HEALTH COMPLAINTS COMMISSIONER

Review of private health service providers offering alcohol and other drug rehabilitation and counselling services in Victoria

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People unfortunately are being taken advantage of, people in a very vulnerable position … Any Tom, Dick or Harry can set up a drug rehab clinic in Victoria.

Toby Lawrence, Director of Arrow Health, <https://www.abc.net.au/news/2017-09-21/victorian-government-urged-to-regulate-private-drug-rehab/8965836>

The receptionist at the office gave me a nine page contract. No one went through the terms with me, the program was not discussed, I was not told what would happen if [my daughter] had to leave the facility. I was sat in a reception area, not even an office, with [my daughter] nodding off and drug affected next to me. My gut feeling was that I wanted to run it by my lawyer before handing over $12,200 but I was desperate, panicked and scared for [my daughter's] life. I wasn't sure what would happen if I waited another couple of days for legal advice. [The client services manager] reiterated the urgency of the situation and told me I needed to get [my daughter] in that day. I understood acting quickly was important as [my daughter] could change her mind so I signed the contract there in the reception area. Then [the client services manager] said they were taking [my daughter] to the doctor for an assessment before taking her to [the facility]. The whole process was very instantaneous. After [my daughter] left, I went to a bank and had the $12,200.00 deposited in [to the provider's] bank account.

Mother of a client at a private alcohol and other drug residential treatment facility

I believe that the prescribing of detox and withdrawal is a good start, however a regulatory framework of minimum therapeutic requirements for rehabilitation needs to be set, still allowing services to have their own flavour. And their own influence.
The regulatory process that has come in has not gone far enough. I believe that only regulating detox and withdrawal is taking the easy option, because …
it still does not stop someone building a $2,000 website, renting a house and calling themselves a drug rehabilitation centre.

Manager at a private alcohol and other drug treatment provider

Unfortunately we're in a system where there [are] no minimum standards in this field … the danger here is if 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.

Professor Dan Lubman, Director, Turning Point, Eastern Health
Source: Four Corners, 'Rehab Inc: The high price parents pay to get their kids off ice', ABC, 12 September 2016

Foreword

On 1 February 2017 the *Health Complaints Act 2016* commenced operation and introduced a minimum set of legal standards with which all general health service providers – including alcohol and other drug (AOD) treatment providers – in Victoria must comply. Prior to 1 February 2017 these general health service providers were not regulated.

In late 2017 the Victorian Government, as part of the commitment made through its *Drug rehabilitation plan*, provided funding to my office to tackle unsafe or poor-quality private AOD treatment providers. This funding enabled me to establish dedicated capacity within my office to investigate this sector based on complaints we had received.

When we began this investigation in May 2018, there had been 49 complaints since 1 February 2017. From 1 May 2018 until 31 August 2019 there were another 53 complaints.

Since the beginning of this sector-wide investigation, at least four AOD treatment providers subject to our investigations have ceased operating. This is in part due to the added scrutiny our investigations have placed on their operations and the introduction of the Health Services (Private Hospitals and Day Procedure Centres) Amendment Regulations 2018.[1]

AOD use contributes to more than $55 billion in preventable health and harms in Australia each year and was responsible for 1795 drug-induced deaths among Australians in 2017. Adverse effects of AOD misuse and addiction are amplified when mental health issues are also present. The evidence suggests that one or more diagnosed mental health problems occurring at the same time as problematic AOD use is common, and this has been a recurrent theme throughout our investigations.

Privately funded AOD services perform an important role in supplementing the publicly funded services in helping treat people affected by AOD addiction. About 40,000 Victorians access public AOD treatment services every year and, while the publicly funded AOD treatment sector is subject to stringent requirements with respect to quality and safety, the same is not true of the privately funded sector. The lack of targeted regulation of the latter means there may be unscrupulous providers or practices preying on individuals and their families at a time when those individuals are at their most vulnerable. The intersection between undersupply, vulnerability and the for-profit model is the space where poor consumer outcomes occur and which, by and large, generates complaints to my office.

Most of the complaints received by my office, and our subsequent investigations, have been primarily about residential rehabilitation and detoxification services that are predominantly based on a 'therapeutic community' model of treatment. This was due in part to an unwillingness of some providers to resolve complaints internally.

Residential rehabilitation is an important stream of treatment that can experience significant wait times in the public system. The evidence suggests that residential/inpatient treatment settings are associated with better outcomes than outpatient treatment for those patients who have higher levels of substance use severity at intake and are less socially stable.[2]

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[1] Health Services (Health Service Establishments) Regulations 2013 s.7(c)(i). The 2018 Regulations only apply to the detoxification phase of treatment and were implemented to make treatment safer.
[2] Lubman, D, Manning, V and Cheetham, A 2017, *Informing alcohol and other drug service planning in Victoria*, Turning Point, Melbourne.

Terms of the investigation

Our investigation was intended to be wide-ranging and had, as its starting point, the issues we had been seeing in complaints to my office. Key themes within complaints related to exploitative billing practices, issues around informed consent, concerns about safety and effectiveness of treatment and inappropriateness of discharge. It was clear from the complaints received that there were issues in the way in which privately funded AOD treatment services were being provided that did not appear in the publicly funded part of this sector.

Methodology

Much of the initial data was obtained from complaints received by my office. Broadly, our methodology was to identify good industry practice standards by engaging with relevant stakeholders in the AOD treatment sector such as Turning Point and Odyssey House Victoria, encouraging the public to contact my office and reviewing complaint trends. Investigations into numerous providers occurred concurrently and ongoing monitoring will continue.

Findings

Overall, we have identified some disturbing patterns within the privately funded AOD treatment sector. By way of summary, it appears that the intersection between undersupply, vulnerability and the for-profit model is the space where poor consumer outcomes seem most likely to occur and that, by and large, generates complaints to my office. Such complaints are heightened by the unregulated nature of the sector. With the exception of the 2018 Regulations, private AOD residential rehabilitation providers are largely unregulated which, as evidenced by the case studies in this report, appears to have had a detrimental effect on the health and wellbeing, and financial situation, of clients and their families.

While we have seen a decline in the overall complaints about AOD treatment providers, there are still significant improvements to be made to the private AOD treatment sector. Importantly, if clients are not aware of their rights and the complaint mechanisms my office provides, we are unlikely to become aware of the problems.

Recommendations

In all, we have made 21 recommendations that we consider would establish a stronger regulatory landscape for providing AOD rehabilitation and counselling services by privately funded health service providers in Victoria. The recommendations will bring privately funded AOD services more closely into line with publicly funded services.

Our recommendations are broken into three key recommendations and a range of supporting recommendations. The three key recommendations would establish a framework to maintain and monitor the quality and safety standards in the private AOD treatment sector to ensure all Victorians accessing AOD treatment services receive high-quality, safe and ethical treatment. Of the supporting recommendations, some are stand-alone and some relate to, and flow from, the key recommendations.

It is acknowledged that implementing the recommendations in this report would take time and considerable resources, and so the recommendations could be introduced in stages.

I want to thank my staff, in particular investigators Troy Maher and Ruth Morgan under the guidance of Ralph Haller-Trost, Assistant Commissioner, Investigations, Legal and Policy for the enormous amount of work that has gone into this major investigation. The work has involved a long and meticulous process with many interviews, site visits and countless hours of research and writing that has led to this thorough and detailed report.

Karen Cusack
Health Complaints Commissioner
4 June 2020

Recommendations

Set out below are the recommendations we consider would support safe and ethical health care in the provision of alcohol and other drug (**AOD**) rehabilitation and counselling services (**AOD treatments**) by privately funded health service providers in Victoria (**private AOD treatment providers**) – that is, those that do not receive public funding. These recommendations are set out in more detail in the body of this report.

Our key recommendations are: for the introduction of a mandatory registration or licensing scheme for all entities operating as private AOD providers; a mandatory registration scheme for all 'AOD workers'; and the introduction of 'protected titles'. In addition, we have identified a number of 'supporting recommendations', many of which flow from the key recommendations.

While we consider the key recommendations would have the greatest immediate, beneficial effect as well as establishing a clear framework for the private AOD sector, we have developed the recommendations so they may be implemented in stages or as standalone proposals. Similarly, while we see the key recommendations as important for this sector, it may be possible to introduce supporting recommendations ahead of the key recommendations.

Key recommendations

1	It is recommended that a mandatory registration/licensing scheme is introduced for all entities/organisations/individuals operating as private AOD treatment providers that offer or provide private AOD treatments. Such a registration/licensing scheme would include a self-reporting/auditing framework based on a set of minimum quality and safety standards (*see supporting recommendations 4–21*).
2	It is recommended that a mandatory registration scheme is introduced for all AOD workers who provide or offer to provide AOD treatment services.[3]
3	It is recommended that the mandatory registration scheme defines and limits the use of titles such as 'AOD counsellor' to those who have reached and maintain a minimum level of prescribed qualifications and ongoing professional training.

Supporting recommendations

4	It is recommended that all private AOD treatment providers use a standardised tool such as the Victorian AOD Intake and Assessment Tool to match treatment to the type, pattern and severity of substance use when assessing and determining clients' treatment plans.
5	It is recommended that all private AOD treatment providers enter into written contracts with clients for providing AOD treatment before treatment begins. All private AOD treatment providers must make a copy of their contract template available on their website and direct prospective clients to that document.

[3] An 'AOD worker' would be defined by their core role in providing direct AOD treatments to clients – as distinct from workers performing training, research, ancillary, domestic, peer support, information and support services or management services. This definition is consistent with *The Victorian alcohol and other drugs workforce development strategy – minimum qualification strategy.*

6	It is recommended that all contracts between private AOD treatment providers and clients comply with Australian contract law and the Australian Consumer Law. These contracts must include: (a) fair and reasonable terms that enable clients to obtain refunds for unused portions of treatment (b) where appropriate, cooling-off periods for clients to review the suitability of the contract and services being offered. For example, a term allowing a cooling-off period would be more appropriate where the contract is the outcome of planned treatment discussions and relates to ongoing provision of services in a residential facility as opposed to services provided on a short-term, urgent basis such as acute detoxification treatment.
7	It is recommended that all private AOD treatment providers be required to obtain from their clients: (a) informed consent before any treatment is provided (b) informed financial consent before any payment is made. Any consent provided must be appropriately recorded. The person engaged by a private AOD treatment provider to obtain and record client consent must be someone engaged by the provider at a management level – for example, the general manager or chief financial officer. Where a client is incapable of providing consent (e.g. due to the effects of AOD intoxication), the relevant consent must be obtained from a suitable next of kin, guardian or person who may lawfully consent on the client's behalf.
8	It is recommended that all private AOD treatment providers comply with the Australian Consumer Law and the 'General code of conduct in respect of general health services' set out in Schedule 2 of the *Health Complaints Act 2016* in relation to their advertising and/or promotional material regarding: (a) any claims they make about the efficacy of their treatment and success rates of their service (b) any statements they make about their staff or contractors regarding qualifications, training, accreditation or professional affiliations (c) any statements they make in relation to endorsements or testimonials.
9	It is recommended that all private AOD treatment providers that are not registered under the Health Services (Private Hospitals and Day Procedure Centres) Amendment Regulations 2018 must, as part of any mandatory registration scheme, be regularly and independently audited to ensure they provide AOD treatment that is considered best practice and is safe and effective and that their premises remain clean, safe and fit for purpose.
10	It is recommended that, as part of any AOD worker registration scheme, AOD workers must be required to obtain specialist qualifications in AOD treatment. Specialist qualifications must be to Certificate IV level or higher as modelled on *The Victorian alcohol and other drugs workforce development strategy – minimum qualification strategy*.
11	It is recommended that all AOD workers with a previous history of AOD addiction ('lived experience') must have maintained recovery for at least 12 months before being permitted to work in the AOD sector.

	Where private AOD treatment providers recruit AOD workers with lived experience, the providers must have processes for providing ongoing on-the-job-training, support and supervision.
12	It is recommended that all private AOD treatment providers that offer treatment to people with 'dual diagnosis' (i.e. patients with one or more diagnosed mental health concerns occurring concurrently with AOD addiction) must either: (a) have access to appropriately experienced, trained and competent staff or contractors to provide AOD treatments to such clients, or (b) take reasonable steps to assist such clients (or potential clients) to find an alternative, suitable health service provider such as a recognised provider of mental health services.
13	It is recommended that all private AOD treatment providers take all reasonable steps to ensure their AOD workers, staff, contractors or any other person engaged in the private AOD treatment facility does not, while the client is receiving AOD treatment within the facility and for a reasonable period of time after treatment has ceased,[4] engage in any conduct that involves: (a) behaviour of a sexual or close personal nature with a client, or (b) a sexual or other inappropriate close personal, physical or emotional relationship with a client.
14	It is recommended that private AOD treatment providers only be permitted to employ people who are appropriately trained to provide emergency assistance. At a minimum, suitably qualified staff must be available on site during operational hours with the following qualifications and skills: (a) Certificate IV in Alcohol and Other Drugs Work (part of this qualification involves a first aid component – first aid certificates must be kept up to date) (b) training in 'Suicide and Self-harm Assessment and Response' and in 'Managing Difficult or Aggressive Clients'.
15	It is recommended that all private AOD treatment providers that treat minors in residential facilities must ensure all minors are housed and treated separately from adult residents or treated in a youth-specific facility. As part of the mandatory registration/licensing scheme, all staff employed in residential facilities must have a valid Working with Children Check.
16	It is recommended that all AOD workers involved in treating minors or employed by private AOD treatment providers that treat minors: (a) be appropriately skilled at treating the complexities of AOD addiction specific to minors (b) have a valid Working with Children Check.
17	It is recommended that all private AOD treatment providers develop a discharge policy that requires them to only discharge clients in a safe and ethical manner. As a minimum, any such policy must include: (a) clear steps for a client to follow after they are discharged such as a GP review, ongoing counselling or engagement in an aftercare program (b) discharge support that encompasses planning in the event of relapse, such as re-entry to the program or review by other community services.

[4] The recommend time period is a minimum of two years, in line with the time frame established by the 'APS Code of Ethics' and 'ACA Code of Ethics and Practice'.

	If a discharge relates to the capacity of an AOD treatment provider to effectively treat a client, the AOD treatment provider must exercise its duty of care to ensure the client is transferred to, or receives, appropriate care.
18	It is recommended that all private AOD treatment providers introduce clear records management systems that document and include a client's assessment, treatment needs, management plan and progress to ensure compliance with the AOD treatment provider's legal obligations in relation to health information under the *Health Records Act 2001*.
19	It is recommended that all private AOD treatment providers comply with the 'General code of conduct in respect of general health services' as set out Schedule 2 of the *Health Complaints Act 2016.* As part of the mandatory registration/licensing scheme, AOD treatment providers must include an education program for staff on rights and obligations under the 'General code of conduct in respect of general health services'.
20	It is recommended that all private AOD treatment providers develop a complaint handling policy that complies with the minimum requirements of the complaint handling standards as set out in the *Health Complaints Act 2016*: • Information about complaint handling processes must be readily available to clients. • Providers must inform clients that if they are not satisfied with the provider's response, the client may make a complaint to the Health Complaints Commissioner.
21	It is recommended that all private AOD treatment providers have comprehensive, written policies and procedures that detail a minimum set of standards of service relevant to the type of AOD treatment being provided that are regularly reviewed and updated. Copies must be easily accessible to clients and potential clients. Applicable policies will form part of the mandatory registration/licensing scheme.

Background

Introduction

On 17 November 2017, the Hon Martin Foley, Minister for Mental Health, announced that the Victorian Government would provide funding to the Health Complaints Commissioner (**HCC**) as part of the government's *Drug rehabilitation plan*. The funding was provided to strengthen the capacity of my office to monitor and investigate complaints about unsafe and sub-standard private alcohol and other drug (**AOD**) treatment providers over 18 months. Due to the number and complexity of the matters arising, the investigation has taken longer than 18 months. In addition, as the primary investigation continued, a number of separate investigations, 15 in total, were also undertaken to deal with specific matters that warranted investigation outside of, and in addition to, the broader systemic investigation.

