Submission No 32

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

Organisation: Drug and Alcohol Multicultural Education Centre (DAMEC)

Date received: 1/03/2013

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Drug and Alcohol Multicultural Education Centre

DAMEC submission to:

Legislative Council Inquiry into Alcohol and Drug Treatment in NSW

Introduction

The Drug and Alcohol Multicultural Education Centre (DAMEC) is one of the few if not the only, non-Government organisation (NGO) that specialises in working with culturally and linguistically diverse (CALD) communities around substance use issues and co-occurring mental health issues. DAMEC's experience as a treatment provider, as well as the evidence it has collected over many years of research point to the fact that CALD clients in NSW do not currently have equal access to all alcohol and other drug (AOD) treatment options. There are several unique factors that impact upon individuals from CALD backgrounds when seeking to address drug and alcohol issues. Although shared language is of primary importance, DAMEC has found time and time again that cultural influences can impact upon the effectiveness of drug and alcohol treatment provided within NSW. With careful planning and strategic initiatives, DAMEC believes that cultural perspectives can be harnessed as a benefit, rather than a barrier to treatment.

This submission will address the inquiry's terms of reference by considering the experience of DAMEC's professional staff, its key stakeholder communities, its elected Board members, its consumer panels and the findings of DAMEC's previous research. DAMEC makes 8 recommendations to the General Purpose Standing Committee. Please note that this submission does not comment on TORs 1b or 6.

DAMEC would welcome the opportunity to offer further consultation on any of the issues raised.

Stakeholder background

DAMEC was established in 1989 as part of the NSW Drug Offensive. It was originally tasked with working with ethnic communities on drug and alcohol issues. Over 23 years, DAMEC has developed its services with the goal of providing a multifaceted response to AOD issues for CALD communities across NSW. DAMEC holds accreditation with the Australian Council on Healthcare Standards (ACHS).

DAMEC is governed by an annually elected Board which comprises drug and alcohol professionals and community members. DAMEC's Board also has targeted positions for representatives from peak Multicultural Health Services across NSW. Community participation and consultation is enhanced within DAMEC by the establishing culturally specific panels. Currently DAMEC has three panels in place.

DAMEC works within a harm minimisation framework and employs a multifaceted approach to fulfil its mission[1]. DAMEC fulfils this objective by providing short term projects, information and training, research, advice to the sector and an outpatient counselling service in Sydney's south west. DAMEC employs 16 FTE's and has offices in Redfern, Liverpool and Auburn. DAMEC is primarily funded through NSW Health NGO funding program. DAMEC also receives specific Commonwealth funding to provide bilingual counselling and co-morbid case management. The service currently provides counselling in Vietnamese, Chinese, Arabic and Khmer. DAMEC also receives State Government funding to run a specific family program and two culturally specific transitional support programs with inmates from Vietnamese and Arabic backgrounds who have histories of drug use and drug related crime.

DAMEC's outpatient counselling service is based in Liverpool (South-western Sydney). In 2012, DAMEC treated 234 clients. DAMEC's counselling model is based upon a strengths based model within a Brief Solution Focused Therapeutic framework incorporating elements of Cognitive Behaviour Therapy and Narrative Therapy. DAMEC's interventions are client centred and responsive to cultural background. At this micro level, the experience of DAMEC's counselling service is showing that many of DAMEC's CALD clients have significant outcomes within this framework where previously their engagement into Drug and Alcohol services were limited. On a macro level, DAMEC's research has found evidence that shows that generally CALD clients across NSW face greater barriers than Caucasian clients when seeking help for AOD issues, and culturally specific treatment modalities are more likely to provide positive outcomes among these groups.

Stakeholder details

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[1] Drug and Alcohol Multicultural Education Centre, 2009, *Strategic Plan 2010-13*. DAMEC, Sydney NSW.

