

Submission
No 29

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

Organisation: Australasian Therapeutic Communities Association

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

Thank you for the opportunity to provide a submission to this inquiry on behalf of the Australasian Therapeutic Communities Association (ATCA). ATCA was established in 1986 and is the peak body for Therapeutic Communities (TC) and other residential rehabilitation services (RRS) in Australia and New Zealand. Our membership currently stands at 42 organisational members, managing 69 TCs and a range of other rehabilitation and support services in community and correctional settings.

Twelve of our members are based in New South Wales. These organisations provide 20 residential programs in community and correctional settings, together with inpatient withdrawal management, day rehabilitation programs, gambling and mental health counselling, child care facilities, family support programs, outclient services and aftercare programs for youth, adults and family groups. (A list of NSW members is provided at the end of this submission).

From 1986 – 2006, ATCA operated as a voluntary group with an elected Board of Management, providing peer support and training to its members and working together to ensure quality standards of treatment were maintained. In 2006, the Association received a grant from the Australian Government Department of Health which facilitated the establishment of a secretariat and the employment of an Executive Officer. This funding is continuing; the secretariat is based in NSW.

TCs are a proven model of effective treatment for a range of issues, including substance use and mental health concerns, and have been shown to be especially effective for people with coexisting mental health and alcohol and other drug (AOD) conditions and those affected by chronic substance dependency. The research base is steadily growing through active partnerships between member agencies and universities. Of particular note are the partnerships with the Universities of New South Wales, Newcastle, Wollongong, Monash, Curtin, Queensland and Deakin, with a growing number of papers published in quality peer reviewed journals in Australia and internationally.

The support of the Australian Government through the Department of Health was further enhanced in 2008, with funding to develop the ATCA Standard. The ATCA Standard was first launched in 2009 and has been designed to fit within a national quality framework for all residential rehabilitation services working with clients with alcohol and other drug issues. In 2014, the ATCA *Standard for Therapeutic Communities and Residential Rehabilitation Services* was certified by the Joint Accreditation System of Australia and New Zealand (JAS-ANZ) and is now available on the ATCA website (<http://www.atca.com.au/atca-standard/>).

Accompanying the ATCA Standard are Interpretive Guides for services working with Adult, Youth and First Nations communities. The development of the ATCA Standard demonstrates our commitment to the sector and to the development of evidence-based services. ATCA is also in the

process of developing a further Interpretive Guide for corrections-based therapeutic communities and AOD programs.

Accordingly, ATCA provides the following information and advice for the NSW Legislative Council Health & Community Services Committee Inquiry into the provision of drug rehabilitation services in regional, rural and remote NSW:

Terms of Reference Comments:

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

ATCA has 12 members based in NSW. Together these members provide 20 residential therapeutic community programs and more than 650 beds across NSW.

The NSW Drug and Alcohol Guidelines for Residential Settings (February 2007)¹ note ‘residential rehabilitation’ is a general term for 24-hour, staffed, residential treatment programs that offer intensive, structured interventions after withdrawal from drugs of dependence, including alcohol. This approach “is based on the principle that a residential setting free of non-prescribed drugs and alcohol provides an appropriate environment in which to address the underlying causes of dependence. Residential treatment services aim to effect lasting change and to assist with reintegration back into the general community after treatment” (page 4).

The document also makes a distinction between residential treatment, which is “intended to produce therapeutic change” and residential care, which is designed as a “welfare intervention” (page 4). While residential care can assist to facilitate treatment for some people, these services do not provide a treatment setting for people experiencing AOD problems. A stay in this sort of residential care will usually provide respite from drug and alcohol use, but will not give residents the skills to remain drug/alcohol free once they have left the facility.

It should be noted that ATCA defines therapeutic community services as those that provide treatment underpinned by the concept of ‘Community-as-Method’ in which the community itself is seen as the main vehicle for treatment and change. The TC model has proven to be a powerful treatment approach for substance use and its related problems in living^{2,3,4}. All TCs take an approach that treats the whole person through the use of peer community, supported by a variety of evidence-based services and interventions related to family, education, vocational training, physical and mental health.

