Submission No 27

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

Organisation: Mission Australia

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Mission Australia

Submission to the

Inquiry into drug and alcohol treatment

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Mission Australia

Mission Australia is a large national not-for-profit organisation that has been transforming the lives of Australians in need for more than 150 years. Our vision is to see a fairer Australia by eliminating disadvantage for vulnerable Australians.

In 2011-12 our 326 Community Services (including our Early Learning Services) assisted 110,389 individuals and 5,732 families. MA Housing also grew its housing management portfolio to 1,418 dwellings in the same year, substantially increasing the number of people we have been able to support into stable accommodation. Our Employment Solutions also offered ten programs that helped 165,000 individuals and assisted 15,850 people move into sustainable employment[1].

In NSW/ACT

In 2012 Mission Australia NSW/ACT strengthened families and children, empowered youth, strived to solve homelessness and supported job seekers through 167 community services, including 12 Early Learning Services centres, and six Employment Solutions programs.

During the year we also opened two new youth wellbeing centres in Coffs Harbour and Dubbo - the *Junaa Buwa! Centre for Youth Wellbeing* and *The Mac River Centre* respectively. These two rehabilitation centres are for young people who have entered, or are at risk of entering, the juvenile justice system. Both are funded by NSW Juvenile Justice and offer rehabilitation and treatment, educational and living skills training plus aftercare support. They help youth build positive futures and are built on the evidence base of Mission Australia's Triple Care Farm (TCF) service model.

TCF is our world-leading residential youth rehabilitation program located near Wollongong, NSW and has achieved significant successes. In 2010, it was named the winner of The Australian and New Zealand Mental Health Services Conference Achievement award for excellence in services for children, infants and adolescents; while in 2009 it won the National Drug and Alcohol Award for Excellence in Services for Young People award. TCF offers five distinct programs - a residential living skills program; counselling and case management program; vocational training education program; a creative arts program; and sport and recreation program. Upon completion of these components the students are provided with the Stepping Out aftercare program which supports students for six months in the community. Outcomes include an observed reduction in substance use; increased quality of life; increased participation in employment; education and training; improved stability in housing; and improved psychological health[2]. The after-care program further helps to reduce the risk of relapse.

Our response

Mission Australia Community Services welcomes the opportunity to respond to the *Inquiry into drug and alcohol treatment - Terms of Reference.* It is the combination of our direct service experience in the provision of drug and alcohol services in NSW and elsewhere as well as our research that informs

[1] Mission Australia (2012) *Annual Report 2012*. Mission Australia: Sydney.

[2] More information about the program and the outcomes achieved can be found in the evaluation of TCF Mission Australia (2011) *Triple Care Farm: A Safe Place for Change 1989-2009*. Mission Australia, Sydney. http://www.missionaustralia.com.au/downloads/fact-sheets/documents/file/60-triple-care-farm

our response. On that basis we have restricted our responses to only those terms of reference where we have direct relevant experience.

Terms of reference

1. 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 having regard for:

(a) The need for appropriate human research, ethics and Therapeutic Goods Administration approval for use of new treatments in clinical trials

(b) The current body of evidence and recommendations of the National Health and Medical Research Council

Mission Australia fully supports the need for approval of treatments through a range of processes such as those outlined above at point (a). Our concerns relate to the limited opportunities that are provided to the community sector services. Not only does this reduce the ability of services to participate in human research and ethics processes more generally but ensures they remain limited in their capacity to do so into the future.

Both the lack of participation opportunities and limited resources available to the community sector have resulted in a paucity of literature on the efficacy of the community sector treatment services in addressing the welfare and health of individuals dependent on drugs or in assisting their families and carers. Their contribution to the community level impact is therefore also unknown. The impact of this is two-fold – firstly, the plethora of information available from these services on treatment efficacy, best practice service models and similar is often overlooked. Secondly, the community sector is not able to contribute to setting the research agenda which is of concern given the community treatment sector often has insights that government and other service providers may not have.

