ATCA

AUSTRALASIAN THERAPEUTIC COMMUNITIES ASSOCIATION

Evaluation of the NGO Treatment Grants Program

ATCA Response - May 2010

Response to

Evaluation of the Non-Government Organisation Treatment Grants Program (NGOTGP)

Australasian Therapeutic Communities Association

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Introduction

The Australasian Therapeutic Communities Association (ATCA) is the peak-body representing Therapeutic Communities across Australia and New Zealand. Therapeutic Communities (TCs) provide an evidence-based approach to alcohol and other drug treatment utilises the use of the community as the prime vehicle for change. As such, TCs have a strong emphasis on both personal responsibility and mutual help within a rehabilitation setting, supported by a range of psychosocial interventions delivered by professional staff.

The ATCA currently includes thirty-three members, which represent a total of 64 TCs operating across Australasia. These services employ approximately 1,000 staff and treat over 10,000 people annually as well as providing additional critical services such as detoxification units, family support programs, child care facilities, exit housing and outreach services. As such, therapeutic communities work at all points of the treatment spectrum, from primary prevention and early intervention, to treatment and aftercare.

TCs have been found to work with a significantly more chaotic and complex group of clients than other treatment modalities. The TC does not generally represent the person's first treatment attempt. It is important to understand that all treatment modalities play a role in the overall treatment landscape and that "one size" does not fit all when it comes to treatment for substance use. Many variables affect an individual's interest and engagement in treatment programs for instance age, mental health, personal crisis etc.

With the release of the *Australasian Alcohol and other Drug Therapeutic Communities Standards and Support Package (2009),* the ATCA is well placed as a major provider of treatment services to work with Governments and treatment services to ensure quality services are established and maintained.

The ATCA Board of Management comprises an elected and co-opted Board of Directors, representing members from organisations in Australia and New Zealand. ATCA Directors are:

- Barry Evans (Chair), The Buttery, NSW
- Garth Popple (Deputy Chair), WHOS, NSW and Queensland
- Stuart Anderson (Secretary), Higher Ground, Auckland, New Zealand
- Gerard Byrne (Treasurer), Salvation Army Recovery Services, NSW, ACT and Queensland
- Eric Allan (Public Officer), Odyssey Victoria
- Carol Daws, Cyrenian House, Perth
- Mitchell Giles, ADFQ and Logan House, Queensland
- James Pitts, Odyssey House McGrath Foundation, NSW

Terms of Reference

It is noted that the Terms of reference for the Evaluation of the NGOTGP are as follows:

1. Assess the efficiency and effectiveness of the program, including:
    - 1.1. Responsiveness of services to program target groups, changing drug use patterns and treatment demand;
    - 1.2. Program requirements, including administration, management and reporting responsibilities;
    - 1.3. Management practices of the NGOTGP projects undertaken by the funded bodies;
    - 1.4. Treatment service efficiency and effectiveness, including value for money;
    - 1.5. Appropriateness of service treatment models and quality assurance practices.
2. Identify future opportunities and risks for the program; and
3. Recommend options for future approaches to the program.

Each of these points is addressed below:

1. Assess the efficiency and effectiveness of the program, including:

1.1. Responsiveness of services to program target groups, changing drug use patterns and treatment demand

Therapeutic Communities (TCs) provide an ideal treatment modality by providing a wide range of services which are responsive to the needs of the community, changing drug use patterns and treatment demand. It is important to acknowledge that most substance users seeking treatment are polydrug users – and therefore whilst it is important to be aware of drug use patterns and trends, what is more important is the level of substance use – and particularly that defined as *hazardous, harmful* and *dependent.*

People can experience drug dependency, no matter what the substance. Therefore the emphasis on **drug type** needs to be replaced with an emphasis on **levels and dependency of drug use,** as reflected in the discussion of the IGCD Expert Reference Group National Drug and Alcohol Clinical Care and Prevention Project (DA-CCP) in relation to the development of clinical care packages**.** These definitions are outlined in Table 1.

