Submission No 20

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

Organisation: NADA (network of alcohol and drug agencies)

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NSW Parliament Legislative Council Inquiry into Drug and Alcohol Treatment

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The Network of Alcohol and other Drugs Agencies (NADA) is the peak organisation for the non government drug and alcohol sector in NSW.

NADA's goal is to support non government drug and alcohol organisations in NSW to reduce the alcohol and drug related harm to individuals, families and the community.

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INTRODUCTION

The Network of Alcohol and other Drug Agencies (NADA) is the peak organisation for the non government drug and alcohol sector in NSW.

NADA represents over 100 organisational members that provide a broad range of services including drug and alcohol health promotion, early intervention, treatment, and after-care programs. These community based organisations operate throughout NSW. They comprise both large and small services that are diverse in their structure, philosophy and approach to drug and alcohol service delivery.

NADA's goal is *'to advance and support non government drug and alcohol organisations in NSW to reduce drug and alcohol related harm to individuals, families and the community'.*

NADA provides a range of program and services that focus on sector representation and advocacy, workforce development, information management and data collection, governance and management support plus a range of capacity development initiatives.

NADA is governed by a Board of Directors primarily elected from the NADA membership. It holds accreditation with the Australian Council on Health Care Standards (ACHS) until 2014.

Further information about NADA, its programs and services is available on the NADA website at www.nada.org.au.

NADA contact

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SUMMARY OF NADA SUBMISSION

NADA is pleased to offer this submission to the Legislative Council Inquiry into Alcohol and Drug treatment in NSW and advocates for some specific issues outlined in our response below. NADA believes that by redirecting the current drug and alcohol budget allocations from public infrastructures to an outsourced program for management by the states specialist drug and alcohol NGO sector we will be able to achieve higher levels of service integration, service level choice for clients and a more integrated drug and alcohol treatment service system. There are many structural inefficiencies in the current public sector dominated drug and alcohol service system that has reduced the access of people and in particular, families and concerned community members, to drug and alcohol services and that has also resulted in less appropriate case management, care coordination and community integration for drug and alcohol clients.

NADA believes that the NSW drug and alcohol program needs some specific reform and development in relation to the role of the NGO specialist sector in providing an expanded intensive case management and aftercare services post intensive treatment for clients and in terms of the management of the states MERIT drug diversion program. NADA believes that this program should be outsourced to the NGO sector from its current government infrastructure as this will lead to expanded treatment options and much better community integration for MERIT clients.

NADA recommends that drug and alcohol service delivery funding be based on the model outlined in the national Drug and Alcohol Clinical Care and Prevention Project (a national project commissioned by the Intergovernmental Committee on Drugs and led by NSW Health). This model adequately addresses funding allocation requirements for the type of program service delivery model mentioned above.
NADA would be keen to take up an opportunity to make a personal representation to the Inquiry to discuss this submission.

RESPONSE TO GENERAL PURPOSE STANDING COMMITTEE NO. 2 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

In reference to 1(a):

NADA recommends that clinical trials into new pharmacotherapies should take into account social determinants, psychological and mental health status, and physical health and well-being of trial participants. As these whole of life issues form the context for which dependence occurs, they should be considered when undertaking research into all forms of treatment including pharmacotherapy, residential rehabilitation or outpatient counselling.

In reference to 1(b):

NADA contends that an additional recommendation be added to the NHMRC list of recommendations. That is: evidence from research should be undertaken in partnership with the Sector peak body (NADA) or individual NGOs who have specific 'front line' or 'coal face' contact and expertise with the research target group. The inclusion of NGO experts on research steering committees assists in the production of evidence so that they can provide expert insight and support into treatment, community based interventions and referrals. As such they are in a unique position to raise and assist with ethical issues that arise among the cohort during the period of research – this should be based on the model of the NADA NGO research grants[1].

Drug facts and treatment approaches for drug dependence

The following statement outlines the evidence and NADA's position in regard to the delivery and effectiveness of treatment services for those who are severely dependent in NSW:

> *"Because drug abuse and addiction have so many dimensions and disrupt so many aspects of an individual's life, treatment is not simple. Effective treatment programs typically incorporate many components, each directed to a particular aspect of the illness and its consequences. Addiction treatment must help the individual stop using drugs, maintain a drug-free lifestyle, and achieve productive functioning in the family, at work, and in society. Because addiction is typically a chronic disease, people cannot simply stop using drugs for a few days and be cured. Most patients require long-term or repeated episodes of care to achieve the ultimate goal of sustained abstinence and recovery of their lives." (NIDA, 2009)*

Treatment for drug and alcohol dependence needs to account for the fact that it is considered a relapsing condition; has 'whole of life' implications; community and family effects; is complex to treat and requires long term follow-up with timely treatment matched accessibility.

Drug and alcohol dependence is a complex multifaceted public health issue that is not always well suited to the silo approach indicative of public health services. Limitations of public pharmacotherapy programs (which is the most dominant mode of treatment in Australia) to provide routine support, individualised case management, and referral follow-up is restricted by high demand, case worker to client ratios, and the inadequate and ongoing access to allied health services. This translates into an inability for many of the public health run services to maximize many of the potential the benefits of pharmacotherapy treatment, simply reducing it to a replacement and maintenance therapy. For this reason, and many other in-built rigidities of the public health system,

> *Many have argued that the not-for-profit non-government organisation (NGO) sector is unique and valuable. For instance, Barraket (2006) has argued that, because the NGO sector is diverse and has on-the-ground networks, it is better placed than either government or private*

[1]NADA supports priority given to building drug and alcohol research capacity, particularly in areas that translate into practice and service delivery improvement. A capacity building model has been established with the NSW non government drug and alcohol sector to develop knowledge, skills and practice in research which is applicable to service providers in achieving improved client outcomes. This model has included research grants and an open Research Network lead by NADA and the Mental Health Coordinating Council (MHCC).

organisations to be responsive to complex social and economic needs [of alcohol and drug dependent people].(ANCD Research Paper 17, 2008, pg 1)

Against this backdrop, fallout public health system limitations renders an ever increasing demand on the NGO sector to respond to clients with more complex treatment needs, are more difficult to stabilise, require long term comprehensive and diverse case management and treatment follow up. This is undertaken with limited resources and faces a culture that does not undertake cross sector partnerships (government/NGO services) which we know assists in treating this complex cohort. (ANCD Research Paper 17, 2008, pg 17).

