

**Submission
No 14**

**INQUIRY INTO THE PROVISION OF DRUG
REHABILITATION SERVICES IN REGIONAL, RURAL AND
REMOTE NEW SOUTH WALES**

Organisation: Lives Lived Well - Lyndon

Date received: 8 December 2017



Submission to NSW Parliamentary Inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales

Paper prepared by Dr Julaine Allan,
Research Manager lives Lived Well - Lyndon



lyndon
in partnership with 
Lives Lived Well

The following document sets out the response from Lives Lived Well – Lyndon to the terms of reference established by Portfolio Committee No. 2 – Health and Community Services for the inquiry into drug rehabilitation services in regional, rural and remote NSW. Lyndon is well placed to respond to the Inquiry as we have been providing rehabilitation services for drug and alcohol problems since 1980. In our response we consider rehabilitation services to include both community based individual and group treatment; and residential programs. Each item in the Committee’s Terms of Reference is addressed separately.



1. The range and types of services including the number of treatment beds currently available;

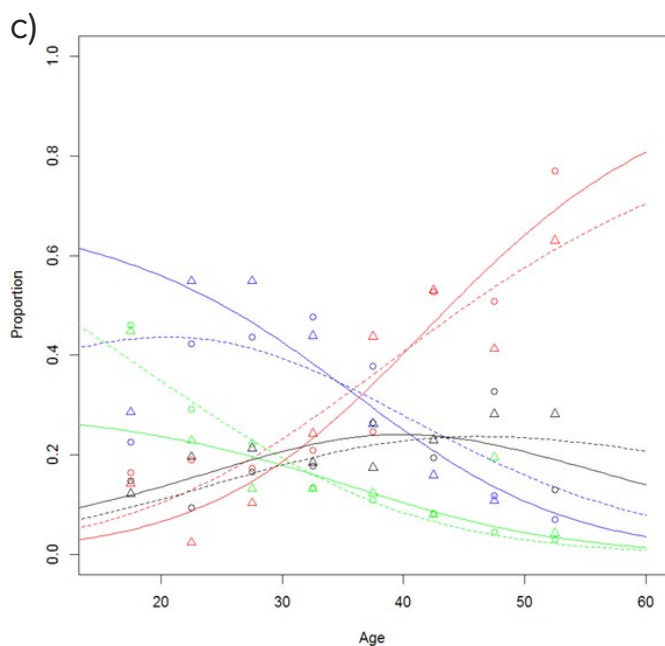
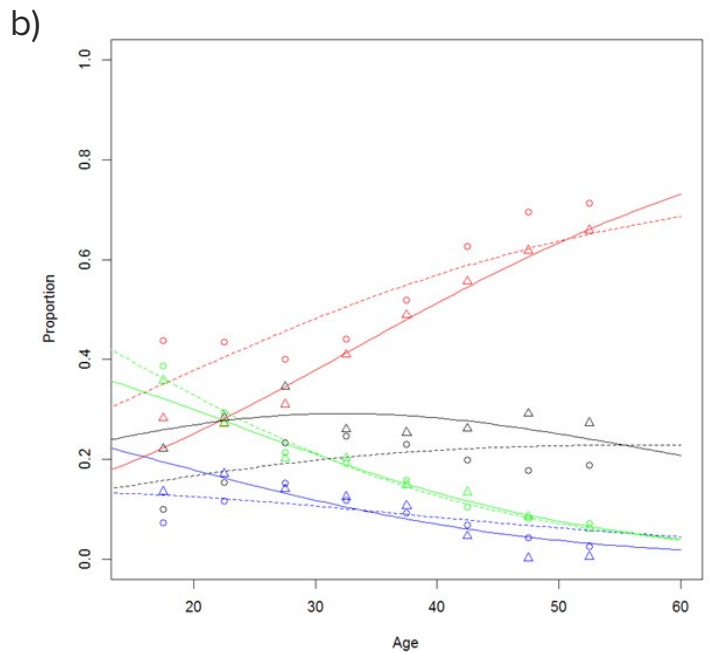
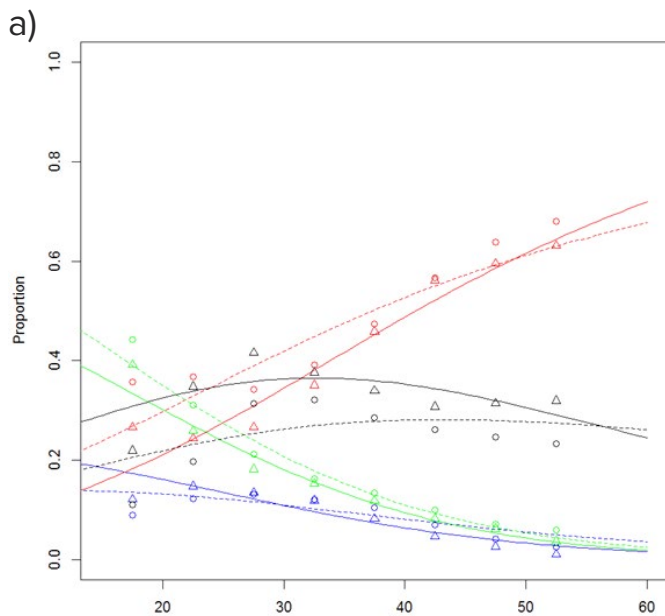
Lyndon, the NSW branch of Lives Lived Well, provides drug and alcohol treatment, support, training and research across rural and remote areas of NSW (see map). Community based services provide assessment, counselling, case management, group therapy and psycho-education; and referral to other support services as well as education and training for the health and community services workforce and general community. Approximately 550 individuals with drug and alcohol problems are assisted each year in community programs.

