Mission Australia's response to the questions on notice following the public hearing on 3 April 2013

NSW Legislative Council
General Purpose Standing Committee No 2 - Inquiry into drug and alcohol treatment

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Question 1: As per the transcript below (p27)

> **Mr THOMAS:** When you say recommendations to the Committee, I guess broadly speaking our recommendation is that when you give the power to the individual to have more input, the outcome actually improves so much more. We can provide data if the Committee would like on some of the comparisons that we have found because that links into how we evaluate it.
> **CHAIR:** That would be very good if you could provide that to the Committee.
> **Mr THOMAS:** I will make a note of that and provide it.

Unfortunately we do not have readily available or easily comparable data in relation to clients who have been court referred versus those who are self-directed to our services. Any comparison would require in depth review and analysis of over 1200 client files to determine which referral group clients fell into and would consequently take months to complete. There is also the added complexity of determining whether court referred clients attended in a voluntary or mandatory capacity.

In terms of recent data we can advise that Triple Care Farm (TCF) provided alcohol and other drug rehabilitation services to 189 young people in 2012. Many more individuals were assisted through phone support and referral to other services. Some 68% of these young people who received our residential services successfully graduated from TCF. Some 92 certificates were awarded in various accredited training courses, approximately 40% have entered into employment following placement from the program and 21% have entered a training or education course. Importantly, the vast majority (91%) of these young people have been placed in stable accommodation. Further life changing outcomes for these young people have been recorded using psychometric measures, showing significant improvements in the young people's substance misuse issues, quality of life (including areas such as health, self-esteem and relationships) and psychological well-being.

Triple Care Farm has evolved to cater to an increasingly complex client group and is now tailored specifically to youth struggling with co-morbid substance use and mental health issues. While the challenges faced by this group of young people are immense, Triple Care Farm continues to emphasise the active role that each individual must play in their own recovery and rehabilitation. Underpinning this model is the conviction that young people have the capacity to make sustained, positive change, if given the appropriate support. More information about Triple Care Farm is available on our website[1].

Young people's frequency of use of drugs is measured at intake to TCF and throughout the aftercare program once they leave the Farm. We see a marked ***reduction in chronic drug use*** for young people leaving the farm. At intake 95% of young people in this group were using at least one drug(s) at chronic levels, which fell to just 24% at 3 months into the aftercare program and to 22% at completion of 6 months of aftercare. An increase in confidence to say no to use of their substance of concern was observed across all situations from intake to follow up. The average in overall confidence for each student was an increase of 31.7%.

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[1] http://www.missionaustralia.com.au/component/content/article/99-ma-community-services/community-services-listing/491-triple-care-farm-tcf

At intake, 39% of the group had been admitted to hospital in the six months prior to application to TCF due to substance misuse or mental health issues, with an average of 1.9 admissions per person. Some 61% of students reported hospitalisation due to substance misuse or mental health issues over their lifetime (excepting the 6 months prior to application), with an average of 1.8 admissions per person. During the six months of aftercare there were no reported new hospitalisations within the group.

These results are achieved with an average stay of 48 days, with 50% of young people graduating the program. Overall we see young people's alcohol and illicit drug use decreasing from being in the "extremely high risk of dependence" category down to "moderate risk of dependence".

Data from one of our newer services Junaa Buwa! from January to September 2012 found that clients had an average length of stay of 53 days and 41% had completed 12 or more weeks of residential treatment. There was also a clinically significant reduction from "High Risk of Alcohol Dependence" down to "At Risk" and from "Extremely High Risk of dependence on one or more drugs" down to "Low Risk".

Question 2: as per the transcript below (p27-28)

> **The Hon. HELEN WESTWOOD:** If I could just turn to that question that we have been talking about—and thank you both for your attendance today—the issue of the designated youth beds. Have there ever been designated youth beds in
> **Ms SULLIVAN:** I guess I can only speak on my experience in the past five years and I have not had any knowledge of detox beds in the State in that five-year period.
> **The Hon. HELEN WESTWOOD:** Have they been requested by advocates? Are you aware of that?
> **Ms SULLIVAN:** Mission Australia is currently advocating for that process. We are putting together a research paper at the present time.
> **Mr THOMAS:** But we have been over several years also. It is a consistent call in a number of meetings we have with government officials and Ministers.
> **The Hon. HELEN WESTWOOD:** Have you ever been given a reason why designated youth beds have not been allocated?
> **Mr THOMAS:** Not that I am aware of. I think it comes down to a funding issue more broadly.
> **The Hon. HELEN WESTWOOD:** Perhaps I will put it on notice, but it would be good to know why it is inappropriate—I think it is probably obvious—that there be youth beds within an adult ward for detoxification purposes.

Firstly we would like to clarify the issue around a lack of designated detox beds for young people. When we are referring to detox beds we are actually referring to public detox beds rather than those that may be available in private facilities. This distinction is important given the point made in our transcript about the most disadvantaged being those who are missing out on treatment options – specifically Aboriginal young people, young people from low socio-economic backgrounds and young people from rural and remote areas. Private detox beds are obviously unattainable for these groups of young people.

In terms of the inappropriateness of youth beds within adult wards, there are several reasons why this is not ideal. Firstly, young people are affected by their physical, psychological and emotional stages of adolescence and therefore have differing health care needs to children and adults. Hospitalisation for whatever reason can also have a major effect on young people that may not be related to their medical needs but is affected by the interaction between the young person and their medical providers. Having young people placed in adult detox wards that are often far from youth friendly can also act as a barrier to treatment for young people.