Where the opportunity to participate in research does exist it is usually at the request of academic or other partners after the nature of the research and/or the research questions has already been determined. In our view this represents a lost opportunity to examine issues affecting the welfare and health of individuals dependent on drugs and their families, carers and the community; it also represents a lost opportunity to determine the most effective and efficient treatment service models. It also means that the current body of evidence and recommendations of the NHMRC are missing valuable contributions.

In relation to naltrexone treatment specifically, Mission Australia shares the concerns raised by the Australian National Council on Drugs about its use[3] that are endorsed in findings by the NSW Coroner on 27 September 2012. We also support the calls by the Australian Injecting and Illicit Drug Users League (AVIL)[4] that there needs to be a review and change to the availability of naltrexone implants particularly as it relates to access through the Therapeutic Goods Administration (TGA) 'Special Access Scheme' Category A[5]. In AVIL's view, one we support, this scheme is being used inappropriately given there are 'safer, less expensive, more effective and evidence-based

[3] The ANCD *Position Statement on Naltrexone Sustained Release Preparations (Injectible & Implants)* is available online at http://www.ancd.org.au/images/PDF/Positionstatements/naltrexonepositionstatement.pdf

[4] AVIL is the national peak organisation that advocates for, and represents, people who use or have used illicit drugs including people with opioid dependence. Their Public Statement on Continued Use of Naltrexone Implants is available at http://www.aivl.org.au/database/sites/default/files/AIVL%20Public%20Statement%20on%20the%20Continued%20Use%20of%20Naltrexone%20Implants.pdf

[5] 'Special Access Scheme' Category A allows the supply of an unregistered medicine if the person is suffering from a life-threatening condition and where there is a lack of alternative treatments.

medications already approved through the standard regulatory TGA process for opioid dependence'. Of greater concern is that the use continues to be permitted despite mounting evidence that adverse health outcomes and even fatalities have been associated with the use of naltrexone implants. It also appears that patients are not being advised that naltrexone is unregistered which, in our view, would affect their ability to provide informed consent to their treatment, particularly in the absence of any discussion about alternative treatment options.

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

Mission Australia Community Services in NSW have significant concerns about the level and adequacy of funding for drug and alcohol services in the state, particularly as the recent reduction in funding has resulted in the closure of a number of our detox beds. This funding reduction has occurred despite increasing demand for services as a result of court-referred treatment orders and the changes to the *Children and Young Persons (Care and Protection) Act 1998*[6] which can require individuals on parent responsibility contracts to attend drug and/or alcohol treatment services as well.

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

Mission Australia would firstly like to differentiate between mandatory treatment that includes the element of voluntary participation through informed consent and mandatory treatment which is involuntary treatment under the *Drug and Alcohol Treatment Act 2007* (NSW); the *Inebriates Act 1912* (NSW); or the *Drug Court Act 1998* (NSW). In our experience there are comparable successful outcomes for clients who attend voluntary services and those who attend court-referred services that include informed consent as part of that engagement.

In our experience, working with large numbers of young people who are referred to our services through the court system, the success stems from empowering an individual to make choices about their treatment options. This includes offering a client-led approach that incorporates quality of life measures and reduction in use indicators rather than the measure of success being linked to an arbitrarily applied time frame.

One of the problems with mandatory (involuntary) treatment as we see it – apart from the lack of informed consent to participate – is that it can result in inappropriate referrals for treatment. For example we have seen young people referred to residential treatment programs for levels of drug use that do not meet the criteria for any form of drug treatment using widely accepted and validated measures of dependency. Removing an individual's ability to consent to treatment, combined with an inappropriate treatment referral, therefore limits the ability to tailor service responses to best meet an individual's needs. It can also lead to restrictive care practices which are both ineffective and lead to inefficient systems of care.