From a survey of 857 community service NGOs conducted by the Australian Council of Social Service (ACOSS) in 2007, 69 percent of respondents reported that their clients had more complex needs in 2005/06 than in 2004/05. In view of this trend, agencies reported that their most pressing training need was how to work with clients that have difficult and complex problems. Research on the social determinants of drug use also highlights the need for a sophisticated understanding of the complex etiology of drug use behaviours and drug harms to inform prevention and management interventions. (Spooner and Hetherington, 2005)

The above statement is consistent with the general view from the drug and alcohol sector that clients' treatment needs increasingly demand a highly skilled multi-disciplinary approach. Complex clients are now considered the norm rather than what was historically viewed as the few that needed additional support. The NGO sector client profile is characterised by those that typically have:

- more than 10 years of poly drug dependence;
- a history of multiple treatment episodes;
- a history of multiple incarcerations and multiple psychiatric admissions (with no clear diagnosis or treatment continuity);
- undiagnosed and/or untreated PTSD;
- had children removed by DOCS;
- acquired BBV's;
- physical ill health, including STI's
- are isolated from family and socially embedded with drug using peers;
- are frequently homeless;
- enter treatment having used drugs during pregnancy;
- a lack of GP continuity;
- major dental problems;
- outstanding legal issues
- child protection issues; and
- a complex cluster of debt.

A lack of resolution and limited on-going follow-up regarding the above cluster of issues are considered relapse stressors. Therefore, the expectation is that non government drug and alcohol treatment services have the capacity to assist individual clients to resolve, or at least be engaged in a process that supports the resolution of, these potential relapse triggers. Research supports the contention that merely addressing drug and alcohol dependence in isolation from the accompanying and 'whole of life' issues is consistent with poorer treatment outcomes. For example:

> *Effective treatment attends to multiple needs of the individual, not just his or her drug abuse. To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems. It is also important that treatment be appropriate to the individual's age, gender, ethnicity, and culture (NIDA, 2012).*

Non government drug and alcohol treatment programs that provide core drug and alcohol treatment interventions as well as individualised complex case management, is time, skill and finance resource intensive. The duty of care responsibility aligned with this level of treatment requires highly skilled, experienced and diversely trained clinical staff, case workers, administration, management and governance support. However, as the sector is under resourced, and often funded for specific time bound projects or activities (often with no funding for administration or infrastructure support), services are forced into making difficult choices based on a hierarchy of need frame that frustrates the workers and restricts the level of interventions afforded to the client upon discharge. Residential treatment programs, requiring 24 hour staffing, are often the preferred option and best fit for clients with a complex needs profile.

Findings from the Australian Outcome Treatment Study (ATOS) show that *"[s]pending more time in residential rehabilitation was associated consistently with improved outcomes across all domains. Time spent in residential rehabilitation was the only treatment to be associated significantly with improvements in physical health, and this may reflect the more holistic nature of treatment in this setting". (Darke, Ross and Teesson, 2007, pg 87)*

> *Longer-term residential treatment programs have been identified in practice and in the research literature as providing significant benefit for people with severe alcohol and drug use problems and complex needs, and to the community. (Ernst and Young 1996, in NSW Department of Health, 2007).*

Diversity of treatment options and treatment matching is also an important factor in treatment retention rates and successful outcomes. The public health drug and sector is frequently restricted in this regard, particularly by not being able to offer long term residential treatment. While the 'one size fits all' approach to treatment, such as pharmacotherapy or 6 outpatient sessions of cognitive behavioural therapy (CBT), may be sufficient for some individuals, a range of treatment options with the capacity for individualised long term treatment plans are an important factor leading to better outcomes. The National Institute of Drug Abuse (NIDA) asserts:

> *No single treatment is appropriate for everyone. Treatment varies depending on the type of drug and the characteristics of the patients. Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society. (NIDA, 2012)*

This point reiterates the limitations of the public health sector's capacity to individualise treatment plans. Drug and alcohol services attached to large, often hospital based, institutions do not have the ability to respond to the range of difficulties that clients bring with them into treatment. Ideally, the diverse and complex needs of the client should be able to be met in-house. Alternatively, closely monitored partnerships and supported referral processes that include cross case management and follow-ups, are mechanisms utilised by the non government sector to meet the specific needs of their individual clients.

> *An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs. A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient may require medication, medical services, family therapy, parenting instruction, vocational rehabilitation, and/or social and legal services. For many patients, a continuing care approach provides the best results, with the treatment intensity varying according to a person's changing needs. (NIDA, 2012)*

Post-care or aftercare is recognised in the literature as being an important relapse prevention treatment component. However there is no systematic approach or dedicated funding to individual services for the provision of post care programs across the sector. In recognition of the importance of post care support and follow-up, services often seek to provide some form of post-care support in the absence of funding. Positive social reintegration and ongoing follow-up support enables early intervention in relapse as the client can be more easily readmitted into intensive support prior to the relapse resulting in full scale dependence. Once a client has re-engaged in drug and alcohol use to the level of severe dependence, it is more likely that the natural history of the relapse will play out and an intervention may only occur through a mental health crisis, overdose or an arrest and re-entry into the public health and judicial systems. Due to the current alignment of the state's drug and alcohol program with the medical model, standard public health sector treatment services are not set up to undertake the necessary individualised after-care that can be provided by the non government sector.

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

NADA provides an overview of funding issues related to the provision of drug and alcohol treatment in NSW, with a focus the community non government drug and alcohol sector.

