Chapter 2

Demand and treatment policies

2.1 This chapter's theme aligns with demand reduction measures in the National Drug Strategy (NDS), but does not provide a detailed description of how alcohol and other drug (AOD) treatment services are implemented and funded across all jurisdictions in Australia, as this is outside the scope of this report.

2.2 The chapter provides a brief overview of the AOD treatment sector, followed by an update on Australia's amphetamine treatment profile for 2015–16 and discussion of the implementation of the National Ice Action Strategy (NIAS).

2.3 The chapter then turns to the issues raised by submitters after the release of the National Ice Taskforce's (NIT) final report and the NIAS, specifically:

- waiting lists to access AOD treatment services;
- residential treatment services;
- private/for-profit treatment services;
- mandatory residential treatment; and
- methamphetamine use and treatment in correctional facilities.

2.4 The chapter concludes by outlining the most recent developments in pharmacotherapy treatment options for crystal methamphetamine use.

Overview of the alcohol and other drug treatment sector

2.5 Australia's AOD treatment sector is complex and diverse. The regulation of the AOD sector is largely the responsibility of each state and territory, and each jurisdiction has its own AOD policies. The interplay between Commonwealth, state and territory funding and policies make the AOD sector a complex policy area. Within each jurisdiction, there are numerous AOD treatment options, primarily separated between specialist and generalist systems of care.

2.6 The specialist AOD treatment system provides drug withdrawal support, psycho-social therapies, residential rehabilitation and pharmacotherapy maintenance. The generalist service system is primarily distinguished by services administered through primary care (general practitioners (GPs)) and general hospitals. The general service system provides treatment types, such as GPs offering pharmacotherapy

maintenance and brief interventions, clinical psychologists proving psycho-social therapy and general hospitals providing withdrawal services.[1]

2.7 There is a range of AOD treatments available in Australia. The primary treatment categories are:

- withdrawal or detoxification programs;
- psycho-social therapies (such as counselling or psychotherapy);
- residential rehabilitation; and
- pharmacotherapy maintenance.[2]

2.8 Within these four key categories are assessments, case management and support, information and education, and aftercare services. These services can be provided via telephone, outreach, group-based and on-line programs.[3]

2.9 This diversified AOD treatment sector provides drug users with an array of treatment options. The Alcohol, Tobacco and other Drugs Council of Tasmania (ATDC) highlighted the importance of this diversity. It explained that drug users access the treatment sector at various points and have numerous needs.[4] Those presenting with a drug issue are very likely to have other associated issues, for example:

> There are some people who will need housing first and then we will fix the drug issue later, or there are some people that have a mental health issue first and then we will fix the AOD issue later, or we need to fix the alcohol and other drugs issue first and then fix the other things after that. I do not think there is any one type of person that actually comes in. I think that people come in with a range of many different types of issues, so we need to have choice in terms of treatment options. There are certain places that some people would not want to go to, so it is about providing choice. I would currently say that we do need more choice and we need more treatment in our treatment mix.[5]

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1 Professor Alison Ritter, Dr Lynda Berends, Dr Jenny Chalmers, Mr Phil Hull, Dr Kari Lancaster and Ms Maria Gomez (Ritter et al.), *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, National Drug and Alcohol Research Centre (NDARC), July 2014, p. 25, http://www.health.gov.au/internet/main/publishing.nsf/content/FD5975AFBFDC7013CA258082000F5DAB/$File/The-Review-of-alcohol-and-other-drug-treatment-services-in-Australia.pdf (accessed 21 December 2017).

2 Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, NDARC, July 2014, p. 25.

3 Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, NDARC, July 2014, p. 25.

4 Dr Jacqueline Hallam, Policy and Research Officer, Alcohol, Tobacco and other Drugs Council of Tasmania (ATDC), *Committee Hansard*, 24 March 2017, p. 8.

5 Dr Hallam, ATDC, *Committee Hansard*, 24 March 2017, p. 8.

2.10 This treatment mix is implemented and funded by Commonwealth, state and territory governments. The National Drug and Alcohol Research Centre's (NDARC) Drug Policy Modelling Program conducted a review of Australia's AOD treatment services (New Horizons report) from July 2014. The report highlighted the complexities of AOD funding in a federated system and attempted to detail the roles of and funding arrangements across Australian jurisdictions. In general terms, the report explained the shared responsibility for healthcare services across Australia:

> States and territories have responsibility for hospital services, the Commonwealth is responsible for funding medical services, and there is shared responsibility for community care and disability services. In more common terms, the Commonwealth funds primary care and pharmaceuticals (through Medicare and [the Pharmaceutical Benefits Scheme]) and the states/territories manage hospitals (with pooled funding from the Commonwealth and state).[6]

2.11 The New Horizons report added that the division of responsibilities between these two levels of government is hard to clarify, and debate about the roles and responsibilities of governments is common.[7] Further, the broad distinction 'does not assist in clarifying respective roles in AOD treatment funding or provision, as it is neither primary care nor hospital services'.[8] The Commonwealth government, however, plays a vital role in allocating funding to the AOD sector (as of 2014 the Commonwealth government provided 39 per cent of all government funding). Further, the NDARC identified four key Commonwealth responsibilities:

- advancing national priorities;
- providing leadership in planning;
- addressing service quality; and
- supporting equity.[9]

2.12 According to the NDARC:

> These responsibilities are fulfilled through investment in direct service delivery and capacity building projects, along with leadership for the nation in planning, quality frameworks and ensuring equity.[10]

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6 Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, NDARC, July 2014, p. 248.

7 Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, NDARC, July 2014, p. 248.

8 Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, NDARC, July 2014, p. 248.

9 Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, NDARC, July 2014, p. 254.

10 Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, NDARC, July 2014, p. 265.

2.13 Professor Steve Allsop, from the National Drug Research Institute (NDRI) at Curtin University, discussed the complexities of AOD use, its treatment and how to adequately respond to methamphetamine use in Australia. Professor Allsop opined that key challenges in responding to methamphetamine problems are 'about establishing well-resourced, evidence-based and enduring prevention strategies'.[11] An adequate response is not driven by warnings to the public about the dangers of crystal methamphetamine use; instead, it is about developing:

> …coordinated investment in addressing the social and other determinants of drug use and methamphetamine use in particular. It is about schooling; it is about employment opportunities; it is about poverty; it is about availability—there are a wide range of factors that need to be addressed.[12]

2.14 In addition, Professor Allsop argued that governments need to 'ensure more and enhanced access to treatment' services.[13] He noted that many people, especially in remote areas, are not able to access timely help when it is needed.[14] Further, governments need to ensure access to treatment that is effective; that is evidence-based treatment:

> ...that addresses the wide range of harms that arise from methamphetamine use, whether that be infectious disease, other physical health problems, and mental health problems; and it means ensuring that access to quality of life is a major focus of treatment outcomes. It is not just about stopping someone using drugs; it is about improving the quality of their lives. It is about establishing effective evidence-based pharmacotherapies…which is a significant gap in our available treatment package at the moment.[15]

2.15 Professor Allsop felt that there needs to be a system in place:

> …that is responsive to changes in patterns of drug use and related problems, because they do change. We do not want to lock ourselves into one way of doing things, addressing one single drug. Most people with drug problems do not have one single drug problem; they have an array of social, legal and other problems, but often they use other substances as well.[16]

Amphetamine treatment profile in 2015–16

2.16 In 2017, the Australian Institute of Health and Welfare (AIHW) published the *Alcohol and other drug treatment services in Australia 2015–16 report*. The report estimates that 134 000 clients had received treatment in 2015–16, an increase since 2013–14 (119 000). This total equates to 1 in 180 people seeking AOD treatment

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11 Professor Steve Allsop, Project Leader, National Drug Research Institute (NDRI), Curtin University, *Committee Hansard*, 3 May 2017, p. 31.

12 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 31.

13 Professor Allsop, NDRI, Committee Hansard, 3 May 2017, p. 31.

14 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 31.

15 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 31.

16 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 32.

services in 2015–16. Fourteen per cent of those presentations were by Aboriginal and Torres Strait Islander peoples.[17]

2.17 AOD service providers facilitated approximately 207 000 treatment episodes in 2015–16, an average of 1.5 episodes per client.[18] Seventy-nine per cent of treatment episodes were closed within three months.[19] Eleven per cent of clients that received treatment in 2015–16, had received treatment in 2013–14 and 2014–15.[20]

2.18 The AIHW reported that the number of treatment episodes for amphetamines had increased by 175 per cent over the past five years, more than doubling from 16 875 treatment episodes in 2011–12 to 46 441 in 2015–16.[21] There were 67 789 closed treatment episodes for amphetamine use in 2015–16.[22] Of this total, 46 441 (23 per cent) treatment episodes listed amphetamine as the principal drug of concern, and 21 348 (11 per cent) as the additional drug of concern.[23]

2.19 Despite the increase in amphetamine presentations, alcohol remained the most prevalent reason for treatment episodes (32 per cent); however, over the past five years alcohol has decreased by 6 per cent.[24] In contrast, treatment for cannabis has increased by 40 per cent over the same five year period.[25]

2.20 The AIHW reported that Indigenous Australians (782 per 100 000 people), who sought treatment for amphetamine as the principal drug of concern were more likely to receive treatment than non-Indigenous Australians (115 per 100 000 people).[26] The AIHW reported that:

> Although a small number of episodes were reported nationally for Indigenous clients for whom amphetamines were a principal drug of concern (almost 7,000), this represents a larger proportion of the Indigenous population across Australia compared with the non-Indigenous population.[27]

2.21 Treatment providers also saw increases in the number of episodes for clients injecting (38 per cent of episodes), and smoking and inhaling (50 per cent of episodes)

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17 Australian Institute of Health and Welfare (AIHW), *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. vii, https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2015-16/contents/table-of-contents (accessed 21 December 2017).

18 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. vii.

19 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. vii.

20 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. vii.

21 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 16.

22 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 18.

23 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 18.

24 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. vii.

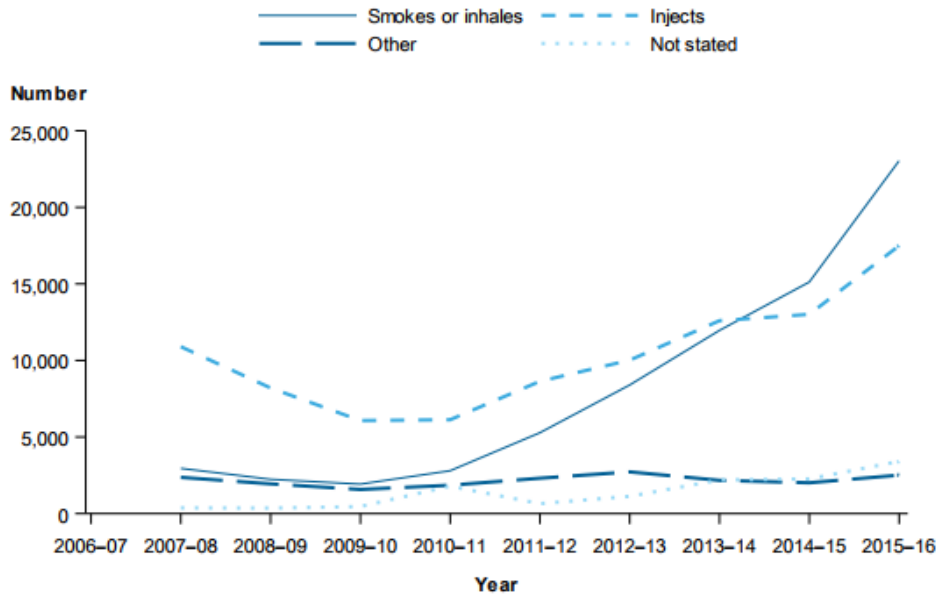
25 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. vii.

26 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 27.

27 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 27.

amphetamine.[28] More than four times as many clients were smoking or inhaling amphetamine in 2015–16 as in 2011–12.[29] Figure 1 shows closed treatment episodes with amphetamine as the principal drug of concern, by the method of use.

Figure 1: Closed treatment episodes for own drug use with amphetamine as the principal drug of concern, by method of use, 2006–07 to 2015–16[30]



Note: 'Other' includes 'ingests', 'sniffs' and 'other'.

2.22 In 2015–16, 69 per cent of amphetamine treatment episodes were for male clients.[31] Most clients that had registered amphetamine as the principal drug of concern were aged 20–39 (74 per cent), followed by those aged 40–49 (16 per cent).[32] For Indigenous Australians, the proportion of clients that sought treatment between the ages of 10–19 was higher compared with non-Indigenous clients of the same age, 10 per cent and 6 per cent respectively.[33]

2.23 Amphetamine users were primarily self-referred or referred by a family member (42 per cent) to treatment services, followed by referrals from health services (24 per cent) and diversionary programs (18 per cent).[34]

2.24 The most common treatment type in 2015–16 for amphetamine use was counselling (38 per cent, which had declined over the past five years (45 per cent in

28 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 27.

29 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. vii.

30 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 30.

31 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 27.