The NSW Guidelines also makes a distinction between TCs and other residential rehabilitation services, noting:

- *Therapeutic communities emphasise a holistic approach to treatment and address the psychosocial and other issues behind substance abuse. The “community” is thought of as both the context and method of the treatment model, where both staff and other residents assist the resident to deal with his or her drug dependence.*
- *Other residential programs deliver regular treatment to residents, such as counselling, skills training and relapse prevention, to address the psychosocial causes of drug dependence⁵*

It is the view of ATCA and its members, that therapeutic communities provide the most effective form of alcohol and other drug (AOD) treatment for people with AOD dependency issues. This is particularly the case for people with multiple and complex needs who require a high level of support. There is strong evidence to support this stance, both in community and correctional settings, and with a wide range of populations.

ATCA members and other NGO service providers in NSW offer a range of services across the continuum from prevention, early intervention and education; to inpatient withdrawal management; residential rehabilitation; opioid substitution programs; day rehabilitation programs; and outclient and aftercare programs. The majority of these programs are located in city areas and towns in regional, rural and remote NSW are not serviced as well as those in the large urban and metropolitan areas of NSW. This is particularly the case for residential rehabilitation beds, outclient and day programs and means that people in regional, rural and remote NSW often have to travel well outside their local area to access treatment.

It is difficult, however, to accurately estimate the number of residential rehabilitation beds available in regional, rural and remote NSW as the funding sources that support these services (private, non-government and state and Australian Government) tend to operate independently of each other. Hence, there is no central registry for the number of beds available.

That said, nine of ATCA's 12 NSW-based members provide services in regional areas. This means that ATCA members are well placed to expand and enhance their service delivery into rural and remote areas.

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

All ATCA members report a significant increase in the number of people presenting with methamphetamine problems. This increase has steadily and substantively occurred over the previous five years and is not surprising given the rapid progression to severe problems associated with methamphetamine use and the lack of other available effective treatment options.

The 2016 National Drug Strategy Household Survey published by the Australian Institute of Health and Welfare in 2017 shows:

- Over 130,000 Australians received AOD treatment in 2015-16. The principal drugs that led clients to seek treatment were alcohol (32%), amphetamines (23%), cannabis (23%) and heroin (6%).
- 1 in 16 (6.3%) Australians aged 14 and over have used meth/amphetamines
- 1 in 70 (1.4%) have used meth/amphetamines in the previous 12 months.

Just over half (52%) of closed episodes with amphetamines as the principal drug of concern lasted less than 1 month, with 23% ending within one day - mostly for assessment only.

In May 2015, ATCA invited member agencies to take part in a snapshot study of methamphetamine presentations. A total of 1057 people took part in the study (1002 in residential treatment) and 666 participants (63%) nominated methamphetamine (specifically “ice”) as their drug of dependence.

- Clients from 22 member organisations (63% of ATCA members), representing 38 services, participated.
- Information was received from participants in 35 TCs (57.4%) and 3 outreach programs.
- 15 of these services were based in NSW.
- 2 of the programs were withdrawal units.
- 1 of the TCs was in a NSW custodial setting.
- 3 TCs were working with young people (14-24yrs), 32 TCs (inc. prison-based TC) with adult populations (18+ yrs).

Forty-eight (48) participants were resident in TCs working with young people (under the age of 18 years). Thirty-nine (81%) of these participants were using Ice prior to entry to the TC. There were 954 participants in TCs working with adults, 601 (63%) were regular ice users. The remaining 55 participants were in outreach and outclient services. Twenty-six (47%) of this group were ice users.

Participation in the study was voluntary and non-identified. Participants provided information on (1) if they had used ice (2) mode of use (3) estimated daily cost of ice usage (4) if they had taken part in an illegal activity to fund their usage (5) if they had used with friends, and (6) if they currently had friends who were still using.