Further, the Royal Australian College of Physicians[2] have identified the following potential risks arising from co-locating children / adolescents with adults in health services:

- The rights of children and young people are not respected.
- Physical, psychological or sexual harm from other patients, staff or visitors.
- Compromises in quality of care for children/adolescents if care is provided by staff without education and training in the care and treatment of children and young people or if the available equipment is inappropriate in size or design.
- Inadequate or inappropriate parent/carer and family support and involvement in care.
- Interruptions to normal development if opportunities for play, leisure and education are not provided.
- Unnecessary trauma from witnessing distressing sights and sounds.
- Compromises in the care of children/adolescents when paediatric staff and resources are diverted to provide care for adult patients.
- Compromises in quality of care for adults if they are placed on a paediatric ward and staff are not experienced in caring for adults.
- Compromises in quality of care for adults if adults feeling ill are disturbed by either noisy children or the continued presence of the child's family, which is a key component of family-centred care.

They also developed the *National Standards for the Care of Children and Adolescents*[3] in2008 that include:

> *Standard 2.2.* Children and adolescents must be cared for on wards that are appropriate for their age and stage of development and must be physically separated from adult patients [13]. Actual age is less important than the needs and preferences of the individual child or adolescent [23].
>
> *Standard 4.4.* Staff involved in the care of children and adolescents should have special training to recognise and meet the special health, psychological, developmental, communication and cultural needs of children and adolescents [11-13].
>
> *Standard 4.8.* As an absolute minimum, any health service admitting children / adolescents must have access at all times to a resource person with paediatric clinical experience and expertise which accord with the following staff standards; 4.2, 4.3 and 4.4. For rural and remote services this may include resources such as tele- or video- conferencing.

These National Standards have since been superseded by the *Standards for the Care of Children and Adolescents in Health Services*[4] which incorporates the previous standards – including those outlined above.

Question 3: as per the transcript below (p28-29)

> **The Hon. HELEN WESTWOOD:** Do those statistics you were talking about cover this period where we have seen this change, or perhaps it is not long enough for you to assess whether or not they have been successful in their programs?
> **Mr THOMAS**: I am not 100 per cent sure, but I will certainly check and will certainly wait, particularly in the last six or 12 months of the data we have available when it has been assessed.

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[2] http://www.racp.edu.au/index.cfm?objectid=393E4ADA-CDAA-D1AF-0D543B5DC13C7B46
[3] These standards are available for download from the above link
[4] http://www.awch.org.au/pdfs/Standards_Care_Of_Children_And_Adolescents.pdf

As per our response to Question 1 above, it is difficult to assess which of the clients were voluntary or mandatory even where there was a court referral for attendance. Consequently determining which clients were assessed appropriately compared to those assessed under duress would require a review of all case files from 2012 onwards.

In the absence of any definitive quantitative data we have provided some qualitative information from our assessment teams which should help to contextualise the issues in some detail.

From 2011-2013 the Intake and Assessment Coordinator at Triple Care Farm has had nil success in securing an assessment interview for a young person while in custody for treatment post-release. Despite multiple advocacy attempts to a number of NSW Correctional Centres and Juvenile Justice Centres, not one inmate was granted day bail to attend an assessment for treatment.

The granting of day bail is commonplace for young people referring from the ACT, with day bail being granted on most occasions where we have advocated. On some of these occasions, young people are presented in physical restraints and with a guard for assessment. On these occasions it is our programs procedure not to proceed for the interview, as the conditions are not appropriate for building a therapeutic relationship with a young person. Prior to assessment we express in writing the conditions necessary for an assessment, and it appears to be variable as to whether the officers transporting young people adhere to the conditions or not.

In the past 12 months, we have had the following issues with Bail Conditions for young people:

- ***When bail conditions state "must reside at {insert treatment facility address}".***
  The consequence of this requirement is that young people do not permanently reside with us, they are admitted for treatment, which is similar to any government health service, so the residential address should stay as is. When the facility address is provided (as per the requirement under current legislation) the person's health records and any existing support services in their local communities cease and are transferred to the local health service here in Robertson. For example, if a young person resides in South Eastern Sydney, they may be connected with a local public mental health worker, psychiatrist and youth health service. If their address moves to Robertson, they are transferred to the local public mental health service that has limited capacity to see the young person within a 12 week period, often waiting on a wait list for psychiatry for long periods. Most recently this wait was 8 weeks.

- ***When bail conditions state "must complete XX weeks of residential treatment" or "Complete the program".***
  The consequence for this requirement is that we are then unable to work on an individual, client centred treatment plan. Often 12 weeks of treatment is not indicated, or an unnecessary use of resources. In many instances the young person has better options for recovery in the community, like access to education and housing, which they must forego in order to meet the requirements of the court. This approach is not person-centred or recovery-oriented, thus recreates a custody-like environment for the young person, which has a negative effect of the other young people in the program.

- ***When the court does not approve leave from the program.***
  Leave is an integral and necessary part of our program. Young people need to have the capacity to try their new skills in relapse prevention, managing their mental health, managing urges and craving, managing stress and accessing support in a real life setting. We cannot simulate these in a residential rehabilitation program. We have inbuilt risk

management processes for young people accessing leave. All leave applications go before a committee and have detailed information about the leave, and a relapse prevention plan developed by the young person and their counsellor. Families and carers are contacted and consent to the leave and all referrers and advised of the requirement of leave at the time of referral, at assessment interview. Despite this, many young people are not granted leave, which replicates a custodial environment , and one which is not therapeutic. In some cases, the court has attempted to put in place bail conditions which do not allow the young person to leave the site. This is completely inappropriate as does not take into account that some of our program is community based, at TAFE, at other local service providers, and in the local community.