Table 1. Levels of drug use

Level	Definition
Abstinence	No drug use
Experimental	Trying a drug and using only once or a few times. (e.g., using LSD once)
Recreational	Using a drug for leisure. The use is usually planned and controlled, and may be specific to particular social situations or settings, such as parties, clubs or at home with friends. (e.g., taking ecstasy at a dance party)
Regular	Using a drug as a normal part of one's lifestyle, although use may still be controlled. (e.g., a glass or two of wine with dinner)
Hazardous	Using a drug in such a way that it will probably cause harm, but has not yet done so. This includes taking serious risks when using a drug, such as: taking excessive amounts of the drug; using a combination of drugs that may interact with each other; sharing injecting equipment; or driving under the influence of the drug.
Harmful	Drug use that has demonstrably led to harm — physical, social or emotional.
Dependence	Using a drug a lot and needing it to feel "normal", to cope with day-day problems, or to stop the symptoms of withdrawal. The need for intensive, specialist treatment options is indicated.

Source: Pols & Hawks (1992); World Health Organisation (1982)

While the overall population use of most drugs has declined over the last decade or remained stable at low levels in recent years, there is some evidence to suggest that people who are using alcohol and other drugs are experiencing greater harms. Over the last decade more than 800,000 Australians aged 15 years and older were hospitalised for alcohol-attributable injury and disease (Pascal, Chikritzhs & Jones, 2009). Prescription and over the counter drugs are frequently associated with harmful use, and the use of performance enhancing drugs in sport is a growing issue. Overall, the harm associated with licit substances is considerably greater than that associated with illicit drugs.

Harmful substance use is associated with problems beyond those experienced by the individual and poses considerable harm to the wider Australian community. For example, it is estimated that for every one person who drinks alcohol in large and/or frequent quantities, at least four other people are negatively affected (Rumbold & Hamilton, 1998). Harmful substance use can have a major impact on families through neglect, violence, separation, and financial and legal problems (Dietze, Laslatt, & Rumbold, 2004). It can affect work colleagues through absenteeism, loss of productivity, and work accidents, and the wider community through accidents and crime (Australian Bureau of Criminal Intelligence, 1998). Depending on the definitions used, up to 70% of crime is related to substance use (House of Representatives, 2003).

ATCA member agencies are ideally placed to address these range of issues and to respond to emerging trends and drug use patterns within the community. Our services remain flexible and our staff capable of working with all clients, regardless of their drug using behaviour. In addition to residential services, which are the traditional hallmark of therapeutic communities, TCs are providing an ever-increasing suite of services including: detoxification; pharmacotherapy withdrawal and stabilization; family programs, including child care and early intervention and prevention programs for families of substance users; specially designed programs for young people; interventions to address comorbidity and mental health issues; aftercare and outreach services; employment training and education. Members are providing TCs within both community and correctional settings and work particularly with offenders and the criminal justice system, through diversionary programs and with victims of crime.

ATCA member agencies vary in size from 10 to 100 beds. Residential program length also varies from several months to one and a half years, with most providing programs of between three and 12 months duration. Length of treatment is divided into stages, and typically includes an intensive residential treatment component followed by a largely unfunded transitional stage as clients move back into the community. TCs also vary in program structure and content, drawing on a wide range of approaches, including 12 Step recovery models, systems theory, psychodynamic theory, cognitive behaviour therapy and social learning theory. A wide range of programs, both residential and non-residential, provide treatment options to suit individual needs.

The age of residents in therapeutic communities range from 15 to >50 years, although the majority of residents fall into the 18 to 30 age group. Reports from therapeutic communities in Australasia (Magor-Blatch & Pitts, 2009) indicate the majority of residents present with alcohol as the primary drug of concern, and amphetamine-type stimulant (ATS) use and cannabis as the secondary drugs of concern, and the primary illicit drugs of concern (Magor-Blatch & Pitts, 2009). This represents an important shift in therapeutic community treatment, since TCs were initially established during a period of significant opiate use and therefore have been seen primarily as treatment agencies working with illicit drug users.

TCs have been found to work with a significantly more chaotic and complex group of clients than other treatment modalities. Good outcomes from TC treatment are strongly related to treatment duration, which are most likely a result of benefits derived from the underlying treatment process. Residents who complete at least 90 days of treatment in a TC have significantly better outcomes on average than those who stay for shorter periods (NIDA, 2002). For individuals with many serious problems (e.g., polydrug use, co-occurring disorders, criminal involvement, mental health disorders, and low employment), research again suggests that outcomes are better for those who receive TC treatment for 90 days or more (Simpson, Joe & Brown, 1997).

