6

Strengthening families through treatment

6.1 A significant and rising number of Australians are seeking treatment for illicit drug use. In 2002-03, it was estimated that government spending on treatment activities was $229.2 million, with the Commonwealth contributing $65 million and the states and territories $164.2 million.[1]

6.2 There is a clear need to make it easier for drug users and their families to be able to access treatment services that give them the best chance of becoming drug-free individuals. Inquiry participants have consistently noted the need to include families in treatment to improve the outcomes for their family member using drugs. The committee also acknowledges that family members often need treatment in their own right as a result of the stress and anxiety caused by drug problems in the family.

6.3 Families seek information from a wide variety of sources about illicit drug use. Several inquiry participants provided examples of the significant demand for advice from families:

- Family Drug Support, an NGO that operates a national telephone information and support service for families affected by drug use, received almost 30,000 calls in 2006. The average length of support calls to the helpline in 2006 was 33 minutes;
- in Victoria, Family Drug Help, a non-government support service for family members of people who have drug or problematic alcohol use received more than 5,400 calls to its helpline and

1 Moore J, *What is Australia's "drug budget"? The policy mix of illicit drug-related government spending in Australia* (2005), p 12.

involved more than 800 family members in support group meetings in 2006;

- in Western Australia, Parent Drug Information Service, a government agency operating a 24-hour confidential telephone service for parents and families, receive more than 1,400 calls per year; and
- Toughlove NSW, a peer-based non-government support service, received over 450 calls for help from parents over a 14 month period to February 2007.

Getting drug users into treatment that works

6.4 People seeking treatment and support for illicit drug use can access a variety of services, including specialist drug treatment agencies, general practitioners, pharmacists, school counsellors and psychologists. There are also a number of non-government organisations (NGOs) that provide support and information to parents about their children's illicit drug use. However, the quality and nature of counselling advice and treatment given is very uneven with no consistent message.

6.5 While there has been an increase in the number of people getting treatment for illicit drug use there remains a large gap between those undergoing treatment and those using illicit drugs. Particularly concerning is the gap between those in treatment and the heavily addicted users.

6.6 In 2004-05, there were 635 specialist drug treatment agencies in Australia, an increase of 130 agencies since 2000-01.[2] Treatment agencies are mostly located in capital cities and inner regional areas, with only 90 agencies located in outer regional and remote areas in 2004-05.[3]

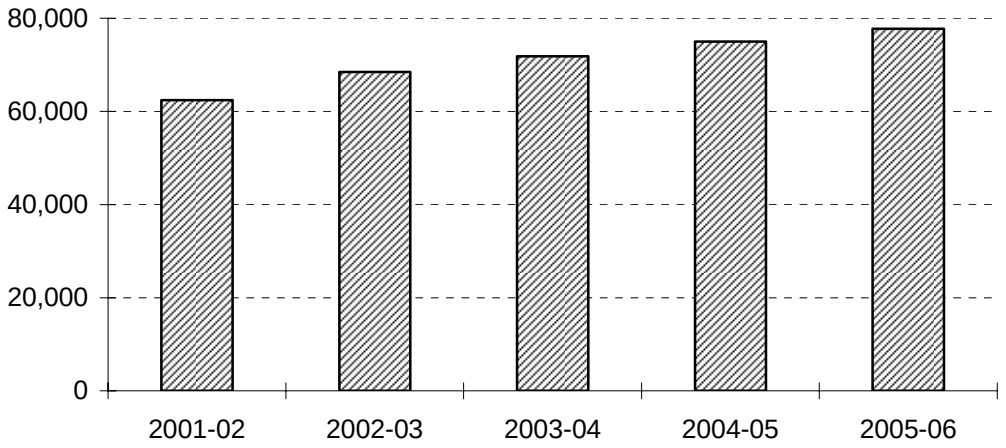
6.7 There has been a steady increase in the number of people seeking treatment from drug treatment agencies for illicit drug use, with the number of closed treatment episodes (a period of contact between a

2 Australian Institute of Health and Welfare 2006, data cube, accessed 12 March 2007 at http://www.aihw.gov.au/cognos/cgi-bin/ppdscgi.exe?DC=Q&E=/Drugs/aodts_prov_0102.

3 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2004-05: Report on the National Minimum Data Set* (2006), cat no HSE 43, p 10.

client and treatment agency that has a defined start and end date) relating to illicit drugs rising from 62,500 in 2001-02 to 77,700 in 2005-06 (figure 6.1).

Figure 6.1 Closed treatment episodes for illicit drugs, 2001–02 to 2005–06 (number)



Source *Australian Institute of Health and Welfare,* Alcohol and other drug treatment services in Australia 2005–06: Report on the National Minimum Data Set *(2007), cat no HSE 53, p 68.*

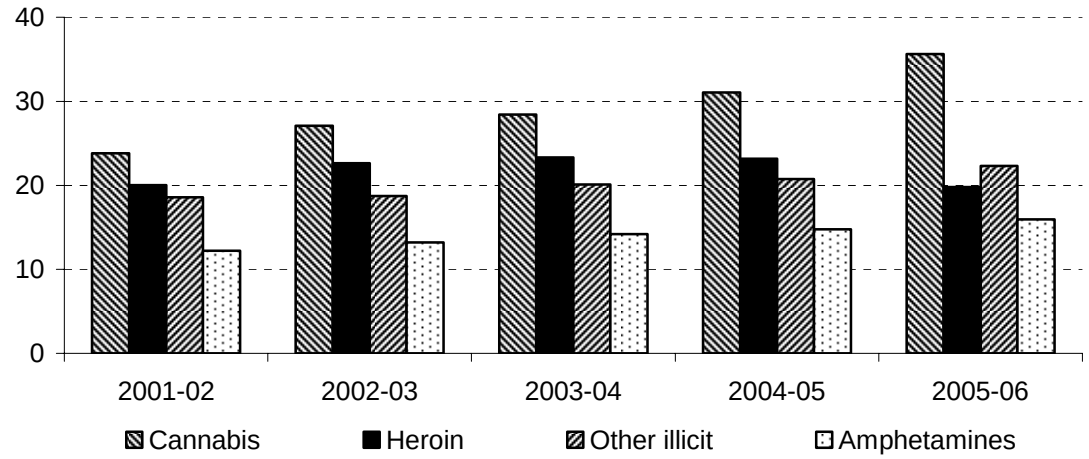
6.8 Much of this expansion in treatment capacity has been funded by the Commonwealth Government, which has lifted its contribution to non-government treatment agencies from $58.6 million over the five years to June 2002, to $115.5 million over the five years to June 2007, then to $170 million over the next four years.[4]

6.9 Almost 80 per cent of the increase in treatment episodes for illicit drug use over the period 2001-02 to 2005-06 was for people nominating cannabis as the principal drug of concern, with the people seeking treatment for amphetamines accounting for the rest of the increase (figure 6.2). While the number of people nominating ecstasy as the principal drug of concern more than tripled over the period 2001-02 to 2005-06, it was cited as the principal drug of concern for only 897 treatment episodes in 2005-06, or 1.2 per cent of the total episodes of treatment for illicit drugs.[5]

4 Australian Government Department of Health and Ageing, submission 170, p 3.

5 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2005–06: Report on the National Minimum Data Set* (2007), cat no HSE 53, p 68.

Figure 6.2 Closed treatment episodes for illicit drugs, by type, 2001–02 to 2005-06 ('000)



Source *Australian Institute of Health and Welfare,* Alcohol and other drug treatment services in Australia 2005–06: Report on the National Minimum Data Set *(2007), cat no HSE 53, p 68.*

6.10 Despite this increase, there are clear gaps between the number of people in treatment for using illicit drugs and the number of drug users. Based on comparisons of recent users of drugs with those undergoing treatment, a very low proportion underwent treatment in the same year (table 6.1). For example, in 2004 only 31,000 people were undergoing treatment where cannabis was nominated as a principal drug of concern, despite there being over 300,000 people that used cannabis every day.

Table 6.1 Recent illicit drug use and frequency of use for selected illicit drugs compared to number of closed treatment episodes by principal drug of concern

	Cannabis	Ecstasy	Meth/ amphetamines	Heroin
Recent use	*1,848,200*	*556,600*	*532,100*	*56,300*
Frequency of use (a)				
Every day	303,105	35,066	57,467	25,335
Once a week or more	421,390			
About once a month	219,936	82,933	85,668	14,525
Every few months	328,980	174,216	155,373	
Once or twice a year	574,790	264,385	233,592	16,496
Treatment episodes	*31,044*	*580*	*14,780*	*23,193 (b)*
Withdrawal management (detoxification)	4,335	28	1,945	5,454
Counselling	11,101	284	6,225	6,645
Rehabilitation	1,535	31	2,158	1,906
Support and case management only	3,090	73	1,202	2,610
Information and education only	7,590	73	526	285
Assessment only	2,823	83	2,331	3,104
Other	570	8	393	3,189

