Submission No 51

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

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LEGISLATIVE COUNCIL INQUIRY INTO DRUG AND ALCOHOL TREATMENT GENERAL PURPOSE STANDING COMMITTEE NO. 2 NSW MINISTRY OF HEALTH'S SUBMISSION

April 2013

Terms of reference:

That the General Purpose Standing Committee No 2 inquire and report on the effectiveness of current drug and alcohol policies with respect to deterrence, treatment and rehabilitation, and in particular:

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
2) The level and adequacy of funding for drug and/or alcohol treatment services in NSW
3) The effectiveness of mandatory treatment on those with drug and/or alcohol addiction, including monitoring compliance with mandatory treatment requirements
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
5) 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
6) 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
7) The proposed reforms identified in the Drug and Alcohol Treatment Amendment Bill 2012.

Executive summary

Alcohol and illicit drug use account for 5.4% of the world's annual burden of disease. Drug and alcohol use contributes to many types of harms in Australian society. There are a number of types of drug-related harm, including those in the domains of health, social and economic functioning, safety and public order, criminal behaviour, corruption and environmental damage. The main sources of these harms include drug use, drug related crime, and societal responses to drugs.

Repeated use of a substance, both illicit and licit, can result in dependence which is characterised by a range of behavioural, psychological and physiological indicators including an overriding focus on acquiring and taking the drug. Chronic drug and/or alcohol use significantly increases the risk of mortality and morbidity for the user. To address addiction and other harms arising from drug and/or alcohol use, Australia has an overarching policy framework articulated in the N*ational Drug Strategy,* which is based on partnerships between the health, law enforcement and education sectors.

The delivery of effective treatment services is continuously challenged due to the fact that drug and/or alcohol users are not homogenous as a cohort. There is a diversity of substance users and a diversity of markets. This coupled with changing demographics and patterns of use such as the emergence of synthetic substances and increased misuse of pharmaceuticals presents challenges for policy makers and service providers to ensure that treatment programs are effective.

In NSW, treatment services for those addicted to drugs and/or alcohol include a broad spectrum delivered within a range of contexts, from withdrawal management, pharmacotherapy and involuntary treatment to counselling, residential rehabilitation, and relapse management services. To ensure that the diversity of population and individual needs are met a system of accessible and comprehensive care, services are provided within the private, public and non-government sectors.

NSW also has a range of court diversion programs to divert illicit drug users, and more recently alcohol users, from the criminal justice system into treatment in order to improve health and social outcomes and reduce re-offending. Diversion programs are well established in NSW and have been evaluated favourably.

The delivery of high quality and effective treatment services in NSW is based on evidence informed clinical practice. The Therapeutic Goods Administration and the National Health and Medical Research Council provide guidance as to appropriate ethical frameworks for research and clinical practice. Treatment services in NSW have demonstrated effectiveness in reducing the social, economic and health harms associated with opioid dependence. In addition such programs have been shown to contribute to reduced levels of crime associated with illicit drug use.

Introduction

Background to the problem

Drug and alcohol use cause many types of harms in Australian society. There are a number of types of drug-related harm, including those in the domains of health, social and economic functioning, safety and public order, criminal behaviour, corruption and environmental damage. The main sources of these harms include drug use, drug related crime, and societal responses to drugs.

Repeated use of a substance, both illicit and licit, can result in dependence which is characterised by a range of behavioural, psychological and physiological indicators including an overriding focus on acquiring and taking the drug. Chronic drug and/or alcohol use significantly increases the risk of mortality and morbidity for the user.

Disorders arising from alcohol use include intoxication, anxiety, depression, alcohol dependence and withdrawal states. Medical complications including liver cirrhosis, pancreatitis, stroke and hypertension are related to daily alcohol intake. Alcohol use is associated with an increased risk of injury to the drinker and others through motor vehicle and other accidents, and an increased risk of violence. It can be a disruptive influence at work and in the family, and a contributor to economic hardship, chronic unemployment, marriage breakdown, neglect of children, sexual problems, disharmony and social isolation.

Illicit drugs not only have dangerous health impacts, but are also a significant contributor to crime. Like alcohol, illicit drugs can contribute to road accidents and violent incidents, and to family breakdown and social dysfunction. Unsafe injecting drug use is also a major driver of blood-borne viral infections.

Other drugs and substances that are legally available can also cause serious harm. The abuse of inhalants, like petrol, paint and glue, can cause brain damage and death. The misuse of pharmaceutical drugs can have serious health impacts and their trafficking contributes to illegal drug-related crime. Pharmaceutical drug misuse is an emerging problem in Australia and internationally. A wide range of pharmaceutical drugs are involved, but opioids (prescription and non-prescription) and benzodiazepines are particularly concerning. Another emerging problem is the use of synthetic substances like synthetic cannabinoids and synthetic cocaine. Governments around the world are currently grappling with legislative reforms and strategies to minimise the impact of these drugs and prevent more from appearing on the market.

Drug and alcohol abuse contributes to and reinforces social disadvantage experienced by individuals, families and communities. Children living in households where parents misuse drugs are more likely to develop behavioural and emotional problems, perform more poorly in school and to be the victims of child maltreatment. Within families where there is substance abuse, there is an increased risk of domestic violence, loss of family income, accident and injuries, and an adverse impact on family life.

The national picture

According to the Australian Institute of Health and Welfare in 2010i:

- Approximately 15% of the national population 14 years and above had used one or more illicit drugs in the past 12 months, with cannabis the most commonly used illicit drug (10.3%), followed by MDMA (‘ecstasy’) (3.0%), and amphetamines and cocaine (each used by 2.1%).
- One in five people drank alcohol at levels that put them at risk of harm during their lifetime, with 18.6% of people likely to drink alcohol at quantities that placed them at risk of lifetime harm.
- Many people who used an illicit drug also used other substances, licit and illicit.
- Australia has approximately one drug overdose death each day.
- Around 8% of people in Australia aged 16–85 years have had a drug use disorder (including harmful use/abuse and/or dependence) in their lifetime.

- In 2010, 10.2% of sentenced prisoners had a drug defined crime as the most serious offence for which they were imprisoned (up from 9.2% in 1992). Some 66% of Australian prisoners reported using illicit drugs in the twelve months prior to incarceration, and 62% of people arrested by police tested positive to illicit drugs in 2010.

The problem in NSW

According to the NSW Population Health Survey:

- The proportion of adults aged 16 and over who drink more than two standard drinks on a day where they drink alcohol is 29.6% of the population in 2011.
- Cannabis remains the most used illicit drug in NSW. Between 2007 and 2010 there was a significant increase from 8% to 9.3% in recent cannabis use for people aged 12 years or older.
- Of the 1.5% methamphetamine recent users in NSW, usage rates were slightly higher amongst males (1.7%) than females (1.4%) for people aged 14 years or older.
- In NSW, ecstasy use in the previous 12 months in 2010 was higher amongst males (3.4%) than females (2.3%). In NSW recent ecstasy use for people aged 14 years or older was 2.8% ranking as the third lowest usage rate in the country.

Global comparisons

In terms of impact of drug and/or alcohol abuse:

- The World Health Organisation estimates that alcohol causes a net harm of 4.4% to the global burden of disease [ii]
- Illicit drug use accounted for 2.0% of Australia's total burden of disease in 2003. Much of this was caused by hepatitis C, which can be contracted by risky injecting practices.
- The social cost of illicit drug use in Australia in 2004–05 was estimated to be $8.2 billion, including costs associated with crime, lost productivity and healthcare.
- The cost to Australian society of alcohol, tobacco and other drug misuse in the financial year 2004–05 was estimated at $56.1 billion[iii]
- Based on self-reported days off work because of drinking, more than 2.5 million work days were missed in 2001, at an estimated cost of $437 million. Costs were also calculated for differences in the illness or injury-related absenteeism of drinkers and non-drinkers. Using this method, almost 7.5 million days off because of any illness or injury were estimated to be alcohol-related, at a cost of $1.2 billion[iv].

Policy and program guidelines

This section covers details on the following: policy and program frameworks; eligibility; current demand measures; service locations and relevant data.

The policy framework

The National Drug Strategy 2010-2015 provides the overarching national policy framework in Australia based on partnerships between the health, law enforcement and education sectors. The overarching approach of harm minimisation, which has guided the National Drug Strategy since its inception in 1985, will continue through 2010–2015[v]. This encompasses the three pillars of:

- demand reduction to prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community;
- supply reduction to prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs; and
- harm reduction to reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs.

The three pillars apply across all drug types but in different ways, for example, depending on whether the drugs being used are legal or illegal. The approaches in the three pillars will be applied with sensitivity to age and stage of life, disadvantaged populations, and settings of use and intervention.

The NSW Government's key priorities for the next ten years are outlined in *NSW State Plan 2021: A Plan to make NSW Number One*. A number of goals articulated in the Plan are of relevance for the delivery of drug and alcohol programs and treatment services in particular: keeping people healthy and out of hospital; prevent and reduce the level of reoffending; and to better protect the most vulnerable members of our community and break the cycle of disadvantage. Further the Plan has a stated target to reduce total risk drinking to below 25% by 2015.

The program response continuum

Across government responsibility

Harms associated with drug and alcohol use arise from and impact on the socioeconomic, community, family and individual environments. Whilst responsibility for providing treatment interventions to reduce harm from use to individuals and families predominantly falls with health, responsibility for reducing broader community impacts falls across government. In order to prevent or break the cycle of harm, including homelessness, crime, disruption to public amenity and domestic violence, it is necessary for collaboration between government agencies including: NSW Police Force, Attorney General and Justice, the Office of Liquor Gaming and Racing, Family and Community Services (Housing, Community, Ageing Disability and Home Care), Education and Communities and Corrective Services.

Responding to drug and alcohol problems requires a whole of community and whole of government response delivered through a spectrum approach. This begins with prevention of uptake of substance use via education about the harmful impacts of drug and alcohol abuse and ends with facilitating abstinence through the delivery of evidence based treatment and community care programs.