In 2018 there will be a total of 36 beds available in Lyndon’s residential (live-in) services all located in Orange, NSW. The residential programs accommodate 500 to 550 people annually. This includes 12 withdrawal beds and 16 residential rehabilitation beds for men and women. In early 2018 an additional 8 beds for women with children will become available in a new facility. The Withdrawal Unit has an average 7 day stay with 350 people attending annually. The residential rehabilitation program, Wattlegrove, offers a 3 month stay with around 65 people accommodated annually. The new women’s service will have an 8 week program with approximately 70 women with up to 2 children attending annually.



2. Specific details regarding rehabilitation services for those with amphetamine and methamphetamine (“ice”) addictions;

Across all Lyndon programs approximately 35% of services are provided for people who identify methamphetamine as their principal drug of concern. The age and gender of people seeking assistance for methamphetamine use differs from those seeking treatment for other drug types. The increase in people seeking treatment for methamphetamine use has changed the sex and age ratio of Lyndon’s clients over time with many more young people, particularly younger women, receiving treatment in 2015-16 compared to the period 2006-2011 (See fig 1). Lyndon’s treatment episode data was comparable to the rest of NSW during 2006-11 (Fig 1 a and b) and could reasonably be expected to reflect service demand across the state in 2015-16 (Fig 1. c). However, while methamphetamine treatment episodes have become more prevalent, treatment episodes for alcohol and cannabis remain the most common overall.



3. The qualification to receive funding as well as the funding arrangements for services be they public, not-for-profit, for profit or on any other basis;

Lyndon is a not for profit organisation. All Lyndon’s services are government funded from a combination of state and commonwealth departments. Lyndon has been accredited by the Australian Council of healthcare Services (ACHS) since 2009. ACHS accreditation processes include auditing the service delivery environment, governance practices and clinical practices of the organisation for compliance with a rigorous set of standards. Government funding requires that an organisation be a registered business operated on a not for profit basis. Accreditation has not been a requirement of funding contracts until recently. However, most funders now require some type of relevant formal accreditation to be able to receive funding.

4. The qualification to receive funding as well as the funding arrangements for services be they public, not-for-profit, for profit or on any other basis;

There are no qualifications or licensing requirements for the establishment of a private or for profit residential rehabilitation service or a community-based service that offers counselling for substance problems in person or on-line. New residential services or treatment businesses would have to comply with local government requirements for land use.

5. The cost to patients/clients, including fee structures provided to families, for accessing rehabilitation services;

Most government funded NGO services in NSW provide free community based services and charge a fee towards costs in residential programs. See table 1 below for an example. The table comes from the [Lyndon website](#).