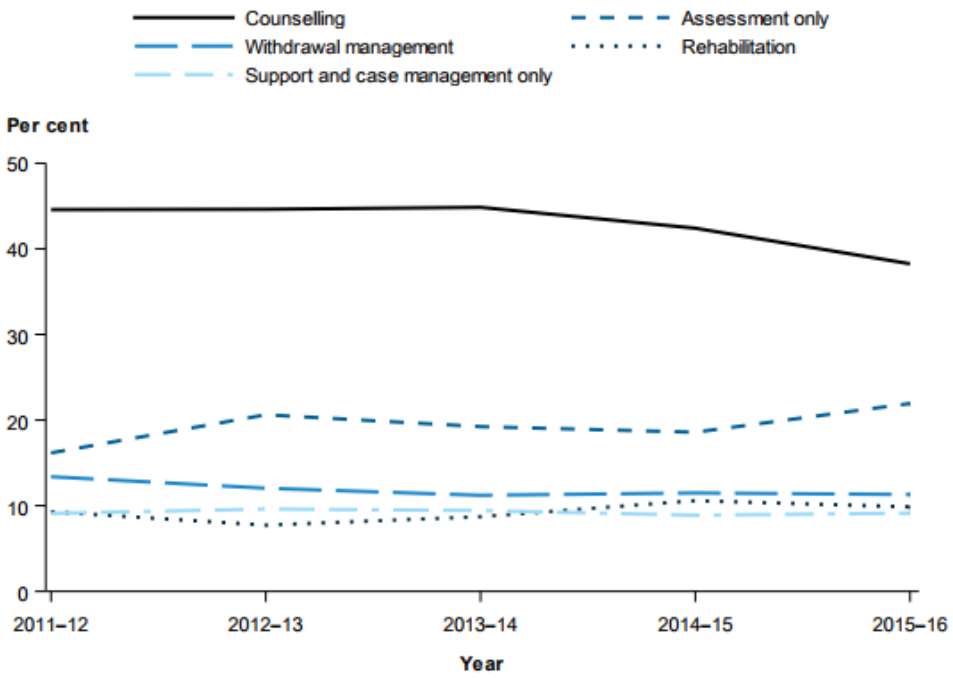
32 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 27.

33 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 27.

34 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 28.

2011–12)),[35] followed by assessment only (22 per cent) and withdrawal management (11 per cent).[36] Treatment programs were more likely to be conducted in a non-residential treatment facility (68 per cent).[37] Figure 2 shows closed treatment episodes with amphetamine as the principal drug of concern, with the top five treatment types received between 2011–12 to 2015–16. Figure 3 shows the main treatment types and selected drug of concern, including amphetamine, from 2013–14 to 2015–16.

Figure 2: Closed treatment episodes with amphetamine as the principal drug of concern, by the top five treatment types, 2011–12 to 2015–16[38]



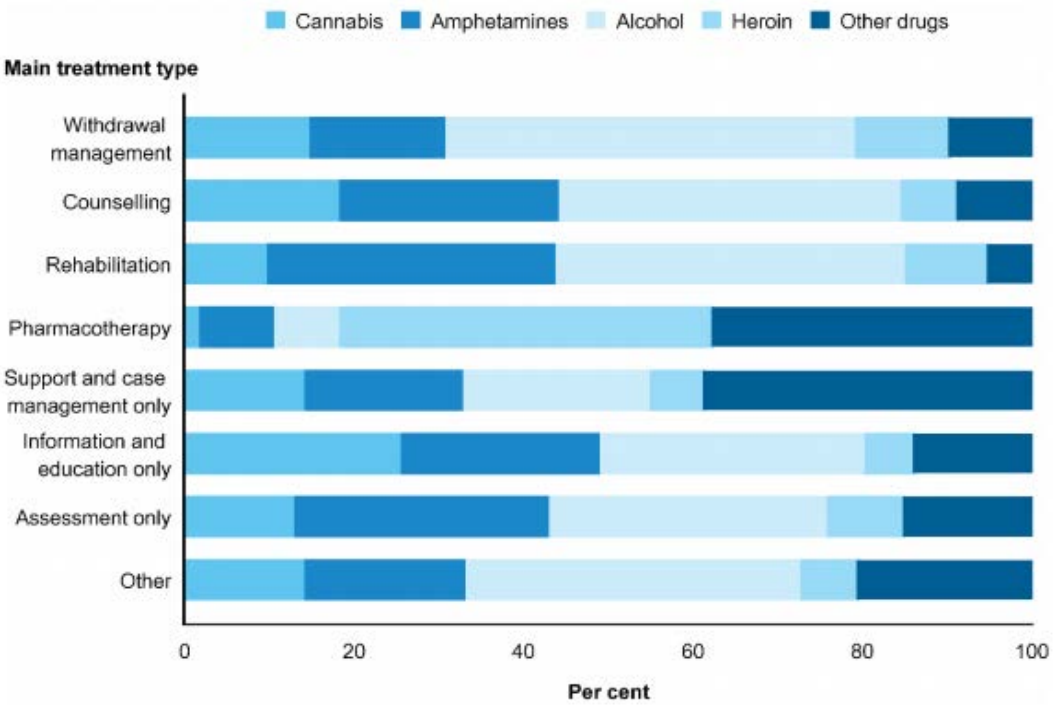
35 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 28.

36 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 28.

37 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 28.

38 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 29.

Figure 3: Clients received treatment in all three years, 2013–14, 2014–15 and 2015–16, by main treatment type and selected drugs of concern (%)[39]



2.25 Fifty-two per cent of closed treatment episodes with amphetamines listed as the principal drug of concern lasted less than one month.[40] Twenty-three per cent were closed within a day and were mostly for assessments only.[41] The median duration of a treatment episode for amphetamine was 28 days, but varied depending on treatment type.[42] For example, the median timeframe for counselling services was 57 days, seven days for withdrawal management, and one day information and education.[43]

2.26 The majority of closed treatment episodes (62 per cent) were completed at the expected cessation time.[44] In these instances, a higher success rate was reported for those clients that were self- or family referred (41 per cent).[45] Twenty-four per cent of closed treatment episodes ended unexpectedly.[46]

Update on the implementation of the National Ice Action Strategy

2.27 Upon their release part way through the committee's inquiry, the NIT and the NIAS addressed a range of issues that had been identified by submitters and witnesses

39 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 48.

40 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 29.

41 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 29.

42 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 29.

43 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 29.

44 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 29.

45 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 29.

46 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 29.

during the course of the inquiry. As already stated in the committee's first report, the committee supports all 38 recommendations in the NIT's final report and the NIAS in its entirety.

2.28 As of 3 July 2017, the following treatment and demand reduction objectives under the NIAS had been implemented:

- Work by the Alcohol and Drug Foundation (ADF) to establish 220 Local Drug Action Teams (LDATs) across Australia by 2020 is underway. The first round saw the establishment of 40 teams across Australia, representing 160 partnerships across local councils, service providers, schools, police and non-government organisations. The objective of the LDATs is to work together to address the harms of drugs, especially crystal methamphetamine, on local communities.[47] Applications are currently open for the third round of the program.[48]
- On 21 March 2017, the ADF launched the *Tackling Illegal Drugs* module as part of its Good Sports Program. The $4.6 million in program funding is intended to help communities build the capacity and confidence to address local illicit drug issues and harms within sporting communities. Over 1200 sporting clubs, many of which are from rural and remote communities, are delivering this initiative.[49]
- On 3 April 2017, the government launched the *Cracks in the Ice* online toolkit. It provides publicly accessible, factual and evidence-based information about crystal methamphetamine to community groups, local councils, parents, friends, teachers, students and frontline service providers.[50]
- The allocation of funding for treatment services through the Public Health Networks (PHNs) (see chapter 5 for further details).[51]
- In October 2016, Turning Point launched the expanded Counselling Online service to provide free counselling for people using AOD, their family and friends.[52]
- In September 2016, the NDARC released the revised *National Comorbidity Guidelines*. The purpose of these guidelines is to increase 'the knowledge and awareness of co-occurring mental health condition in alcohol and other drug treatment settings, improve the confidence and skills of AOD workers, and

47 Department of Health (DoH), *National Ice Action Strategy,* 3 July 2017, http://www.health.gov.au/internet/main/publishing.nsf/Content/MC15-009596-national-ice-taskforce (accessed 7 December 2017).

48 Alcohol and Drug Foundation (ADF), *Local Drug Action Team Program,* https://adf.org.au/programs/local-drug-action-teams/ (accessed 7 December 2017).

49 DoH, *National Ice Action Strategy*, 3 July 2017.

50 DoH, *National Ice Action Strategy*, 3 July 2017.

51 DoH, *National Ice Action Strategy*, 3 July 2017.

52 DoH, *National Ice Action Strategy*, 3 July 2017.

increase the uptake of evidence-based care'.[53] The revised guidelines include the most up-to-date evidence of best-practice, and were updated in consultation and collaboration with clinicians, researchers, consumers and carers from across Australia. The NDARC is currently developing an online training tool to accompany the second edition of these guidelines.[54] And,

- From 1 July 2016, the Commonwealth government allocated $1.7 million over four years for the University of Adelaide to continue to develop and expand its Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) and Brief Intervention (BI) (ASSIST-BI) across the primary health, mental health, and emergency care sectors and the community correctional setting. The ASSIST-BI is a tool for health professionals to screen for hazardous or harmful use of illicit drugs, tobacco and alcohol.[55] Presently, ASSIST-BI is 'the only screening instrument responsive to changes in drug use patterns as it screens for the use of alcohol, tobacco, amphetamines, cannabis, cocaine, inhalants, opioids, sedatives and hallucinogens'.[56]

Committee comment

2.29 The committee urges Commonwealth, state and territory governments to continue to implement the recommendations and strategies established by the NIT and NIAS as a matter of priority.

Key issues: treatment and demand reduction measures

2.30 This section considers a number of key issues faced by the AOD treatment sector. Many of these issues remain unresolved, despite the initiatives implemented as part of the NIAS.

Waiting lists for alcohol and other drug treatment services

2.31 A concern consistently expressed to the committee during the course of the inquiry is the long waiting lists faced by individuals seeking to access AOD treatment services, particularly residential treatment facilities. Centracare,[57] the National Association of People with HIV Australia and Positive Life NSW,[58] The Salvation Army,[59] the Ted Noffs Foundation,[60] Professor Nadine Ezard,[61] the Queensland

53 DoH, *National Ice Action Strategy*, 3 July 2017.

54 DoH, *National Ice Action Strategy*, 3 July 2017.

55 DoH, *National Ice Action Strategy*, 3 July 2017.

56 DoH, *National Ice Action Strategy*, 3 July 2017.

57 Ms Helene Nielson, Assistant Executive Manager, Centracare, *Committee Hansard*, 28 July 2015, p. 45 and p. 47.

58 Mr Craig Cooper, Secretary, Treasurer and Chief Executive Officer, National Association of People with HIV Australia and Positive Life NSW, *Committee Hansard*, 29 July 2015, p. 21.

59 Ms Kathryn Wright, Territorial Drug and Alcohol Director, The Salvation Army, *Committee Hansard*, 29 July 2015, p. 29.

60 Mr Mark Ferry, Chief Operating Officer, Ted Noffs Foundation, *Committee Hansard*, 29 July 2015, p. 52.

Network of Alcohol and Other Drug Agencies[62] and Queensland Health[63] all voiced concern about long waiting lists for residential rehabilitation and counselling services for people presenting with crystal methamphetamine and other AOD issues.

2.32 Long waiting lists are largely due to the number of people seeking access to limited AOD treatment services. Research by the NDARC in 2014 estimated that approximately 200 000 people access AOD treatment services in Australia each year.[64] Despite the significant number of people that are provided with support, the NDARC conservatively estimated that unmet demand (the 'number of people in any one year who need and would seek treatment') is between '200 000 and 500 000 people *over and above* those in treatment in any one year'.[65] The New Horizons report remarked that overall 'there is substantial unmet demand for AOD treatment' in Australia.[66]

2.33 Prior to the release of the NIT final report/NIAS, the Victorian Alcohol and Drug Association (VAADA) expressed concern about waiting times and access to treatment:

> The waiting times, however, are often lengthy and difficult for people, and that creates a range of waiting lists and threshold problems for people coming in and not being able to come in when the availability is there.
>
> Whatever the perception, there is a need to reaffirm the efficacy of the AOD treatment sector in addressing issues related to methamphetamine dependence and, moreover, ensuring that treatment is readily available to the community when people require it.[67]

2.34 In 2017, ATDC advised the committee that there remains a need to address long waiting lists for people accessing AOD treatment services in both Tasmania and around the country.[68] People based in regional and remote areas are particularly impacted because they do not have the treatment options available to people based in urban areas such as Hobart.[69] The ATDC noted that, anecdotally, people are waiting

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61 Professor Nadine Ezard, St Vincent's Hospital, *Committee Hansard*, 29 July 2015, p. 73

62 Ms Rebecca MacBean, Chief Executive Officer, Queensland Network of Alcohol and Other Drug Agencies (QNADA), *Committee Hansard*, 30 July 2015, p. 3.

63 Mrs Rebecca Armitage, Allied Health Manager, Metro North Mental Health, Alcohol and Drug Service, Queensland Health, *Committee Hansard*, 30 July 2015, p. 27.

64 Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, NDARC, July 2014, p. 13.

65 Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, NDARC, July 2014, p. 13.

66 Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, NDARC, July 2014, p. 183.