> *According to several conservative estimates [in the USA], every dollar invested in addiction treatment programs yields a return of between $4 and $7 in reduced drug-related crime, criminal justice costs, and theft. When savings related to healthcare are included, total savings can exceed costs by a ratio of 12 to 1. Major savings to the individual and to society also stem from fewer interpersonal conflicts; greater workplace productivity; and fewer drug-related accidents, including overdoses and deaths (NIDA, 2012)*

Grant funding for drug and alcohol service delivery through the non government sector in NSW is a patchwork of historical, program specific and one-off or ad-hoc funding. Many organisations receive grants from DOHA, NSW Health, other government departments and/or other funding enterprises. These grants contribute to an organisation's annual operational budget and are generally managed as a global budget for the provision of services to clients. The proportion of an organisation's budget from government grants and self-generated income streams varies across the sector, with the majority of organisations managing multiple contracts and funding and performance agreements as well as fundraising and/or sponsorship.

Throughout the last decade, either through additional requirements written into funding agreements or where there has been an increase in funding streams, NGOs have come to bear the costs of mounting compliance requirements and industrial pressures. Such cost drivers include:

- Formal quality improvement programs and accreditation
- Increases in contract and funding agreement performance reporting
- Compulsory data management and reporting
- Industrial Award increases
- Substantial increases in transportation costs
- Increases in market rental and infrastructure maintenance costs
- Service provision for clients with more complex and difficult needs
- Media and marketing costs
- Human resources and workforce development costs.

Funding arrangements have not sufficiently addressed the 'cost creep' of these operational pressures. The result has been a steady, albeit reluctant, reallocation of resources from direct client service delivery to administrative, compliance and monitoring functions.

Funders must be cognisant of the manner in which different grants and funding sources contribute to a 'whole of life' model of service delivery within non government drug and alcohol services, as well as to global budgeting and robust governance mechanisms that include infrastructure, human resources, service development and quality improvement. Additionally, it should be clearly articulated whether grants are fully funding particular service delivery activities or whether they are making a contribution towards the associated costs and the extent of that contribution.

Expectations of value for money, performance, client outcomes and accountability can be best met by focusing on models of funding that address the core issue of organisational sustainability. This focus takes into account the infrastructure, human resources and operational cost drivers that enable an appropriate service delivery infrastructure to exist for effective program and service delivery. Annual indexation increases should be applied to all grants to support organisations to meet the real and increasing cost of goods and services.

Concerns are raised over short term funding contracts as this has a negative impact on the organisation's ability to retain staff, provide continual services, and build on corporate and sector knowledge. The ideal funding agreement would be of five years duration, with the option of reviewing and amending at year three or four by both parties. At a minimum, all service delivery grants should relate to funding agreements of no less than three years. Short term collaborative funding relationships are more suited to 'seeding' the development of new and innovative services to address emerging issues. Funding availability to trial innovative approaches to treatment and care delivery is supported by NADA, recognising that there is often a lack of evidence for some interventions and that the evidence base needs to be developed in order to respond to emerging issues and practice changes. The community sector is well positioned to participate at a much higher level than is currently available to them in the trialling innovative interventions.

As recommended in the 2010 Productivity Commission Research Report, the length of funding and performance agreements should reflect the time period required to achieve agreed service outcomes rather that standard contract periods.

There is general agreement among NADA members that funding should move away from 'bed' and 'case based' funding, and that the funders should fund service operations (core) in addition to appropriately qualified clinical staff and diversely trained staff. This model would enable outcomes-based reporting and support

strategic planning of the sector. Funding should have a clinical focus that manages risk and provides supervision for the workforce.

Funding should maintain and continue to develop organisation and workforce capacity, with a focus on working with the complexity of clients' needs. Complex needs include not only mental health, but also health and social issues such as medical, physical health, child protection and domestic violence, as well as brain injury, cognitive disability, and clients connected to the criminal justice system. It must be recognised that in order to treat the complex needs of clients, NGOs need to maintain linkages and partnerships, as well as continue to capacity build through developing relationships with specialist expertise. As such, organisations need to be funded appropriately to facilitate high level professional clinical care and complex case management, as well as provide post care support and follow-up.

NADA's *Workforce Profile and Skills Audit of NGO Alcohol and Other Drug Agencies (2008)* showed that the community sector is facing the challenges of an aging workforce and low remuneration compared with similar positions in the public sector, resulting in impediment to recruitment and poor retention rates. Career progression and career structure in the sector is also an issue due to the industrial awards that guide the sector. While the recent pay equity decision at a federal level means better pay for women workers in particular, the improved level of remuneration is still not be able to compete with public and private sector levels of pay. As previously stated, this is a disincentive in the recruitment of new workers to the non government sector.

NADA recommends that drug and alcohol service delivery funding be based on the model outlined in the national Drug and Alcohol Clinical Care and Prevention Project (a national project commissioned by the Intergovernmental Committee on Drugs and led by NSW Health). This model adequately addresses funding allocation requirements for the type of program structure mentioned above.

NADA and members strongly support the recommendation in the 2010 Productivity Commission's Research Report *'Contribution of the Not-For-Profit Sector'* that Australian Governments should fully fund those services and activities that government would otherwise have to provide directly, in contrast to the 'grant contribution' funding model currently utilised by NSW Health.

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

Therapeutic jurisprudence

Diversion Programs: Magistrates Early Referral into Treatment (MERIT)

The MERIT program is characterised as a therapeutic jurisprudence diversion program and commenced as a pilot program in 2000. In contrast to the NSW Drug Court program, MERIT is a pre-plea program that offers a defendant with charges pending and a 'demonstrable illicit drug use problem' the option of entering into an intensive (up to 12 weeks) treatment program prior to sentencing. Exclusion criteria include sexual and violent offences. Successful completion of court mandated treatment is then considered, usually positively, when the individual returns to court for review and sentencing. Referrals to MERIT can be made by Police, Solicitors,

Magistrates, probation and parole as well as self-referral. Potential candidates do have the option of declining treatment in preference for a custodial sentence. The 3 aims of the Drug Court treatment system are:

- reduce drug dependency
- promote community re-integration
- reduce drug related crime

The ultimate aim is to break the cycle of crime and drug use. The outcomes of the MERIT program can be divided 3 outcome areas, program, post program and unintended outcomes.