NSW Health program elements across the continuum

To effectively deliver on these objectives requires a comprehensive system of care and a cross government and public health approach. The taxonomy of services that form the drug and alcohol program in NSW covers a continuum in order to prevent and reduce the impact of drug and alcohol related harm.

This continuum includes:

1. Prevention, health promotion, and early and brief intervention;
2. Evidence based treatment and extended care services;
3. Specialist services;
4. Involuntary and criminal justice diversion programs;
5. Comorbid conditions; and
6. Treatment for specific population groups.

These services are delivered across and by government, non-government and private sector providers. This composition is necessary in order to ensure an effective system that addresses the breadth of individual, family and community needs arising from problematic substance use.

The types of services include education and awareness interventions, biological interventions and psychological and social interventions.

1. Prevention, health promotion, and early and brief intervention

Preventing drug misuse can be more cost-effective than treating established drug problems. Prevention efforts can help reduce personal, family and community harms, allow better use of health system resources, generate substantial economic benefits, and produce a healthier workforce.

A key step in preventing the uptake of drugs is changing population culture so that drug misuse is no longer seen as a cultural norm. This involves improving community understanding and awareness of the drugs that are being used, their effects and harms associated with their misuse, and the choice of effective interventions and treatments.

Both universal and targeted strategies are essential to build stronger communities and improve resilience. Investment in development across the life course is needed, as well as specific problem prevention strategies. Such investments need to incorporate structures for child and youth development and early interventions and safety nets across the life course for those who begin problematic trajectories. To do this effectively requires a whole of government response and in NSW there is a strong commitment across agencies to ensure that policies and programs reflect the principles of harm reduction.

Early initiation to drug and alcohol use can lead to adverse long term health, criminal and social outcomes and reduce lifetime opportunities[vi]. Educating young people, parents and broader community members on the harmful impacts of drug and alcohol misuse has been a function of governments and community organisations for many years (for example, temperance movements commencing in the 1920's).

In 2012/13 the NSW Ministry of Health provided funding for school based education programs, community based programs, peer education activities and social marketing activities and the drug and alcohol resources to reduce drug and alcohol problems and harms in the community. There is significant evidence of the effectiveness for school based programs to reduce the uptake and prevent drug use and alcohol misuse. Programs that build on, support and enhance school curriculum are more successful than stand alone activities. Peer education remains a useful strategy to deliver drug and alcohol education to at risk populations and community engagement and development strategies, whilst the evidence is less strong, are important strategies to engage and mobilise communities at risk.

Education activities in NSW can all be conceived under elements of the three pillars of harm minimisation framework. A majority would draw on elements from two or more pillars in their design. For example, school education programs work at both the demand and harm reduction levels, whilst programs delivered to advise on the legal impacts of provision of alcohol to minors drawn on supply and demand levels.

There is much evidence to suggest that programs designed and delivered on multiple levels are more effective at preventing and reducing drug alcohol misuse than single, one off strategies.

NSW Ministry of Health alcohol social marketing campaigns

The Ministry produce and implement a number of social marketing campaigns each year to ensure the community remain informed of current concerns and risks and make lifestyle changes to enjoy better health.

Research conducted by the Ministry indicates that there is an increasing consensus that, rather than only focusing on individual behaviour, social marketing that seeks to reduce the incidence of undesirable drinking behaviour should aim to change values, beliefs and norms that surround alcohol consumption. This new direction for alcohol social marketing is motivated by the understanding that drinking practices, including 'problem' drinking, are learned and reinforced socially; that is to say, they are products of the culture within which they occur.

Ministry of Health campaigns and resources promote healthy choices and provide information on risk and harms associated with alcohol and other drug use along with treatment and service options.

Ministry of Health campaigns include:

- *The 2012 state-wide Aboriginal Prenatal Mental Health and Drug and Alcohol Campaign Stay Strong and Healthy – It's Worth It*.

The Campaign aims to raise awareness of Aboriginal pregnant women and their partners of the risks of drug and alcohol consumption during pregnancy as well as the potential challenges of dealing with a mental illness.

The key message "Stay Strong and Healthy – It's Worth It" is a reminder that healthy choices during pregnancy mean a stronger and healthier baby.

The Campaign also aims to raise awareness of services available to Aboriginal pregnant women and their families across NSW. These include 11 new specialist mental health, drug and alcohol services co-located in Aboriginal Maternal and Infant Health Services in Shellharbour, Taree, Wagga Wagga, Griffith, Gosford, Narellan, Coffs Harbour, Mount Druitt, Dubbo, Walgett and Broken Hill.

The shame, stigma and lack of knowledge about mental health and drug and alcohol issues during and after pregnancy are often a major barrier preventing Aboriginal women from seeking professional services.

Campaign communication materials include: radio, print and online advertising, posters, a postcard, an illustrated storybook and an online Facebook page.

- *What are you doing to yourself?* – campaign is aimed at educating young people (16-29) about the risks associated with binge or excessive drinking and public drunkenness.

The creative executions and messages place the responsibility on the individual, and focus on how much they drink and the consequences. A key finding from a previous evaluation showed that the campaign performed very well for a print campaign, achieving higher prompted recall (67%) than the Australian Government campaign "Don't turn a Night Out into a Nightmare" (61%) and slightly lower than the current RTA "No one thinks big of you" (76%) – both of which included a large TV spend.

The campaign is print based and creative executions include posters, in-venue advertising, print media and outdoor. There is capacity to develop a digital/social application for the campaign.

In 2012/2013 the campaign was implemented in the Kings Cross area as a key action in the NSW Government's Kings Cross Management Plan.

There has been a greater focus on males in the campaign creative executions. The 2008 NSW Population Health Survey indicates that in 2008, 1 in 10 adults engaged in high risk drinking behaviour – a significantly higher proportion of males (13.4 per cent) than females (6.7 per cent.)

- *'Know when to say when'* – campaign has a long term objective of engagement with the broader community about how and why we drink, and how we as a community need to change negative drinking practices as a long-term solution to problematic alcohol use and to contribute, along with existing education, policy and regulatory initiatives (over the next five to ten years).

The 2011 evaluation reported the campaign achieved good reach across the target audience with nearly two out of three recalling having seen the ad (63%). There is also evidence that the campaign effectively targeted risky and high risk drinkers with messages that encouraged them to contemplate their current drinking behaviour.

Campaign material includes TV, print, online and digital.

Research also indicates that cultural change is most likely to be achieved if the social marketing strategy is supported by other measures; for example, community programs, including Community Drug Action Teams (CDATs) and liquor accords; online and telephone support services for people who want to get help to deal with an alcohol problem; responsible commercial practices; and ongoing enforcement of existing legislation.

Drug info @ your library

In 2012/2013, funding was provided to the Library Council of NSW (State Library of NSW) to fund the Drug Information in Libraries Project. The Drug info @ your library Project provides easy-to-read and accurate information about alcohol and illicit drugs for the NSW community. The Project has been providing accessible drug information to communities through the drug info website www.druginfo.sl.nsw.gov.au and public libraries since 2002. The project is a partnership between the NSW Ministry of Health and the State Library of NSW.

The Drug info collection of books, booklets and free pamphlets is available in 374 public libraries across NSW. Forty six per cent of the NSW population are registered library users. An internal review of the Drug info service conducted in early 2012 in regional and metropolitan public libraries reported that all librarians consulted stated the collection was extensively browsed and read within public libraries.

In 2011/2012 there were 16,163 visits and 56,359 page views to the Drug info website.

An independent evaluation of the 'Drug info at your library' project in 2010 reported the Drug info project is "viewed by stakeholders and strategic partners as providing an essential service".

'Your Room Website'

The "Your Room" drug and alcohol consumer website is a joint project of Alcohol & Drug Information Service (ADIS) and NSW Health. The website provides accurate, up-to-date and accessible drug and alcohol information for consumers through the promotion of drug and alcohol materials, campaigns and resources, Community Drug Action Teams (CDATs) and provides counselling, referral and treatment information.

Alcohol & Drug Information Service (ADIS)

The Alcohol and Drug Information Service is a 24 hour, 7 day a week helpline funded by NSW Health to provide support, information, crisis counselling and referral for alcohol or drug issues.

Drug and alcohol resources

There are a number of print resources produced to provide information and education to the NSW community on drug and alcohol issues, these include:

- 'Guides to Dealing with Alcohol for Teenagers and Parents', which aim to provide teenagers and parents with information on dealing with alcohol.
    - The Guides to dealing with teenagers and alcohol education resources targets young people aged 16 to 18 years and their parents with information about the risks associated with alcohol misuse, public drunkenness and excessive drinking. An independent evaluation of 'Guides to dealing with alcohol for teenagers and parents' reported a high uptake of the resources by the target audience and the guide was rated as "useful" by 81% of parents who had looked at it.
    - The Guide to dealing with teenagers and grog targets Aboriginal young people and their parents. The resources stress the legal and health implications of consumption of alcohol by minors. In the evaluation of the Aboriginal resources, Aboriginal parents stated the parent resource increased their knowledge of strategies to overcome barriers influencing their children's behaviour toward alcohol.
- The Drug Smart wallet information cards is a resource that targets young people 11 and 17 years of age and provides advice and guidance on some of the drugs and situations they may encounter. Approximately 25,000 are distributed each year primarily through the CDAT network.
- Drug Facts: a suite of 8 fact sheets with information on alcohol, marijuana, speed and ice, heroin, cocaine, hallucinogens, benzodiazepines and ecstasy. The topics covered include side effects, withdrawal, effects on pregnancy and the law.
- Family Matters: How to approach drug issues with your family booklets; an information booklet designed to help parents answer questions when talking to their children about drugs (available in English and 15 community languages).

<u>Programs to raise family, student and community awareness of alcohol related harms</u>

The Liquor Act 2007 makes it an offence to sell alcohol to people under the age of 18 years; to supply (provide) unless a parent or guardian; to buy on behalf of a person under the age of 18 years.