67 Mr Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association (VAADA), *Committee Hansard*, 27 July 2015, p. 31.

68 Dr Hallam, ATDC, *Committee Hansard*, 24 March 2017, p. 10.

69 Dr Hallam, ATDC, *Committee Hansard*, 24 March 2017, p. 10.

up to eight to 10 weeks for treatment services, such as counselling, case management or other support services.[70] Specifically, the ATDC reported that the north-west coast area of Tasmania has minimal access to AOD and mental health services.[71]

2.35 The committee questioned Holyoake Tasmania about reports of it having to send people to mainland Australia for AOD treatment services.[72] Holyoake Tasmania confirmed this and advised that it was doing so because there are insufficient detoxification beds available in the state.[73]

2.36 In a position paper from August 2017, the Australian Medical Association (AMA) re-iterated calls to increase the availability of treatment services to address long wait times. The AMA stated that the 'lack of treatment services affects patient outcomes'[74] and 'waiting for extended periods of time to access treatment can reduce an individual's motivation to engage in treatment':[75]

> In most instances demand for treatment outweighs its availability. This can mean people wait for extended periods to access treatment, which can results in withdrawal and deteriorations in motivation to engage in treatment. Timeliness in accessing suitable treatment is vital.[76]

2.37 Professor Allsop commended efforts by the Commonwealth, state and territory governments to address the demand for treatment services; however, Professor Allsop argued there remains 'an enormous unmet need, and it is in the access to that service'.[77] Professor Allsop added that it was not just about the location of a service, but also the hours it is open, and whether it meets the needs of the individual or particular group seeking to access the service.[78]

2.38 On 30 May 2017, the Senate Standing Committee on Community Affairs (Community Affairs Committee) and the Department of Health (DoH) discussed the collection of national data on average wait times for accessing residential

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70 Dr Hallam, ATDC, *Committee Hansard*, 24 March 2017, p. 11.

71 Dr Hallam, ATDC, *Committee Hansard*, 24 March 2017, p. 11.

72 Ms Sarah Charlton, Chief Executive Officer (CEO), Holyoake Tasmania, *Committee Hansard*, 24 March 2017, p. 16.

73 Ms Charlton, Holyoake Tasmania, *Committee Hansard*, 24 March 2017, p. 16.

74 Australian Medical Association (AMA), *Harmful substance use, dependence and behavioural addiction (Addiction) – 2017*, AMA position, https://ama.com.au/position-statement/harmful-substance-use-dependence-and-behavioural-addiction-addiction-2017 (accessed 29 November 2017).

75 AMA, 'Substance abuse needs mature policy approach', *Media release*, 14 August 2017, https://ama.com.au/ausmed/substance-abuse-needs-mature-policy-approach (accessed 29 November 2017).

76 AMA, *Harmful substance use, dependence and behavioural addiction (Addiction) – 2017*, AMA position, https://ama.com.au/position-statement/harmful-substance-use-dependence-and-behavioural-addiction-addiction-2017 (accessed 29 November 2017).

77 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 38.

78 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 38.

rehabilitation services. The DoH informed the Community Affairs Committee that it did not collect this data 'in a detailed or quotable form' and added that '[w]aiting times are not actually captured in the alcohol and drug national minimum dataset at this particular point in time, but that is certainly an item that we are developing currently'.[79]

2.39 On 5 January 2018, the DoH subsequently advised the Community Affairs Committee that funding had been allocated to the AIHW 'to support the development of this data item through the Alcohol and Other Drug Treatment Services National Minimum Data Set Working Group'.[80] The DoH added that 'the expert group to guide the data development has yet to be established' and for that reason 'a work plan including timelines for development has not yet been drafted'.[81]

The window of opportunity

2.40 The committee heard that timely access to treatment services is vital because it creates a 'small window of opportunity where people are addicted to ice are ready' to undergo treatment:[82]

> …cognitively, for many of them, they are absolutely unaware of the damage they are doing to themselves and to their families. So, a capacity to reflect and say, 'I need to change this,' for many people with an ice addiction is not going to happen. They have no concept and no insight into what is going on. They need the motivation to change. When they have a window of opportunity—perhaps they have been well for a while and a critical incident happens and they realise that something has to change—at the moment we cannot get them quick help in Australia.[83]

2.41 The Australian Psychological Society (APS) explained that often the trigger for an individual to seek the support of AOD treatment services is a significant event or a realisation that something has to change. Access to AOD treatment services, however, is difficult and can take weeks or months before anything is in place. During this time, the window of opportunity can pass.[84]

2.42 The issue of having a limited window of opportunity was also raised by Professor Allsop, who opined that if an individual arrives at an emergency department:

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79 Mr David Laffan, Assistant Secretary, Drug Strategy Branch, Population Health and Sport Division, DoH, Senate Standing Committee for Community Affairs, *Committee Hansard*, 30 May 2017, p. 71.

80 DoH, answers to question on notice, No. SQ17-001525, 30 May 2017 (received 5 January 2018).

81 DoH, answers to question on notice, No. SQ17-001525, 30 May 2017 (received 5 January 2018).

82 Dr Louise Roufeil, Executive Manager Professional Practice, Australian Psychological Society (APS), *Committee Hansard*, 27 July 2015, p. 60.

83 Dr Roufeil, APS, *Committee Hansard*, 27 July 2015, p. 60.

84 Dr Roufeil, APS, *Committee Hansard*, 27 July 2015, p. 60.

> …you do not want the emergency department to phone up a treatment service and hear the treatment service say, 'Yes, we can see them in four weeks' time.' That is a missed opportunity. If a GP raises drug use with one of their patients, they need to be able to get that person into treatment immediately. So we need to be able to get people into treatment, and then to have clinicians who are able to retain, engage and support people whose relationships and capacity to form relationships might have taken a battering, and then to make sure that those treatment services understand the more prolonged nature of methamphetamine, the impact on relationships—perhaps sometimes suspicion and agitation—and how to manage these things. I think there has been an enormous amount of work done, and the treatment services that we have available now are much more easily accessible and much more capable of responding. But, at the end of the day, there are still far more people in need than we have treatment places for, so sometimes people end up in prison, in the justice system, quite simply because we could not get them into treatment. People end up with their problems becoming worse, both for them and for their families, quite simply because we could not get them into treatment.[85]

2.43 The committee heard that some organisations have the capacity to provide preliminary support to people during the period they are waiting to access a treatment service. For example, the Palmerston Association provides waitlist groups and phone support services for those waitlisted,[86] as does The Salvation Army.[87]

Initiatives to reduce waiting times

2.44 The NIT recognised that 'unmet demand is a longstanding issue' and supported 'further investment to strengthen the capacity of services to respond more effectively and ensure that more people are getting the help and support they need, when they need it'.[88]

2.45 The NIT, however, did caution against the investment of resources into more costly and less-effective models of treatment. In its final report, the NIT argued that such investments are unlikely to have a significant impact on the AOD sector, and that funds should be dispersed by those with knowledge of local needs.[89] Subsequently, the NIT recommended that:

> The Commonwealth, state and territory governments should further invest in alcohol and other drug specialist treatment services. This investment must:
>
> - target areas of need—this includes consideration of regional and remote areas and Indigenous communities

85 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 38.

86 Palmerston Association, *Submission 100*, p. 3.

87 Ms Wright, The Salvation Army, *Committee Hansard*, 29 July 2015, p. 29.

88 National Ice Taskforce (NIT), *Final Report*, p. 131.

89 NIT, *Final Report*, p. 132.

- be directed toward evidence-based treatment options and models of care for every stage of a patient journey
- involve consultation across the Commonwealth, states and territories and the alcohol and other drug sector
- be subject to a robust cost-benefit evaluation process
- ensure service linkages with social, educational and vocational long-term supports.[90]

2.46 In response to this recommendation, the Commonwealth government announced that $241.5 million would be invested in AOD treatment service delivery via PHNs, expanding early intervention initiatives through online counselling and information, and providing $13 million to introduce new Medicare Benefits Scheme items for Addiction Medicine Specialists to increase treatment availability.[91] These announcements were incorporated in the NIAS.

Committee comment

2.47 It is apparent to the committee that delaying a drug user's access to AOD treatment services significantly undermines their chance of achieving a successful treatment outcome. The small window of opportunity when a drug user is seeking support and treatment must be capitalised upon. Long waiting lists to access services are a major problem, and governments and the AOD treatment sector must continue to address this issue.

2.48 Investment in AOD treatment services is central to addressing Australia's capacity to respond to crystal methamphetamine abuse. Failure to provide sufficient treatment options to meet demand may, as noted by Professor Allsop, result in further pressure on police resources, the justice system and the prison system. This is already borne out in the substantial increase in the number of defendants finalised for a principal illicit drug offence in Australia's criminal courts over recent years.[92] It also results in negative impacts on the physical and mental health of illicit drug users, and places additional stressors on their families and communities. The committee believes that these issues can be substantially diminished with timely access to AOD treatment services.

2.49 The committee commends the work of governments, across all jurisdictions, to provide additional funding to the AOD treatment sector. These additional funds allow a greater number of drug users (an additional 15 000 clients between 2013–14 and 2015–16)[93] to access treatment services and support. In particular, the committee

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90 NIT, *Final Report*, p. 132.

91 Commonwealth of Australia, *Taking action to combat ice*, December 2015, p. 2, http://www.health.gov.au/internet/main/publishing.nsf/content/396377B005C71DD0CA257F100005FD5C/$File/combat%20ICE%20glossy.pdf (accessed 21 December 2017).

92 See Parliamentary Joint Committee on Law Enforcement, *Inquiry into crystal methamphetamine (ice): First report*, September 2017, pp 167–168.

93 See paragraph 2.16. AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. vii.

applauds the Commonwealth government for additional AOD funding announced as part of the NIAS. However, the committee considers that further additional funding for the AOD sector is warranted: chapter 5 considers this issue in greater detail, in particular the prioritisation of government funding towards law enforcement (supply reduction) measures rather than treatment (demand) and harm reduction measures. That chapter also considers whether additional funding could be directed to AOD treatment services via the Confiscated Assets Account under the *Proceeds of Crime Act 2002.*

2.50 During the course of the inquiry, some submitters and witnesses complained that since the implementation of the NIAS, wait lists remain. The committee suggests that insufficient time has elapsed since the implementation of the NIAS for a meaningful assessment to be made of its impact on waiting times, and that it may take some time for additional treatment services to come online and an impact to be seen.

2.51 As recommended in its first report, the committee does expect that thorough and transparent progress reports on the implementation of the NIAS will be made publicly available and will include assessments of the effectiveness of the NIAS, and AOD policies more broadly. Such an assessment will require reliable national data on unmet demand for treatment services and the length of time people are waiting to access such services. Currently, as the DoH advised the Community Affairs Committee, this data is not collected.

2.52 This committee commends the work commenced by the DoH and AIHW to collect data on demand and waiting times for treatment services. The committee considers that the collection of this data will be key to assessing the effectiveness of measures to reduce waiting times, and enable informed decisions to be made about future policies and their funding. The committee therefore recommends that the DoH and AIHW establish an expert group and progress the development of an AOD treatment waitlist dataset item as a matter of priority.

Recommendation 1

2.53 The committee recommends that the Department of Health and the Australian Institute of Health and Welfare establish an expert group and progress their work to develop an alcohol and other drugs treatment waitlist item as part of the Alcohol and Other Drug Treatment Services National Minimum Data Set.

Residential treatment services

2.54 Residential (inpatient) rehabilitation services are AOD treatment services offered in a residential facility for an extended period of time. The purpose of these services is to help clients cease their AOD use, and to address the psychological, legal, financial, social and physical impacts of problematic drug use.[94]

94 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 64.

2.55 Data from 2015–16 shows that residential treatment accounted for 14 per cent of treatment episodes for clients presenting with AOD issues.[95] During this period, 35 per cent of closed residential treatment episodes lasted one to three months, and 31 per cent lasted two to 29 days.[96] Table 1 shows the number of closed treatment episodes provided in residential rehabilitation, by duration from 2011–12 to 2015–16.

Table 1: Closed episodes provided for own drug use with main treatment type of rehabilitation, by duration, 2011–12 to 2015–16[97]

Duration	2011–12	2012–13	2013–14	2014–15	2015–16
1 day	379	346	377	397	593
2–29 days	2994	2461	3329	3315	3717
30–90 days	2903	2814	3479	4050	4207
91–182 days	1465	1552	1959	2013	2172
183–364 days	697	630	765	928	782
365+ days	227	186	257	334	403
Total	8665	7989	10 166	11 047	11 874

2.56 Some research has demonstrated a strong economic case in favour of residential rehabilitation. For example, the VAADA submitted that:

- research from the Australian National Council on Drugs (2012) showed for Indigenous populations, a saving of $111 458 per offender is made when a person is dealt with in a residential rehabilitation facility compared with imprisonment. A further saving of $92 759 is made when improved health-related quality of life and lower mortality rates are taken into account;[98] and
- a 2013 study found for every person that is provided with residential rehabilitation 'there is a conservative new economic benefit of approximately $1 [million]'.[99]

2.57 The APS informed the committee that psychological treatment offered during residential rehabilitation is effective because of the challenges users face when they

95 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 10.

96 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 64.

97 AIHW, *Alcohol and other drug treatment services in Australia 2015–16: Data tables: SE State and territory (episodes)*, 28 June 2017, https://www.aihw.gov.au/getmedia/d7fda0d8-12f5-4dba-a1eb-7d1468fd9525/SE-State-and-territory-episodes.xls.aspx (accessed 15 February 2018).