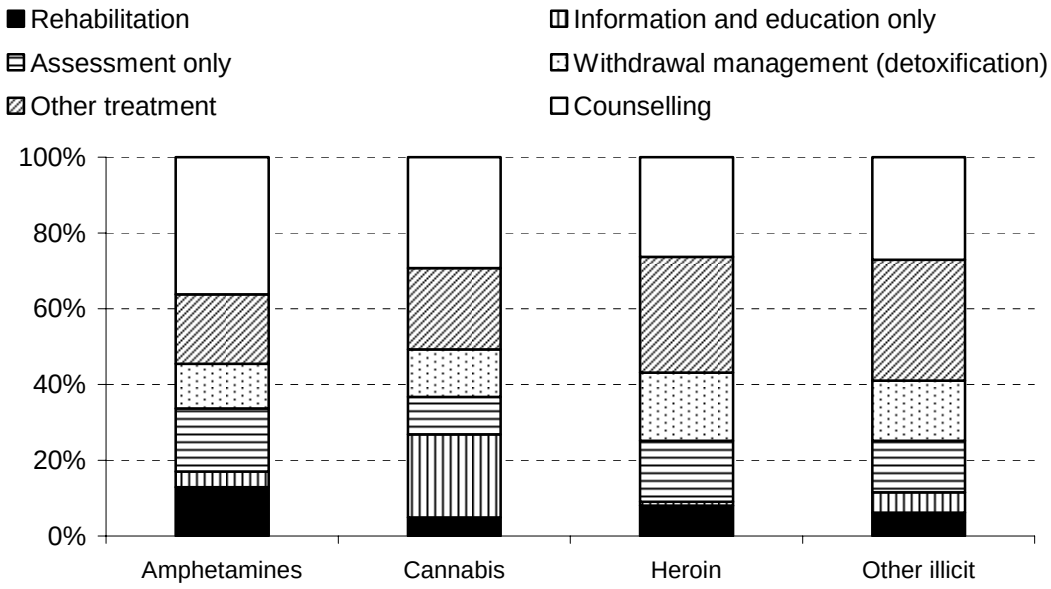
Note *(a) Categories combined for some drug types (b) In 2004, around 38,000 people were participating in pharmacotherapy programs for opioid dependence, which are excluded from these treatment data.*

Source *Australian Institute of Health and Welfare,* Alcohol and other drug treatment services in Australia 2004-05: Report on the National Minimum Data Set *(2006), cat no HSE 43, p 109;* 2004 National Drug Strategy Household Survey Detailed findings *(2005), cat no HSE 66, pp 43, 57, 60, 65.*

6.11 The committee is also concerned that the main form of treatment for illicit drug use is counselling. In 2005-06, the main treatment type provided to people seeking treatment for illicit drug use varied with the principal drug of concern (figure 6.3). Overall for illicit drugs, counselling accounted for the highest proportion of closed treatment episodes when amphetamines (39.2 per cent), cannabis (32.4 per cent) and heroin (29.6 per cent) were the principal drug of concern.[6]

6 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2005–06: Report on the National Minimum Data Set* (2007), cat no HSE 53, p 86.

Figure 6.3 Illicit drug closed treatment episodes by selected principal drug of concern and main treatment type, 2005-06



Note *'Other treatment ' includes support and case management.*

Source *Australian Institute of Health and Welfare,* Alcohol and other drug treatment services in Australia 2005–06: Report on the National Minimum Data Set *(2007), cat no HSE 53, p 86.*

6.12 Counselling — which generally involves a range of approaches such as motivational interviewing, problem solving skills, drug refusal skills and relaxation[7] — relies on people being willing to change their behaviour and does not necessarily address the physiological aspects of addiction. As noted in chapter four several inquiry participants questioned the quality of counselling that was provided within the harm minimisation approach. The committee also heard from one treatment provider that was funded to provide 'counselling' as part of a drug diversion program that involved nothing more than sitting participants in front of a video.

6.13 It is important that resources are directed to treatment approaches that have the most success in getting individuals drug free. While there are agencies that have a high rate of success in making individuals drug free — such as the Australian Drug Treatment and Rehabilitation Programme whose average success rate over the last five intakes has been 93 per cent of people remaining drug-free and who have also gone back to either work or study — the committee

7 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2005–06: Report on the National Minimum Data Set* (2007), cat no HSE 53, p 33.

found it difficult to assess how most treatment providers were in meeting this goal.

6.14 The committee considers that it is important that the success drug treatment providers have in making individuals drug free is the most important indicator for assessing treatment approaches. In chapter four the committee recommended that the Commonwealth Government should only provide funding to treatment and support organisations which have a clearly stated aim to achieve permanent drug-free status for their clients or participants.

6.15 While the committee recognises that individuals undergoing treatment for their illicit drug use can relapse, it is important that the significant funds that are spent on treatment approaches are channelled to those approaches that are more likely to achieve the outcome of a drug-free individual. This could be measured by looking at an individual's drug-free status at intervals of two and five years after their initial treatment.

Recommendation 22

6.16 **The Department of Health and Ageing include, as part of the next round of illicit drug treatment funding agreements, requirements that:**

- **treatment organisations collect and report data on their success rate in making individuals drug free after they have completed their initial treatment; and**
- **give priority to funding those treatment approaches that demonstrate their success in making individuals drug free.**

Further, the Department should maintain a database containing such information and make it public.

Commonwealth support for drug treatment

6.17 The Commonwealth Government provides significant support to families through a range of general programs, as well as support for drug treatment services.

6.18 The Department of Families, Community Services and Indigenous Affairs and the Department of Health and Ageing provided an overview of the programs and payments to families to support the general community and particular population subgroups.[8] Some aspects of general programs that assist specific population groups include:

- Grandparent initiatives — from July 2007, strengthening social security legislation to make it easier for Centrelink to ensure that income support payments for principal carers, including grandparents, are provided to the person who is actually providing the majority of day-to-day care for the dependent child (discussed in chapter nine); and
- The Emergency Relief Program (ERP) provides immediate assistance to people in financial crisis to deal with their immediate crisis situation in a way that maintains the dignity of the individual and encourages self-reliance. Funding is provided to a range of community and charitable organisations to assist them to carry out their normal emergency relief activities. Assistance from emergency relief providers is usually in the form of purchase vouchers for goods, part-payment of accounts, or material assistance such as food or clothing. Approximately 800 community organisations, operating through more than 1300 outlets, received $31.2 million funding through the program in 2006-07.[9]

8 Australian Government Department of Families, Community Services and Indigenous Affairs, submission 172; Australian Government Department of Health and Ageing, submission 169.

9 Australian Government Department of Families, Community Services and Indigenous Affairs, submission 172, pp 9–18.

6.19 In addition to general programs, both departments fund services to deliver drug treatment (box 6.1). Examples of some of the services funded include:

- Strengthening Families program:
  - ⇒ Focus on the Family — How to drug proof your kids project (national);
  - ⇒ Early Support for Parents — Grandparents Raising Grandchildren Support project (Hobart, Launceston and Ulverstone, Tasmania);
  - ⇒ Women's Health Service — Pregnancy, Early Parenting and Illicit Substance Abuse project (Perth, Western Australia);
  - ⇒ Odyssey House Victoria — Counting the Kids National Brokerage Fund project (Victoria, ACT and Tasmania);[10]
- Non-Government Organisation Treatment Grants program:
  - ⇒ We Help Ourselves — supported withdrawal (New South Wales);
  - ⇒ Gold Coast Drug Council (Mirikai) — youth dual diagnosis program (Gold Coast, Queensland); and
  - ⇒ Western Australian Council on Addictions — Saranna Women's Residential program (Perth, Western Australia).[11]

10 Australian Government Department of Families, Community Services and Indigenous Affairs, submission 187, p 6.

11 Australian Government Department of Health and Ageing, submission 170, pp 5–9.

Box 6.1 Commonwealth funding for drug treatment

In addition to funding provided to the states under general revenue funding agreements, the Commonwealth funds a range of initiatives that specifically target illicit drug treatment. There are a number of specific programs that aim to reduce illicit drug use in Indigenous communities.

Non-Government Organisation Treatment Grants Program — provides funding for the establishment, expansion, upgrading and operation of non-government treatment services. The funding aims to strengthen the capacity of non-government organisations to achieve improved service outcomes and to increase the number of places available. To date, over $142 million has been provided to over 200 organisations:

- $58.6 million over five years to June 2002;
- $115.5 million over five years to June 2007; and
- $170 million over the next four years to better equip organisations to tailor treatment and services to amphetamine type stimulant users ($22.9 million) and provide more flexible family therapies and detoxification arrangements to people and their families who are trying to fight drug addiction. Additional treatment and residential places will also be provided to better meet the particular needs of young people in drug and alcohol treatment.

Illicit Drugs Diversion Initiative — The primary objective of the initiative is to increase incentives for drug users to identify and treat their illicit drug use early. It also aims to decrease the social impact of illicit drug use within the community and to prevent a new generation of drug users committing drug-related crime from emerging in Australia. The Department of Health and Ageing administers the initiative through funding agreements with State and Territory Governments. The Commonwealth has allocated more than $340 million to the initiative since 1999.

Strengthening and Supporting Families Coping with Illicit Drug Use — provides support for families, including parents, grandparents, kinship carers and children of drug-using parents. This is achieved through the provision of education, counselling support services, advice and referral services, and targeted projects for families. The projects, including a brokerage fund, support children of drug using parents by giving them the opportunity to participate in normal childhood activities like playgroup, music lessons and sporting activities. The 2004 budget allocated $13.6 million over four years to the program. There are currently 21 services being provided on a local and national basis by 20 non-government organisations.

Source *Australian Government Department of Families, Community Services and Indigenous Affairs, submission 172; Australian Government Department of Health and Ageing, submissions 169 and 170.*

A single point for advice and referral

6.20 Families need easy access to information and advice about drug treatment services that will enable their family member to become a drug-free individual.

