junk food package, a tobacco package and even a marijuana care package



- These are not the same as the Drug and Alcohol Clinical Care and Prevention (DA-CCP) model

# Why the interest in care packages?

- There is currently no nationally agreed population based model for drug and alcohol service planning.
- In 2001 NSW Health developed a model for estimating mental health service need and demand. The model is called the Mental Health and Clinical Care and Prevention (MH-CCP) model and has been favourably reviewed in international literature\*
- In 2007 the Australian Burden of Disease study (AusBoD) was published and showed Mental Disorders accounted for 13.3% (ranking 3<sup>rd</sup>) for total health loss and highest at 24.2% for non-fatal health loss.

\* Pirkis J. Harris M. Buckingham W. Whiteford H. Townsend-White C. International planning directions for provision of mental health services. *Administration & Policy in Mental Health*, 2007; 34(4):377-87.

# Why the interest in care packages?

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- In 2008-09 the Mental Health & Drug & Alcohol Office of NSW Health revised the MH-CCP model and incorporated AusBoD epidemiological estimates
- In 2009 MHDAO proposed to IGCD that this “CCP” modelling could be adapted to Drug & Alcohol service planning, and the DA-CCP project began
- Important factor – the community would expect the Government to know what is needed in terms of service delivery

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

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- The project was commissioned early in 2010 by the Ministerial Council on Drug Strategy through the Intergovernmental Committee on Drugs (IGCD) as a project under the cost shared funding model (CSFM)
- The Mental Health and Drug & Alcohol Office within the NSW Department of Health is the lead agency
- It is based on a modelling process developed in NSW for mental health services planning<sup>1</sup> in 2000.

1. Pirakis J. Harris M. Buckingham W. Whiteford H. Townsend-White C. International planning directions for provision of mental health services. *Administration & Policy in Mental Health*, 2007; 34(4):377-87.

# Steering Committee

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- The project is overseen by the DA-CCP Steering Committee which provides final decisions on all matters related to the model.
- The representatives on this committee include:
  - One health official from each state and territory
  - Two health officials from the Dept of Health and Ageing, i.e. OATSIH and Drug Strategy Branch
- The co-chairs of the Steering Committee are David McGrath, Director, Mental Health and Drug & Alcohol Programs, NSW Health, and Simon Cotterell, Assistant Secretary, Drug Strategy Branch, Department of Health and Ageing
- The SC meets via teleconference for 1-2 hours twice a year.

# Expert Reference Group

- The DA-CCP Expert Reference Group provides advice on the clinical and technical information to go into the model. Representatives include:
  - One health official from each state and territory (Susan Alarcon & James Hunter, WA)
  - Two health officials from the Dept of Health and Ageing, i.e. OATSIH and Drug Strategy Branch
  - One representative from Australian Chapter of Addiction Medicine (AChAM), ADCA, ANCD (Garth Popple), ATCA (Lynne Magor-Blatch)
  - To further assist in the development of the Indigenous Care package – Dennis Grey, Deputy Director NDRI, has also recently been appointed to the ERG
- Associate Professor Alison Ritter, NDARC, is the chair
- The ERG meets face to face at least four times a year – with some groups (e.g. ATCA Board) meeting as required to develop packages between meetings

# Aim and objectives

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- To build the first national population based model for drug and alcohol service planning. This was to be endorsed by the MCDS – at this stage the endorsement process is unclear following the MCDS communiqué of 25 February.
- To use standard epidemiological, clinical and service use information to estimate the need and demand for services.
- To use clinical evidence and expert consensus to specify the care packages required by individuals and groups.
- To calculate the resources needed to provide these care packages, for example FTE staff per 100,000 population, and the beds/ treatment places per 100,000 population.

# Expected benefits

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- Provide transparency and consistency across all jurisdictions for estimating the need and demand for drug and alcohol services - across the spectrum from prevention and early intervention to the most intensive treatment.
- Provide the same basis for all jurisdictions to estimate the gap between current need being met, and the resources required to fill that gap.
- For example – if the model predicts that we need say 200 treatment places per 100,000 population and there are only 80 current places, then it can be argued that we are only meeting 40% of need.
- The development of a national model that can be adapted for use within each Australian jurisdiction.

# The national model is able to provide ...

- Standardised “Australian average” estimates of need and demand for a range of agreed D&A services per 100,000 people across the whole age range, and across the continuum of care from prevention to tertiary treatment.
- Estimates of the staffing, beds, and treatment places per 100,000 age-specific population to meet the estimated demand.
- Estimates of the outputs to be expected from the resources.
- A template that individual jurisdictions can adapt to address regional and other variations as needed.
- A standard reference point for planning information.

# The national model is able to provide ...

- Comprehensive documentation of the evidence underlying the parameters used in the model so that it can be modified as new evidence becomes available, and adapted to local evidence – this is the “Technical Manual”.
- An Excel spreadsheet with the details of the modelling.
- An Excel “calculator” that applies the model to population projections in a convenient manner, and a “User Manual” for it.



# The model cannot provide ...

- A resource distribution formula that incorporates the characteristics of regional populations – it is an “Australian average” model only.
- That said, the model does provide the opportunity to develop unique care packages for specific population groups, using a model based on the weighting of jurisdictional outputs.
- The model also incorporates the notion of Mild, Moderate and Severe – and in some areas (e.g. residential rehabilitation) there is an additional weighting for complex clients.

# The template of the model

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- The Drug and Alcohol Clinical Care and Prevention (DA-CCP) model has 8 panels, and has a logical flow from top to bottom and from left to right.
- The left to right flow of the model shows the Clinical Care and Prevention (CCP) aspect to the model. This CCP spectrum is retained in all 8 panels of the model from top to bottom.

# Some preliminary comments

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- Model is based on the population or notional 'town' of 100,000 people who are of a specified age e.g. 18-64 years
- We make an assumption that every 'town' of 100,000 people is the same. Hence we model a standard 'town' of 100,000 people.
- Typically the estimates generated by the model are applied to much larger geographical areas e.g. the adult population (aged 18-64) in NSW is approximately 4.2 million based on the 2006 census. Hence the estimates generated by the model (using a population of 100,000) are multiplied by 42 when applied to the adult population of NSW.