Program	Payment Type	Cost	Comments
Lyndon Withdrawal Unit	Direct payment or via Centrepay	\$130 one off payment	Covers accommodation, meals, group sessions and detox related scripts Does not cover non detox related scripts Doctor’s visits are bulk billed
Wattle Grove Rehab Program	Direct payment or via Centrepay	\$270 per week \$240/week subsidised place if no access to rent assistance	Covers accommodation, meals, group sessions, organisation funded outings. Does not cover any pharmacy, including scripts, non-organisation funded outings Doctor’s visits are bulk billed
Community based non-residential service	nil	Free	No limit on number of sessions

6. The waiting lists and waiting times for gaining entry into services;

The waiting time for residential services varies from week to week. An admission to the withdrawal program will take between 3 days and 2 weeks depending on bed availability. People will usually wait 8 to 12 weeks for admission to the residential rehabilitation program and must attend either Lyndon Withdrawal Unit or another supervised withdrawal program prior to entry.

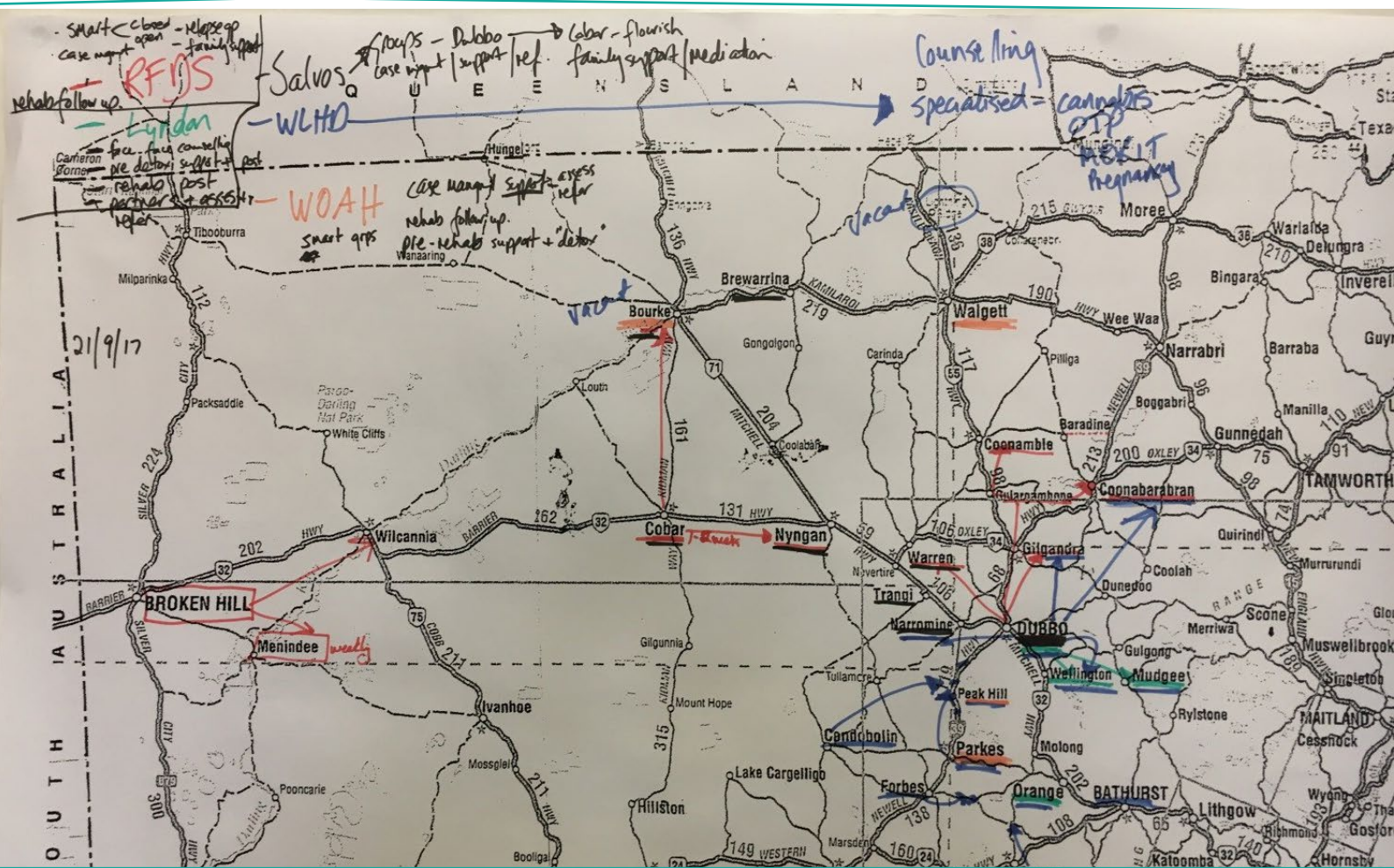
We do not keep a waiting list for residential rehabilitation longer than twenty to twenty five people because the time frame for their entry would be many months. People on the waiting list are required to call in every two weeks to say if they still want to stay on the list or if they have found another program. If they do not make contact they are removed from the list. If there are already twenty five people on the waiting list, people seeking admission are asked to call back in a week and are offered community support or admission to the withdrawal program only. Lyndon receives approximately 30 calls every day for people wanting a residential rehabilitation bed.