6.21 Many inquiry participants noted the difficulties they had in accessing information about the effects of illicit drugs and where to go to access treatment and help. A parent told the committee that:

> The earlier families can get help the greater the chance that they are in the best position to support themselves and the member(s) using. In my case it took a crisis with my brother before help was accessed. This help needs to be more readily available so as to avert a crisis and give understanding and support to families and friends. When family and friends are supported through improved communication and education in variety of areas this leads to a better outcome.[12]

6.22 The Australia Drug Foundation (ADF) noted that:

> As shown by the numbers of family members who contact the ADF, there is a huge demand for information and support from the community. However, a common complaint from families is that they find it difficult or confusing to know where to go to for assistance. This is particularly true when they are seeking to access treatment, other intervention or support services.
>
> Not all situations require the same response and many families need a range of services from different disciplines. Lack of identifiable services is a source of frustration to many. Many family members have been on a merry-go-round of services before they find the information and support best suited to them.[13]

6.23 Better informing families, particularly parents, about the dangers of illicit drugs is an important part of strengthening a family's capacity to prevent the use of illicit drugs. The committee believes that it should be easier to access information about drugs and where to get

12 Ennik M, submission 13, p 2.

13 Australian Drug Foundation, submission 118, p 13.

help. It is also important that information is available at all times of the day.[14]

6.24 The Australian Drug Foundation favoured a centralised approach to providing help to families:

> A centralised information system is required to assist families to identify the type of service(s) they require and what is available in their locality or region. A centralised, 'one-stop-shop' service for families could offer a comprehensive range of support services including telephone, website and online networks (for example, online counselling, chat groups, question and answer forums etc).[15]

6.25 A centralised approach could also lead to the development of a more 'client-centred' approach to treatment:

> In the context of co-occurrence of drug and other issues being an expectation rather than an exception, a dilemma noted by many experts is that clients are often not treated in a holistic manner. Instead, they are referred from one service to another, each dealing with part of a client's problems. Experts suggested that better integrated client and family support services (a 'one-stop shop' approach which wrapped services around clients and families) would be a major step forward. Such an innovative practice model would mean that funding for a client's treatment and family support would be seen as a whole and would follow the client through different services.[16]

6.26 The committee is in favour of centralising for families where they go to get information and help. An approach applied to aged care services in recent years is a possible model that could be applied to drugs (box 6.2).

14 Toughlove Victoria, submission 112, p 3.

15 Australian Drug Foundation, submission 118, p 14.

16 Families Australia, submission 152, p 15.

Box 6.2 Carelink — Coordinating information and support — A possible model for drug treatment and information services?

Carelink Centres were established in 2000 to provide a single point of contact for older Australians to a range of service providers including health professionals, carers and aged care facilities. The centres are regionally-based and are operated by organisations that already provide services in the region, including community based, religious, charitable, private, and local and State government providers.

The centres are connected nationally by a 1800 telephone number and a shopfront in each of the 54 regions. Each Commonwealth Carelink Centre has extensive regional networks and maintains comprehensive databases containing community aged care, disability and other support services. Shopfronts are operated by organisations that already provide established services within their region. Their extensive local knowledge ensures they provide a quality service. This regional focus enables each Centre to develop an awareness of the entire range of services available, to establish networks with local providers and ensure information is up to date.

Source *Commonwealth Carelink Centres, 'Welcome to the Commonwealth Carelink Centre Website', viewed on 23 July 2007 at http://www9.health.gov.au/ccsd/index.cfm.*

6.27 It is also important that families know that when they make contact with an information and referral service they will get the right advice and information about who to contact for drug treatment.

6.28 The committee is concerned that not all treatment services funded by the Commonwealth and the states and territories identify that abstinence is the goal of treatment. A survey of the managers of alcohol and other drug specialist treatment services conducted in 2002 found that only 15 per cent of managers identified that their service practised an exclusively abstinence approach, with a harm minimisation approach (which *could* include abstinence) used in 77 per cent of services (table 6.2).

Table 6.2 Treatment approaches in the alcohol and drug treatment sector, 2002

Agency	Government	Non-government organisation	Private	Total
	n (%)	*n (%)*	*n (%)*	*n (%)*
Harm minimisation (a)	88 (90)	83 (71)	10 (53)	181 (77)
Exclusively abstinence	6 (6)	23 (20)	6 (32)	35 (15)
Other approaches (b)	3 (3)	10 (8)	1 (5)	14 (6)
Missing (non response)	1 (1)	1 (1)	2 (10)	4 (2)
Total	98 (42)	117 (50)	19 (8)	234 (100)

Note *(a) Managers identified a continuum of harm minimisation that could include abstinence. (b) Other approaches identified: a client directed approach and abstinence that can include harm minimisation.*

Source *Roche A et al, 'Alcohol and other drug specialist treatment services and their managers: findings from a national survey',* Australia and New Zealand Journal of Public Health *(2004), vol 28, no 3, p 255.*

6.29 Hon Ann Bressington MLC told the committee about the different messages that drug users can get when they seek treatment:

> The messages that drug users are given when they seek out treatment is to cut down, 'Only use weekends; there is no need to stop altogether; you can recreationally use these drugs.' These are counsellors: 'I used to, and I still recreationally use; I have managed to keep my drug use under wraps on weekends only for quite some time now.' The addict in a person will grab onto that and run with it, and Ryan will tell you himself that he heard those messages and it put him off getting involved in treatment for some months, to the point where he was suicidal and misdiagnosed with a mental illness.[17]

6.30 The committee notes that the Commonwealth Department of Health and Ageing is undertaking a project with states and territories to develop a national database of alcohol and drug treatment services to 'comprehensively describe the number and nature of these services'.[18] An initial version of the database was expected in mid 2007.[19] It is important that this database is able to identify whether treatment agencies have making individuals drug free as the goal of treatment. This database can then be used by a Carelink-like service to assist families find a treatment service.

17 Bressington A, transcript, 23 May 2007, p 4.

18 Australian Government Department of Health and Ageing, submission 170, p 3.

19 Australian Government Department of Health and Ageing, submission 170, p 3.

Recommendation 23

6.31 **The Department of Health and Ageing, in conjunction with other appropriate agencies:**

- **establish a regionally-based information and referral service, modelled on the *Carelink* aged care information service, that incorporates a 1800 telephone number and a regional network and database of service providers, to assist families obtain information about illicit drugs and how they can access treatment; and**
- **only include treatment agencies on the database that have the objective of making individuals drug free.**

Timely access to services

6.32 Evidence was given to the committee on numerous occasions that without timely access to services, drug addicted users found it impossible to take advantage of the 'window of opportunity' that would present itself to have the desire to get off drugs. A former drug addict told the committee that:

> I became addicted and it took seven years for me to realise that I had to stop. In those seven years—this is where it is important to this forum—I would get windows of opportunity to get out. I would feel like I could go to rehab or detox and everything like that but, when I would get on the phone to get in contact with [a treatment agency], there would not be a place available. The feeling of 'okay, I've had enough, I can get out' would disappear. I would go back into it.[20]

6.33 Glastonbury Child and Family Services told the committee that:

> Staff in the Family Services Program within Glastonbury report a need for more immediate rehabilitation responses. The impact of illicit substance use is such that when a decision is made to cease use then a prompt service system response is required. Frequently when trying to address their illicit substance use clients have to telephone during intake

20 Christopher, transcript, 7 April 2007, p 68.

> hours or wait several weeks before they can be admitted to withdrawal, rehabilitation or other drug treatment services.[21]

6.34 After accessing initial treatment, it is also important that individuals are able to seamlessly progress through different treatment stages. Often people undergoing treatment require several different forms of treatment as they progress through their rehabilitation. In 2005-06, 15 per cent of closed treatment episodes reported more than one treatment type.[22] Where detoxification was the main treatment type reported, 39 per cent of episodes included as least one other treatment type.[23]

6.35 To take advantage of the small window of opportunity to get people off drugs, services need to be available at the right time. Professor Gary Hulse of the University of Western Australia told the committee:

> We cannot have this mentality where you have these huge waiting lists, you make people jump over hurdles, and where they have to ring up and make an appointment in a week's time to come down and have an assessment: 'Yes, now you have to be seen by a medical officer next week.' These are heroin users. People report and say, 'Of those people who enter our program, this is our success rate.' What about the people who have not entered that program because of the hurdles that you have made them jump? Set up services, which are opportunistic, which allow you to assess people and provide good medical assessment and psychosocial assessment at that time, withdraw them and get them onto a treatment. Don't lose that 30 per cent or 40 per cent who then do not come back for treatment.[24]

6.36 Professor Hulse gave the committee an example of how integrating hospital services with a drug treatment clinic led to improved outcomes for drug users:

> Referrals from the Perth naltrexone clinic used to be made up to the hospital for treatment of hepatitis C. Very few patients—perhaps two out of every 10 referrals—used to come up, which is what you can imagine. Heroin users have

21 Glastonbury Child and Family Services, submission 74, p 12.

22 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2005-06: Report on the National Minimum Data Set*, cat no HSE 53, p 33.

23 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2005-06: Report on the National Minimum Data Set*, cat no HSE 53, p 33.

24 Hulse G, transcript, 21 March 2007, p 7.

> better things to do than simply make another trip to another place, especially to a hospital; it is very daunting. It is a bit like coming to parliament. You do not understand it; there are people running around corridors doing who knows what.
>
> [The hospital] set up a room at the Perth naltrexone clinic. Every Tuesday, that becomes a hospital room. A general practitioner room is next door. It is a basic one-stop shop. They go and see the GP and get a referral to the hospital. They walk from one door to the next door, see the hospital and then enter into ribavirin and pegylated interferon treatment. This is how services should run. This is about integrating different services so you provide the easiest convenience to the maximum number of people. … The results from this service are good in terms of resolution of hepatitis C. Patients were not lost from treatment. Patients remained in contact with the hospital, and there was good resolution of HCV for those patients.[25]

6.37 Despite the growth in treatment capacity, many inquiry participants expressed frustration at not being able to access drug treatment services in their area, being told that they would need to wait until places became available or that there would be delays in moving between different stages of treatment, such as detoxification and rehabilitation.[26] It is important to note that detoxification can be a necessary first step to entering rehabilitation. In some cases, this can be done rapidly using medicinal drugs. For example, as used for some patients prior to the insertion of naltrexone implants at the Perth Clinic. A parent told the committee:

> There are countless facilities that can help to a point but these all have waiting lists and most in my opinion appear to work independently of each other.[27]

6.38 A seamless transition between different types of services, such as detoxification and rehabilitation, is important so that people undergoing treatment do not relapse.[28] Nar-Anon Family Groups Australia told the committee that:

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25 Hulse G, transcript, 21 March 2007, pp 18–19.

26 Bowman D, submission 38, p 1; Hayes H, submission 51, p 2; Moore M, submission 95, p 1; Families and Friends for Drug Law Reform, submission 122, pp 13-14; McMenamin H, transcript, 30 May 2007, p 34.