In 2008, among students aged 12-17 years, 77.2 per cent had ever had an alcoholic drink. Students aged 12-15 years (72.3 per cent) were significantly less likely than students aged 16-17 years (89.6 per cent) to have ever had an alcoholic drink. There was no significant difference between males and females. In regards to provision of alcohol, students reported that parents, friends supplied, or it was purchased on their behalf, (2008 Secondary Students Health Behaviours Survey). 'Secondary supply' is a term applied to alcohol provided to a minor from an adult or another minor. Programs aiming to educate on the health and legal impacts of alcohol secondary supply have been developed in New South Wales.

'Supply Means Supply'

A Central Coast Health Promotion Service program, the model of 'supply means supply' brings health workers, police, parents and young people together to improve individual and family members awareness of the legal and health risks associated with providing alcohol to people under the age of 18 years. The program is supported by local media campaigns that provide information on the potential legal and health ramifications of providing alcohol to minors.

Your Choice

'Your Choice' is a NSW Police led program that draws on the 'Supply Means Supply' model of provision education for young people (under 18 years), parents and community members on supply

of alcohol. In 2011 an evaluation of the Your Choice program was conducted on behalf of the NSW Police and Foundation for Alcohol Research and Evaluation (FARE). The evaluation found that there is confusion regarding the laws and fines on supplying alcohol to minors (especially parents to children); that social marketing strategies require lengthy exposure periods for impact; that greater involvement with community activities and school education would assist in reinforcing the messages and greater clarity of messages on which aspects of secondary supply are illegal[vii].

2. Evidence based treatment and extended care services

Harm reduction and abstinence are complementary principles underpinning the delivery of drug and alcohol treatment in NSW. Available treatment interventions reflect a stepped care system to address the range of individual needs and desired bio-psycho-social outcomes. The continuum ranges from withdrawal management to involuntary care.

Withdrawal management is provided to assist in managing symptoms of withdrawal either medically or symptomatically. These services are provided through hospitals, specialist inpatient units or in the community. In order to prevent relapse and remain substance free, withdrawal management is preferably followed by psychosocial interventions, either in the community or in residential settings; and/or pharmacotherapy maintenance treatments.

NSW drug and alcohol treatment programs have models of care that underpin their operation and are guided by health policies and a suite of guidelines that provide an overarching framework to support the delivery of safe and effective treatment. Further to this, the programs are evaluated from time to time to ensure they meet the primary objectives of improving the health and welfare of individuals and families that access them.

The majority of state government funded drug and alcohol treatment is provided in generalist drug and alcohol services located in Local Health Districts, often aligned with major hospitals or other community health centres. In NSW in 2010/11 the most common treatment type was counselling (31%), followed by withdrawal management (21%) and then support and case management (11%). A smaller proportion of people seeking treatment accessed residential rehabilitation programs, predominantly provided by non-government organisations.

The National Drug Strategy 2010-2015 states: “Treatment interventions should also be tailored to the varying needs of individuals (including the potential for access to substance-specific treatment and services).” To ensure this, the NSW Government facilitates access to a broad range of approaches to accommodate for individual treatment goals and outcomes and the specific needs of particular substances and for specific populations.

<u>Drug and alcohol treatment services in NSW</u>

The delivery of effective treatment services is continuously challenged due to the fact that drug and/or alcohol users are not homogenous as a cohort. There is a diversity of substance users and a diversity of markets. This coupled with changing demographics and patterns of use such as the emergence of synthetic substances and increased misuse of pharmaceuticals presents challenges for policy makers and service providers to ensure that treatment programs are effective.

The delivery of high quality and effective treatment services in NSW is based on clinical practice being evidence informed. In NSW the Government is responsible for ensuring that there is range of accessible drug and alcohol treatment services available in the community and that these services meet the range of biological, psychological and social needs of individuals. This includes establishing clear referral pathways to specialist services from hospitals and the primary health services.

Local Health Districts deliver a range of drug and alcohol services along a continuum of care including: Withdrawal Management (Detoxification); Pharmacotherapy; Psychosocial Counselling; programs for specific substances; Inpatient Residential Rehabilitation; the Involuntary Treatment Program; Case Management and Assertive Outreach; Relapse Prevention & Aftercare Services.

Included in the range of services are court diversion programs to divert illicit drug users, and more recently alcohol users, from the criminal justice system into treatment in order to improve health and social outcomes and reduce re-offending. Diversion programs are well established in NSW and have been evaluated favourably. They operate according to evidence-based practice and reflect a successful coordinated whole-of-government approach. NSW has the largest suite of diversion programs in Australia, with a combination of police and court based programs operating within an interagency approach. NSW Ministry of Health is responsible for the provision of drug and alcohol treatment and other health services for the Magistrates Early Referral into Treatment program, Cannabis Cautioning and Adult Drug Court.

Diversion Programs have become a major part of the treatment effort and make use of several treatment modalities with the aim of encouraging drug offenders to enter treatment instead of the prison system.

In addition to services provided by LHDs, non-government organisations deliver a large proportion of drug and alcohol treatment services in NSW. The Government provides funding to support over 1000 treatment places in a range of non-government service types. Treatment options in the non-government sector include community day programs; living skills programs; a range of residential programs, including short-term programs, methadone to abstinence programs and long-term therapeutic communities. In 2011/12 the Government invested additional funding towards improving the range of treatment options in the non-government sector for people wishing to exit off opioid treatment, for people exiting custodial settings and for people with highly complex needs.

<u>General (non-drug specific) treatment services</u>

A number of core elements of the drug treatment spectrum are designed to apply across all drug types. These include withdrawal management services (detoxification), residential rehabilitation services, consultation liaison services and outpatient counselling services. The design of these services and the models of care applied do not vary significantly for any given client irrespective of the type of drug used.

Drug and alcohol consultation liaison services

Drug and alcohol morbidity is a common occurrence amongst patients presenting at the emergency departments (ED) of NSW hospitals, yet this condition is frequently unidentified increasing the risk of inappropriate treatment, post-operative morbidity, behavioural incidents, and high rates of re-presentation, re-admission and re-injury.

Consultation/Liaison services are specialist services provided to the wards of general hospitals to improve screening, referral and diagnosis of patients with drug or alcohol problems. They are most commonly staffed by nursing and medical staff.

Consultation Liaison services, practised extensively over the world, provide ED staff with direct access to support with patient management and treatment advice. Currently the Ministry of Health provides funding to five Local Health Districts and the Children's Hospital at Westmead to operate enhanced drug and alcohol Consultation Liaison services to improve ED performance indicators by reducing blockages; increase the early identification of patients with drug and alcohol problems and improve their health outcomes and improve generalist staff capacity to identify and refer patients with drug and problems to appropriate services.

Drug and Alcohol Consultation Liaison Services are intended to provide direct access to specialist drug and alcohol services for support, treatment advice and/or assistance with the management of specific conditions in patients presenting to Emergency Departments or admitted to inpatient wards with drug and alcohol related issues. These services provide an effective way to ensure that complex hospital presentations are managed appropriately in a timely manner and that vital hospital resources can be used more efficiently. An evaluation of these services in NSW is currently underway with a view to establishing an evidence base for the outcome and cost effectiveness of drug and alcohol consultation liaison services.

Withdrawal management

Withdrawal management services are designed to safely manage the withdrawal syndrome associated with cessation of drug use. It can be undertaken in an inpatient, residential or ambulatory setting. This can occur in a designated detoxification unit in the public, NGO or private sector, in a general hospital bed, in a general practice setting or managed on an outpatient basis in the patients home. There can be serious and potentially life threatening complications from withdrawal that require medical management but in many cases withdrawal can be managed safely in the patients home.

Residential rehabilitation

Residential rehabilitation services are long term residential programs lasting from three to twelve months, run by the non government sector, with a view to providing a safe environment for skills development in managing the clients addiction, and to provide a break from the social environment that frequently contributes to addictive behaviours.

Outpatient services

Outpatient services are frequently psychosocial in nature and involve counselling, skills development, relapse prevention and management of physical consequences of the patients long term drug use (eg Hepatitis C, or Liver disease).

3. Specialist services

NSW Health has established substance-specific treatment. The rationale for substance-specific treatment is essentially two-fold. Firstly, standalone substance-specific services can attract into treatment drug users who may not identify with clients of mainstream services and would not otherwise seek help. They may believe that such services will not understand the difficulties they experience and will not be able to assist. The existence of substance-specific services provides a clear signal to users of a particular drug that their issues are understood. This is particularly the case for cannabis which many in the community, and even in health services, do not consider to be a problematic drug so the existence of cannabis-specific clinics demonstrates to cannabis users that their problems with the drug are being taken seriously.

Secondly, the profiles of users of different drugs vary and the effects of different drugs vary. Clinicians in substance-specific treatment services develop expertise in helping users of the specific drug.

<u>Cannabis clinics</u>

Six cannabis clinics for dependent cannabis users commenced operation between 2003 and 2009 in Western Sydney, Central Coast, Orange, Southern Sydney, North Coast and Hunter New England. These clinics have helped more than 6,000 people. The clinics aim to reduce the health, social and legal problems and risk of harm associated with cannabis use, and assist people using cannabis who want to become abstinent. The clinics were established due to commonly held perceptions in the drug and alcohol sector that clients with problematic cannabis use are reluctant to approach or attend a generic drug and alcohol service, and that a specifically targeted service would likely attract people currently not accessing services.

NSW Health commissioned an evaluation in 2007 which demonstrated favourable findings:

- Clients provided positive feedback about their experience including: free access, availability of a specialist service that acknowledges the seriousness of cannabis dependence, one on one counselling services, and the non-judgemental approach of clinic staff.
- The clinics were largely operating in accordance with the available evidence and identified best practice about cannabis treatment, which confirms that the approaches shown to be

most effective are psychosocial, particularly Cognitive Behavioural Therapy, Motivational Interviewing and related tools.
- The clinics do attract clients who would be unlikely to attend a generic drug and alcohol service.
- Customers of the clinics reported a reduction in use and abstinence at completion.
- The clinics helped facilitate better access for some population groups, including access to other types of services such as mental health. This was particularly important in rural and remote settings.
- The clinics were effective in establishing relationships with other service providers.