Access to community based services varies considerably across the region with a range of providers working in different locations at different times. The more remote a location the fewer drug and alcohol services are available. In Bourke during 2016 and 2017 both NSW Health and the Aboriginal Medical Service drug and alcohol positions were vacant most of the time so no local services were available. The Salvation Army Drug and Alcohol Worker from Dubbo visited quarterly during this time. New Western NSW Primary Health Network funding will provide two assessment and referral workers in Bourke during 2018.

Access to Lyndon's community based services depends on staff availability in the location of the referral. For example, services are provided in Mudgee and Wellington on one set day a week and people from those centres will wait until the designated day for a face to face appointment. However, referrals are generally responded to within 48 hours with a phone assessment.



In an effort to streamline services around the Dubbo region and western NSW, Lyndon established a planning group with local NSW Health managers, Salvation Army, Orana Haven-Weigelli Hubs Manager and Royal Flying Doctor Service D&A Program manager. The intention is to plan service delivery as a group and share referrals to avoid gaps and duplications. A colour coded photo is provided below to illustrate the locations of service delivery. Note that the only places services are provided most days are Dubbo, Orange, Broken Hill, Cowra, Forbes and Parkes. Visiting services are typically sporadic and changeable resulting in inconsistent service availability for rural towns. Since the map was created in September 2017 the service delivery locations and availability has changed for all outreach towns and the Salvation Army service based in Dubbo has no drug and alcohol worker at the time of writing.



7. Any pre-entry conditions for gaining access to residential rehabilitation services;

To enter Lyndon's residential rehabilitation programs people must have completed a telephone assessment and been allocated a bed followed by a medically supervised physical withdrawal process. People with severe mental illness where medication is not working or not being used are required to stabilise their symptoms before they come into the program. Convicted sex offenders are not accepted. Ideally people will have tried less intensive community-based rehabilitation programs before applying for a residential program. However, some courts and child protection agencies view residential programs as the preferred type of treatment and require people to attend residential programs to be able to leave jail or as part of a plan for family restoration even if their drug use is minimal or has ceased.

8. Investigate the evidence regarding the efficacy and impacts of mandatory detoxification programs for those who self-harm or are subject to an Apprehended Violence Order (AVO);

There are strong links between domestic and family violence and drug and alcohol consumption – particularly alcohol (see for example <https://ndarc.med.unsw.edu.au/blog/alcohol-fuelled-violence-rise-despite-falling-consumption>). However, it would require legislative change to mandate detoxification programs for offenders and then funding to ensure enough programs were available for those required to complete them. As detoxification is a physical treatment only, it would be unlikely to achieve any change in behaviour as a result. Public health policy changes to price and availability will have the biggest impact on violence related to alcohol rather than highly costly programs targeting individuals.

People who self-harm require a sensitive treatment approach to the underlying reasons for harm not a mandatory detoxification program.