TCs primarily work with individuals who have been unable to respond to outpatient services and who may be seeking abstinence within a harm minimisation context (this allows for prescribed medications and pharmacotherapies), rather than substitution as their primary goal. The TC does not generally represent the person's first treatment attempt. It is important to understand that all treatment

modalities play a role in the overall treatment landscape and that "one size" does not fit all when it comes to treatment for substance use.

Often people will have tried a number of approaches before seeking the relative restriction, but also the sense of security which a residential setting can provide. They may have used less intense approaches in the past and/or tried pharmacotherapy treatments. TCs tend to treat those with entrenched and more self-destructive dependence patterns and for whom the prognosis of recovery by less intensive methods is not good.

1.2. Program requirements, including administration, management and reporting responsibilities

The 2009 report produced by the Australian National Council on Drugs (ANCD), *The Burden of Submission Writing and Reporting for Alcohol and Other Drug Non-Government Organisations,* aptly illustrates the issues faced by the NGO sector in relation to program requirements, including administration, management and reporting requirements. Also of consideration are the requirements of submission writing, even when an organisation has a proven track record and is applying for refunding of a core program.

As the report highlights, NGOs are struggling with the burden of reporting, and while all welcome the opportunity to seek funding for core programs and innovative projects, the cost to the organisation, particularly in terms of staff time, is considerable. As noted in the report, NGOs point to the increasingly complex and time consuming task of reporting, with no additional funding provided to accommodate reporting and administrative requirements. A number of NGOs surveyed in this report, describe sacrificing frontline staff in order to appoint administrative staff to meet compliance requirements with some even making choices between the standards they set and whether they provide services at all (ANCD, 2009).

The ATCA believes there needs to be a drastic change to the current program requirements and administrative burden placed on NGOs and the way in which NGOs are required to report. The ATCA makes the following recommendations, reinforcing those included in the ANCD (2009) report:

Approved Providers –

- Firstly, the ATCA strongly believes that NGOs that have demonstrated a strong and reliable history of project and financial management should receive an "Approved Provider Status" which negates the continual need to justify their credentials. These NGOs would receive a "Treatment Provider Number" and once they have met the requirements to be placed on an approved register, reports would be provided on a yearly (rather than quarterly of half-yearly) basis as part of the regular reporting and auditing process.

- A model which is worth consideration exists within Community Housing in NSW. Once an NGO has received accredited status and is placed on a register, it is an acknowledgement that certain requirements have been met and the submission process for further funding is therefore streamlined without the need to continually gather information to prove the organisation's credentials.

- Long-term funding recipients should not have to continually justify their ability to manage projects and funding. Therefore, reporting should be reduced from quarterly and six-monthly to annual reporting periods. Six-monthly financial reports are seen as a way of maintaining good fiduciary control, however, the full

report currently required could be replaced with a field visit from a project officer, where a semi-structured interview could take place and replace the formal reporting process. This would not only assist in building better understanding and relationships between funding body and funded organisation, but also establish a sense of partnership between Government and NGO in providing quality treatment services. It would also serve to assist Government departments to maintain an awareness of the services which they fund and to build trust in the organisation.

- Standardised nationally recognised registration/accreditation processes should be accepted and, once completed, be recognised as covering issues such as governance and risk management, thus excluding the need to report on these items separately. With the release of the *Australasian Alcohol and other Drug Therapeutic Community Standards (2009),* the ATCA is uniquely placed to work with Governments to provide quality assurance of residential services meeting the ATCA Standards. Therefore, if an organisation can provide evidence of accreditation under the ATCA Standards, this will provide assurance of treatment methodology and an awareness that certain standards have been adopted and maintained.

Reporting processes –

- Streamlined, standardised, online reporting templates, which are consistent across all government departments, should be established and provided.

- Accounting requirements should be simplified in line with standard Australian accounting practices and in keeping with standard accounting packages used by NGOs.

- Organisational audits which include individual program/project details should be accepted in place of the considerable amount of information currently required as part of administrative and accounting practices. There is also an added issue currently of funding crossing over financial years, causing a number of accounting and auditing issues for funded organisations.

