Submission
No 50

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

Organisation: Australasian Therapeutic Communities Association (ATCA)

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ATCA

AUSTRALASIAN THERAPEUTIC COMMUNITIES ASSOCIATION

ATCA Response

Inquiry into drug and alcohol treatment by the New South Wales Legislative Assembly - 28 March 2013

This submission is prepared on behalf of the

Australasian Therapeutic Communities Association

by
Associate Professor Lynne Magor-Blatch
Executive Officer

and
ATCA Board of Directors:
Barry Evans (Chair), Garth Popple (Deputy Chair),
Eric Allan (Secretary), Gerard Byrne (Treasurer),
Carol Daws, Mitchell Giles and James Pitts

atca@atca.com.au

Our Vision

The Therapeutic Community model of treatment is recognised and embraced by community and governments across Australasia.

Our Mission

We support, represent and advocate for programs that restore a sense of self, hope and belonging through the use of the Therapeutic Communities model of treatment.

Our purpose

- To advance the Therapeutic Communities Model in Australasia
- To promote community awareness of the Therapeutic Communities Model of treatment in Australasia
- To ensure consistency in approach through the application of the ATCA Essential Elements in practice
- To encourage capacity building in Therapeutic Communities through a variety of peer support and professional development opportunities
- To advocate for recognition and funding for Therapeutic Communities in Australasia
- To encourage and support ongoing research into the Therapeutic Communities Model
- To support and network with organisations and individuals interested in, or aspiring to become members of the ATCA

1. 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 which is based on the use of the community as the prime vehicle for change. As such, TCs have a strong emphasis on both self-help and mutual help within a rehabilitation setting, supported by a range of psychosocial interventions.

The ATCA currently represents forty Organisational, Group, Provisional and Affiliate Members, and a total of 63 TCs across Australasia. These services employ more than 1,000 staff and treat over 9,000 people annually within residential programs, as well as providing additional critical services such as detoxification units, family support programs, child care facilities, exit housing and outreach services to a further 23,000 people annually. As such, therapeutic communities work at all points of the treatment spectrum, from primary prevention and early intervention, to treatment and aftercare. Twelve of our TCs are based in prison services in New Zealand and Australia, representing a growing trend in Australasia to provide treatment services within the prison setting. In the past year, prison-based TC programs worked with more than 1,700 prisoners, providing targeted interventions within the prison setting and follow-up in the community post-release.

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.

Our programs provide ground-breaking and innovative examples of work from which we are able to learn. We were among the pioneers in work with single men and women, couples and families with children, both within and outside the treatment setting. The work of these programs has led the way in addressing the generational issues of substance use and provided an opportunity for early intervention and prevention programs with some of the most at-risk members of our society, the children of substance-using parents. All TCs have active partnerships with a range of government and non-government services, and work particularly with child protection services in all States and Territories to ensure the protection of vulnerable children and to establish better parent-child relationships.

We have been working with complex populations for many years, and our TCs have been the pioneers in working with people with comorbid mental health and substance use disorders. We are working with people on pharmacotherapies, providing both methadone reduction to abstinence within a TC setting and pharmacotherapy stabilisation options for people wishing to remain on pharmacotherapies. Many of our TCs also provide outreach and aftercare programs which include pharmacotherapy stabilisation, providing an example of the way in which we are able to effectively work within the medical model to provide the best opportunities for our client group.

Over the past four decades, since the inception of the therapeutic movement in Australasia, there has been a significant shift in the variety of services delivered by therapeutic communities. Many of our services are providing Harm Minimisation Outreach Services to the broader community, and many TCs have benefited from funding through Proceeds of Crime to work with correctional and forensic populations groups through MERIT and other diversion programs. A number of TCs have successfully combined detoxification and rehabilitation services to provide a throughcare model of treatment.

All TCs would now fit within the concept of the Modified (or Enhanced) Therapeutic Community, with length of programs shortened, complex populations, families, young people and children now part of

the TC treatment landscape. Therapeutic Communities are no longer contained within the walls of residential treatment but provide innovative and creative responses to the range of substance use issues.

Thirteen of the ATCA's 40 members are situated in New South Wales (NSW), providing a total of 18 residential services. One of these is in a prison setting, and one service works specifically with Aboriginal and Torres Strait Islander substance users. In addition to the 18 TCs, NSW ATCA members provide a range of community-based programs across the harm minimisation spectrum, including education and prevention programs, detoxification, early childhood development and aftercare services. NSW TCs also provide rehabilitation and treatment for men and women within mixed- and single-gender programs, for young people and families.

2. Background

The National Campaign Against Drug Abuse was launched in 1985, and the ATCA had its beginnings shortly thereafter in the context of the Melbourne Premier's Conference when representatives from the alcohol and other drug sector gathered to discuss strategies for service provision. The ATCA supports the approach of Australian governments to harm minimisation and its three pillars of: Harm Reduction, Demand Reduction, and Supply Reduction. Therapeutic communities, whilst being primarily a tertiary level treatment within the pillar of Demand Reduction, incorporate many harm reduction initiatives into their day to day practice. These include HIV education, distribution of split/safe kits, education of residents on relapse, the dangers of alcohol, and safer sex practices.

The use of alcohol and other drugs contributes 5.4% to the global burden of disease (WHO, 2013). Tobacco and alcohol are the drugs most commonly used in Australia, with tobacco the leading cause of preventable illness and death, and accounting for 8% of the total burden of disease in 2003 (AIHW, 2011). The excessive use of alcohol provides a considerable risk factor, contributing 3.2% to the total burden of disease and injury in Australia (Begg et al., 2007) and representing significant social cost, estimated at $36 billion (Laslett et al., 2010). Most importantly, it needs to be acknowledged that much of this cost is borne by children, families and the community, where results of personal consumption often result in violence and injury.