Therapeutic communities working with young people reported the highest percentage of ice users in treatment – **overall 81% of clients in treatment on that day reported using ice prior to entry to the TC** – and one of the TCs reported **91% residents in treatment having used ice prior to entering the residential program.**

TCs working with **adult populations** reported overall **63% of residents in treatment were ice users – with 12 of the 32 TCs (37.5%) reporting more than 80% of the current population as ice users.** One of the smaller ATCA members reported 100% of current population as ice users. Outreach programs had lower numbers reporting use of ice, with 47% of participants.

The **average daily financial cost of ice usage amongst all participants in the study was \$327.00 per day** – however, many participants admitted to much higher daily costs. Not surprisingly, similar percentages across all conditions stated they had been involved in illegal activities to fund their use (74% Youth, 68% Adults, 65% Outreach) – Total: 69%.

This study provides an important snapshot of people seeking treatment for methamphetamine use. Certainly, non-residential services play an important role in the continuum of services which need to be available to people who are using alcohol and other drugs. However, as shown in this study, people who participate in outclient services do not have the same level of severity of dependence as those coming into residential programs. Those attending outclient services are categorised as mild and moderate severity, while those seeking residential admission are in the severe range.

Therapeutic communities and residential rehabilitation centres remain the best option for people requiring intensive support and assistance to overcome the problems associated with their methamphetamine use.

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.

Quality assurance is of paramount importance to ATCA and in order to become a member of ATCA, all organisational and group members must hold industry accreditation. Members are then expected to undertake a further quality assurance process by becoming certified against the ATCA Standard.

As noted above, the ATCA Standard was first launched in 2009 and has been designed to fit within a national quality framework for all residential rehabilitation services working with clients with alcohol and other drug issues. It has therefore been designed in two tiers:

1. Residential Rehabilitation Services
2. Therapeutic Communities

The first level of the Standard allows an organisation to gain certification against a set of criteria that are directly applicable to a Residential Rehabilitation Service for alcohol and other drug use. For services considering a transition to the Therapeutic Community model, working with this Standard will assist in providing guidelines to assist a service that is seeking certification as a Therapeutic Community.

The criteria against which ATCA members are certified are:

1. Performance Expectation 1: The Residential Community
2. Performance Expectation 2: Resident Member Participation
3. Performance Expectation 3: Strategic Human Resource Management
4. Performance Expectation 4: Information Management and Appropriate Use/Evaluation of Data
5. Performance Expectation 5: Workplace Health and Safety
6. Performance Expectation 6: Health and Safety Risk Management
7. Performance Expectation 7: Community as Method
8. Performance Expectation 8: Therapeutic Community Leadership and Management Principles
9. Performance Expectation 9: Therapeutic Community Resident Member Participation
10. Performance Expectation 10: Therapeutic Community Strategic Human Resource Management
11. Performance Expectation 11: Use of Data from the Therapeutic Community
12. Performance Expectation 12: Rules in the Therapeutic Community
13. Performance Expectation 13: Continuous Improvement

To achieve certification as a **Residential Rehabilitation Service**, agencies need to meet 80% of the Performance Objectives in each **Performance Expectation numbered 1–6** identified as ‘essential’. This represents the minimum level of activity required to demonstrate competency in agency practice in the residential rehabilitation setting.

The second level of the Standard allows an organisation to seek certification as a **Therapeutic Community**. To achieve certification as a Therapeutic Community, 80% of all Performance Objectives identified as ‘essential’ must be achieved. The Performance Objective 7.1 “Community as Method” must be within the 80% of achieved criteria.

The essential criteria relate to those policies and procedures which should be in place, and they describe how agencies conform to the Therapeutic Community model. The Standard also documents the service delivery needs of the target community and what management, staff and consumers of the agencies should know about the Therapeutic Community model and its implementation within the service under review.