Stimulant Treatment Program (STP)

NSW Health established two clinics, one at St Vincent's Hospital, Darlinghurst and another in Newcastle to provide treatment to stimulant users. The Stimulant Treatment Program offers outpatient services to people 16 years and older seeking to stop or reduce their stimulant use.

An evaluation of the STP conducted over a period from 2008 to 2010 found:

- The STP attracted a group of treatment-naive stimulant users (36% of participants), including a substantial minority of educated clients who were in full-time work and stable relationships.
- Of those who entered the service dependent on stimulants (n = 104), 51% and 52% remitted from dependence at 3 and 6 month follow-up respectively.
- Remission from stimulant dependence was more common among first-time treatment entrants and younger clients.
- Participants who remitted from stimulant dependence showed significant reductions in hostility, psychotic symptoms, injecting drug use, crime and disability due to poor mental health.

Drugs in Pregnancy services

Substance use in pregnancy raises issues that are not solely pertinent to the health of the mother and the unborn child; it has potential to impact on the safety, welfare and wellbeing of all children in the family. In NSW there are a range of Specialised Substance use in Pregnancy Services that operate at a number of hospitals and at Drug and Alcohol Services across the State. These services provide support to pregnant women and their families throughout the pregnancy, during the birth and in the weeks and months following delivery.

The 2005 NSW Ombudsman's Report - Volume 2 - Review of Child Deaths recommended that NSW Health:

- Facilitate common benchmarks and standards for the provision of drugs in pregnancy services.
- Provide ongoing state-wide coordination and development of drugs in pregnancy services.
- Evaluate the effectiveness of drugs in pregnancy services in NSW.

Following these recommendations a state-wide review of Substance Use in Pregnancy Services (SUPS) in 2009 highlighted the need to develop and implement state-wide standards of care and common assessment tools, so that substance use in pregnancy could be identified and treated consistently across. There are a number of actions underway to ensure that both specialty and general health services work together to provide identification and early intervention for substance using in pregnancy, with a particular focus on enhancing cross-sectoral identification and response to foetal alcohol spectrum disorder.

Opioid treatment

Opioid drugs include heroin, morphine, pethidine, and oxycodone.

Opioid dependence relative harms

Less than 1% of the Australian population aged 14 years and over will have used heroin or another opioid for non-medical purposes in the last year[viii]. Despite the low prevalence of use, the economic and social cost of opioid drug use is relatively high due to:

- loss of life through fatal overdose, with heroin-related deaths occurring at a much younger age than deaths attributed to alcohol or tobacco;
- treatment of overdose and other medical consequences of injecting drug use;
- transmission of hepatitis C, hepatitis B and HIV;
- community loss due to criminal activity;
- law enforcement and judicial costs; and
- loss of quality of life for users and their families, including personal and economic cost of imprisonment.

Heroin and opioid dependence in general, is a major area of focus for drug and alcohol treatment services because the harms are disproportionate to the prevalence of use, and it is second only to alcohol as the drug of principal concern amongst people seeking treatment.

Opioid dependence is a chronic relapsing condition and opioid dependent individuals represent a significantly marginalised and vulnerable sector of society. Many are without secure accommodation, have low levels of education, are unemployed and reliant on government income support. In addition, mental health issues and opioid dependence are common co-morbidities. Opioid dependence is also frequently associated with criminal activity and many opioid dependent individuals have spent time incarcerated, further compounding their social marginalization and disadvantage.

Prevalence of opioid dependence

In 2000, the National Drug and Alcohol Research Centre (NDARC) estimated that Australia had 74,000 heroin users (6.9 per 1000 adults aged 15–54 years). Of those 74,000, it was estimated slightly under half (35,400) of these individuals resided in NSW. In 2009, the Drug Policy Modelling Program (DPMP) provided new estimations on the number of heroin dependent individuals in Australia. The figure was approximated between 80,000 and 100,000[ix].

Whilst heroin remains the most common drug injected by illicit drug users, following trends in the United States, Australia has seen an increase in the use of prescribed pharmaceutical opioids such as oxycodone by illicit drug users, a trend that is confirmed by the Australian Illicit Drug Reporting System (IDRS)x. The use of drugs such as oxycodone by drug injecting users surpasses that of heroin most predominately in non-metropolitan areas of NSW where heroin is less available.

However, similar to the trends seen in the United States, there has been a significant increase in the number of non-injecting prescribed pharmaceutical opioid dependent individuals in Australia. There are no definitive estimations on this population, a group that remains largely hidden and includes individuals who have developed iatrogenic opioid dependence as a result of chronic pain management. Given the preference for long-acting opioids such as oxycodone for the treatment of chronic pain, it is likely the prescribing of such opioids will continue to increase as a larger proportion of the population ages, developing chronic pain issues and as additional formulations of these medications become available.

Currently, there is insufficient data collected on the use of prescribed and non-prescribed 'over the counter' pharmaceutical opioids to fully describe this population and further research into this area is urgently required.

Opioid treatment outcome research

The Opioid Treatment Program in NSW chiefly uses methadone and buprenorphine plus naloxone in its treatment of opioid dependence. Buprenorphine was first introduced in 2001 and buprenorphine–naloxone in 2006. These medications have not only expanded treatment options,

but they have a high safety profile, with a very low risk of overdose, reduced risk of diversion and are long acting with the ability to alleviate withdrawal symptoms. Relapse prevention treatment using oral naltrexone is also available, however, this is primarily used to treat alcohol dependence.

There is strong evidence of the effectiveness of programs such as the NSW Opioid Treatment Program in reducing the social, economic and health harms associated with opioid dependence. In addition such programs contribute to reduced levels of crime associated with illicit drug use.

The United Nations Office on Drugs and Crime (UNODC) and the World Health Organisation (WHO) report that when the broader costs associated with drug dependence such as crime, health and social productivity are taken into account, the ratio of return on investment for every dollar spent providing treatment is 13:1[xi]. Opioid maintenance or substitution treatment is recognized worldwide as the 'gold standard' for opioid dependence and in 2005, methadone and buprenorphine were added to the WHO Model (Complementary) list of Essential Medicines. In 2001, the National Evaluation of Pharmacotherapies for Opioid Dependence (NEPOD) found that methadone maintenance treatment was the most cost-effective for opioid dependence in Australia with the highest rates of retention[xii]."

There is strong evidence that methadone maintenance treatment reduces heroin use, crime, risks associated with injecting drug use and mortality[xiii]. Those in opioid substitution treatment significantly reduce illicit opioid use and criminal behaviour. "The rate of each approximately halves with each year that a patient remains in treatment" [xiv]. Further, the March 2004 Bureau Brief of the NSW Bureau of Crime Statistics and Research (BOCSAR) citing a study by Mattick et al (2004) stated that, "…offending rates were found to be significantly lower for most people during periods when they were in methadone treatment than during periods when they were out of it" and that for "… every 100 persons in methadone for one year, NSW gets 12 fewer robberies, 57 fewer break and enters and 56 fewer motor vehicle thefts[xv]". More recent research by the National Drug and Alcohol Research Centre (NDARC) has found that the "Risk of re-incarceration was reduced by an average of 20 percent while participants remained in OST post-release[xvi]".

Psychiatric co-morbidity is prevalent among heroin users and is generally associated with poorer treatment outcomes, however research indicates methadone maintenance can reduce levels of patient distress, ameliorating patients' symptoms of depression and anxiety notable even in the first week of treatment[xvii].

Individuals who are opioid dependent often use other illicit and licit drugs at harmful levels. However retention in methadone maintenance treatment may significantly reduce these risks[xviii]. Reductions in illicit and licit drug use result in significantly reduced risks of fatal and non-fatal overdoses, less ambulance call outs and emergency department presentations.

In addition to this it is evident that programs such as the NSW OTP have the highest treatment retention rates with research demonstrating that participation in an opioid treatment program results in major improvements in a patient's social, personal and physical functioning. This is reflected in stabilisation of social relationships, work and other activities.

NSW Opioid Treatment Program

Opioid treatment is delivered in a range of service settings in NSW, including public clinics, private clinics, community pharmacies and general practice. Recently in NSW a regulation was passed to enable small non-government organisations to dispense opioid treatment in their residential services.

There are over 19,000 patients on the NSW OTP. Of these patients, 21% were dosed /dispensed opioid treatment pharmacotherapy in public clinics, 19% in private clinics, 49% in community pharmacies and 11% within correctional facilities. The majority of patients (59%) were prescribed and medically managed by a private prescriber (private clinic or GP prescriber), 33% by a public prescriber and 8% by a Justice Health prescriber.

Whilst the majority of patients engage in opioid treatment for less than five years, the NSW opioid treatment program has been demonstrated to have the highest treatment retention rates with research demonstrating that participation in an opioid treatment program results in major improvements in a patient's social, personal and physical functioning. This is reflected in stabilisation of social relationships, work and other activities[xix]

To further improve the outcomes arising from opioid treatment follow up care is necessary for people wishing to successfully cease maintenance treatment. To that end, the NSW Government invested additional funding towards the provision of non-government community based services for people wishing to cease opioid treatment and better integrate into the community through access to a range of health, social and vocational services.