# Scope

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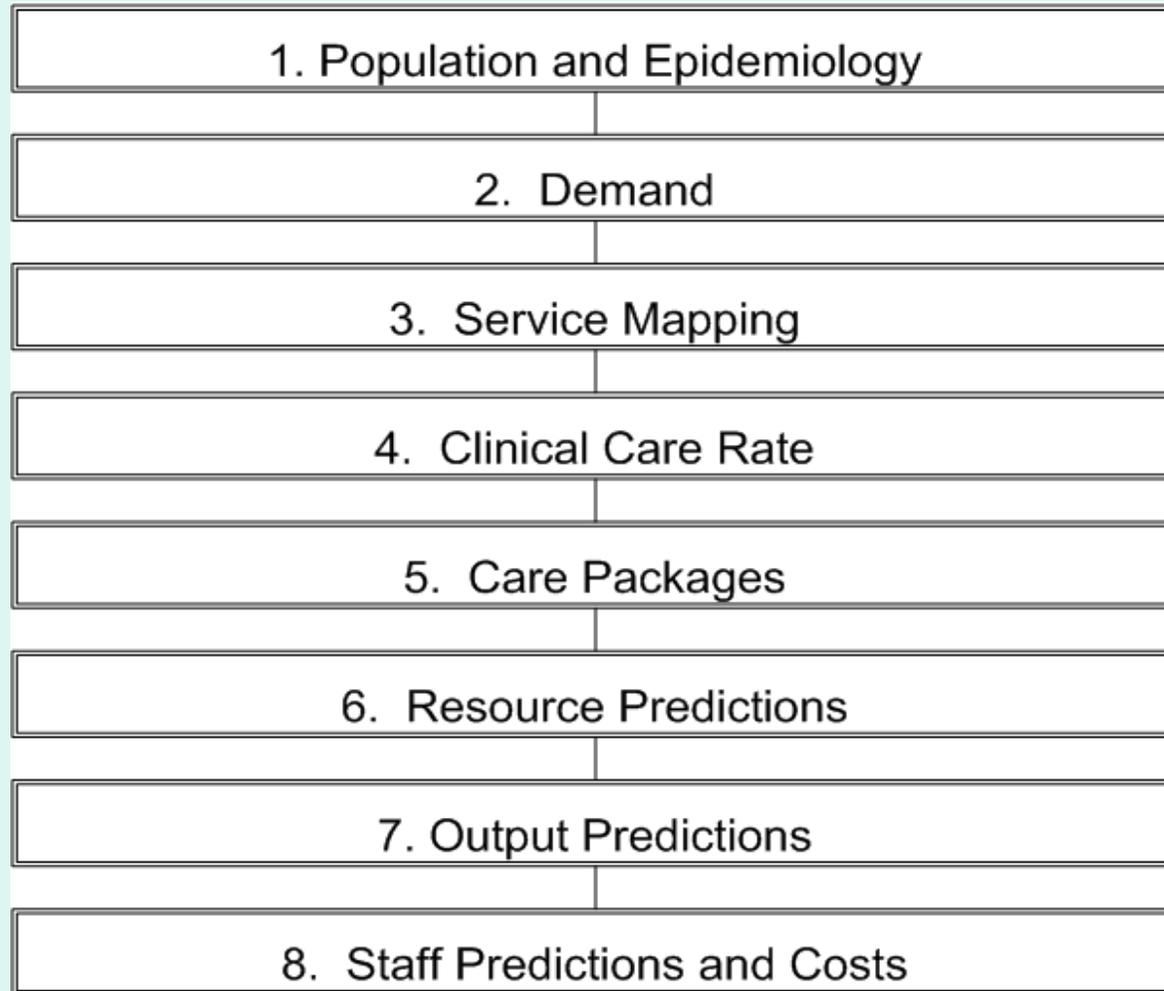
- A broad range of service settings, including:
  - Outpatient, community based treatment
  - Community outreach services
  - Inpatient, hospital based treatment
  - Inpatient, community based treatment
  - Primary care services (eg. GPs, youth)
  - Prisons
- All Sectors:
  - Public, non-government & private service providers
- All alcohol and other drug services regardless of funding source

# Scope

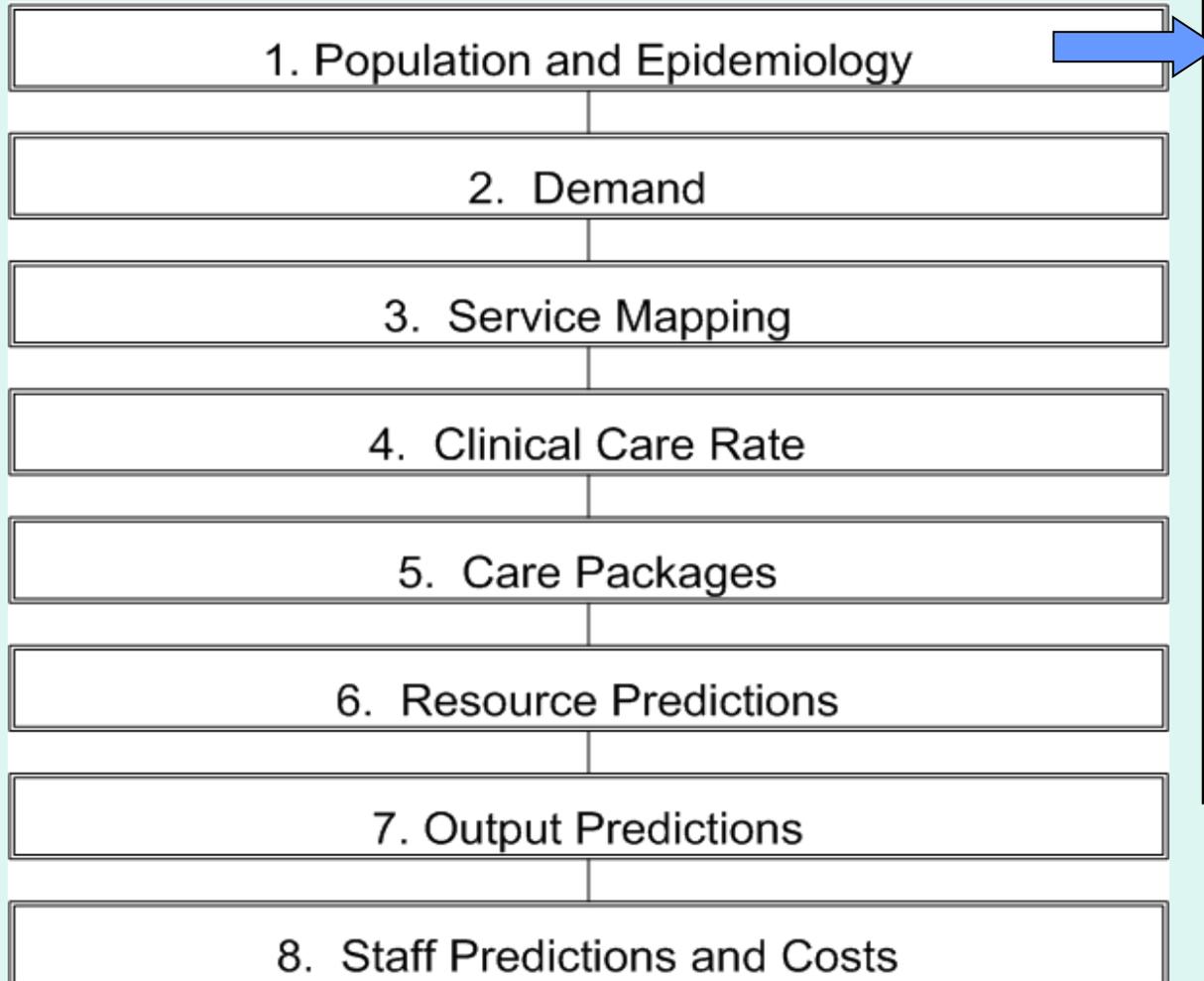
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- Importantly – it is agreed that the model is about **what ‘should be’**, not what currently is.
- ‘Should be’ is defined as the sufficient numbers of treatment places and evidence-informed care packages.
- Treatment numbers are to be based on what should be, and that the model counts people and not episodes.
- Care packages to be best practice/ evidence based. In the absence of best practice / evidenced based, then “Toyota” (rather than Ferrari) care packages that are adequate or sufficient will be developed. Care packages will not be developed using a guiding principle of what is currently received.

