

MAJOR CONCERNS

ABOUT THE CDHB ALCOHOL AND DRUG PROJECT

SUMMARY DOCUMENT (SEPTEMBER 2009)

1.0 Introduction

This paper is an expression of concern from the academic staff of the National Addiction Centre (NAC) about the outcome of the CDHB's planning for alcohol and drug services, reflected in a Summary Document (September 2009).

During the 2009 planning process various concerns were expressed by both the NAC as well as the National Committee for Addiction Treatment (NCAT).

The NAC, venued within the University of Otago Christchurch, includes four multidisciplinary academic staff, who hold joint clinical positions within the CDHB. Each has extensive experience in the addiction treatment field in clinical, research, teaching and managerial roles.

NCAT is the "peak body" for the national addiction treatment field, supported by the Ministry of Health. On this group are representatives from services, including the CDHB, research, workforce development, Maori, Pacific, and consumer representatives.

Amongst a number of concerns about the Summary Document, two key ones are:

1. Inequity of access to alcohol and other drug (AOD) treatment for individuals in contact with the Justice System, which appears discriminatory and could be considered a breach of human rights; and
2. The apparent lack of consideration of relevant local and overseas research data to inform planning, particularly research on the effectiveness of residential treatment.

2.0 Response to concerns expressed

Initial concerns raised about the plight of addicted people involved in the Justice System were acknowledged by Planning and Funding staff with the following comment... *justice clients were the focus of discussion during one working group meeting and this is reflected in the written information. The intention is to provide the same access for justice clients as provided to other members of the community and this is focused primarily on engagement with the hope that this will result in better outcomes.*

However, in the Summary Document (September 2009), the following position was re-stated under the heading of "Justice Clients".

Justice Clients:

Legal pressure can sometimes result in people reflecting on their situation. Information, education and brief intervention is appropriate at this point and should be provided by primary care, probation officers, prison staff etc. with the support of AOD specialists.

AOD assessment and treatment will be available to those who require it and are able to engage. People waiting for sentence will be able to access community groups (education, building motivation etc) and collaboration with corrections may result in joint initiatives for this group.

Once sentencing is completed entry into specialist AOD services will be viable for those who remain in the community.

Long-term treatment programmes to provide sentencing/prison release options for people in prison is not viable. AOD services funded by corrections to meet the needs of the prison population are supported and linking is required to ensure adequate transition planning for release into the community.

As per the agreement that exists between health and corrections, reports required for Courts and Parole Boards will be funded by these bodies. AOD services will provide support for prisoners due for release, although this is unlikely to be the provision of direct access into containment type facilities. The support may be best provided through collaborative work with prison release staff and will not necessarily involve comprehensive assessment and subsequent reports.

Next, a letter of concern was sent to Planning and Funding by NCAT (20.11.2009) regarding a Press article (2.11.2009) titled *\$14m a year, but where does it go?* Concern was expressed that significant changes to AOD services in Christchurch were being planned despite a reported lack of information on how well services worked, which implied suggested changes were based on opinion with little consideration given to gathering data on the current system, including clinical outcomes or service modeling that included a cost-benefit and impact analysis. The risks inherent in opinion based planning had been raised in previous feedback. It is particularly concerning when a set of opinion based ideas are out of step with most other DHBs nationally.

In the context of the reported lack of local data, the reported comment that residential programmes have *failure rates of up to 90%* appeared therefore to be an opinion. The considerable research literature in respect to residential treatment categorically negates the generalisation of up to the 90% failure rate reported. In terms of local data, NCAT pointed out that Odyssey House Christchurch, for example, has considerable client demographic and treatment related data, including a published paper on residents' characteristics at entry and three month retention rates (Mulder et al 2009).

3.0 Concerns elaborated and explained

3.1 Terminology and barriers to assessment and treatment

From a health service perspective, the term "Justice Clients" implies that such individuals and their whānau are outside of the health service boundary and thereby are not valid AOD treatment service clients.