Although a number of strategies have been implemented to address the harms associated with alcohol use, a number of effective policies are yet to be adopted. The ATCA, in a previous submission to the National Drug Strategy, highlighted the following:

Among the challenges for 2010 – 2015, risky drinking, alcohol-related violence and accidents are highlighted as continuing to cause significant harms. This needs to be extended to include the considerable concerns relating to Fetal Alcohol Spectrum Disorders (FASD), and the growing recognition of intergenerational issues of alcohol misuse. This poses some very real health concerns for the Australian community, and should also be seen in relation to prevention and early intervention strategies, particularly when we consider that FASD is often seen within families and amongst siblings, evident of the fact that education on the risks of alcohol use in pregnancy have often been lacking. It is an indictment on our health system that siblings within families suffer the life-limiting effects of FASD through a lack of early intervention and screening.

As noted, the misuse of alcohol continues to cause concern in Australian society and its use cannot be addressed without consideration of supply. Differences in legislation between States and Territories and the role of each of the three tiers of Government – Federal, State and Local – need to be considered in the development of strategies related to the availability of alcohol in the community. This includes the number of outlets, opening hours and restrictions on sale.

In this context, the ATCA supports increasing the price of alcohol through the introduction of a minimum price and through reform of taxation, which would see volumetric-based taxation applied

to all alcohol products. Further reforms should include reduced access and availability and restriction of advertising and promotion of alcoholic products, particularly to young people. It is noted that NSW has undertaken a number of inquiries relating to alcohol and other drugs in the past 12 months, and it is therefore hoped that a considered and coordinated approach will therefore be adopted across all areas of inquiry.

The recent alcohol summit held by the NSW ACT Alcohol Policy Alliance (NAAPA) called on the government to 'to embrace proven, evidence based policies to prevent and reduce alcohol-related harms'. This has come in the wake of the tragic death of Thomas Kelly in Kings Cross last year, an event which served to remind all Australians of the harms associated with excessive use of alcohol, and particularly its effect on innocent members of the community. NAAPA is calling on the NSW Government to restrict advertising and promotion, and to reduce outlet density and trading hours. Other actions which are needed include supporting the work of emergency service personnel, including police, paramedics, doctors, nurses and other hospital staff, who are often exposed to dangerous and vulnerable situations in dealing with intoxicated and substance-affected individuals.

The Terms of Reference are addressed as follows:

The delivery and effectiveness of treatment services for those addicted to drugs and/or alcohol, including naltrexone treatment, with reference to the welfare and health of individuals dependent on illicit drugs and the impact on their families, carers and the community.

Treatment for substance use is both effective and cost-efficient. What is important to understand, is that a complex issue such as substance use requires a number of strategies and interventions to address the range of community concerns in relation to prevention, early intervention and treatment.

In The UK, the National Treatment Agency for Substance Misuse defined four tiers on the basis of a combination of *setting*, *interventions* and the *agency responsible* for providing the interventions (National Treatment Agency, 2002). In Canada, a five tier model (a revised version of the English model) was adopted in 2008, where each tier consists of 'functions' defined as a higher-order grouping of like services or interventions aimed at achieving similar outcomes. The five-tier Canadian model consists of:

- Tier 1: Population-based health promotion and prevention targeted at the general population.
- Tier 2: Early intervention & self-management functions targeted to people at risk.
- Tier 3: Treatment planning, risk/crisis management and support functions targeted to individuals with identified problems.
- Tier 4: Specialized-care functions targeted to people assessed/diagnosed as in need of more intensive or specialized care.
- Tier 5: Highly specialized-care functions targeted to individuals with complex problems.

Of particular importance to this discussion, is the work which has been undertaken by the Drug and Alcohol Clinical Care and Prevention (DA-CCP) Modelling Project Reference Group, supported by the Mental Health and Drug and Alcohol Office (MHDAO, NSW Health) in the development of a nationally agreed population-based planning model to estimate the need and demand for drug and alcohol health services across Australia.

The overall aim of the project has been to arrive at a nationally agreed drug and alcohol health services planning model. The recently completed model has now been provided to the Intergovernmental Committee on Drugs (IGCD) and has incorporated available evidence and expert advice to arrive at a transparent and defensible framework for jurisdictions to estimate the need and demand for drug and alcohol health services. The modelling follows the standard population health

approach of including all ages and the whole spectrum of services from prevention and early intervention to the most intensive forms of care. As far as possible, the standard 'Australian' model includes principles and parameters for adapting it to the populations and service structures of individual jurisdictions in a transparent and agreed way, but further modification and use of the model is for each jurisdiction to determine.

The model also recognises that substance use sits within a continuum that includes recreational and intermittent use to severely dependent, and therefore the range of responses needs to be appropriate to these varying needs.

That said, it is of some concern that the terms of this inquiry include reference to naltrexone, particularly as the NSW State Coroner has only recently endorsed the position and recommendations of the Australian National Council on Drugs (ANCD), which recommends clinical trials be undertaken to determine the safety and efficacy of naltrexone implants. The ANCD paper further notes that continued use through the Special Access Scheme is ethically problematic as it puts patients at risk.

The paper stems from a roundtable held in August 2012 by Australian National Council on Drugs medication-assisted treatment for opioid dependence (MATOD), which supported the role of medically assisted treatment within a comprehensive treatment system (ANCD, 2012a). Naltrexone is used in the management of alcohol and opioid dependence (NHMRC, 2010), and was approved for use in Australia in oral form and by prescription. It is a receptor antagonist which binds to the receptor, disrupting the interaction and inhibiting the function of an agonist or inverse agonist at the receptor. As such, naltrexone can reduce cravings. However, as with most if not all medications, the effectiveness of oral naltrexone is significantly reduced by non-compliance (ANCD, 2012b).