For agencies that have participated in other quality certification programs, a further set of criteria, called ‘good practice criteria’ has been developed. These criteria are intended to reflect what are sometimes referred to as ‘systems elements’ and are primarily related to monitoring and evaluation of agency practices. An agency will be awarded ‘good practice’ certification if, in addition to meeting 80% or more of the essential criteria, 80% of the ‘good practice’ criteria are met.

In 2014 the ATCA Standard for Therapeutic Communities and Residential Rehabilitation Services was certified by the Joint Accreditation System of Australia and New Zealand (JAS-ANZ) and is now available on the ATCA website (<http://www.atca.com.au/atca-standard/>). Independent certifiers review and measure the quality of services and their delivery (including governance and other important elements of service delivery) against the ATCA standard using the specific Interpretive Guide designed for the population group served by that service.

It is our understanding that funding for private for profit residential centres providing treatment services are not subject to any accreditation requirements to operate within NSW. This creates an enormous concern for the sector and for the families seeking support and rehabilitation services.

It is our belief that an industry accreditation is the BASIC requirement for funding and ATCA strongly recommends that such accreditation be a necessary requirement to provide residential

treatment for individuals affected by alcohol and other drug dependence and associated problems.

The vulnerability of clients (and their families) demands such regulation and oversight.

4. Registration and accreditation process required for rehabilitation services to be established.

ATCA strongly supports the development and implementation of a registration and accreditation process for all AOD treatment services.

Our commitment to the sector, to families and the wider community is clearly demonstrated through the work we have undertaken and achieved in the development and implementation of quality standards for the sector.

ATCA also strongly recommends that ATCA and other AOD treatment provider peak bodies be included in the development and implementation of any registration and accreditation processes.

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

ATCA members generally provide their services free of charge to clients, although clients contribute a portion of their social security benefits to offset operating costs not fully covered by Government assistance.

ATCA is very concerned at the recent proliferation of profit motivated residential services that charge exorbitant fees to people (and their families) because of the lack of investment in the not-for-profit system and subsequent long waiting lists. These private services vary in quality but ultimately seek to profit on the desperation of people and their families to seek timely AOD treatment.

There are some instances in the private sector where private health insurance will cover costs, and for some services (e.g., psychology and other allied services) Medicare may be accessed. However, the number of episodes and types of treatments permitted vary from insurer to insurer and through Medicare. There may be a 'gap' payment that the client or their family will have to pay and the severity of presenting issues will almost certainly exceed both Medicare and private insurance limits.

Fee for service private providers, which operate in an unregulated market, are able to determine their own charges, this can run to tens of thousands of dollars per treatment episode. There is strong anecdotal evidence of families borrowing from financial institutions, using credit cards or extending mortgages to cover the cost of treatment for their family member.

There is a role for private providers of AOD treatment, but this should be linked to supporting not-for-profit centres and services wherever possible, as the recent lack of investment in the NGO sector has created an unfortunate and unregulated market opportunity for for-profit entrepreneurs.

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

Waiting list information is far more complex for AOD treatment than it appears given all the variables involved and the changing motivation of people to seek and enter treatment.

Nonetheless, ATCA estimates that the **average waiting time for most people seeking treatment in therapeutic communities and residential rehabilitation centres is likely to exceed 2 months**. This contradicts all we know about the need for services in a timely fashion to meet the needs of clients, and particularly at a point of readiness for change.

Considerations for the management of people on wait lists are complex, and include both their presenting AOD issues together with mental health conditions, risk of homelessness and engagement with the criminal justice system. For those with methamphetamine dependency issues, many of these issues are exacerbated.

Where a client requires withdrawal management prior to admission to a residential treatment services a further wait period is usually experienced, as detox beds are not always available on demand. Added to this, as withdrawal must be seen in the context of an entry point into treatment (rather than treatment in its own right), most withdrawal services will only accept people once a residential rehabilitation bed has been identified to facilitate a seamless transition into treatment. This may then have the effect of delaying a person's entry into treatment – often with disastrous consequences, and even death.