Operationally we have also seen a reduction in the use of 'day release' options to enable individuals who are remanded in detention to attend our services to undertake assessments for treatment - even where this relates to mandatory treatment. Previously young people (up to 24 years for some of our services) were able to attend the service as part of their preparation for release and/or for the requirement of their order. This approach enabled the assessment to be undertaken in the agency where the person would receive treatment, with confidentiality assured and as per best practice

[6] Section 38A Parent responsibility contracts - specifically s38A (5)(a) attendance of a primary care-giver for treatment for alcohol, drug or other substance abuse during the term of the contract,

guidelines. There have been recent changes with clients either attending for their assessment under supervision (including handcuffed) or the service being asked to attend the detention facility to complete the assessment there. These practices are not conducive to an effective or accurate assessment nor do they suggest informed consent. It is unclear whether this revised practice is the result of recent changes to the *Bail Act* but we are concerned about their impact on our ability to undertake assessments.

As an organisation we are also concerned about mandatory treatment more generally as such responses are often based on little evidence as to their efficacy. What is more concerning is that such treatment disproportionately affects some of the most marginalised sectors of our community. We would therefore like to see greater emphasis on the evaluation of these mandatory treatment regimes, particularly compared to treatment outcomes achieved where informed consent is provided at the outset of the treatment program.

We would point out that Mission Australia is aware that involuntary treatment may be the only way some people will ever access treatment. It is our belief that there is a need to maintain an individual's right to refuse treatment but ensure that individuals do so fully cognisant of the implications of their refusal. We are also concerned about some of the practices we have heard emerging in response to gaining consent indirectly – see our response to Terms of Reference 7 for more specifics.

4. 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

Mission Australia is aware that there are excellent integrated service models in the community sector but unfortunately note the lack of awareness of these services. All three of the programs we highlighted in our introduction treat co-morbid conditions. We are fortunate that our services do not have to place limitations on the number of beds available to people presenting with co-morbid conditions. Other services have to place limitations or restrictions on the number of beds they can provide for people with co-morbid conditions because of the minimal funding available for co-morbid services.

In addition to the three programs already outlined we also operate integrated services to treat co-morbid conditions in our aged care facilities in NSW. Annie Green Court and Charles Chambers Court provide residential aged care for elderly people who have experienced homelessness[7].

Further to our response to Terms of Reference 1, increasing the contribution the sector can make to setting and participating in the research agenda would be of substantial benefit for two reasons. Firstly, it would help to raise awareness of the integrated services available within the community and secondly, the involvement of such services in the research agenda would help to build and strengthen the available body of evidence.

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

We note the Object of this Bill is to 'amend the *Drug and Alcohol Treatment Act 2007* to further provide for the involuntary rehabilitative care of persons with severe substance dependence'. Our concerns about involuntary treatment have been raised in response to Terms of Reference 4. In

[7] More information about these services is available at http://www.missionaustralia.com.au/component/content/article/99-ma-community-services/community-services-listing/518-residential-aged-care

addition we have concerns about the inclusion of the new option for rehabilitation where it provides for naltrexone implantation. We would reiterate our concerns expressed at ToR 1 on this topic.

Mission Australia is also concerned about the proposed amendments to the 'procedure for assessing persons for involuntary treatment, including by adding to the persons who can request an assessment and to the circumstances in which a person can be involuntarily treated'. The proposed revised Section 9 - *Certain persons may request assessment of person with suspected severe substance dependence* – adds substantially to the list of individuals who can request assessment. Given the consequences of the request for assessment, namely involuntary treatment, we are gravely concerned about this proposed reform.

Section 9A(4) indicates that 'A dependency certificate must not be issued in relation to a person unless the accredited medical practitioner has sought the involvement of the person in the process of planning and developing a personalised plan for the person's rehabilitation and treatment'. We acknowledge and support that provision as it requires participation on the part of the individual that will become subject to a dependency certificate. This implies that some element of informed consent would exist in the process. There are concerns in the sector that assessments to determine whether or not a dependency certificate will be issued have been done in an indirect manner which would appear contrary to this provision. In our view s9A(4) could and should maintain an individual's right to consent to assessment and their right to refuse treatment should not simply exist at the expiration of their dependency certificate.