

**Submission
No 49**

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

Organisation: Wesley Mission

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Inquiry into Drug and Alcohol Treatment by the Legislative Council of the NSW Parliament

(General Purpose Standing Committee No.2)

**Submitted by Wesley Mission, Sydney
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Andrew Mitchell, General Manager
Employment, Residential, Training & Health





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1. Executive summary

Wesley Mission operates two private not-for-profit hospitals at Kogarah and Ashfield for acute care of persons with mental health disorders, substance abuse disorders and combinations of these. The treatment approach is based on a philosophy of the nature of drug and alcohol dependence being a psychobiological “driving force” to take addictive substances. An evidence-based holistic model is adhered to that treats the physical and psychological factors of substance addiction and co-morbid conditions. Limitations of the service noted are the private nature of the health care setting, the voluntary nature of the setting and the financial sustainability of the funding model.

Comments are made to various components of the inquiry terms of reference, including:

- general advances made in recent years for treatment of persons with alcohol and drug-related disorders being considerable yet patchy in service delivery;
- promising medications and therapies should be evaluated by controlled studies with funding made available;
- patients at Wesley hospitals reporting a lack of access to post-hospitalisation rehabilitation services;
- the importance of compulsory treatment for the most severely affected people with substance dependence;
- the need to develop and expand integrated treatment services catering for people with comorbid conditions of drug and alcohol dependence and mental health issues; and
- the need for increased access to information about legal deterrents, adverse health and social impacts and the addictive potentials for drugs and alcohol.



Wesley Mission welcomes the opportunity extended to it by the Committee to prepare this submission and also to give evidence during the Committee's Hearings. Professor John Saunders, the Director of the Alcohol and Drug Program at Wesley Hospital (Kogarah) will be representing Wesley Mission and will be providing evidence in person.

Wesley Mission engages with, and provides services for, thousands of people with alcohol and drug-related disorders through its community, health, aged care, homeless, employment and pastoral services. The most concentrated experience of alcohol and drug disorders derives from the two hospitals within the group, which are based at Kogarah and Ashfield. In addition there are specific community services for other addictive disorders provided through Wesley Mission's Gambling and Financial Counselling Services.

Wesley Hospitals at Kogarah and Ashfield are private, not-for-profit acute hospitals which provide treatment for persons with mental health disorders, substance use disorders and combinations of these. Both hospitals admit voluntary patients who present with addictions for detoxification, appropriate pharmacotherapies, and group and individual therapy. There are extensive aftercare programs and individual therapy available for relapse prevention, promotion of recovery, and continuing management of mental health disorders.

Our treatment approach is based on an agreed philosophy about the nature of these disorders, which is a psychobiological "driving force" to take addictive substances. This does not mean a uniform and unvarying philosophy, but does require that all involved are in agreement with certain key principles (established in a participatory way) and that there is mutual respect among the professional disciplines in recognition of the different knowledge and skills that various professional disciplines offer. This evidence-based, holistic



model effectively treats the physical and psychological factors of substance addiction and the co-morbid conditions that often present in this patient population.

The limitations of our service include;

- (i) the private nature of the health care setting, which may exclude persons with addictions who do not have private health fund cover, support through Workers' Compensation, or the finances for a self-funded admission,
- (ii) the voluntary nature of the setting, which can preclude high acuity presentations (such as immediate suicidal intent) as the hospitals do not have locked units, and
- (iii) the balance between the length of stay that is beneficial to the patient and the optimal length of stay from a financial sustainability aspect¹.

¹ The rebates that private hospitals receive from health funds generally follow a sliding scale. The longer the patient stay, the lower the daily rebate private hospitals may receive from private health funds. Beyond a particular length of stay, the rebate Wesley Mission receives from a health fund will not fully cover the costs of caring for the patient.



1 Treatment services

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

During the past 20 years there have been considerable advances in treatment for people with alcohol and drug-related disorders. The term “treatment” in this context means a range of interventions including brief interventions, medications targeting the addictive process, therapy, whether individual or group, self-help through the 12-Step fellowships such as AA and affiliation with other cognate organisations. Treatment has developed most noticeably for alcohol dependence and related disorders and for heroin and other opioid dependence and related disorders. Effective approaches for cannabis and psychostimulant related disorders are at an earlier stage. There continues to be controversy about the role of maintenance treatments (including methadone and buprenorphine) versus treatments that have abstinence from all opioid drugs as their objective; naltrexone is included in the latter category.