# The DA-CCP Template

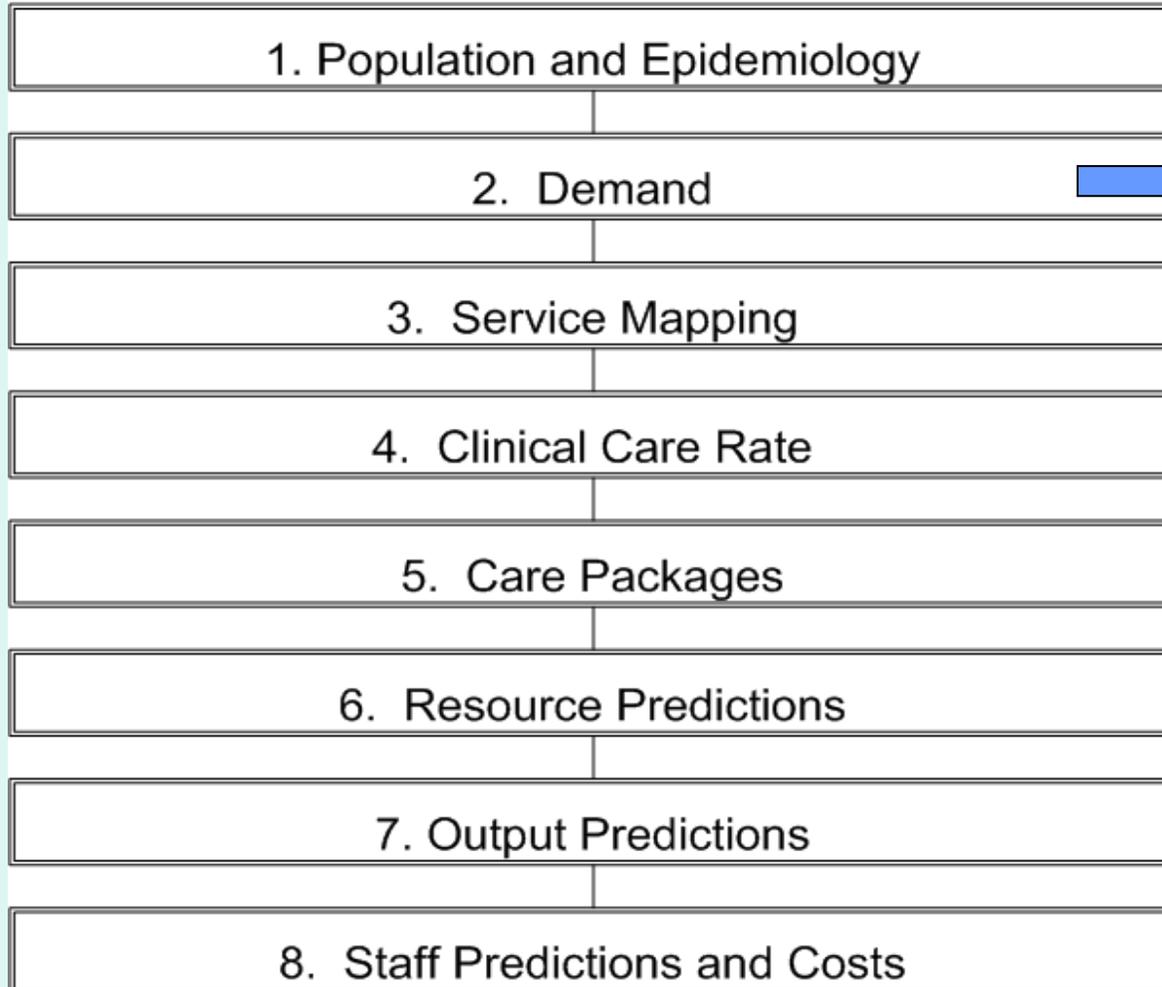


# The DA-CCP Template



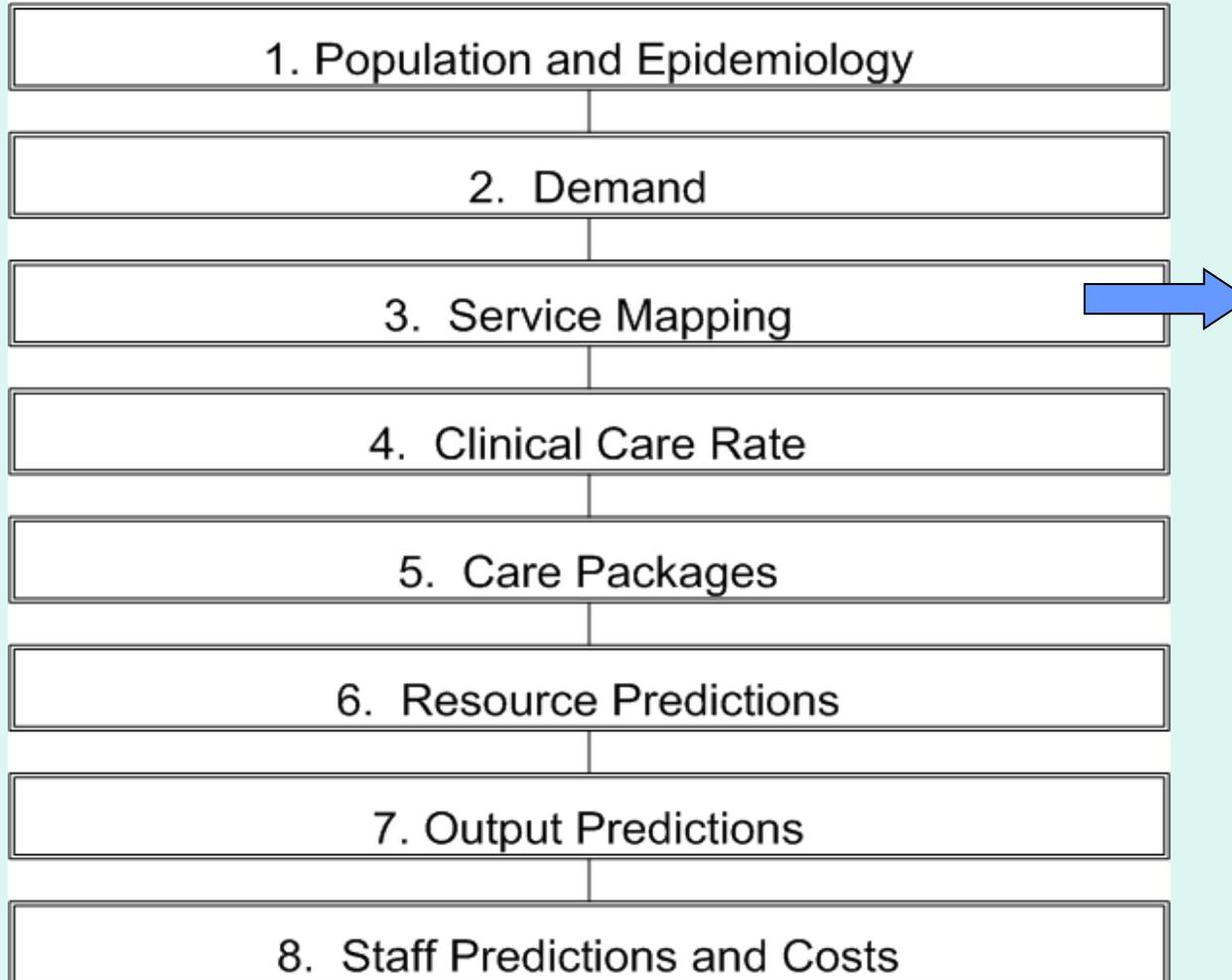
- Based on a notional town of 100,000 people
- The majority (approx 85%) of the people in the town are well
  - Promotion & prevention services
- A minority (approx 15%) have health problems
  - Receive clinical care ranging from mild to most intense

