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RACP Submission

Consultation on the draft National Treatment Framework – Version 3

July 2019

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of 17,000 physicians and 8,000 trainee physicians, across Australia and New Zealand. The College represents a broad range of medical specialties including addiction medicine, general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, and geriatric medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

RACP members see first-hand the many and varied harms caused by addiction when treating their patients in Australia's addiction clinics, rehabilitation centres, liver clinics, cancer wards, and hospital emergency departments.

RACP Submission

Thank you for this opportunity to provide feedback on the third version of the draft National Treatment Framework (NTF). This submission has been led by the RACP's Australasian Chapter of Addiction Medicine (AChAM) in consultation with relevant committees.

Feedback on the draft NTF

We welcome the development of this National Treatment Framework which seeks to "facilitate strategic planning of treatment and interventions and provide the context for national and state treatment processes, programs and policies"[1].

Section 1 - Preamble

In its preamble, the draft NTF makes the following statements: "treatment works and has been shown to be a cost-effective investment, resulting in cost savings to society" and "treatment is highly effective in helping individuals reduce or cease their substance use (demand reduction); improve their health, social and emotional wellbeing (harm reduction); and leads to reductions in the availability of substances (supply reduction)." In our view, the term "treatment works" is too simplistic and carries the risk of "over-interpretation" by some (i.e. it might be seen as implying that all treatments are equally effective and of equal merit when we know some are just not). We therefore strongly recommend these statements are reworded to acknowledge this fact.

Section 2 - Purpose of the National Treatment Framework

As outlined in Section 2 *Purpose of the National Treatment Framework*, the NTF's aims are four-fold:

1. provide a nationally endorsed shared understanding of alcohol and other drug (AOD) treatment for funders, providers, and treatment seekers and their families/friends;
2. facilitate role clarity, collaborative planning and purchasing, and effective and efficient monitoring;
3. achieve better communication amongst funders/purchasers, treatment providers and related systems of care; and
4. inform the general public and giving them a clear sense of what alcohol and other drug treatment is and what they can/should expect.

Whilst we feel the current draft goes some way to addressing the first aim to "provide a nationally endorsed shared understanding of alcohol and other drug (AOD) treatment for funders, providers, and treatment seekers and their families/friends", it not clear that the current draft addresses the remaining three aims, nor that it is feasible to do so in such a short document which is directed at both funders/purchasers and the general public (i.e. it will likely have too much detail for a lay person and not enough for service providers and funders).

Section 3 – Principles for Effective AOD Treatment and an Effective Treatment System

This section should clearly outline that the principles set out are aspirational and are not universally true in the current Australian treatment system.

We agree that the emphasis on "person-centred" treatment is important, however, the NTF also needs to acknowledge that treating health professionals need to include family and significant others in the focus for treatment for persons suffering from substance use disorder and that it's not "all about one individual" in isolation. Many clients have families, drive cars, work in occupations where some risk may be posed by substance use and/or treatments like MATOD etc. (e.g. mining and airline industry have zero-tolerance policies).

In this context, it is particularly important to recognise and acknowledge the needs of affected children in the NTF. Not only are there biological risks associated with their exposure to these drugs in utero, but there are also social risks, that unless appreciated and responded to, may compound biological risks.

[1] National Treatment Framework, Version 3, June 2019, p.5

Section 4- Alcohol and Other Drug Interventions and Alcohol and Other Drug Treatment

In this section, the draft NTF breaks down treatment into three distinct categories: interventions, engagement and treatment. However, we would recommend revising this categorisation as these are not mutually exclusive categories. For example, treatment can be an intervention and engagement is a process that needs to happen as part of treatment to provide the individual with the most appropriate treatment; consultation liaison in hospital is an intervention and can also include treatment (i.e. it is not only a hospital-based referral system as treatment can occur in hospital).

Hospitals and hospital clinics are another setting for both inpatient and outpatient treatment which is not specifically listed, and we would recommend explicitly referring to this treatment setting in the document.

This section also needs to emphasise that for most people a combination of treatment (e.g. counselling and pharmacotherapy) is typically more effective than single therapy. Most of the studies on pharmacotherapy emphasise this point and could be used as a reference for this statement. The discussion on treatment types included in the current draft appears to suggest they are separate and do not overlap, however, it should be acknowledged that counselling can occur with pharmacotherapy and withdrawal and pharmacotherapy can occur in residential treatment.

With regard to the principle of treatment being culturally responsive, the NTF should stress that all health (and welfare) services, including mainstream services, should seek to provide culturally safe care.

This section would also benefit from outlining the process of referral to AOD services as it may differ from the rest of the health system where patients seek referrals from their GP to access specialist care.

The reference to Naltrexone should be removed as it is not an effective treatment for opioid dependence.

Given the relative infancy of the specialty of addiction medicine, we feel the draft NTF would benefit from acknowledging that treatment is continually evolving and that it may be worthwhile participating in clinical trials, as this will promote engagement for the client, but also potentially benefit future generations of people suffering from a dependence issue.