27 Bowman D, submission 38, p 1.

28 Australian Family Association, submission 59, p 4.

> Many addicts attempt many times to overcome their addictions, and they have incredibly difficult times trying to find rehabilitation beds after detoxification. It can take literally weeks for them to keep ringing rehabilitation centres, daily, to find a bed. No wonder so many relapse and can end up overdosing and sometimes dying.[29]

6.39 Service providers were also frustrated that they were not able to help all people seeking treatment.[30] A drug treatment provider told the committee that:

> I am now the facilitator of a support group in the City of Hume, which has been established for five years. The group offers education, accurate information and support. I assist families to make changes in their lives which in turn has an effect on their loved one's drug use.
>
> Recovery from addiction is not just a matter of ceasing the drug of choice; it is about learning a whole new life. Moreover, treatment seems to be very poorly coordinated especially the gap between detoxification and rehabilitation.[31]

6.40 The expansion in treatment capacity being funded by the Commonwealth should go some way to improving timely access to services. The committee believes that the implementation of its recommendation regarding the 'one-stop-shop' telephone hotline should also lead to better coordination and integration at a local level to reduce the delays and interruptions in accessing treatment.

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29 Non-Anon Family Groups (Australia), submission 115, p 5.

30 Association for Prevention and Harm Reduction Programs Australia, submission 130, p 11; Family Matters SA, submission 158, p 2; Blatch C, Goldbridge Rehabilitation Services, transcript, 7 March 2007, p 25; Harris S, Parent Drug Information Service, transcript, 14 March 2007, p 57; Besley S, Blacktown Alcohol and Other Drugs Family Services, transcript, 2 April 2007 p 12.

31 Hayes H, submission 51, p 2; Morrissey J, submission 12, p 4; Moore R, submission 155, p 2; Newman M, Grandparents Assisting Grandkids Support, Gold Coast Region, transcript, 7 March 2007, p 37; Bressington A, transcript, 23 May 2007, p 3; Dawe S, transcript, 13 June 2007, p 21.

Promoting family-inclusive treatment

6.41 'Family-inclusive' treatment involves treating the drug user in the context of their significant relationships with their family members and community.[32] Copello, Velleman and Templeton note that there are three general types of interventions for substance abuse that involve family members:

- working with family members to promote the entry and engagement of drug users into treatment;
- the joint involvement of family members and drug-using relatives in the treatment of the drug user; and
- responding to the needs of the family members in their own right.[33]

6.42 A wide range of family-inclusive treatment and support models are already used by some treatment providers. Examples provided to the committee include:

- family-friendly rehabilitation services that provide for live-in arrangements for children whose mothers or parents are undergoing treatment;[34]
- grandparent support groups;[35]
- counselling and peer support for family members with a member using illicit drugs;[36] and
- parenting and communication skills training.[37]

6.43 The Government of Western Australia Drug and Alcohol Office provided examples of services provided as part of its 'family sensitive practice project' that assists agencies within the sector to provide more family-inclusive services including:

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32 Centacare Catholic Family Services, submission 116, p 3.

33 Copello A et al, 'Family interventions in the treatment of alcohol and drug problems', *Drug and Alcohol Review* (2005), vol 24, p 371.

34 Cyrenian House, submission 110, p 5.

35 Glastonbury Child and Family Services, submission 74, p 6; Baldock E, Canberra Mothercraft Society, transcript, 28 May 2007, p 31.

36 Glastonbury Child and Family Services, submission 74, p 9; Government of Western Australia Drug and Alcohol Office, submission 82, p 7; Smith L, Toughlove NSW, transcript, 3 April 2007, p 1; Holyoake, submission 117, p 2; Centacare Catholic Family Services, submission 116, p 3.

37 Cyrenian House, submission 110, p 5; Relationships Australia, submission 143, p 5; Van Nguyen V, UnitingCare Burnside, transcript, 2 April 2007, p 10.

- family counselling — providing for family members of a drug user to attend treatment services with or without the user being present;
- a family counsellor based at rehabilitation centres — to keep the communication flowing between the resident, the agency and family members;
- structured parent support groups — parents attend a set weekly program which provides information and strategies for management and coping; and
- peer support groups — where parents support one another in a safe and confidential environment.[38]

6.44 Family-inclusive treatment approaches may not be appropriate for all individuals where family relationships have broken down. As noted in chapter ten, however, they can often be more effective than conventional approaches that focus only on treating the drug user. Odyssey House stated in their submission that family-based treatment for adolescent substance abuse has been found superior to other treatments in the following:

- improved engagement and retention in treatment services;
- reduced drug use;
- improved behavioural and emotional problems associated with drug use;
- improved school attendance and performance; and
- improved family functioning.[39]

6.45 Many participants considered that treatment services needed to involve families more in the treatment of drug users.[40] Centacare NT noted that historically services had an individual focus, focusing on the user to the exclusion of all others. Families have been seen as an

38 Government of Western Australia Drug and Alcohol Office, submission 82, pp 6–7.

39 Odyssey House Victoria, submission 111, p 8.

40 Family Drug Support, submission 15, p 5; King Edward Memorial Hospital for Women, submission 19, p 10; Hayes H, submission 51, p 2; Colquhoun R, submission 73, p 1; Family Drug Help, submission 76, p 4; Dawe S et al, submission 80, p 4; Name withheld, submission 86, p 9; Australian Institute of Family Studies, submission 103, p 8; Odyssey House Victoria, submission 111, p 3; Centacare Catholic Family Services, submission 116, p 2; Australian Drug Foundation, submission 118, p 14; Royal Australasian College of Physicians, submission 119, p 20; Alcohol and Drug Foundation ACT, submission 123, p 4; Relationships Australia, submission 143, p 6; Families Australia, submission 152, p 4.

adjunct to the treatment of the substance misuser rather then being helped in their own right.[41] Family-based models recognise that:

- living with a drug user is devastating;
- it impacts on all family members physically and emotionally; and
- family members have generally tried all manner of things prior to accessing help to try and cope; some work and some do not.

6.46 Despite the benefits of further including families in treatment, there may be significant barriers to expanding family-inclusive treatment services in the drug treatment sector. Dr Christopher Walsh highlighted a number of impediments including:

- conceptualising the patient's substance use problem in isolation from the broader family context;
- blaming families for their loved one's addiction;
- lack of staff education about family issues, such as how to deal with families, including how to diplomatically engage with family members without alienating the patient;
- a lack of staff education about the issues facing families and a resulting therapeutic arrogance in a significant minority of therapists. This further alienates families and makes it more difficult for them to obtain the help and understanding they need;
- not thinking of the drug user's family as a potential resource when appropriate;
- a lack of organisational structure that is supportive of family sensitivity:
  - ⇒ appropriate forms and intake procedures;
  - ⇒ screening tools to identify family issues;
  - ⇒ appropriate funding contingencies that include time for communicating with family members; and
  - ⇒ appropriate family sensitive professional supervision; and
- a practical interpretation of the harm minimisation paradigm that has become reductionist in many drug treatment services. It should include minimisation of harm to family and the broader community as well as to the substance users.[42]

41 Centacare NT, submission 60, p 5.

42 Walsh C, submission 84, p 3.

6.47 Dr Walsh also outlined the cultural impediments to expanding family involvement in treatment :

> The cultural impediments to family sensitive practice are deeply entrenched although improving somewhat in recent years. … This reflects a general attitude that our patients are only the people in front of us not the systems of the families to which they belong.
>
> In its worst form, this reductionistic view can manifest in rehabilitation and detoxification services refusing to tell families if their loved one is currently under treatment at their service. This is supposedly to protect the privacy and confidentiality. However, this reluctance to give out information is often against the drug user's wishes and the family is left wondering if their loved one has become uncontactable because they have died or disappeared on the streets.[43]

6.48 The committee considers that the role of families needs to be more strongly promoted to clinicians and treatment service providers. This will require a change of mindset and approach by the health system and drug treatment sector — moving away from a 'patient-doctor' model towards a model that is based on information sharing and bringing in family members for support as required.

6.49 The committee also considers that cultural change within the drug treatment sector could be accelerated by adopting other suggestions about restructuring funding arrangements to encourage family-sensitive practices, such as setting funding aside for family contacts and other family interventions, and using measures of family satisfaction as part of the assessment of service delivery.[44]

6.50 As a direct funder of many non-government organisations involved in the drug treatment sector, the Commonwealth is well positioned to directly influence the inclusion of family-inclusive practices.

6.51 The committee also considers that there is an opportunity to improve data collected by drug treatment services to include information on family-inclusive treatment.

6.52 By including such information in the Alcohol and Other Drug Treatment Services National Minimum Data Set, an annual collection

43 Walsh C, submission 84, p 5.

44 Walsh C, submission 84, p 4.

coordinated by the Australia Institute of Health and Welfare, it will be possible to monitor the extent to which family-inclusive treatment models are being used.

6.53 By collecting and reporting data on family-inclusive treatment services, the committee considers that it will be easier to monitor whether families are being given a higher priority under the National Drug Strategy and the extent to which services are able to incorporate these treatment models into their services.

Recommendation 24

6.54 **The Australian Institute of Health and Welfare work with relevant government and non-government agencies to include in the Alcohol and Other Drug Treatment Services National Minimum Data Set measures relating to the use of family inclusive services to treat illicit drug use.**

Privacy issues for family members

6.55 Many inquiry participants whose children had been using illicit drugs registered their frustration with 'the Privacy Act', which appeared as an impediment to every attempt they made to find out if their son or daughter was in treatment, how they were progressing, and how they could best be cared for and supported.