Response to Terms of Reference

TOR 1a. The delivery and effectiveness of treatment services for those addicted to drugs and/or alcohol, including naltrexone treatment

Key points:

1) **A range of treatment options should be available to CALD communities including naltrexone, however research has shown better outcomes with alternative medical treatments such as opiate replacement or other antagonists (buprenorphine, methadone).**

2) **Health promotion campaigns that develop community understanding of dependency as a psychosocial health issue are likely to open up demand for a more effective range of treatment approaches to suit culturally diverse clients.**

3) **Many treatment modalities are unsuitable for the needs of CALD clients as they require Western psycho-education, English fluency and periods of separation from family.**

4) **Information needs to be provided in key languages to ensure that people seeking treatment can make an informed choice about which treatment is likely to be most effective for them.**

DAMEC believes that one option for treatment alone cannot possibly meet the needs of all people with drug dependency. A range of medical and non-medical treatment options should be made available to all people in NSW. Many treatment options are not currently accessible to culturally diverse clients. This presents a significant equity issue. The main reasons for this according to DAMEC research are communication difficulties with services, family exclusion from treatment processes, a lack of understanding of services available, as well as poverty and social exclusion. It is important to understand that communication difficulties extend beyond language, but also include the cultural relevance or comprehensibility of particular treatment modalities.

Over DAMEC's history, misunderstanding, confusion and shame associated with seeking treatment for CALD communities stand out as influential factors. In fact, many communities themselves see dependency as a weakness of spirit and the drug dependent client is seen to be a subject of great shame within the family. Communities that see dependency as an illness are more likely to seek a prescribed medical approach to treatment. DAMEC has had many experiences with Vietnamese families who have sought quick solutions to their family member's heroin dependency. Many are sent back to Vietnam to recover, many access treatment centres that promise a range of unrealistic expectations. Many of these clinics use rapid opiate detox and naltrexone treatments, which are further discussed in the last paragraph of this section. After a family has spent tens of thousands of dollars, many of these clients continue to be dependent. As such, health promotion campaigns should focus on developing an understanding of dependency as a psychosocial health issue in order to increase communities' understanding of a variety of treatment approaches, including non-medical options.

In terms of the delivery and effectiveness of specific treatment options for CALD clients, DAMEC finds that many of the treatment modalities need a minimum of some English to be able to participate. DAMEC is one of the few services with bilingual counsellors on staff, and the agency regularly receives phone inquiries from outside of its area (including interstate) requesting help in particular languages. Furthermore, without the provision of information about treatment options serious equity issues are presented with regards to informed choice. For example, DAMEC finds that many Vietnamese people serving custodial sentences are placed on pharmacotherapy without any explanation or understanding of treatment options. Upon release these issues are often exacerbated by the person reporting anxiety and being prescribed benzodiazepines without due caution.

In addition, many CALD clients disengage from therapeutic community treatment settings for issues other than language. CALD clients often draw heavily on their families for support. Therefore, for a whole range of reasons CALD clients cannot be away for six months or 3 months in treatment. Currently within NSW there are no day treatment facilities for CALD clients. Day treatment facilities operate with a capacity for clients to return to their family each day. All of DAMEC's preliminary work has identified that this is a major gap within the AOD treatment field.

To DAMEC's knowledge, some clinics that use naltrexone do not apply the World Health Organisation's definition of dependency as being a chronically relapsing condition. These clinics fail to clarify with consumers that it may take several treatment attempts to deliver a sustainable

outcome, and they only offer one or two treatment options. There is limited aftercare counselling. These clinics may quote outstanding success rates, however DAMEC urges caution in interpreting this data, in particular, because much of it uses questionable measures at best, and almost none of it shows longitudinal outcomes.

Recommendation:

1) **That the NSW Government ensures that all treatment options are made more accessible to CALD communities.**

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

Key points:

1) **Funding for a day clinic for CALD clients is likely to address the disadvantaged faced by some groups in residential treatment settings, and thus foster positive outcomes.**

DAMEC believes that more funding should be made available for non-government drug and alcohol agencies. Although funding within the Government provided sector may also be seen as inadequate, DAMEC does not have the background to make legitimate comment.

Health promotion and prevention need to be adequately funded to curb the increasing social burden of drug use, and the proportion of primary health care funds that will otherwise be taken up in treating chronic health conditions resulting from AOD use. (See TOR 5 response).