Overall, this section needs to be more comprehensive to adequately acknowledge the complexities of treatment. With regard to treatment types, the document also needs to acknowledge that involuntary treatment pathways are in place in some states (currently Victoria, New South Wales and soon South Australia). We would therefore recommend that the document explains the meaning of voluntary, involuntary and coercive treatment. It would also be useful for the document to include a brief outline of what such systems are currently in place in Australia and to include descriptions of brief interventions in contrast with more extended interventions, case conferencing and case management.

Section 5 Planning, Purchasing and Resourcing Interventions, Engagement and Treatment

We recommend clarifying the key principle for purchasing interventions and treatment listed on p.17, under Section 5.2, “processes increase system capacity” as it is not clear what it refers to in this context.

One the principles outlined in Section 5.3 is “the meaningful engagement of clients and their families in AOD planning and purchasing (consistent with the principles across this Framework) requires resourcing/funding”. Whilst many but not all AOD services have some level of consumer participation (most public funding bodies usually require it), it would be useful for the NTF to provide information about what this means and how it operates. This section should also point out where such support can be sought to assist those service providers that do not currently operate with consumer input.

Section 7 - Monitoring, Service Reporting, Evaluation and Research

In this section, one of the principles mentioned is “efficiency: non-duplicative monitoring systems are in place”; at present, there is a lack of clarity particularly with regard to State and Commonwealth funding for residential rehabilitation beds which is a major challenge for the AOD sector. The document would benefit from addressing this issue to acknowledge that in the current system, it is not uncommon for a funder not to know what another funder is funding, and that there are different reporting mechanisms in place with different KPIs and little transparency. It would be useful for the NTF to suggest how the issue of duplication can best be addressed to improve the current system.

In addition, this section should also acknowledge that many treatment providers already engage in quality assurance and clinical research. In our view, the NTF would benefit from outlining the importance of quality assurance and clinical research and include information on how it should be conducted e.g. ethics approval process, research governance etc.

Section 8 – Evolution

In Section 8 *Evolution*, the draft states that "Compared to other nations, Australia has a very good alcohol and other drug service system". Whilst we acknowledge that the Australian AOD treatment system has many positives compared to some countries, it also has shortcomings, and these should be clearly acknowledged in the NTF.

Additional comments

- As this is a document designed for the general public as well as service providers and policy makers, we would recommend noting that complete abstinence from substance use is not always possible for some clients. We acknowledge that the NTF refers to harm minimisation, however, explaining this further may be of benefit to the general public as many families of individuals suffering from substance use disorder see complete abstinence as the only goal possible, when for some harm minimisation and ongoing engagement is perhaps a better strategy.
- Whilst we appreciate that the draft NTF has largely been developed through consultation, it would benefit from including relevant references to evidence that the interventions being suggested work. For example, when the NTF refers to treatment being cost effective, a reference could be added to the "Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment" study[2], which was the landmark study showing every $1 invested in drug treatment saved $7.
- We recommend that the NTF acknowledges particular concerns regarding barriers to treatment entry/engagement that can include issues around confidentiality and professional ethics in a setting that provides care for clients engaged sometimes in illicit drug use and also criminal activities. For example, some clients may fear that they will be reported and that their employer or other authority will be notified. Due to these concerns, sometimes clients forbid physicians from undertaking what they might consider as appropriate health professional collegiate communication (e.g. letter to GP). In addition, in some jurisdictions, mandatory reporting exists for drug dependence as well as child safety and some individuals (e.g. AOD-impaired health professionals, pilots, etc), may hesitate to access treatment because of fear of disclosure. Hence, the NTF should outline how treatment providers can ensure confidentiality to all clients as well as their rights and responsibilities (i.e. being responsible for their care and with the best possible treatment approaches).
- The NTF should acknowledge that clients have a responsibility not to threaten/abuse other clients or staff. The latter when particularly serious often results in involuntary discharge from treatment, that also can be a source of anger, frustration and misunderstanding for clients and the principles around this should be spelt out in this document.
- The current draft NTF does not include much information relating to GPs as service providers, who are critical to the AOD treatment system. The GPs' role as service providers should be more clearly acknowledged and articulated in the NTF.
- The NTF should stress the issue of accessibility of treatment for those living in rural and remote areas in particular where access is currently very difficult and outline that accessibility should be a priority for AOD services.
- The NTF could also mention the use of telehealth services particularly for individuals living in rural and remote communities where access to AOD services is often difficult. Telehealth could also be particularly useful to assist health workers in rural and remote areas with case-based learning.

Concluding remarks

The development of the NTF is an important step to guide a national response to alcohol and other drug treatment and to complement the effective implementation of the National Drug Strategy. In order to succeed, it is essential that it is fully supported by both Federal and all State and Territory Governments as they fund and further develop their AOD sector and that it is adhered to by service funders, providers and clinicians. We hope that with this support, it can succeed in driving accountability and improve service levels for patients across the country.

[2] Gerstein, Dean R., et al. "Evaluating recovery services: the California drug and alcohol treatment assessment (CalDATA) general report." *Sacramento, CA: California Department of Alcohol and Drug Progams* (1994).

Thank you again for the opportunity to provide feedback on the third version of the draft National Treatment Framework. Should you require any further information about this submission, please contact Claire Celia, Senior Policy & Advocacy Officer, on Claire.Celia@racp.edu.au.