The *Health Complaints Act 2016* (**Act**), which established my office, created a new category of health service providers, namely 'general health service providers' and included a code of conduct (**Code**) that sets out a minimum set of legal standards that all general health service providers in Victoria must adhere to. The Act also put in place interim complaint handling standards that apply to all health service providers in Victoria.

Central to the obligations set out in the Code, is the principle that general health services must be provided in a safe and ethical manner (Code clause 1). The other Code obligations support that core principle and reflect good health practice such as:

- recognising the limitation of treatment a provider can provide
- maintaining the necessary competence in the provider's field of practice
- not misinforming clients about products, services or qualifications
- not financially exploiting clients
- not engaging in sexual misconduct.

Despite the commencement of the Act and the Code, my office continued to receive complaints about private AOD treatment providers that raised concerns about their Code compliance. Between 1 February 2017, when the Act commenced, and 31 August 2019, we received 102 complaints relating to AOD treatment services. The issues most commonly raised in these complaints were exploitative billing practices – sometimes involving treatments costing up to $32,500 – and a lack of informed consent for financial and treatment decisions. Concerns about the safety and effectiveness of treatments, cleanliness of facilities and inappropriate discharge of patients were also raised in complaints. What is notable is that across these complaints:

- providers of AOD treatment services whose services were funded by government had a much lower complaint profile
- most complaints to my office about private AOD treatment providers related to two of the most prominent providers in Victoria.

Since the beginning of our major investigation, at least three private AOD treatment providers subject to our investigations have ceased operating. This appears to be due to the pressure our investigations have placed on their operations and the introduction of the Health Services (Private Hospitals and Day Procedure Centres) Amendment Regulations 2018 (**the 2018 Regulations**). Some providers have directly attributed the 2018 Regulations and our increased

scrutiny of the sector as a reason for discontinuing services.

This document provides:

- an overview of our role and functions
- an overview of the complaints we have received about private AOD treatment providers
- an overview of the types of issues raised across these complaints
- a review of these issues against the Code
- recommendations we believe would help improve the quality and safety of services offered by private AOD treatment providers in Victoria.

Role of the Health Complaints Commissioner

The Act establishes my role as an independent and impartial office to receive and deal with complaints about health service providers in Victoria. Under the Act complaints fall broadly into three categories:

- complaints by the person who received or sought the health service: s.5
- complaints about a health service received or sought by another person: s.6
- complaints by carers: s.7.

The range of matters that a person can complain to my office about under ss.5 and 6 is broad and includes:

- the unreasonable provision of a health service
- the unreasonable failure to provide a health service
- in the case of general health service providers, a failure to comply or act consistently with a code of conduct applying to the general health service.

Part 4 of the Act also empowers my office to conduct investigations into health service providers in Victoria. In summary, the Act provides for three types of investigations:

- Complaint investigations (s.45): These are matters where I have decided that a complaint is to be the subject of an investigation rather than a complaint resolution process. The triggers for a s.45 investigation include, among other things, the unsuitability of a complaint for a complaints resolution process, the failure (without reasonable excuse) by a health service provider to participate in a complaint resolution process and the contravention of a code of conduct applying to a general health service.
- Minister-referred investigations (s.46): These are matters that are investigated following a referral to me by the Minister.
- Commissioner-initiated investigations (s.47): These are investigations I can initiate in relation to any matter that a person would be able to make a complaint about under ss.5, 6 or 7 of the Act.[5]

What is a ‘health service’ under the Act?

The definition of ‘health service’ under the Act is broad. Section 3 of the Act states that:

[5] Further information about my office is available at: https://hcc.vic.gov.au/.

health service means the following services—

(a) an activity performed in relation to a person that is intended or claimed (expressly or otherwise) by the person or the provider of the service—

(i) to assess, predict, maintain or improve the person's physical, mental or psychological health or status; or

(ii) to diagnose the person's illness, injury or disability; or

(iii) to prevent or treat the person's illness, injury or disability or suspected illness, injury or disability;

(b) a health related disability, palliative care or aged care service;

(c) a surgical or related service;

(d) the prescribing or dispensing of a drug or medicinal preparation;

(e) the prescribing or dispensing of an aid or piece of equipment for therapeutic use;

(f) health education services;

(g) therapeutic counselling and psychotherapeutic services;

(h) support services necessary to implement any services referred to in paragraphs (a) to (g);

(i) services—

(i) that are ancillary to any other services to which this definition applies; and

(ii) that affect or may affect persons who are receiving other services to which this definition applies[6];

(j) any other prescribed services;

AOD treatment services are 'health services' under the Act.

What is a 'general health service provider' under the Act?

AOD treatments are diverse and complex and in some cases involve concurrent treatment from multiple health professionals such as doctors, psychologists, nurses and counsellors. AOD treatments are also offered, promoted and provided by entities that engage individual health professionals.

The *Health Practitioner Regulation National Law* (**National Law**) provides a registration and compliance framework for 16 registered health professions such as doctors, nurses, psychologists and paramedics.

Under the Act, a health service provider who does not practice a health profession is a 'general health service provider'. By defining general health service providers and introducing the investigation powers referred to above, the Act significantly expanded the remit of the HCC over

[6] Examples of services to which paragraph (i) applies are laundry services, cleaning services and catering services.

that of the Office of the Health Services Commissioner and established a clear regulatory role for my office within Victoria with respect to health services.

Importantly, the definition of general health service provider captures both individuals and bodies corporate. This means that in addition to support workers, counsellors and therapists providing AOD treatments, the business entities that offer, promote and provide these services will also be general health service providers under the Act.

While my office does receive complaints about registered health practitioners, complaints relating to their professional misconduct are generally referred to the Australian Health Practitioner Regulation Agency (**Ahpra**) to deal with under the National Law.

The Code – Schedule 2 of the Act

Schedule 2 of the Act sets out the 'general code of conduct in respect of general health services' (**Code**). A copy of the Code is reproduced at the end of this document. The core principle underpinning the Code is the obligation to provide general health services in a safe and ethical manner.

The obligations in the Code are not aspirational standards that providers should strive to attain. Instead, they are a minimum set of legal standards with which all general health service providers in Victoria must comply.

The Code also applies to practitioners registered under the National Law who operate outside their area of registration – for example, a physiotherapist (a registered profession) providing reiki therapy (a general, or non-registered profession).

In summary, the Code requires general health service providers to:

- provide safe and ethical health care
- obtain consent for treatment
- take care to protect clients from infection
- minimise harm and act appropriately if something goes wrong
- report concerns about other practitioners
- keep appropriate records and comply with privacy laws
- be covered by insurance
- display information about the Code and about making a complaint.

The Code also states that general health service providers must not:

- mislead clients about their products, services or qualifications
- put clients at risk due to their own physical or mental health problems
- practice under the influence of drugs or alcohol
- make false claims about curing serious illnesses such as cancer
- exploit clients financially
- engage in sexual misconduct or an inappropriate relationship with a client
- discourage a client from seeking other health care or refuse to cooperate with other practitioners.

Sanctions

The sanctions powers are set out in Parts 7 and 8 of the Act:

- Under Part 7, I can publish general health warning statements (during an investigation) and health warning statements (on completing an investigation). The preconditions for publishing such statements are set out in ss.84 and 87 of the Act.
- Under Part 8, I can make interim prohibition orders (**IPOs**) and prohibition orders (**POs**). These sanctions apply only to general health service providers. The preconditions for making such orders are set out in ss.90 and 95 respectively.

In summary, I must not make an IPO unless:

- I reasonably believe that the relevant general health service provider has either contravened a code of conduct applying to the general health service being provided or been convicted of a prescribed offence[7]
- I am satisfied that it is necessary to make the order to avoid a serious risk to the life, health, safety or welfare of a person or the health, safety or welfare of the public.

I can make an IPO during an investigation under Part 4 of the Act. An IPO can prohibit a general health service provider from providing all or part of the general health service being investigated for up to 12 weeks or impose conditions on providing the general health service being investigated for up to 12 weeks.

The prerequisites for POs are similar, except that I can only make a PO after an investigation has been concluded and that POs can be in place permanently.

The Act requires me to publish IPOs and POs on our website and in the *Government Gazette*.

Complaint handling standards – Schedule 1 of the Act

These standards are supported by the obligations in Code clause 17, which require general health service providers to give their clients access to the Code as well as information about how to make complaints to my office.

[7] No offences have been prescribed for the purposes of the Act.

Interim standards for complaint handling

The following interim minimum standards for handling complaints apply to all health service providers in Victoria:

(a) that a complaint made by a person about a health service provided to or sought by a person or an offer of a health service to a person, be promptly acknowledged and an attempt to resolve the complaint made in a manner that is appropriate to the circumstances;
(b) that information about how a complaint may be made and the procedures for making a
(c) complaint is to be provided to a person who is provided or offered a health service by the health service provider;
(d) that the complaint information is provided in an accessible and understandable form;
(e) that a person who has made a complaint be informed of the progress of the complaint and any outcome of the complaint;
(f) that personal information collected in respect of a complaint be kept in a confidential manner;

Health service principles

Section 4 of the Act sets out eight 'health service principles'. For general health service providers, these principles are effectively enshrined in the Code. Unlike a breach of the Code, a breach of the health service principles cannot form the basis of a sanction against a general health service provider.

These principles provide that all Victorian health services must:

- be accessible
- be safe and of high quality
- provide their services with appropriate care and attention
- treat consumers and their carers with respect, dignity and consideration
- provide adequate and clear information about treatments, costs and other options
- apply an inclusive approach with consumers when making decisions about healthcare
- respect the privacy and confidentiality of personal information
- ensure comments or complaints about the service can be made easily and that any comments or complaints are addressed.

Health Records Act

My office also administers the *Health Records Act 2001.* The Health Records Act defines the rights and responsibilities for handling health information in Victoria. In summary, it states that health information should be collected with consent and used or disclosed for the primary purpose it was collected, or for a directly related and reasonable secondary purpose.

Health information can only be used or disclosed for a non-related purpose in some circumstances such as when there is a serious risk to someone or the information is needed to evaluate the service received. Any organisation collecting health information must ensure the information is up to date and relevant to their work. They must also store, transfer and dispose

of health information securely to protect privacy. If a health service provider moves premises or closes down, they must post a public notice about what will happen with their records and how patients can access their health records.

Methodology

As noted above, the way AOD treatments are provided is diverse, complex and may involve treatment by various health professionals. This means that in some cases more than one regulatory regime can apply to the same health service provider.[8]

In broad terms, AOD treatment providers can be broken down into three main types:

- *Publicly funded AOD treatment providers whose funding and performance is tied to service-level agreements* – for example, Odyssey House.
- *Registered day procedure centres and private hospitals*. These entities are private, for-profit operators whose activities in relation to providing acute detoxification services are overseen by the Department of Health and Human Services (**DHHS**). In some cases these activities may form only a part of a larger program of AOD treatments offered by an AOD treatment provider.
- *Other, privately run providers of AOD treatments that mainly operate on a for-profit basis*. These can range from individuals (e.g. counsellors practising on their own) to sophisticated business entities employing a wide range of health professionals, in some cases across multiple locations.

While my office can receive complaints about any of these types of providers, the complaint trends indicate that privately run services are the greatest source of complaints and potential consumer detriment.[9] Accordingly, our focus has been on this cohort of providers, with a particular emphasis on those providers against whom consumers registered complaints with my office.

To develop our understanding of the AOD treatment sector my office adopted a three-stage approach:

1. Information gathering

- We identified good industry practice standards by:
    - reviewing relevant literature and media reports
    - engaging Turning Point (a national addiction treatment centre) to provide general advice and opinion on specific investigations
    - engaging with Odyssey House and conducting a site visit to its therapeutic community in Lower Plenty
    - inviting private AOD treatment providers that were not the subject of an investigation by my office to tell us about their policies and processes
    - engaging with regulatory stakeholders such as the Private Hospitals and Day Procedures Unit within DHHS following the implementation of 2018 Regulations.

[8] For example, the National Law, the Health Services (Private Hospitals and Day Procedure Centres) Amendment Regulations 2018, obligations under the *Public Health and Wellbeing Act 2008*.
[9] See the 'Complaints overview and analysis' section.

- We used media releases, newspaper publications and similar activities to encourage members of the public to contact my office.
- We reviewed trends and issues across complaints to my office about private AOD treatment providers.

2. Investigations under the Act

Between 4 May 2018 and 31 December 2019 my office:

- commenced seven complaint investigations under s.45
- began five Commissioner-initiated investigations under s.47
- formally interviewed four providers and conducted three site visits
- made two IPOs to avoid a serious risk the health, safety or welfare of the public.

As at the date of this report, 11 investigations remain ongoing.

3. Reporting and monitoring

This stage includes:

- finalising this report
- monitoring complaints about AOD treatment providers to identify what further action might be required. This action will remain ongoing as part of our functions under the Act.

This report proposes to identify specific issues in the private AOD treatment sector through de-identified case studies. Please note that some case studies refer to the same complaint, investigation or factual circumstances.

Which complaints were investigated?

The decision to conduct an investigation is one I make on a case-by-case basis, having regard to the particular circumstances of the matter. When deciding to conduct investigations I focus on and prioritise matters where there is a serious risk to the health safety or welfare of a person or the public and where my office is the only body that is able to take regulatory action to prevent or minimise that risk.

Some of the challenges identified by my staff in the course of reviewing the private AOD treatment sector, and that have limited our ability to conduct formal investigations under the Act, have been that:

- Complainants often want to remain anonymous. In some cases this has been because they are staff who do not want to lose their job, especially in smaller communities, or because they are worried about reprisals from the provider (especially if they are concerned about criminal behaviour).
- The nature of AOD addiction and the challenges associated with recovery mean that establishing contact with a potential complainant or witnesses has been difficult in itself. Maintaining that contact and securing reliable evidence is that much harder – even where someone has come forward. There have been many instances where we have lost contact with them and have been unable to reconnect with them. Considering the personal circumstances and experiences of clients and their families, this is not surprising but results in a low conversion rate from ‘leads’ to investigations. Nevertheless, my staff have been able to obtain a considerable volume of anecdotal material in addition to the first-hand

evidence, which has informed much of this report.

- Given the sums involved in private treatment, many complainants simply want a refund so they can move on and, in many cases, seek treatment elsewhere. The Act does not empower me to order compensation or to compel providers to refund their clients, although if a resolution is achieved in the course of a complaint investigation, s.50(1) requires me to record that as part of an investigation report. In practice, however, providers under investigation (across all general health services) have not tended to try to resolve a complaint or make resolution offers as part of an investigation process. In this context, that process demands a high level of commitment from complainants and witnesses in circumstances where there is little to no prospect of a financial outcome and where they often have competing demands for their time and resources. In some cases my office has been able to help complainants achieve financial outcomes by dealing with the matter in a complaint resolution process rather than by way of a complaint investigation.

Misuse and addiction

It is estimated that AOD abuse contributes to more than $55 billion in preventable health and other harms in Australia each year.[10] Alcohol consumption is associated with an increased risk of chronic disease, injury and premature death.[11] Illicit drug use can have severe health effects including poisoning, mental illness, self-harm, suicide and death by accidental overdose.[12]

AOD abuse is responsible for approximately 5% of all deaths in Australia:

- 4.5% of all deaths (6,660) in Australia in 2011
- 6.7% of the total burden of all disease and injuries in Australia in 2011 ('total burden' refers to the impact of dying early and living with disease or injury).

Source: Australian Institute of Health and Welfare 2018, *Impact of alcohol and illicit drug use on the burden of disease and injury in Australia: Australian Burden of Disease Study 2011*

According to preliminary estimates in a recent report by the National Drug and Alcohol Research Centre, there were 1,795 drug-induced deaths among Australians in 2017 (1,591 drug-induced deaths among Australians aged 15–64 years).[13] Most of these deaths were accidental.[14] Opioids were the main drug cited in drug-induced deaths occurring in Australians in 2017 (1,171 deaths), with most of these deaths attributed to pharmaceutical opioids.[15] The rate of drug-induced deaths has been increasing but has not reached the rate observed in 1999 (13.2 versus 9.8 deaths per 100,000 people aged 15–64 in 1999 versus 2017, respectively).[16]

[10] Collins, D and Lapsley, H 2008, *The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05*, National Drug Strategy monograph series no. 64, Department of Health and Ageing, Canberra.
[11] AIHW 2018, *Impact of alcohol and illicit drug use on the burden of disease and injury in Australia: Australian Burden of Disease Study 2011*, Australian Government, Canberra.
[12] Ibid.
[13] National Drug and Alcohol Research Centre, UNSW Sydney, viewed 30 September 2019, <https://ndarc.med.unsw.edu.au/resource/trends-drug-induced-deaths-australia-1997-2017>.
[14] Ibid.
[15] Ibid.
[16] Ibid.