ATCA services generally utilise an active management of wait list (or wait pool) approach in an attempt to reduce harm, keep people engaged, supported and “treatment ready”. This includes engagement in outclient and other support services. However, the wait list crisis is compounded for those in regional, rural and remote areas of NSW by the distance needed to travel to access treatment, cost of transport (including money for petrol and other travel costs) and the lack of availability of public transport.

Waiting lists are the result of demand for services, and in particular residential rehabilitation services. Simply put, demand is exceeding the supply of treatment places available. The lack of availability has come about as a result of the inadequacy of the funding allocated for residential rehabilitation, with the last major injection of funding into the sector in 2000, as a result of the 1999 NSW Government Drug Summit. Since this funding came into the sector, any new funding has required the development and delivery of new services – rather than the consolidation and expansion of existing services. This has resulted in a sector that is inadequately funded to meet increased demand and cost escalation.

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

Pre-entry requirements are determined by individual services and are geared to particular populations (youth, adult, men, women, families, Aboriginal and Torres Strait Islander etc). ATCA members' approach to pre-entry is to work with potential clients and referral sources to remove barriers and to provide ease of access to services.

Therefore, while readiness for change is an important consideration, our services recognise that motivation is a fluctuating state, and as such it is important that options are available at the time of presentation and assessment. All services have admission criteria – and will undertake a comprehensive AOD and mental health assessment process. This assessment interview includes screening for a history of AOD use, co-occurring mental health conditions, additional needs such as legal matters, physical health conditions and family factors.

It is important to understand that this process is based on **inclusion criteria**, rather than an exclusion process. Nevertheless, not all potential clients will be suitable for all treatment options. To this end, ATCA members offer a range of services across NSW to cater for a wide variety of presentations. It is important that these are supported and expanded.

This emphasises the need to consider the continuum of service provision – since in this field, ‘one size’ does not ‘fit all’.

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).

This is a complex area for consideration and requires a partnership approach between health, justice and social services. Most residential facilities have a strong stance on issues of violence, and therefore need to consider this on a case by case basis. For some people, violence and crime have been committed in the context of substance use, and therefore, once the substance use is addressed, the person may not pose the same level of risk. However, services that include family groups (including women with children) remain vulnerable to this type of risk and it is unlikely that such services will include these clients as the triggers for clients escaping domestic and family violence are significant.

ATCA has reviewed the available evidence regarding compulsory treatment and as a result does not support the introduction of mandatory treatment except in exceptional circumstances and for limited periods of time.

ATCA supports voluntary community based treatment and in our experience the requirements (security etc.) to manage mandated clients for treatment may represent a real threat to the supportive therapeutic environment required for AOD treatment.

Many ATCA members have also visited compulsory treatment centres that exist in the Asian Region and reported that the outcomes are far from desirable or effective. That said, there is a need to expand the legislation to consider people who are at risk to themselves and others due to their substance use.

A consequence of the de-institutionalisation of mental health care is that individuals with mental health problems have come under increasing contact with the criminal justice system. That system is ill-equipped to cope with this development. Both the Commonwealth and New South Wales parliaments have enacted provisions to establish diversionary schemes as an available alternative in dealing with individuals with mental problems who come before the courts. The purpose of diversionary schemes is to redirect those people away from the justice system into treatment, to facilitate complete rehabilitation, where appropriate. This has the potential benefits both for offender and the wider community, in reducing offending behaviour and in improving mental health care for the offender.

Part 3 of the *Mental Health (Forensic Provisions) Act 1990* (sections 31-36) deals with summary proceedings before a Magistrate relating to persons affected by mental disorders. Part 3 sets up two diversionary schemes, under sections 32 (persons suffering from mental illnesses or conditions) and 33 (mentally ill persons).

While all jurisdictions have in place diversionary options for people affected by AOD use who come before the criminal justice system, there is a need to consider provisions under the law for people who are acutely affected by substance use and who therefore pose an immediate risk to themselves or others. Currently legislation does not adequately provide an option for medical personnel and police to detain a person in a safe environment whilst they are sobering up or withdrawing.