Injectible naltrexone and naltrexone implants were developed overseas, and introduced amid considerable publicity and expectation as a way of addressing non-compliance with oral naltrexone through a slow release medication regime, which is longer lasting. However, it should be noted that Naltrexone implants have not been approved for human use in Australia due to a lack of results from clinical trials demonstrating their pharmaceutical quality, safety and efficacy.

The National Health and Medical Research Council (NHMRC) has funded five research projects relating to naltrexone. While the drug has been approved for use in Australia under very specific circumstances, recent concerns suggest that any use should be withdrawn until further research is conducted to meet NHMRC scientific and ethical standards in order to demonstrate safety and efficacy. The ATCA does not at this time support the use of naltrexone implants. Our members have seen the devastating result of this method of treatment, where implants have been provided without support and counselling, resulting in the person either removing them without appropriate surgical care in order to continue drug use, or using other drugs (such as amphetamine-type stimulants (ATS)) which are processed by different brain receptors (naltrexone blocks the opioid receptor). Problematic substance use must be seen as a symptom of underlying issues. Therefore removing the substance without effective treatment of underlying concerns will not of itself provide an answer.

The welfare and health of individuals dependent on illicit drugs impacts on families, carers and the community. It is therefore imperative that the needs of families and carers are acknowledged through appropriate funding support and resourcing. Too often families are stigmatised in this process, and without adequate support, the generational cycle of substance use is likely to continue.

In order to address the needs of families and provide appropriate support, funding needs to be provided at a number of levels –

1. Family support services, including Family Drug Support, a NSW-based organisation, should be strengthened and resourced. Families are important. They know first-hand the trauma and chaos substance use can cause, and are the ones who understand their family member more

than anyone else. Too often families are left to work through issues in isolation, becoming exhausted and giving up. However, when supported they can become a vital force for positive change.

2. The principle of family or systemic therapy is that the problems of one person are related to or caused by their family situation. One of the main assumptions of family therapy is that the problem is not 'in the person' but 'between persons'. This simply means that problems are created by the interactions between family members. Therefore, working with the whole family is important in the recovery of the individual. Individuals accessing treatment do better if their family members are involved in the process. This also maximizes treatment benefits and provides the opportunity to stop the generational cycle of substance use.

3. Family members themselves need their own counselling and support. Sometimes families are themselves involved in the problematic use of substances, and unless this issue is addressed, recovery for the family member who has identified as having a problem, will be difficult. Therefore funding needs to be provided to services that are able to work with the whole family unit. This includes working with child protection in the development of a strategy to enhance the connectivity between mental health, substance use and child abuse and neglect.

4. Action is needed at community and systemic level to strengthen families. Therefore, the capacity of services, including therapeutic communities, to provide family support in drug treatment programs should be funded and resourced.

5. Too often substance use results in the displacement of children, often into the care of grandparents and other family members, who receive inadequate financial, emotional and psychosocial support. This needs to be urgently addressed.

6. Research into early intervention strategies aimed at families, children and young people to guide whole-of-society and whole-of-community approaches to building family wellbeing and resilience should be promoted and supported. This will also focus on reducing substance abuse and its associated problems, including violence, child abuse and neglect.

7. Additional resources should also be provided to public education and media that are evidence-based and comprehensive.

The level and adequacy of funding for drug and/or alcohol treatment services in NSW

The current level of funding in NSW and across Australia is inadequate. The NSW Government has the opportunity currently to be a leader in the field through the adoption of the DA-CCP model, a process which has been led by NSW MHDAO. Despite this, recent decisions affecting the NSW alcohol and other drugs sector will see approximately 55 organisations defunded. This will further reduce the availability of services in a sector already seriously under resourced and under serviced.

There is a principle that all people who need services should have access to them. Furthermore, services should provide effective, evidence-based treatment and should be of the same high quality as any other part of the healthcare system, offering a range of treatment options in both the government and non-government sectors that are attractive, flexible and affordable, and appropriate to treatment needs.

The National Drug Strategy encompasses three pillars of Harm, Demand, and Supply Reduction. However, the majority of funding provided to support the National Drug Strategy is spent on drug law enforcement compared to treatment and prevention. While this is an important part of the overall strategy, the consequences arising from heavy reliance on law enforcement and the criminal

justice system have contributed to community attitudes which discriminate against individuals who are seeking support. An effective response to substance use problems requires a primarily health and social approach. Such approaches are more effective, have fewer unintended negative consequences and are more cost-effective.

This also includes the opportunity for diversion from the criminal justice system to rehabilitation. *An economic analysis for Aboriginal and Torres Strait Islander offenders: Prison vs residential treatment*, released by the National Indigenous Drug and Alcohol Committee, estimates the cost of keeping someone in prison at $315 per day, compared with residential treatment estimated at between $204 and $285 a day. Although this might not seem like a huge saving, the NIDAC report provides an overall savings figure of $111,458 per offender. As well as the financial benefits, other pluses include the association of community residential treatment with lower recidivism rates, better health outcomes, lower mortality and health-related quality of life.

Pitts and Yates (2010), reviewing the findings of a 2001 ATCA survey, noted considerable costs associated with substance use and criminal behaviour. Their study of the cost effectiveness of residential therapeutic community treatment included costs associated with medical care, productivity losses, policing, legal and other criminal justice costs (including the value of stolen goods), and maintaining someone in prison.

Responses were gathered from 433 residents in TC treatment, who estimated daily drug use expenditure prior to treatment at $302 a day, or approximately $110,242 per person per annum. For the whole cohort, this represented close to $47 million per year. When law enforcement, court costs, health care and welfare benefits were included, the annual total rose to nearly $63 million, or $145,000 per person. These estimates are conservative, not taking into account housing, loss of employment earnings, or family and society health and welfare costs.