4. Involuntary and criminal justice diversion programs

It is important to distinguish between mandatory treatment, for which there is a very limited evidence base in Australia, and coercive treatment and/or diversion programs. In Australia there are a range of approaches to coercion or compulsion of individuals with drug and/or alcohol addiction into treatment which are consistent with the literature[xx], including:

- Civil commitment to drug treatment is defined as the 'legally sanctioned, involuntary commitment of a non-offender into treatment for drug or alcohol dependence' (New South Wales Standing Committee on Social Issues, 2004). It pertains to individuals who have committed no offence and allows them no choice in the matter.
- Court-mandated treatment is defined by the New South Wales Standing Committee on Social Issues (2004) as 'the treatment of an offender, required by a court order'. It usually occurs where the offender's dependence has contributed to the offending behaviour.
- Coerced treatment is characterised by the presence of an offence, and some degree of choice, albeit limited, in the individual's decision to access treatment or face legal sanctions.
- Compulsory treatment is defined as treatment that has a mandate based in legislation and/or government-implemented programs. This broad definition is adopted due to its common usage in the field and general understanding that 'compulsory treatment' encompasses a wide range of coercive situations including drug diversion mechanisms, referrals within custodial settings, and civil commitment. It excludes the informal coercive mechanisms of family, friends and social institutions.

<u>Civil programs</u>

In NSW, there has been an option for mandatory treatment of people with severe alcohol and drug problems for the past century. This was previously been provided under the Inebriates Act 1912. However, a review of that Act, recommended at the 2003 Summit on Alcohol Abuse and subsequently conducted in 2004 by the Parliament of New South Wales Standing Committee on Social Issues, concluded that the Inebriates Act is "fundamentally flawed" and recommended that it be "immediately repealed" "[xxi].

The response of the New South Wales Government to the Report on the Inebriates Act 1912 recommended the establishment of short-term, involuntary care to protect the health and safety of people with severe substance dependence, who have experienced, or are at risk of, serious harm and whose decision-making capacity is considered to be compromised due to their substance use[xxii].

Subsequently, trial legislation (the NSW Health Drug and Alcohol Treatment Act 2007) was enacted to permit a trial of an alternative involuntary treatment framework as a possible replacement to the Inebriates Act.

The Involuntary Drug and Alcohol Treatment program

Under this model, a person can be referred for assessment for involuntary treatment by a medical professional, (such as General Practitioners, Emergency Department staff or Addiction Medicine

specialists) or a family member. If the person refuses to undergo an assessment, a referrer can apply to a magistrate for permission to conduct a mandatory assessment, which can include a NSW Police escort to the Involuntary Treatment Unit (ITU). If the person meets all criteria for involuntary treatment and there is a bed available, the person is admitted for up to an initial period of up to 28 days. In the model, the first phase of inpatient treatment focuses on the acute medical management of substance withdrawal and referral to other specialist medical care if required. The next phase of inpatient care provides an appropriate range of supportive interventions, such as nursing, psychology, social work and occupational therapy. Workers from an aftercare service commence planning for voluntary aftercare within the first few days of the person's inpatient stay.

A Memorandum of Understanding (MOU) was established between NSW Attorney General's Department, Department of Ageing, Disability and Home Care, Department of Community Services, Department of Education and Training, TAFE NSW, Housing NSW, Department of Health and NSW Police 'to provide for the health and safety of persons with a severe substance dependence through involuntary detention, care, treatment and stabilisation and aftercare'.

The model was trialled in four secured beds at Nepean Hospital, Centre for Addiction Medicine in Sydney West Area Health Service (SWAHS), with the first patient admitted in February 2009.

An evaluation was undertaken of the Involuntary Drug and Alcohol Treatment Trial (the Trial). The aims of the evaluation were to test a number of aspects of the trial, including the effectiveness and efficiency of the new system of involuntary drug and alcohol treatment for severely substance dependent people, the legislation that underpins the Trial and whether the proposed system is more beneficial than the Inebriates Act 1912. It also tested whether the Trial delivers the care that is required to meet the needs of people with severe drug and alcohol dependence (and their families) and whether the interests of the dependent person are maintained as paramount.

Findings from the evaluation of the involuntary treatment trial indicated that the new legislation and system of care is effective and efficient for treating severely substance dependent persons.

The system is effective by providing appropriate treatment, including supervised withdrawal, medical, nursing and allied health treatment of severe medical co-morbidities and also supportive aftercare in the community. The interpretation of the legislation through the Model of Care and implementation of the Interagency Memorandum of Understanding is also consistent with contemporary values regarding human rights and dignities of severely substance dependent people.

The trial demonstrated positive clinical and psychosocial outcomes for patients during the involuntary period:

- Providing the opportunity for medical conditions and physical health to be properly assessed and addressed and enabling patients to complete an extended period of abstinence that they would not be able to complete as voluntary patients.
- Improved social relationships, which was the most marked psychological change to patients over the first four week period particularly with family.
- Reduction in symptoms of mental health such as depression.
- 80% of involuntary patients take up post-discharge voluntary aftercare.

Positive outcomes were maintained post-discharge for patients accessing aftercare:

- The majority of patients were observed by the aftercare service to have better general, mental and physical health than 6 months previous.
- It was identified by the aftercare service that the support most commonly provided to clients related to relapse prevention and medical treatment.

Other major findings included:

- The legislation, to the extent it was been tested, provided an overall appropriate legal structure for the services being provided.
- The interests of the dependent person were maintained as paramount.

- The program successfully engaged families and carers of those people admitted.
- The voluntary aftercare component of the trial was a successful and important part of the model of care.

In conclusion NSW Health determined that overall the policy objectives of the Drug and Alcohol Treatment Act 2007 are valid and the terms of the Act remain appropriate for securing those objectives.

Subsequent to the positive findings from the involuntary treatment trial, the Government endorsed a proposal to introduce a new state-wide involuntary drug and alcohol treatment program in NSW. The program, underpinned by the Drug and Alcohol Treatment Act 2007 commenced in September 2012 at two sites- Bloomfield Hospital in Orange, Western NSW and Herbert Street Clinic at the Royal North Shore Hospital in St Leonards. A comprehensive Model of Care has been developed to provide the overarching framework for the delivery of the treatment program. The Model of Care articulates the 28 day involuntary inpatient component as well as a longer term voluntary community based program.

The commencement of the state-wide program in September 2012 resulted in the suspension of the Inebriates Act 1912. There are currently discussions underway seeking to repeal the Act.

Diversion and court mandated programs

Drug treatment policy in Australia has developed within the context of a strong harm minimisation philosophy. Complementing this is an increasing emphasis on the use of the criminal justice system to divert defendants into drug treatment.

Magistrates Early Referral Into Treatment (MERIT) program

Following the Drug Summit, New South Wales introduced the Magistrates Early Referral Into Treatment (MERIT) program on a pilot basis in a rural location — the North Coast Region. Following an evaluation of the pilot in 2003, the program has been progressively introduced into a total of 65 Local Courts across New South Wales (as at 30 June 2011) and is potentially available to over 81.3% of charged defendants[xxiii]

MERIT is a court-based program targeting adult defendants appearing before a participating Local Court who have a demonstrable illicit drug problem, and who are motivated to participate in drug treatment and rehabilitation. Defendants are referred to MERIT pre-plea (i.e., no admission of guilt is required for participation) and will return to court to answer their charges either upon completion or termination from the program. The magistrate has discretion to consider the defendant's treatment response when sentencing.

The MERIT program aims to break the cycle of drug abuse and crime. To achieve this, the program addresses the underlying health, mental health and social welfare issues considered instrumental in bringing defendants in contact with the criminal justice system.

MERIT has been operating for over 12 years and been the subject of a number of evaluations proving MERIT to be successful in reducing recidivism rates and substance use and improving health and social welfare functioning.

In terms of impact on re-offending after MERIT, people completing the MERIT program have been found to have substantially lower rates of re-offending than non-completers. In 2008, 36.1% of MERIT non-completers appeared before court within 6 months of exiting the program compared with 21.3% of those who completed the program. This was a statistically significant difference. By 12 months following program exit, 48% of defendants not completing MERIT and 32.6% of those completing had re-appeared in court on fresh charges. This difference in re-offending rates was also statistically significant[xxiv].

The MERIT program has been found to have a positive impact on health outcomes. NSW Health operates a comprehensive MERIT data collection system that incorporates a range of treatment outcome tools. Data indicates that in 2009, MERIT participants reported statistically significant

reductions in the number of days of use of all illicit drug types at program exit, compared to program entry rates. There was also a reduction in the mean number of drug classes used in the previous month and a significantly decrease in severity of dependence for program participants from program entry to exit across all drug types. Further to this, MERIT completers experience a significant reduction in psychological distress and improved physical and mental health.

In summary, the MERIT program provides access to drug treatment for a large number of Local Court defendants, many of whom have not previously received such services. The program is associated with positive outcomes for participants and reductions in reoffending, consistent with both its criminal justice and health objectives.

To build on the effectiveness of MERIT for illicit drug users, the NSW Government has been trialling MERIT for alcohol since 2009/10. The trial is currently being evaluated by BOCSAR. A small number of courts and Local Health Districts have been provided with funding to deliver MERIT services for defendants with primary alcohol use with a view to establishing an evidence base to support the expansion of MERIT to include alcohol.

The Adult Drug Court program

The first specifically designated 'drug court' commenced in western Sydney, New South Wales, in 1999 on a limited trial basis, established under the Drug Court Act 1998. Section 3 of the Act sets out the objectives the Drug Court seeks to achieve. These are:

- to reduce the drug dependency of eligible persons, and
- to promote the re-integration of such drug dependent persons into the community, and
- to reduce the need for such drug dependent persons to resort to criminal activity to support their drug dependencies.

A second Drug Court – the Hunter Drug Court – was established at the Toronto Court in March 2011. A third Drug Court – the Sydney Drug Court – commenced operation at the Downing Centre on 14 February 2013.

The NSW Drug Court Program is not strictly a mandatory program as eligible persons must be willing to participate. The alternative is, however, a lengthy prison sentence. The duration of the program for each participant is at least one year and is typically 15 months.

Once accepted onto the program, participants receive close judicial supervision with weekly, sometimes twice weekly, report-backs to the Court in Phase 1 which lasts for at least 3 months. In addition, compliance with the participant's treatment plan and other conditions set by the Court is closely monitored by health service providers and officers of the Community Compliance and Monitoring Group (part of Corrective Services NSW).

The NSW Drug Court Program has undergone a number of evaluations. In 2008, the Bureau of Crime Statistics and Research (BOCSAR) re-evaluated the Drug Court's effectiveness regarding recidivism, following the Bureau's earlier evaluations of 2002.