# The DA-CCP Template



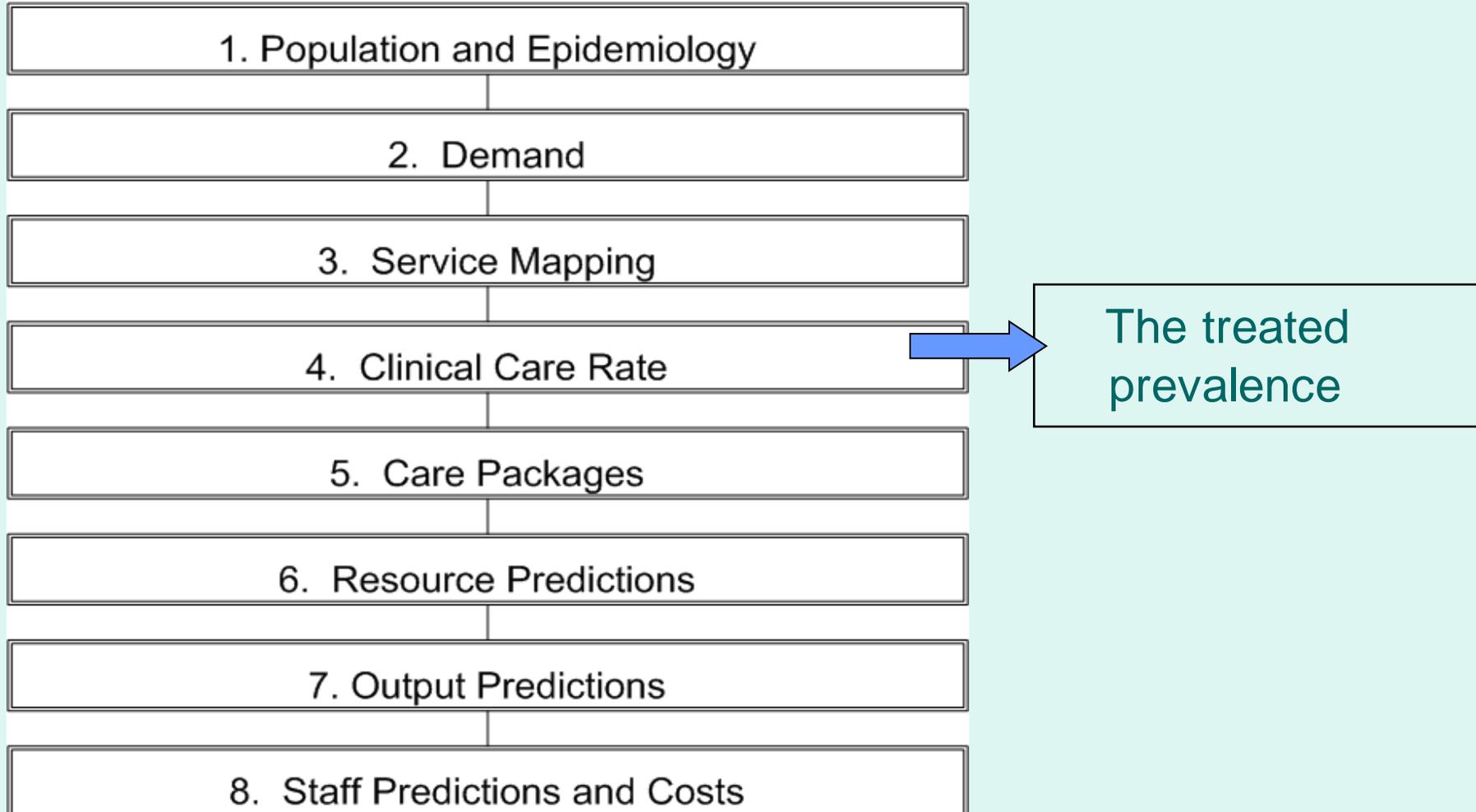
- Recognises that not all people in need of clinical care will demand it, or perceive a need for it.

# The DA-CCP Template

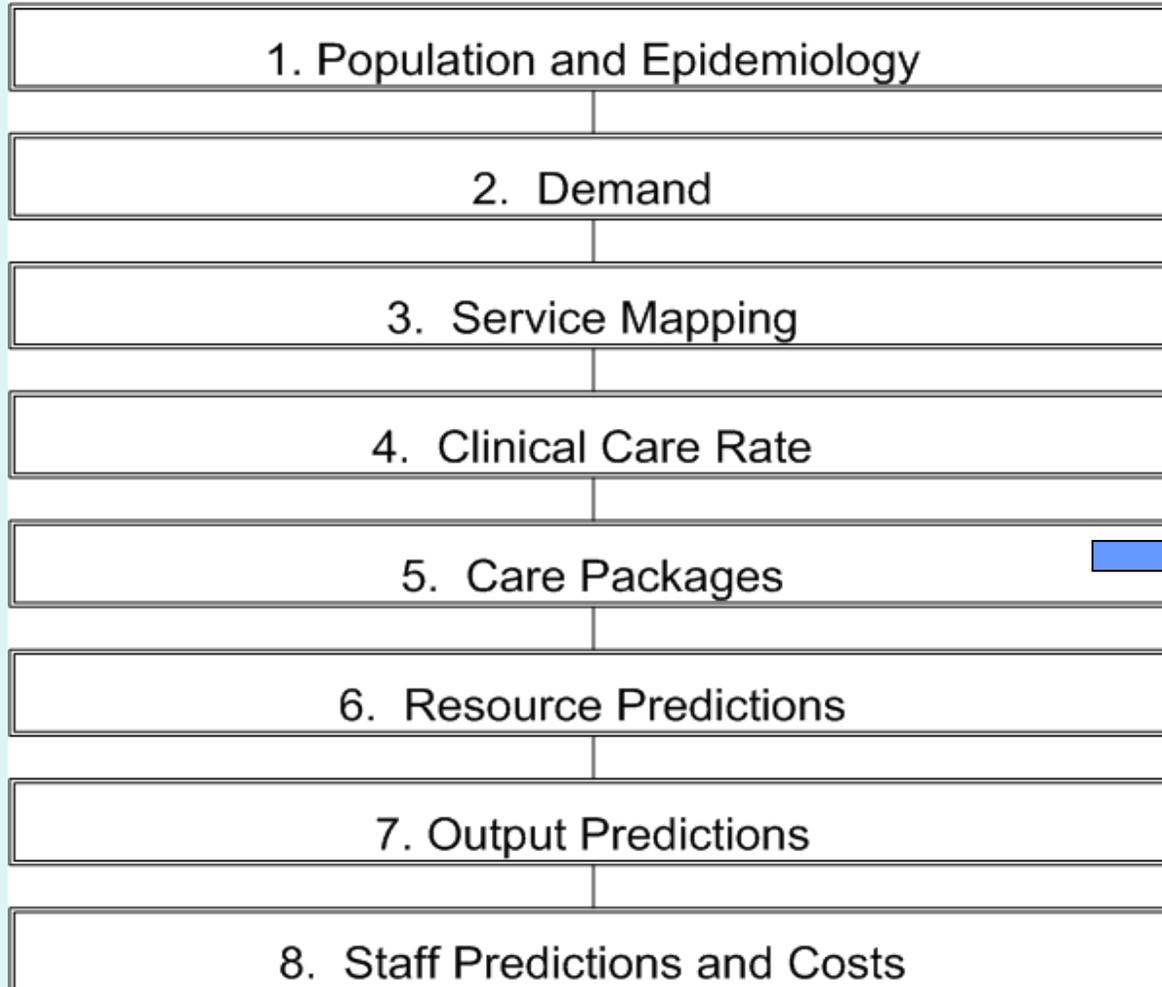


- Identification of the kind of services provided across the spectrum of clinical care, from mild to severe problems, eg:
  - Screening
  - Assessment
  - Brief intervention
  - Counselling
  - Aftercare
  - Outpatient withdrawal
  - Hospital withdrawal
  - Community Residential withdrawal
  - Community Residential rehabilitation