6.56 This observation was made by the Alcohol and Drug Foundation ACT:

> Families talk about their frustrations with a system that excludes them once their family member or friend is in treatment. Having worked hard to support their family member to get into a treatment program, they are often then blocked from the process, with treatment agencies refusing to engage with them. This may leave them feeling angry and confused; increasing their feelings of guilt and further delay the family's healing process.
>
> When we finally managed to get some help for our daughter we were excluded, rather than included in the process. We'd call up to see how she was going, and we were told that because she was an adult and because of privacy laws, they

> couldn't give us any information. We didn't even know if she was still there. We went back to not sleeping all over again.[45]

6.57 A clinician treating people on maintenance programs told the committee that:

> Often families are excluded from involvement, including the use of family resources to support the person in recovery to being denied any information about the course of treatment. This policy is highly prejudicial to facilitating recovery and almost invites the person to relapse to drug use. The family is the unit that often is the most caring and resourced to assist in recovery and knowledge of the person's status is the most potent weapon in assisting them to be drug free.
>
> Involvement of the family from the beginning and throughout treatment can also benefit the family by helping them understand the effect of the addiction, the mechanisms that sustain it and the strategies to combat it. Involvement also means that dysfunctional and negative behaviour and misinformation about drug use can be modified to assist the person. Moreover, involvement can also be a healing process for the family.[46]

6.58 Three families told the following stories:

> Our son went to a psychologist which turned out to be very expensive over many months and in the end, of no use. When we rang this man up to see how the counselling sessions were going we were told that because of the privacy laws he could not tell us.[47]
>
> We approached the staff of [a treatment centre] on a number of occasions trying to access our son's medical records but this was denied us as he was not a minor. This is the law and we accept it, however there are times when some flexibility is needed in order to assist the addicted person. Families are the strongest, most loving link the drug user has and to be 'shut out' from being able to help is distressing in the extreme.[48]
>
> My son was not capable of making an informed decision about anything even to go to the toilet; he wanted help, could

45 Alcohol and Drug Foundation ACT, submission 123, p 4.

46 Colquhoun R, submission 73, p 1.

47 Toughlove Victoria, submission 112, p 3.

48 Riley M, submission 34, p 5.

> not speak because of the drugs, slurred and dribbled. I rang agencies, detox centres but they would not help me, they told me they could only speak with him, I explained he couldn't speak. Families need to be able to advocate on behalf of their drug-affected child.[49]

6.59 Families highlighted that information about another person's treatment was especially important in circumstances where the family could be put at risk. A family with a son with a mental illness and illicit drug addiction said that:

> There is a big problem about privacy. When we went to the drug counsellor a few years ago, when [our son] agreed to go, they refused to discuss anything with us, so we had to go to a separate one. With mental health it is a bit different—they involve the loved one. You can go and see their psychiatrist, you can sit in family meetings, but for some unknown reason, with drugs it is completely private and it really encourages the drug user to use that. What is really scary now with [our son] is that, when he finally gets out, we are going to have to be very careful about how we deal with him. I do not think we should have him in the car. We will most probably meet him in open places because, if he has had some speed or some ice, he could kill us. So if he or any drug user is going to a counsellor, it should be mandatory for the counsellor to warn their family that their loved one is becoming dangerous because they are starting to use speed, they are starting to use ice. You have to protect.[50]

6.60 A couple described a similar incident in which a family felt at risk due to the lack of information provided about their daughter's aftercare:

> We have encountered recently an incident involving a person whose illicit drug use combined with antidepressants has seemingly resulted in mental disorder. The family wishes to be supportive, but can get no information from the doctor or hospital about the drugs used, the cause of the problem, or possible outcomes. The person was discharged still in a frightening condition, a danger to themselves and others. The family was (and is) faced with the prospect of housing an aggressive and possibly dangerous daughter, or leaving her out on the street with nowhere to go. All too often this is the

49 Quon M, submission 8, p 6.

50 Mercer I, transcript, 30 May 2007, p 11.

> choice ... danger to the family, or relegating a loved one (who is unable to take care of themselves) to life on the streets. Without the benefit of knowing exactly the nature of the problem they are facing, the family is powerless to help (the addict or themselves) in any realistic way.[51]

6.61 Health information and privacy in Australia is a complex area, regulated by common law obligations of confidence that health professionals must abide by, as well as a set of overlapping federal, state and territory legislation.[52] Health information is a particularly sensitive type of information, with particular conditions attached to its disclosure.

6.62 At the Commonwealth level, the handling of health information is regulated through the Privacy Act by the National Privacy Principles (NPPs) (for the private sector), the Information Privacy Principles (IPPs) (for the public sector) and Public Interest Determinations.[53]

6.63 Some state and territory jurisdictions (New South Wales, Victoria, the ACT and the NT) have developed their own privacy legislation for their public sectors; Queensland relies on administrative arrangements. Victoria, New South Wales and the ACT have also enacted law that regulates the handling of health information in the private sector.

6.64 The disclosure of client information is also regulated by ethical and professional codes of conduct, such as the Australian Medical Association Code of Ethics and the recently released code of ethics and values for the drug sector. Produced by the Alcohol and Other Drug Council of Australia (ADCA), it calls for 'privacy and confidentiality to the extent permissible by law', given that the illegal nature of drug use and the stigma attached to drug dependency make confidentiality an issue for clients.[54] The enabling legislation of many health agencies may also contain secrecy provisions that apply to its staff.[55]

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51 Glover C and C, submission 45, p 1.

52 Australian Government Office of the Privacy Commissioner, *Getting in on the Act: The Review of the private sector provisions of the Privacy Act 1988* (2005), p 64.

53 Australian Government Office of the Privacy Commissioner, *Getting in on the Act: The Review of the private sector provisions of the Privacy Act 1988* (2005), p 64.

54 Alcohol and Other Drug Council of Australia, *Making values and ethics explicit: A new code of ethics for the Australian alcohol and other drug field* (2007), p 9.

55 Australian Government Office of the Privacy Commissioner, *Getting in on the Act: The Review of the private sector provisions of the Privacy Act 1988* (2005), p 65.

6.65 The fact that a person is over the age of eighteen does not necessarily change the way in which their health information can be disclosed, as the Privacy Act does not specify an age at which a person is considered of sufficient maturity to make his or her own privacy decisions. Doctors address each case individually, having regard to the child's maturity, degree of autonomy, understanding of the relevant circumstances and the type and sensitivity of the information sought to be accessed. The Australian Medical Association suggests, for example, that in the case of a young teen, 'the doctor might quite properly take the view that access to the records without the child's consent would be a breach of confidentiality'.[56] The committee believes, however, that parents are entitled to know when their children are engaging in illegal acts.

6.66 Some disclosures are permitted or mandated by law, regardless of whether the patient gives consent, such as notifications of communicable diseases that pose a public health risk, or in reporting child abuse.[57] In nearly all cases, however, health professionals will be extremely averse to disclosing *any* information to a third party about a current or past client without explicit consent, for legal reasons and to preserve the client relationship.

6.67 A model based on the consent of the person, consistent with current privacy principles, was suggested as a way of involving families more in treatment:

> I strongly recommend that when people voluntarily enter treatment that families are involved and that policies that specifically exclude families be reviewed. This can be facilitated by having the client sign an authority to release information that specifically names family members, family doctor etc. and that it be made clear that the family, client and treating professionals will work together to facilitate recovery. The client maintains control of who is able to have information if sensitively handled. It is also important to understand the dynamics of the family and to identify those who have been harmful in the past and to prevent harm during the recovery process.[58]

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56 Australian Medical Association, 'Privacy questions and answers', viewed on 28 August 2007 at http://www.ama.com.au/web.nsf/doc/SHED-5G58KD.

57 Australian Medical Association, 'Privacy questions and answers', viewed on 28 August 2007 at http://www.ama.com.au/web.nsf/doc/SHED-5G58KD.

58 Colquhoun R, submission 73, p 1.

6.68 The National Health Service in the United Kingdom has published a document about privacy and confidentiality principles in health practice, and its model of 'explicit informed consent' may be useful to apply to individuals undergoing treatment for drug problems:

> Explicit informed consent means that the [individual undergoing treatment] should understand the nature and extent of the disclosure that is to be made, who is likely to receive the information and how it may be used. A general release form, which gives permission for the release of 'any relevant information', is not likely to be consistent with the principles of explicit consent. Consent does not need to be written, though a signed consent form is good practice. Informed consent does not last indefinitely. [An individual undergoing treatment] can withdraw consent at any time and should periodically be given the opportunity to do so.[59]

6.69 The use of an informed consent framework should be encouraged by service providers as a means of getting families more involved. Clients undergoing treatment drug problems should be offered this option as a matter of course at their initial appointment.

6.70 Obtaining informed consent is obviously difficult, however, from someone who is drug dependent, and may well also have co-occurring mental health issues (chapter eight). This committee has heard evidence that drug users often think or behave irrationally, often underestimate the extent and nature of their drug addiction, and may suffer from recurring psychoses and other mental illnesses.[60]

6.71 There may be scope within the existing regulations to disclose information to a family member where a person is deemed 'incapable' of giving or communicating consent. Under the National Privacy Principles, a health service can provide information to a 'person responsible' (a parent, spouse, sibling, close friend or carer) where the individual is physically or legally incapable of giving consent to the disclosure, or physically cannot communicate consent to the disclosure.

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59 National Health Service, National Treatment Agency for Substance Misuse, *Confidentiality and information sharing* (2003), p 5.

60 Colquhoun R, submission 73, p 1; Toughlove Victoria, submission 112, p 3; Riley M, submission 34, p 5; Quon M, submission 8, p 6; Mercer I, transcript, 30 May 2007, p 11.

6.72 Disclosure can occur:

- because it is necessary for the provision of appropriate care or treatment to the individual; or
- for compassionate reasons.