Currently within NSW there are no day treatment facilities for CALD clients. Day treatment facilities operate with a capacity for clients to return to their family each day. Given that, for many CALD groups, family is considered a core responsibility and also support mechanism, funding treatment services that involve families is crucial. All of DAMEC's preliminary work has identified that this is a major gap within the AOD treatment field.

Recommendations:

1) **That the NSW Government considers funding a Day Treatment program for CALD clients with AOD issues.**

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

Key points:

1) **DAMEC Counselling Service has experienced an exponential growth of legally mandated clients attending the service. In this submission, DAMEC considers the challenges associated with this from a therapeutic standpoint including lack of informed consent.**

DAMEC's counselling service has experienced a dramatic increase in clients referred through various arms of the criminal justice system: Community Offender Services, Magistrates Early Referral into Treatment (MERIT), Forum Sentencing and Corrective Services. DAMEC does not require compulsory attendance however the referring criminal justice body may require attendance and has enforcement powers. Since 2009, around one third of clients came to the service through this form of coercion. This proportion has now grown to two thirds of clients attending the service[2]. This positions DAMEC to comment on the effectiveness of mandatory non-medical treatment, though DAMEC acknowledges the differing nature of this form of treatment in comparison with mandatory detoxification and residential care.

DAMEC's recent counselling service evaluation indicated that the overwhelming majority of clients in this mandated group did not understand the treatment that they were required to take up[3]. It is DAMEC's opinion that the effectiveness of mandatory treatment is contingent upon clients understanding the treatment that they have been required to undertake. DAMEC is aware that when the service accepts court mandated clients, these CALD clients are very ill informed about their treatment options. A large percentage is already being treated with pharmotherapies without adequate explanation from medical practitioners. Many are on blockade doses on release which does not necessarily suit ongoing management and support. Furthermore, clients who do not have an understanding of treatment are likely to display low motivation and resentment towards it. As has been outlined in other parts of this submission, the ability of individuals from CALD backgrounds to understand drug and alcohol treatment depends on the provision of language and culturally

[2] Drug and Alcohol Multicultural Education Centre, 2009-2012, National Minimum Data Set.
[3] Rowe, R., 2012, *Evaluation of DAMEC Counselling Services*. DAMEC, Sydney NSW.

appropriate resources, trained professionals who understand various cultural perspectives regarding drugs, as well as medical and non-medical interventions.

Many CALD clients and their families are first introduced to AOD treatment through prison. The recent evaluation of the Vietnamese Transitions Program collected testimonies from professionals working in AOD treatment and transitional support programs in Corrections, which suggested that clients who spoke minimal English were missing out on most health programs because of language barriers[4]. Furthermore, this evaluation noted that before contact with DAMEC's culturally specific support program for persons with drug use issues, of the 16 people who had been previously incarcerated, only half had ever received AOD counselling and 1 had received pharmacotherapy while in prison. These are significantly different findings to those for the general prison population, and point to significant disadvantages in treatment access which contribute to recidivism.

Not enough is known about the potential impacts of mandatory medical treatment and residential care for people from CALD backgrounds. It is DAMEC's belief that early intervention is more cost effective and socially beneficial in the long-term.

Recommendations:

1) **That the Government undertake research on the particular effects that involuntary treatment is likely to have upon individuals and communities from CALD backgrounds.**

2) **That the NSW Government examine its information strategies for AOD to ensure translated and culturally appropriate information is available.**

[4] Rowe, R., 2012, *Evaluation of the Vietnamese Transitions Project*. Crossroads Social Research, Sydney NSW.