9. The gaps and shortages in the provision of services including geographical, resources and funding;

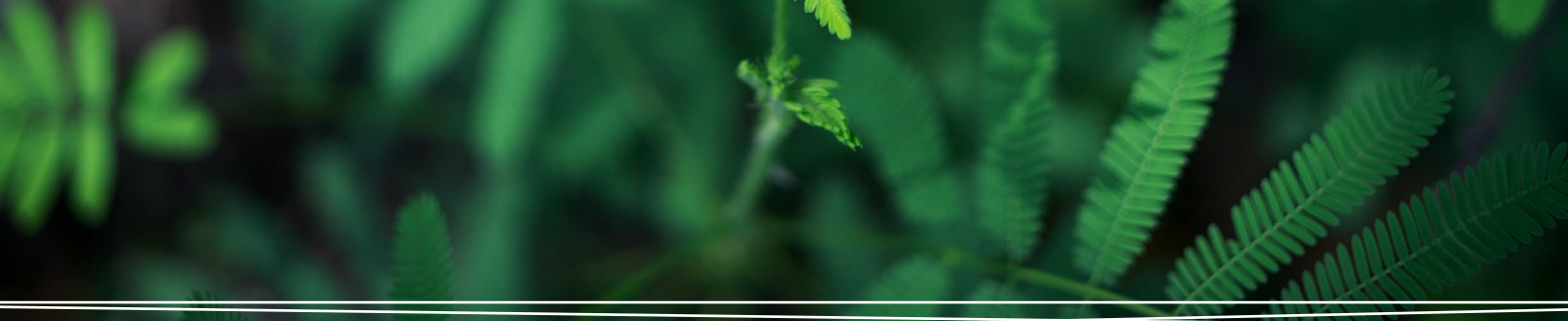
All government funding is short term. Contracts are for 1 to 3 years with no guarantee of continuing. While there has been some new state and commonwealth funding available in recent years there has been no increases to existing funding. This has resulted in fewer staff employed and reductions in service delivery. For example there has been no increase in commonwealth funded programs, including no CPI, since 2012.

Geographically, services are clustered in urban areas and along the coast. A Western NSW Local Health District review conducted in 2012 found that there were 9 drug and alcohol positions for every 100,000 people in western NSW with half of these positions unfilled. The map above demonstrates the variations in service delivery across the western region.

10. Issues relating to the provision of appropriately qualified health professionals to fill positions in rehabilitation services

Experienced drug and alcohol practitioners are difficult to recruit in rural and regional areas. Lyndon provides training and student placement opportunities to build skills in the health and welfare sector. There are no undergraduate university courses with D&A subjects relevant to clinical practice and few social work, psychology and similar allied health courses with any drug and alcohol content at all. Lyndon has developed a short workshop called Drug and Alcohol First Aid designed for health and community service practitioners to provide some basic information about drugs and their effects and how to talk to people about their substance use (<http://www.lyndon.org.au/drug-alcohol-first-aid/>). The workshop aims to increase the skills of a range of practitioners to be able to respond effectively to people with drug and alcohol problems and build the skill base in the community. The workshop has been evaluated as effective by the National Centre for Education and Training on Addiction at Flinders University (see <http://onlinelibrary.wiley.com/doi/10.1111/dar.12619/abstract>).





11. Evidence of rehabilitation services that have had both successful and unsuccessful outcomes, including what characteristics constitute a successful outcome and how reliable is the data collection and reporting mechanisms currently in place;

Reducing any substance use is the same as quitting smoking – hard to do and takes a substantial period of time. Returning to treatment should be encouraged and multiple episodes expected. Treatment outcomes reflect those observations – For example, less than 60% of individuals who receive treatment for alcohol dependence become abstinent or show significant improvement in functioning following treatment (1, 2). More than half will relapse in the first year after treatment (3). An economic comparison of eight different types of interventions aimed at reducing alcohol-related harm showed that the intervention most appropriate for alcohol dependence (residential treatment with a pharmacotherapy) is expensive (4). Older residential rehabilitation clients usually have significantly longer treatment episodes, and were more likely to have multiple episodes, compared to younger clients because of their relapse over time (5). Older people may have better outcomes in the end but also use more resources and have higher needs than younger people.

Our recent systematic review completed by Lives Lived Well researchers at the University of QLD found that recent studies provide evidence that residential treatments are an effective treatment option for clients that may improve their mental health, and to a lesser extent their quality of life (i.e. social engagement, employment), while reducing substance use and offending. Residential treatment is particularly effective for those with complex needs and those that complete treatment (6). It is not possible to predict who will have a good outcome and who will relapse. Consistent individual-level predictors for positive treatment outcomes are less severe dependence, low psychopathology ratings; high self-efficacy; good motivation; and treatment goals (7, 8). This means that the less severe the person's dependence and the fewer other problems they have the more likely they will be able to reduce their substance use. Overall individual variability is so great that there is no way to match a person and a treatment type. The general rule of thumb is that the more severe an individual's problems the more intense the treatment should be in that it should be longer, holistic and multifaceted. That is it addresses all the person's needs not just their substance use.

