Submission
No 41

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

Organisation: South Pacific Private Hospital

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Madeleine Foley
The Director
General Purpose Standing Committee No. 2
Parliament House
Macquarie Street
Sydney NSW 2000

Dear Ms Foley,

Please find attached the submission from South Pacific Private Hospital to the NSW Legislative Council Inquiry into Alcohol and Drug Treatment.

Yours sincerely,

Dr Teoh

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Submission to Parliament of NSW Legislative Council Inquiry into Alcohol and Drug Treatment

On behalf of South Pacific Private Hospital it is our pleasure to provide evidence to the NSW Parliament Upper House Inquiry into Alcohol and Drug Treatment. We thank the committee for opening such an important inquiry.

South Pacific Private is a licensed and accredited private psychiatric hospital specialising in the integrated medical, psychiatric, and psychotherapeutic treatment of addictions, mental illness, and co-occurring conditions. The treatment program is evidence based with a comprehensive and holistic approach to addressing the underlying core issues, trauma, and family dynamics that may have fuelled the development of the presenting problem.

We have been providing treatment for Australians with addictions and mood disorders since 1993, utilising a program based on the renowned Meadows Treatment Centre in Arizona, US. Over that time we have treated 7,500 clients and see an average of 530 clients a year, with an average in-patient stay of 21 days. All our clients are followed up at one week, and 3 months post discharge.

A cornerstone of successful treatment at South Pacific Private is the Family Program, where family members are invited to participate in the client's treatment by attending an intensive 4-day workshop, which runs from Friday to Monday most weeks of the year.

Through a series of psycho-education lectures, structured exercises, and guided discussions the participants learn about family relational dynamics and healthy listening, communication and conflict resolution skills in a confidential and safe environment. The family is supported in exploring difficult and challenging issues that may not have been addressed effectively in the past, within the family.

70 per cent of clients' families attend this program. Our holistic treatment model at SPP involves psychosocial support looking at the biological, psychosocial, social and spiritual aspects of recovery.

We have recently introduced an outpatient program for people in community with posttraumatic stress disorder and or/ experience of trauma because PTSD and previous trauma is so highly prevalent among our clients and among clients seeking treatment for drug and alcohol addictions – an Australian study estimated that 80 per cent of drug and alcohol clients have experienced a previous trauma and that close to half have active PTSD.

Although we are an adult treatment centre we recognise that drug and alcohol addictions are passed down through the generations for a multiple of reasons including genetic susceptibility and family and social environment. With this is in mind we will be introducing an outpatients' children's program based on an evidence based program run at the renowned Betty Ford Clinic in the US aimed at providing prevention and coping strategies for children at risk due to their family background of addictions.

As an integrated treatment centre with a team of five psychiatrists, two GPs, 21 therapists (including psychologists) and 26 nurses and the only accredited hospital in Australia providing this model of recovery based care, incorporating, but not limited to, 12-step programs, we believe we are well placed to offer informed comment in the inquiry and to address the terms of reference.

1. The delivery and effectiveness of treatment services for those addicted to drugs and/or alcohol, including naltrexone treatment, with reference to the welfare and health of individuals dependent on illicit drugs and the impact on their families, carers and the community having regard for:
(a) The need for appropriate human research, ethics and Therapeutic Goods Administration approval for use of new treatments in clinical trials
(b) The current body of evidence and recommendations of the National Health and Medical Research Council

The model of care at South Pacific Private uses pharmacological treatments for detoxification and withdrawal purposes only in treatment for drug and alcohol addictions, so we will not comment on naltrexone specifically. Based on our treatment experience of 20 years in Australia we comment as follows:

- SPP sees addiction as a disease with biological, psychological, social and spiritual components. This disease can be arrested but not cured through permanent abstinence from the chemical or process.
  The American Society of Addiction Medicine (ASAM) released a new definition of addiction in 2011: Addiction is characterized by inability to consistently abstain, impairment in behavioural control, craving, diminished recognition of significant problems with one's behaviours and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.
  Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic

biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviours.
Dr David Meelee (Addiction Specialist and Consultant to SPP) states:
"There is a need for comprehensive addiction treatment of the underlying disease process in the brain that has biological, psychological, social and spiritual manifestations."
Implications for treatment mean that in order to foster an accountable attitude in clients the productive attitude for health professionals to have is to recognize *"personal responsibility is important in all aspects of life, including how a person maintains their own health. You are not responsible for your disease, but you are responsible for your recovery."*
Just as people with diabetes and heart disease need to take personal responsibility for how they manage their illness, those with addiction need to do the same.

- Appropriate management has to include case by case evaluation tailor made to the client and a full range of treatments need to be made available to individuals and their families suffering from the harmful consequences of drug and alcohol addictions. In our own programs we recognise that some potential clients are not biologically or emotionally ready to go down the road of abstinence based recovery. In particular some clients with opiate addiction may be more suited at that point in time to opioid substitution therapy. **Nevertheless, the gold standard of treatment for drug and alcohol addictions in our experience is to achieve *abstinence from drugs and alcohol* and if that is not possible to reduce the potential harmful consequences of addiction. For non-opiate based addictions we believe that abstinence based recovery should remain the primary goal of treatment.** Abstinence is best achieved through comprehensive assessment and individualised treatment planning, multidisciplinary case management, medically supervised detox, if appropriate, group therapy integrating evidence based treatment including cognitive behaviour therapy and step facilitation, comprehensive psycho-education, family programs and aftercare planning.

- Australia still has one of the highest rates of alcohol abuse in the world (*Teesson et al*[1]). It has one of the highest rates of cannabis use (along with New Zealand) in the world (*Degenhardt, Hall et al*[2]); we have an ageing population of heroin users (*National Drug Strategy Household Survey 2010*[3]) – suggesting that while the harms from heroin may have been reduced little inroads have been made into assisting individuals recover from a chronic lifelong condition. The NDSHS reported that recent illicit drug use increased in 2010, mainly due to an increases use of people who had used cannabis, pharmaceuticals for non-medical purposes cocaine and hallucinogens. Use of other drugs including heroin remained stable. A trend we have noted in our hospital is the increased acuity of clients accepted or admission**. *It is very clear that as a country we have to do something different.***

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

While we cannot comment on the overall funding for drug and alcohol treatment services in NSW, as a private hospital specialising in dual diagnosis patients we have observed considerable unmet need. We currently have 600 inpatient admissions annually staying an average of 20 days. To meet the demand for beds we are in the process of increasing our capacity. The current average inpatient stay of 20 days is based on clients' and their health funds' capacity to pay. Ideally we would recommend a minimum inpatient stay of 35 - 40 days as we believe, based on overseas evidence, that this would provide optimum outcomes for patients, and would achieve an overall saving for the system through reduced annual client treatment days. Current funding models applied in Australia do not generally allow for these longer in patients stays. We would recommend that funding should be based on annual client days not a single inpatient stay – as this would not only improve outcomes it would reduce cots to the public purse and to health funds.

We have observed increased acuity among our clients admitted for treatment, in particular among young men addicted to ice and other methamphetamines. In the light of our experience we would urge an urgent review of how the community funds public and private inpatient treatment given that there is a cost benefit to successful integrated treatment which reduces the need for clients to return for treatment – the "revolving door".

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

It is the nature of addiction that addicts will resist treatment that they see is designed to take away the drug of choice that is central to their life. Whatever drives the need for chemically altering their mood is of no interest for the addict which is why **it *takes on average 18 years from the onset of symptoms of problems to actually seeking out treatment in Australia.***

Addicts in trouble with the law as a result of activities related to their drug use are often well down the road into addiction. Taking the opportunity presented, the government has a duty of care to at least provide access to treatment as early as possible, when the opportunity arises as part of sentencing. Mandatory treatment is unlikely to be as successful as voluntary treatment but the rewards of even partial success have long-term benefits to the addict, their family and society.