- Key performance indicators should be streamlined to be more meaningful and reportable and kept to a finite number of no more than six items.

Submission process –

- We support the development of a two-stage submission process such as an initial expression of interest followed by a formal submission where there is intention to fund the program/project. It is noted that this has been introduced by some Government departments at Australian, State and Territory level, providing an opportunity for organisations to initially provide an Expression of Interest or first stage submission, and then, after passing through to a second round, to provide a fully costed and extensive submission.

Funding to support administrative processes –

- Submission and reporting requirements should include funding and support for additional costs incurred, e.g. administration, evaluation and the development and maintenance of standardised databases required for reporting purposes. The burden of reporting often falls to CEOs and other senior staff members. However, funding to cover the administrative costs of reporting are rarely provided as part

of the funding allocation, often requiring considerable "volunteer time" by organisations in meeting these requirements. Additionally, where funding to cover these costs is sought, there is too often an attitude that funds allocated to administration will "rob" the funded project or program of direct service funding.

Continuity –

- Funding needs to be approved at least three months prior to commencement dates of new or ongoing funded programs and projects. The current situation does not encourage forward planning or provide continuity of programming or employment for staff, who are often employed only on short-term contracts and given little employment security.

- Funding periods should also be increased to four years to allow NGOs to provide continuity of programs and service delivery.

1.3. Management practices of the NGOTGP projects undertaken by the funded bodies:

The ATCA notes that over past decades non-government organisations have increasingly been involved or been asked to take the lead in the provision of services to support and treat people with substance use problems. Continuing to build the capacity of the NGO sector is therefore vital in further strengthening outcomes across the sector.

The NGO sector has been tested over time, and under difficult circumstances. The NGO sector needs to be appropriately funded and to have access to the resources to manage projects effectively – this includes an evaluation and infrastructure component of all funded projects. Once again, those NGOs that have been effectively managing projects and finances over a period of time should be identified through a process which awards an "Approved Provider" status with a "Treatment Provider Number" given to these agencies. This would mean a reduction in the repetitive nature of many of the processes for both NGO and Government Project Officers, who are asked to continually collect the same materials over and over for NGOs for whom there is a proven track record of good management.

The discrepancies in funding between the Government and NGO sector need to be addressed – particularly in relation to wage disparities. Therefore, NGOS need to be fully funded to increase staffing levels, to raise the professionalism of staffing structures and to attract appropriate staff, with consideration to range and level of skills and expertise. People working within NGOs are poorly paid in comparison to their Government-employed counterparts, and do not typically receive the same range of benefits and opportunities.

Legislative requirements, over which NGOs have no control, in relation to such things as wages, superannuation and workers compensation payments must be fully funded by Governments. The NGO sector does not have the capacity to absorb increases of this nature and without funding the only alternative is to reduce services or staffing numbers to meet the increases in salary levels and other legislative requirements.

Current funding periods encourage short-term projects rather than long-term strategies. NGOs need security of funding and a change (or return) to four-year funding rounds would provide the opportunity for continuity of service delivery.

1.4. Treatment service efficiency and effectiveness, including value for money

Treatment for alcohol and other drug use works, and is cost-effective. There is no doubt about this, and reviews are consistent in their findings that most addiction treatment yields net economic benefits to society (NCAT, 2008). It is estimated that for every dollar spent on substance treatment, there is a $4 to $7 reduction in the cost associated with drug-relayed crimes (NIDA, 2006).

It is important to acknowledge that not only is addiction a chronically relapsing condition, but that substance use does not occur in isolation, and mental health, physical health and social problems often co-exist with substance use (NCAT, 2008). Each person's journey is different, and evidence suggests that people gain cumulative benefit from a series of treatment episodes. Just as initiation into substance use and the development of dependency is not an "event" but a process, treatment and recovery also follow a process.

Research also shows that entry into treatment will have an immediate impact (NCAT, 2008) and it is important that the NGO sector is therefore funded to an optimal level to provide the range of services needed to meet demand in a timely manner. For those with severe dependency issues, engagement in intensive treatment for at least three months will improve outcomes (Gowing, Cooke, Biven & Watts, 2002).