Therapeutic communities have also been found to be effective in custodial settings, with significant improvements found through studies comparing prison-based TC treatment with no treatment or other prison-based programs. Research also shows that participation in post-prison aftercare is critical to the effectiveness of prison-based therapeutic community (TC) treatment (DeLeon et al., 2000).

Aftercare, or continuing care, is an important part of the treatment process, and one that is dramatically underfunded – particularly to residential treatment services, which primarily deal with individuals who have severe drug dependency issues, and whose lives have become chaotic and complex. Continuing care that includes both primary care and specialty care management to support ongoing monitoring, self-care, and treatment as needed has been found to be important for long-term recovery of individuals with substance use disorders (Chi, et al., 2011). If the benefits of investment in treatment services are to be fully realized, governments need to make a greater investment in throughcare and continuing care models.

The effectiveness of mandatory treatment on those with drug and/or alcohol addiction, including monitoring compliance with mandatory treatment requirements

ATCA recognises the value of diversion into treatment and diversionary options that are provided at four points - pre-arrest, pre-trial, pre-sentence, and post-sentence (ANCD, 2013). Weatherburn and colleagues (2008) compared outcomes for two groups of drug court participants – those who had successfully completed a treatment program and those who had not, with a third group who were eligible for drug court diversion, but excluded for various reasons, generally resulting in imprisonment. Results showed participants undertaking court diversion, even without completing the treatment program, experienced better outcomes.

A meta-analysis of drug treatment courts (Latimer, Morton-Bourgon & Chrétien, 2006) examined 66 individual drug treatment programs. It found significant reductions of 14% in recidivism rates for participants over control/comparison groups – clear evidence that drug courts helped reduce crime. Most importantly, they put people in contact with the health and drug treatment system. Evaluation of the NSW MERIT program produced an estimated annual net benefit of $16,622 per successful program participant in 2003 (Wundersitz 2007). US studies show that treatment and other investment costs are on average $1,392 lower per drug court participant than traditional criminal justice system processing. Reduced recidivism and other long-term program outcomes resulted in average public savings of $6,744 per participant (or $12,218 with victimisation costs included) (Finigan et al., 2007).

Clearly, diversion programs can reduce drug use and crime, and most importantly, save lives. Cost savings and benefits outweigh the cost of delivering such programs. However, mandatory treatment which is involuntary, is not supported by ATCA and there is currently little evidence for its effectiveness. This was acknowledged in 2011 by the Queensland Government in its information paper for the *Inquiry into severe substance dependence: a model for involuntary detoxification and rehabilitation* by the Health and Disabilities Committee (2011).

However, in the Australian context, mandatory treatment may be seen as similar to the quasi-compulsory treatment system in Europe, where orders are made only with the consent of the offender. A review of international literature shows that treatment status (either mandatory or voluntary), self-awareness of substance use problems, and the severity of dependence are all associated with treatment effectiveness. These factors have been found to impact on effectiveness by mediating participant motivation. In this context, diversion into treatment may have a positive effect on treatment retention and outcome for those with severe drug-use problems.

It is important that the criminal justice system provides a level of choice for offenders and that treatment and rehabilitation services, both within and outside the custodial setting, are adequate to meet the need. This means establishing both pharmacotherapy and therapeutic community treatment within the prison setting, and ensuring that sufficient aftercare and post-release treatment places are provided for those exiting the custodial setting.

The adequacy of integrated services to treat co-morbid conditions for those with drug and/or alcohol addiction, including mental health, chronic pain and other health problems

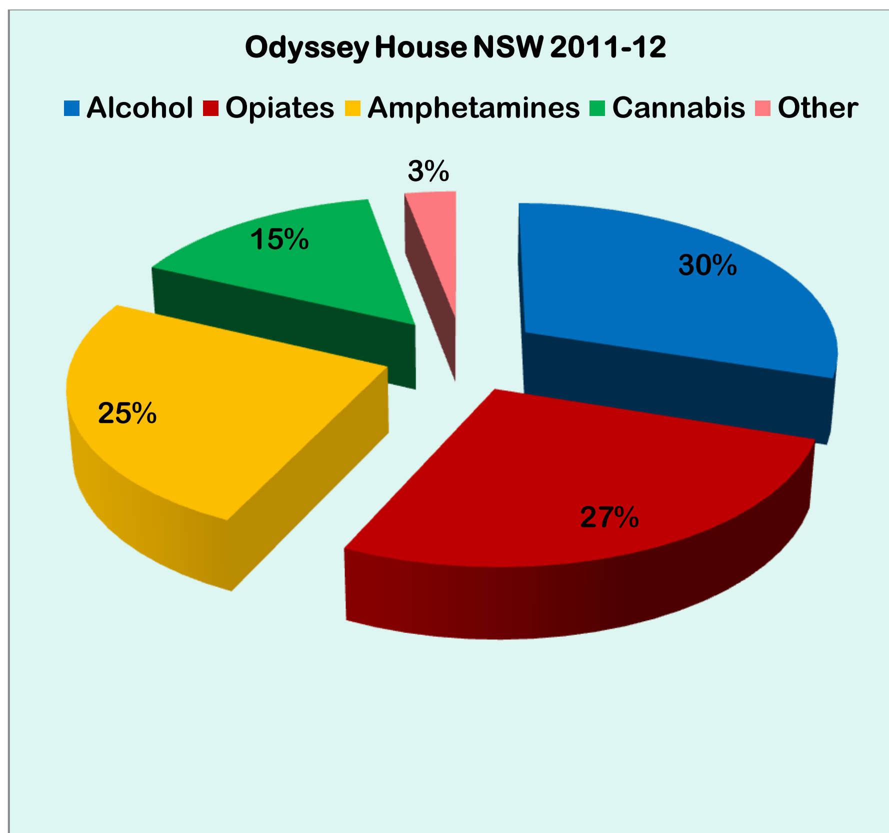
It is well acknowledged that comorbidity or co-occurring disorders are the expectation, rather than the exception, in substance use treatment. Mental health problems are one area of comorbid presentation, however those with severe substance use dependencies present with a range of psychiatric and psychosocial concerns. This is especially true for those accessing therapeutic community treatment.