6.73 The disclosure should be limited to the information that is reasonable and necessary to achieve either of the above purposes. Also, it cannot occur if this is contrary to wishes expressed by the individual before losing the ability to give or communicate consent. Importantly, disclosure of information to a 'person responsible' does not, in itself, represent an entitlement for that person to make health care or medical treatment decisions for the individual.[61]

6.74 The extent to which this principle is translated into everyday clinical practice is unclear; certainly family members who gave evidence to this inquiry felt that they were unable to obtain information either for compassionate reasons or reasons of ongoing care, even when the drug user was thinking and behaving irrationally, unable to communicate or psychotic. This issue, with respect to ongoing care, was in fact raised by the Australian Medical Association in a submission to the 2004 review of the Privacy Act:

> The access provisions together with restrictions on access to patient information fail to take sufficient account of the patient's carer's need to know information about the patient. Not only is a carer required to provide an appropriate environment for the patient being cared for, but may need to know what medication the patient is required to take, the patient's condition on discharge from hospital, what problems they may encounter, and details of follow up appointments. Disclosure of this information to the carer is necessary for the patient's ongoing care, whether or not the patient consents.[62]

6.75 Health information privacy is complex, and the committee suggests that a review is needed to assess whether the current set of laws, regulations and ethical codes allow reasonable access to information

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61 Australian Government Office of the Privacy Commissioner, National Privacy Principles (Extracted from the *Privacy Amendment (Private Sector) Act 2000*), subclause 2.4; Australian Government Office of the Privacy Commissioner, *Guidelines on privacy in the private health sector* (2001), p 23.

62 Australian Medical Association, *Submission to the Review of the Private Sector Provisions of the Privacy Act* (2004), p 16.

for family members. Because disclosure, where it may occur, is still at the discretion of doctors, nurses, and drug counsellors, there also needs to be cultural change so that professionals better understand families' position and allow them access to information about another's treatment.

Recommendation 25

6.76 **The Department of Health and Ageing promote, as part of the next round of funding arrangements for non-government drug treatment agencies, models of explicit informed consent for giving families information, which include a discussion about information management with all drug users on their initial consultation with health professionals.**

The Attorney-General, in consultation with state and territory governments and professional bodies, review whether the National Privacy Principles and Information Privacy Principles adequately allow for the position of families of clients with drug addictions, particularly with respect to subclause 2.4 and the definition of a client who is incapable of giving or communicating consent, and particularly where:

- **families will be involved in the ongoing care of the client;**
- **the behaviour or state of the client in treatment suggests that families may be placed at physical risk; and**
- **families make a compassionate request to know of the client's whereabouts and state of health.**

Treating affected family members

6.77 Many families with a drug user experience high rates of anxiety, depression, affected job performance and marital stress and breakdown.[63] A parent told the committee that:

> Family members need long-term, robust support and training to ensure an integrated, empathetic approach to recovery. A family that is 'healing' from their exposure to addiction, who understands their role in the recovery process and is willing

63 Centacare NT, submission 60, p3.

> to be involved can be of great assistance in the recovery of the person coming off illicit drugs.[64]

6.78 Tonie Miller, a former member of the Australian National Council on Drugs (ANCD), told the committee that:

> Parents need to be encouraged to focus on their own needs and the needs of their other children, while the drug-using member can be referred to assistance, IF they will accept it. The needs of parents and other siblings are likely to have been forgotten in the family's efforts to impact on the drug-using member. It may have become the family's focus.[65]

6.79 Family Drug Help told the committee about some of the problems that can arise in a family where a member is using illicit drugs:

> Family members start to change when they acknowledge they have their own problem, and start to let go of forever trying to fix their addicted family member. The family member's problem is typically related to the drug use, but separate, such as:
>
> - I have no real relationship with my child;
> - All the family income goes on drugs;
> - My partner in not emotionally available to me;
> - I am scared to ask for my basic needs;
> - I am placing the needs of the addicted member above the needs of other family members;
> - My partner / child does not respect my home / my right to a peaceful / clean space; and
> - My friends no longer visit our house.[66]

6.80 Inquiry participants highlighted a range of treatment services that were specifically aimed at treating non drug-using family members.[67] Some examples of services targeting families funded under the Commonwealth's *Strengthening families* program include:

- The Women's Health Service in Perth through the Pregnancy, Early Parenting and Illicit Substance Use project has conducted support

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64 Drug Free Australia, submission 42, p 9.

65 Miller T, submission 78, p 4.

66 Family Drug Help, submission 76, p 7.

67 Glastonbury Child and Family Services, submission 74, p 6; Baldock E, Canberra Mothercraft Society, transcript, 28 May 2007, p 31; Smith L, Toughlove NSW, transcript, 3 April 2007, p 1; Family Drug Support, submission 15, p 2; Family Drug Help, submission 76, p 7.

groups for new mothers and their babies, children's art therapy groups, a recreational physical activity program and a training program for other service providers;

- Grandparents Raising Grandchildren (Tasmania) - the project aims to assist grandparents and other kinship carers raising children of drug-using people. Services provided include support and counselling (including regional support groups); case management (including brokerage for specialist services); advocacy; information and skill development for grandparents; and referral; and
- The Aboriginal Kinship Program in Adelaide assists Indigenous families by providing intensive case management to families and individuals affected by illicit drug use. Key strategies include case management, linking clients with other support agencies and brokerage funds. Work is also focused on case managing Aboriginal people who use illicit drugs through agencies such as corrections, police, prisoner support services and community health services.[68]

6.81 The main objectives of treatment programs for family members include:

- providing opportunities for non drug-using family members to engage in some normal social activities because the family has concentrated on supporting a drug user;[69] and
- peer support for parents / grandparents to share experiences and build self esteem.[70]

6.82 The Victorian Alcohol and Drug Association suggested that there was a need for resources to be provided for specialist family-oriented drug treatment services to develop capacity to advocate for and consult with families of drug users and that resources be given to general drug treatment services to develop referral protocols to family-oriented agencies.[71] A further suggestion was that the drug treatment

68 Australian Government Department of Families, Community Services and Indigenous Affairs, submission 172, p 4.

69 Odyssey House Victoria, submission 111, p 5.

70 Baldock E, Canberra Mothercraft Society, transcript, 28 May 2007, p 31; Family Drug Support, submission 15, p 5; Family Drug Help, submission 76, p 7.

71 Victorian Alcohol and Drug Association, submission 100, p 3.

sector develop standardised screening tools for clients that includes a method for gauging the needs of clients' families.[72]

6.83 The committee supports the provision of services to allow families to regain a sense of normal functioning and re-integrate into community life. It is important that drug treatment service providers are aware of the strains imposed on family members and are able to provide services to them or direct them to support services available elsewhere. The committee also believes that there is a need to both increase awareness about the need for family members to get treatment and support and to let families know where they can go for help.

6.84 The adoption of the committee's recommendation for a single point of contact about illicit drugs should provide an important access point for families to services for their drug-using family member, but also for themselves. It is important that the promotion of this new contact point, if adopted, highlights to families that they can also get help for their own needs.

Recommendation 26

6.85 **The Department of Health and Ageing, as part of the next funding round for the** *Non Government Organisation Treatment Grants Program* **give priority to funding services that help family members affected by a family member's drug use.**

Recommendation 27

6.86 **The Minister for Health and Ageing, in conjunction with the states and territories, develop:**

- **a range of standardised screening tools to identify the needs of families affected by a family member's drug use; and**
- **a set of referral protocols for families that need help in their own right to address the impact that caring for a drug-using family member has had on their lives.**

72 Victorian Alcohol and Drug Association, submission 100, p 3; Walsh C, submission 84, p 3.

6.87 Services have emerged that do assist families get support and advice. These include Toughlove, Family Drug Support, Grandparents Assisting Grandkids Support, Kinkare and Family Drug Help.[73] Local Drug Action Groups, a not-for-profit organisation in Western Australia that focuses on locally-based prevention strategies told the committee that:

> One of the most powerful ways of helping families is through the peer self-help process. Parents can listen to how others cope, realise they are not alone, possibly hold their heads up with pride again as they see other 'normal' parents in the same position, understand more about what their child is dealing with, pick and choose from approaches they hear in the group to suit their own situation. They need the input of professional information along the way, so that the choices they make are based on knowledge, not rumour or mis-information as is common in the drug field.[74]

6.88 A member of Toughlove, a not-for-profit parent support group, told the committee that:

> Toughlove has given us hope and strategies to take back control of our home and our lives. We have like minded parents who can support us at any time of the night or day when we are in crises not just during business hours. These parents have been through what we have gone through or similar. They are not judgemental and believe what we say we are going through, having gone through the heartache themselves.[75]

6.89 Another parent highlighted to the committee the benefits of belonging and contributing to parent support groups:

> I have been attending Parent Support Group meeting for around three years. Going to 'Group' has been the single most and best coping strategy for me. Just knowing that every other parent attending knows what you are going through and understands gives / gave me the strength to keep going. One of the best things about our 'Group' is the gentle but

73 Lubach M, Kinkare, transcript, 7 March 2007; Family Drug Support, submission 15, p 2; Local Drug Action Groups, submission 159, p 1; Toughlove NSW, submission 126, p 2; Toughlove Victoria, submission 112, p 1; Family Drug Help, submission 76, p 3.

74 Centacare Catholic Family Services, submission 116, p 15.

75 Toughlove Victoria, submission 112, p 3.

> constant reminder to look after ourselves. My family have and are also very supportive of myself.[76]

6.90 Peer-support groups provide an invaluable resource for members of families affected by drug use, building confidence, disseminating information and sharing experiences that can be crucial in improving family functioning. These groups can also strengthen a family's protective factors to prevent others in the family taking up drugs.

6.91 The committee considers that treatment services need to be aware of peer-support groups in their region and make parents and grandparents aware of the potential benefits that belonging to such a group can bring. Public campaigns about illicit drugs should also raise awareness about peer-support groups as a way of sharing experiences and building a defence against drug use in the rest of the family.

Mandatory treatment

6.92 By definition, illicit drug users are making impaired decisions, and are usually unable to realise the impact and consequences of their drug use. Compulsory treatment is successfully used in Sweden and logically should have a role to play in Australia.