Program Outcomes: The intended outcomes for the MERIT program are to:

- Decrease drug related crime by participating defendants for the duration of the program
- Decrease drug related crime by participating defendants following program completion
- Increase community protection
- Improve health and social functioning for the duration of the program and in the post program period
- Reduce sentences due to better rehabilitation prospects.

Post-Program Outcomes: Once a defendant has completed the MERIT program, it is hoped they will:

- Cease their drug related crime
- Cease their illicit drug use
- Make lifestyle changes that support a drug-free existence
- Improve their health and social functioning

Unintended Outcomes: Possible unintended program outcomes are:

- Increased remand numbers if offenders fail to comply with bail conditions
- Increased number of court appearances by MERIT clients due the provision of Judicial supervision
- Added strain on some of the Area Health Services to provide the full range of drug treatment services. (Bolitho, Crawford and Flaherty, 2005)

The treatment framework provided through MERIT includes a number of health and welfare services. In addition MERIT participants are supposed to be treatment matched, which includes;

- detoxification,
- counseling,
- pharmacotherapies
- residential rehabilitation,
- community outpatient services, and
- case management. (Bolitho, Crawford and Flaherty, 2005)

As at the end of September 2005 there had been 8797 MERIT referrals; 5212 acceptances to the program, and, 2941 completions. The profile of MERIT participants are:

- males aged on average at about 28 years old.
- non-Aboriginal (83%)

- not married (75%)
- unemployed (86%),
- born in Australia
- have spent time in jail (53%), and,
- have a highest educational level of Year 10 (74%). (Bolitho, Crawford and Flaherty, November 2005)

The main focus areas of the evaluation were: reoffending; cost effectiveness; legal issues; social and health outcomes, and, participant feedback. The summary of the evaluation findings are as follows:

Re-offending & sentencing outcomes: MERIT participants were less likely to have reoffended at 3 and 12 month than non-participants. The successful completion of the MERIT referred treatment participants had a more positive impact on drug, theft and property offences than other types of offences.

Cost effectiveness: A reduction in incarceration rates, policing, hospital admissions and the cost of reduced criminal activity was estimated to save approximately 1.28 million.

Legal Issues: It is recommended that there should be a separate legislative framework to govern Drug Courts and the MERIT programs.

Social and health outcomes: Drug use reduced significantly among MERIT participants. This reduction was sustained at 3 and 9 month follow-up. Overall drug related risk-taking behaviour also significantly reduced from self-report data obtained at baseline and program completion.

Participants' feedback: Interviews undertaken with participants upon admission, completion and 3 and 9 month follow-up: found that over 80% of respondents indicated that they were satisfied with the treatment plan and caseworker support. In addition at 3 and 9 month follow up participants reported maintaining the positive changes that they had learnt through their treatment episode.

Specific MERIT funding is provided to non government drug and alcohol organisations to accommodate MERIT participants with timely access and admission into treatment, particularly residential treatment. Dedicated funding for MERIT clients is necessary as the non government drug and alcohol treatment environment is under resourced and in high demand. This purposeful funding is indicative of the underfunding of non government treatment beds and outpatient support in the context of the limits of residential options in the public sector and other costly public health drug and alcohol services. Purposeful non government MERIT funding is relatively low across the State with a relatively small number of NGO's funded to accommodate 48 dedicated MERIT residential rehabilitation beds.

NADA contends that the limited MERIT funding currently provided to the non government sector by NSW Health falls well below the sector's capacity to support the MERIT program. The non government sector is well positioned to centralise coordination of the MERIT programs as a means of providing a mechanism through which MERIT participants would have much better access to a diverse range of community based treatment options. This compares to the limits and resource intensive current model run by Local Health Districts (LHDs) that generally utilise internal referral pathways and services. This results in a template approach to treatment which homogenises treatment through the replication of treatment services available throughout the different LHDs. This comment from LHD MERIT staff sums up the focus of government staff in terms of referral pathways: *"MERIT staff have focused on building relationships with the courts, legal professions and police and limited time with NGOs". (NSW Department of Health, 2004)*

NADA argues that the entire MERIT program be tendered out to the NSW non government drug and alcohol specialist sector in order to facilitate better client access to appropriate community based treatment options and after care support.

Mandatory drug and alcohol treatment trends

Australian prison data over the last decade shows continual growth in the number of people incarcerated, despite crime rates decreasing or remaining stagnant relative to population growth rates in Australia. Overall, prisoner numbers in Australia continue to increase, and involvement of Aboriginal and Torres Strait Islander people in the criminal justice system has worsened to the point where they are now over-represented in the prison system. Much local and international research highlights the role of alcohol and drug use in this trend. Illicit drug use, involvement in the illicit drug trade, and drug and alcohol related crime, including violence, plays a significant role in an individual's, and in particular Indigenous peoples' involvement in the criminal justice system.

There are complex criminogenic and non-criminogenic factors that contribute to an individual's relationship between drug use and offending behaviour. Those in custody are often already the most socially and economically disadvantaged, in addition to having poor health and involvement in crime many of these underlying issues have not been able to be targeted within the context of low threshold drug treatment. Current trends in offender rehabilitation include low threshold interventions, such as pharmacotherapies, and psycho-social interventions.

Within the justice sector the emphasis of treatment services shifts to factors that contribute to risks of re-offending. Repeated incarceration embeds people in an institutionalised community of people with criminal histories reducing exposure to a broader range of pro-social relationships and increasing criminogenic risks for crime. In this context, assessment concerns relate to the level at which drug and alcohol use is one of a number of possible criminogenic factors that contributes to the risk of re-offending. Policy directions in the justice sector seek to broaden the role of law from a purely punitive function toward exploring therapeutic jurisprudence initiatives that incorporate notions of well-being, self-determination and human rights. This expansion has resulted in structural changes such as Drug Courts and associated mandated rehabilitation programs. However, people's health sometimes worsens after release from prison, and services are difficult to access for those labelled as 'criminal' or 'deviant'. Risks of relapse post-release are significant, and mortality rates are extremely high. Many gaps exist between services, the newly devised Intensive Drug and Alcohol Treatment Program (IDATP) John Morony and Dillwynia correctional centres takes therapeutic jurisprudence and mandatory treatment to the next level through increasing the scope and reach of alcohol and drug treatment in custodial settings.