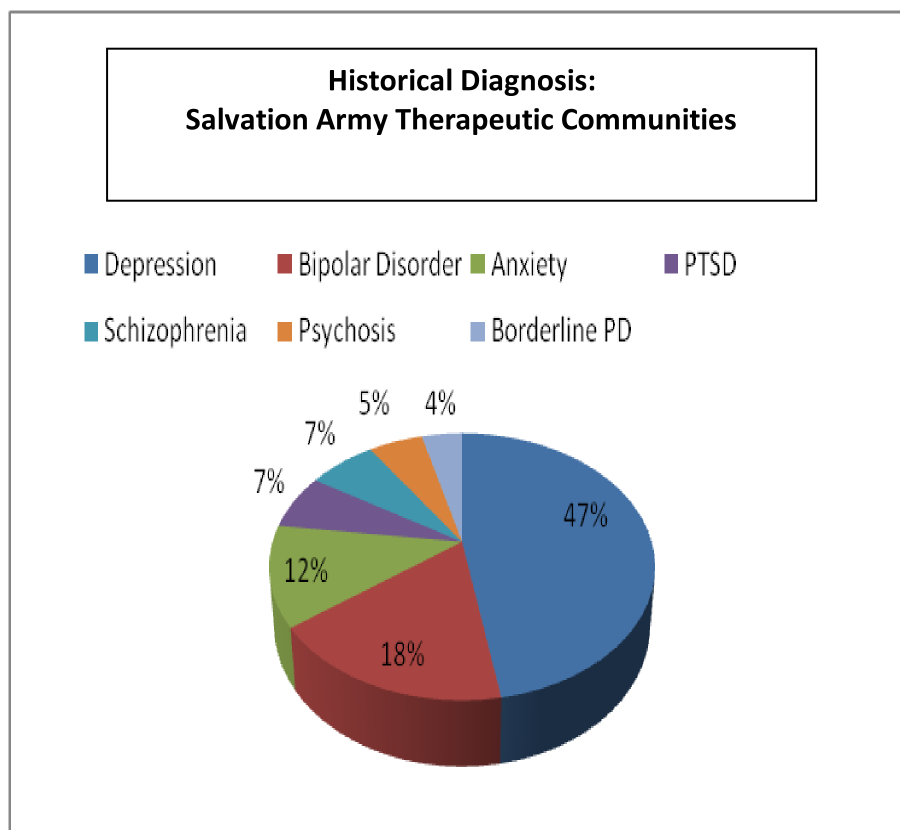
Therapeutic community populations include those who are severely substance dependant and treatment resistant. Clients typically present with co-occurring disorders, including –

- Alcohol - Most prevalent co-morbid disorders are anxiety disorders (19%) and affective (or mood) disorders (13%)
- Other drug problems - Prevalence of co-morbid anxiety disorders (28%) and affective disorders (26%)
- 2/3 people in treatment have diagnosed personality disorder, with prevalence rates of 44% among those with alcohol dependence and 79% among those with opiate dependence
- There is also a strong association between Attention Deficit Hyperactivity Disorder (ADHD) and substance abuse disorders

Therapeutic community populations also include the homeless, offenders, families, adolescents and

children. Changing presentations are also evident, and illustrated below through recent report of NSW agencies, showing drugs of concern on presentation, and psychiatric diagnoses.





There is also a close association between substance use and chronic pain. Chronic pain poses a considerable health problem in Australia and overseas, accounting for many tens of billions of dollars of lost productivity and health care costs. Pain also has a devastating effect on the physical,

emotional, social and economic wellbeing on pain sufferers and their families. However, there are two competing forces of concern in relation to the prescribing and use of pain medications. Firstly, there has been increased clinical attention to the under-treatment of pain, resulting in increased prescribing of opioid medications. However, this has been followed by a shift in patterns of misuse from illicit to prescription drugs, with this noted as one of the areas of significant increase in the most recent National Household Survey (AIHW, 2011).

Opioids are potent pain medications, but they do not work for all people and may have a range of undesirable and even life-threatening effects. Additionally, they have also been found to be most useful in cases of acute, rather than chronic pain, where their effectiveness is more limited. Nevertheless, they are widely prescribed for long durations of time to people with chronic pain, thereby increasing the risk of dependency. Of particular concern is the rise in prescription opioid deaths, caused by three key factors. Firstly, opioids have inherent risks. They suppress the drive to breathe, particularly in combination with other medications and alcohol. Secondly, there is a mistaken belief that as these drugs are prescribed, they must be safe. Opioid medication can be addictive, and the use of these has risen dramatically in the past years (Nuckols et al., 2012). Finally, as patients have previously been under-treated or untreated, there is now increased emphasis on attaining adequate pain control. These factors have contributed to opioid-related substance abuse and overdose, calling for the need for new standards of care and policies to address these issues.

The funding and effectiveness of drug and alcohol education programs, including student and family access to information regarding the legal deterrents, adverse health and social impacts and the addictive potential of drugs and/or alcohol

The National School Drug Education Strategy has included contracted funding to each State and Territory to enhance school drug education activities, such as:

- professional development for teachers in the area of drug education;
- information and education for parents on drug matters;
- school and community partnerships, including new ways of delivering drug education and information on healthy lifestyles;
- engaging indigenous communities in school drug education; and
- for a range of nationally strategic initiatives, undertaking research and promoting best practice.