Therapeutic Communities are diverse in terms of the range of programs offered. This is appropriate as each agency aims to be responsive to the particular needs of its client group. In general, programs aim to have enough structure to ensure a degree of order, security and clarity, while allowing room for residents to fail, make mistakes and learn from experience.

For many, the TC is an alternative to lengthy imprisonment and as such the TC can be seen as a cost-effective option to prison. TCs offer the possibility for complete lifestyle change, and treatment frequently leads to the individual becoming a contributing member of society. TC treatment costs need to be examined in the context of alternative treatment costs, including: hospitalisation, imprisonment, the cost to the community of the substance-user remaining in the community, the cost of police intervention, and the one-off cost of successful treatment versus on-going costs of maintenance approaches, as well as long term recidivism.

Almost all TCs are non-government agencies and are in part reliant on non-government funding. Any cost/benefit analysis should recognise that TCs are one of the few areas of drug and alcohol treatment where, to a degree, the "user pays" principle has been implemented. Clients contribute to the financial cost of treatment in addition to their labour within the community in housekeeping, hospitality, horticulture and office management. This provides a range of esteem building activities critical to good treatment outcomes, and reduces the cost to Government as well as providing job skills training and increasing the therapeutic value of the treatment program.

In a study to assess the cost benefit of TC treatment, Pitts (2009) assessed the cost benefits of TC treatment by calculating the cost to society of each person's drug misuse history in the year prior to TC treatment. Costs analysed included: value of merchandise stolen; costs to courts, including solicitors; costs of policing; productivity losses and medical care. These costs were placed against the cost of TC treatment indicated by drug-free, crime-free days and the monetary value apportioned against this (Pitts, 2009).

For the 62 participants in the study, costs associated with substance use in the year prior to treatment totaled $49,751,159.00 or $802,438.00 per person. This equates to a cost to the community of $2,198.00 per person per day (Pitts, 2009). Even the most expensive AOD treatment options are far below this figure – therefore the cost benefits to the community are enormous.

Balanced against these figures is a sound case for reviewing the funding to NGOs to provide services at an equitable level, and particularly in relation to their Government counterparts, recognizing that an increase in funding levels is still cost effective when compared to the cost of not providing treatment.

There has been also been an increasing expectation on the service sector to meet higher levels of presentations around dual diagnosis. A "no wrong door" policy is admirable and requires robust resources to be done well.

1.5. Appropriateness of service treatment models and quality assurance practices.

An optimal treatment system will provide a range of treatment options of varying intensity provided in various settings and utilising a range of treatment modalities (NCAT, 2008). Such a system would include screening and brief interventions; outreach services; online and use of computer-based counselling; withdrawal services; pharmacotherapies, including both stabilization and withdrawal programs; outpatient and community-based specialization services; residential and therapeutic community treatment; aftercare and supported accommodation (also known as re-entry within therapeutic communities).

Culturally and gender-specific programs and those for particular groups – including families and young people - should also be available. Clients should be provided with choice to seek the services which are most suited to their treatment requirements at the time. Families should also be included in the treatment process, and services should be funded to provide family support in partnership with other specialist agencies.

Generally, more intensive treatment methods (such as therapeutic communities) should be provided for people with more severe dependency issues. People with severe addiction problems, especially in combination with mental and physical health issues, are more likely to require intensive day treatments, residential and therapeutic community treatment of at least three months duration (EIU, 2004; Gowing et al., 2002). A responsive service system will provide services based on population needs, including culturally-appropriate services, with regard to:

- Population needs
- Sufficient treatment capacity to ensure ready access to treatment
- Addressing of local service gaps
- Delivering equity
- The provision of evidence-based treatments
- Integrated response to people with complex needs
- Involvement of consumers in the funding, planning, delivery and evaluation of services (NCAT, 2008).

The New South Wales *Drug and alcohol treatment guidelines for residential settings (2007),* differentiate between services which provide residential *care* (intended as a welfare intervention) and residential *treatment* (intended to produce therapeutic change) and make a further distinction between residential treatment services and therapeutic communities.