Also, "Justice Clients" are not a homogenous group. Such individuals comprise a heterogeneous group of citizens and include those with charges pending or unresolved, individuals on probation, individuals facing sentencing who could benefit from mandated treatment, and individuals in prison requiring specialised addiction related assessments. In the Summary Document there was no discrimination between a person who may have been charged with a minor offence and a person who may have been charged with multiple serious offences. Further, people are presumably still considered innocent until proven guilty.

While it is acknowledged that the Summary Document is a high level document, the statements pertaining to "Justice Clients" (p.16) strongly suggest barriers to accessing assessment and treatment which are not in accordance with the international literature on motivation, engagement and external coercion. Nor are they in accordance with national policy on an integrated approach to addiction treatment for people with addiction and legal issues (eg funded DHB Court alcohol and drug assessor roles, the national health/justice interface focus, and the significant funding increase

for residential programmes as part of the methamphetamine response supported by the Prime Minister).

3.2 *Barriers to assessment and treatment for individuals with outstanding or unresolved legal charges*

A deliberate barrier currently exists, outlined in the Specialist Mental Health Service Community Alcohol and Drug Service's (CADS) policy (Service Provision Framework, 1st July 1998 reviewed June 2009, Table 1B Acceptance Criteria-Assessment) which excludes ...*consumers with outstanding or unresolved legal charges*.

It is highly likely that many individuals with outstanding or unresolved legal charges may require a more intensive level of intervention than, *Information, education and brief intervention...provided by primary care, probation officers, prison staff etc. with the support of AOD specialists* (Summary Document, September 2009). Many of those charges are a direct consequence of their addiction.

New Zealand research findings (Adamson et al 2006) show that 40% of patients presenting to outpatient DHB Community Alcohol and Drug Services in Christchurch and Hamilton met criteria for more than one substance use diagnosis with the most common dependence diagnoses being nicotine, alcohol, cannabis, amphetamine, opioid and sedative. Furthermore, almost three-quarters had a current Axis 1 psychiatric disorder, most commonly an anxiety (65%) or mood (53%) disorder. At admission, less than one quarter were employed demonstrating the significant disability associated with addiction. Contact with mental health services was high amongst the samples and over half (56%) had attended an outpatient service, 18% had been an inpatient and 33% were currently prescribed medications, mainly antidepressants. Finally, a high rate of past criminal involvement was also found, with two thirds having one or more criminal conviction and one third having served a past term of imprisonment.

3.3 *Individuals with opioid dependence*

While the re-design project excluded opioid substitution treatment (OST), the aforementioned CADS policy and the statements in the Summary Document pertaining to "Justice Clients" have significant implications for present and future individuals seeking OST from the Christchurch Methadone Treatment Programme. Such individuals present or are referred to CADS for assessment and, following assessment decisions are made as to the individuals suitability for admission to methadone treatment. Due to the illegal and expensive nature of opioid drug use most individuals with severe opioid dependence are involved in criminal activity at the point of entry to OST as shown by local Canterbury research findings (Adamson et al 1998; Sheerin et al 2003). About two-thirds of Christchurch Methadone Treatment Programme clients have reported that wanting to reduce their contact with undesirable peers and reduce criminal offending were major drivers to their seeking treatment (Deering et al 2004)

The reason for the importance of prompt access to OST is that opioid dependence is associated with high rates of premature mortality, overall estimated to be 13 times the rate of their peers (Hulse et al 1999). For the majority of individuals with severe opioid dependence, their addiction is associated with physical and mental health problems and associated impairments in personal, social and role functioning (Ward et al 1999). While New Zealand injecting drug users have low rates of HIV, New Zealand OST clients have high rates of hepatitis C virus (HCV) (Kemp et al. 1998). Local Canterbury research findings have confirmed the cost-effectiveness of OST (Sheerin et al 2004) and identified that treatment for HCV could be enhanced by reducing barriers to admission to OST and achieving stabilisation at an earlier age.