School drug education needs to be considered in light of the evidence in relation to its effectiveness. The most successful drug education programs in schools have been found to be those that use a social influence approach (which aims to teach young people to avoid taking drugs by resisting peer pressure by increasing coping skills, rather than a competence enhancement approach). It is also important that drug education is coordinated to include the wider community and has parental involvement, and that it addresses the whole school environment, promoting positive relationships and behaviours, reducing victimisation and bullying and increasing social connectedness. A recent Victorian study provides evidence to support the effectiveness of well planned, evidence-based education programs for schools.

To be effective, school drug education needs to be part of a systematic and well-coordinated approach (Midford et al., 2005), and part of a broader strategy to prevent or delay drug use. It should include emphasis on both legal (including tobacco and alcohol) and illicit drug use. For example, the successful tobacco campaign was an intervention that included school education, social marketing, taxation, advertising and marketing controls, as well as smoking restrictions.

Recommendations for school-based drug education include:

- Early recognition skills
- Timely responses to young people 'at risk' of disconnection from peers, family, school and the community

- Community-based activities for young people at risk of becoming disconnected
- Effective responses for young people disconnected from community life
- Individualised support approaches
- New approaches for engaging young people in community learning environments
- Access to diverse vocational learning experiences
- Access to employment opportunities and programs

In 2005, Professor Alan Reid produced the report, *Rethinking National Curriculum Collaboration: Towards an Australian Curriculum.* The report acknowledged that over the past 35 years there had been various attempts at national curriculum collaboration in Australia. These were largely shaped by the Constitutional reality that the States and Territories have responsibility for curriculum – a reality that tended to restrict the range of possibilities for national curriculum approaches. The research project conducted by Professor Reid aimed to explore (a) whether the concept of national curriculum collaboration for the compulsory years of schooling is still relevant in a globalising world, and (b) if so, how it might be advanced in more educationally productive ways, whilst recognising the constitutional realities of Australia's federal system.

As a result of the report and subsequent discussion, and through agreement of Australian Education Ministers, a capabilities-based Australian curriculum has been proposed to provide a means by which the Australian government might take a leadership role in achieving genuine national curriculum collaboration in the compulsory years of schooling.

Two key capability areas highlighted in the report and of particular interest to this discussion are:

1. Understanding self e.g., Understanding the social, physical and emotional self, maintaining social, physical and emotional well being, personal past and futures, self-esteem, identities (e.g., cultural, community, family, gender), relationship between the personal and the interpersonal.
2. Ethics and values e.g., empathy, integrity, compassion, equity, social justice, responsibility, resilience, connectedness, diversity, honesty, tolerance.

The evidence supporting prevention shows that early use of alcohol, cannabis and other illicit drugs predicts subsequent risk of problematic and dependent use (Social Research Centre, 2010). In the case of tobacco, preventing early use is crucial as most smokers take up smoking during adolescence. Comparatively few smokers begin the use of tobacco in adulthood. Therefore, if school drug education can assist in preventing or delaying the initiation of tobacco, alcohol and illicit drug use, it is likely that results will be seen in the subsequent reduction of problematic use. This will also have other benefits, including improved mental health and social wellbeing, and increased education and future career prospects (Loxley et al., 2004). As the risks attached to drug use escalate the earlier drug use begins, early prevention and intervention will assist in reducing short- and long-term harm.

A harm reduction approach has been adopted by Australian secondary schools for alcohol, although not for tobacco or illicit drugs. This approach is supported by a systematic review of universal multi-drug education programs (Foxcroft & Tsertsvadze, 2012), which found that *reduced* 'binge drinking' was a more likely outcome of drug education than *abstention* from alcohol by young people.

Apart from formal drug education, schools can reduce many personal and social risk factors that predispose young people to drug use and promote the protective factors that have been found to lessen the likelihood of substance use and other risk behaviours. Protective factors include: connectedness with school, positive peer and adult relationships, and a strong sense of future prospects (Allsop, 2012). Bond and colleagues (2004) report on a whole school health promotion approach, adopted by the Gatehouse Project. This program promoted students' emotional and behavioural well-being, improved staff-student relationships and students' relationships with their peers to promote a sense of wellbeing and security, so that students felt accepted and worthwhile and able to learn. Among other results, alcohol and tobacco use among the students fell by 3–5%

respectively, highlighting the effect schooling has on young people's health status.

There are also other aspects of school life that support drug education messages and positive behaviours. Therefore a strategy should also include an emphasis on prosocial behaviours, including a focus on anti-bullying, the development of positive relationships and building positive self-esteem.

Another related issue in the context of the school community is the use of alcohol as gifts and in fundraising activities. This issue was addressed by the Australian National Council on Drugs in 2009, with a recommendation that fundraising should not include alcohol and that any fundraising activities should be considered in light of a whole-of-school approach. While it was acknowledged that schools using alcohol in fundraising do not use children to transport the product, nevertheless, children are by nature of the fact that they are providing information to families and others, taking part in a promotional activity for alcoholic products.

Adopting fundraising activities that promote health requires commitment and support from school fundraising committees and other members of the school community. Sometimes changing practices may be challenging, as it is perceived that healthy alternatives to fundraising will not be as successful. Schools across Australia have been encouraged to take a 'whole school' approach to promoting health, a commitment to ensuring that fundraising activities either reflect health messages taught in the classroom - that is, they are 'health promoting', or are at the very least 'health-neutral' – which means neither promoting nor discouraging healthy living.

The strategies and models for responding to drug and/or alcohol addiction in other jurisdictions in Australia and overseas, including Sweden and the United Kingdom.