The expansion of MERIT and Drug Courts in NSW is also recommended. Where these are established in partnership with residential facilities (see Auckland Drug Court as an example)⁶ the results are impressive.

Drug courts provide a number of cost-related and social benefits to the community, operating as an alternative to imprisonment and addressing the underlying issues related to their offending. Although difficult to quantify, the health and social benefits of drug courts, not just for the offender but for their family and community, are equally important. These benefits include reductions in drug use and associated health issues, easing the burden these offenders place on the health system, the reunification of families, babies born drug-free, the retention of stable accommodation, engagement of offenders in employment, education and training, and a reduction in offending.

Even when offenders do not successfully graduate from the drug court program, they are likely to experience benefits from having participated. Therefore, it should not be assumed that graduation from the program is the only measure of success, as it is likely that many participants who do not complete treatment have nonetheless made positive gains and may return to treatment of their own volition.

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

ATCA believes that people across NSW (and Australia) should be able to access residential AOD treatment services. While the provision of residential treatment services in every urban, regional, rural and remote centre is not feasible, there are significant gaps in availability that have been identified in many existing reports. In particular, many reports into court based diversionary programs have highlighted the limited access for people in rural and regional areas to appropriate treatment services⁷. This has a profound impact on access for First Nations people.

It is important to understand that the same market forces that drive AOD use (supply and demand) also drive the demand for AOD services. The current increase in the use of Ice in NSW, particularly in regional, rural and remote areas of NSW, has caused a marked increase in the demand for AOD services. This has placed additional pressure on an already under-resourced sector that is struggling to meet demand.

Substance use does not happen in isolation. It is a result of a number of factors, including personal, social and environmental factors. Social and environmental factors include a lack of housing and employment opportunities, social connectedness and integration – issues which confront rural and remote communities. It is therefore not surprising that our regional, rural and remote centres are under pressure and experiencing increasing use of substances.

The lack of availability of residential rehabilitation places is further compounded by the fact that there has been no increase in funding to those service providers whose residential services are struggling to meet demand – resulting in substantial waiting lists to those services.

What is needed are enhancements to funding (without the need for a competitive tender process) to those residential providers that can bring more residential rehabilitation places on line immediately.

This has been addressed in other jurisdictions. For example, the Australian Capital Territory (ACT) Health Department recently provided grant enhancements to residential rehabilitation providers to help meet the increase in demand and to better manage wait lists in the ACT.

The evidence of the lack of services for people in regional, rural and remote NSW can be seen in the lengthy waiting lists for access to services, the lack of services in regional, rural and remote areas of NSW and the inability of people from regional, rural and remote NSW to access services without significant cost and disruption to their own and their family's lives.

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

Workforce development and support is of considerable concern to ATCA. This needs to be seen both in the context of **training**, and **financial support**. The latter includes provision of funding to organisations to support the employment of appropriately qualified and trained staff; provision of wages and incentives comparable to the Government sector; and continuity of funding to ensure ongoing employment.

The majority of government and NGO AOD services are experiencing some difficulty in recruiting appropriately qualified health professionals to fill positions in rehabilitation services, and particularly those based in regional and rural areas. Members of ATCA have in place recruitment processes that ensure that only those applicants who are appropriately qualified for a particular position will be considered for that position. As the range of positions may be wide (AOD workers, nurses, social workers, psychologists and other allied health workers) the range of qualifications and skills needed will also be wide.

Services that are located in metropolitan, urban and coastal regional areas may find recruitment easier. However, recruitment of Registered Nurses to work in inpatient withdrawal management services and complex mental health and co-occurring AOD use services, can be difficult. This is often impacted by the shortfall in Registered Nurse applicants across Australia.