A 2019 study ranking drug harms in Australia found that alcohol and crystal methamphetamine were the two most harmful substances followed by heroin, fentanyl and cigarettes/tobacco.[17] The 2019 study ranked the substances by 'harm to the user' and 'harm to others'. The most harmful substances to users were fentanyl, followed by heroin and crystal methamphetamine.[18] The most harmful substances to others were alcohol, followed by crystal methamphetamine and cigarettes/tobacco.[19] Overall, alcohol was ranked the most harmful drug.[20]

Data collected by the Australian Institute of Health and Welfare (**AIHW**) shows that in 2017–18, 149 publicly funded specialist AOD treatment agencies provided 68,296 treatment episodes to 33,206 clients in Victoria:[21]

- Alcohol was the most common principal drug of concern in episodes provided to clients for their own drug use in Victoria (32% of episodes).[22] Amphetamines were also common as a principal drug, accounting for more than one-fifth of episodes (23%), followed by cannabis (17%) and heroin (6%).[23]
- Nearly all (94%) clients were receiving treatment for their own drug use, and most (67%) of the clients were male.[24] Most of these clients (56%) were aged 20–39 years.[25] Around one in 16 clients were Indigenous Australians (6%), which is lower than the national average (16%).[26] In the public sector, counselling is the main treatment type, with 37% of treatment episodes involving counselling.

The adverse effects of AOD misuse and addiction are amplified when mental health issues are also present. 'Dual diagnosis' clients can present a particular challenge for health service providers, requiring special skills and training to deal with the additional complexities and vulnerabilities of such clients.

The number of publicly funded places for those seeking help from AOD treatment providers is limited when considered against the scale of the problem. In that regard, private AOD treatment providers can be an attractive option to those seeking help but who cannot, for one reason or another, access publicly funded services.

What is equally clear, however, is that, when seeking help, clients and/or their families are often desperate and highly vulnerable while having to make important and often expensive decisions on treatment options in an environment where there is little formal regulation or easily accessible information to help them make informed choices that best meet their needs. The intersection between undersupply, vulnerability and the for-profit model is the space where poor consumer outcomes occur and which, by and large, generates complaints to my office.

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[17] Bonomo, Y, Norman, A, Biondo, S, et al 2019, 'The Australian Drug Harms Ranking Study', *Journal of Psychopharmacology*, vol. 33, no. 7, pp. 759–768.
[18] Ibid.
[19] Ibid.
[20] Ibid.
[21] AIHW, Australian Government, Canberra, viewed 30 September 2019, <https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2017-18-key-findings/contents/data-visualisations>.
[22] Ibid.
[23] Ibid.
[24] Ibid. This is different for clients receiving treatment or support for someone else's drug use where the majority of clients were female (60%).
[25] Ibid.
[26] Ibid.

Alcohol and other drug treatment

Treatment settings

The predominant AOD treatment models in Australia are:

- residential and non-residential detoxification
- residential rehabilitation
- outpatient treatment (including medical management and psychological therapies).

In Victoria, these services are typically provided by publicly funded non-government organisations within consortiums in defined geographic catchments and/or as part of a health network or hospital.

Public residential rehabilitation

In the Victorian public system, residential rehabilitation provides a safe and supported environment in a community-based setting.[27] Services offer 24-hour staffed residential therapeutic treatment programs of an average of three months' duration.[28] A range of interventions are offered, such as individual and group counselling with an emphasis on mutual self-help and peer community, and supported reintegration into the community.[29]

Residential rehabilitation provides a structured and therapeutic environment for people to address issues related to AOD use and addiction. These services deliver a mix of evidence-based treatment interventions that vary in duration and intensity. They typically deliver individual and group counselling and life skills with an emphasis on self-help and mutual support to support reintegration into community living. The target group for publicly funded residential rehabilitation includes:[30]

- clients who have experienced substance dependence or harm
- clients seeking to address the issues related to their AOD use
- clients at high risk of harm from AOD misuse impacted by multiple life complexities such as mental illness, homelessness or family violence
- clients requiring a sustained period of structured tertiary intervention in a therapeutic environment
- clients whose home or social circumstances don't support non-residential rehabilitation options
- clients who are assessed as treatment-ready at admission (i.e. AOD-free, stabilised on pharmacotherapy treatment or undertaking slow-stream pharmacotherapy withdrawal treatment).

[27] DHHS 2019, State Government of Victoria, Melbourne, viewed 30 September 2019, <https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/aod-residential-treatment>.
[28] Ibid.
[29] Ibid.
[30] DHHS 2018, *Alcohol and other drugs program guidelines Part 2: program and service specifications*, State Government of Victoria, Melbourne.

Privately funded residential rehabilitation

The treatment provided by private residential rehabilitation treatment providers can vary considerably. Some providers base their treatment partly on the public system, international models or a combination of both.

The two main private AOD treatment providers we have investigated base their treatments on modified versions of the 'Minnesota model' (see below) and the 'therapeutic community model'. This is similar to the treatment offered by publicly funded AOD treatment providers such as Odyssey House, which operates as a therapeutic community and is a Certified Therapeutic Community Member of the Australasian Therapeutic Communities Association (**ATCA**).

A number of rehabilitation programs, particularly in the United States, are based on 12-step principles such as 12-step facilitation, the most well known being the Minnesota model (developed by Minnesota's Hazelden Foundation). These programs offer a comprehensive treatment program that includes 12-step meetings.

Treatment models used by private AOD treatment providers that we investigated predominantly consisted of counselling in group or one-on-one settings, engaging in 12-step programs, fitness and wellbeing activities and external medical treatment such as taking clients to offsite general practitioners (**GPs**) or psychologists. Some providers have a psychologist contracted to work at the facility but generally use offsite psychologists or psychiatrists.

Some of the smaller operators focus on external 12-step programs and use external medical services in a therapeutic community-type environment. These providers will transport clients from the residential facility to the various treatment programs and medical professionals.

Four private AOD residential treatment providers also offer residential detoxification as the initial stage of treatment. Detoxification services are discussed below.

The therapeutic community model

Therapeutic communities are alcohol and non-prescribed drug-free environments in which people with addiction issues live together in an organised and structured way to promote their recovery. The ATCA defines a 'therapeutic community' as:

> *... a treatment facility in which the community itself, through self-help and mutual support, is the principal means for promoting personal change.*
>
> *In a therapeutic community residents and staff participate in the management and operation of the community, contributing to a psychologically and physically safe learning environment where change can occur.*
>
> *In a therapeutic community there is a focus on social, psychological and behavioural dimensions of substance use, with the use of the community to heal individuals emotionally, and support the development of behaviours, attitudes and values of healthy living.*

Source: ATCA Standard for Therapeutic Communities and Residential Rehabilitation Services

Residential and non-residential detoxification

Residential detoxification services support clients to safely withdraw from AOD dependence in a supervised residential or hospital facility or at home (non-residential). Detoxification services treat people experiencing specific symptoms affecting their physical or mental health after they stop using AOD. It is important that withdrawal services are conducted in a suitable environment, with oversight from appropriately qualified medical practitioners and nursing staff.[31]

The primary purpose of community residential drug detoxification is to achieve effective neuroadaptation reversal from AOD dependence.[32] Detoxification is not a standalone program but rather one step that contributes to longer term behaviour change.

The following populations may be suited to residential detoxification services:[33]

- people who require 24-hour supportive care and medical supervision to withdraw
- people with psychological or social crises requiring a high level of support
- people requiring pharmacotherapy and medical care for acute withdrawal symptoms and non-acute illnesses

[31] Victorian Government 2018, *Response to the Parliamentary Inquiry into Drug Law Reform*, Victorian Government, Melbourne.
[32] DHHS 2018, *Alcohol and other drugs program guidelines Part 2: program and service specifications*, State Government of Victoria, Melbourne.
[33] Ibid.

- people assessed as ‘complex’, with a moderate to high AOD dependence, poly drug use, or a history of previous unsuccessful withdrawal attempts
- people whose family or accommodation circumstances are less stable, such as clients lacking supportive friends or family, or stable housing.

AOD detoxification refers to a period of medical treatment where a person is assisted to overcome physical dependence to AOD. The aims are to achieve a substance-free state and relieve the immediate symptoms of withdrawal, as well as treat any co-occurring medical or psychiatric disorders.[34]

AOD detoxification can occur in residential and non-residential settings. Residential detoxification services support clients to safely withdraw from AOD dependence in a supervised residential or hospital facility. The purpose of these services in the public system is to support people with complex needs or those whose family and accommodation circumstances are less stable and unsuited to non-residential withdrawal.

Non-residential withdrawal services support people to safely withdraw in community settings, in coordination with medical services such as hospitals and GPs.[35]

As of 1 July 2018, AOD treatment providers offering acute detoxification services must be registered with DHHS as a private hospital under the 2018 Regulations – this is explained further in the ‘Regulation of alcohol and other drug treatment’ section.

12-step model

The treatment programs offered by some AOD treatment providers consist of access to free ’12-step programs’ run by Alcoholics Anonymous (**AA**) and Narcotics Anonymous (**NA**) as their main form of addiction treatment. Not surprisingly, where providers have charged clients significant sums only to ‘outsource’ treatment to programs to which clients could gain access independently and for free, complaints arise.

Twelve-step programs such as AA and NA provide a set of guiding principles outlining a course of action for recovery from addiction, compulsion or other behavioural problems. AA and NA describe themselves as a fellowship of men and women who share their experience, strength and hope with each other so that they may solve their common problem and help others to recover from alcoholism/addictions.

[34] Lubman, D, Manning, V and Cheetham, A 2017, *Informing alcohol and other drug service planning in Victoria*, Turning Point, Victoria.
[35] DHHS 2019, State Government of Victoria, Melbourne, viewed 30 September 2019, <https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/aod-system-overview>.

12 steps of Narcotics Anonymous

1. We admitted that we were powerless over our addiction, that our lives had become unmanageable.
2. We came to believe that a Power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over to the care of God as we understood Him.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed and became willing to make amends to them all.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take personal inventory and when we were wrong promptly admitted it.
11. We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to addicts, and to practice these principles in all our affairs.

Source: Narcotics Anonymous, https://www.na.org.au

Outpatient treatment

Treatment for AOD addiction also occurs in outpatient settings. In addition to non-residential detoxification services, treatment can include the following:[36]

- *Therapeutic day rehabilitation:* These programs are intensive, structured interventions that aim to address the psychosocial causes of AOD dependence. Programs typically involve motivational enhancement, cognitive behaviour therapies and individual and group counselling, self-help and peer support.
- *Care and recovery coordination:* These services assist clients to manage their recovery needs following treatment and to access other support services such as housing and employment.
- *Pharmacotherapy:* These services use prescribed substitution medication (e.g. methadone, acamprosate, naltrexone and buprenorphine) to help treat addiction.

We have received very few complaints about outpatient treatment programs. Although some private AOD treatment providers offer therapeutic day rehabilitation programs, complaints specifically about these types of services have not been the subject of investigations.

[36] DHHS 2018, *Alcohol and other drugs program guidelines Part 2: program and service specifications*, State Government of Victoria, Melbourne.

Case study 1

In 2017, a complainant contacted my office about AOD treatments being offered by an individual in Melbourne.

The provider primarily advertised AOD treatments on social media and has offered counselling and rehabilitation services for AOD addiction in at least three states in Australia, including Victoria.

At the time, the provider was the subject to a PO issued by the Health and Community Services Complaints Commissioner of South Australia. Under that order, the provider was prohibited from providing health services in South Australia.

In 2018, my office successfully prosecuted the provider under s.102 of the Act. Under s.102, it is an offence for a person to provide general health services in Victoria if the person is prohibited from providing health services in another state or territory.

In 2019, we received information alleging the provider was again advertising AOD treatment services, this time using a different name.

Our investigation found the provider had breached Code clauses 1 and 2 and that he posed a serious risk to the health, safety or welfare of the public. Accordingly, I made a PO against him, prohibiting him from providing, offering or advertising any general health services in Victoria.

Effectiveness of treatment

There is empirical evidence regarding the effectiveness of specific AOD treatment types including:

- residential and non-residential detoxification and rehabilitation
- psychological therapies (including acceptance and commitment therapy, motivational interviewing and cognitive behaviour therapy (**CBT**))
- care coordination
- pharmacotherapy (e.g. medications to treat alcohol dependence such as naltrexone and acamprosate and opioid substitution therapies (methadone and buprenorphine)).

While these treatment approaches have been found to be effective, they are dependent on robust quality frameworks and governance. This allows matching treatments to needs, ensures that workforce competencies for differing treatment types are maintained and that risks are monitored.

Residential rehabilitation

Because the complaints about AOD treatment received by my office and our investigations have been primarily about residential rehabilitation and detoxification services, information about the effectiveness of these treatment models is set out in more detail below.

A literature review by Lubman, Manning and Cheetham, 2017, noted that studies comparing

inpatient and outpatient rehabilitation found limited support for the use of one setting over the other; however, client characteristics have been found to moderate the effects of the setting.[37] For example, Rychtarik et al, 2000, found that clients with more severe alcohol problems benefited more from inpatient than outpatient care. [38] The opposite was true for those with low levels of alcohol problems.[39]

Similarly, Tiet et al, 2017, found evidence suggesting that intensive treatment may be differentially beneficial for some subgroups of patients such as those who exhibited more severe symptoms and were less socially stable.[40] These results provide some support to the hypothesis that treatment in inpatient/residential treatment settings produce better outcomes than outpatient treatment for those patients who have higher levels of substance use severity at intake.[41]

Improved outcomes are also more likely among clients who spend longer periods in treatment.[42] Retention in treatment for at least 90 days is more likely to be associated with positive outcomes; however, longer periods in treatment of up to one year or more show continuing improvement in outcomes of treatment for addiction.[43]

Therapeutic communities provided significant improvements in psychological functioning, employment and legal outcomes in recovery from addiction.[44] The length of stay in treatment and participation in subsequent aftercare were important variables in determining recovery status.[45]

There are limited Australian longitudinal studies looking at the effect of duration of treatment programs on outcomes:

- The 2008 Australian Treatment Outcomes Study looked at heroin users in settings of opioid substitution therapy, residential rehabilitation and detoxification. It found that there were substantial reductions in criminal involvement and improvements in general physical and mental health.[46] Positive outcomes were associated with more time in maintenance therapies and residential rehabilitation and fewer treatment episodes (where multiple episodes suggested fragmented care rather than continuity of care).[47]
- The 176 participants in the 2012 MATES study stayed in residential rehabilitation treatment for a median period of eight weeks, and 23% were methamphetamine abstinent at one year. Abstinence rates were increased in those who stayed in treatment for longer than 13 weeks

[37] Lubman, D, Manning, V and Cheetham, A 2017, *Informing alcohol and other drug service planning in Victoria*, Turning Point, Victoria.
[38] Rychtarik, RG, Connors, GJ, Whitney, RB, et al 2000, 'Treatment settings for persons with alcoholism: evidence for matching clients to inpatient versus outpatient care', *Journal of Consulting and Clinical Psychology*, vol. 68, no. 2, pp. 277–289.
[39] Ibid.
[40] Tiet, QQ, Ilgen, MA, Byrnes, HF, et al 2007, 'Treatment setting and baseline substance use severity interact to predict patients' outcomes', *Addiction*, vol. 102, no. 3, pp. 432–440.
[41] Lubman, D, Manning, V and Cheetham, A 2017, *Informing alcohol and other drug service planning in Victoria*, Turning Point, Victoria.
[42] Ibid.
[43] Ibid.
[44] Vanderplasschen, W, Colpaert, K, Autrique, M, et al 2013, 'Therapeutic communities for addictions: a review of their effectiveness from a recovery-oriented perspective' *The Scientific World Journal*, vol. 2013, p. 22.
[45] Ibid.
[46] Lubman, D, Manning, V and Cheetham, A 2017, *Informing alcohol and other drug service planning in Victoria*, Turning Point, Victoria.
[47] Ibid.