Looking overseas to models of good practice provides the opportunity to expand on the local knowledge base and to learn from others. However, it needs to be recognised that Australia leads the way in many aspects of drug policy and implementation. The Harm Minimisation approach adopted by Australia has provided benefits which place Australia ahead of many other countries, resulting in better harm-related outcomes, particularly in the reduction of transmission of HIV.

Sweden has had a long history of focusing on zero tolerance. In its aim is to achieve a drug free society, Sweden places strong emphasis on drug law enforcement efforts. Widespread drug testing, and penalties ranging from rehabilitation treatment and fines, to prison sentences of up to ten years long are part of the Swedish policy. At the same time, other strategies used in Sweden to achieve its goal include prevention and treatment. However, harm reduction has not been a feature of Swedish policy until recently although this recent attention is only focused on alcohol (Ministry of Health, 2013).

While a report by the United Nations Office on Drugs and Crime (UNODC, 2007) praised Sweden for having one of the lowest drug usage rates in the western world, the conclusions of the UNODC report have been criticized for being unscientific and fundamentally biased in favor of repressive drug laws. According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), in 2005 the rate of drug-related deaths per capita in Sweden was more than twice that of the Netherlands (EMCDDA, 2007).

Caution also needs to be taken in reviewing current UK policies, as studies have yet to be released on the controversial Payment by Results (PBR) scheme. The aim of the UK Government is to reduce the number of people misusing illegal and other harmful drugs, to increase the number of people who successfully recover from dependence on these drugs, and to identify and prosecute those involved in the drug trade. The UK has therefore moved towards a policy that aims for all clients to be drug free. In late 2010, the United Kingdom introduced its new drug strategy *Reducing demand, restricting supply, building recovery: supporting people to live a drug free life*. While recognizing that

‘the causes and drivers of drug and alcohol dependence are complex and personal’ and that ‘the solutions need to be holistic and centred around each individual’ this policy rejects the notion of harm reduction. As a consequence, funding is centred around services that aim to have clients drug free at the end of treatment and a payment by results approach has been introduced that only pays services for a client if that client is drug free six months after treatment.

This is a potentially dangerous policy which cuts across human rights legislation. Potentially, it will result in only those clients who are in the mild to moderate range of drug use being accepted into treatment. Those who are chaotic and with complex substance use problems, and for whom substance use is an entrenched behaviour, are less likely to be accepted into treatment, as they are less likely to show positive results six months after treatment completion. For therapeutic communities, this is the prime population group. Therefore, the payment model will create uncertainty for services and will run the risk that services will only take accept clients who are likely to respond to treatment. Services will potentially refuse those who are more complex and more vulnerable. In essence, it works against what the government is trying to achieve and means that those who need treatment most will be the ones least likely to receive it.

Potentially, this model does not recognise the important public health role played by many harm reduction services such as needle and syringe programs (NSPs) which have been supported by the Australian Government since their inception in 1987 and have been instrumental in preventing the spread of blood borne viruses. It also potentially cuts across research which recognizes the need for flexibility in program delivery in the context of substance use as a chronically relapsing condition.

At the same time, it does promote a policy of understanding that continuing care and a throughcare model is essential to the success of long-term recovery. It is therefore important that funding is provided to services to support the person on this recovery journey, with an understanding that resocialization and re-entry to a prosocial lifestyle in the community cannot be achieved without targeted support.

Recovery is a term receiving wide usage both overseas and in Australia. It has long been used in the mental health arena, but has a different meaning in the substance use field. In the Australian context, a roundtable, hosted by the ANCD in 2012, agreed on the following:

a) That Australia’s National Drug Strategy has been, and needs to continue to be, based on the principle of harm minimisation, which has provided common ground in Australia for almost three decades and which incorporates supply, demand and harm reduction;

b) That the National Drug Strategy, which was developed after extensive consultation and input from the AOD sector and has been agreed to by all governments already has as an objective to support people to recover from dependence and reconnect with the community;

c) That recovery does not mean that abstinence must be the goal for all people with alcohol and other drug problems;

d) That recovery is supportive of harm reduction policies and programs;

e) That recovery supports a range of evidence based interventions including pharmacotherapy treatment and maintenance programs for people with alcohol and drug problems;

f) That people seeking to either be abstinent, choosing to continue or unable to stop using drugs and alcohol all deserve appropriate and effective assistance and support without facing unnecessary risks of harm to themselves or others;

g) That recovery, regardless of definition, should not be the sole basis for a national drug strategy, particularly as it would tragically undermine the gains available from both harm and demand reduction;

h) That the drug and alcohol treatment sector remains grossly under-funded, and a s a result the expectations of the community in reducing harm and drug and alcohol use cannot be achieved;

i) That any requirement for every service to provide resource-intensive holistic (e.g., pharmacotherapy, psychosocial, physical, criminal justice, housing, etc.), support will inevitably result in treatment being available to fewer people and lead to an increase in people receiving no help at all;

j) That there is an urgent need for more broad-spectrum post-treatment services to help drug and alcohol dependent people avoid relapse;

k) That continuity of care is critical, as treatment and recovery can take many forms and pathways over long periods of time;

l) That families and friends are very important in treatment and peer-support models are very effective, but are underutilised and under-supported;

m) That whilst the term recovery is used in other sectors, the term, as used in the alcohol and other drug sector, needs to be recognised as being quite distinct, particularly from mental health;

n) That there is a critical need to eradicate stigma and discrimination so that more people can talk openly about their drug and alcohol use, treatment and recovery, without adverse outcomes;

o) That any Australian drug and alcohol recovery model needs to be considered in the context of the National Drug Strategy and reflect Australian cultures and views, as well as avoid its language being politicised;

p) That the alcohol and other sector has a duty of care and leadership responsibilities to the community to ensure that political processes do not confuse or misuse the concept of recovery to cause further harm for our most disadvantaged people;

q) That Australia has an accumulated depth and breadth of expertise and experience in reducing harm and providing treatment and this needs to be better communicated to policy makers and the community;

r) That there is a need for investment in knowledge translation as well as in more research.