# The DA-CCP Template

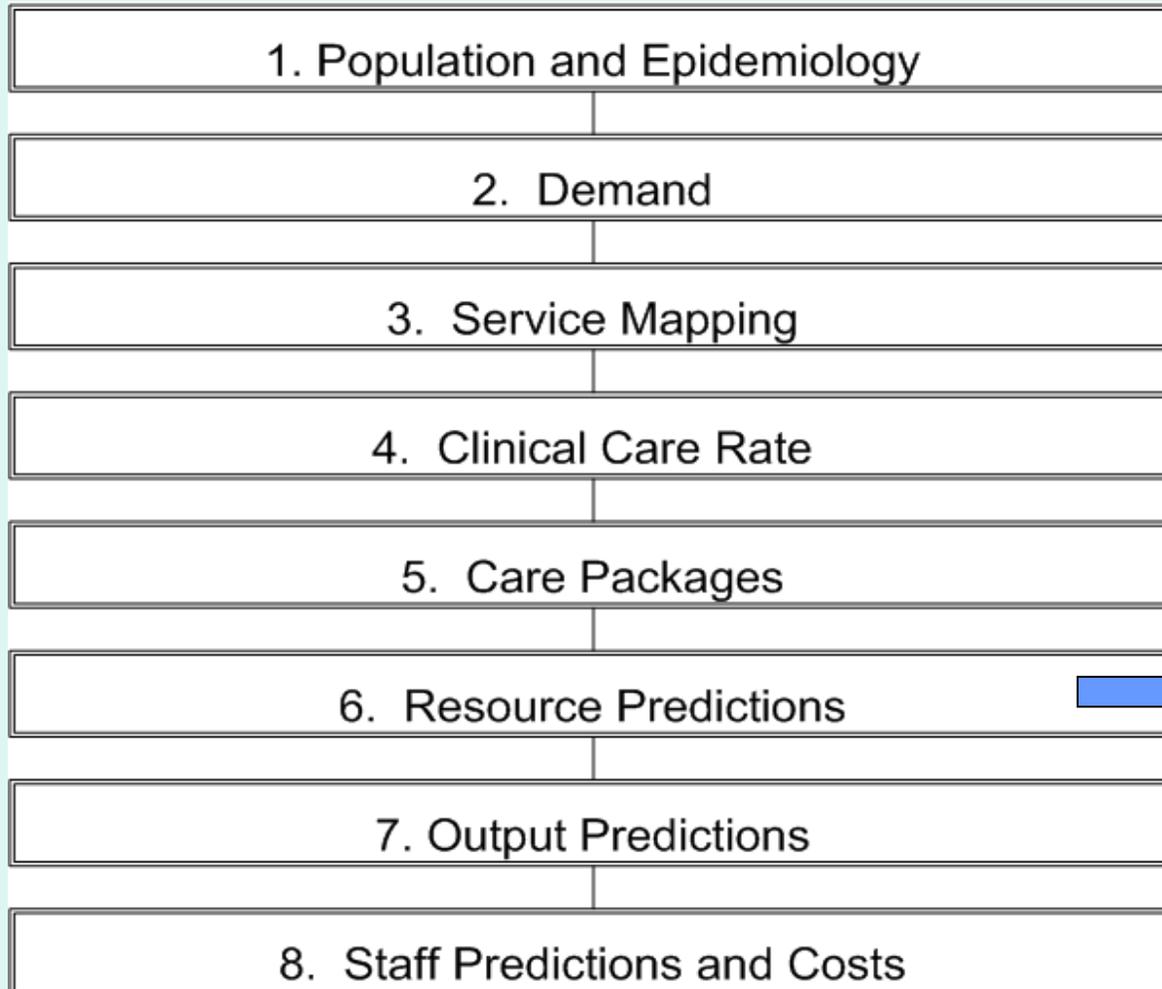


# The DA-CCP Template



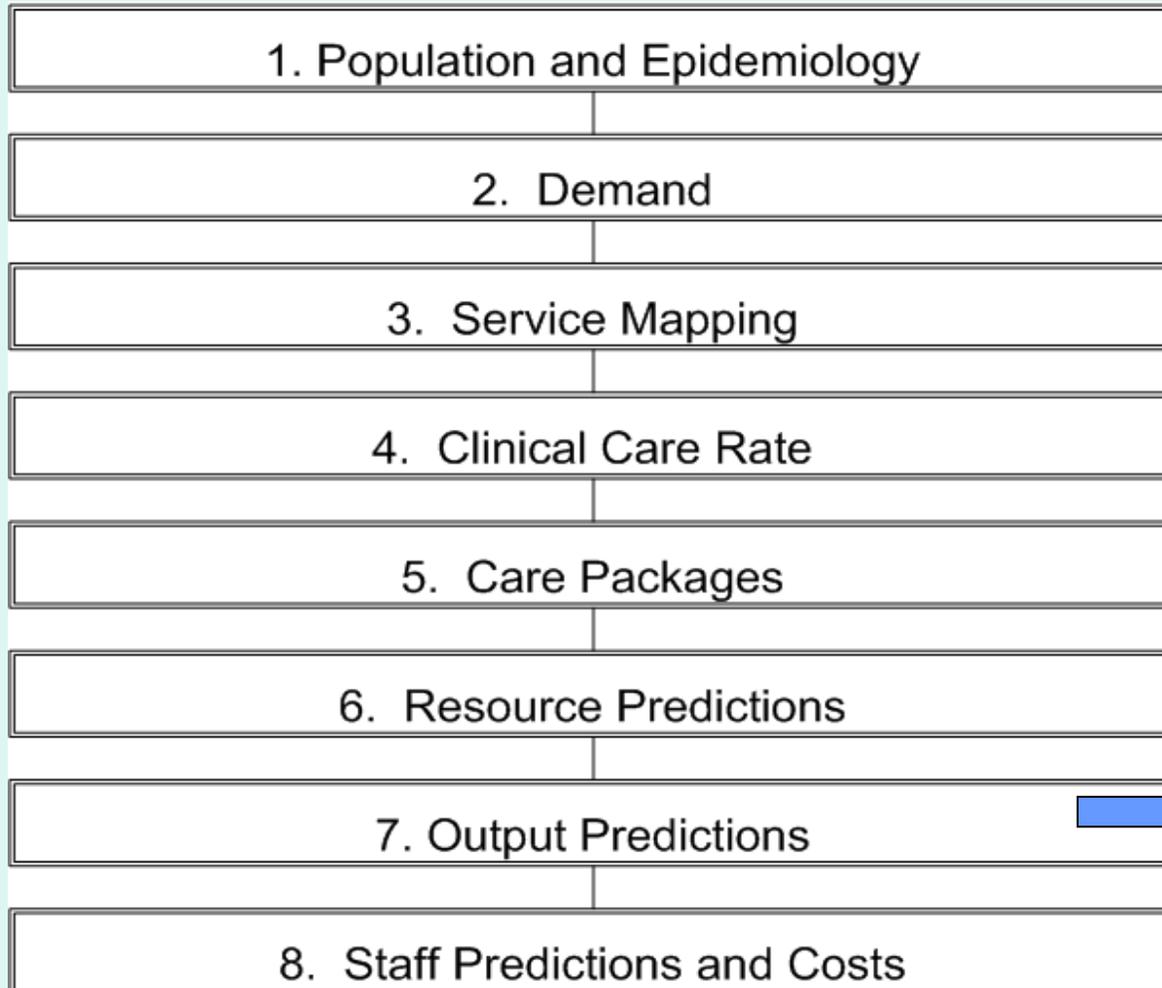
- Specifies the care for a person for a year with a specific need
- The level of care that is specified is adequate, anything less would be unsatisfactory
- Level of care is specified in terms of:
  - (1) Community-based care:  
*frequency & duration* of service delivered for an individual or a group  
eg. 1x 60 min assessment
  - (2) Treatment facility:  
*average length of stay* in a facility which may range from days to weeks  
eg. 1 x 90 day admission