Another factor that severely impacts recruitment and retention of all staff types is the uncertainty around funding and the short funding terms, two examples of this are:

- NSW Ministry of Health funding has been extended by 12 months twice in the past two years whilst the NGO funding program was under review, before providing three agreements in 2017.
- Commonwealth Department of Health has also twice extended grants for 12 months while reviewing its grant program, before providing a two-year extension in 2017.

The result of this is that NGO AOD providers are only able to offer employment contracts for 12 months, thereby providing no employment security. Additionally, notification of the extension of grants comes very late in the grant cycle and staff, without any guarantee of ongoing employment, seek more secure employment elsewhere to ensure their future and that of their family. Ironically, these staff members are often 'snapped up' by the Government system where they will be assured of better job security and benefits.

In terms of training, ATCA has addressed this issue with the development of the Therapeutic Communities Training Course. The course will commence its roll-out in February 2018, with the first of the training programs offered in Sydney (on the WHOS campus). It will then be followed in Melbourne, Perth and Brisbane.

The training course has been developed to assist in expanding the potential 'TC work-ready' workforce pool. The key aim of the course is to support AOD practitioners, support workers and other relevant professionals and students to develop knowledge, attitudes and skills that can be applied in the TC context.

The course is suited to those who have a base qualification and/or knowledge of addiction-related practice and who wish to develop knowledge and skills for application in the TC context.

Course structure

The TC training is a 17-week course, with each participant completing:

- 48 hours of face-to-face learning facilitated by a trainer.

- a 40-hour supervised professional skills practicum in a TC.
- 12 hours of self-directed learning.

The TC Training Course compliments and supports the ATCA Standard – ensuring both a work-ready workforce and staff who understand and maintain the need for evidence-based practice within a quality assured environment.

Training Modules include:

- Module 1. Course orientation and Overview of TC
- Module 2. Community as method
- Module 3. TC structure, organisation and environment
- Module 4. Relationships in the TC
- Module 5. Staff roles and responsibilities and rational authority
- Module 6. Group work, community tools, work as therapy & continuing care
- Module 7. Supervised practicum

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.

ATCA supports the collection of data, and particularly outcome focused data for all AOD treatment services. There is a wealth of evidence and a growing evidence base for therapeutic community treatment. ATCA members have active partnerships with a number of university research institutes – including National Drug and Alcohol Research Centre (NDARC) at UNSW; and Universities of Newcastle, Wollongong, Monash, Curtin, Queensland and Deakin, with a growing number of papers published in quality peer reviewed journals in Australia and internationally.

The ATCA Executive Officer (Dr Lynne Magor-Blatch) is an Associate Editor of the International Journal of Therapeutic Communities (see <http://www.emeraldinsight.com/journal/tc>) and in 2016 was guest editor of a special Australasian edition (<http://www.emeraldinsight.com/toc/tc/37/3>) – Volume 37, Issue 3.

ATCA services provide a high quality and evidence based range of services and supports for people with AOD use issues. Our members are committed to continually reviewing their services to improve the outcomes for individuals, families and communities.

An essential part of the work of all our members is the collection and analysis of service outcome data, which is also used in individual client case planning and service development. The information obtained from routine outcome data is used to evaluate the effectiveness of treatment interventions, to make informed clinical decisions regarding treatment plans and service development, and to evaluate clients' response to these developments.

The World Health Organization⁷ characterises addiction as a chronic relapsing condition. It is therefore important to understand the fact that, just as substance dependency is not an 'event' but the result of a process over time, so too recovery is a journey over time. As such, it is expected that there will need to be a number of treatment episodes for some people before lasting change is achieved.

Retention in treatment is a key factor in achieving successful outcomes. So too, is duration of treatment⁸. The longer a person spends in treatment, the better the outcomes. This may not be a single type of treatment, but a number of episodes over a number of treatment types. It is therefore important to offer a continuum of integrated services.