(to 43%).[48]

- The 2015 Patient Pathways study recruited 796 clients, of which approximately one-third undertook residential rehabilitation. At one-year follow-up, half the participants had 'reliably reduced' their primary drug of choice and one-third had ceased all primary drugs of choice.

The 2012 MATES and 2015 Patient Pathways studies are both large longitudinal studies that highlight the effectiveness of residential rehabilitation, with similar outcomes of 40–50% success at one year.

12-step programs

There is strong empirical evidence regarding the effectiveness of 12-step programs. A Cochrane Review on AA and other 12-step programs for alcohol dependence demonstrated that engagement in AA was superior in promoting abstinence in comparison with widely used treatments such as CBT.[49] Project Match, one of the largest studies of treatment for alcohol dependence, compared 12-step facilitation with two other standard forms of AOD therapy (motivational enhancement and CBT) and found that 12-step approaches had similar or better outcomes than these modalities.[50]

Twelve-step programs combined with other treatment types (e.g. CBT, alcohol and opioid pharmacotherapies) are strongly associated with long-term abstinence. Clients with comorbid mental health disorders have also been found to benefit from AA, supporting the model of combining 'conventional' treatments with this form of mutual aid.

In the 2015 Patient Pathways study, clients with alcohol but not illicit drugs as their primary drug of concern were two and half times as likely to be abstinent or to have reliably reduced their drinking if they attended AA, NA, self-management and recovery training or other recovery meetings following specialist AOD treatment.[51] There was also a trend for higher rates of treatment success among those attending more meetings in the previous 12 months, with more than 50% of those attending at least monthly on average responding to treatment.[52]

[48] McKetin, R, Najman, JM, Baker, AL, et al 2012, 'Evaluating the impact of community-based treatment options on methamphetamine use: findings from the Methamphetamine Treatment Evaluation Study (MATES)', *Addiction*, 107(11), pp.1998–2008. The Methamphetamine Treatment Evaluation Study (MATES) was established in 2006. Regular follow-up studies have been undertaken since to measure outcomes across specific cohorts. See also: https://www.ncbi.nlm.nih.gov/pubmed/28421682.
[49] Ferri, M, Amato, L and Davoli, M, 2006, 'Alcoholics Anonymous and other 12-step programmes for alcohol dependence', *Cochrane Database of Systematic Reviews*, no. 3, article no. CD005032.
[50] National Institute on Alcohol Abuse and Alcoholism, Project Match, National Institute of Health, viewed 30 September 2019 <https://pubs.niaaa.nih.gov/publications/projectmatch/matchintro.htm>.
[51] Lubman, DI, Garfield, JBB, Manning, V, et al 2016, 'Characteristics of individuals presenting to treatment for primary alcohol problems versus other drug problems in the Australian patient pathways study', *BMC Psychiatry*, vol. 16, no. 1, p. 250.
[52] Ibid.

Publicly funded residential rehabilitation services in Victoria

The efficacy and the effectiveness of AOD treatment is well founded in evidence.[53] A review of the AOD treatments in Australia by the National Drug and Alcohol Research Centre found that AOD treatment:[54]

- reduces AOD consumption
- improves health status
- reduces criminal behaviour
- improves psychological wellbeing
- improves participation in community.

In addition, there are significant gains for the community. It is estimated that for every $1.00 invested in AOD treatment, society gains $7.00.[55] The savings that accrue to governments from AOD treatment are generally through direct savings in future healthcare costs, productivity gains and savings in the criminal justice system.[56]

Part of the Victorian Government's *Drug rehabilitation plan* is to provide additional funding for residential rehabilitation services to reduce harms caused by AOD addiction.[57] The Victorian Government is providing funding for 529 beds in 2019–20 and intending to increase the number in 2020–21.[58] The 2019–20 funding distribution for residential rehabilitation services is:

- general residential rehabilitation: 335 beds
- general residential withdrawal: 94 beds
- 28-day program for subacute withdrawal and intensive stabilisation: eight beds
- population-specific services in residential settings: 55 beds – youth (15), dual diagnosis (28), Aboriginal services (12)
- population-specific services in residential withdrawal settings: 37 beds – youth (33) and mother and baby unit (four).

Residential rehabilitation treatment services

The Victorian Government-funded AOD treatment system provides a range of general and specialist residential rehabilitation services. These treatments provide a structured and therapeutic environment for people to address issues related to their AOD use.

In Victoria, residential rehabilitation services deliver a combination of evidence-based treatment interventions that vary in duration and intensity. Services typically deliver individual and group counselling and life skills with an emphasis on self-help and mutual support to assist

[53] National Drug and Alcohol Research Centre, UNSW Sydney, viewed 30 September 2019, <https://ndarc.med.unsw.edu.au/resource/new-horizons-review-alcohol-and-other-drug-treatment-services-australia>.
[54] Ibid.
[55] Ettner, SL, Huang, D, Evans, EA, et al 2006, 'Benefit-cost in the California treatment outcome project: does substance abuse treatment "pay for itself"?', *Health Services Research*, vol. 41, no. 1, pp. 192–213.
[56] National Drug and Alcohol Research Centre, UNSW Sydney, viewed 30 September 2019, <https://ndarc.med.unsw.edu.au/resource/new-horizons-review-alcohol-and-other-drug-treatment-services-australia>.
[57] Department of Premier and Cabinet 2017, *Drug rehabilitation plan: new action to help save Victorian lives*, State Government of Victoria, Melbourne.
[58] Provided by DHHS on 28 March 2019.

reintegration into community living.

As noted above, there are 335 government-funded beds available in Victoria for general AOD residential rehabilitation and 94 residential withdrawal beds.[59] In addition, there are eight beds for a 28-day subacute withdrawal and intensive stabilisation in a residential setting. This program focuses on clients with medically complex withdrawal needs and socially complex rehabilitation needs.[60] Clients will stay for approximately 28 days depending on their needs.[61]

Population-specific treatment services

In addition to the general AOD treatment framework, the publicly funded system also offers AOD treatment services targeted at treating groups with specific needs. There are 55 government-funded population-specific beds for residential rehabilitation treatment and 37 residential withdrawal beds.[62] A description and breakdown of the population-specific services that are available in Victoria is provided below.[63]

Dual diagnosis services – 28 beds in Victoria

Dual diagnosis residential treatment services address the needs of adults experiencing dual diagnosis who are not well accommodated by general rehabilitation services. These individuals may require a higher level of clinical support and targeted intervention to meet their treatment needs.

Aboriginal services – 12 beds in Victoria

Aboriginal services offer holistic, culturally appropriate care, support and treatment to Aboriginal clients, families and communities to help reduce the harms associated with AOD use. Aboriginal people may choose to access mainstream services. Where people with a similar level of need are assessed as requiring AOD treatment services, priority is given to Aboriginal people. All 12 beds are located in the Mornington Peninsula.[64]

Youth-specific services – 48 beds in Victoria

Youth-specific services help vulnerable young people up to the age of 25 to address AOD issues. This is achieved through a family-based approach, where appropriate, that is integrated with other services including mental health, education, health, housing, child protection and family services. There are eight publicly funded youth-specific facilities in Victoria that provide 15 residential rehabilitation beds and 33 residential withdrawal beds.[65]

[59] Ibid.
[60] Ibid.
[61] Ibid.
[62] Ibid.
[63] Ibid.
[64] Ibid.
[65] Ibid.

Mother and baby residential withdrawal unit – four beds in Victoria

The mother and baby residential withdrawal unit has been developed to improve the accessibility and effectiveness of treatment services for mothers who are AOD-dependent to strengthen their parenting skills and reduce risk to children.

Regulation of alcohol and other drug treatment

Key recommendations

Key recommendation 1

It is recommended that a mandatory registration/licensing scheme is introduced for all entities/organisations/individuals operating as private AOD treatment providers which offer or provide private AOD treatments. Such a registration/licensing scheme would include a self-reporting / auditing framework based on a set of minimum quality and safety standards.

Key recommendation 2

It is recommended that a mandatory registration scheme is introduced for all 'AOD Workers' who provide or offer to provide AOD treatment services.

Key recommendation 3

It is recommended that the mandatory registration scheme defines and limits the use of titles such as 'AOD counsellor' to those individuals who have reached and maintain a minimum level of prescribed qualifications and ongoing professional training.

Regulation

In Australia, publicly funded AOD treatment service providers must follow the relevant state or territory department's accreditation standards, policies or guidelines. They must maintain health accreditation standards and are externally assessed.[66]

Private AOD residential rehabilitation providers are not required to adhere to such requirements and are largely unregulated in Australia. There is no requirement for private AOD treatment providers offering residential rehabilitation treatment services to register with the relevant

[66] Australian Broadcasting Corporation (ABC) 2 May 2018, viewed 1 October 2019, <https://www.abc.net.au/news/2018-05-02/drug-rehab-what-works-and-what-to-keep-in-mind-when-choosing/9718124>.

government department unless, and only to the extent that they are required to register with DHHS under the 2018 Regulations, if they provide acute detoxification services. In New South Wales there is the option for privately run AOD rehabilitation services providing clinical interventions to be accredited against the same service standards as non-government services; however, this is not mandatory within New South Wales, Victoria or nationally.

This lack of regulation or uniformity has prompted stakeholders to push for a national quality framework that applies to all AOD treatment services Australia-wide including public, for-profit and not-for-profit residential rehabilitation services.[67] The National Ice Taskforce recommended that the Commonwealth, state and territory governments should work with the specialist treatment sector to design and implement a national quality framework that sets the standards for:

- *the delivery of evidence-based services for the population, with clear expectations of the quality standards for each service type*
- *workforce capabilities, which must be matched to the service-type and population need*
- *cross-agency partnerships and collaboration*
- *monitoring and evaluation of outcomes and effectiveness to inform continuous quality improvement.*[68]

In addition, an inquiry into crystal methamphetamine (ice) by the Commonwealth Government recommended:

> *… 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.* [69]

A national quality framework would set a nationally consistent quality benchmark for AOD treatment services, including private providers.

Establishing such a framework was endorsed by members of the Ministerial Drug Alcohol Forum on 14 June 2018.[70] We understand that the details of this framework are currently being settled, with a view to implementing accreditation for publicly funded providers in mid-2021.

Service providers will have until 30 June 2021 to gain accreditation with the standards. Jurisdictions have agreed that the framework will apply to all government-funded providers. Victoria has not indicated that it intends to develop a new scheme to regulate non-government-funded providers.

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[67] Commonwealth of Australia, Parliamentary Joint Committee on Law Enforcement 2018, *Inquiry into crystal methamphetamine (ice) final report*, Senate Printing Unit, Parliament House, Canberra.
[68] Commonwealth of Australia 2015, *Final report of the National Ice Taskforce*, Department of the Prime Minister and Cabinet, Canberra.
[69] Commonwealth of Australia, Parliamentary Joint Committee on Law Enforcement 2018, *Inquiry into crystal methamphetamine (ice) final report*, Senate Printing Unit, Parliament House, Canberra.
[70] See: <https://www.health.gov.au/resources/publications/ministerial-drug-and-alcohol-forum-mdaf-communique-14-june-2018>.

Turning Point reviewed standards employed in the AOD field across Australia and identified the following quality standards as the most commonly used in Australian AOD settings:

- National Safety and Quality Health Service Standards (NSQHS)
- Quality Improvement Council (QIC)
- Evaluation of Quality Improvement Program (EQuIP)
- International Standards Organisation (ISO9001)
- Department of Human Services standards (Victoria)
- Department of Health and Human Services standards (Tasmania)
- WA Networks of Alcohol and Other Drug Agencies (WANADA)
- Australasian Therapeutic Communities Association (ATCA).

Of these standards WANADA and ATCA were specifically developed for the AOD sector, although there are commonalities between the generic and specific AOD standards.

Private hospitals and day procedure centres

Some specific aspects of AOD treatment are regulated. As detailed below, Victoria has taken steps to regulate acute detoxification services so they are only provided by registered facilities to ensure these providers are monitored.

Individuals

As already mentioned, there are 16 health professions that are regulated under the National Law and overseen by relevant boards and Ahpra. These professions include individuals who may routinely provide AOD treatments either in their own right or as part of a larger setting, and include psychologists, medical practitioners and nurses.

However, individuals who do not practice one of the 16 health professions regulated by the National Law fall outside that framework. They may, however, be members of professional bodies such as the Australian Counselling Association that in some cases may set voluntary standards of practice for their members.

In addition, health complaints entities, such as my office, have an important role to play in dealing with disputes and investigating non-registered health professionals. In Victoria, and jurisdictions like New South Wales, South Australia and Queensland, health complaints entities have a regulatory function that includes applying the set of standards that, in Victoria, are found in the Code.

Regulation of government-funded treatment providers

DHHS policy and funding guidelines require state-funded AOD treatment providers to comply with relevant accreditations and standards.[71] Organisations that receive funding to deliver AOD

[71] DHHS 2019, State Government of Victoria, Melbourne, viewed 30 September 2019 <https://www2.health.vic.gov.au/alcohol-and-drugs/aod-service-standards-guidelines/aod-service-quality-accreditation>.

treatments must comply with any quality framework or policy initiative adopted by DHHS.[72]

DHHS has policies that specifically relate to AOD treatments. The Victorian AOD program guidelines outline the Victorian Government's principles and objectives, key service delivery requirements and minimum performance and reporting standards for Victorian Government–funded AOD programs and services. The guidelines inform the delivery of funded programs and services that aim to reduce AOD-related harm.

In addition, these AOD treatment providers are encouraged to work towards implementing the Victorian AOD treatment principles and must establish and implement plans to deliver services consistent with the *Victorian alcohol and other drug client charter*.[73] The *Victorian alcohol and other drugs workforce development strategy – minimum qualification strategy* also requires new workers entering the sector without relevant qualifications to obtain a specialist qualification in AOD or addiction at the Certificate IV level or higher to be eligible to work in a DHHS-funded AOD service.

DHHS documents and policies relevant to AOD treatment:

- *Alcohol and other drug program guidelines*
- *Victorian alcohol and drug treatment principles*
- *Victorian alcohol and other drug client charter*
- *Victorian alcohol and other drugs workforce development strategy – minimum qualification strategy*
- *AOD performance management framework*
- *Catchment-based intake and comprehensive assessment process*
- *Policy and funding guidelines*.