The Bureau's study covered a period between February 2003 and April 2007, and involved 645 in the Drug Court Group, and 329 individuals in a Comparison Group. After controlling for pre-existing differences between the treatment and comparison groups, BOCSAR found that, when compared with those in the Comparison Group, Drug Court participants (whether ultimately successful on the program or not) were:

- 17% less likely to be reconvicted for any offence;
- 30% less likely to be reconvicted for a violent offence; and
- 38% less likely to be reconvicted for a drug offence.

And in relation to those who successfully completed the Drug Court program, they were found to be:

- 37% less likely to be reconvicted of any offence at any point;
- 65% less likely to be reconvicted of an offence against the person;

- 35% less likely to be reconvicted of a property offence; and
- 58% less likely to be reconvicted of a drug offence.

Cost-effectiveness of the drug court program

The Centre for Health Economics Research and Evaluation (CHERE) undertook an analysis in November 2008 of the cost-effectiveness of the NSW Drug Court. CHERE concluded that the NSW Drug Court program is a cost-effective use of government resources.

Their primary finding was that the Drug Court program provides a net saving of $1.758 million per year when compared with conventional sanctions (jail) – even after the cost of incarcerating program failures is considered. It is of note that in the CHERE analysis the cost of incarcerating program failures represented more than half the total costs attributable to the program.

When net saving was added to the 2008 BOCSAR finding that Drug Court participants have demonstrated better effectiveness in terms of time to first offence, CHERE concluded that, from a cost effectiveness perspective, the Drug Court program is cheaper and produces better outcomes than conventional sanctions.

It is noted that the health and social benefits of people living productive lives, rather than the vicious cycle of reoffending and re-incarceration, is not calculated in these evaluations. It is feasible to deduce that this additional social and health benefits would incrementally increase the cost-effectiveness of the drug court program.

The current courts at Parramatta, Toronto and the forthcoming Downing Centre have a total capacity of 280 participants at any one time. More than half of these will eventually not serve a custodial sentence.

The Drug Court Program is a multi-agency program involving NSW Health, the NSW Police Force, Office of Director of Public Prosecutions (DPP), Corrective Services NSW and Legal Aid NSW. It is requires some financial investment to establish as it requires upfront funding for NSW Health, NSW Police and the Department of Attorney General and Justice (Office of Director of Public Prosecutions, Corrective Services NSW, and Legal Aid). The financial benefits accrue over time as reduced re-offending deliver savings to the Police, the DPP and Corrective Services.

Recently the Senior Drug Court judge, Judge Roger Dive, calculated that the 73 participants who were not required to go back to gaol in one year had a total non-parole period of 67 years. The conservative cost of the jail time alone was $5.5 million.

The Compulsory Drug Treatment Program

The Compulsory Drug Treatment Correctional Centre (CDTCC) is a purpose-built facility erected for the Compulsory Drug Treatment Program (CDTP). The CDTP began in August 2006 and operates as a five-stage post-sentencing program for males. Drug treatment and rehabilitation is provided in Stages 1-3 primarily from the CDTCC followed by Stage 4 (parole) and Stage 5 (voluntary case management) in the community where appropriate.

In 2010 BOCSAR conducted an evaluation to assess the impact of the CDTP on the health and wellbeing of participants, measuring changes in perceived coercion, affective reactions, treatment readiness and therapeutic alliance, gauging participant satisfaction with various aspects of the program, and monitoring participants' drug use whilst on the program.

Participants' health and wellbeing appeared to improve over time on the program. Although the program was coercive, the vast majority of participants felt that their participation in the CDTP was voluntary. Participants made positive comments about the program and consistently expressed their desire to be in the program regardless of what stage they were in. This is encouraging evidence that offenders in the program genuinely wanted to change their behaviour.

5. Comorbid conditions

In NSW the high prevalence of comorbidity requires that responsibility for provision of service goes across and outside of specialist drug and alcohol services. Comorbidity is defined as presence of two or more diseases in the same person. People with co-morbid conditions are more likely to have highly complex and complicated illness courses, including increased risk of illness and injury, poorer psychiatric and physical outcomes, increased difficulties in management of social and welfare needs and an increased likelihood of relapse. For these reasons it is important that an integrated approach to service delivery is applied.

Primary health care services

Under the national health reforms, the Commonwealth Government assumed full funding and policy responsibility for the delivery of primary health care. Arising from the reforms some newer models of integrated care have been established. These primary care services have been established to better address local health care needs and better address service delivery gaps. The intention is to build a health system that provides more integrated and coordinated care for patients and in turn provide more community based, rather than hospital based care. Two of the central features of the reforms are Medicare Locals and headspace.

Drug and alcohol service strategic planning should ensure that partnerships and linkages are established with both of these services in order to continue to build an effective community based integrated care system for people with comorbid conditions.

Medicare Locals

Medicare Locals are primary health care organisations that work with local primary health care providers, Local Hospital Districts and communities to ensure that patients receive the right care in the right place at the right time.

Medicare Locals operate as health system planners at the regional level. They have primary responsibility for identifying and assessing the health care needs of their populations, improving the coordination and integration of primary health care in local communities, addressing service gaps, and making it easier for individuals, carers and service providers to navigate their local healthcare system. Medicare Locals' roles and responsibilities include making it easier for patients to access the services they need by better linking local general practitioners (GPs), nursing, allied health and other health professionals, hospitals and aged care, and maintaining up to date local service directories.

Headspace

The National Youth Mental Health Foundation, *headspace,* was launched in 2006 as a Commonwealth Government funded initiative designed to provide a coordinated focus on youth mental health and related drug and alcohol problems for young people aged 12-25 years. Administration of the program occurs through the Commonwealth Department of Health and Ageing (DoHA) in collaboration with the *headspace* National Office.

Headspace sites provide young people with access to specialist, holistic health and mental health services in a purpose built, youth-friendly environment. In some locations, the NSW Health funded Youth Mental Health Services have chosen to locate their services within *headspace* sites.

The services provided by *headspace* sites include:

- General health care
- Mental health and counselling
- Education, employment and other services
- Alcohol and other drug services

Drug and alcohol and mental health comorbidity

The 2007 National Survey of Mental Health and Wellbeing included 16 million Australians aged between 16-85 years:

- 45% or 7.3 million had a mental disorder at some point in their life.
- 20% or 3.2 million had a 12-month mental disorder.
- 5.1% (819,800) had a 12-month Substance Use disorder.
- 2.9% of those surveyed met the criteria for alcohol abuse.
- Of the 2.8 million people who reported that they drank nearly every day, more than one in five (21%) had a 12-month mental disorder.
- Of the 183,900 people who misused drugs nearly every day in the 12 months prior to the survey interview, almost two-thirds (63%) had a 12-month mental disorder.
- Almost half (49%) of the people who misused drugs nearly every day had a 12-month Substance Use disorder, 38% had a 12-month Anxiety disorder, and 31% had a 12-month Affective disorder.

Comorbidity guidelines

The *NSW Clinical Guidelines for the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings* have been written for practitioners working in the health sector, in particular, drug and alcohol and/or mental health services who provide care for people with comorbid mental health and substance use disorders.

The complex presentations, illness trajectory and poor outcomes for people with comorbid mental health and substance use disorders has led to the need to identify and develop a set of guidelines to provide direction for the care and treatment of this client population. The goal of these guidelines is to improve client care and outcomes. There is a commitment to and awareness of the need to address the challenges of comorbid mental health and substance use disorders.

The principle behind the guidelines is that all clients should receive care that addresses the full spectrum of their illness(es), regardless of where they present . This 'no wrong door' principle is essential for the delivery of integrated services and advocates that the responsibility of providing care that addresses the range of client needs is the responsibility of the provider/service where the client presents.

The Guidelines describe comorbidity in relation to situations where people have problems related both to their use of substances (from hazardous through to harmful use and/or dependence) and to their mental health (from problematic symptoms through to highly prevalent conditions, such as, depression and anxiety, to the low prevalence disorders such as psychosis).

Mental Health and Drug and Alcohol Comorbidity Programs in NSW

In 2006 in recognition of the need to improve the way the system addressed the incidence and management of comorbid conditions a co-morbidity package was introduced to better integrate mental health services with drug and alcohol services. Program elements of the comorbidity package include (see previous descriptions for details):

- Stimulant Treatment Programs.
- Cannabis clinics.
- Assertive follow up: after-care workers in four Local Health Districts to establish and maintain effective linkages with the range of service systems that impact on a client's life, in order to facilitate the provision of integrated care, with linkages to a solid support network within the local community. The after-care workers will ensure continuity of care for clients through a case management process.
- Residential Rehabilitation: enhancement funding was provided to a non-government organisation, the GROW Community. The GROW Community is the only residential rehabilitation service in NSW that specifically provides mental health and drug and alcohol treatment.

- Drug and alcohol consultation liaison services.

Chronic pain and drug and alcohol comorbidity

Pharmaceutical drug misuse is an emerging problem in Australia and internationally. A wide range of pharmaceutical drugs are involved, but opioids (prescription and non-prescription) and benzodiazepines are particularly concerning.

It is estimated that chronic pain costs the Australian economy $34 billion per annum and is the nation's third most costly health problem. The NSW Government recently launched the *NSW Pain Management Plan 2012-2016* in response to recommendations contained within the Pain Management Taskforce Report. The Plan provides strategic direction for pain management services across NSW - providing a cohesive and coordinated approach to the roll out of services state-wide.

The Plan outlines initiatives to improve access to services; increase workforce capability; and invest in research into the management of pain. The evidence-based model of care identified in the plan provides a framework for an integrated, stepped approach to pain management which is intended to apply across public and private sectors - from prevention in community-based services to complex tertiary care.