While residential *care* services will provide respite from alcohol and other drug use, they will not generally provide clients with skills to remain drug free once leaving the facility. Residential *treatment services* generally include living and parenting skills training, case management and evidence-based counselling interventions, such as cognitive behavioural therapy (CBT) and motivational interviewing (MI) and most will also utilise group work within the context of a structured program. Therapeutic communities will include all these interventions, but include them within the context of a holistic

treatment approach to address the biopsychosocial issues underpinning substance use. The "community" is seen as both the context and the method of treatment.

The partnering of services in a mentoring relationship is encouraged, and as such the ATCA sees as one of its important roles, the development of a mentoring relationship with Indigenous services, for which the therapeutic community method of treatment is particularly applicable. *The Kimberley Custodial Plan: An Aboriginal Perspective - Stage two Report* (2006) found the Therapeutic Community Model to be appropriate and "should inform the design and development" of services for Kimberley Aboriginal people. In this role we will work with Governments to address the strategies encompassed in *Closing the Gap*. (See also "Indigenous residential treatment programs for drug and alcohol problems: Current status and options for improvement." M.Brady, Discussion paper No. 236/2002 ISSN 1036-1774.

The ATCA notes with concern the decision of some quality assurance bodies (e.g., Quality Management Services) to discontinue the use of the Alcohol, Tobacco and other Drugs (ATODS) module from their standards packages and to subsume these modules within the core standards. The "generalising" of AOD standards within a core package is of considerable concern, particularly as NGOs are forced to undertake an accreditation process through the adoption of standards which do not "fit" their particular programs – e.g., hospital standards which include medical practices in which many NGOs would not engage or have the resources to introduce.

The development and accreditation of sector-specific standards has been undertaken by the ATCA with the release of the *Australasian Alcohol and other Drug Therapeutic Communities Standards and Support Package (2009).* The ATCA's objective in developing the set of service standards was to ensure the integrity of the "Therapeutic Community" principle would be maintained and continue to stand as a model of best practice in the treatment of substance misuse and co-occurring disorders. The Standards aim to:

- Identify and describe good TC practice which can be incorporated into a national quality framework
- Enable Therapeutic Communities to engage in service evaluation and quality improvement, using methods and values that reflect the TC philosophy
- Develop a common language which will facilitate effective relationships with all jurisdictions (national, state and territory)
- Provide a strong network of supportive relationships
- Promote best practice through shared learning and developing external links.

ATCA members' participation in the process of developing the TC Standards is a demonstration of the solidarity and goodwill within the TC sector. The TC Standards have been developed by the sector for the sector.

Of equal importance in the quality assurance process is the *maintenance* of standards. The cost of sustaining accreditation must be considered as part of an ongoing funding component – both for NGOs undertaking the accreditation and continuous quality assurance process, and for the ATCA, as an accrediting body. The cost to the NGO sector to maintain quality services and to undertake the audits required by Governments needs to be acknowledged and provided for in funding allocations.

The ATCA sees itself playing an increasingly important role in working with Governments to ensure the provision of quality services, particularly within the residential setting.

2. Identify future opportunities and risks for the program

There are a number of opportunities for the program to expand and to develop mentoring and partnership relationships, especially between large and small NGOs and mainstream and Indigenous services. However, in order to expand and develop the program, NGOs must be assured of sustainable funding, which is adequate to meet the need.

The opportunity to build cooperative and partnership relationships across the sector and with Governments is also important, and particularly the development of mentoring relationships with Indigenous communities.

The prime risks to the NGO sector include:

- The discontinuation of funding through the NGOTGP and a corresponding reduction in service provision.

- An over-reliance on drug-specific treatment – e.g., funding only for alcohol treatment, amphetamine-type stimulants, cannabis etc. This does not take into consideration the fact that drug use patterns within the community may change rapidly in response to a number of factors, such as substance availability. As an example, the funding for ATS services was released in response to data collected in 2004, however by 2007 information collected showed a reduction in ATS use within the Australian community. Nevertheless, it was within this context that funding was released.

- Linking funding to NMDS data without fully considering the impact of polydrug use and co-occurring issues of mental and physical health and social determinants to substance use.

- Lack of sustainable funding – Government grants that are not paid on time, causing NGOs to delay or suspend vital services and to release staff members who cannot be paid either on time or appropriately for the level of service they are providing.