12. Current and potential threats to existing rehabilitation services.

The major threat to existing therapeutic communities and residential rehabilitation treatment centres can be characterised as follows:

- A lack of understanding by government funding bodies (in particular NSW Ministry of Health - Population Health Branch) of the critical role of therapeutic communities and residential rehabilitation treatment centres in AOD treatment.
- The myth that NGO residential treatment is expensive. When compared to prison options, Hospital Emergency Departments, mental health wards and hospital beds, residential treatment is a cost-effective treatment option that saves lives, and money.
 - An ATCA published study ⁹ of 345 people in TC treatment, found that based on an estimated treatment cost of \$98.00 per day ¹⁰ the overall cost of treatment for the people in this study for one year would be \$12,340,650.00.
 - This is compared to an estimated cost to the community in law enforcement, justice, health and welfare costs of **\$62,767,332.00**.
 - Therefore, TC treatment for this cohort would provide a **savings of \$50,426,682.00 over a 12mth period – or \$146,164.30 per person per annum. This is a savings of \$400.00 per person per day.**
- A lack of understanding on the efficacy of therapeutic communities and residential rehabilitation treatment centres in providing AOD treatment.
- An outdated view of the treatment provided by therapeutic communities and residential rehabilitation treatment centres.
- A lack of any investment in therapeutic communities and residential rehabilitation treatment centres, particularly in NSW when compared with recent significant expansions occurring in Western Australia, Queensland and Victoria, and previous expansions in South Australia and the Northern Territory. This impacts on service sustainability, the increasingly complex and multiple needs of clients, cost escalation, demand increase and staffing challenges. Indeed, it would be fair to characterise the NSW funding commitment to therapeutic communities and residential rehabilitation treatment centres as being inadequate and in real need of funding commitments.

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

The level of innovation demonstrated by ATCA members needs to be better understood and celebrated. As identified earlier, there is a real lack of understanding of how far therapeutic communities and residential rehabilitation treatment centres have progressed in their development and delivery of treatment over the last two decades in particular. Many countries and services from around the world regularly send delegations to study and learn from the Australian experience and expertise in providing therapeutic communities and residential rehabilitation treatment.

It is very frustrating that such recognition is often not reflected in the funding decisions of governments.

The approach of ATCA members to residential rehabilitation is to work with client to build their own capacity to manage their own lives in a positive and productive way. This involves a person-led, strengths based approach, based on a learning and life skills development model. There is a strong focus on community connections and working with clients to build their own range of community

based support services and social and recreational networks, as these are what will sustain the person when they return to their own environment.

ATCA supports a range of treatment options being available for people experiencing AOD problems, including methadone, buprenorphine and naltrexone. However, we would not support any treatment, particularly medicated based treatment being provided without an appropriate level of evidence of safety and effectiveness.

14. Any other related matters.

ATCA welcomes this inquiry and would be pleased to have the opportunity to meet with the committee to discuss these matters in more depth. We would also welcome the opportunity to organise visits to therapeutic communities and residential rehabilitation treatment centres within NSW for committee members.

The ATCA Chairperson and Treasurer both provide a range of services in NSW for adults and families seeking services, and another of our Board members provides treatment services for young people. All are able to provide any further information that may be required.

Submitted on behalf of ATCA
Dr Lynne Magor-Blatch
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ATCA members based in NSW

- The Buttery – Byron Bay (Regional)
- The Lyndon Community – Canowindra and Orange (Regional)
- Odyssey House McGrath Foundation – Sydney
- Calvary Riverina Drug and Alcohol Centre – Wagga Wagga (Regional)
- Ted Noffs Foundation – Sydney
- The Salvation Army Recovery Services – Sydney, Central Coast (Regional)
- WHOS – (We Help Ourselves) – Sydney, Hunter Valley (Regional)
- Ngara Nura – Department of Corrections, Long Bay Gaol, Sydney
- Namatjira Haven – Alstonville (Regional)
- ONE80TC – Hawkesbury (Regional)
- Watershed – Wollongong (Regional)
- Ngaimpe Aboriginal Corporation (The Glen) - Chittaway Point (Regional)

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