Despite the advances in treatment, its broad provision is still patchy. Whereas approximately 60 per cent of people with heroin dependence are engaged in some form of treatment, the figure for alcohol dependence is only 10 per cent. Specialist services could not hope to manage everyone with substance disorders who are candidates for treatment. Inevitably for most



substances, the generalist health care services including general practitioners and community health services must take a greater role. Given this position, one must acknowledge that generalist health professionals often feel swamped by the frequent multiple needs of patients with substance dependence. Furthermore, due to the nature of substance dependence a person's attention is often diverted from their health and wellbeing to the incessant drive to consume the substance and satisfy the compulsive aspects of their dependence.

With regard to the statement on clinical trials of new treatments, we would entirely agree that promising medications and also therapies should be evaluated by controlled studies and that funding should be made available for this option. This would include not only naltrexone but also medications for the treatment of cannabis and psychostimulant dependence, given the paucity of effective approaches to these substantial health problems.

2. Funding

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

Wesley Hospital patients frequently report the lack of access to:

- (i) short term rehabilitation programs that are government funded,
- (ii) half way housing,
- (iii) supported accommodation and



(iv) addictions specialists in the community.

Additionally, in order to meet the needs of families impacted by individuals dependent on illicit drugs and /or alcohol we have engaged the services of the Family Drug Support Agency, although from our experience, access to community support services for families and care-takers is limited.

3. Mandatory treatment requirements

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

Mandatory treatment occurs in two contexts in New South Wales. The first is mandatory treatment through the criminal justice system. Worldwide there is considerable evidence for the benefits of diversion at various stages in the justice system into the healthcare system and away from only criminal penalties.

The real gap in knowledge is on the effectiveness of mandatory treatment for those who have not committed any offence but who have not shown a response to a range of voluntary treatments. For a century the New South Wales Inebriates Act (1912) provided for compulsory treatment of various types, including long term hospital treatment. This has been replaced by the Drug and Alcohol Treatment Act (2007, with more recent amendments), which provides for compulsory treatment for up to three months. Wesley Mission would like to emphasise the



importance of compulsory treatment for the most severely affected people with substance dependence. There has been considerable emphasis placed on respecting the human rights of people with substance dependence and the sentiment amongst the professional drug and alcohol community that is opposed to the notion of compulsory or coerced treatment. Due to the problematic nature of substance dependence, patients are often in a state of denial of their disorder and its severity. The lot of many patients is the remorseless progression of their disorder until they have developed permanent brain damage or succumbed to the medical or psychiatric end results, often fatally.

For the above reasons and due to the chronic nature of drug and alcohol dependencies, Wesley Mission is an advocate for mandatory treatment.

4. Integrated services

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

Up to the 1970s drug and alcohol dependence was often treated in the psychiatric sector through special wards in mental hospitals and associated clinics. With the expansion and reorientation of drug and alcohol services to a public health and harm reduction philosophy, the links between drug and alcohol services and mental health services became progressively weaker. Indeed some drug and alcohol services and eminent practitioners denied the very need for mental health services to be involved. This had the effect of forcing an artificial



distinction between the two types of disorders and resulted in the deeply unsatisfactory situation that people with drug and alcohol disorders were often excluded from mental health services and yet were being treated by staff who had no training or experience in mental health disorders.

Only in recent years has the public system attempted providing more integrated services, through the appointment of specialist nurses in dual diagnosis and the appointment of a new breed of addiction psychiatrists. It is important to note the efforts of the Royal Australian and New Zealand College of Psychiatrists in establishing specialist training in addiction psychiatry and there are now a large number of qualified addiction psychiatrists. In addition the Chapter of Addiction Medicine of the Royal Australasian College of Physicians provides training for a new generation of addiction medicine specialists.

In the private hospital system there was never the schism between treatment for drug and alcohol disorders and mental health disorders. Therefore the private sector, for which nearly 50 per cent of Australian adults are eligible for treatment, has continuously provided and generally expanded its treatment for dual diagnosis conditions.

Since the 1960s Wesley Hospitals at Kogarah and Ashfield have provided continual treatment for patients with dual diagnoses. They have also expanded their provision of treatment by the appointment of addiction specialists familiar with dual diagnosis conditions. With respect to the adequacy of integrated services to continue the treatment of co-morbidity in those with drug and alcohol addictions, Wesley Mission has encountered difficulty in placing co-morbid clients into



long-term rehabilitation facilities due to these centres inability to manage complex co-morbid presentations.