Drug and alcohol interventions must not be delivered in a vacuum. People have underlying issues that often require intensive clinical support alongside basic life and social skill development such as literacy and numeracy. People often have a vision for themselves in the future that includes a sense of hope – therapeutic jurisprudence is attempting to tap into this strength to assist people in achieving successful treatment outcomes that include reductions in alcohol and drug dependence and re-offending. Treatment success is bolstered through intensive post release support that assists with housing, connections with others, skill development, income security and self-efficacy.

Interventions known to 'work' post-release include supported employment services matched with housing, literacy and numeracy and substance abuse education some of which are coordinated and at times delivered

in partnership with NGO based and multi-faceted service provision. These treatment strategies have resulted in reduced recidivism among parolees.

Nonetheless, and consistent with the trend to exclude the non government sector from having high level participation in new treatment innovations, IDATP is relying on government funded partners such as Justice Health at the exclusion of and developing partnerships with the NGO sector. NADA believes this is another missed opportunity to engage the non government drug and alcohol sector as a high level partner with access to diverse multi-disciplinary expertise 'on the ground' in a range of locations, with the capacity to deliver services in the custodial setting and do a lot of the re-integration work because of both their proximity and relationships within the community, that also includes access to housing and outpatient follow-up. In addition, this has been a missed opportunity to share the resources between the government and non government sector which would enable equitable growth across both treatment sectors facilitating the integration of innovation to be embedded.

This government dominated, resource intensive model for mandatory treatment is expanded upon in the current Involuntary Drug and Alcohol Treatment Program (IDAT) facility run by the NSW Health. Legislated through the Drug and Alcohol Treatment Act 2007 and devised to replace the Inebriates Act 1912. There are 2 IDATP units in NSW, - Royal North Shore Hospital and Orange Hospital - which operate based on the positive findings from a 2 year trial at Nepean Hospital. The 2 units house 8 to 12 beds each, with the eight bed facility in Orange funded annually at $2.9 million for a 28 day stay.

Severely dependent alcohol and drug users already characterise those who dominate the profile of non government residential treatment admissions at a greatly reduced cost relative to government funded services. In a funding environment that is dominated by cost cutting and service closure from a cost benefit analysis perspective, it would be more prudent to provide additional funding to services that are already established within the community and delivering specialised care to particular populations (for example, women and children, Aboriginal, and those on pharmacotherapies) within the severely-dependent cohort.

The dominance of the government sector in the mandatory treatment domain sends a message that the community sector is only able to act as a catch-all for the fall-out from government services and are unable to provide specialised services. This runs counter to the increasing burden of formal quality improvement and accreditation that is a mandatory aspect of a funding agreement with NSW Health. While increasing pressure on the non government sector to 'professionalise', the government continues to invest internally. At the same time as restricting and/or defunding smaller NGOs (who often don't have the staff or resources to meet accreditation standards) that would be well suited to the provision of intensive and specialised treatment. Treatment delivered by these smaller NGOs would be less costly and able to facilitate community case managed partnerships that is the established best practice intervention for relapse prevention. Building partnerships between the government and community sector into funding contracts will broaden the development of new and innovative interventions to address the emergence of new drug and alcohol harm trends.

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

The current expectation is that the community sector caters to the needs of patients with both drug and alcohol dependence and mental health issues, as co-morbid clients now characterise the norm. This expectation has been translated into a necessity to treat co-morbid clients based on the current profile of clients that, in particular seek admission to residential settings. As listed above, the profile of those seeking treatment at the severe end of the drug use dependency continuum bring into treatment a history of crisscrossing services that specialise in stabilising one or the other mental health or drug and alcohol issues. The complexities of mental health issues in the drug and alcohol sector predominantly relates to limited periods of stabilization so that a clear mental health diagnosis can be made outside of the context of the often crisis orientated lifestyle that is consistent with those who are severely dependent. This is particularly relevant in relation to psycho-stimulant use, as separating the effect of the drug and the mental health symptomatology while the person is still using is challenging even for the most experienced clinical professional. Frequently the only means by which clarity can be obtained, and as such an accurate diagnosis and treatment plan can be devised, is through a period of abstinence, ongoing observation in a stable environment, and a comprehensive history and assessment carried out by a clinical professional who has experience in both the domains of mental health and alcohol and drug. In addition, while the NGO sector is expected to treat co-morbid clients there is often no specific funding to hire the necessary experienced cross sector staff to do so.

This creates a situation where NGOs are frequently reliant upon the public mental health system for assessment and support. The barriers to this reliance is multi-dimensional, one barrier is a lack of professional recognition provided by the hospital based mental health staff to NGO staff; a rejection of observations and assessments made by NGO staff; and the psychiatrists that undertake the assessments are registrars doing their rotation through the mental health hospital system and have little or no experience in either AOD or mental health. ADCA (2008) have summarised additional barriers for NGOs in treating individuals with complex co-morbidities:

- a paucity of services,
- poor integration of services,
- difficulties in making an appropriate diagnosis,
- competing professional and service paradigms,
- a failure to involve consumers and families,
- marginalisation and stigmatisation of clients and families,
- lack of training, skills and commitment of staff; and
- an inability to recruit skilled staff.

The case study below provides some insight into the issues that act as obstacles toward integration both within AOD and mental health public health systems and the community sector. Importantly, the case study highlights some of the problems that impede constructive clinical cross-case management between individual community based AOD services and public sector AOD and mental health services.

Case study: Frankie *, Indigenous woman 42 years. Location - Inner Sydney.