98 VAADA, *Submission 95*, p. 7.

99 VAADA, *Submission 95*, p. 7.

remain in the community. Dr Louise Roufeil commented that it was far harder for an addicted crystal methamphetamine user:

> …to walk back into their community or the people they used to socialise with and not give in again. Residential rehabilitation is incredibly difficult to access for young people and for adults at the moment, and the ongoing psychological care to support people until they are at a point that the addiction is under control is very difficult to access.[100]

2.58 The NDRI referred to the role of residential treatment in the treatment 'mix' available to consumers.[101] In this context, the NDRI highlighted a number of important considerations when treating methamphetamine users, including:

- the long withdrawal and recovery period and the high relapse rate for methamphetamine users (especially crystal methamphetamine users). This is relevant because it is 'crucial to ensure services are funded to reflect 14–day withdrawal, longer-term treatment (12–18 months) and especially assertive follow-up/aftercare';[102] and
- the need for funding and evaluating to be directed towards innovative withdrawal treatment models (such as step-up/step-down)[103] that include a combination of non-residential and residential treatment, along with additional psychological intervention trials.[104]

2.59 A Turning Point study into patient pathways in AOD treatment, as part of the *Patient Pathways National Project* (2014), confirmed the importance of residential treatment in a patient's treatment journey, especially for methamphetamine use.[105] The study found that rates of abstinence during the 30 day period prior to a follow-up were higher for participants that used long-term residential treatment as part of their primary treatment (56 per cent), compared to outpatients (33 per cent) and acute withdrawal (30 per cent). Further:

> Participants who had been in residential rehabilitation at any point in either the year preceding their [primary index treatment] or the year following had significantly greater rates of abstinence at follow-up. Abstinence rates in the past month were highest when the [primary drug of concern (PDOC)] was meth/amphetamine (61%), followed by opioids (45%); cannabis (34%) and lowest for alcohol (28%). Fourteen percent of the sample reported complete

100 Dr Roufeil, APS, *Committee Hansard*, 27 July 2015, p. 54.

101 NDRI, *Submission 113*, p. 6.

102 NDRI, *Submission 113*, p. 6.

103 UnitingCare ReGen, *Submission 22*, p. 7.

104 NDRI, *Submission 113*, p. 6.

105 Turning Point, *A Study of patient pathways in alcohol and other drug treatment*, Patient Pathways National Project, Final Report, June 2014, p. xii, http://www.health.gov.au/internet/main/publishing.nsf/content/C51C9F3326D93748CA258082001232CB/$File/Patient%20Pathways%20National%20Project.pdf (accessed 21 December 2017).

> abstinence from their PDOC throughout the entire follow-up year, and this was highest when the primary drug was meth/amphetamine (26%, a rate markedly higher than reported in the [Methamphetamine Treatment Evaluation Study (MATES)] cohort study in 2012). Taking a conservative estimate and assuming all participants who withdrew or were lost to follow-up were still using their PDOC, the rate of treatment success in the entire baseline sample (excluding those known to be deceased or incarcerated at follow-up) was 38% with 27% abstinent from their PDOC in the 30 days prior to follow-up.[106]

2.60 The study highlighted the effectiveness of residential treatment and engagement with mutual aid groups[107] as part of a patient's treatment.[108] For this reason, the study recommended increasing the availability of rehabilitation places, and reducing waiting times for long-term residential care as means of improving outcomes for drug users.[109] Further, the study noted that:

> …it is crucial that funders and specialist service providers recognise the critical role that rehabilitative services play in a comprehensive specialist treatment system, particularly for individuals who have greater levels of complexity. The qualitative findings indicate that long waiting times for access to residential treatment are a key barrier to treatment engagement. It is imperative that such unmet needs are addressed, and that the benefits of residential rehabilitation are promoted among clinicians and clients.[110]

2.61 The NIT's final report discussed the role of residential rehabilitation for the treatment of crystal methamphetamine and the long-held belief that it is the most effective way to achieve abstinence.[111] The NIT stated that residential rehabilitation for crystal methamphetamine:

> …and other methamphetamine users, even residential rehabilitation, as a single course of treatment, achieves low rates of sustained abstinence or reductions in use. A lack of extended follow-up is likely to be a factor behind these low success rates.[112]

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106 Turning Point, *A Study of patient pathways in alcohol and other drug treatment*, Patient Pathways National Project, Final Report, June 2014, p. xii.

107 Mutual aid groups, or self-help groups, are community-based groups that offer collective AOD support services. Typical mutual aid groups are Alcoholics Anonymous or Narcotics Anonymous. See Recovery Connect, *Mutual Aid Groups*, https://www.recoveryconnection.com/in-recovery/mutual-aid-groups/ (accessed 15 February 2017).

108 Turning Point, *A Study of patient pathways in alcohol and other drug treatment*, Patient Pathways National Project, Final Report, June 2014, p. xiii.

109 Turning Point, *A Study of patient pathways in alcohol and other drug treatment*, Patient Pathways National Project, Final Report, June 2014, p. xvi.

110 Turning Point, *A Study of patient pathways in alcohol and other drug treatment*, Patient Pathways National Project, Final Report, June 2014, p. xvi.

111 NIT, *Final Report*, p. 122.

112 NIT, *Final Report*, p. 122.

2.62 It agreed that residential treatment has an important place in the treatment of crystal methamphetamine use, but that budget constraints mean 'few residential rehabilitation places can be funded in comparison to less intensive forms of treatment'.[113] Therefore, the NIT suggested that:

> The challenge for policy makers is to fund a mix of services that balances the availability of treatment with effectiveness and population need. In terms of effectiveness, residential rehabilitation on its own does not deliver particularly high rates of long-term abstinence or reductions in use, despite short-term positive results.[114]

2.63 The NIT referenced the NDARC's *Methamphetamine Treatment Evaluation Study* from 2010, which compared abstinence rates for people who had attended residential treatment facilities for methamphetamine use (248 people in total) with a control group that received no treatment (101 people) or had received detoxification (112 people).[115] That study found that:

- three months after participants had received treatment, 47 per cent of the treatment group were no longer abstinent compared with 82 per cent of the control group;
- a year after the commencement of treatment, 80 per cent of those who attended residential rehabilitation facilities were no longer abstinent, compared with 93 per cent from the control group; and
- at the three year mark, 88 per cent of residential rehabilitation attendees were no longer abstinent, compared with 93 per cent of the control group.[116]

2.64 The study concluded that the absence of long-term follow-up support was the most likely contributor to people failing to remain abstinent.[117] It added that specialist treatment programs are usually provided for a maximum of 12 months, 'which does not account for the extended withdrawal and recovery period associated with ice'.[118]

2.65 The study continued:

> …poor outcomes were observed for heavier injecting methamphetamine users and those with psychotic symptoms and high levels of psychological distress on entry to treatment. On the other hand, around one-third of methamphetamine users recovered without further drug treatment. Positive outcomes were associated with longer and more intensive treatment programs. These findings highlight the chronic and relapsing nature of methamphetamine dependence for a large proportion of methamphetamine users, and a need for a more intensive and sustained treatment approach for

113 NIT, *Final Report*, p. 128.

114 NIT, *Final Report*, p. 128.

115 NIT, *Final Report*, p. 128.

116 NIT, *Final Report*, p. 128.

117 NIT, *Final Report*, p. 128.

118 NIT, *Final Report*, p. 128.

> this population, with a particular emphasis on follow-up care and relapse prevention.[119]

2.66 The NIT highlighted in its final report the importance of having the 'right mix' of treatment service options to meet the needs of the community:

> …especially in light of the resource constraints currently facing the specialist AOD sector. Services need to be able to adapt their treatment programmes to incorporate interventions that are evidence-based for treating ice and other methamphetamine dependence. This includes moderately-intensive lower-cost interventions, such as cognitive behavioural therapy with contingency management and follow-up support, which can be delivered in both a residential and non-residential setting. Residential rehabilitation for ice and other methamphetamine users should be targeted towards those with more severe dependence and health needs, and those with more significant social disadvantage.[120]

2.67 The NIT also recommended that the Commonwealth government fund research into evidence-based treatment for methamphetamine including treatment settings (such as residential and non-residential treatments).[121]

2.68 UnitingCare ReGen's 'Step-up, Step-down' model was a treatment model referenced often by submitters and by the NIT. This model is a stepped care approach for methamphetamine use, and includes:

- Assessment, clinical review and care planning to identify people suitable for non-residential withdrawal support from nursing professionals.
- Those found suitable are provided with home-based withdrawal support while on a waiting list for a residential withdrawal service. Non-residential support includes:
    - education on harm reduction strategies and self-care;
    - motivational interview and counselling support;
    - advice on the withdrawal experience and residential care services;
    - liaison with general practitioners and linking consumers with other support services; and
    - family support services during home-based withdrawal.
- A consumer admission into a residential withdrawal service is provided for up to 10 days. A 'consumer's participation in the program during the first few

119 NDARC, *Methamphetamine treatment evaluation study (MATES): Three-year outcomes from the Sydney site*, 2010, https://ndarc.med.unsw.edu.au/resource/methamphetamine-treatment-evaluation-study-mates-three-year-outcomes-sydney-site (accessed 11 December 2017).

120 NIT, *Final Report*, p. 122.

121 NIT, *Final Report*, p. 156.

days of withdrawal would be relaxed if required to accommodate a methamphetamine "crash" period'.[122]

- Residential support is followed by a step-down service that includes:
  - continued withdrawal information and management; and
  - counselling and case management support that links with other services when required.[123]

2.69 UnitingCare ReGen asserted that this model better prepares consumers for residential treatment and reduces the likelihood that a resident has used methamphetamine in the 24 hours leading up to their admission.[124] It also reduces the amount of time a consumer spends in residential care (6.3 days on average), and achieves better physical and mental health results at the three-month follow-up.[125]

Demand for residential rehabilitation

2.70 Evidence to the committee demonstrated that demand for residential treatment services has increased. For example, the Palmerston Association reported that in 2015–16, 180 people participated in its residential program representing an increase of 18 per cent from the previous year.[126] It also observed an increase in the number of people seeking treatment for methamphetamine more broadly: 53 per cent of residents reported methamphetamine as their primary drug of concern (38 per cent in 2013–14).[127] By way of contrast, alcohol accounted for 28 per cent in 2015–16 (47 per cent in 2013–14).[128]

2.71 The Palmerston Association recognised this increase as part of a growing awareness in the community about the impact methamphetamine use has on individuals and families.[129] The VAADA attributed the increase to the paucity of publicly funded residential beds and increased public perception that residential treatment is the ideal form of treatment.[130]

2.72 As foreshadowed earlier, the committee also heard that there is a lack of residential treatment services across the nation. This shortage is particularly acute in regional and remote regions.[131]

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122 UnitingCare ReGen, *Submission 22*, p. 7.

123 UnitingCare ReGen, *Submission 22*, p. 7.

124 UnitingCare ReGen, *Submission 22*, p. 8.

125 UnitingCare ReGen, *Submission 22*, p. 8.

126 Palmerston Association, *Submission 100*, p. 2.

127 Palmerston Association, *Submission 100*, p. 2.

128 Palmerston Association, *Submission 100*, p. 2.

129 Palmerston Association, *Submission 100*, p. 2.

130 VAADA, *Submission 95*, p. 7.

131 VAADA, *Submission 95*, p. 7.

2.73 The Western Australian Network of Alcohol & Other Drug Agencies (WANADA) and the VAADA reported that the Western Australian (WA) and Victorian governments, respectively, have made additional investments in residential rehabilitation services. The WANADA informed the committee that WA's 2016 methamphetamine strategy[132] included an additional $6.2 million over two years for 60 rehabilitation service beds (52 assigned to residential rehabilitation and eight for low-medical withdrawal).[133] The VAADA reported that the Victorian government had provided funding for an additional 18–20 residential beds in the Grampians region.[134] Further, the Victorian Department of Health is set to provide an additional 100 residential rehabilitation beds by March 2018.[135] Other initiatives announced by the Victorian government include:

- a rapid withdrawal and rehabilitation model for complex clients in hospital;
- a new advisory service for individuals in urgent need of locating a suitable service; and
- measures to tackle poor quality or unsafe services by private rehabilitation clinics.[136]

2.74 Similar investments have been undertaken by other state and territory governments:

- In June 2017, the South Australian (SA) government announced its $8 million Ice Action Plan to increase the number of residential rehabilitation beds in regional areas by 15.[137]
- In 2016, the New South Wales (NSW) government announced $75 million over four years for AOD treatment services including detoxification and treatment programs for young people and pregnant women.[138]

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132 WA's Methamphetamine Action Plan Taskforce is tasked with informing the WA government on how to distribute the $131.7 million committed to the plan. See Noor Gillani, 'Taskforce seeks input over meth scourge', *The West Australian,* 18 February 2018, https://thewest.com.au/news/kalgoorlie-miner/taskforce-seeks-input-over-meth-scourge-ng-b88747039z (accessed 21 February 2018).

133 Western Australian Network of Alcohol & Other Drug Agencies (WANADA), *Submission 107*, p. 9.

134 VAADA, *Submission 95*, p. 7.

135 Department of Health (Vic), *Residential treatment services,* https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/aod-residential-treatment (accessed 30 November 2017).

136 Department of Health (Vic), *Residential treatment services,* https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/aod-residential-treatment (accessed 30 November 2017).