TOR 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

Key points:

1) **The retreat from an access and equity agenda has negatively impacted upon the capacity of integrated services to meet the needs of CALD clients.**

2) **There is a great need for improved diagnostic, management and support services for CALD clients with co-morbid conditions.**

3) **Previous efforts to specifically address these issues have missed the opportunity to engage mental health clients with co-morbid conditions.**

DAMEC has received funding from the Commonwealth over the past six years to build capacity and linking projects between mental health services and drug and alcohol services for CALD clients. Overall these projects have been less than successful. Apart from the complications associated with mental health and AOD services working within different paradigms and approaches, access and equity have slipped from the agendas of service providers over the past years. In other words, DAMEC has difficulty placing CALD communities on the agenda of some services, let alone achieving best practice co-morbid case management with these groups. Culturally relevant approaches are needed to respond to differing life experiences and stresses to which many ethnic communities have been exposed, including pre- and post-migration experiences.

The reality is that many of the clients seen at DAMEC's Counselling Service have substance use as their first presenting issue but this may not be their primary diagnosis. Mental health issues are the most common issue for DAMEC's clients. These conditions are often poorly diagnosed, unmanaged and neglected. DAMEC's response has been to employ two psychologists on staff who work with the AOD counselling team to specifically manage these presentations.

In 2007, NSW Health funded an initiative called Co-Exist. It was a unit established within the management framework of the Transcultural Mental Health service and was tasked with facilitating CALD clients with substance dependency and mental health issues. DAMEC believes the

establishment of the unit was flawed and did not fulfil its objectives. One of the major difficulties was that Co-Exist did not adequately provide a much needed client access service. In prioritising training for other services, it missed the opportunity to engage mental health clients with co-existing conditions.

The fundamental issue with Co-exist was the development of priorities. Although DAMEC was involved in the initial advisory committee, advice was ignored and the agency was structured to be a "support unit" assisting the sector through training and advice. What was clearly needed and what DAMEC advocated for in the initial funding was a client-based agency, providing either inpatient or outpatient services in conjunction with mental health services but also as an alternative to their own inpatient clinics. This failed to materialise, as a result the service was restricted in writing strategic plans and training programs, and became bogged down trying to develop work plans. When DAMEC's outpatient counselling service worked with Co-Exist, clients would be managed within the mental health treatment modality and DAMEC's contact would be lost. There was no true co-case management. As a result of this, and in spite of efforts to change the direction of the agency, DAMEC disengaged with the service.

DAMEC has tried to establish working relationships with its local mental health services. There have been two major difficulties. Firstly, mental health services do not currently offer appropriate interpreters or flexible access pathways for CALD clients. Secondly, mental health services are overloaded. Their capacity to take any clients who are not an immediate danger to themselves or others is limited. DAMEC clients who require mental health review used to be placed on a waiting list for approximately over 8 weeks to see a psychologist. DAMEC has responded by creating two psychologist positions to undertake mental health management within its own service. This has delivered significant outcomes for clients.

Recommendations:

1) **That the NSW Government examines alternative models of care for CALD clients with co-existing mental health and substance use issues that are culturally sensitive and appropriate.**

2) **That the Co-Exist model be re-worked to include a focus on developing a client-based service that adopts assertive case management.**

TOR 5. Funding and effectiveness of drug and alcohol education programs

Key points:

1) **Education programs are currently underfunded, and the trend against funding health promotion and prevention in NSW is problematic.**

2) **Factors impacting upon the outcomes of education projects include the lack of continuity of funding to train staff from key cultural groups and develop rapport among communities, and the lack of funding for extra resources needed to penetrate language specific communities.**

A grossly underfunded area for AOD is within health promotion and prevention. It has been shown that one of the most cost effective elements into health cost is tertiary intervention[5]. Within AOD services, DAMEC has seen a steady decline in real funding since 2007-8. This funding decline has occurred across both State and Commonwealth jurisdictions and across portfolio areas including Health and Education. Without these preventative programs not only is NSW going to see an increase in alcohol and other drug use but also a dramatic increase in the proportion of primary health funding being directed towards treating the effects of substance use: including chronic conditions caused by long term alcohol and other drug use. DAMEC has very few translated resources to help CALD clients as most drug and alcohol resources that are in languages other than English are now over 10 years old. Funding to review and renew these important resources has not been an ongoing State or Federal priority. Bilingual counsellors at DAMEC have commented on the lack of available resources in Arabic, Mandarin, Cantonese and Vietnamese. Furthermore, often the few resources that are available are not gender and age appropriate[6].