The current reporting systems are useful for identifying how many people enter and exit treatment services but not what they achieve by doing so. A positive outcome should be linked to the individual's goal in entering treatment. Goals can include a reduction in surveillance by the criminal justice system or participation in education as much as changes in substance use. However, the outcome should also take into consideration the range of factors that person has to deal with in achieving that goal or goals. It is difficult to see how these individualised factors can be effectively reported.

A US study estimated that up to 80% of variance in treatment outcome was explained by the type of treatment provided and the characteristics of the clinic in which it was provided (especially staff morale), meaning a minority of treatment outcome was associated with individual client characteristics (9). System factors are underrated in treatment outcomes. There are better outcomes from more stable and well-resourced systems in urban areas that have higher case-loads (9, 10); higher staff to patient ratios (10, 11); specialised treatment units (12); and have teaching status (13). The critical lack of resources in rural areas has significant impact on the range and type of services provided.

The current reporting system does not identify how many drug and alcohol or mental health services people use or how often. Linkage across data sets would provide information about patterns of service use. A study is being conducted by a National Drug and Alcohol Research Centre team including the Lives Lived Well research manager, linking data from all government and non-government drug and alcohol services and all in-patient and out-patient mental health services including those provided in emergency departments. The results of this study will be available in early 2018.

12. Current and potential threats to existing rehabilitation services;

Funding security remains the biggest threat to the future of existing services. This includes the short-term and changing emphasis of government funding as well as the limited options for support from the philanthropic sector. In addition, the growing expectations to provide wrap-around or holistic care for people that are inclusive of mental illness, physical illness and socio-economic deprivation have expanded the scope of practice of drug and alcohol services without additional expansion in funding. The skills and capacity of the drug and alcohol workforce have to be upgraded to provide these comprehensive services and there are associated costs.

13. Potential and innovative rehabilitation services and initiatives including naltrexone;

Lyndon's Wattlegrove residential rehabilitation program has designed program elements specifically to cater for people with cognitive impairment. Approximately 50% of people in residential programs will have a cognitive impairment (16). Cognitive impairment is known to impact on people's ability to participate in treatment (17) and is associated with poorer long-term outcomes (18). Currently, other than Wattlegrove, there are no specialist drug and alcohol residential rehabilitation programs for people with cognitive impairment in Australia. Current approaches to drug and alcohol treatment in Australia and internationally predominantly use cognitive behaviour therapy and other psychosocial treatment methods. Psychosocial treatment methods are based on cognitive and behavioural change activities where people in treatment analyse situations that may pose risks to reducing their substance use. Therefore, learning, problem solving, and planning for the future are the key tasks needed in rehabilitation treatment. Cognitive skills are necessary to receive, encode, and integrate new information, organise this information into behavioural plans, and execute these plans. People with cognitive impairment may require more time to process content, and additional support to learn and use new information, suggesting that this group will experience challenges in engaging in and utilising un-adapted cognitive behavioural program content. The program elements included extended treatment duration, the use of simplified written materials that incorporate practical examples and role-plays, and provision of one-on-one staffing where needed, were integrated into the program design. Program elements can be adjusted as research and knowledge evolves, allowing for the program to incorporate continuous quality improvement and be a leader in drug and alcohol rehabilitation for people with cognitive impairments.



There are several well evidenced pharmacotherapies for substance dependence including successful opioid and alcohol treatments. These can be prescribed by General Practitioners. However, few provide drug and alcohol treatment and screening rates are low. Opioid treatment in particular is very limited in rural and remote areas yet is the most successful type of treatment for opioid dependence (19). GPs can receive on-line training and additional Medicare payments for becoming a prescriber yet do not. Lyndon's Addiction Medicine Specialist provides training for GPs in Western and Southern NSW to promote screening, brief interventions and the use of pharmacotherapies for substance dependence. However, it would be helpful if government emphasised the importance of the GP role and responsibility in addressing substance dependence.