Accreditation requirements

Funded AOD treatment services in Victoria must comply with the requirements of relevant accreditations and standards.[74] They must continue to be accredited within existing generic accreditation frameworks by an entity certified by either the International Society for Quality Health Care (ISQua) or the Joint Accreditation System of Australia and New Zealand.[75]

Health services providing AOD treatment services (e.g. public hospitals) are required to be accredited against the NSQHS Standards delivered by the Australian Commission on Safety and Quality in Health Care (certified by ISQua).[76]

In addition to meeting accreditation requirements, as a condition of funding, service providers must agree to the DHHS procedures for incident reporting and must establish and implement

[72] Ibid.
[73] Department of Health 2011, *Victorian alcohol and other drug client charter*, State Government of Victoria, Melbourne.
[74] Department of Health and Human Services 2019, State Government of Victoria, Melbourne, viewed 30 September 2019 <https://www2.health.vic.gov.au/alcohol-and-drugs/aod-service-standards-guidelines/aod-service-quality-accreditation>.
[75] Ibid.
[76] Ibid.

plans to deliver services consistent with the *Victorian alcohol and other drug client charter*[77] and the *Victorian alcohol and other drug treatment principles*.[78]

Service requirements

DHHS's AOD program guidelines require all government-funded residential rehabilitation services to meet the following service requirements:[79]

- build on the comprehensive assessment and treatment plan to determine the clinical and psychosocial components of the treatment required, engaging and involving clients and families, as appropriate
- deliver treatment and support, referral and transition support (face-to-face, phone)
- provide a range of treatment interventions that support behavioural change, social and life skills development and relapse prevention including counselling and therapeutic group work
- utilise a model of care that incorporates evidence-based interventions and management approaches
- utilise symptomatic medications, pharmacotherapies and supportive care consistent with best practice and evidence-based guidelines, as required
- provide recovery-focused case management for clients including a negotiated individual treatment plan with a community reintegration component
- provide access to a medical practitioner, including a GP or addiction medicine specialist, to provide generalist and specialist medical support during residential rehabilitation treatment, as required
- provide access to appropriate nursing and psychological care, as required
- facilitate client access to other services appropriate to their health and welfare needs, including providers of non-residential AOD treatment and support, mental health treatment and support, housing services, vocational training and employment skills
- deliver community reintegration support including referral into safe and appropriate accommodation where necessary
- cultivate effective and productive relationships and referral pathways with relevant agencies, in particular AOD providers, addiction medicine specialists, mental health providers and other community-based health/human services/support services
- work with other AOD services to provide bridging support pre- and post-treatment to assist in client transition into and out of the residential rehabilitation setting
- provide appropriate referral to services for carers and families of those affected by AOD use
- provide, with the appropriate consent, client summaries to the original referral source, intake service as well as to the services the client has been linked with
- operate seven days per week, 24 hours a day.

Cost of treatment

Government-funded residential rehabilitation services generally charge a nominal fee or

[77] Department of Health 2011, *Victorian alcohol and other drug client charter*, State Government of Victoria, Melbourne.
[78] Department of Health 2013, *Victorian alcohol and drug treatment principles*, State Government of Victoria, Melbourne.
[79] DHHS 2018, *Alcohol and other drugs program guidelines Part 2: program and service specifications*, State Government of Victoria, Melbourne.

contribution towards the cost of treatment. This is usually a percentage of Centrelink payments. These payments vary between service providers.

Priority access to treatment

The public AOD treatment system provides priority access to treatment based on need. The DHHS Victorian AOD program guidelines state that:

> *Need is based on the severity of the AOD dependency, including frequency and amount of use and other life complexity factors such as being at risk of experiencing family violence, homelessness, or being required to attend treatment as a part of a court order*.[80]

AOD treatment services are not substance-specific. All services are allocated based on the greatest need regardless of substance type.

The AOD program guidelines provide that where there are similar levels of clinical and other need, priority is given to those people who:[81]

- have dependent children who rely on them for their safety and wellbeing
- are in contact with the justice system, particularly those referred to treatment by courts, corrections, police or parole boards
- have a history of long-term homelessness
- identify as Aboriginal or Torres Strait Islander
- have a co-existing intellectual disability or an acquired brain injury
- have a mental illness
- are subject to or have been discharged from compulsory treatment under the *Severe Substance Dependence Treatment Act 2010*
- have identified issues relating to family violence
- have child protection involvement, or
- require treatment as a part of a court order to achieve reconciliation with their children.

Where there is more than one eligible person with a similar level of severity, access priority is determined based on the relative lengths of time they have waited for AOD treatment.[82]

Access to services / wait times

About 40,000 Victorians access AOD treatment services every year.[83] However, access to services remains an issue. Although DHHS is implementing a bed vacancy coordination system, it was unable to provide my office with current wait-time estimates. However, anecdotal material in media highlights that many people are unable to access appropriate AOD

[80] DHHS 2018, *Alcohol and other drugs program guidelines Part 1: overview*, State Government of Victoria, Melbourne.
[81] Ibid.
[82] Ibid.
[83] DHHS 2019, State Government of Victoria, Melbourne, viewed 30 September 2019, <https://www2.health.vic.gov.au/alcohol-and-drugs>.

treatment,[84] and lengthy wait times was also identified in the Victorian parliamentary inquiry into drug law reform.[85]

As part our review, Odyssey House informed us that wait times can vary considerably because priority is given to vulnerable groups. For example, the approximate wait time for a single male will be between one and three months, while the approximate wait time for an Aboriginal woman is one to three weeks.

Wait times in the public system

An Aboriginal man from rural Victoria told us he had waited four months in the remand centre to be bailed to Odyssey House for AOD treatment. He said he had been at Odyssey House for 12 months and had not used any AOD substances in that time.

He told us that people addicted to AOD needed more access to services like Odyssey House and that wait times needed to be significantly decreased because delays give addicts time to reconsider their decision to get help.

Such anecdotal reports are supported by the high unmet need and demand for treatment. It is estimated that less than half of those seeking AOD treatment in Australia can access appropriate treatment.[86]

Information provided to my office by complainants and other stakeholders supports the view that the high level of demand and long wait times for the public system has left a gap that private AOD treatment providers have, in turn, sought to fill.

Regulation of acute detoxification in Victoria

Residential services support clients to safely detoxify from AOD dependence in a supervised residential or hospital facility. Acute detoxification from AOD can be dangerous, with a risk of death.[87]

To manage the risk of detoxification, the Victorian Government amended the 2018 Regulations so that private overnight residential detoxification services can only be provided in a DHHS-registered facility. The 2018 Regulations came into effect on 1 July 2018. Unregistered premises had to stop providing residential withdrawal services and only provide rehabilitation services.[88] Facilities only offering the rehabilitation phase of AOD recovery are not within the scope of the 2018 Regulations and do not require registration.

As at 30 June 2019 four private AOD treatment providers have been registered under the 2018 Regulations:

[84] See: Dow, A 2018, 'Desperate families "exploited" by drug and alcohol detox operators', *The Age*, Melbourne, viewed 30 September 2019, <https://www.theage.com.au/national/victoria/desperate-families-exploited-by-drug-and-alcohol-detox-operators-20180421-p4zaxy.html>.
[85] Parliament of Victoria 2018, *Inquiry into drug law reform*, Victorian Government Printer, Melbourne.
[86] Ritter, A, Berends, l, Chalmers, J, et al 2014, *New horizons: the review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, Sydney.
[87] Victorian Government 2018, *Response to the Parliamentary Inquiry into Drug Law Reform*, State Government of Victoria, Melbourne.
[88] Ibid.

- Arrow Health
- Dayhab
- Habitat Therapeutics
- The Hader Clinic.[89]

The 2018 Regulations appear to have had a significant effect on the private AOD treatment sector. Since the introduction of the 2018 Regulations we have observed a decline in private AOD treatment providers offering detoxification services, and at least three providers that have come to our attention have closed down – two of those directly attributed the 2018 Regulations and our increased scrutiny on the sector.

Support for regulation

All publicly funded AOD treatment services, as well as private hospitals, must be accredited to receive funding. In our view, private AOD treatment providers should have to comply with the same accreditation standards.

The Australian Medical Association (Victoria) stated in its submission to the Victorian Parliament's Inquiry into Drug Law Reform (20 March 2017) that:

The impact of ice is evident across the Victorian community regardless of location or socio-economic status. Victoria's Ice Action Plan was a welcome response, however there needs to be greater investment in residential rehabilitation. This includes increased public places and the appropriate regulation of private services.

Private clinics, which families often resort to in desperation, can be very expensive, with courses of treatment running into tens of thousands of dollars. This industry requires proper regulation to ensure accountability for patient safety and quality of care, and to protect vulnerable families from exploitative practices. The Victorian Government needs to create a regulatory framework and standards for private residential drug rehabilitation programs (where they are not already subject to stringent quality standards).

The Victorian Government currently regulates other private sector activities for vulnerable people, such as Rooming Houses and Supported Residential Services – regulation is also required for private residential drug rehabilitation programs.

[89] DHHS 2016, State Government of Victoria, Melbourne, viewed 30 September 2019, <https://www2.health.vic.gov.au/hospitals-and-health-services/private-hospitals>.

Complaints overview and analysis

Between 1 February 2016 and 31 August 2019, the HCC and the Office of the Health Services Commissioner received 118 complaints about AOD treatment providers. A profile of these complaints is depicted in **Figures 1 and 2**. In summary:

- Sixteen complaints were made under the previous *Health Services (Conciliation and Review) Act 1987* and 102 were made under the Health Complaints Act.
- Ninety-seven of these complaints related to private AOD providers. In contrast only 17 complaints related to publicly funded AOD treatment providers.[90]
- In four cases we were not able to identify which provider was the subject of the complaint.

There seem to be two main reasons that explain the greater number of complaints about private AOD treatment providers:

- Higher levels of scrutiny tied to public funding means that good industry practice is more likely to be maintained by publicly funded AOD treatment providers.
- The significant costs charged by private AOD treatment providers is a key driver of complaints when clients do not achieve the outcomes they hoped for or when these providers do not deliver what was promised.

Also notable is that:

- Between 1 February 2016 and 31 August 2019, most of the complaints received by the Office of the Health Services Commissioner and my office related to two private providers. Thirty-eight per cent of complaints related to one provider (Provider 1) and just under 11% related to another (Provider 2) – see **Figure 2**.
- Thirty-one per cent of complaints related to providers with less than three complaints.

[90] 'Publicly funded' includes any provider receiving public funds.

***Figure 1**: Complaints to the HCC about public and private AOD treatment providers from 1 February 2016 to 31 August 2019*

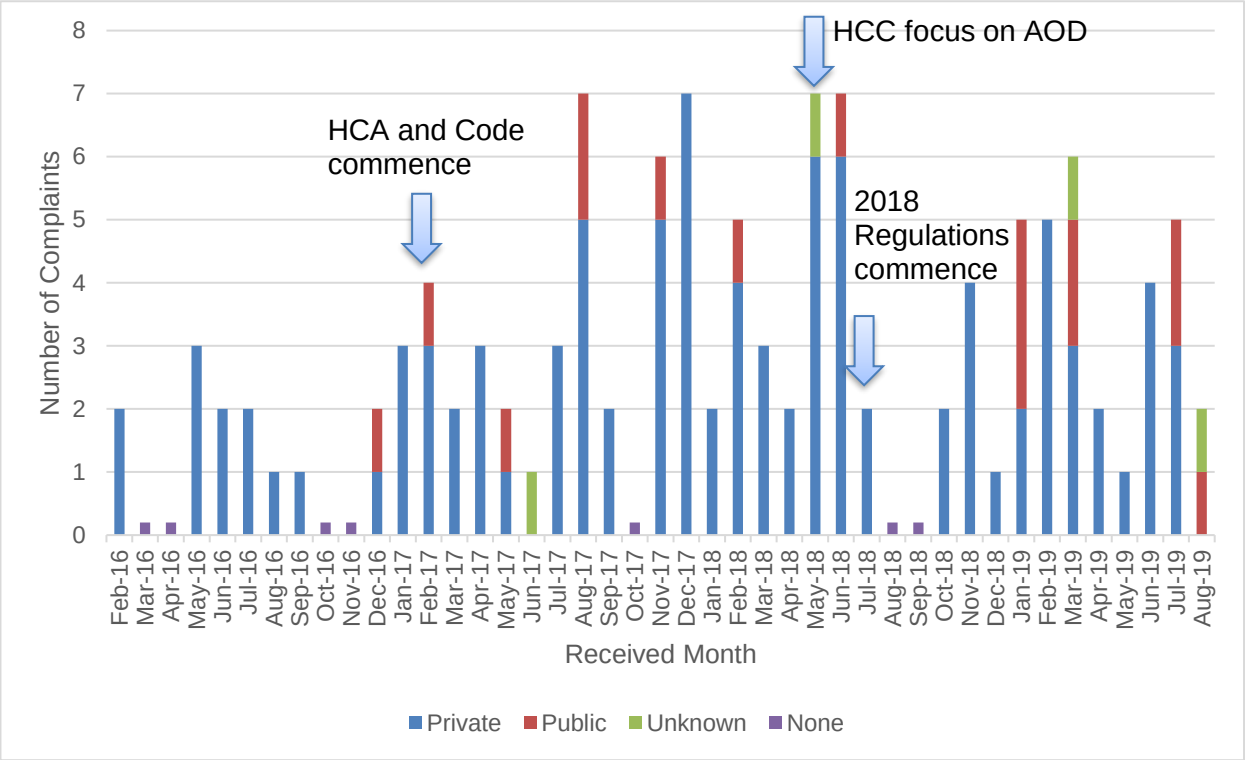
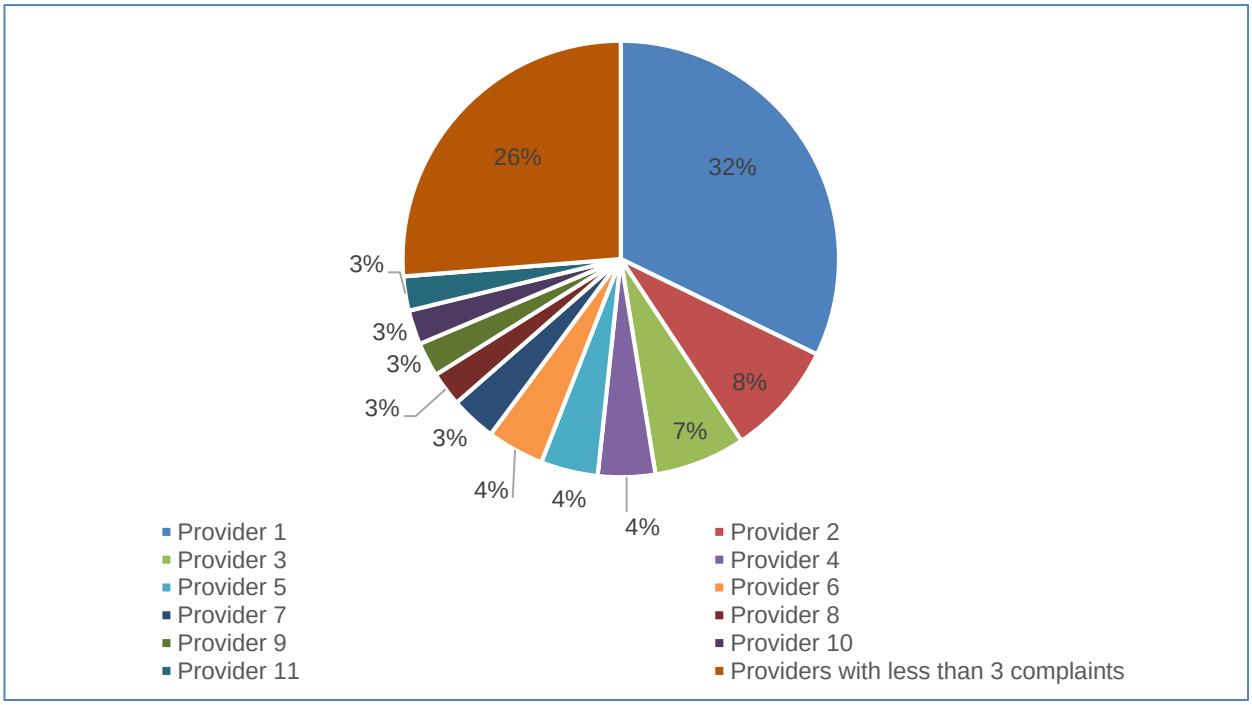


***Figure 2**: Percentage of complaints by public and private AOD treatment providers from 1 February 2016 to 31 August 2019*



Complaint trends

Shortly after my office announced its focus on the AOD sector in May 2018, complaints to my office increased, coinciding with media we published inviting Victorians to report their concerns about private AOD rehabilitation services. Complaints peaked in May and June 2018 and then dropped off in August and September 2018, with no complaints received during those months. The commencement of the 2018 Regulations on 1 July 2018 was another factor in the decline in complaints to my office about the private AOD treatment sector. From our engagement with providers, we understand that the compliance requirements of the 2018 Regulations caused some providers to withdraw from the sector entirely because it was too difficult or expensive to comply. Notably, two private AOD treatment providers that did remain in the sector and registered under the 2018 Regulations informed us that the standards required to obtain registration under the 2018 Regulations were a key driver in improving their overall service delivery.