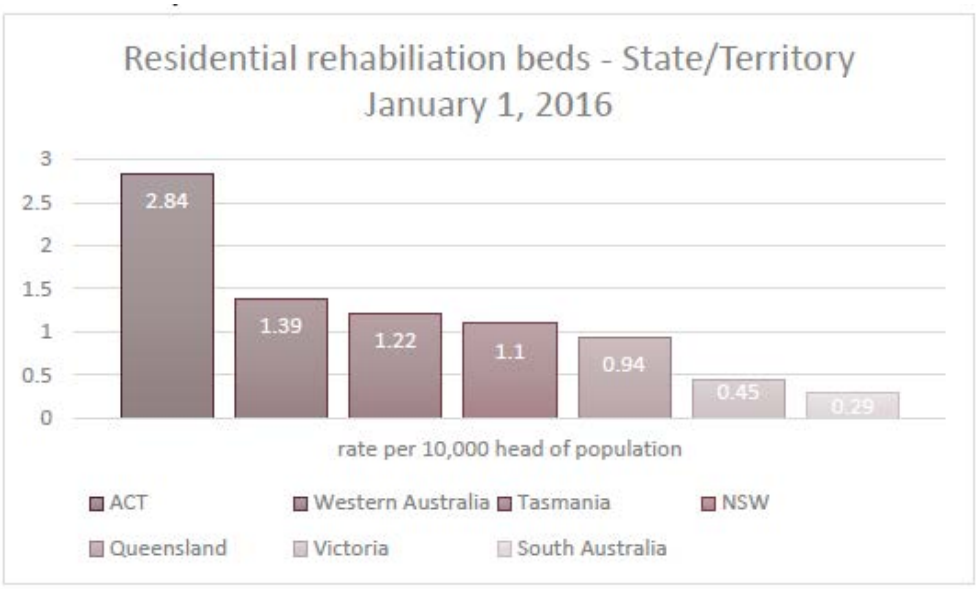
137 Angelique Donnellan, 'Ice problem in SA to be tackled by Government's $8 million 'Stop the Hurt' strategy', *ABC News,* 15 June 2017, http://www.abc.net.au/news/2017-06-15/sa-government-pledges-eight-million-dollars-tackle-ice-problem/8622024 (accessed 21 December 2017).

- On 2 June 2017, NSW opened its first youth drug detoxification clinic in the Illawarra.[139] This facility can house up to 10 youths aged 16 to 24 years old.[140]
- In 2015, the Tasmanian government invested $4.8 million for AOD treatments, including 12 new residential rehabilitation beds in the north-west of the state.[141]

Availability of residential rehabilitation

2.75 The VAADA submitted that the Australian Capital Territory (ACT) has the highest number of residential rehabilitation beds per 10 000 people, whereas SA has the lowest. Figure 4 shows the number of residential rehabilitation beds available per 10 000 head of population as of 1 January 2016.

Figure 4: number of residential rehabilitation beds available per 10 000 head of population as of 1 January 2016[142]



2.76 According to VAADA, the lack of residential rehabilitation beds has a number of negative consequences. These include unmet demand being met by the expansion of unregulated private rehabilitation facilities, acute health issues due to untreated dependency resulting in preventable mortality, and demand on the justice system.[143]

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138 Chloe Hart, 'NSW's first youth drug detox clinic opens in Knights Hill', *ABC News*, 2 June 2017, http://www.abc.net.au/news/2017-06-02/nsw-first-ice-drug-clinic-helps-youth-in-crisis/8585768 (accessed 30 November 2017).

139 Ms Hart, 'NSW's first youth drug detox clinic opens in Knights Hill', *ABC News*, 2 June 2017.

140 Ms Hart, 'NSW's first youth drug detox clinic opens in Knights Hill', *ABC News*, 2 June 2017.

141 NIT, *Final Report*, p. 201.

142 VAADA, *Submission 95*, p. 8.

143 VAADA, *Submission 95*, p. 8.

2.77 The VAADA therefore recommended that the Commonwealth government develop a plan to increase the capacity of residential rehabilitation facilities. This plan would need to be adequately resourced, address existing gaps, meet current demand by region and promote partnerships with existing service providers.[144]

Committee comment

2.78 Residential treatment is a vital component of the AOD treatment sector. It provides 24-hour care in a safe space, and removes drug users from the environment that may contribute to their problematic drug use. Residential treatment also demonstrates broader economic benefits for Australian communities, and if best-practice principles are applied, has better health outcomes for drug users.

2.79 Although effective, treatment in residential rehabilitation facilities cannot be a stand-alone treatment option. This form of treatment must be provided in conjunction with sufficient pre- and post-care services (such as non-residential nursing support, ongoing counselling and educational services). Without ongoing support, then long-term abstinence from drug use may be undermined.

2.80 The NIT and NIAS both highlight the importance of offering a diversified treatment mix. The committee echoes these sentiments and recommends that Commonwealth, state and territory health departments ensure adequate pre- and post-care services are provide in partnership with residential treatment programs to promote on-going abstinence by AOD users. This best-practice measure should also be applicable to the for-profit and not-for-profit residential treatment sectors.

Recommendation 2

2.81 The committee recommends that Commonwealth, state and territory health departments ensure adequate pre- and post-care services are provided in partnership with residential treatment programs.

2.82 The committee is concerned that demand for residential treatment services outweighs supply. This is a particular concern for those seeking residential treatment in regional and remote communities. It also impacts on the availability and waiting times to access other treatment services, as well as the likelihood of treatment success.

2.83 The committee commends those Australian governments that have invested additional resources to increase the capacity of residential treatment services in their jurisdictions. However, there is disparity in the number of residential rehabilitation beds available per 10 000 head of population in different jurisdictions. As discussed in the following section of this chapter, a consequence of limited residential treatment facilities is growth in for-profit residential services, which may not apply best-practice treatment principles and can be prohibitively expensive.

2.84 The committee recommends that individually and collectively the Commonwealth, state and territory governments develop and implement plans to increase the capacity of residential rehabilitation across Australia in a way that ensures equitable access, particularly for those in regional and remote areas.

144 VAADA, *Submission 95*, p. 8.

Recommendation 3

2.85 The committee recommends that Australian governments individually and collectively develop and implement plans to increase the capacity of residential rehabilitation across Australia in a way that ensures equitable access.

Private treatment services

2.86 Residential rehabilitation is provided by public, not-for-profit and private/for-profit providers. Private residential rehabilitation centres play an important role in the ecology of AOD treatment services. However, media reports and evidence submitted to the committee have shown that the private sector is largely unregulated and, as a result, may be detrimental to their health and wellbeing, and also to their financial situation.

2.87 This issue received national attention on 12 September 2016 when the Australian Broadcasting Corporation's (ABC) *Four Corners* aired an investigation into the private rehabilitation sector amid concerns about the cost of treatment services and the lack of regulation in the industry.[145] *Four Corners* found that high demand for residential rehabilitation facilities has forced families to turn to private rehabilitation centres.[146] At some of these facilities, families were paying up to $30 000 for a single stay.[147] While some of these centres are effective, others appear to be focused on profits without being able to demonstrate results for patients.[148]

2.88 *Four Corners* reported that each year there are more than 32 000 requests for residential rehabilitation placements, far outweighing the approximately 1500 publicly funded drug and alcohol rehabilitation beds available. Professor Dan Lubman, a psychiatrist and addiction medicine specialist told *Four Corners* that people expect treatment offered in a paid facility to be better than a publicly funded centre; however, these services are 'often worse than what is offered in the public system'.[149] Further, there are no minimum standards for these facilities, which has meant that people are:

> …offering legitimate treatments or claiming to offer legitimate treatments that are not based on evidence, that aren't supported by the literature, aren't covered by an appropriate clinical quality and government standards.[150]

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145 Four Corners, 'Rehab Inc: The high price parents pay to get their kids off ice', *ABC*, 12 September 2016, http://www.abc.net.au/4corners/rehab-inc.-promo/7827128 (accessed 30 November 2017).

146 Four Corners, 'Rehab Inc: The high price parents pay to get their kids off ice', ABC, 12 September 2016.

147 Four Corners, 'Rehab Inc: The high price parents pay to get their kids off ice', ABC, 12 September 2016.

148 Four Corners, 'Rehab Inc: The high price parents pay to get their kids off ice', *ABC*, 12 September 2016.

149 Four Corners, 'Rehab Inc: The high price parents pay to get their kids off ice', *ABC*, 12 September 2016.

150 Four Corners, 'Rehab Inc: The high price parents pay to get their kids off ice', *ABC*, 12 September 2016.

2.89 Submitters and witnesses similarly warned that the lack of residential rehabilitation places has led to the expansion of the unregulated private rehabilitation market. For example and as stated in paragraph 2.75, the VAADA observed that one of the negative consequences of unmet demand for public residential rehabilitation services has been the expansion of unregulated private rehabilitation facilities.[151]

2.90 The WANADA expressed concern about the growth of the unregulated private rehabilitation sector, and stated that there needed to be a way to:

> …demonstrate the application of evidence-based practice for treatment services. People at some services—the one that you mentioned in terms of the *Four Corners* report—spend a significant amount of money, but there is no guarantee that this is evidenced. There was one more recently about a service in Western Australia on *Australian Story*. While it is not necessarily big outlays, there is concern that there is no requirement for accreditation of private services that are not receiving government funding. We are concerned that evidence-based practice is not being monitored when it is in place. WANADA's interest is in meeting the community needs through an evidence-based practice approach.[152]

2.91 UnitingCare ReGen opined that the lack of accountability for the private AOD treatment sector has been a longstanding concern in the industry.[153] It acknowledged that there are private services that provide good quality care; however, the lack of 'regulations or requirements for transparency allows some services to make unfounded marketing claims of success'.[154] For example, marketing that targets and exploits vulnerable families who are seeking a cure for their loved one, and thus 'helps justify the often exorbitant fees charged by these services'.[155] It also reinforces the belief that you 'get what you pay for' as services that are publicly funded do not charge, or charge at a minimum cost, and do not undertake similar marketing strategies.[156]

2.92 The rise in private AOD services, according to UnitingCare ReGen, is due to the rise in community concern about methamphetamine and the lack of capacity within the publicly funded treatment system to accommodate those seeking these

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151 VAADA, *Submission 95*, p. 8.

152 Ms Jill Rundle, WANADA, *Committee Hansard*, 3 May 2017, p. 27.

153 Laurence Alvis, CEO, UnitingCare ReGen, *Decline of mainstream media a boon for for-profit drug services; a bust for informed debate*, 11 August 2016, http://www.regen.org.au/news-advocacy/regen-in-the-media/781-decline-of-mainstream-media-a-boon-for-for-profit-drug-services-a-bust-for-informed-debate-11-08-16 (accessed 1 December 2017).

154 Alvis, *Decline of mainstream media a boon for for-profit drug services; a bust for informed debate*, 11 August 2016.

155 Alvis, *Decline of mainstream media a boon for for-profit drug services; a bust for informed debate*, 11 August 2016.

156 Alvis, *Decline of mainstream media a boon for for-profit drug services; a bust for informed debate*, 11 August 2016.

services. The committee also heard concerns about the role of the media in uncritically promoting private AOD services.[157]

2.93 UnitingCare ReGen recommended the Commonwealth, state and territory governments commit to developing a nationally consistent regulatory framework for private AOD treatment providers, similar to that already in place for private hospitals. These standards and compliance requirements should promote transparency, service quality and ethical practices to 'help prevent unethical practice within the sector and, most importantly, improve the effectiveness of services for vulnerable individuals and families'.[158]

2.94 In its report, the NIT recommended (Recommendation 17) the development of a national quality framework that sets standards for:

- the delivery of evidence-based treatment services with clear expectations of the quality standards for each type of service;
- workforce capabilities matched to service-type and population need;
- cross-agency partnerships and collaborations; and
- the monitoring and evaluation of the quality framework's outcomes and effectiveness to inform continuous quality improvements.[159]

2.95 The committee questioned the DoH about the *Four Corners* report and the private rehabilitation sector. The DoH informed the committee that it was working with the Ministerial Drug and Alcohol Forum (MDAF), and with colleagues from the states and territories to develop a national quality framework for AOD services.[160] A limiting factor for the Commonwealth government is that regulation of these services is the remit of the states and territories, such that the Commonwealth government does not have a regulatory role.[161] The DoH, however, stated that this division of responsibility makes a national quality framework:

> …the important piece that holds this together. But a couple of things have been done in response to the Ice Taskforce around the comorbidity guidelines and things like that. Trying to provide as much guidance so that there is national consistency in treatment services has been an objective there.[162]

2.96 The DoH added that the national framework is being applied to the public sector, and then 'we will look to see how we can extend that across the private

157 Alvis, *Decline of mainstream media a boon for for-profit drug services; a bust for informed debate*, 11 August 2016.

158 Alvis, *Decline of mainstream media a boon for for-profit drug services; a bust for informed debate*, 11 August 2016.