# The DA-CCP Template



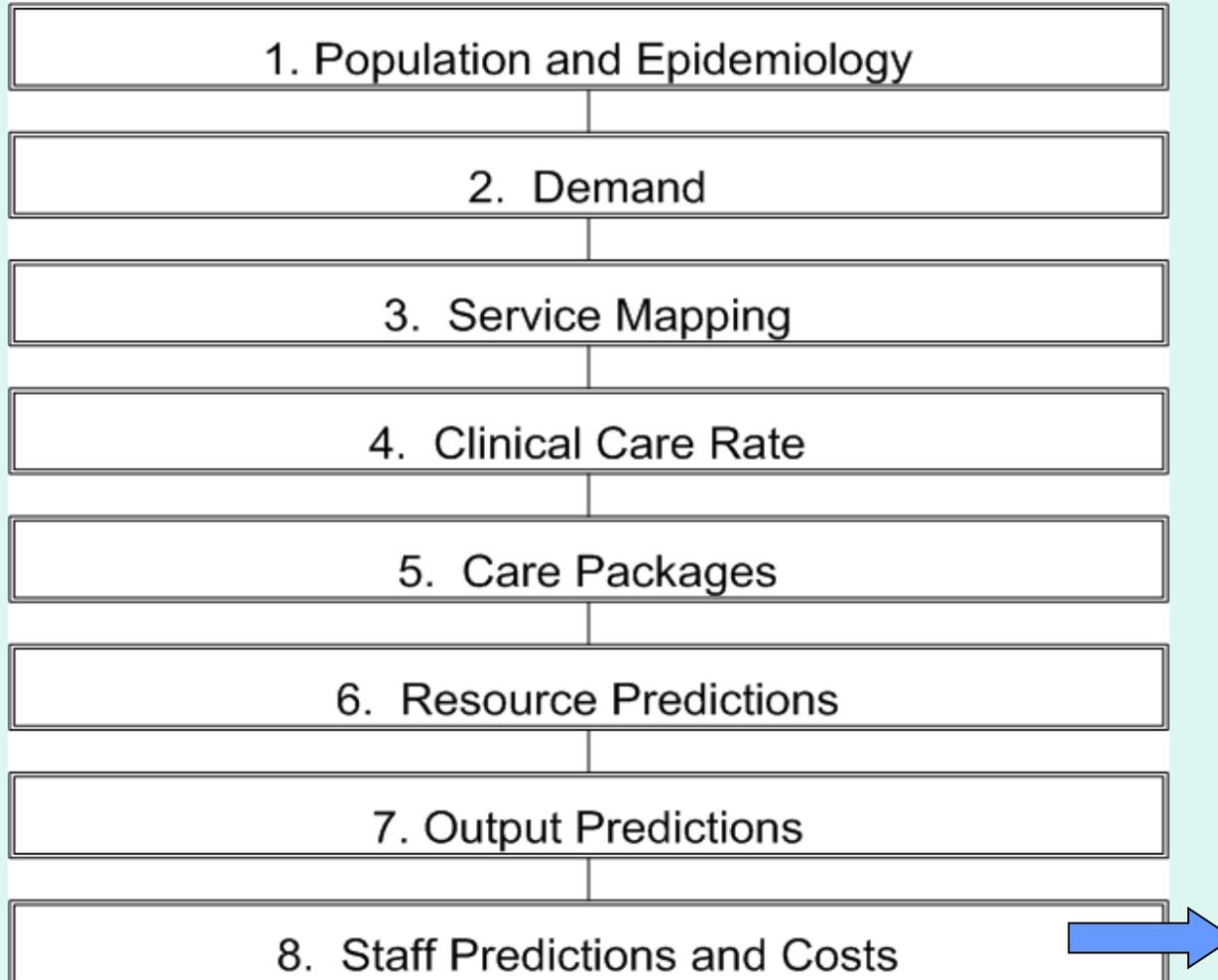
- Generates predictions eg. beds or places per 100,000 population,
- FTE staff per 100,000 population

# The DA-CCP Template



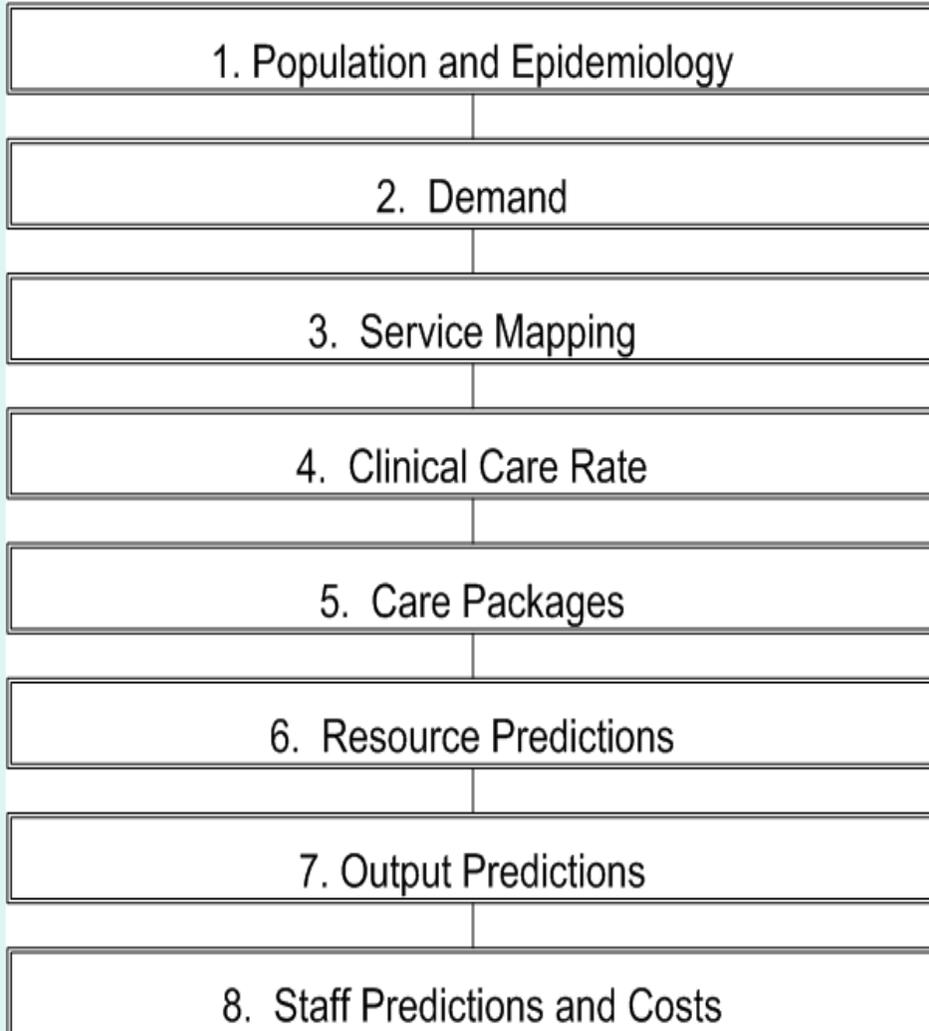
- Generates predictions  
eg. separations per  
100,000 population,  
eg. occupied bed or  
place days per 100,000