Recommendations;

- To maintain quality and stability in drug and alcohol services for regional, rural and remote NSW and develop them into the future we recommend that;
- Substance dependence is viewed as a health condition that commonly recurs and typically requires multiple attempts for people to get it under control;
- A range of treatment types is required to meet the varying needs of people with substance problems
- Low incomes, lack of transport and limited availability of services are recognised as significant barriers for rural people in accessing drug and alcohol services; and that access and availability be addressed in funding programs
- Sufficient funding is provided for at least five years at a time to adequately staff programs with qualified clinicians
- General Practitioners are required to screen patients for substance dependence and provide standard pharmacotherapies as routine care
- Universities are required to include subjects in their health related undergraduate degrees that develop clinical skills relevant to drug and alcohol practice

References;

1. Mann K, Schäfer DR, Längle G, et al. The long-term course of alcoholism 5, 10 and 16 years after treatment. *Addiction*. 2005; 100(6): 797-805.
2. Moos RH, Moos BS. Rates and predictors of relapse after natural and treated remission for alcohol use disorders. *Addiction*. 2006; 106: 212-22.
3. Haber P, Lintzeris N, Proude E, Lopatko O. *Guidelines for the Treatment of Alcohol Problems*. Canberra: Australian Government Department of Health and Ageing; 2009.
4. Cobiac L, Vos T, Doran C, Wallace A. Cost-effectiveness of interventions to prevent alcohol-related disease and injury in Australia. *Addiction*. 2009; 104: 1646–55.
5. Copeland J, Indig D. Patterns and correlates of treatment: findings of the 2000-2001 NSW minimum dataset of clients of alcohol and other drug treatment services. *Drug and Alcohol Review*. 2004; 23(2):185-94
6. De Andrade, D. The effectiveness of residential treatment services for individuals with substance use disorders: A systematic review completed for Lives Lived Well. 2017; University of QLD.
7. Adamson SJ, Sellman JD, Frampton CMA. Patient predictors of alcohol treatment outcome: A systematic review. *Journal of Substance Abuse Treatment*. 2009; 36: 75-86.
8. Morley KC, Teesson M, Sannibale C, et al. Clinical Predictors of Outcome from an Australian Pharmacological Relapse Prevention Trial. *Alc & Alcoholism*. 2010; 45(6): 520-6.
9. Ball J. C., Ross A. *The effectiveness of methadone maintenance treatment: patients, programs, services, and outcome*. New York: Springer-Verlag; 1991.
10. Simunovic M, Rempel E, et al. Influence of hospital characteristics on operative death and survival of patients after major cancer surgery in Ontario. *Can J Surg*. 2006; 49: 251-58.
11. Bach PB, Cramer LD, Schrag D, et al. The Influence of Hospital Volume on Survival after Resection for Lung Cancer. *N Engl J Med* 2001; 345: 181-8.
12. Kane RL, Shamliyan TA, et al. The Association of Registered Nurse Staffing Levels and Patient Outcomes: Systematic Review and Meta-Analysis. *Med Care*. 2007; 45(12): 1195-204.
13. Rafferty AM, Clarke SP, Coles J, et al. Outcomes of variation in hospital nurse staffing in English hospitals: Cross-sectional analysis of survey data and discharge records. *Int J Nurs Stud*. 2007; 44(2): 175-82.
14. Smedh K, Olsson L, Johansson H, Aberg C, Andersson M. Reduction of postoperative morbidity and mortality in patients with rectal cancer following the introduction of a colorectal unit. *British Journal of Surgery*. 2001; 88: 273-7.
15. Elferink M, Krijnen P, et al. Variation in treatment and outcome of patients with rectal cancer by region, hospital type and volume in the Netherlands. *EJSO*. 2010; 36: S74-S82.
16. Allan, J., Kemp, M., & Golden, A. The prevalence of cognitive impairment in a rural in-patient substance misuse treatment programme. *Mental Health and Substance Use*, 5(4). 2012; 303-313. doi.org/10.1080/17523281.2012.711767
17. Hensold, T., Guercio, J., Grubbs, E., Upton, J., & Faw, G. A personal intervention substance abuse treatment approach: Substance abuse treatment in a least restrictive residential model. *Brain Injury*. 20(4). 2006; 369-81 doi:10.1080/02699050500487563
18. Brorson, H., AJo Arnevik, E., Rand-Hendriksen, K., & Duckert, F. Drop-out from addiction treatment: a systematic review of risk factors. *Clinical Psychology Review*, 33(8). 2013; 1010-24. doi:10.1016/j.cpr.2013.07.007.
19. Allan, J. Prescription opioids and treatment in rural Australia: a failure of policy for Indigenous Australians. *Substance Abuse*. 36(2):3, 2015; DOI:10.1080/08897077.2014.990132