* *not her real name. This is derived from a range of case studies in the non government drug and alcohol sector.*

Alcohol and Drug use History: 12 years alcohol primary dependence, cannabis and amphetamines secondary dependence

Treatment History: Multiple detoxification episodes, 3 inpatient residential treatment admissions – with the longest period of abstinence of 6 months

Family History: Alcohol dependent Mother; Absent Father.2 children: 6 and 4 years old permanent removal by DOCS into the care of sister with monthly visitation. The relationship between Frankie and the Sister was strained at best and the Sister did not live locally.

Trauma History: Gang raped at gun point as a teenager and domestic violence

Assessment: Alcohol dependence, undiagnosed and untreated depression, anxiety and complex PTSD

Treatment Plan: Medicated detoxification in a women's only NGO. Assessed and admitted to 6 month small women's and children's intensive residential program post detoxification.

First month in residential treatment: Assessment, observations and clinical support

- Complex range of issues identified through case management including recent removal of children
- Psycho-social assessment identified high on Depression and Anxiety scales and a history of untreated trauma (details of which were undisclosed)

Patient referred to GP with a referral from the Staff psychologist to assess pharmaceutical options for the management of depression and anxiety. In spite of patient's reluctance to 'take pills' because of cultural interpretations of prescribed medications, the patient agreed to take medication on a short term basis to manage risk and seek stabilization in order to maximize the benefit of the residential treatment program.

Second Month in residential treatment: Lack of Integration between the mental health public sector model and the NGO model.

- Development of Case Management Plan - including organizing visitation with children and contact with Mother
- Development of Treatment Plan – Stabilisation of anxiety and depression (medication and one on one sessions with psychologist). Moved off peer supervised support and outings. Participation in all aspects of program including group therapy and parenting assessment and support.

As the patient stabilized in treatment she started to escalate in her mood resulting in a psychotic break. Mental Health crisis team were called and the patient was assessed as not being a suicide risk and therefore referred to outpatient mental health facility at local public health hospital.

The patient's behaviour scared the other residents and as such she became somewhat isolated in treatment. She required constant monitoring by staff and reassuring 'reality checks'. Frankie required many one on one sessions with staff and consultant psychologists'. At the same time the outpatients mental health facility was called and the AOD worker requested priority be given to the patient because of the psychosis (risk to self and others, took up a lot a staff time which manifested in inequity of support for the other residents). The NGO was informed that the patient would have to go through the 'usual' process of assessment; she had no 'immediate' access to mental health support in the public health sector apart from admission through the emergency department. This 'usual' process to attend the outpatient service on assessment day, wait in the waiting room to be assessed by a mental health nurse who decides if the patient was met the criteria to be

assessed by a Registrar Psychiatrist. In the interim the patient was referred back to the GP for an 'urgent' re-assessment and medication review, resulting in the prescribing of an anti-psychotic medication. However, because the patient did not fit the mental health criteria (ie: Bi-polar or Schizophrenia) for the medication – she also did not meet the criteria for the PBS cost reduction and had to pay the full price of the medication in spite of being on the disability pension.

The patient was escorted by a staff member to the mental health facility where they sat in the waiting room for assessment. The staff member gave the mental health nurse a thorough referral written by the consultant clinical psychologist. The staff member was not provided with any professional courtesy and the client went through a very distressing long assessment. The mental health nurse then proceeded to make another appointment for her to see the Psychiatric Registrar at the end of the week. Again a staff member escorted the client to the mental health unit with another detailed referral letter to be re-assessed by the Registrar. The Registrar diagnosed the client with Bi-polar and was returned to the residential with another script for anti-psychotic medications. The Registrar was called by the Manager of the service to discuss the diagnosis in the context of her recent disclosure that she had been gang raped at gun point, had recently had her children removed and had just detoxed off alcohol. The Registrar was dismissive and informed the Manager that upon review by the senior Psychiatrist the diagnosis was Bi-polar. This diagnosis had the effect of making the client more agitated and fearful and required a lot of support to undermine the diagnosis made by the staff of the mental health unit. Frankie required a lot of reassurance that her symptoms were much more likely to be related to her trauma and Department of Community Services (DOCs) removal of her children which were emerging post her cessation of alcohol use. That her alcohol use was both the cause and effect of how she was feeling, that she was experiencing mental health symptoms, but that they were more likely related to Post Traumatic Stress Disorder (PTSD - life trauma experiences) than any organic mental health problem that she may also have.

In spite of the NGO treatment service and the mental health facility being funded by and located within the same Local Health Network, there was no priority given to the patient as an inpatient in a local NGO service. The process that played out was consistent with entering the facility as an individual 'off the street', no professional priority was given to the NGO. There was no attempt made by the Registrar to liaise with or offer guidance to the clinical staff of the service who ultimately disagreed with the diagnosis made by staff and 2 psychologists at the NGO, in spite of the Registrar's lack of experience in either mental health or AOD. No professional recognition was offered to the staff at the NGO and no credence was given to the 24 hour a day observations made by the staff or the one on one sessions had with the patient by clinical psychologists - and the assessment by the NGO that she was experiencing a psychotic break as a combination of untreated PTSD and the stress and shame of having her children recently removed from her care.

The medical model dominates the mental health sector; addiction medicine dominates the AOD sector in the public health system. The community sector acts as the multi-disciplinary third treatment network that is the catchall for those that can't be clearly situated in one or the other model, which apart from those on pharmacotherapy, is most of the AOD treatment seeking populations. While evidence supports an integrated model of treating both a person's mental health and AOD issues simultaneously, the NGO sector is often under resourced to hire the necessary experienced clinical staff and the public health sector operates its service provision through silos. In addition, the addiction and medical models do not have the systems or cultures (mindset) to cross-case manage patients with the NGO sector. There a very few NGOs fully funded to manage co-morbidities - this needs urgent funding attention, as the NGO admitting these clients with no integrated support in the public health sector in order to provide simultaneous treatment for both disorders.

Enhancing Mental Health Clinical Capacity in AOD NGO Sector: proposing an Integrated Model

The public sector delivers services through silos, making the integration of Addiction medicine and Mental Health medicine very challenging. What is sometimes referred to as the third sector (the NGO sector) is well positioned to function across the artificial demarcations that are an artefact of these silos. Evidence base best practice in the AOD / mental health sector supports an integrated model of care that operates to stabilise and treat both morbidities simultaneously as required. The third sector is not restricted by the 'silo effect' and as such is in a much better position to facilitate integrated treatment models than the public sector.