It is of note that the National Practice Guidelines for Opioid Substitution Treatment in New Zealand (MOH 2008) state that the comprehensive assessment for suitability for OST should start within two weeks of the person presenting or being referred (p.4). Should delay occur then the Guidelines provide for the option of the provision of interim methadone prescribing. This option is not available in Canterbury (Deering et al 2008).

3.4 *The influence of legal pressure on engagement into treatment and treatment outcomes*

The statement that ...*Legal pressure can sometimes result in people reflecting on their situation* does not address the issue of heterogeneity. In a review of the substance abuse literature on effectiveness of various levels of coercion (Anglin et al 1998) which again provided overall support for “Justice Clients” doing as well or better than voluntary clients in and after treatment, the authors supported the careful use of terminology ie use of the term *legal pressure* to “...describe the extent that an “offender” experiences discomfort over the potential consequences of noncompliance”; *legal referral* to describe a specific procedure of referral to treatment via probation, parole, diversion or specific sentencing requirements; and *legal status* to describe any form of legal involvement including charges, warrants and incarceration.

These authors made the important point that while external sources of coercion bring people into contact with the treatment system individuals differ in their levels of internal motivation thereby reinforcing the importance of providing prompt access to assessment.

Finally, in contrast to the CDHB Summary Document statements these authors made a number of relevant recommendations in respect to levels and style of interventions:

1. Individuals with low levels of criminal offending and less severe and complex substance related issues are best served with briefer interventions;
2. Individuals with longer term and more serious substance use disorders and offending histories will require longer term (eg three–nine months), more structured treatment approaches with attention to mental health, education and vocational training (with the expectation of several episodes of treatment);
3. For community based treatment clients the importance of taking a flexible, individualised, harm minimisation versus abstinence approach to substance use as long as the overall recovery process is not greatly disrupted - with the ability to provide more intensive treatment eg detoxification and residential treatment in response to relapse, acknowledging the chronic relapsing nature of addiction.

3.5 *Residential treatment*

The lack of differentiation between types of residential treatment in the Summary Document is concerning, particularly when considered alongside the reported comment that residential programmes have *failure rates of up to 90%* (Press article 2nd November). There is a considerable research literature with respect to residential treatment including evidence on effective models of treatment, duration of treatment and client groups for whom residential treatment is of benefit which categorically negates the generalisation of up to the 90% failure rate reported. Furthermore, the lack of differentiation amongst types of residential treatment services coupled with the Summary Document’s statement that residential programmes of up to three months will be supported runs the risk of both under servicing and over servicing.

3.6 *Therapeutic Community Programmes*

Therapeutic community (TC) programmes such as Odyssey House in Auckland and Christchurch include effective residential treatment components for a specialized group of patients. They are largely designed to provide treatment for individuals with the most severe and complex addiction

related issues, including associated legal issues. Many such individuals require habilitation as opposed to rehabilitation (Gerstein & Harwood 1990) and have frequently experienced significant adversity and social disadvantage in their lives and are less connected with their families and other support networks. Overseas studies have highlighted client profiles that incorporate a complex range of substance use and co-existing mental and physical health and social issues (e.g. US Drug Abuse Treatment Outcome Study (DATOS), Melnick et al 2000; UK National Treatment Outcome Research Study (NTORS), Gossop et al 1998; and the Woolshed evaluation, Mattick et al 1998).

The local study conducted by Professor Mulder and Odyssey House staff investigating the three month outcomes of Odyssey residents showed a similar client profile (Mulder et al 2009).

A central component of the TC treatment model is the structured delivery of programme components. This structure moves community members away from their negative behaviours, through the programme and ultimately towards the goal of integration into the wider community. To facilitate this process TC programmes are divided into stages (NIDA 2003). These typically include induction/early treatment, primary treatment and re-entry. In general, specific time spent in each stage is of less significance than remaining in treatment for a significant proportion of the programme and progress through stages. However, with increasing financial and other resourcing pressure, where TCs have traditionally allowed for 18-24 month stays, more recently the trend for many programmes is to reduce stays to 12 months or less (NIDA 2003).