159 NIT, *Final Report*, p. x.

160 Dr Wendy Southern, Deputy Secretary, DoH, *Committee Hansard*, 24 March 2017, p. 23.

161 Dr Southern, DoH, *Committee Hansard*, 24 March 2017, p. 23.

162 Dr Southern, DoH, *Committee Hansard*, 24 March 2017, p. 23.

sector'.[163] The committee reminded the DoH that the topic addressed in the *Four Corners* program was about private clinics and the damage that is being done by these unregulated service providers. In response, the DoH confirmed that this issue had been discussed by the National Drug Strategy Committee (NDSC) and the MDAF, largely 'in the context of the quality framework and what we can do there and a conversation for individual jurisdictions to have about how they could regulate the private sector'.[164]

2.97 In a 16 December 2016 communique, the MDAF identified as a priority the implementation of a quality framework 'to provide consistent and appropriate treatment in accordance with best practice'.[165]

2.98 On 27 March 2017, the Australian Network of State and Territory Alcohol and Other Drug Peaks (Network of Peaks) released a press release on the national AOD quality framework. The Network of Peaks, drawing from previous attempts by governments to develop a national quality framework for the AOD sector, advocated for a quality framework that:

- is driven by the AOD sector and is a working collaboration with the health departments;
- involves leadership from the AOD peaks and national AOD research centres and is governed by a working group that reports to the NDSC (with co-chairing arrangements shared between a non-government representative and a NDSC representative);
- is aligned with, and a component of, the National AOD Treatment Framework (that needs to be developed first); and
- has clear deliverables that includes start and end dates with adequate resources.[166]

2.99 The Network of Peaks highlighted the need for there to be a clear difference between a national AOD quality framework (focused on compliance and monitoring of evidence-informed practice) and accreditation (continuous quality improvement around systems management).[167]

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163 Dr Southern, DoH, *Committee Hansard*, 24 March 2017, p. 24.

164 Dr Southern, DoH, *Committee Hansard*, 24 March 2017, p. 24.

165 Ministerial Drug and Alcohol Forum, *Ministerial Drug and Alcohol Forum Communique*, 16 December 2016, http://www.health.gov.au/internet/main/publishing.nsf/Content/55E4796388E9EDE5CA25808F00035035/$File/MDAF%20Communique.pdf (accessed 1 December 2017).

166 Australian Network of State and Territory Alcohol and Other Drug Peaks (Network of Peaks), *A national alcohol and other drug quality framework brief 1: For AOD peak bodies' State, Territory and Australian health department contacts*, 27 March 2017, http://www.atoda.org.au/wp-content/uploads/2017/03/AOD-Peaks-Quality-Framework-Statement-Final-270317.pdf (accessed 1 December 2017).

167 Network of Peaks, *A national alcohol and other drug quality framework brief 1: For AOD peak bodies' State, Territory and Australian health department contacts*, 27 March 2017.

2.100 The Commonwealth government last considered a national AOD quality framework in 2013–14. Turning Point, together with the DoH, set out to establish a national quality framework for the AOD treatment sector by developing guidelines that:

- complemented other models and frameworks with which the AOD sector complies;
- were adaptable, flexible and suitable for the range of AOD issues and service types, including Indigenous-specific services;
- considered the needs of clients with comorbidities and the need to maintain the capacity of services to manage these clients;
- considered all sources of funding;
- described quality standards for all service types;
- established clear guidelines, policies and procedures to achieve and maintain quality standards;
- incorporated accreditation models currently in place; and
- considered accreditation and minimum qualifications.[168]

2.101 The outcome of this project is not known to the committee.

2.102 The conduct of private rehabilitation facilities has been in the spotlight in Victoria. As of 1 December 2017, the Victorian Health Complaints Commissioner (Complaints Commissioner) had received 26 complaints about private rehabilitation clinics.[169] Issues most commonly brought to the Complaint Commissioner's attention were:

- exploitative billing practices (for example treatment costing up to $30 000);
- lack of informed consent for clients' financial and treatment decisions;
- safety concerns;
- the effectiveness of treatment;
- the cleanliness of treatment facilities; and
- the inappropriate discharge of patients.[170]

2.103 In a media release, the Complaints Commissioner reminded general health service providers not covered under the Australian Health Practitioner Regulation

168 Turning Point, *National Project: The AOD quality framework project–the development of a quality framework for Australian governments funded drug and alcohol treatment services,* July 2013–June 2014, http://www.turningpoint.org.au/Research/Clinical-Research/CR-Projects/The-AOD-Quality-Framework-Project.aspx (accessed 10 January 2018).

169 Health Complaints Commissioner, *Private drug and alcohol rehabilitation*, 1 December 2017, https://hcc.vic.gov.au/news/105-private-drug-and-alcohol-rehabilitation (accessed 6 December 2017).

170 Health Complaints Commissioner, *Private drug and alcohol rehabilitation*, 1 December 2017.

Agency (AHPRA) of their obligations under the general code of conduct, which took effect on 1 February 2017.[171] The *Code of Conduct for General Health Services* establishes standards such as safe and ethical conduct, appropriate treatment advice, and requirements not to misinform clients and not to financially exploit clients.[172]

2.104 On 16 February 2018, the Victorian government announced $550 000 in further funding to the Complaints Commissioner 'to conduct a wider investigation into the private drug and alcohol counselling sector in Victoria'.[173]

Committee comment

2.105 As discussed earlier, there is a shortage of places available in residential treatment services across most Australian jurisdictions. In turn, this has led to the growth in for-profit residential rehabilitation services. The committee is supportive of for-profit residential rehabilitation; however, these services must be regulated to ensure best-practice treatment principles are applied in a cost-effective manner with the objective of achieving positive health outcomes for its residents.

2.106 The committee is very concerned by the allegations raised by *Four Corners* and by the Victorian Health Complaints Commissioner. These allegations indicate a need for the development of a national AOD quality framework that ensures best-practice across the AOD treatment sector. A national AOD quality framework must be applicable to public, not-for-profit and for-profit residential rehabilitation service providers.

2.107 Although the Commonwealth government does not have a regulatory role in relation to drug treatment centres, it can facilitate a national dialogue and development of regulations. The Commonwealth's responsibilities include advancing national priorities, providing leadership in planning, addressing service quality and supporting equity. All of these responsibilities are relevant to the development of a quality framework to regulate all residential rehabilitation service providers. Indeed, the regulatory framework governing private hospitals is an example of the Commonwealth's role in facilitating a similar national initiative. Such an approach can be applied to the AOD treatment sector.

2.108 The NIT recommended that the Commonwealth government fund research into evidence-based treatment for methamphetamine, in particular for best-practice measures in treatment facilities (both residential and non-residential).[174] The

171 Health Complaints Commissioner, *Code of Conduct for General Health Services,* 1 December 2017, https://hcc.vic.gov.au/sites/default/files/code_of_conduct_full_text_a3_poster.pdf (accessed 6 December 2017).

172 Health Complaints Commissioner, *Code of Conduct for General Health Services,* 1 December 2017.

173 Health Complaints Commissioner, *Commissioner investigates drug & alcohol services,* 16 February 2018, https://hcc.vic.gov.au/news/125-commissioner-investigates-drug-alcohol-services (accessed 21 February 2018).

174 This recommendation is considered further in the context of private treatment services.

committee supports the NIT's recommendation and further recommends that following this research, and as a matter of priority, the Commonwealth, state and territory governments establish a national quality framework for all AOD treatment services including public, for-profit and not-for-profit residential rehabilitation.

Recommendation 4

2.109 The committee recommends that the Commonwealth, state and territory governments, as a matter of priority, establish a national quality framework for all alcohol and other drug treatment services including public, not-for-profit and for-profit residential rehabilitation.

2.110 Further, development of the framework must take into account the expertise of those working in the AOD field, as well as lessons learnt from previous attempts to develop a national quality framework. For this reason, the committee recommends the development of a national quality framework in partnership with representatives of the AOD treatment sector.

Recommendation 5

2.111 The committee recommends that the development of a national quality framework for alcohol and other drug treatment services is undertaken in partnership with representatives of the alcohol and other drug treatment sector.

Mandatory residential treatment

2.112 Compulsory or mandatory treatment describes those circumstances where an individual is compelled to undergo an AOD treatment program, often in lieu of criminal sanctions. These mandatory treatment programs are often court mandated, for example through a drug court[175] or form part of a drug diversionary scheme.

2.113 The following section considers evidence to the committee, which provides a range of views on the role and appropriateness of mandatory residential treatment. While some submitters were supportive of mandatory residential treatment, others were critical and argued there is minimal evidence to support it.

2.114 Professor Paul Dietze from the Burnet Institute informed the committee that mandatory (residential) treatment was 'particularly fraught' and that he was not aware of any evidence that this treatment option benefits illicit drug users. The primary problem with this approach, according to Professor Dietze, is that 'it is very difficult to keep someone in against their will...[as] you would essentially be imprisoning them'.[176] Further, Professor Dietze referred to rehabilitation centres in South East Asia that have been demonstrated to violate human rights and have very limited success,

175 Australian Institute of Criminology, *Australian responses to illicit drugs: Drug Courts,* http://www.aic.gov.au/criminal_justice_system/courts/specialist/drugcourts.html (accessed 16 January 2018).

176 Professor Paul Dietze, Deputy Director, Burnet Institute, *Committee Hansard,* 9 September 2015, p. 6.

stating that 'there are alternatives that people can engage in well before you would engage in a compulsory treatment'.[177]

2.115 When asked about the merits of custodial mandatory treatment of young people, Dr Roufeil from the APS responded that it was better than other alternatives, but '[t]here will always be problems when [treatment] is mandated' and for that reason, '[i]t is not ideal'.[178] Dr Roufeil further considered that, if a court-mandated custodial system was in place, it would need to be informed by evidence-based interventions, such as a therapeutic diversionary approach, rather than a supportive approach.[179]

2.116 Holyoake Tasmania commented on the effectiveness of mandatory treatment more broadly, in the context of Tasmania's court-mandated treatment program. When asked whether people seeking treatment come with a willingness to admit that they have a problem, Holyoake Tasmania replied that almost all are willing, but those who are court-mandated clients are generally not successful:

> Look, to be perfectly honest, whilst I appreciate that that is a process that is one step closer to perhaps assisting people rehabilitate, there are a significant number of those court-mandated clients who just seek to come to have a box ticked and learn how not to get caught next time. That is the truth. You cannot make somebody rehabilitate from drugs; they have to want to do it. That is the truth.[180]

2.117 When asked about forced rehabilitation (residential treatment), Holyoake Tasmania conveyed that it has limitations, and ultimately:

> ...forced rehabilitation does not work…These court-mandated clients are not all doomed to fail—I do not mean that—but they are more likely to fail because you are more likely to achieve your goals if you truly want to achieve them rather than you have been forced.
>
> …
>
> Look, if you locked people up, you might get a very small percentage of people who see the light when they are locked up, but most of them will be resentful. No, it does not work. Look at prohibition. That is not how it works.[181]

2.118 A similar line of questioning was put to the Palmerston Association. In response, its CEO, the Honourable Sheila McHale pointed out that the WA government was considering mandatory residential rehabilitation and the Palmerston Association 'stops short' of rejecting this option in its entirety, but:

> …quite frankly there is very scant evidence to show that it does work. One of the fundamental motivators for recovery to work is actually motivation

177 Professor Dietze, Burnet Institute, *Committee Hansard,* 9 September 2015, p. 6.

178 Dr Roufeil, APS, *Committee Hansard,* 27 July 2015, pp 60–61.

179 Dr Roufeil, APS, *Committee Hansard,* 27 July 2015, p. 61.

180 Ms Charlton, Holyoake Tasmania, *Committee Hansard,* 24 March 2017, p. 19.

181 Ms Charlton, Holyoake Tasmania, *Committee Hansard,* 24 March 2017, p. 19.

> of the individual him or her self. I always thought that the call for mandatory reporting was a cry for help from parents, that they just wanted somebody to take away the family member and sort them out. Mandatory rehab will not alleviate those sorts of anxieties in the way that it was being looked at because it is actually quite a convoluted process. Here in WA, I think the number of beds that was being considered was about four, so it is a drop in the ocean and on that basis we would work with government to have a look at it. But there is a high degree of scepticism as to whether it will work or not. We did not want to throw the idea out without having the government do some more work on it.[182]

2.119 The WA Primary Health Alliance (WAPHA) argued 'that a voluntary approach seeking to have treatment is highly correlated to getting a good treatment outcome'[183] and that 'treatment efficacy is much greater'.[184] The WAPHA agreed that 'it is hard to get people to treatment that may not have that insight at a certain point' but:

> …we have to keep in context though they are small in number but very visual. Those people who are quite unwell, are having a psychosis impact from their use and do not have the insight of wanting treatment are small in number but high impact in terms of need and demand.[185]

2.120 The WAPHA recognised the problems families face when dealing with a family member using crystal methamphetamine and acknowledged mandatory residential treatment may provide them with a sense of safety. That said:

> …the evidence about that type of treatment being successful is not strong. It is not to say that it will not work for some people, but for people to be willing to accept the issue will have greater treatment efficacy than being dragged against their will. I appreciate that, on occasion, for people's own safety, you may need to not necessarily require their treatment but contain them in a way that is safe for them for a period, and that often does happen in a hospital in an acute unit. But my sense is that, in an overarching way, while conversely it would work for some I think the efficacy of it working for the population is not well tested.[186]

2.121 Although the WAPHA asserted that there is no evidence to support mandatory residential treatment, it did acknowledge that it may be appropriate in limited circumstances, for example if a person's mental health and wellbeing are at risk and there is potential for self-harm.[187] In these instances:

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182 Ms Charlton, Holyoake Tasmania, *Committee Hansard*, 24 March 2017, p. 17.