> *Many drug-addicted individuals also have other mental disorders. Because drug abuse and addiction—both of which are mental disorders—often co-occur with other mental illnesses, patients presenting with one condition should be assessed for the other(s). And when these problems co-occur, treatment should address both (or all), including the use of medications as appropriate (NIDA, 2012)*

The following is a proposed Model of an Integrated AOD and Mental Health treatment intervention that can be devised in the community sector for AOD services. This is specifically applicable for services who have no or insufficient funding for 'on staff' AOD/Mental Health specialist clinicians.

This model was developed and trialed at a women's and children's residential rehabilitation unit, based on the desire to integrate the AOD program with more standardised mental health treatment interventions. Overall building the clinical capacity of the service to undertake an integrated model of best practice AOD and mental health treatment in house. The outcomes of which are outlined below.

Model: Enhancing mental health capacity in a AOD NGO

Psychiatrist (private): Consulting / Visiting (Medicare bulk bill to individual client) undertake comprehensive assessment, prescribe and undertake interim medication reviews, have input with clinical staff into treatment plans, liaise with staff or consulting psychologist and service GP (ideally visit service monthly or fortnightly)

Psychologist (private): on Staff or Consulting (Medicare rebated mental health care plans between individual and psychologist); liaison between psychiatrist, GP and AOD staff, incorporate mental health treatment into AOD treatment; assist AOD workers with managing mental health treatment issues in house, rather than needing to refer to emergency or discharge because they don't have the capacity to manage mental health symptoms.

Service GP: liaise, assess, prescribe and review medications, manage mental health care plans between individual and psychologist/s

Developing the Model

All of these services are available to individuals within the community. Building partnerships with private practitioners working in the community who have expertise and experience in the area of mental health and AOD is usually beyond the organisational capacity of individuals characterised as severely dependent. NGO's typically do not have the funding to hire staff with this level of expertise and experience, or may have funding for a part time psychologist who is carrying the more complex clinical case load of the facility, and support the

AOD workers who provide most of the daily support, facilitate program interventions and manage much of the day to day crisis management. Some services extend their clinical capacity through partnering with universities and allowing psychology students to undergo clinical placements in their service. This private sector partnership model is an alternate to the student model.

Developing this model requires the service to work through their networks to locate private sector practitioners to may have the desire to support the community sector because of a particular interest in working with these 'type' of clients, or practitioners who are researchers and wish to continue undertaking part-time clinical work. Partnering with these type of private practitioners gives clients at the lower end of the socio-economic spectrum and are socially excluded who are experiencing severe dependence, and often crisis managed through the public sector and are resource intensive (time and money). Access to specialized care would usually not be accessible in the normal course of seeking help and support for their drug dependence.
After identifying interested parties, meeting with the practitioners both independently and as a group (where possible) is an important aspect of building this model. It is crucial in order to come to understandings and agreements about role clarity and service partnerships.

Costs of Model
The financial burden for this model falls to Medicare with additional funds for 'gaps' or additional work, such as group facilitation, falling to the service when possible. The financial aspect of the model is contracted between the individual and the practitioner through mental health care plans and bulk billing, with the service provision partnership aspect being made between the service and clinical practitioner. Therefore this model has the capacity to greatly enhance the clinical capacity of the service without the financial burden attached if they were 'on staff'.

Outcomes of Model

- Decreased referrals to the public mental health sector
- NGO better able to integrate AOD and mental health treatment
- Increased retention rates related to the ability to manage mental health issues in-house.
- Increased ability and confidence for AOD staff to be supported to manage clients with mental health symptoms in service
- Decrease in mental health related crisis management and discharges, with the ability to facilitate early interventions in-house (the immediate facilitation of an intervention related to observations made by AOD staff in regard to an escalation in mental health symptoms in 'real time').

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.

Health promotion as a priority and investment focus is welcomed, as this is currently an under-resourced area in the prevention and early intervention of alcohol, tobacco and drug misuse. There is much evidence indicating that prevention and early intervention of such misuse is effective at reducing harm for individuals and communities, and is a cost effective health intervention. It must be noted however, that campaigns aimed at reducing peoples' motivation to use alcohol, tobacco and drugs need to be targeted to certain populations in order to gain reach and relevance, and that this is best done through organisations with expertise in working

with those population groups. NADA emphasises that education campaigns should be informed by a range of sources and stakeholders.

A small number of NADA members are funded to carry out localised health promotion initiatives; with increased funding the sector has the expertise and capacity to expand its role in this area.
NADA recommends the development and implementation of a dedicated budget for a statewide education and prevention program to be delivered by the NGO sector. Such a budget could be linked to the sparse education and prevention components that currently exist within the NGO AOD program sector and be used to substantially enhance the sectors capacity to develop and deliver community close programs.

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

NADA provides no comment.

7. The proposed reforms identified in the Drug and Alcohol Treatment Amendment Bill 2012

There is a multitude of evidence that suggests that severely dependent drug users achieve better treatment outcomes in long term residential treatment. The other successful treatment option for severely dependent individuals is pharmacotherapy maintenance programs known as replacement therapies, as opposed to the limited outcomes achieved through the use of adverse therapies such as naltrexone for this cohort. While it is widely recognised that there should be a variety of treatment options available for people at different places along the drug use continuum and who have different needs and circumstances, severely dependent individuals have been widely researched in terms of treatment matching. Residential long term treatment with aftercare programs is predominantly provided by the NGO sector in NSW. Consistent with being severely dependent, detoxification is the necessary first step in the treatment episode. However, there is almost no evidence to support the contention that detoxification in isolation has much impact on drug use and other risk behaviour. There appears to be no mechanism in the Amendment Act for those who cease to comply post detoxification, ultimately creating increased overdose risk. Further, if a person with a naltrexone implant 'goes missing' the ability to support and monitor this person outside of the mandatory frame creates a whole range of un-researched issues and potential risks.