The key factor in mandatory treatment is the design of the treatment program which should be holistic and designed to enhance motivation for the individuals to explore, understand and deal with coexisting addiction and mental illness, such as depression, and underlying trauma related conditions, which are likely to be present in a large percentage of this population.

The Inebriates Act has been largely forgotten, but we understand that some public treatment facilities in NSW have begun using it again. It allows for any member of the family who has a person with a severe alcohol problem to legally force the person to get treatment including hospitalisation. We believe that it can be useful in extreme circumstances where there is a serious danger to the person and family.

Mandatory Treatment is useful in extreme situations, if it is properly implemented and not abused and if there are appropriate measures in place to ensure patient compliance and reduce any potential risk of violence.

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

Dual Diagnosis / Comorbidity

SPP specializes in the treatment of co-occurring addictions and mental illness.

The high prevalence of coexisting mental health and drug and alcohol disorders is well established in both clinical practice and throughout the literature. Clients with a comorbid mental health and substance use disorder (SUD) are more likely to have highly complex and complicated illness courses, a high dependence on clinical services and poorer long-term prognoses.

The prevalence of mental illness, trauma and post-traumatic stress disorders is much higher in patients being treated for substance use disorders and other addictions. Around 50 – 70 per cent of AOD clients are reported to also have a mental health problem.

An Australian study found 80 per cent of Australian patients in treatment for substance use disorders have been exposed to trauma and 45 per cent have

active PTSD at the time of treatment (Dore et al *Drug and Alcohol Review*, vol. 31, no. 3).

When patients have comorbid mental illness and substance abuse it is best practice to start treatment for both disorders simultaneously as the two interact to maintain each other. The practice of treating the two conditions separately leaves sufferers on a treadmill of using substances to medicate their mental illness. It also see patients excluded from treatment in cases where mental health facilities refuse to treat them unless they have received prior treatment for their SUD. At South Pacific Private we see a lot of childhood trauma and abuse in patients being treated for addictions.

The increasing awareness of the prevalence of comorbid mental health problems in patients with drug and alcohol disorders is extremely welcome, but we believe even more needs to be done to increase awareness and promote integrated treatment for people with SUD and mental illness. Since we were established 23 years ago we have based our treatment model on integrated treatment for people with dual diagnosis. Our central philosophy is that comorbity is extremely common, that one feeds the other – mental illness and substance use - and that without an integrated approach patients risk being on a treadmill of recurring illness at huge personal cost to themselves, their families and the community, as well as being extremely expensive for the public purse.

In light of increasing focus on comorbidity we believe it is essential that facilities that purport to provide treatment for co-occurring mental illness and substance use disorders actually have the capacity to do so. We would like to draw the committee's attention to the Dual Diagnosis Capability in Addiction Treatment measure which has been developed in the US.

http://www.samhsa.gov/co-occurring/ddcat/

We also welcome the committee's awareness of other co-morbidities including chronic pain and other physical illnesses. In particular:

- We are highly supportive of increased awareness of and treatment for chronic pain. However medications prescribed for chronic pain are extremely addictive and at our facility we are seeing an increased number of admissions for clients addicted to prescription medications and we expect that to increase.

- We would like to draw the committee's attention to the extremely high rates of tobacco smoking among clients admitted for treatment for mental health problems and substance use disorders. It is well known that people with mental health and substance use issues have higher rates of smoking than the general population – approximately double. If we are serious about

helping patients overcome their addictions we cannot ignore this pervasive addiction which also places them at high risk of cardiovascular disease, respiratory disease and cancer in addition to their other problems.