183 Ms Learne Durrington, WA Primary Health Alliance (WAPHA), *Committee Hansard*, 24 March 2017, p. 19.

184 Ms Durrington, WAPHA, *Committee Hansard*, 24 March 2017, p. 19.

185 Ms Durrington, WAPHA, *Committee Hansard*, 24 March 2017, p. 19.

186 Ms Durrington, WAPHA, *Committee Hansard*, 24 March 2017, p. 19.

187 Ms Durrington, WAPHA, *Committee Hansard*, 24 March 2017, p. 20.

> …a mandatory type of treatment would create safety for a person but whether it would create a good outcome in terms of treatment, the numbers would have to be tested. I imagine they would be quite low, because we are actually asking people to change their behaviour, to have insight into their behaviour and the triggers. Very few people do that well in an environment where it is involuntary.[188]

2.122 The WANADA rejected mandatory residential treatment as a viable option for dealing with AOD dependent individuals.[189] It argued that there is no point pursuing mandatory treatment because there is not sufficient access to voluntary residential treatment services.[190] The result, in WANADA's view, is that mandatory residential treatment:

> …will result in people who would otherwise want to get in voluntarily, or whatever, getting themselves in circumstances so that they will be put into compulsory treatment. We need adequate voluntary services to start with, and then let us look at that as an option. I understand the evaluation from New South Wales is looking positive in terms of its compulsory treatment. I know that Western Australia went down that track—even drafting legislation…with the last government—but it is an expensive process, which could, at this stage, contribute to increasing access by people who are actually self-motivated to access treatment.[191]

2.123 WANADA referred to drug diversionary programs and cited the positive outcomes of these, acknowledging there is a:

> …degree of mandated, coerced treatment that is having some great outcomes, which is not necessarily a specific focussed program. I know this new state government is talking about prison-based alcohol and other drug services for men and women—significant numbers: 250 men, 60 women. We do not have a therapeutic community in our prisons in Western Australia. Most other jurisdictions have prison therapeutic communities. Let us start in the obvious places. We already have the facility—they have got the beds in prison—so let us support a therapeutic approach to addressing the more than 70 per cent of people in prison with alcohol and other drug issues who would benefit from treatment. Let us start there. Let us start with voluntary.[192]

2.124 In August 2017, the WA government announced it would allocate $9.6 million to establish the state's first AOD rehabilitation prison.[193] An existing

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188 Ms Durrington, WAPHA, *Committee Hansard*, 24 March 2017, p. 20.

189 Ms Rundle, WANADA, *Committee Hansard*, 3 May 2017, p. 30.

190 Ms Rundle, WANADA, *Committee Hansard*, 3 May 2017, p. 30.

191 Ms Rundle, WANADA, *Committee Hansard*, 3 May 2017, p. 30.

192 Ms Rundle, WANADA, *Committee Hansard*, 3 May 2017, p. 30.

193 Angie Raphael, 'Labor pledges $9.6m to WA's first drug and alcohol rehab prison', *The Age*, 27 August 2017, http://www.theage.com.au/wa-news/labor-pledges-96m-to-was-first-drug-and-alcohol-rehab-prison-20170827-gy54qs.html (accessed 25 October 2017).

minimum security male prison (Wandoo Reintegration Facility) will be converted into an AOD rehabilitation prison for women.[194] The 80-bed facility is part of the WA's *Methamphetamine Action Plan*.[195]

2.125 Ms Jennifer Bowles, an advocate for mandatory residential treatment and a former magistrate with the Children's Court of Victoria,[196] outlined her research into the effectiveness of mandatory residential treatment for young people. Ms Bowles reviewed mandatory residential treatment programs in Sweden, England, Scotland and New Zealand. Her research found that court sanctioned mandatory residential treatment for young people 'is as effective as voluntary treatment, provided the facilities had key essential qualities',[197] namely that these facilities are: therapeutic and not punitive; and training and education is available to residents.[198] Ms Bowles acknowledged human rights concerns and high costs associated with implementing mandatory treatment.[199]

2.126 While advocating for mandatory residential treatment, Ms Bowles qualified that she is not critical of existing voluntary services, but is critical of a model that expects:

> …children as young as 13, 14 or 15 to go independently and say to their mates down at the railway station, the park or wherever they might be, 'I'm just going off to see my drug and alcohol counsellor.' They just do not do it. They cannot even get to court on time, let alone worry about getting to a drug and alcohol counsellor. My concern is that the voluntary model works for some but, for the vast majority of the really serious young people we are seeing, it does not work.[200]

2.127 Mandatory residential treatment was addressed in the NIT's final report. The NIT provided an overview of existing mandatory residential treatment legislation in

194 Raphael, 'Labor pledges $9.6m to WA's first drug and alcohol rehab prison', *The Age*, 27 August 2017.

195 Raphael, 'Labor pledges $9.6m to WA's first drug and alcohol rehab prison', *The Age*, 27 August 2017.

196 Ms Jennifer Bowles, *Submission 74*, p. 6.

197 Ms Jennifer Bowles, *Committee Hansard*, 27 July 2015, p. 18.

198 Ms Bowles, *Committee Hansard*, 27 July 2015, p. 18.

199 Ms Bowles, *Committee Hansard*, 27 July 2015, p. 18.

200 Ms Bowles, *Committee Hansard*, 27 July 2015, p. 20.

NSW, Victoria, Tasmania and the Northern Territory.[201] The NIT did not make a conclusion on the merits of mandatory residential treatment; however, it did note the high costs associated with this treatment and questioned whether these costs can be justified 'given the limited resources and lack of a robust evidence base'.[202] The NIT acknowledged concerns that mandatory treatment 'may diminish the capacity for treatment to be delivered flexibly and in a manner that enables the individual to own their problem'.[203] Finally, issues arising from an ethical and human rights perspective were also raised as a potential concern.[204] The NIT noted the complexity of mandatory treatment and referred to research that suggests:

> …while there is some evidence mandatory treatment for short periods can be an effective way to reduce harm, there is little evidence to support its effectiveness in rehabilitating or achieving long-term behavioural change.[205]

2.128 Mandatory residential treatment was not referenced in the NIAS.

Committee comment

2.129 The committee understands why many people—often outside the AOD treatment sector—hold the view that mandatory residential treatment is a viable option for drug users. The committee has heard numerous accounts where families have reached the limits of their capacity to support loved ones through their drug addiction. In these instances, it is not surprising that families and communities support mandatory treatment.

2.130 Evidence to the committee was largely critical of mandatory residential treatment, with many submitters and witnesses arguing it is not an effective response to problematic AOD use. As discussed in this chapter, many experts recognise that motivation to undertake AOD treatment must come from the individual, and cannot be enforced upon them. Without this underlying motivation, the success of treatment is limited. However, there may be a role for mandatory residential treatment in instances where a person is likely to harm themselves or others around them.

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201 New South Wales, Victorian and Tasmanian legislation provides for mandatory treatment for people with AOD dependence issues. The Northern Territory legislation provides for mandatory treatment for people with volatile substance misuse, such as solvents and petrol, as well AOD dependencies. Limitations are in place under each jurisdiction's legislation, such as a requirement for a person to be at risk of serious harm and if less restrictive treatment is not available to that person. Substance dependence must also be severe, and mandatory treatment considered beneficial to the person. Detention periods vary, depending on each jurisdiction, and may be extended with the approval of an authorised officer (for example a magistrate or responsible medical officer). See NIT *Final Report*, 2015, p. 63.

202 NIT, *Final Report*, 2015, pp 63–64.

203 NIT, *Final Report*, 2015, pp 63–64.

204 NIT, *Final Report*, 2015, pp 63–64.

205 NIT, *Final Report*, 2015, p. 64.

Methamphetamine use and treatment in correctional facilities

2.131 During the course of the inquiry, the use of methamphetamine in correctional facilities was identified as a significant problem. In 2015, the AIHW reported in *The health of Australia's prisoners 2015* (the AIHW prisoners' health report) that 67 per cent of all prisoners had used an illicit drug in the 12-months prior to entering a correctional facility.[206] The AIHW report also found:

- the most commonly used illicit drug was methamphetamine, with 50 per cent of respondents reporting its use over the reporting period;[207]
- ten per cent of prisoners discharged[208] from correctional facilities reported using an illicit drug whilst in prison;[209] and
- six per cent reported injecting drugs[210] of which four per cent of discharged prisoners reported sharing a needle whilst in prison.[211]

2.132 In 2015, the ACT was the only jurisdiction that had announced a needle and syringe exchange program (NSP)[212] in its correctional facilities.[213]

2.133 Although the AIHW prisoners' health report indicated problematic drug use existed in correctional facilities, the AIHW noted limitations with the report's data. For example, in 2015, NSW did not provide discharge data and no drug use data was provided by Victoria. Further, drug use data is self-reported and the AIHW concluded that it is likely that current illicit drug use in correctional facilities is 'underestimated because prisoners can be reluctant to disclose this kind of information'.[214]

2.134 The issue of illicit drug use in correctional facilities was canvassed by submitters and witnesses. Mr Craig Cumming, from the Centre for Health Services Research at the University of Western Australia, noted that methamphetamine had

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206 AIHW, *The health of Australia's prisoners 2015*, 2015, p. 96, https://www.aihw.gov.au/reports/prisoners/health-of-australias-prisoners-2015/contents/table-of-contents (accessed 21 December 2017).

207 AIHW, *The health of Australia's prisoners 2015*, 2015, p. 97.

208 New South Wales does not provide discharge data, and Victoria did not collect data for these indicators. Data is self-reported, and therefore likely to be underestimated. See AIHW, *The health of Australia's prisoners 2015*, 2015, p. 102.

209 AIHW, *The health of Australia's prisoners 2015*, 2015, p. 102.

210 AIHW, *The health of Australia's prisoners 2015*, 2015, p. 102.

211 AIHW, *The health of Australia's prisoners 2015*, 2015, p. 103.

212 Harm reduction services in correctional facilities are discussed further in chapter 4 of this report.

213 AIHW, *The health of Australia's prisoners 2015*, 2015, p. 102.

214 AIHW, *The health of Australia's prisoners 2015*, 2015, p. 102.

become the most prevalent illicit drug used by the prison population.[215] Through his engagement with prisoners, Mr Cumming had found people:

> …attribute their incarceration to using methamphetamine. Sometimes that is because they have committed the property crime to fund their habit or they have dealt in drugs because it is the only way they can afford to take them. At other times they have committed a violent offence or an offence against a person because of the state they were in due to being intoxicated.[216]

2.135 Mr Cumming also noted that many prisoners use methamphetamine as a form of self-medication.[217]

2.136 The Penington Institute argued that the notion that correctional facilities are drug-free spaces is a myth that must be rejected in order 'to have a mature conversation around' the issue,[218] and:

> Our prisons are still chock-a-block with people with drug addiction problems. In fact, there is an ice problem inside our prisons as well; people are not only being incarcerated with drug addiction, but continuing their drug addiction whilst inside.[219]

2.137 While it is known that prisoners use methamphetamine in correctional facilities, the committee heard there are inadequate treatment options available to them. Mr Cumming referred to the WA's Office of the Inspector of Custodial Services' report that 'medical and health services are not up to standard'.[220] He emphasised the importance of establishing treatment services in the prison system because this is a:

> …subset of the population that we know are the most afflicted with this problem, and the one area where they could be helped is the area where they are not getting helped—when they go to prison.[221]

2.138 The South Australian Network of Drug and Alcohol Services opined that it is essential for AOD treatment services to be offered in Australia's correctional facilities:

> In South Australia it is extremely difficult to get treatment services into prisons. I think that is probably problematic across the whole of the country. I think there is a really important space there for non-government organisations that have very good skills in working with people with drug and alcohol problems to be able to work with people in Corrections and to make those connections and to be able to do work with people whilst they

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215 Mr Craig Cumming, University of Western Australia (UWA), *Committee Hansard*, 3 May 2017, p. 33.

216 Mr Cumming, UWA, *Committee Hansard*, 3 May 2017, pp 33–34.

217 Mr Cumming, UWA, *Committee Hansard*, 3 May 2017, p. 34.

218 Mr John Ryan, CEO, Penington Institute, *Committee Hansard*, 27 July 2015, p. 10.

219 Mr Ryan, Penington Institute, *Committee Hansard*, 27 July 2015, p. 13.

220 Mr Cumming, UWA, *Committee Hansard*, 3 May 2017, p. 38.

221 Mr Cumming, UWA, *Committee Hansard*, 3 May 2017, p. 38.

> are incarcerated. A person should not go into prison as a drug addict and come out of prison still with the same problem, having had continuous use through that.[222]

2.139 The lack of funding to support prison treatment programs is, in Holyoake's view, a major problem.[223] Of its annual funding of $100 000, none was made available to prison AOD treatment programs.[224] Holyoake's employees:

> …go into prisons and we get no money. No-one gives us any money to do that, at all, no-one. We could have three groups running at the moment. The need in prison is so strong. What I think the general public do not understand, or maybe the government does not understand, is that whole revolving-door thing. These guys and girls, mostly guys, come in and out and in and out. Crime and drugs are so deeply related that you have to do something to break that cycle or it is just going to keep happening.[225]

2.140 The WANADA discussed prison treatment programs in the context mandatory residential treatment facilities in WA. It argued that rather than investing in mandatory facilities, money should be directed to establishing AOD treatment services in WA's prisons.[226] The WANADA informed the committee that WA did not have therapeutic options for prisoners and investment needs to be made to address 'the more than 70 per cent of people in prison with alcohol and other drug issues who would benefit from treatment'.[227]

2.141 The committee heard examples of services available in some correctional facilities. The Queensland Network of Alcohol and Other Drug Agencies referred to the ACT's Alexander Maconochie Centre as a potential AOD treatment model.[228] The Alexander Maconochie Centre's Solaris program provides therapeutic assistance to people who have six months or less of their sentence remaining. Through the program, prisoners receive help to address the issues that contributed to their drug use, with the aim to assist prisoners once they are released from the correctional facility.[229]

2.142 The National Aboriginal and Torres Strait Islander Legal Service (NATSILS) spoke of the Northern Australian Aboriginal Justice Agency's prison support program and post-release program. According to NATSILS, these initiatives have reduced recidivism and have made sure upon their release people are supported in the

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222 Mr Michael White, Executive Officer, South Australian Network of Drug and Alcohol Services, *Committee Hansard*, 28 July 2015, p. 52.