6.93 Several inquiry participants expressed their support for a mandatory treatment regime, whereby drug users were coerced into treatment rather than relying on voluntary treatment models.[77] The committee understands that the ANCD have sponsored some Australian-based research into compulsory treatment models.[78]

6.94 The brother of a former drug addict told the committee about his frustrations in waiting until his brother was 'ready' to undergo treatment:

> … at no time during his dealings with 'the system' was my brother required to enter into a drug and alcohol treatment / rehabilitation program. During the times when I was feeling desperate about my brother's health, I rang

76 Name withheld, submission 161, p 1.

77 Name withheld, submission 155, p 2; Lopez J, submission 24, p 1; Drug Advisory Council of Australia, submission 37, p 2; Australian Family Association, submission 59, p 4; Australian Family Association SA Branch, submission 72, p 2.

78 Vumbaca G, Australian National Council on Drugs, transcript, 28 May 2007, p 43.

> different service providers for advice / help, to be told every time there was absolutely nothing could be done except to wait until my brother was ready to accept help for himself.[79]

6.95 There are various forms of coercive treatment that are in place in Australia built around the judicial system. Opportunities for directing drug users into treatment programs are provided along the various steps that drug users encounter as they progress through the judicial system. Spooner, Hall and Mattick summarised the general steps as:

- pre-arrest — when an offence is first detected, prior to a charge being laid. Diversionary measures here can include police discretion (e.g. offence detected but no action taken); an infringement notice (e.g. fine but no record); informal warning (no record); formal caution (verbal warning with record kept, but no further action); and caution plus intervention (i.e. warning and record, plus information or referral to an intervention program);
- pre-trial — when a charge is made but before the matter is heard at court. Measures can include treatment as a bail condition (e.g. no conviction recorded if treatment program completed successfully); conferencing; and prosecutor discretion (e.g. treatment offered as alternative to proceeding with prosecution);
- pre-sentence — after conviction but before sentencing. Includes measures such as delay of sentence where the offender may be assessed or treated. The process can include sanctions for non-compliance and incentives such as no conviction recorded;
- post-conviction / sentence — as a part of sentencing. Diversionary measures here include suspended sentences of imprisonment requiring compliance with specific conditions (e.g. participation in treatment, abstinence from drugs, avoidance of specific associates, etc.); drug courts (i.e. judicially supervised or enforced treatment programs); and non-custodial sentences involving a supervised order, probation or bond requiring participation in treatment as part of a sentence; and
- pre-release – i.e. prior to release from detention or gaol on parole. Options include transfer to drug treatment (e.g. while still in custody, being transferred to a secure residential treatment program which is supervised 24 hours a day) and early release to treatment such that an

79 McIntyre R, submission 81, p 4.

> inmate may be released early from detention into a structured, supervised treatment program.[80]

6.96 In 2005-06, almost 15,000 closed treatment episodes for illicit drugs were referred by police or court diversion initiatives.[81] This represents an increase of over 8,000 closed treatment episodes referred by police or court diversion programs compared with 2001-02.[82]

6.97 As noted previously, the Commonwealth is supporting the *Illicit drugs diversion initiative* to divert drug users from prison to undergo drug treatment. This is an important area to be pursued. The committee notes with interest that the Department of Health and Ageing has commissioned an evaluation of this initiative to assess:

- the costs and benefits of the initiative — conducted by the Allen Consulting Group;
- the long term impact of police drug diversion on reducing contact with the criminal justice system, including the identification of factors that contribute to delayed or reduced levels of re-offending and the seriousness of offending — conducted by the Australian Institute of Criminology; and
- the effectiveness of the initiative in rural and remote Australia — conducted by the Australian Institute of Health and Welfare.[83]

6.98 The committee looks forward to the public release of the evaluation reports, expected in the near future, following their consideration by the Intergovernmental Committee on Drugs.

6.99 The Tasmania Government noted that it will commence a pilot diversion program from July 2007 providing diversion for offenders at three different stages:

- bail diversion — allowing for shorter-term treatment as a post-plea option;

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80 Spooner C et al, 'An overview of diversion strategies for Australian drug-related offenders', *Drug and Alcohol Review* (2004), vol 20, pp 281–294.

81 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2005–06: Report on the National Minimum Data Set* (2007), cat no HSE 53, p 70.

82 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2001–02, Report on the National Minimum Data Set* (2003), cat no HSE 28, p 76.

83 Australian Government Department of Health and Ageing, submission 169, p 6; Australian Government Department of Health and Ageing, 'Senate Order on Departmental and Agency Contracts', viewed on 4 September 2007 at http://www.health.gov.au/internet/wcms/publishing.nsf/Content/D4F19A7423043FFCCA256F1800502554/$File/Health%20Senate%20Order%20Listing%200607.pdf.

- sentencing into drug treatment — allowing for longer-term treatment through the current range of sentencing options; and
- drug treatment order — allowing for supervised community-based drug treatment as an alternative to incarceration.[84]

6.100 The Queensland Government noted that an extensive evaluation of its diversion initiatives was also underway and was showing some evidence of a positive impact:

> An evaluation of the Drug Court Program in Queensland found that recidivism was reduced; few graduates re-offended and; average time to re-offending was longer than for comparison groups.
>
> … Evaluation of the Queensland Court Drug Diversion and Police Diversion programs (which fall under the Queensland Illicit Drug Diversion Initiatives) showed that both programs were very well received by all stakeholders and participating offenders. Offender self-reports indicated a 56 per cent reduction or cessation of use of cannabis at 6 month follow-up. A key point was a 28 per cent reduction in the number of court cases that would otherwise have occurred in the first two years of the program.[85]

6.101 Outside of the justice system, coercive treatment models can still be used by providing incentives, or disincentives, to participate in treatment programs. The Canadian Centre on Substance Abuse noted that:

> Coerced treatment refers to the delivery of substance abuse treatment services to individuals who are either reluctant or refuse to enter treatment unless they risk losing something important to them. For a single mother, it may be the thought of losing custody of her children; others may respond to a spouse's threat to leave unless the problem is addressed. In such cases, personal choice remains part of the process since the person can still refuse to attend treatment.[86]

6.102 A key benefit of community-based coercive treatment is that it leads to people undergoing treatment who otherwise may not seek

84 Tasmanian Government, submission 174, p 6.

85 Queensland Government, submission 173, p 5.

86 Canadian Centre on Substance Abuse, 'Mandatory and coerced treatment', viewed on 20 July 2007 at http://www.ccsa.ca/NR/rdonlyres/379BFB3A-02A1-49B3-9ABB-CCEF7EF9A811/0/ccsa0036482006.pdf.

treatment. This may be because they are in denial or do not recognise the impact of their drug use on those around them.[87]

6.103 In an Australian context, the committee considers that there are opportunities to introduce various forms of coercive treatment. In the words of one witness, 'coerced treatment is preferable to no treatment'.[88] Options include:

- linking welfare payment to undergoing drug treatment. One model requires mandatory drug testing for welfare recipients with those returning positive tests may be required to receive treatment and abstain from drug use or risk losing their benefits;[89]
- referral to treatment for drug use in pregnancy, as discussed in chapter four – this could include intervention by child protection authorities and imposing requirements for parents to graduate from treatment programs and stay drug-free in order to retain custody of children;[90]
- laws providing for parents and legal guardians to apply to a court to order their children into treatment for severe addictions. As part of a program implemented in Canada, a court will only grant forced confinement if a child is in danger to himself or others and all other means of treatment have been exhausted. During their confinement, which can last up to five days, service providers give supervised detoxification, assessment and support. Families also undergo counselling;[91] and
- mandatory random drug testing in schools, with children returning a positive test required to undergo treatment.[92]

6.104 A further option explored by the committee was the use of a 'rewards' or 'voucher' system to give people an incentive to be drug free (box 6.3).[93]

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87 Name withheld, submission 164, p 2; Centrelink, submission 128, p 6; Susan, transcript, 3 April 2007, p 74.

88 Homel R, transcript, 13 June 2007, p 21.

89 Macdonald S et al, 'Drug testing and mandatory treatment for welfare recipients', *The International Journal of Drug Policy* (2001), vol 12 no 3, pp 249–257.

90 Butler M, 'Pregnancy: Opportunity or invasion', *OfSubstance* (2007), vol 5 no 1, p 7.

91 Canadian Foundation for drug policy, 'Families using mandatory treatment program for youth', viewed on 20 July 2007 at http://www.mapinc.org/newscfdp/v07/n847/a06.html.

92 Bressington A, transcript, 23 May 2007, p 19.

93 Homel R, transcript, 13 June 2007, pp 21–22.

Box 6.3 Rewarding drug users to stay in treatment

Rewarding drug users for returning 'clean' drug tests during treatment or for continuing to attend treatment has been part of a number of relatively small-scale programs in North America.

Some examples of rewards-based incentives offered to drug users include:

- attendance at a clinic three times per week for drug testing. If testing clean, participants were granted as much as $US40 worth of vouchers that could be redeemed for things like food, gift certificates and rent money;
- a 24 week outpatient program for cocaine users involving one or two individual counselling sessions per week. Patients submit urine samples two or three times each week and receive vouchers for negative samples, with the value of vouchers increasing with consecutive clean samples. Patients may exchange vouchers for retail goods that are consistent with a cocaine-free lifestyle; and
- a program for homeless crack addicts that, for the first two months, required them to spend 5.5 hours daily in the program, which provides lunch and transportation to and from shelters. Interventions include individual assessment and goal setting, individual and group counselling, multiple psychoeducational groups. After two months of day treatment and at least 2 weeks of abstinence, participants graduate to a four month work component that pays wages that can be used to rent inexpensive drug-free housing. A voucher system also rewards drug-free related social and recreational activities.