Complaint issues

Figure 3 and 4 provide further insights into complaints to my office after 1 February 2017:

- **Figure 3** compares the number of AOD treatment–related complaints received by my office involving general health service providers and other providers (e.g. hospitals and health practitioners registered under the National Law) between 1 February 2017 and 31 August 2019. Eighty-seven per cent of these complaints related to general health service providers.
- **Figure 4** analyses these complaints against general health service providers by issue. The issues are based on a taxonomy that reflects the obligations on these providers as set out in the Code. The most common issue raised in complaints is that AOD treatments are not being provided in a safe and ethical manner, followed closely by allegations of financial exploitation, misinformation and a lack of competence.

Figure 3: *Comparison of complaint numbers about AOD treatments between 1 February 2017 and 31 August 2019: general health service providers compared with non-general health service providers*

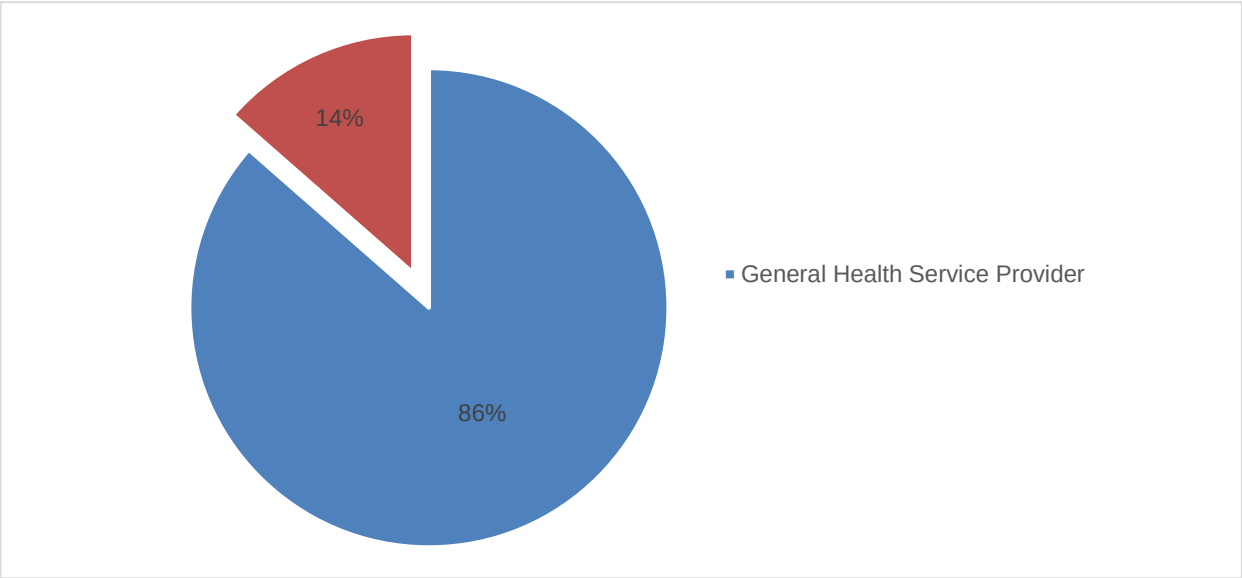
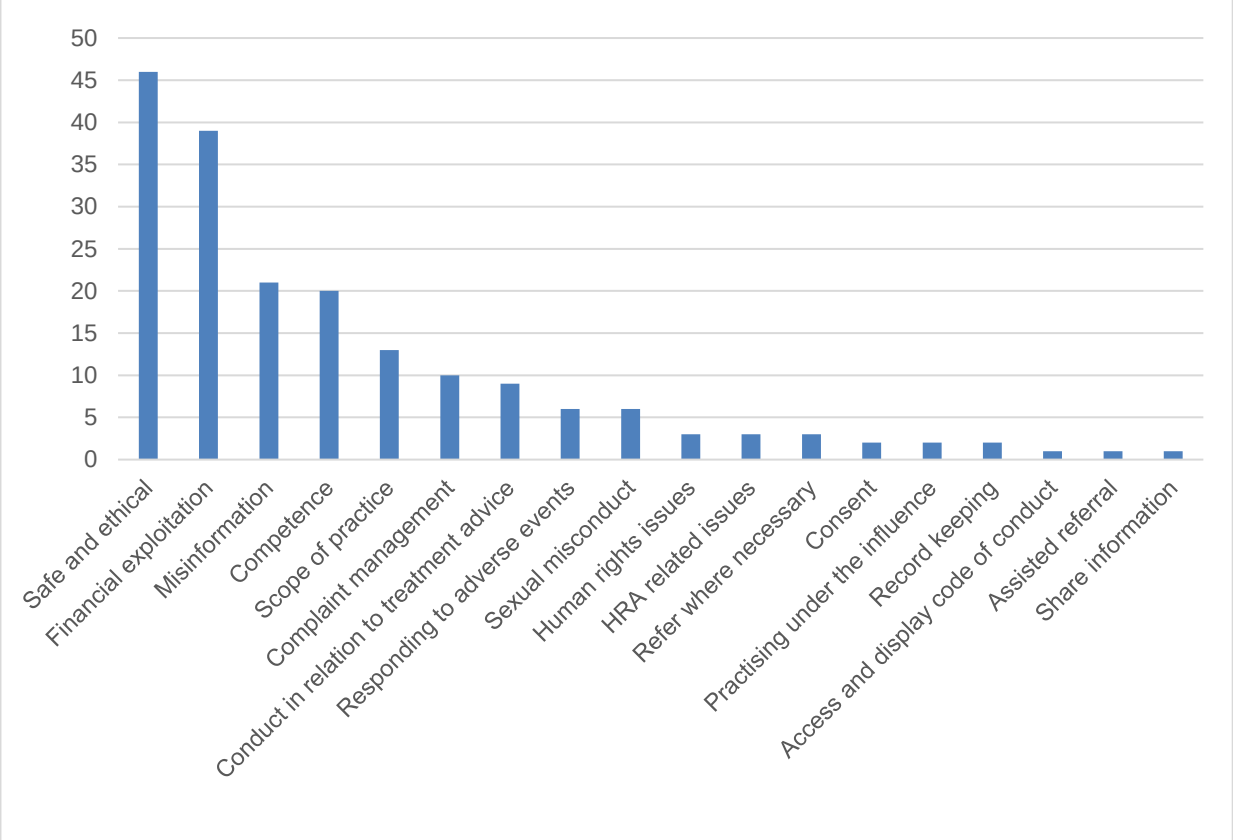


Figure 4: *Issues raised in complaints about general health service providers providing AOD treatments between 1 February 2017 and 31 August 2019*



- Most of the complaints about private AOD treatment providers alleged that AOD treatments were not being provided in a 'safe and ethical manner' (Code clause 1(1)). Code clause 1(2) includes the specific obligations to:
  - maintain the necessary competence (Clause 1(2)(a))
  - not provide a health service outside the provider's experience or training, or provide services the provider is not qualified to provide (Clause 1(2)(b))
  - only prescribe or recommend treatments or appliances that serve the needs of clients (Clause 1(2)(c))
  - recognise the limits of the treatment a provider can provide and to refer clients to other competent health service providers in appropriate circumstances (Clause 1(2)(d))
  - recommend to clients that additional opinions and services be sought where appropriate (Clause 1(2)(e))
  - assist a client to find other appropriate healthcare services if required and practicable (Clause 1(2)(f))
  - encourage clients to inform their treating medical practitioner (if any) of the treatments of care being provided (Clause 1(2)(g))
  - have a sound understanding of any possible adverse interactions between therapies and treatments being provided or prescribed and any other medications or treatments, whether prescribed or not, that the provider is, or should be, aware that a client is taking or receiving, and advise the client of these interactions (Clause 1(2)(h))
  - provide services in a manner that is culturally sensitive to the needs of the provider's clients (Clause 1(2)(i)).

- Other Code clauses raised in complaints to my office about AOD treatments included:
  - obtaining consent (Clause 2)
  - conduct in relation to treatment advice (Clause 3)
  - reporting provider conduct (Clause 4)
  - responding to adverse events (Clause 5)
  - infection control (Clause 6)
  - infectious medical conditions (Clause 7)
  - claims to cure illness (Clause 8)
  - misinformation (Clause 9)
  - practising under the influence of alcohol or unlawful substances (Clause 10)
  - physical or mental impairment (Clause 11)
  - financial exploitation (Clause 12)
  - sexual misconduct (Clause 13)
  - privacy (Clause 14)
  - record keeping (Clause 15)
  - insurance (Clause 16)
  - access to and displaying the code of conduct (Clause 17).

- Non-Code related concerns raised in complaints about AOD treatments included:
  - complaints about providers' complaint management practices – these fall under the interim standards for complaint handling in Schedule 1 of the Act
  - complaints that fall under the Health Records Act
  - complaints relating to the *Victorian Charter of Human Rights and Responsibilities Act 2006*.

When considering the information set out in **Figure 4**, the following should be noted:

- Some Code clauses were not raised in complaints at all. For example:
  - Clause 4 – the obligation to report concerns about the conduct of other health service providers
  - Clause 6 – the obligation to adopt standard precautions for infection control
  - Clause 8 – the obligation to not make claims to cure certain serious illnesses
  - Clause 11 – the obligation to take appropriate steps if suffering from a physical or mental impairment
  - Clause 14 – the obligation to comply with relevant privacy laws
  - Clause 16 – the obligation to be covered by appropriate insurance.

Using the obligations under the Code as a framework, the remainder of this document:

- profiles de-identified case studies based on the complaints received by my office between 1 February 2016 and 31 December 2019
- suggests recommendations to be considered in order to promote safe and ethical health care by private AOD treatment providers in Victoria.

Common issues in complaints and investigated matters

The most common issues raised across the complaints and investigated matters include:

- disputes about refund requests, in particular where clients prepaid for services and were unable to get refunds for unused treatment periods when exiting a rehabilitation program early
- allegations of misinformation and misrepresentation.

Allegations of misinformation and misrepresentation often go hand in hand with refund complaints because unhappy clients describe the gap between what they say the provider promised and the actual services provided. Common themes were:

- promotional material was misleading
- the facilities were in poor condition
- staff were either not qualified or underqualified
- clients were exited early without good grounds.

Other areas of complaint included:

- financial exploitation
- sexual misconduct
- drug use in facilities
- children being treated in adult facilities
- poor handling of adverse events
- poor complaint handing.

Serious risk to a person or the public

As set out on page 18, where, in the course of an investigation, I reasonably believe that a general health service provider has contravened a code of conduct applying to a general health service being provided and I am satisfied there is a serious risk to the health, safety or welfare of a person or the public, I can issue an IPO.

In May 2019 I initiated a s.47 investigation into a private AOD treatment provider after receiving information that raised concerns that its services were not being provided in a safe and ethical manner. The premises on which the services were being provided had previously been used as a brothel.

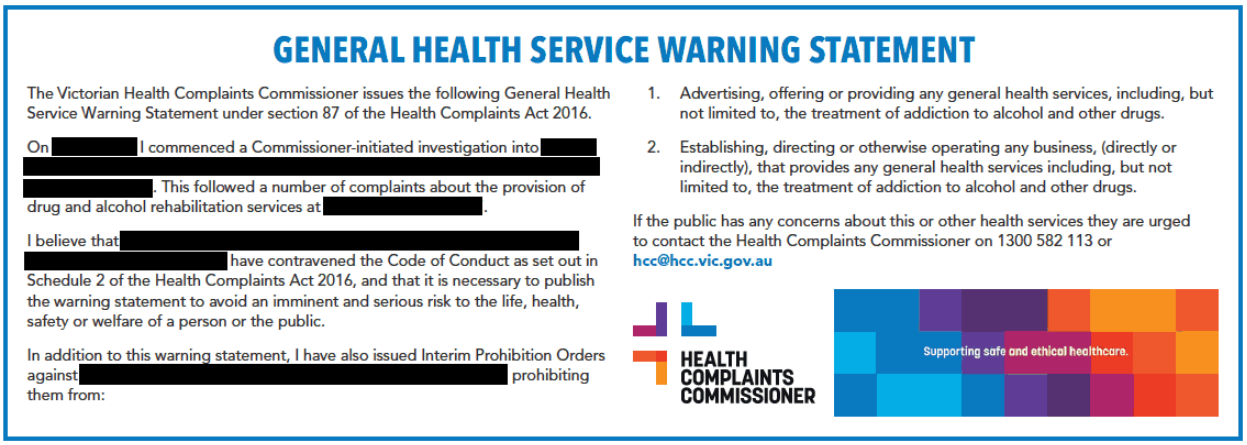
The concerns raised with my office alleged the service had links to organised crime, that staff had been violent towards a client, that hygiene and treatment standards were very poor and that there appeared to be no treatment programs in place.

In the course of the investigation my office visited the facility with consent of the business operators. While the internal fit out of the facility still appeared to reflect its former use as a brothel, the main areas were clean and it had a kitchen with basic foods for clients. Because clients were responsible for cleaning their own rooms the cleanliness of rooms varied. The business operators also informed my staff they were offering placements for students studying counselling and/or psychology.

Several months after our site visit, Victoria Police informed my office that they had executed a search warrant as part of an investigation into alleged drug trafficking. The warrant located a clandestine drug laboratory set up at the premises to manufacture methamphetamine. Three men were charged with drug and weapons offences.

Based on information available to me I decided to issue an IPO to avoid a serious risk to the health, safety and welfare of the public. I also decided to issue a General Health Service Warning Statement under s.87 of the Act (Box 1) that, as required by the Act, was published in a newspaper circulating throughout the state and on our website. My investigation remains ongoing.

Box 1: General Health Service Warning Statement



GENERAL HEALTH SERVICE WARNING STATEMENT

The Victorian Health Complaints Commissioner issues the following General Health Service Warning Statement under section 87 of the Health Complaints Act 2016.

On [redacted] I commenced a Commissioner-initiated investigation into [redacted]. This followed a number of complaints about the provision of drug and alcohol rehabilitation services at [redacted].

I believe that [redacted] have contravened the Code of Conduct as set out in Schedule 2 of the Health Complaints Act 2016, and that it is necessary to publish the warning statement to avoid an imminent and serious risk to the life, health, safety or welfare of a person or the public.

In addition to this warning statement, I have also issued Interim Prohibition Orders against [redacted] prohibiting them from:

1. Advertising, offering or providing any general health services, including, but not limited to, the treatment of addiction to alcohol and other drugs.
2. Establishing, directing or otherwise operating any business, (directly or indirectly), that provides any general health services including, but not limited to, the treatment of addiction to alcohol and other drugs.

If the public has any concerns about this or other health services they are urged to contact the Health Complaints Commissioner on 1300 582 113 or hcc@hcc.vic.gov.au

HEALTH COMPLAINTS COMMISSIONER

Supporting safe and ethical healthcare.

Suitability for treatment – intake and assessment

Several consumers told us they had decided to leave their AOD program early because their AOD treatment provider was either not providing them with treatment that met their needs or provided treatment that was unsuitable. Based on those complaints it appears that, in some cases, private AOD treatment providers have been prepared to accept clients simply because the client is able to pay for services upfront, regardless of whether or not the provider is able to provide the client with appropriate treatment. These complaints raise concerns about how well providers meet their obligations under Code clause 1 (see below) as well as their obligation to not financially exploit their clients (Code clause 12 – considered later in this document).

Code clause 1: Safe and ethical treatment

A general health service provider must provide general health services in a safe and ethical manner.

Part of the obligation to provide safe and ethical health care includes observing the obligations in Code clauses 1(2)(b) and (c), namely:

- to not provide a health service of a type that is outside the provider's experience or training, or provide services that the provider is not qualified to provide
- to only prescribe or recommend treatments that serve the needs of clients.

A key ingredient in complying with those obligations is to match clients to the correct service model or treatment type and to ensure the appropriate staff and tools are available to deliver those treatment models. A key determinant of this process is the complexity and severity of AOD use.