An essential component of the Plan and its strategic directions is the provision of integrated care for people suffering from chronic pain. This includes the establishment of multidisciplinary pain clinics in NSW that offer effective alternatives to reliance on opioids for chronic pain. The clinics reduce hospital and emergency department presentations due to overuse of opioids – an increasingly critical problem around the world. They offer effective treatments to minimise pain related chronic disability and depression, as well as providing programs that allow people to self-manage their pain so that they can return to their normal lives.

A key factor in ensuring their success will be effective coordination and communication across disciplines, particularly given the growing prevalence of misuse of pain medication and long term dependency on opioid treatments to manage pain.

There has been an increase in the prescribing of certain opioid and benzodiazepines medications which has been accompanied by an increase in harms. In 1998-99 pharmaceutical opioids accounted for 33% of opioid poisonings, but by 2007-08, this had grown to 80%.

The misuse is due to numerous factors including pain management, poor prescribing practices and an increase in the intentional misuse of pharmaceutical drugs. For example, data from the Medically Supervised Injecting Centre shows that since May 2006 pharmaceutical opioids are the most commonly injected substance.

NSW Health has a number of strategies in place to respond to pharmaceutical misuse, including:

- Training programs for prescribers;
- Implementation of the NSW Health Pain Management Plan;
- Enhancing the Opioid Treatment Program;
- Investigations of reports concerning the misuse and abuse of prescription drugs and the inappropriate prescribing by doctors;
- Investigation of the implementation of real-time on-line monitoring of Schedule 8 prescription opioids.

Other health problems

There are a range of other health problems or conditions that can compound the risks arising from a person’s drug and/or alcohol addiction. Further to this, existing services may not currently have the capacity or skill set to effectively manage people with comorbid conditions and thus highly complex needs.

Drug and alcohol and cognitive impairment

There is considerable anecdotal evidence to suggest that people with cognitive impairment or intellectual disability experience difficulties accessing and engaging with drug and alcohol treatment services.

Whilst lower levels of substance use are identified amongst intellectually disabled people than for the general population, research has shown that intellectually disabled people who use alcohol tend to experience a greater rate of alcohol-related problems than members of the general population[xxv]

In response, the NSW Ministry of Health has established a number of programs aimed at improving the accessibility of drug and alcohol services for people with a cognitive impairment:

- Training for Magistrates Early Referral Into Treatment Workers on working with clients who have a cognitive impairment.
- The new NSW Health Centralised Intake Telephone Guidelines include information for intake workers about providing telephone assessments for people with a cognitive impairment.
- Provision of funding for a number of programs which aim to enable drug and alcohol non-government organisations to increase their capacity to provide services to people who present with co-existing intellectual disability, acquired brain injury or involvement with the criminal justice system. These include staff training, enhancements to service practices and a resource manual.

Alcohol Related Brain Injury

Alcohol Related Brain Impairment (ARBI) refers to a physical impairment to the brain sustained as a result of alcohol consumption. Due to variations in a number of factors (e.g. amount and frequency of consumption or individual differences) an ARBI may be mild, moderate, severe or very severe. An ARBI is typically associated with deficits in cognition, balance and coordination and often results in neurological complications.

Estimates of the incidence and prevalence of ARBI are particularly difficult to ascertain due to under diagnosis, and the estimates that are available are difficult to compare because of different study populations and the differing methodologies employed. In 2003, the incidence of ARBI in Australia was estimated at 23 per 100,000 for males and 6 per 100,000 for females (AIHW, 2003).

Autopsy studies have produced estimates of the prevalence of Wernicke-Korsakoff syndrome (alcohol related brain injury associated with thiamine deficiency) in Australia at around 2% of the adult population (AIHW, 2003).

NSW Health has provided funding to the Brain Mind and Research Institute (BMRI) to conduct two research studies into the prevalence of and treatment for Alcohol Induced Brain Impairment (AIBI) in 16-40 year olds in NSW. The results of these studies have informed the development of an AIBI Guidelines Document that provides information on the development, identification and treatment of AIBI for use in the NSW drug and alcohol treatment sector. NSW Health has provided the BMRI with additional funding for the 2012/13 financial year to allow continued research into this population presenting at Hospital EDs to further inform identification and treatment of this population as they present to drug and alcohol services across NSW.

6. Treatment for specific population groups

There are particular population groups for whom integrated services are fundamental for addressing the range of health, social and welfare needs that arise as a result of their drug and/or alcohol use.

Older people

Internationally we are faced with an ageing population. Researchers have predicted that by 2020 substance use disorders will have doubled (Draper). This will have significant implications for the planning and delivery of health services.

Among 'older people' data indicates:

- In Australia 7.4% aged 65-74 and 2.5% over 75 years have used an illicit drug in their lifetime[xxvi]
- In NSW, 31.7% of adults aged 65- 74; and 16.6% of adults over 75 years drink more than 2 standard drinks a day when consuming alcohol[xxvii]
- In 2012, 3.6% of the Australian population aged 65-74 and 6.1% aged over 75 years used benzodiazepines for non-medical use over the past 12 months (AIHW)
- Participants in the Needle and Syringe Program, aged over 50 years increased from less than 1% in 1999 to almost 9% in 2009
- Illicit Drug Reporting System (IDRS) reported opiate injectors aged over 45 increased from-4% in 2000 to 25% in 2010
- Of the 46,446 people receiving pharmacotherapy treatment in Australia in June 2011, 70% were living in NSW and Victoria and 16% (more than 7,400 people) were aged over 50.

The trajectory of patterns of drug and/or alcohol use indicates that in the coming decades there will be a higher prevalence of problematic drug and/or alcohol use among people over 65 years. Of particular note is alcohol use. Older adults report drinking for a range of reasons including to reduce pain, because of a "meaningless life", anxiety, depression, loneliness and sleep problems (Draper, 2012[xxviii]).

For older people there is a high risk of comorbid cognitive disorders and physical health issues – some related to substance abuse, some coincidental. Older patients are more likely to be taking medications and thus presenting a high risk of alcohol/drug interactions accentuated by age-related changes in absorption and metabolism. All of these factors provide important considerations for the delivery of treatment and care. Integrated service delivery is fundamental in the effective management of comorbid conditions for older people (Draper).

Currently few Australian drug and alcohol services cater specifically for the needs of older people. Studies into appropriate care for older people suggest that services need to be based upon modified strategies and approaches that include a culture of respect, age-specific settings, flexibility and a holistic approach that embrace the psychological, physical and social needs of older people. (Draper).

Older adults are less likely to attend specialist referral services for substance abuse and mental health treatment for a number of reasons including lack of recognition of the problem or understanding of the impacts of drug and/or alcohol use; reliance on general practitioners for the provision of health advice and perceptions and/or stigma associated with addiction. For this reason, it would be beneficial for an integrated model to incorporate primary care settings and specialist aged care services (Draper).

Young people

Results from the 2007 Australian National Survey of Mental Health indicates that 12.7 per cent of people aged 16-24 are estimated to have a substance use disorder, with higher rates among young men than young women (around 16% of males and 10% of females, Australian Bureau of Statistics, 2009). Harmful use of alcohol was the most commonly reported substance use disorder (at around 9%).

Research indicates that treatment halts the escalation of young people's substance misuse and prevents subsequent problems as adults. Second, treatment has a significant preventative impact in reducing the lifetime *'scar'* [xxix] on earnings associated with poor education and employment outcomes during adolescence and into adulthood. Further to this, treatment has been found to

result in reductions in levels of crime. In terms of cost-benefit of treatment, effective treatment can reduce the cost implications from drug and/or alcohol related crime and health care[xxx]

Research has repeatedly identified that adolescents tend to not seek help for health problems including alcohol and other drug problems and mental health problems.

Aboriginal populations

NSW has the largest Aboriginal population in Australia, estimated at 172,261 people (about 2.5% of the NSW population). Surveys of Aboriginal people have shown that Aboriginal people are more likely to abstain from alcohol than non-Aboriginal people; however, those who do consume alcohol do so at hazardous levels. Health Statistics NSW reported between 2006 and 2009, four in ten Aboriginal adults reported engaging in risk drinking (46.9% of men and 40.8% of women) [xxxi].

Problems related to drug and alcohol use within Aboriginal communities in NSW are complex, influenced by interrelated individual, historical, social, cultural, economic and environmental factors. The complexity of needs in Aboriginal communities presents a significant challenge to health services. Drug and alcohol use is often associated with mental health issues, violence, erosion of family and community structures, incarceration, inter-generational trauma, poor physical health and cultural and spiritual loss.

There is a large disparity in life expectancy and health outcomes between Aboriginal and non-Aboriginal people in NSW. The higher burden of disease in Aboriginal people is due to largely preventable diseases such as cardiovascular disease, type 2 diabetes, mental disorders, chronic respiratory disease and cancer[xxxii]. Risk factors contributing most to the higher burden of disease in Aboriginal people are tobacco, high body mass, physical inactivity, high blood cholesterol, and alcohol (Aboriginal Health report card, NSW Health 2012).

Aboriginal people and alcohol

Excessive use of alcohol is a risk factor for liver disease, pancreatitis, diabetes and some cancers. Alcohol also contributes to motor vehicle accidents, falls, burns and suicide, and has been associated with social issues including family violence and breakdown, child abuse and neglect, diversion of income and high levels of incarceration.

Whilst the hospitalisation rates for alcohol are much higher than those for non Aboriginal people (almost twice as high), the rate of hospitalisation attributable to alcohol has been declining in Aboriginal males since 2006-07 and in Aboriginal females since 2008-09. (healthstats.nsw.gov.au)

Aboriginal people and substance use

The National Aboriginal and Torres Strait Islander Health Survey, 2004 – 5 shows that the substances most commonly used in the last 12 months were marijuana (23%), amphetamines (7%) and analgesics/sedatives (for non-medical purposes) 6%.