# The DA-CCP Template



- Generates staffing predictions & costs  
eg. AOD staff per 100,000 population in the community  
eg. AOD staff per 100,000 population for beds or places in treatment facilities

# The DA-CCP Template - Managing Population Characteristics



- Based on a notional town of 100,000 people
- The majority (approx 85%) of the people in the town are well
  - Promotion & prevention services
- A minority (approx 15%) have health problems
  - Receive clinical care ranging from mild to most intense

How does the model account for population characteristics?

eg: Low SES  
Indigenous populations  
Prison populations  
Rural populations  
Remote populations  
CALD populations

# The population and the epidemiology

A notional 'town' of 100,000 people (or standardised age grouping based population)

Prevention  
(approx 85%)

Concept of a prevention  
and promotion

Clinical Care for substance use disorder (approx 15%)  
Increasing intensity

Concept of a mild  
illness or risk

In this category we  
would expect  
larger numbers of  
people who would  
generally receive  
clinical care of a  
lesser intensity

Concept of a  
moderate illness

In this category  
we would expect  
moderate  
numbers of  
people who would  
generally receive  
clinical care of  
moderate intensity

Concept of 'intense'  
treatment

In this category we  
would expect  
smaller numbers of  
people who would  
generally receive  
clinical care of a  
greater intensity

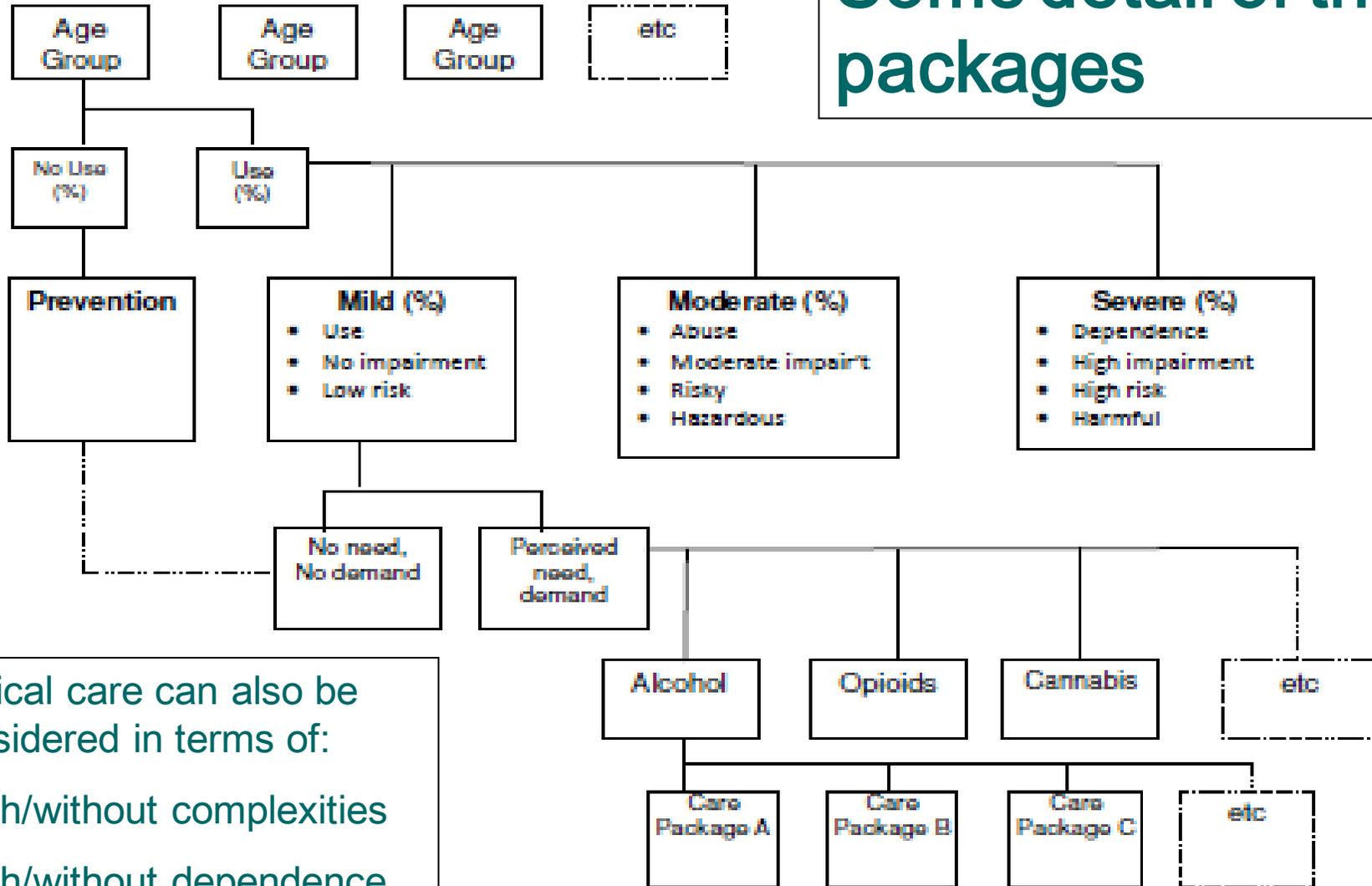
# Scope & current issues

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- The primary task is to build a national DA-CCP model that can be adapted by each jurisdiction as required
- The current drugs to be modelled are: alcohol, opioids, cannabis, stimulants, benzodiazepines as per AusBOD epidemiology: tobacco as a principal drug of concern is out of scope; if time permits, then inhalants may be modelled
- The second task is to build an Indigenous DA-CCP model based on the endorsed “Australian average” model, that can be adapted by each jurisdiction as required

# Some detail of the packages

## DA-CCP SCHEMA



Clinical care can also be considered in terms of:

- with/without complexities
- with/without dependence

# Age Groups

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## Child and Adolescent:

- Ages 0-4 (including the perinatal period);
- Ages 5-11;
- Ages 12-17

## Adult:

- Ages 18-24;
- Ages 25-64

## Older Person: Ages 65+

# Implications

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For each drug, the care for a person with a specific need for a year needs to be defined in terms of:

- Age group
- Severity of presentation (mild, moderate, severe)

And for each of these:

- Frequency & duration of sessions (outpatient treatments)
- Number of bed days, readmission rate & occupancy rate (for inpatient/residential treatments)

- The level of care that is specified for an “average” person is adequate, anything less would be unsatisfactory.
- The care includes both care in the community, and care requiring a bed or a place at a treatment facility.