Turning Point has informed us that an AOD treatment provider's assessment needs to focus on matching treatment to the type, pattern and severity of substance use. In Victoria, publicly funded treatment services use a standardised tool (the Victorian Intake and Assessment Tool) to inform treatment plans. In practice this means that, following client intake, best practice involves matching the client with a suitable treatment plan. Treatment matching in such a setting will be informed by the severity and complexity of the client's presentation. An important consideration for the treatment provider is how risk will be managed. For example, where detoxification therapy is planned and the patient has a known risk history of complicated withdrawal (e.g. alcohol withdrawal seizures), the preferred treatment may be within a setting of medically supervised residential care rather than outpatient management by an AOD clinician.

Another important aspect of AOD treatment is choosing the right treatment for the individual client. All clients should be assessed at intake and, where a client's needs identified at intake lie outside the scope of the provider's expertise, consideration should be given to referring the client to a service that does have capacity to appropriately treat the client and manage their physical or psychiatric risk. The imperative should be to provide the best treatment to the client

in the most appropriate setting. That approach aligns with the obligations in Code clauses 1(2)(b), (d) and (e). These factors are especially relevant in treating 'dual diagnosis' clients, an issue that is specifically discussed below.

Supporting recommendation 4:

It is recommended that all private AOD treatment providers utilise a standardised tool such as the Victorian AOD Intake and Assessment Tool, to match treatment to the type, pattern and severity of substance use when assessing and determining clients' treatment plans.

Refunds and financial exploitation

Complaints about being unable to obtain refunds and complaints alleging financial exploitation due to misrepresentations by providers have also been common. Related complaints also included concerns such as:

- clients being assisted by providers to access superannuation funds to pay for treatment without appropriate advice on taking that step
- exploiting clients for free labour without remuneration under the guise of 'treatment'.

Code clause 12: General health service providers not to financially exploit clients

(1) A general health service provider must not financially exploit the provider's clients.

(2) Without limiting subclause (1):

(a) a general health service provider must only provide services or treatments to clients that are designed to maintain or improve clients' health or wellbeing; and
(b) a general health service provider must not accept or offer financial inducements or gifts as a part of client referral arrangements with other health service providers; and
(c) a general health service provider must not ask clients to give, lend or bequeath money or gifts that will benefit the general health service provider directly or indirectly.

Refund complaints

Across the complaints to my office about private AOD treatment providers, refunds are the most common outcome requested. Refund-related disputes most often arise when a client leaves the program early (either voluntarily or because they are 'exited' early by the provider').

A significant driver for these complaints is the high upfront payment that private AOD treatment providers often require before agreeing to take on a client. The two providers we received the most complaints about between 1 February 2016 and 31 August 2019 charge:

- $13,000–$13,750 for 30 days in residential treatment
- $24,495–$32,500 for 90 days in residential treatment.[91]

Other drivers giving rise to refund disputes include:

- concerns about the competence of the provider (i.e. not getting what was advertised or paid for)
- lack of treatment or inadequate treatment
- mental health issues going untreated
- sexual misconduct and harassing behaviour of staff and other clients
- poor facilities and misrepresentation of treatment services and facilities.

Some providers, when faced with a refund request, rely on 'no-refund' contract terms to deny the request. An example of such a term is shown below at **Figure 5.**

Figure 5: *Term from a contract used by a private AOD treatment provider*

Any amount of the Program Fees paid is not refundable under any circumstance. In particular, the Patient acknowledges and agrees that in the event that the Patient exits the Clinic before the End Date, they will not be entitled to a refund of any amount of the Program Fees paid.

Case study 2

Grace travelled from interstate for treatment for AOD addiction. Her circumstances were complicated by her mental health issues.

Grace told us that she realised within three hours of being there that the provider's facility was not suitable for her. She felt uncomfortable because many of the clients were heavily addicted and she had not known that some clients would be receiving court-ordered treatment. The stories some clients relayed horrified her. She also felt the provider was not equipped to treat people with dual diagnosis.

Grace asked the support workers to retrieve her mobile phone so she could call her husband – they refused unless she promised not to speak to her husband about wanting to leave. When she was able to call her husband, she had to whisper so the support workers could not hear her. Grace had paid a $10,000 deposit for a 90-day program. Although she discharged herself just three hours after arrival the provider refused her request for a refund.

[91] While other providers may have varying levels of treatment and costs, 30–90 day treatment programs were the most common programs we received complaints about.

The general manager of the same provider has, independently of this complaint, informed us that:

> *... it is absolutely made 100% clear to all prospective patients and families that, your designated treatment plan is payable on admission. If you choose to leave treatment early, we do not provide cash refunds we provide treatment credits. That is clearly explained on all the treatment agreements, it is clearly explained by the accounts administrator …*

Case study 3

John was bailed to a private AOD treatment provider. His mother paid for 90 days of treatment. After an incident at the facility, John absconded 58 days into his treatment program. John's mother sought a refund of $9,244 for the unused portion of the treatment program. The provider refused, stating:

> *This was on the very clear understanding that if he was to leave treatment early there would be no refund payable. This is also a condition of the court bailing him and is on court record. Courts will never bail anyone to private treatment on the understanding if they leave early, they will receive a refund. This negates any suggestion of commitment and surety that the patient is committed to stay.*

The unwillingness of some providers to offer refunds has been an ongoing concern and may, in some circumstances, be capable of being described as financial exploitation (see the discussion below regarding the application of the Australian Consumer Law (**ACL**)).

As noted above, what some providers offer in place of a refund is a 'treatment credit' that the client can put towards further treatment at a later time. However, for the reasons set out below such credits have limited, if any, value.

Case study 4

Sarah had a history of 'ice' addiction. Her mother prepaid almost $17,000 for Sarah to undergo a 90-day treatment program at a facility the provider was closely affiliated with outside Victoria. She had to sell her house to be able to make the payment. Sarah's mother had tried to reduce the upfront payment to one month's worth of treatment but was told she had to pay for the full three months upfront.

Sarah left the facility early and returned to Victoria. The Victorian provider told her she could have a 'treatment credit' of just over $13,000, which equated to the unused portion of the prepaid fees. Sarah had a few days of treatment at the Victorian provider before pulling out altogether. In total her treatment spanned 10 days. The Victorian provider refused to provide a refund for the remaining unused treatment, stating Sarah was welcome to use the remaining treatment credit instead but that it had nothing to refund because it never received any payment. The complaint is being handled through our complaint resolution process.

The Australian Consumer Law

The Australian Consumer Law (**ACL**) provides broad protection to consumers including those engaging with private AOD treatment providers. The ACL is set out in Schedule 2 of the *Competition and Consumer Act 2010* (Cwlth). Broadly, the ACL applies to consumer transactions for all goods and services entered into after 1 January 2011, except financial services.

The ACL applies in all states and territories and to all Australian businesses. It is administered by the Australian Competition and Consumer Commission (**ACCC**) and state and territory consumer protection agencies and is enforced by all Australian courts and tribunals, including the courts and tribunals of the states and territories.

The ACL protects 'consumers', and s.3 of the ACL states that a person is taken to have acquired particular goods or services as a consumer if, and only if:

a. the amount payable for the goods or services is less than $40,000, or
b. the goods or services were of a kind ordinarily acquired for personal, domestic or household use or consumption, or
c. the goods consisted of a vehicle or trailer acquired for use principally in the transport of goods on public roads.

The ACL provides that unfair terms covered in contracts are void. A term is 'unfair' when it:

- causes a significant imbalance in the parties' rights and obligations arising under the contract
- is not reasonably necessary to protect the legitimate interests of the party who would be advantaged by the term
- causes detriment (whether financial or otherwise) to a party if it were to be applied or relied on.[92]

The ACL also sets out 'consumer guarantees'. The service provider must guarantee that the services will be:

- provided with due care and skill
- fit for any specified purpose
- provided within a reasonable time.

If the service fails to comply with one of the above consumer guarantees, the consumer may have access to a number of remedies, including refund, compensation or cancellation of the contract.

A consumer's rights under the consumer guarantees cannot be excluded. A term of a contract is not enforceable if it purports to exclude the operation of a consumer guarantee or exclude liability for a failure to comply with a consumer guarantee.[93]

[92] ACL s.24(1).
[93] ACL s.64.

Under the ACL, businesses must not engage in unconscionable conduct when dealing with other businesses or their customers.[94] As highlighted by the ACCC, there are a number of factors a court will consider when assessing whether conduct in relation to the selling or supplying of goods and services to a customer/client complies with the ACL.[95] These include:[96]

- the relative bargaining strength of the parties
- whether any conditions were imposed on the weaker party that were not reasonably necessary to protect the legitimate interests of the stronger party
- whether the weaker party could understand the documents used
- the use of undue influence, pressure or unfair tactics by the stronger party
- the requirements of applicable industry codes
- the willingness of the stronger party to negotiate
- the extent to which the parties acted in good faith.

In our view, contracts for general health services by private AOD treatment providers attract the ACL, in particular the consumer protections regarding:

- misleading or deceptive conduct (s.18 ACL)
- making false/misleading representations about the sale of goods and services (s.29 ACL)
- unconscionable conduct (ss.20, 21 ACL)
- unfair terms in consumer contracts and standard form consumer contracts (ss.23–28).

The ‘misleading or deceptive conduct’ and ‘making false or misleading representations in relation to the sale of goods and services’ aspects of the ACL are addressed later in this document in the ‘Misinforming clients’ section.

In our view, contract terms such as those in **Figure 6** are open to being considered unfair under the ACL or, at least, false or misleading about the representation they make about the existence, exclusion or effect of consumer guarantees. In our view, they are also open to be characterised as financial exploitation under the Code (Clause 9). The following are noted in this regard:

a) Based on complaints to my office, clients and their families are usually very vulnerable when signing up for AOD treatments:
    - The demand for AOD treatments outweighs the supply of government-funded services, in particular community rehabilitation services.
    - The prepayment model appears to be commonly used by private AOD treatment providers.
    - Community-based rehabilitation programs are the most effective method of treating long-term addiction. The upfront costs of accessing privately funded treatment programs places clients at a significant disadvantage and stress. The cost to access private services means that clients’ families, whose resources may already be stretched, are stretched even further, resorting to desperate measures (e.g. extending a

[94] ACL ss.20, 21.
[95] ACCC 2019, Commonwealth of Australia, Canberra, viewed 30 September 2019, <https://www.accc.gov.au/business/anti-competitive-behaviour/unconscionable-conduct>.
[96] This is not an exhaustive list and it should be noted that the court may also consider any other factor it thinks relevant.

mortgage or applying for an early release of superannuation entitlements) to try to secure a place.
- By the time they seek to access these services, clients and their families are often desperate for a place and the risks of not being able to access treatment is acute. There is often little, if any, time or opportunity to 'shop around' or negotiate.

This accumulation of circumstances leads to a significant disparity between clients and private AOD treatment providers, with the former in a far weaker position to negotiate or even walk away from the offer of a place. A client's vulnerability may also be relevant in the context of unconscionable conduct to the extent a provider took advantage of the vulnerability of the client to obtain their signature to a disadvantageous contact. That same vulnerability manifests itself again if the client is exited from a program and desperate to find a new place or if the program has failed.

b) Our concerns are amplified by four additional factors:
- Where a client leaves a long-term program early, the provider receives the benefit of the full prepayment without having to provide all of the service. Even allowing for some financial cost to the provider in providing some services and having to find a replacement client, the provider still gains a windfall if the client does not return.
- Rehabilitation stays of less than 90 days have been shown to be less effective at addressing long-term, complex addiction issues. Turning Point informed my office that while any option for ongoing treatment is likely to be more beneficial than no treatment or abandonment of a client, there is little experience or evidence to support a model of piecemeal-purchased treatment (i.e. treatment that is driven by financial imperatives rather than client needs). Instead, the research on residential rehabilitation attributes positive outcomes to at least 90 days of consecutive treatment. As such, there is a risk that outcomes will be diminished by fragmented treatment. For example, offering a client to come back for treatment may not be as effective as if they stayed consecutively for the entire 90 days, especially if the client has relapsed. Accordingly, offering a 'treatment credit' for the balance of a 90-day program no longer gives a client access to a program that will be as effective for them.
- Clients are unlikely to take up a 'treatment credit' if the relationship with the provider has broken down, the provider cannot meet the client's needs or effectively treat them or where the client has relapsed. Given their experience in dealing with vulnerable clients, private AOD treatment providers must know that while 'treatment credits' might appear reasonable in the first instance, they actually represent a 'low risk' response and potential windfall opportunity, especially where the client is most likely focused on finding a new provider or otherwise unlikely to return. Given this, it seems unconscionable for providers to refuse to provide refunds.
- Based on complaints to my office, some private AOD treatment providers also appear to rely on contract terms to give them wide-ranging discretion to exit a client early with little recourse for the client for any review. This is especially worrying where the provider seeks to terminate services for client behaviour that is symptomatic of the very condition the provider claims to be able to treat and manage.

Figure 6: *Termination clause in private AOD treatment contract*

Termination

The Clinic will be entitled to review the Patient's treatment and/or terminate this Agreement at any time during the Treatment Period if:

(a) payment of the Program Fees have not been made in accordance with clause 3 or clause 4 (if applicable);

(b) the Patient is found to be in possession of alcohol and/or illicit drugs or legal drugs which have not been authorised by the Treatment Team;

(c) the Patient is observed dealing alcohol and/or illicit drugs or legal drugs which have not been authorised by the Treatment Team;

(d) the Patient is found to be in possession of a weapon (whether or not the weapon is being used by the Patient);

(e) the Patient is physically or verbally abusive, or violent towards any employee(s) and/or other patient(s) at the Clinic;

(f) the Patient behaves in a manner which, in the reasonable opinion of the Clinic, jeopardises the reputation of the Treatment Program and/or the Clinic.

Financial exploitation – labour and Centrelink payments

One of the complaints we investigated involved direct financial exploitation of a client; our investigation found this provider in breach of Code clause 12. This matter is summarised in **Case study 5**.

Case study 5

Jack had a history of homelessness and AOD abuse. The director of a private AOD treatment provider got to know Jack and told him he was developing a property into a 'life restoration community'. In his conversations with Jack, the director referred to the AOD treatment program at the community, treatment plans for substance abuse/trauma and programs for personal development. Jack understood that he would have to assign his Centrelink payments to the provider in exchange for an AOD treatment program.

Once at the property Jack had to surrender his mobile phone and wallet and was told he could not contact external people without prior approval. In addition to signing over his Centrelink payments Jack was required to perform manual labour at the property for up to six days per week without payment.

After eight months Jack decided to leave – the provider had not provided him with any meaningful AOD treatments and refused to refund Jack's Centrelink payments, claiming they were Jack's portion of the rent.

Our investigation found that, despite the director's claim to the contrary, he was providing a general health service and had breached the Code. Specifically we found that requiring Jack to assign his Centrelink payments to the provider in addition to performing unpaid work without providing any substantive treatment breached the obligation under Code clause 12 not to financially exploit clients. The provider informed us it was no longer providing AOD treatment. We made recommendations requiring the provider to inform us before providing any general health services in future and requiring the provider to first demonstrate its compliance with the Code and the complaint handling standards. We also recommended the provider limit the ability of its director to offer any general health services.

Accessing superannuation for treatment

In some cases AOD providers allegedly helped clients obtain an early release of their superannuation entitlements to pay for AOD treatments. This issue has also been the subject of some media reports.[97]

Individuals may apply to gain early access to their superannuation on compassionate grounds for 'medical treatment and medical transport for themselves or a dependant' if the medical treatment cannot be readily available through the public health system and the individual or their dependant has:[98]

- a life-threatening illness or injury

[97] Booker, C 2015, 'Retirement funds spent on ice rehab', *The Age*, Melbourne, viewed 30 September 2019, <https://www.theage.com.au/national/victoria/retirement-funds-spent-on-ice-rehab-20150628-ghzvmh.html>.
[98] Australian Taxation Office 2019, Commonwealth of Australia, viewed 30 September 2019, <https://www.ato.gov.au/>.

- acute or chronic pain, or
- acute or chronic mental illness.

The Australian Taxation Office can only release superannuation on compassionate grounds if the individual:

- meets the eligibility requirements of the compassionate ground they are applying for
- has not paid for the expense
- cannot afford to pay the expenses without accessing their superannuation
- is a citizen or permanent resident of Australia or New Zealand
- provides all required supporting evidence and invoices/quotes.