In terms of CALD communities, previous prevention messages, campaigns and programs have had limited penetration. This is due to no funding being allocated to these communities except through DAMEC and DAMEC's programs themselves being underfunded. DAMEC has run prevention and

[5] Vos, T., Carter, R., Barendregt, J., Mihalopoulos, C., *et al*, 2010, *Assessing Cost-Effectiveness in Prevention (ACE–Prevention): Final Report.* University of Queensland, Brisbane and Deakin University, Melbourne, VIC.

[6] *Evaluation of DAMEC Counselling Service*, 2012.

tertiary intervention campaigns within newly arrived migrant and refugee communities however the funding was through the Commonwealth and not sustained after the initial three year period although major outcomes were achieved[7]. DAMEC has previously been involved in several other short term health prevention projects, for example targeting smoking among youth (outreach focus) and AOD service clients (workforce development focus)[8] and Arabic and Vietnamese communities (culturally specific information and outreach focus)[9]. Recurring factors impacting upon the outcomes of these projects included the lack of continuity of funding, the extra resources needed to penetrate language specific communities, the unique nature of each cultural group, the time necessary to develop relationships of trust with community leaders, and the lack of trained staff within key cultural groups.

Recommendation:

1) **That the NSW Government increase health promotion and prevention funding, and that a percentage of this funding recognises the particular needs of CALD communities.**

[7] Sowey, H., 2007, *African Companions Report*. DAMEC, Sydney NSW.

[8] *Swap the Smoke Final Report*, 2006. DAMEC, Sydney NSW.

[9] *Health is Gold* (project), 1996. DAMEC, Sydney NSW.

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

Key points:

1) **DAMEC raises concerns about the use of mandatory naltrexone implants with drug dependent persons from CALD backgrounds.**

2) **DAMEC prefers an approach that draws upon cultural support systems such as family relationships, and advocates for a specialist Day Clinic to be funded in NSW.**

3) **It is DAMEC's view that mandatory treatment may disproportionately target individuals from CALD communities, given that these groups are less likely to have been offered early interventions or voluntary treatment alternatives.**

DAMEC welcomes new options for treatment and alternatives to detention. However, it is this organisation's experience that many persons from CALD backgrounds could be adversely affected by mandatory naltrexone implants. This opinion is based on past and present experiences of clients being prescribed medical treatments with little to no explanation, and lack of appropriate language resources to explain the range of treatment options available to them. DAMEC is also concerned about the current absence of psychological support services and aftercare for CALD clients who might opt for the naltrexone implant (as per the proposed amendment). DAMEC is aware of a dearth of literature which suggests that replacement therapies, such as methadone maintenance achieve better outcomes than adverse therapies.

The proposed amendments to the Bill include persons who are "likely to benefit from mandatory treatment" but who are "unable or unwilling to participate in treatment voluntarily"[10]. It is of crucial importance that the aforementioned gaps in AOD service provision to persons from CALD backgrounds are not assumed to imply an individual's unwillingness or inability to participate voluntarily in treatment. The previous Bill included a requirement that a person had to have been offered voluntary treatment prior to a dependency certificate being issued. The changes appear to

[10] NSW Parliament, 2012, *Drug and Alcohol Treatment Amendment Bill 2012,* p3.

withdraw that requirement. When working with ex-inmates with co-morbid mental health and AOD issues as well as a range of transitional support issues, DAMEC's experience is that these clients are too often put in the "too hard basket" by mainstream agencies. DAMEC supports the NSW Government to take assertive steps to address the disadvantages faced by CALD groups in accessing AOD treatment. It is DAMEC's view that mandatory treatment may disproportionately target individuals from CALD communities, given that these groups are less likely to have been offered early interventions or other voluntary treatment alternatives.

Recommendation:

1) **Appropriate steps should be taken to ensure that CALD communities are offered all voluntary treatment options.**

2) **That research into the impacts of the Bill's implementation on CALD communities is undertaken.**