223 Ms Charlton, Holyoake Tasmania, *Committee Hansard*, 24 March 2017, p. 17.

224 Ms Charlton, Holyoake Tasmania, *Committee Hansard*, 24 March 2017, p. 17.

225 Ms Charlton, Holyoake Tasmania, *Committee Hansard*, 24 March 2017, p. 17.

226 Ms Rundle, WANADA, *Committee Hansard*, 3 May 2017, p. 30.

227 Ms Rundle, WANADA, *Committee Hansard*, 3 May 2017, p. 30.

228 Ms MacBean, QNADA, *Committee Hansard*, 30 July 2015, p. 3.

229 Ms MacBean, QNADA, *Committee Hansard*, 30 July 2015, p. 3.

community.[230] Although successful, NATSILS also noted a lack of funding for similar services in Central Australia[231] and recommended:

> …there needs to be a focus on resources: what their current state is, and what needs to happen to increase them—so resources both in the community and resources within the prison system that are specifically focused on dealing with substances, and that recognise the priority needs in particular communities and cater specifically for the particular substances around which there is most need in that particular community.[232]

2.143 The NIT's final report considered AOD treatment in the corrections system. It recognised that all states and territories provide AOD treatment programs in their correctional system; however, the focus and design of these programs varies. Broadly, these treatment programs consist of:

- harm reduction measures to enhance awareness about the physiological effects of AOD misuse;
- psycho-educational activities aimed at improving prisoners' understanding and awareness of the link between drug misuse and crime;
- therapeutic programs for groups to address AOD misuse, withdrawal, behaviour development, emotional management, relapse prevention and enhancing problem-solving and communication skills;
- the separation of prisoners from prison culture in order to undergo a dedicated therapeutic treatment program; and
- detoxification programs.[233]

2.144 The NIT reported that the most effective treatment programs available in correctional facilities are based on therapeutic community models. The NIT's report listed numerous programs available in correctional facilities in each of the states and territories.[234] It concluded that these programs could be improved by offering enhanced transitional services, such as pre-release and post-release programs.[235] These transitional programs have been demonstrated to halve the risk of recidivism for participants.[236]

2.145 The NIT also highlighted evidence that suggested that appropriate access to psychostimulant and other non-opioid drugs treatment services in correctional

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230 Mr Mark O'Reilly, Representative, National Aboriginal and Torres Strait Islander Legal Services (NATSILS), *Committee Hansard*, 30 July 2015, p. 12.

231 Mr O'Reilly, NATSILS, *Committee Hansard*, 30 July 2015, p. 12.

232 Mr O'Reilly, NATSILS, *Committee Hansard*, 30 July 2015, p. 12.

233 NIT, *Final Report*, p. 82.

234 NIT, *Final Report*, pp 83–84.

235 NIT, *Final Report*, p. 85.

236 NIT, *Final Report*, p. 85.

facilities is poor.[237] Indeed, the committee received similar evidence: for example, Rural Health Tasmania reported that NSW correctional facilities offered and placed non-opioid dependent inmates (such as methamphetamine users) onto opioid replacement therapy programs.[238]

2.146 The NIT opined that the design of correctional facility AOD treatment programs should align with best-practice approaches and be available to all correction-based populations.[239] The NIT subsequently recommended that '[u]nder the National Drug Strategy framework, state and territory governments should increase the focus on evidence-based approaches to treatment in correctional facilities and youth justice centres'.[240]

2.147 The NIAS noted that AOD programs are delivered in Australia's correctional facilities, but such programs were not included under the strategy itself.[241] NIAS funding guidelines for PHNs specifically prevents funds being directed to AOD treatment programs in correctional facilities.[242]

Committee comment

2.148 Evidence presented to this inquiry indicates a lack of understanding about illicit drug use in Australia's correctional facilities. The AIHW prisoners' health report provides an important insight into illicit drug use in correctional facilities; however, the committee is concerned that some jurisdictions provide incomplete data to the AIHW. This issue is further compounded by the likelihood of prisoners not fully disclosing their illicit drug use.

2.149 Acknowledging that self-reported data under-reports drug use, it is vital that accurate and comprehensive data is provided to the AIHW by all states and territories so that governments and AOD treatment service providers have sufficient information to develop treatment programs for Australia's prisoners. For this reason, the committee recommends Australian governments, in partnership with the AIHW, establish nationally consistent datasets and regular reporting of illicit drug use in Australia's correctional facilities.

237 NIT, *Final Report*, p. 85.

238 Rural Health Tasmania, *Submission 4*, p. 8.

239 NIT, *Final Report*, p. 85.

240 NIT, *Final Report*, p. 85.

241 Council of Australian Governments (COAG), *National Ice Action Strategy (NIAS)*, 2015, p. 13.

242 DoH, *Drug and Alcohol Treatment Services Workshop*, PHN National Forum, 23 March 2016, p. 23, http://www.health.gov.au/internet/main/publishing.nsf/Content/00069147C384180DCA257F14008364CB/$File/Drug%20and%20Alcohol%20Treatment%20Services%20Workshop-Department%20of%20Health.pdf (accessed 18 January 2018).

Recommendation 6

2.150 The committee recommends Australian governments, in partnership with the Australian Institute of Health and Welfare, establish nationally consistent datasets and regular reporting of illicit drug use in Australia's correctional facilities.

2.151 The lack of appropriate AOD treatment services available in Australia's correctional facilities is of concern. It is evident that prisoners are more likely to enter the corrections system with an existing illicit drug problem and that their drug use may become more problematic whilst detained in a correctional facility. This is a particular concern for those with methamphetamine addictions, because evidence suggests the availability and use of methamphetamine in correctional facilities is common.

2.152 The committee advocates for AOD treatment programs aimed at prisoners during, prior to and after their release. The committee does not consider it appropriate that people leave correctional facilities with more problematic drug use patterns or with a related health issue due their drug use, as a result of their imprisonment. For these reasons, the committee supports the NIT's recommendation for state and territory governments to increase the focus on evidence-based approaches to AOD treatment services in correction facilities and youth justice centres.

2.153 Although the committee is supportive of AOD treatment programs being offered in correctional facilities, it is outside the Commonwealth government's jurisdiction and is ultimately a service that is offered and funded by state and territory governments.

Pharmacotherapy

2.154 Pharmacotherapy describes treatments where an illicit drug is replaced with a legally prescribed and dispensed substitute. In Australia, the most common pharmacotherapy treatment is methadone for people with opioid addiction.[243] According to Harm Reduction Victoria, pharmacotherapy enables the drug user to:

> …stabilise their condition, allowing them to devote more time to managing or repairing their lives. Once stabilised, clients may find they wish to strive for a drug-free existence by slowly reducing their dosage – or else they may be satisfied with a maintenance program.[244]

2.155 Although pharmacotherapy is available for people with opioid addiction, there is currently no pharmacotherapy substitute for people with meth/amphetamine addiction, including crystal methamphetamine. This means treatment options are restricted to behavioural therapies or drug detoxification programs. The absence of

243 Harm Reduction Victoria, *What is Pharmacotherapy?*, http://hrvic.org.au/pharmacotherapy/general-information/what-is-pharmacotherapy/ (accessed 20 December 2017).

244 Harm Reduction Victoria, *What is Pharmacotherapy?*, http://hrvic.org.au/pharmacotherapy/general-information/what-is-pharmacotherapy/ (accessed 20 December 2017).

pharmacotherapy treatment may undermine the effectiveness of treatment for people presenting with the most severe meth/amphetamine addictions.

2.156 Professor Rebecca McKetin is one of Australia's leading experts in meth/amphetamine treatment and is currently trialling two new medications for methamphetamine dependence: lisdexamfetamine and n-acetylcysteine.[245] Professor McKetin advised that the two trials have been funded by the National Health and Medical Research Council (NHMRC).[246] One trial is using lisdexamfetamine, a long-acting form of amphetamine, in substitution therapy to minimise:

> …the harms associated with illicit use by giving people a prescription drug, which has a lot less harm associated with it. The drug trial I am leading is looking at a drug that should reduce people's desire to continue to use methamphetamine and, hopefully, reduce the severity of the psychiatric effects that they experience from using the drug.[247]

2.157 Lisdexamfetamine is already available on the market to treat obesity, narcolepsy and attention deficit hyperactivity disorder (ADHD). The second drug being trialled by Professor McKetin is n-acetylcysteine, which is currently used to treat chronic obstructive pulmonary disease and paracetamol overdose.[248]

2.158 Professor McKetin explained the effect of these drugs on a patient, in the context of their crystal methamphetamine use:

> Neither of those drugs perfectly replicate that effect. The lisdexamfetamine is a long-acting drug. It does not produce the high that crystal meth gives people but it will, in having some similar actions, reduce their propensity to need to go out and use the drug. It will stop the cravings, stop some of the awful effects someone gets when they stop using. It is a little bit like we have buprenorphine for opioid addiction—it has a different pharmacological action but similar enough that it stops people needing to go out and get the illicit drug. The drug that I am using is quite a novel drug. It has a very different action. It does not have any action that is similar to methamphetamine whatsoever. What it does is it acts as a buffer in the brain to bring their brain state back to something that is a little bit more similar to what it was like before they started using the drug.
>
> When you start using the drug and you take it once, you get high. But what happens over time is your brain adapts and it learns. It is those plastic changes in the brain that are targeted by this particular medication. It actually acts as a buffer against those changes so people do not get the same cravings they would get when they are addicted to the drug. Normally they go into withdrawal, start craving, and then go back and use the drug. When

245 NDRI, *Staff profile: Associate Professor Rebecca McKetin*, http://db.ndri.curtin.edu.au/staff/staff.asp?persid=537 (accessed 20 December 2017).

246 Professor Rebecca McKetin, NDRI, *Committee Hansard*, 5 May 2017, p. 35.

247 Professor McKetin, NDRI, *Committee Hansard*, 5 May 2017, p. 35.

248 Professor McKetin, NDRI, *Committee Hansard*, 5 May 2017, p. 35.

> they are on this medication, the cravings that they normally get going into that withdrawal phase would be less severe and so they are more in control of their drug use.[249]

2.159 Due to the availability of these two drugs on the market and the commercial production of these drugs, Professor McKetin opined that the use and production of these drugs would be a cost-effective solution to treat amphetamine addiction if shown to be effective.[250] It would also reduce the time required to achieve regulatory approvals.[251] However, if found effective 'it would still be a long way before we would be able to put something into practice'.[252]

2.160 While pharmacotherapy is an effective treatment option for people with drug addictions, Professor McKetin advised the committee that there is a role for both this form of therapy and psychological interventions, and that they 'would go hand in hand'.[253] Professor McKetin explained that:

> …you get the best results when you put the two together. With the pharmacotherapeutic options, not everyone wants to take a drug and they may not be so severely dependent that it is actually appropriate, and it would also depend on the type of drug. The lisdexamfetamine is more suited to people who are very heavily dependent and using every day whereas the drug that I am trialling might be suitable for someone who is using in a binge pattern because it does not have any psychoactive effect in and of itself; all it does is help the person resist the temptation to use. There are different places for pharmacotherapy for different people, and different types of therapies that could work along side the psychological interventions.[254]

2.161 Professor McKetin's colleague, Professor Allsop, emphasised her comments and stated that 'it is not either/or with these treatments' and their use 'depends on individual need'.[255] Further, Professor Allsop asserted that pharmacotherapy treatments should be equally considered alongside other treatments, and policymakers must not debate whether one treatment is better than another, but instead focus on what treatment is most suited to each individual:

> It is probably better to conceptualise the psychosocial interventions. Depending on need, some people may have a range of other problems that merit intensive counselling support. Other people might not need that, but certainly might need investment in improving the quality of their life, their access to employment and the way in which their family works. There are a

249 Professor McKetin, NDRI, *Committee Hansard*, 5 May 2017, p. 35.

250 Professor McKetin, NDRI, *Committee Hansard*, 5 May 2017, p. 35.

251 Professor McKetin, NDRI, *Committee Hansard*, 5 May 2017, p. 35.

252 Professor McKetin, NDRI, *Committee Hansard*, 5 May 2017, p. 35.

253 Professor McKetin, NDRI, *Committee Hansard*, 5 May 2017, p. 36.

254 Professor McKetin, NDRI, *Committee Hansard*, 5 May 2017, p. 36.

255 Professor Allsop, NDRI, *Committee Hansard*, 5 May 2017, p. 36.

> lot of people affected by methamphetamine whose relationships have taken a heck of a battering. Most interventions that are effective tend to combine a range of counselling, social interventions, housing, employment, recreational opportunities, family life and the support of families. And, depending on the individual needs, pharmacotherapies are sometimes part of that. So it is not about it is this treatment or that treatment. Unfortunately, one of the things that has happened commonly in the debate in the drug field has been, 'My treatment is better than yours,' rather than trying to work out what treatment might work best for what person under what circumstance.[256]

256 Professor Allsop, NDRI, *Committee Hansard*, 5 May 2017, p. 36.