The comorbidity of drug and alcohol dependence with chronic pain results in clinical management problems that challenge any practitioner and service. Provision of treatment for such patients is unplanned and uncoordinated. It has been exacerbated by changes in legislation governing the prescription of Schedule 8 drugs (e.g. morphine) and Schedule 4D drugs (e.g. benzodiazepines): the needs of these patients are generally not adequately provided for by the regulatory authorities such as the Pharmaceuticals Services branch of the NSW Ministry of Health. Furthermore there seems to be a fundamentally poor understanding of the issues of chronic pain and dependence between addiction specialists and pain management specialists.

The third major area of comorbidity involves people with drug dependence (most commonly injecting drug users) who also have a blood borne virus infection, most commonly Hepatitis C. There is evidence from worldwide scientific studies that treatment is more assured if it is provided within the context of a drug treatment clinic (i.e. integrated treatment).

The fourth area Wesley Mission identifies is the lack of provision of mental health assessment and management among patients attending public and private opiate treatment clinics ("methadone clinics"), despite the high levels of comorbid psychiatric disorders seen in these patients.



5. Drug and alcohol education programs

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

One of the unexpected findings in drug and alcohol education programs is that drug and alcohol education in schools do not produce the expected benefits. Indeed control trials of school education approaches in the USA have often shown higher levels of alcohol and drug use in school students receiving education compared with those who have received none.

Positive developments for older students (e.g. college and university students) have been found from electronic (website-based) interventions, which provide easy access and also confidential tailored information about alcohol use. This approach has the potential for being expanded to other forms of substance abuse. Professor Saunders has considerable experience in brief interventions, both in health care settings and when presented electronically e.g. through websites.

The feedback Wesley Mission has obtained from our patients regarding funding and effectiveness of drug and alcohol programs in the community indicates a lack of access to information about legal deterrents, adverse health and social impacts and the addictive potential of drugs and/or alcohol.



6. Responding to drug and/or alcohol addiction

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

Other countries have very different philosophies and approaches to the management of drug and alcohol dependence. In the USA there is a strong emphasis on recovery from strict abstinence from alcohol and other drugs. This is strongly supported by the self-help groups such as Alcoholics Anonymous (AA). There is correspondingly less emphasis on public health approaches such as opiate maintenance and needle-syringe availability programs. In most of Europe by contrast there is a strong focus on public health and harm minimisation strategies. The Nordic countries such as Sweden also differ: they have a strong emphasis on compulsory rehabilitation programs, with many young people attending specific youth rehabilitation programs. Russia does not permit any form of opioid maintenance (i.e. with methadone or buprenorphine). Instead naltrexone is widely prescribed for alcohol and opioid dependence.

Australia's drug treatment services in the public, private and non-government sectors provide a range of treatments and compare well internationally. However with the evolution of different forms and combinations of substance use and their occurrence with mental disorders, chronic pain and infectious diseases, there is a constant need to develop and expand new and more integrated forms of treatment.



Wesley Mission supports strategies in other jurisdictions, such as Sweden and the UK, in which a tightening of drug laws combined with early intervention policies prioritising access to services for socially at risk families has led to an improvement in treatment outcomes.

7. Proposed reforms

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

Wesley Mission supports the proposed reforms identified in the *Drug and Alcohol Treatment Amendment Bill 2012*, given that the progressive nature of drug and alcohol dependencies often lead to custodial sentences which can further entrench the degenerative, downward spiral of criminal activities in an attempt to maintain an addiction.

8. Conclusion

Some concluding comments

The private sector, including Wesley Hospitals, has shown a consistent commitment to drug and alcohol treatments. It has grasped the challenges posed by the most complex combinations of disorders with comorbid disease states. Although the private sector tends to be overlooked in formal enquiries, it provides a valuable resource which (through the combination of private health insurance, veterans' affairs, workers compensation insurance and through self-funding) is available to approximately 50 per cent of Australians. Its contribution is significant, its reach is extensive and its evidence based outcomes considerable.



Wesley Mission

220 Pitt Street, Sydney Australia
PO Box A5555, Sydney South NSW 1235
(02) 9263 5555
wesleymission@wesleymission.org.au
www.wesleymission.org.au

Superintendent/CEO: Rev Dr Keith V Garner

ABN 57 996 964 406

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