In order to effectively address the treatment needs of Aboriginal and Torres Strait Islander populations NSW Health ensures that all drug and alcohol policies and programs are developed in consultation with key Aboriginal stakeholder groups. To assure this, a number of mechanisms have been established:

- Eight Aboriginal residential rehabilitation services across NSW are being supported with funding provided to Aboriginal Community Controlled Health Services and specialist Aboriginal non-government organisations.
- The Ministry of Health has funded Aboriginal Drug and Alcohol Traineeship positions and a coordinator position to increase the Aboriginal drug and alcohol workforce in Local Health Districts and non-government drug and alcohol services.
- The Aboriginal Health and Medical Research Council's Aboriginal Drug and Alcohol Network provides policy advice and workforce development activities to improve Aboriginal drug and alcohol worker practice across Local Health Districts and Aboriginal Community Controlled Sectors. The network is supported by the Aboriginal Health and Medical Research Council.

- The NSW Ministry of Health contributes funding for an Addiction Medicine Staff Specialist in the Hunter/New England Local Health District. This position has the specific focus of providing addiction medicine clinical support and training to drug and alcohol staff working with Aboriginal communities, in the Tamworth and New England region.

National Partnership Agreement: Indigenous Early Childhood Development Program – mental health and drug and alcohol teams

At the Council of Australian Governments (COAG) meeting on 2 October 2008, Australia's first National Partnership Agreement (NPA), the Indigenous Early Childhood Development (IECD) National Partnership Agreement, was signed as the next step to achieve the COAG Closing the Gap targets for Indigenous children. There was a shared commitment to improve Indigenous child mortality by providing better access to antenatal care, teenage reproductive and sexual health services, child and maternal health services and integrated child and family services which focus on quality early learning, child care and parent and family support.

One of the elements of this Partnership Agreement specifically focuses on antenatal care and mental health and drug and alcohol service provision. This provides funding for 10 secondary mental health and 10 secondary drug and alcohol services linked to Aboriginal Maternal Infant Health Service programs.

The key aims of the mental health and drug and alcohol services are:

- to improve identification and early intervention for pregnant Aboriginal women with vulnerabilities including mental health and drug & alcohol problems, and
- to strengthen the structures, procedures and processes that support effective continuum of care between community antenatal care providers, hospitals and community providers following birth.

Eleven Mental Health and Drug and Alcohol Services have been established in 9 Local Health Districts with an extra 2 outreach services. They are co-located in Aboriginal Maternal and Infant Health Services (AMIHS) programs in urban, regional and remote areas of NSW. 20 new specialist mental health and drug and alcohol positions and mental health, drug and alcohol Aboriginal trainees (two mental health and six drug and alcohol) have been funded as part of the initiative. Implementation of this program is being evaluated in order to determine its effectiveness and appropriateness. The evaluation will provide an evidence base to inform any decisions about long term sustainability of the program.

<u>Culturally and Linguistically Diverse populations</u>

The NSW Government provides funding to the Drug and Alcohol Multicultural Education Centre (DAMEC) to reduce the harm associated with the use of alcohol and other drugs within culturally and linguistically diverse (CALD) communities in New South Wales. DAMEC achieves these objectives through project work, provision of information to the sector and community, research and a CALD Alcohol and Other Drugs counselling service based in Sydney South West. Targeted programs include working with Vietnamese offenders to reduce recidivism and drug relapse; CALD parenting groups; an outpatient counselling services for CALD communities; and working with CALD clients with co-morbid mental health drug and alcohol issues.

Funding

Collins and Lapsley estimated in Australia in 2004/5 costs attributable to drug and alcohol use[xxxiii]:

- Tangible costs attributable to alcohol in 2004/05 were $10.8 billion, to tobacco were $12.0 billion, and to illicit drugs were $6.9 billion.
- Alcohol and illicit drugs acting together in the causation of crime contributed a further $1.1 billion.
- Labour and health costs constituted the major cost component for alcohol.
- Workforce costs were a large component of tobacco tangible costs.
- Crime costs comprised a very high proportion of illicit drug costs.
- In relation to intangible costs, with the exception of pain and suffering of road accident victims, only the value of loss of life (to be precise, the loss of a year's living) could be estimated. Intangible alcohol costs were $4.5 billion, tobacco costs $19.5 billion and illicit costs $1.3 billion.

Collins and Lapsley further estimated that total Commonwealth, State and Territory government expenditure on drug abuse in 2004/5 was $5288 million. Of this 60% was directed at preventing and responding to crime and 37% was attributable to the health sector. This represents only a small percentage of the total costs, both tangible and intangible, of the harms to Australian society arising from drug and/or alcohol use.

In making assessments of the level and adequacy of funding, and in particular where the investments should be made, it is important to consider the evidence base available to demonstrate the effectiveness and cost-effectiveness of drug and alcohol related treatment interventions in the health sector[xxxiv]. An example of this is provided by Ritter and Caulkins (2007): the cost for a person to not use heroin for one year was approximately $5000 for pharmacotherapy maintenance; $11,000 for residential rehabilitation and $52,000 for prison.

This is further evidenced by an Australian National Council on Drugs (ANCD), the peak national body informing Drug and Alcohol Policy 2012 report on Supply, Demand and Harm Reduction Strategies in Australian Prisons. One of the recommendations was to increase resources and access to treatment in prisons, stating that there was a "significant imbalance between the implementation of supply reduction programs such as drug detection dogs and urine testing, compared to programs that reduce the demand for drugs, such as treatment, and to reduce harms from drug use." The report noted the National expenditure on corrective services across Australia 2008-09 was $2.8 billion with ongoing operating costs $210 per prisoner per day.

A ten year follow-up study of NSW Inmates in methadone treatment found a 20% reduction in re-incarceration and a decrease in mortality for those who left prison on methadone and remained on it after release (Larney, Toson, Burns and Dolan, 2012).

An important consideration for improving the way in which evidence informs practice and consequently funding allocation would be to consider expenditure on interventions with a stronger evidence base at levels that correlate to the level of harm of a particular substance. Measuring community and individual costs attributable to drug and alcohol use against costs to deliver treatment programs provides a strong financial rationale for investment into treatment and community based programs.

Drug and alcohol treatment services in NSW are provided in the government, non-government and private sectors. Investments into these are provided by both Commonwealth and State governments. Each sector provides vital components of the treatment services spectrum and is necessary given that there is no uniform presentation for drug and/or alcohol addiction. To ensure that treatment is patient-centred requires a breadth of treatment options in a range of service settings for a variety of population groups.

The NSW Ministry of Health was commissioned in early 2010 by the (national) Ministerial Council on Drug Strategy to lead the development of 'The National Drug and Alcohol-Clinical Care and Prevention (DA-CCP) Planning Model'. The project's aim is to develop a nationally agreed population

based planning model that will estimate the need and demand for drug and alcohol health services across Australia. The model will also be used at estimate need and demand at state and territory level. It is expected the National DA-CCP model will be complete by the end of June 2013 subject to endorsement of the Inter-Governmental Council on Drugs.

Whilst a framework for undertaking a demand and supply analysis has yet to be completed, the Ministry of Health ensures, where possible, that treatment gaps identified, through research and data collection, are addressed. For example, NSW has the largest proportion (approximately 50%) of Australia's opioid dependent population, estimated at 34,000 to 42,000 heroin-dependent injecting drug users and a larger, less identifiable population of non-injecting pharmaceutical opioid dependent individuals. The NSW Opioid Treatment Program currently provides treatment to over 19,000 patients.

Additional funds were provided in 2011/12 by the Government to support the delivery of opioid treatment across NSW. The Ministry of Health will be assessing the effectiveness of this additional funding in meeting the identified gaps in the opioid treatment system via the monitoring of key performance indicators and movement through the opioid treatment program.

In terms of current global expenditure on drug and alcohol treatment, the NSW Government funds a substantial proportion of the specialist services currently providing drug and alcohol treatment. Many of these services are provided through the public health sector in services located within Local Health Districts however the primary health care and non-government sectors are also provided with government funding for the delivery of drug and alcohol treatment and rehabilitation programs.

Integrating service delivery across the sectors is becoming increasingly important. The responsibility for ensuring that there is adequate investment across the continuum of care, both within and outside of health rests with both State and Commonwealth governments. Primary care services, frequently the first point of contact and source of management of ongoing health needs, are outside of scope for state government responsibility yet linkages are critical to effective health care.

Non-government organisations deliver a large proportion of drug and alcohol treatment services, primarily residential. Funding to these organisations has largely been provided by grants from both Commonwealth and State governments. There are a number of review processes occurring at both state and federal levels that will ideally assist in creating clear governance and funding frameworks to provide a basis for effective and efficient resource distribution that is based on current health priorities and policy objectives.

Future resource distribution will be informed by a number of key developments currently occurring for the drug and alcohol sector and the health sector more broadly, including:

- Finalisation of the DA-CCP model that will estimate drug and alcohol resources needed.
- Drug and alcohol information system development, including agreement on a number of key performance indicators for drug and alcohol; a state-wide drug and alcohol information system which will standardise data collection and incorporate outcome measures; and improved performance reporting processes.
- Activity based funding model for the purchasing of services.
- Ongoing review of services to determine continued cost effectiveness of programs.
- State and Commonwealth reviews of the non-government sector.

Eligibility criteria

Specific eligibility criteria are not mandated centrally by the Ministry of Health for the majority of Drug & Alcohol programs. Intended cohorts to access specific service types are identified via a process of clinical guideline development which provides the frameworks for clinicians to make decisions about admitting patients to individual programs. There are exceptions to this, such as the court diversion programs, where eligibility is proscribed through the criteria described to the court for the purposes of making an order such as nature of the offence and other clinical characteristics as identified earlier in the submission. In the main though eligibility is determined clinically on the basis of the clinical guidelines for the service type, and the interface with the mix of clinical resources available at that geographical service location.

Waiting lists

There is no central repository of waiting lists for Drug & Alcohol services. These services are predominantly community based, many operate on a state-wide basis and operate across private NGO and public sectors and as such waiting lists are not a useful measure of service demand. Individual services may keep lists of those interested in future service delivery however these can't be aggregated on a central basis.

Service locations and outcomes achieved

Reference to service locations and outcomes achieved is made under individual program descriptors.

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