In terms of mandatory treatment, operating in the health sector (distinct from treatment offered in custodial settings) it is difficult to access evaluation data in relation to the Involuntary Drug and Alcohol Treatment (IDAT) programs. The current roll out of the Drug and Alcohol Treatment Act 2007 manifested in Involuntary Drug and Alcohol Treatment Programs which offers a 28 day stay in a purposefully developed hospital based unit in 2 sites across NSW. A review of the Drug and Alcohol Treatment program found that the system of care was effective, including medically supervised detoxification, severe co-morbidities being managed by Doctors and Nurses with the 'provision' of supportive aftercare. In the trial of the Involuntary Treatment Unit (ITU) run through Nepean Hospital in 2009, there were 89 referrals during a period of 18 months, with 81 assessments undertaken, 42 dependency certificates issued resulting in 35 admissions. NSW Health is currently not in a position to expand the current manifestation of IDAT without a very costly up scaling of the current program.

In regard to the mandatory introduction of naltrexone implants there is a dearth of data regarding treatment efficacy. Apart from a private naltrexone provider in WA who has reported local positive outcomes there have been no clinical trials in Australia to support the effectiveness of naltrexone implants as an evidence based best practice intervention in drug and alcohol treatment for severely dependent individuals. It would therefore be prudent prior to the introduction of such an intrusive mandatory component of the treatment to, at the very least, invest in a randomized control pilot study.

Current research on counseling and maintenance pharmacotherapy treatments suggest that:

> *Recent studies with randomised designs {with patients receiving maintenance therapies) have failed to show consistently that the provision of additional services, including counselling, achieves better outcomes (Mattick et al, 1998 in Taskforce on Illicit Drugs, 2001, pg 130 -131).*
>
> *Intensive services, when set up as separate services, seem to render treatment more expensive with only marginal improvements in effectiveness (Kraft et al, 1997 in Taskforce on Illicit Drugs, 2001, pg 130 -131).*
>
> *Although there is no well-tested model of drug counselling in MMT, counselling should be based on reflective listening to develop an empathetic alliance, whether the counseling is provided by a specialist or a general practitioner (Mattick et al, 1998). Mandatory psychotherapy or counselling is unlikely to be beneficial, and may even have a negative impact on patients' attitudes to treatment (Mattick et al, 1998). Supportive counseling is particularly important when patients are detoxifying from buprenorphine or methadone. (in Taskforce on Illicit Drugs, 2001, pg 130 -131).*

Post reduction support and counselling according to this evidence is more beneficial than mandating it at the onset of pharmacotherapy treatment. Contrary to the Amended Act model that is not supported by evidence, proscriptive 'one size fits all' outpatient care does not support the flexibility of appropriate treatment matching that should be determined by the clinical needs and 'whole of life' issues of specific patients.

In terms of the inclusion of young people aged between 16 and 18 there would have to potentially be a separate unit to accommodate these young people. Housing adults and young people who are severely dependent in the same unit could create numerous ethical, risk and duty of care problems that requires much more thorough investigation and consultation. As well there is currently no infrastructure in place to support the roll-out of this type of proscribed treatment for this age group, in terms of both in-patient and outpatient care.

NSW Health is not well positioned to facilitate this type of mandatory care without community partners, however currently there are almost no systems or pathways in place for NSW Health to cross case manage severely dependent patients outside of their own public health domain. Historically the community sector, even if funded within the same local health network, is given no priority in terms of access or cross case management opportunities with public health services. New policies and mechanisms would need to be put in place to operate this type of long term mandated care underpinned by access equity. That is, to include 'special populations' such as women and children, CALD and ATSI that are generally treated within the community sector. While the community sector is at times compelled by necessity to refer clients in residential community treatment to clinical public health services, particularly mental health clients to public health

system, NSW Health based AOD services predominantly refer within their own networks. Even so apart from long term pharmacotherapy maintenance clients, the public health care system is not set up for long term (3 month intensive care) even in an outpatient setting. An example of this is the above mentioned point that Department of Health administered MERIT programs generally refer internally, however this strategy would inevitably need to be reviewed because of the prerequisite length of treatment and profile of the clients proposed in the Amended Act.

Unlike other maintenance pharmacotherapies Naltrexone does not eliminate 'cravings', and with abstinence being a legislated outcome of the application of the Act, there is a high risk of opiate overdose, risk of increased use of other drugs and the manifestation of psychological problems in alternate, possibly more harmful behaviours.

If naltrexone implants where to be introduced it would be within the medical model which is synonymous with a 'one size fits all' approach to treatment. Nonetheless, this runs counter to the evidence based best practice treatment of AOD patients who often require both core aspects of a program and individualized case managed care that is usually facilitated through personalised treatment plans to address the specific issues related to 'that' individual. The mandatory implant component of the Act takes agency away from the person which is inconsistent with the evidence of efficacy of person centered treatment that promotes input, choice and self-determination.

Workforce development is also an issue in terms of the introduction of this Amendment Act because Naltrexone implants are not currently utilised in NSW as a routine treatment option. Therefore training and expertise would need to be developed by those undertaking treatment in order to intervene on the potential, to date under-researched harms associated with this model. If this model is to be considered seriously, the Amendment Act should not be legislated for until a thorough pilot is trialed and thoroughly reviewed and evaluated by reputable external researchers.

Conclusion and Recommendations

The NSW Drug and Alcohol program within the Department of NSW Health has been operating in its current form since the 1999 Drug Summit. NADA believes it is time for the government to re-examine the current funding structure and policies for the delivery of drug and alcohol services across NSW. We perceive this Inquiry can provide a timely and procedurally appropriate opportunity for the government to reshape the structure and function of drug health services across the state; through focusing on the expansion of community based services. This can be achieved by increasing the focus on delivering services that have community based proximity, deliver integrated and client centered interventions that also include broader community and family's needs. By way of increasing the focus on the community AOD sector and restructuring funding arrangements, there is an opportunity to enhance the role of community based treatment services to better meet the needs of the wider NSW community.

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