Source *Ornstein C, 'Meth users respond to reward program'*, The Seattle Times *(2005), viewed on 22 July 2007 at http://www.uchc.edu/ocomm/newsarchive/news05/dec05/methusers.html; National Institute of Drug Abuse*, Principles of Drug Addiction Treatment: A research based guide, *Community reinforcement approach plus vouchers, viewed on 22 July 2007 at http://www.nida.nih.gov/PODAT/PODAT11.html.*

6.105 Professor Dawe told the committee about the experiences of rewards-based treatment approaches in North America:

> There is actually a lot of evidence that giving people, for example, supermarket vouchers and clothing vouchers et cetera for clean urines is effective. I think that is really interesting. You are not giving people money to buy drugs but you are rewarding people and helping people in that early stage of their recovery. Obviously there is a point at which you are going to have to stop giving people $20 gift vouchers for clean urine, but in those early stages of recovery that has also been found to be really effective, particularly

> with cocaine, because, of course, there is no replacement therapy available for cocaine addiction.[94]

6.106 In terms of the models presented here, the committee believes that a mandatory referral and treatment model for children aged up to 17 years is attractive, where voluntary-based treatment approaches have failed. Such an approach recognises the importance of intervening early to prevent long-term damage. Implementing such a model, however, is likely to require significant changes to state-based legislation and an expansion of treatment service capacity.

6.107 The committee considers that given the importance of such an initiative, the Commonwealth should make an appropriate contribution to the likely additional cost in expanding the drug treatment system. In the short term, the Commonwealth could examine implementing the model on a staged state-by-state basis.

Recommendation 28

6.108 **The Commonwealth Government:**

- **enter negotiations with the states and territories to change legislation to allow for children aged up to 18 years to be placed in mandatory treatment for illicit drug addiction with an organisation or individual which has as its treatment goal making individuals drug free; and**
- **provide the appropriate funds required to increase capacity to assist children and the families of those made subject to mandatory treatment.**

6.109 The committee is also attracted to rewards-based treatment models for drug users. The committee considers that the Commonwealth should undertake further research on implementing such a model in Australia and fund several small-scale trials of various approaches.

94 Dawe S, transcript, 13 June 2007, p 21.

Recommendation 29

6.110 **The Department of Health and Ageing:**

- **undertake research on the implementation of a rewards-based model for drug treatment participation in Australia that offers drug users positive incentives to undergo treatment; and**
- **conduct a number of small-scale trials across Australia to examine the effectiveness of a rewards-based treatment participation approach.**

Dual diagnosis treatment

6.111 As noted in chapter eight, dual diagnosis presents many difficulties for treatment and rehabilitation that are a frustration to families as well as a cost to the community. In addition to the complications brought on by uncertain interactions between illicit drug use and mental illness, the committee heard how the shifting back and forth of responsibility between mental health and drug treatment services ultimately puts an added burden of care on families.[95]

6.112 Many of the recommendations above will assist sufferers of dual diagnosis as well as their families, as they too need access to information about services and treatments, family-inclusive treatment, and transitions between counselling, detoxification, rehabilitation and aftercare.

6.113 Treatment for dual diagnosis can be more complex, however. Firstly, given that clinical recognition of co-occurring drug use and mental disorders is fairly recent, there is not consensus on the best form of treatment.[96]

6.114 Some of this derives from disagreement over the scientific evidence on the basis for co-occurring mental disorders and illicit drug use. There is also a lack of research on the potential interactions between prescription psychiatric drugs and antidepressants with illicit drugs of uncontrolled quantity, purity and content. For example, both the ANCD and Beyondblue note that more research is needed on

95 Walsh C, submission 84, p 3.

96 NSW Health, *The management of people with a co-existing mental health and substance use disorder: Discussion paper* (2000), p 15.

potential for toxic side effects between the use of psychiatric medications (antipsychotics) and methamphetamines.[97]

6.115 There are three basic models of service provision for treating people with comorbid disorders:

- serial treatment – treating one disorder before treating the other, often the one that presents the most acute problems (such as psychosis);
- parallel treatment – treating both disorders at the same time through different providers, for example, a patient in a drug rehabilitation program also attending a psychiatrist having first detoxed; and
- integrated treatment – in which the same individual, team or service provides both mental health and drug use treatments simultaneously.[98]

These models have advantages and disadvantages, and may need to be individually suited to drug users depending on the severity of their drug use relative to their mental health problems and other circumstances surrounding their treatment – for example, if they have dependent children, or if they are able to travel to access services.

6.116 As a NSW Health report noted in 2000, despite the fact that people with dual diagnosis use health services more than people with a single disorder, there are very few specialist services which focus on the ongoing care and management of individuals affected by both disorders.[99] For most drug users, a lack of communication and cultural differences between the mental health and drug treatment sectors mean that they are 'falling through the gaps' in the treatment system.

97 Beyondblue, submission 151, p 2.

98 Teesson M and Proudfoot H, eds, National Drug and Alcohol Research Centre, *Comorbid mental disorders and substance use disorders: Epidemiology, prevention and treatment* (2003), p 133.

99 NSW Health, *The management of people with a co-existing mental health and substance use disorder: Discussion paper* (2000), p 9.

Box 6.4 Involuntary legal scheduling for mental health patients

There are different mechanisms for involuntary treatment and care according to state or territory mental health legislation. The states and territories also differ in who has the authority to 'schedule' a patient, what length of time they can be detained and for what purposes.

In New South Wales, a person may be detained in a psychiatric hospital if they fall within the definition of 'mentally ill' or 'mentally disordered' and have an 'involuntary legal schedule' applied to them. A person cannot be considered mentally ill solely because they take drugs.

A mentally ill person is defined as someone experiencing hallucinations, delusions, serious thought disorder, serious mood disorder or sustained irrational behaviour suggesting the presence of one of these symptoms.

A mentally disordered person is defined as someone whose behaviour is so irrational that they place themselves or someone else at risk of serious physical harm. A mentally disordered person can only be kept in hospital for a maximum of three working days and a doctor must examine them every 24 hours. A person cannot be admitted this way more than three times each month.

The most common way a person is detained in a psychiatric hospital is by a doctor completing a certificate that states that the person is mentally ill or mentally disordered. This certificate is called a Schedule 2. The doctor may only complete the certificate if she or he has seen the person and considers that no care other than hospital treatment is appropriate and available.

As soon as possible after admission to hospital, the person will be examined by another doctor. If that doctor considers the person to be mentally ill or mentally disordered, a second examination will be arranged. If not, the person will be discharged. If after two (or, in some circumstances, three) examinations, the medical superintendent considers the person to be mentally ill, then she or he will be brought before a magistrate. The magistrate will conduct a hearing to decide whether the person needs to remain in hospital. The person must be represented by a lawyer at the magistrate's hearing unless she or he decides otherwise.

There is no national data for the use of involuntary treatment orders. In New South Wales in 2005, 10,015 mental health patients were involuntarily admitted to hospital on a doctor's certification.

Source *NSW Health website, viewed on 28 August 2007 at http://www.health.nsw.gov.au/legal/pdf/mentalhealthip1.pdf and http://www.health.nsw.gov.au/legal/pdf/mentalhealthip2.pdf; New South Wales Government, Mental Health Review Tribunal , Annual Report 2005 (2006), p 41; Mental Health Act, Frequently Asked Questions about the Mental Health Act 1990 (NSW), http://www.cs.nsw.gov.au/Mhealth/consumer/faq_mentalhealthact.html#3.*

6.117 King Edward Memorial Hospital for Women, for example, said that existing services did not have the necessary capacity or expertise to manage clients they were seeing who were undergoing drug-related psychoses shortly after giving birth:

> Mothers who become psychotic in the peri-natal period require specialised support for themselves as well as their infant. This is likely to become an increasing problem with the rise in use of methamphetamines with its serious associated risks on mental health. Existing services do not adequately manage these mothers who have a dual diagnosis of mental illness and substance misuse issues.[100]

6.118 Also in Perth, the Western Australian Network of Alcohol and other Drug Agencies reported that the demands of clients with co-occurring mental health disorders, psychosis in particular, were putting strain on drug treatment services. This was stretching existing resources, adding to workload and training issues, and causing occupational health and safety concerns.[101]

6.119 The Gold Coast Drug Council also reported an acute shortage of dual diagnosis counsellors and treatment options on the Gold Coast:

> There are no specialist counsellors on the ground in the Gold Coast. You really have to understand this. We have this huge growth… We just do not have the resources and counsellors on the ground to deal with this. The person who is seeking help is turned away versus their parents versus their grandparents. There are simply not the services to go around.
>
> As we said, we are expecting an explosion at Coomera. I treat one in 10. As far as I understand, Mirikai is the only dual diagnosis therapeutic community in the country that is public. We are just saying no, no, no.[102]

6.120 The committee anticipates that significant recent investments by the Commonwealth may alleviate some strain in this area of health service delivery. As detailed in chapter eight, the National Comorbidity Initiative (2003-04 to 2007-08) and the Council of Australian Governments (COAG) National Action Plan on Mental Health 2006–2011 have allocated over $105 million to co-occurring

100 King Edward Memorial Hospital for Women, submission 19, p 5.

101 Western Australian Network of Alcohol and other Drug Agencies, submission 138, p 3.

102 Alcorn M, Gold Coast Drug Council, transcript, 7 March 2007, p 31.

drug use and mental health disorders; to provide more services, train and develop the workforce, and raise community awareness.[103]

6.121 Other jurisdictions have also invested in dual diagnosis services. The Victorian Government, for example, has established four dual diagnosis teams to assist clinical and mental health services and drug treatment services across the state to achieve better outcomes for clients with dual diagnosis.[104] In 2006, dual diagnosis was identified as a state-wide training priority for all clinical mental health services.[105]

6.122 The committee commends the substantial investment in dual diagnosis by the Commonwealth and State governments.

103 Australian Government Department of Health and Ageing website, 'National Comorbidity Initiative', viewed on 25 July 2007 at http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-pubhlth-strateg-comorbidity-index.htm#project7; Council of Australian Governments, *National Action Plan on Mental Health 2006-2011* (2006), pp 9–10.

104 Victorian Government Department of Human Services, *Dual diagnosis: Key directions and priorities for service development* (2007), p 12.

105 Victorian Government Department of Human Services, *Dual diagnosis: Key directions and priorities for service development* (2007), p 19.