ATCA supports these principles and urges the NSW Government to take time to study and review the outcomes of the UK model before adopting any such approach. While it is the aim of therapeutic communities to work with clients to achieve recovery, including abstinence, we do so within a harm minimisation framework, recognizing that as some people recover and move out of substance use, others become exposed to substance use for a variety of reasons. This requires a whole person and whole-of-community approach to not only prevent the uptake of harmful substances, but to address the underlying family and social issues which underpin harmful substance use.

The proposed reforms identified in the Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012

This Bill, introduced by Revd Hon Fred Nile MLC, contains a number of proposals to amend the Drug and Alcohol Treatment Act 2007. It is the considered opinion of ATCA that the proposed bill contains

many areas of concern and should not be adopted without serious amendment.

The statement in the proposed Bill commences in a positive way – the provision of rehabilitation in preference to incarceration is supported by ATCA, as too is relapse prevention education. However, the option of "having naltrexone implanted under their skin" is completely rejected by ATCA for reasons previously cited in this submission and on the basis of the recent NSW Coronial Inquiry into the deaths of three people after being treated with naltrexone implants at a Sydney clinic and the 2011 review of the evidence by the NHMRC which recommended that this treatment *only* be used within the context of a clinical trial.

As noted earlier in this submission, naltrexone is a receptor antagonist which blocks the *opioid* receptor so that the person using a substance (such as heroin) will not get any effect from the drug. Neurotransmitters are chemicals located and released in the brain to allow an impulse from one nerve cell to pass to another nerve cell. Psychostimulants (including amphetamines) affect neurons containing dopamine in the areas of the brain known as the limbic and frontal cortex. Opiates, such as heroin and morphine, appear to mimic naturally occurring peptide substances in the brain that act as neurotransmitters with opiate activity called endorphins. Natural endorphins of the brain act to kill pain, cause sensations of pleasure, and cause sleepiness. Endorphins released with extensive aerobic exercise, for example, are responsible for the "rush" that long-distance runners experience. Alcohol is one of the depressant drugs in widest use, and is believed to cause its effects by interacting with the GABA receptor.

What this indicates, is that naltrexone will have an effect on only some drug use. While it has been found to be useful in assisting alcohol withdrawal, it has not been proven effective for long-term use with opioid use. The implant also has limited life, and then needs to be replaced. However, therapeutic communities too often see the result of people switching to another drug, such as amphetamines, as these neurotransmitters have not been blocked by naltrexone, or removing the implant without proper medical care – literally "digging it out" of their bodies, as while the physical cravings have been addressed through the use of naltrexone, the person has received no help for the psychological issues underpinning their substance use.

This Bill also uses the words "involuntary rehabilitative treatment". As discussed previously, while there is good evidence for diversion into treatment, involuntary treatment, except in extreme conditions where the person is of danger to themselves and others, denies human rights and the right to choice over treatment.

It is noted that in Victoria, the *Severe Substance Dependence Treatment Act 2010* provides for the detention and treatment of people with severe alcohol or drug dependence. In this instance, application may be made to the Magistrates' Court of Victoria, for a detention and treatment order to be made in respect of a person with severe alcohol or drug dependence. The court may order an involuntary period of detention (14 days) and treatment of the person in a treatment centre.
The following criteria must apply before detention and treatment can be considered:

1) The person has a 'severe substance dependence', which is determined if:
    - the person has a tolerance to the substance; and
    - the person shows withdrawal symptoms when the person stops using, or reduces the level of use of, the substance; and
    - the person is incapable of making decisions about his or her substance use and personal health, welfare and safety due primarily to the person's dependence on the substance; and
2) Because of the person's severe substance dependence, immediate treatment is necessary as a matter of urgency to save the person's life or prevent serious damage to the person's health; and
3) The treatment can only be provided to the person through the admission and treatment of the person in a treatment centre; and

4) There is no less restrictive means reasonably available to ensure the person receives the treatment.

Application is made using the 'Application for a Detention and Treatment Order' form, which must be accompanied by a 'Recommendation for a Detention and Treatment Order' completed by a prescribed registered medical practitioner under s12 of the Severe Substance Dependence Treatment Act 2010. There are strict time limits that apply to the making of this application.

The proposed NSW Bill does provide some of these assurances, including limitations on the time a person can be held – however, 90 days is far too long (Schedule 1[32]), and needs to be reduced to 14 days. The focus on post-rehabilitative care is welcomed (Schedule 1[38]), but this needs to emphasise the case worker's relationship with the treatment agency. 'Aftercare' as a term has been replaced by 'continuing care' or 'throughcare' which emphasises that planning for aftercare should commence at the point of intake, rather than as a 'tacked-on' after-thought when treatment is completed.

Summary

In summary, therapeutic communities would acknowledge that many of our clients come to us and do well when faced with the alternative of prison. Although it is widely accepted that people have to be at a readiness stage in order to accept and benefit from treatment, we are also aware of thousands of success stories where diversion to treatment as an alternative to prison, or the opportunity to undertake treatment whilst in prison, have lead to long-term change and success.

For these strategies to be successful, they must be undertaken within a coordinated care approach and in partnership between health, welfare, justice and treatment agencies. In order to do this, there needs to be an understanding and acceptance of a throughcare model of treatment and a considerable injection of funds into substance use treatment to provide services which have the opportunity of long-term success.

The Australasian Therapeutic Communities Association, with NSW members, welcomes the opportunity to provide input into the inquiry. We would also welcome the opportunity to talk further with the Inquiry Committee.

Yours sincerely

Lynne Magor-Blatch
Executive Officer
atca@atca.com.au

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