- The changes within Government departments that result in frequent changes to project officers working with NGOs. The lack of continuity and poor system of handover causes enormous problems for NGOs, often resulting in delayed funding through assessment of milestone payments and frustrations as new project officers request information which is already on file as they attempt “to get across the project”.

3. Recommend options for future approaches to the program

It needs to be recognised that the same level of accountability demanded of the NGO sector also needs to be applied to Government funding bodies. Therefore sustainability and consistency within Government departments in terms of staffing needs to be maintained, and the development of cooperative and partnership relationships encouraged.

There needs to be more foresight and understanding of the demands on the NGO sector and the sector needs to be funded to be responsive to the community. We argued for many years about the need to address the considerable health and social outcomes of alcohol abuse at a time when we were only funded to address illicit drug use. The risk now is that we will be funded only to address alcohol use when as a sector we are continually responding to the considerable and varied presentations we receive – including both licit and illicit drug use, mental health needs, homelessness etc.

Continued and increased emphasis needs to be given to early intervention and treatment strategies, recognizing that whilst reduction or interruption of supply is an important strategy, funding must also be provided, and increased, to address the treatment needs of the community, particularly at a tertiary treatment level. As some people move out of addiction, others are recruited in. The need to maintain a focus on harm reduction strategies, which includes facilitating access to treatment, continues to be a high priority.

Research has shown that the most effective treatment programs for substance dependency are those which include training in stress management and self-control, social and negotiation skills, job skills, and work habits. This social and behavioural approach is one of the hallmarks of therapeutic communities.

Employment appears frequently in the literature as an outcome criterion for substance users in treatment, and most clinicians subscribe to the belief that work plays an important role in recovery from dependency. Despite the importance attached to employment, many treatment modalities have not been shown to be effective in increasing client employment after treatment.

Many members of the ATCA are changing this through the introduction of accredited training programs for residents while they are undertaking rehabilitation within therapeutic community programs. Residents entering the TC are able to undertake training in accredited courses in a variety of training areas, including hospitality, business skills, hairdressing, building, horticulture, administration, acquisition of drivers licenses, advanced driver training, first aid and computer skills . These programs need to be acknowledged and funded as a way of reducing recidivism and relapse into problematic substance use along with better outcomes for individuals and the community.

Workskills and Job Training Programs assist in addressing one of the underlying causes of substance use and repeated relapse – lack of, or low, employment skills. This is part of a holistic approach to drug treatment within TCs, which includes individual and group counselling, cognitive behavioural therapy, creative therapies, parenting skills, relapse prevention, stress management and relationship counselling. These strategies need to be supported as part of an overall response to drug treatment services in Australia.

There will be a continuing need to consider an holistic and partnership approach to service funding across Governments and across agencies to ensure that the needs of the community are addressed. We can expect to see an increasing need to address mental health and substance use issues and to accept that comorbidity is now the expectation, rather than the exception. This places further stress on treatment services, and particularly highlights the need to fund at a level which allows both an increase in numbers of staff members in services, and an increase in expertise within those services.

The minimum requirement of a Certificate IV in AOD work, whilst welcomed by the sector, does not fully consider the considerable issues with which our clients present to treatment. Funding to employ a skilled and competent work force, with specialist staff who are paid accordingly, is urgently required.

We need to be able to increase our co-existing disorder capability at service level, to improve workforce alignment between the Government and NGO sectors, and remove the disparity between drug treatment and mental health services so that a robust service system may flourish that can accommodate the client group we see.

We need to be able to provide an integrated response and in this capacity, TCs see themselves as providing a “No Closed Doors” response.

There also needs to be an increased capacity to work with and within the criminal justice system, providing treatment services within a diversionary framework and within custodial settings with a more difficult to engage forensic group of clients.

Future program approaches need to be concerned also with what keeps people from seeking or accessing treatment and to addressing the barriers to treatment. These include: social pressure to keep using, fear of what might happen when contact is made with a service, and service perceptions of suitability or unsuitability (NCAT, 2008). This should be done in partnership with the NGO.

However, of absolute importance is the need to fund the NGO sector at a level which will allow it to be responsive to the varied needs of the community. It is not enough to just provide funding – funding must be provided at a level which supports the provision of high quality treatment services which are readily available in sufficient quantity and suited to the wide diversity of needs.

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