# Alcohol Care Packages

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- Developed first. Now that this task is completed, we have moved on to the Opiate Care Packages
- **Are these very different?**
- For example – in residential rehabilitation (inc therapeutic communities) we have conceptualised these as being quite similar – but likely to have less medical (physical health) care
- Some specific drug-types (e.g. Amphetamine) may need to have additional mental health care
- In each case we are looking at Standard package and additional support for more complex cases, remembering that residential rehabilitation (RR) is for severe and complex cases

# Care Packages

- Care packages (18-65 age group) are currently being developed for mild, moderate & severe problems
- In the model, and according to known information – 2,020 of the people in the town of 100,000 will be in the **Mild and Moderate** category
- Only approximately 500 will be in the **Severe** category
  
- What services do people in the Severe category receive?
  1. Psycho-social (counselling)
  2. Detoxification
  3. Non-residential rehabilitation
  4. Residential rehabilitation (RR) (approximately 15 per 100,000 people or 1,890 in the 18-64 age range across Australia (approx 12.6 mill people), 18-64 years of age)

# Care Packages

- Each Unit of Service (type of treatment) is made up of different Types of Activities defined in terms of frequency, duration & amount
- **Examples of “activities” –**
  - Assessment
  - Review
  - Group Therapy
  - Psychosocial interventions (counselling 1:1)
  - Consultation Admission and Discharge
  - Case Conference (simple and complex)
  - Referral
  - Aftercare
  - Family Engagement
  - Care Coordination/Case Management
  - Diagnostic Testing
  - Telephone Support
  - Medication Prescribed
  - Peer Support

# Example 1

## Mild-moderate alcohol use – community-based setting:

- care delivered in the community for an individual or a group
- 1 x 60 minute assessment, 6 x 30 minute consultations, 1 x 30 minute review etc

Unit of Service = outpatient counselling for moderate alcohol problem

### Activities:

- Comprehensive Assessment
- Consultation
- Psychosocial Counselling 1:1
- Family engagement
- Referral
- Review

### Duration: (number & duration)

- 1 x 60mins
- 1 x 30mins
- 6 x 60mins
- 1 x 90mins
- 1 x 30mins
- 1 x 60mins

# Example 2

## Severe alcohol use – residential rehabilitation:

- RR is conceptualised as being provided through a number of different packages for varying lengths of time –
  - 8 weeks (1<sup>st</sup> building block – this could be the total treatment time or form part of a longer period of treatment)
  - 12 weeks (3 months)
  - 26 weeks (6 months)
  - 52 weeks (12 months)
- In all cases we need to package a full year of treatment.
- So – what additional treatment would we expect someone who is entering a 26 week residential program to have both before and after the period of residential rehabilitation?

# Example 2

## Severe alcohol use – residential rehabilitation:

- 26 week residential program –
  - Assessment – 1 x 60 min + 1 x 60min transfer/referral of care/follow up
  - Detoxification – outpatient or residential. Both these have a number of activity “cards” such as (residential detox):
    - 1 x 15 min assessment (intake)
    - 2 x 40 min assessment (detoxification)
    - 1 x 45 min medical consult
    - 5 x 90 min group sessions (calculation of how many staff – ratio staff: clients)
    - 5 x 60 min reviews
    - 1 x 15 min medical review
    - 1 x 30 min referral / transfer of care / follow up
  - Outpatient detox also needs dispensing events – e.g. 5 x Valium, 5 x Thiamine etc.

**2-4 Weeks**

# Example 2

## Severe alcohol use – residential rehabilitation:

- 26 week residential program –
  - **Start pre-residential phase** – 8 weeks in 1<sup>st</sup> Support or Assessment – this could include psychoeducation, assessment, collecting mental health, medical and other support documentation
  - **Start residential phase** - consideration of a week in a residential setting – how many groups, how many counselling sessions, psychoeducation, medical treatment, psychologist, psychiatric consults, peer support activity, work and pre-employment skills etc.
  - 26 week program might have or Induction Phase (8 weeks), Treatment (10 weeks), Transition & Supported Accommodation (8 weeks)

+ 8 Weeks  
= 12 Weeks

+ 26 Weeks  
= 38 Weeks

# Example 2

## Severe alcohol use – residential rehabilitation:

- 26 week residential program –
  - **Post treatment phase** – Referral to GP and psychologist through Better Outcomes, peer support and fellowship groups, may attend groups such as SMART Recovery
- Implication:
  - To make resource predictions regarding required staffing levels, all alcohol and drug treatments provided by services (public, non-government & private) need to be captured in a care package
  - Also looking at **completion** and **partial completion** of treatment rather than treatment failure

+ 14 Weeks  
= 52 Weeks

# Managing Individual Characteristics

## *Polydrug use:*

- Yet to be decided by the modelling team – either separate care packages for “polydrug”, or else the separate care packages for each drug type (eg. benzodiazepine & alcohol care packages) can be combined up; too early to say at this stage

## *AOD & mental health comorbidity:*

- Built into the level of care that is specified for an “average person” presenting with an AOD problem.
- Co-occurring mental health problems may be greater in some population groups and/or treatment settings – can determine % of people with serious and complex problems who require a more intensive care package.

# Managing Individual Characteristics

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*Physical health and social issues: (ie, problems with liver functioning, housing, employment, etc):*

- The model does not factor in broader social system costs or more general health costs, for example: accommodation, liver transplants, HCV treatments, although they impact on AOD treatment. These services are the domain of more specialised health and broader community-based services.
- AOD services have the role of linking clients to these services, ie. Care coordination

# Current issues

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- Many issues arise because DA-CCP is the first national drug and alcohol service planning model. These include:
  - Complex disorders, different costs in different settings, private settings, diversion programs, mandated treatment
  - Acknowledged that care packages are for INDIVIDUALS – one of the issues particularly for Aboriginal people is need to look at Family unit
- The need to agree on terminology for the components of services and the service taxonomy as a whole
- Other issues arise because of the demands of national health reform, including a possible governance review of the MCDS itself

# Current issues

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- However, the sands are shifting. We don't know at this point what, if anything, will replace the MCDS, other than vague “relevant Ministers would meet on occasions when Ministerial-level policy decisions and direction were required” (MCDS Communiqué, 25 Feb 2011).
- The ERG has only just started to look at cost implications – and will get more fully into this in the 2<sup>nd</sup> year.
- We are mindful of the implications in relation to possible Health and Hospital Reforms – once again, the political situation here has become very fluid.

# DA-CCP Timelines

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November 2009 - project endorsed by MCDS

April 2010 – project commences

May 2011 – mid term report to be provided to MCDS – this has been accepted and additional resources provided – particularly in relation to the Indigenous care package

May 2012 – final report to be provided to MCDS