- There is evidence to suggest that the risk of relapse of the substance use disorder is higher for those who kept smoking. There are several explanations for this, including the biological link with the dopamine system. Research has suggested that relapse to alcohol use is *less* likely among persons given a smoking cessation intervention, and that those who are abstinent from smoking are more likely to remain abstinent from alcohol. Our own experience with clients has borne this out:

- South Pacific Privates current year 3 month follow up data shows:
  47% of respondents were smokers on admission
  - 36% of these quit smoking while in treatment and remained abstinent from nicotine at 3 months
  - 82% of those that remained abstinent from smoking after treatment had also remained abstinent from all other addictions
  - Of those clients who picked up smoking again after treatment 62% remained abstinent from all other addictions, at 3 months.

- The relapse rate for clients who also give up smoking at the same time as other addictive substances or processes, is significantly lower than the relapse rate for clients with addiction issues who continue to smoke after treatment.

- Research by Lawrence and colleagues from Western Australia suggest that smoking not only impacts on mental health clients' physical health *"it is likely that smoking complicates or exacerbates mental illness and its treatment."*

- In its consideration of comorbid mental health and drug and alcohol use treatment we would urge the committee to also address the often overlooked area of tobacco use in people with mental illness and comorbidity.

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

At SPP every day we see the end results of the devastation that addiction to drugs and alcohol can bring to individuals and their families. We support any efforts in the community and in schools to prevent harmful use of drugs and alcohol. However we wish to draw the committee's attention to the fact that addictions are passed down through the generations and attempts to break the cycle of the "family legacy" must be supported.

Addictions generally involve the whole family and there is strong evidence for intergenerational transfer of addictions and substance use disorders.

Family therapy is an essential component of a recovery-based approach to treatment. At SPP 70 per cent of our client's families attend our one-week family programs. Family therapy as part of a recovery based approach to treatment will improve outcomes for individual clients, their families and enhance client's prospects of achieving long term recovery and "recovery capital" essential to long term recovery.

Family members who are not using drugs or alcohol problematically have a high likelihood of suffering from mental illness such as depression and anxiety - fuelled by the unhealthy behaviour that abounds in these unfortunate families such as enabling, control, care-taking and perfectionism.

Both current research and our experience tell us that clients embrace recovery more effectively when family members also have the opportunity to engage in educational and support programs designed to meet their needs.

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

South Pacific Private hospital is based upon the renowned Meadows Treatment Centre in Arizona in the US. Both programs are holistic and focus on the underlying traumas underpinning an individual's addiction. http://www.themeadows.com/about/why-the-meadows

Later this year we will be introducing a children's program aimed at early intervention for children aged between 6 and 12 who are at risk of developing drug and alcohol problems because they have a parent with drug and alcohol use problems. The aim is to reach these kids before they have taken their first drink or drug. This program is based upon the children's program at the Betty Ford Clinic.
http://www.bettyfordcenter.org/family-and-children/children/index.php

It is a central tenet of our submission to the Inquiry that while Australian has a proud history in reducing the harms from drugs it has been less successful in supporting treatment models focussed on long term abstinence from drugs. Australia should rightly be proud of the success of its harm reduction programs, in particular OST and NSP in reducing harms to individuals and the community. However it is our contention that it is not a question of either/or and in fact harm reduction and recovery is part of the mix of what should be on offer as part of Australia's response to drug and alcohol problems.

We are supportive of recent developments in Scotland, England and New Zealand which have incorporated recovery based models into drug and alcohol treatment strategy and also of recent developments in Victoria

The Victorian Government has published its blueprint for reform. *New Directions for Alcohol and Drug Services. A Roadmap* which states that: "The system should be centred on the person, family and culturally inclusive and oriented towards helping people to recover, to reconnect with their families and to reintegrate into their communities."

We support the Scottish Government's definition of recovery. *Recovery is a process through which an individual is enabled to move-on from their problem drug use towards a drug-free life and become an active and contributing member of society. Moving to an approach that is based on recovery will mean a significant change in both the pattern of services that are commissioned and in the way that practitioners engage with individuals.* (From: *The Road To Recovery*, Scottish Government National Drug Strategy, 2008).

Yours Sincerely,

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