The minimum treatment duration of around three months (not maximum duration as implied in the Summary Document) for treatment effectiveness was identified and replicated in the large-scale outcome studies conducted in the US (Drug Abuse Reporting Programme (DARP) (Simpson & Sells 1983); Treatment Outcome Prospective Study (TOPS) (Hubbard et al 1989); DATOS (Hubbard et al 1997) and in the UK NTORS (Gossop et al 1999). However, while longer duration in treatment predicts greater success, as Gossop et al (1999) emphasize, the best outcomes relate to completed planned duration of treatment. Furthermore, these authors observed that identifying a critical time in treatment does not necessarily relate to clinical improvement, although as the authoritative Institute of Medicine Report on *Treating Drug Problems* concluded in 1990 that "...those clients who stay in therapeutic communities for at least a third or half of the planned course of treatment ...at least 2-12 months, varying from program to program for reasons that are not yet clear - are much closer to achieving the treatment's goals at follow-up than those who drop out earlier" (Gerstein & Harwood 1990, p.166) ...and further..."The outcomes from the earlier dropouts basically cannot be distinguished from those of individuals who did not enter any treatment modality" (Gerstein & Harwood 1990, p.167).

However, while time in treatment is highly significant it must be coupled with engagement, participation and progress in meeting individualised treatment goals associated with the stages of treatment. Important issues to address are family involvement, social support, childcare, coexisting mental health issues, education, employment and cultural issues as well as re-entry and continuing support. *Retention success* may also be linked to an individual having multiple admissions suggesting a cumulative effect (De Leon 2000). Together with the findings from the retention literature, the fact that a proportion of those who leave treatment early are likely to re-present signals the importance of effort put into increasing motivation for treatment amongst all individuals referred. Thus it is important to engage all individuals who enter the TC door and welcome back those who re-present.

4.0 Final comments and proposal

Providing alcohol and drug treatment for “Justice Clients” is a daunting challenge in the current environment of cost-containment and budgets managed in separate silos. There are particular issues related to longer-term therapeutic community programmes which impact directly on the awkward Health/Justice interface.

There are also challenging clinical issues about client motivation and dropout as well as concerns about reduced access to services for other client groups if access is widened to everyone, including people who are concurrently involved in the Justice System.

However, to exclude people involved in the Justice System from specialist addiction treatment, even on the basis of “charges pending” is bizarre and as grossly inequitable as excluding them from specialist cancer or heart disease assessment and treatment. It is even more bizarre given the close relationship between offending and addiction when the Justice System connection can enhance treatment effectiveness. We emphasize that the exclusion of these potential clients is not simply part of the proposed regional planning document, but reflects *current* practice within the CDHB’s alcohol and drug service.

There are serious health related implications for drug addicted individuals and their whānau in contact with the Justice System. The proposed re-design of Canterbury’s alcohol and drug services, could impact severely on the whole Canterbury community. Further limiting the access to assessment and treatment for these citizens may solve short term problems in the CDHB’s alcohol and drug service, but in the end is likely to have a negative impact on the Region as a whole, including more high profile tragedies reported in the media.

Finally, although there remain many gaps in the international literature on effective addiction treatment and service configuration, it would be imprudent to proceed with a new regional plan for alcohol and drug services that is not well supported by what is currently scientifically established.

4.1 Proposal

It is suggested that the CDHB set up a small working group of key stakeholders to consider the issues above and develop an appropriate plan for the development of equitable and coordinated client care pathways for individuals and their whānau who are in contact with the Justice System; and that this is enacted before the Board begins to consider any new plans based on the Summary Document (September 2009).

NAC staff would welcome an invitation to be part of such a group.

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