Case study 6

Emily took out a loan to help pay for AOD treatment for her adult son, Peter. The provider told her Peter had superannuation funds that could be accessed to help pay for treatment. The provider's contract suggested that it offered financial advice, although it was unclear if anyone the provider employed was licenced to provide such advice.

Peter had two funds with insurance benefits payable in the event of his death – one account held greater benefits than the other. Emily sought regular updates from the provider about Peter's financial arrangements – she specifically stated it was important to retain the insurance benefits because 'due to the fact of his substance abuse over the last several years he will find it very difficult to get insurance again'.

Peter successfully accessed his superannuation funds. However, Emily later discovered the provider had also arranged to consolidate the funds, resulting in the account with the higher benefits being closed. When Peter died some time after ceasing treatment his estate received a lesser amount under the death benefit. Emily felt that in the course of assisting Peter the provider had been motivated to access the greater level of funds rather than acting in Peter's best interests.

Case study 7

Charlotte and her husband Tom met with a provider to arrange for Tom to be admitted to a 30-day residential rehabilitation program the following day. The manager told them they would be able to access their superannuation funds to pay for Tom's treatment. On that basis Charlotte and Tom agreed that to ensure Tom could get treatment as soon as possible they would prepay $12,500 on their credit card and reduce that debt once the superannuation funds were released. The provider then refused to assist them to apply for an early release of their funds. By the time the superannuation fund confirmed they were not eligible for an early release of funds Tom had completed his treatment.

The providers involved in these complaints have since confirmed they no longer offer to assist clients to access superannuation funds to pay for treatment.

Supporting recommendation 5

It is recommended that all private AOD treatment providers enter into written contracts with clients for providing AOD treatment before treatment begins.

All private AOD treatment providers must make a copy of their contract template available on their website and to direct prospective clients to that document.

Supporting recommendation 6

It is recommended that all contracts between private AOD treatment providers and clients comply with Australian contract law and the Australian Consumer Law. These contracts must include:

(a) fair and reasonable terms that enable clients to obtain refunds for unused portions of treatment, and

(b) where appropriate, cooling off periods for clients to review the suitability of the contract and services being offered. For example, a term allowing a cooling off period would be more appropriate where the contract is the outcome of planned treatment discussions and relates to ongoing provision of services in a residential facility as opposed to services provided on short term, urgent basis such as acute detoxification treatment.

Consent

Consent to treatment has been raised with us, in particular by clients stating they signed contracts for treatment while they were intoxicated or in the addiction withdrawal phase. Such complaints raise concerns about whether these clients properly understood what they were signing up to and how providers manage the challenges presented by such clients, especially when they are seeking treatment for the very condition that may compromise their ability to enter into a contract to treat that condition.

Code clause 2: General health service providers to obtain consent

Prior to commencing a treatment or service, a general health service provider must ensure that consent appropriate to that treatment or service has been obtained and complies with the laws applying in Victoria.

Processes for obtaining consent for AOD care vary jurisdictionally across private and public treatment services. In some cases consent documents are developed locally and are specific to a health service or treatment program.

Given the complexities with which some AOD clients present, informed consent obligations can pose a real challenge for providers. However, given the prevalence of those complexities in this

sector and the specialist services they offer, it is our view that private AOD treatment providers should possess the capability to manage these situations and have robust processes in place that ensure vulnerable clients are not exploited and appropriately understand what they are signing up for and/or are about to receive by way of treatment.

This means that, to comply with the Code, providers need to ensure consent to the contract and treatment programs are properly obtained in advance, that consent processes and assessments are properly documented as part of a client's clinical record and that a copy of relevant documents is given to the client for reference.

Importantly, obtaining informed consent in the AOD sector involves not only an understanding of the challenges posed by clients suffering from AOD addiction but also understanding the impact of issues such as intellectual disability and cultural/language differences. It also involves ensuring clients understand the treatment model, their rights and responsibilities, their behavioural boundaries during treatment and their treatment goals. This is particularly important given:

- the duration of some AOD treatments
- the vulnerability of some clients and the power imbalance between providers and clients during treatment
- the very limited external contact clients are sometimes allowed during treatment
- the duration of the commitment required from clients for effective treatment
- the costs involved.

Case study 8

Carly had an alcohol use disorder and admitted herself for treatment at a private residential AOD treatment facility costing almost $14,000. When Carly arrived at the provider's office, she told them she had been drinking alcohol and that she had 'a fair few'. She was then given some paperwork to sign, including the contract for AOD treatment. She was then breathalysed by the provider, returning a blood alcohol concentration (BAC) result of approximately 0.275 (over five times the legal driving limit).

After three days Carly left treatment because the residential facility was in a different location from where she had understood it would be and because the treatment environment was negatively affecting her mental health. When she asked for a refund, she was told the contract had a 'no refund' clause.

Carly was able to negotiate a full refund from the provider through our complaint resolutions process.

Case study 9

Ella told us her brother Edward had been addicted to crystal methamphetamine for about four years and her family had decided to help him. Ella and her family met with the general manager of a private AOD treatment provider and arranged for Edward to be admitted the next day. As part of Edward's admission process, he was taken to see a GP who prescribed him four Valium, which he took before being taken to the residential treatment facility. Edward slept all the way to the facility. Once he arrived, he signed a contract while still affected by Valium. Ella told us Edward would have been in no state to sign a contract.

Supporting recommendation 7

It is recommended that all private AOD treatment providers must be required to obtain from their clients:
(a) informed consent before any treatment is provided
(b) informed financial consent before any payment is made.

Any consent provided must be appropriately recorded.

The person engaged by a private AOD treatment provider to obtain and record client consent must be someone engaged by the provider at a management level, for example the general manager or chief financial officer.

Where a client is incapable of providing consent (e.g. due to the effects of AOD intoxication) the relevant consent must be obtained from a suitable next of kin, guardian or person who may lawfully consent on the client's behalf.

Misinforming clients

Clause 9 of the Code protects clients from general health service providers engaging in misinformation or misrepresentation in relation to the products or services they provide.

Complainants have raised concerns about misinformation or misrepresentation in advertising and promotional materials. Often these complaints have centred on the standard of the AOD treatment facilities. Given the high fees charged for residential services in particular, complainants have high expectations about the quality of the treatment and services that will be provided.

These issues intersect with the ACL, as discussed below.

Code clause 9: General health service providers not to misinform their clients

(1) A general health service provider must not engage in any form of misinformation or misrepresentation in relation to the products or services the provider provides or the qualifications, training or professional affiliations the provider holds.

(2) Without limiting subclause (1):

(a) a general health service provider must not use the provider's possession of a particular qualification to mislead or deceive clients or the public as to the provider's competence in a field of practice or ability to provide treatment; and
(b) a general health service provider must provide truthful information as to the provider's qualifications, training or professional affiliations; and
(c) a general health service provider must not make claims either directly to clients or in advertising or promotional materials about the efficacy of treatment or services the provider provides if those claims cannot be substantiated.

Complaints about misinformation or misrepresentation in promotional materials include that:

- photographs and descriptions of the facilities on websites and brochures did not accurately represent the facility
- advertised services were not available, or only available in a limited capacity
- the quality of services provided did not match what had been promised
- access to medical professionals was limited and generally only available off site
- staff members listed on websites did not actually work at the facility
- through advertising material or verbally, providers made unsubstantiated claims to persuade potential clients to enter treatment.

The Australian Consumer Law

A broad outline of the ACL is set out under 'Refunds and financial exploitation' and is relevant to when private AOD treatment providers misrepresent their products and services.

In our view, the general health services provided by private AOD treatment providers attract the ACL, in particular the consumer protections regarding:

- misleading or deceptive conduct (s.18 ACL)
- making false or misleading representations in relation to the sale of goods and services (s.29 ACL).

As noted above, the ACL also creates a minimum set of standards, the 'consumer guarantees', that apply when a consumer buys a service. In effect, when a consumer buys services, the service provider must guarantee that the services will be:

- provided with due care and skill
- fit for any specified purpose
- provided within a reasonable time.

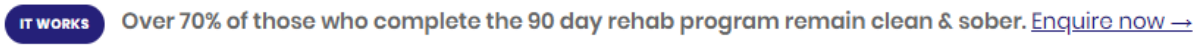
While the Code offers a broad protection from misleading conduct, the ACL provides a more comprehensive consumer protection framework in this area.

Unsubstantiated claims about the efficacy of treatment

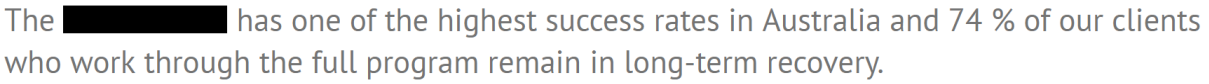
Some AOD treatment providers make claims about the efficacy of their treatments. Sometimes these claims are published on their websites. The two matters depicted in **Figure 7** provide examples of some of these statements.

Figure 7: *Screenshots of two provider websites making similar claims of success*

Website 1:



Website 2:



Case study 10

A former employee of a private AOD treatment provider informed us that the director of the provider had published a video on the provider's Facebook page in which the director stated 'this works, and it can work for you'.

We specifically consulted with Turning Point about claims such as those in **Figure 7**. In summary:

- There is no accepted industry standard for 'successful treatment', although one approach is to consider successful treatment as the attainment of recovery from addiction following treatment.[99]
- Claims about percentages are difficult for clients to understand because the point at which the outcome was measured is often unknown and it is unclear if the claims take into account clients who drop out of treatment. For example, if a treatment program has a 95% dropout rate but only the remaining 5% are assessed for recovery on the day of discharge, the 'success rate' might be high across the 5%, but the overall statistic is misleading.
- There is limited material that compares the efficacy of different treatments and enables informed conclusions to be made about their relative effectiveness. Some treatments work better for certain drug use patterns, types or behaviours. A key to the success of a treatment type is therefore how well it is matched to client needs.
- Both the 2012 MATES and 2015 Patient Pathways studies looked at outcomes of residential

[99] In North America, for example, it has been defined by the Betty Ford Institute Consensus Panel as 'a voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship', which may be further differentiated by stages of early (first year), sustained (one to five years) and stable (more than five years) sobriety.

rehabilitation and each found outcomes of 40–50% success at the one-year mark. This is substantially lower than the 70–74% claimed in **Figure 7**.

The claims made by the providers in **Figure 7** are under investigation.

Misrepresentations about services

Another concern raised in complaints relates to the availability of services. Private AOD treatment providers advertise a wide range of activities as part of the overall treatment program they offer, such as art therapy, yoga, massages, hiking, swimming and other sporting activities. However, several complainants informed us that these services were, in fact, not available. In other cases complainants said that they understood that, given the high cost of the private AOD treatment, such activities would be included in the price when in fact they were only available at an additional cost.

In other instances, we were informed that while facilities like swimming pools, spas and gyms were available on site, these services were of poor quality or not useable. For example, a private AOD treatment provider was alleged to have informed potential clients there was a swimming pool at the treatment facility even though the pool had never been functional and had been removed.

Supporting recommendation 8

It is recommended that all private AOD treatment providers comply with the Australian Consumer Law and the 'General code of conduct in respect of general health services' set out in Schedule 2 of the *Health Complaints Act 2016* in relation to their advertising and/or promotional material, regarding:

(a) any claims they make about the efficacy of their treatment and success rates of their service
(b) any statements they make about their staff or contractors regarding qualifications, training, accreditation or professional affiliations
(c) any statements they make in relation to endorsements or testimonials.

Standards of facilities

The quality of the environment in which private AOD treatments are provided has also been a theme across the complaints to my office. In addition to misrepresentation complaints (see above), safety concerns have been raised in connection with the conditions at some facilities.

Relevant Code clauses:

Code clause 1(1): General health service providers to provide services in a safe and ethical manner.

Code clause 9(2)(c): a general health service provider must not make claims either directly to clients or in advertising or promotional materials about the efficacy of treatment or services the provider provides if those claims cannot be substantiated.

Health service principle 4(b): that a health service is safe and of high quality.

To better understand these concerns and the environment in which private AOD treatment providers were delivering health services we conducted site visits to three private AOD treatment facilities. We also visited Odyssey House to provide us with a comparison based on a publicly funded residential treatment facility.

The private AOD treatment provider about which we had received the most complaints had been criticised strongly by complainants about the standard of its facilities. One client told us that it was 'very dirty', there were 'rips in the leather couches' and had 'old carpet', and that although he didn't 'expect the Ritz' the facility did not meet his expectations. This client also told us that during his stay there were two occasions when clients went 'on strike' due to the conditions of the facility: once due to a 'cool-room' not working and once due to a scabies outbreak. In this client's view, the provider did everything they could to minimise costs including getting clients to clean the premises instead of hiring cleaners.

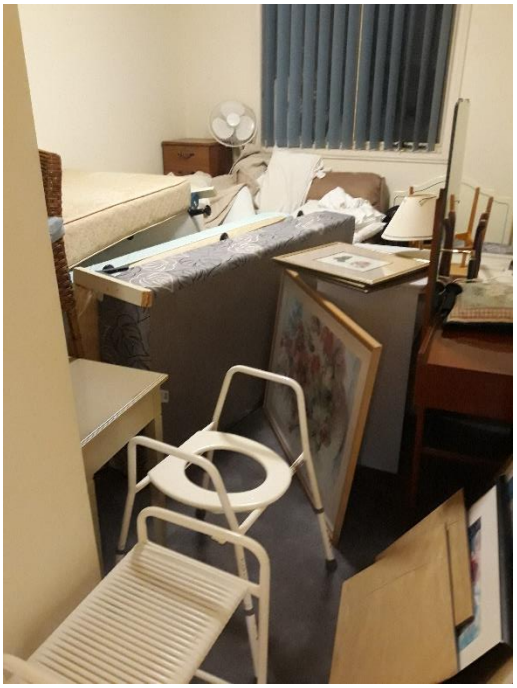
Another client provided us with photographs of the transitional housing facility operated by this same provider. This client was moved from one transitional housing facility to a newly opened transitional housing facility during the course of her treatment. The new facility had previously been an aged care home and was set up to treat clients and, as part of the move, clients were required to clean it. The client described the new facility as a 'halfway house' that was 'filthy and uninhabitable'. This client also told us that:

- the carpets were filthy and stained
- the facility smelt like moth balls and urine and the toilets had mould on them
- furniture was scattered around the facility and the rooms were small
- the showers and bathrooms were putrid and the windows could not be opened
- the facility was mixed male and female.

This client also provided us with photographs she had taken during her stay in mid May 2018 – see **Figure 8**.

Figure 8: *Photographs of transitional housing facility provided from client*

Cluttered bedroom



Mouldy toilet

Cluttered common area

Stained floor and chair

A seperate client provided us with photographs of a facility operated by another provider. This client told us that in their initial consultation with the provider they were shown a brochure with a beautiful facility and luxurious amenities, but when the client stayed at the facility the place was falling apart. This client also provided us with photographs, although these were taken after the client had left the facility and they were only able to access outside areas (**Figure 9**).

Figure 9: *Photographs of residential rehabilitation facility provided by complainant*

Dam

Gym

Tennis court

Fallen tree in yard

Site visits

We conducted site visits to three private AOD treatment facilities run by different providers and also visited a facility run by Odyssey House. Each of the private treatment providers consented to the site visits. Our presence was generally welcomed and, notably, each private treatment provider expressed similar ideas about improving the private AOD treatment sector through regulation. In each case we were provided with a tour of the facility and were able to speak to staff and observe clients. These visits are described below (on a de-identified basis).

Site visit to Odyssey House

We visited the site operated by a government-funded AOD treatment provider, Odyssey House, in Lower Plenty to get a different perspective on AOD treatment services and identify a benchmark of good industry practice in the AOD sector.

Odyssey House's residential rehabilitation program is based on the therapeutic community model of treatment, and Odyssey House is a certified Therapeutic Community Member under the ATCA.[100] Odyssey House provides intensive residential treatment for individuals and families, including parents with addictions and their young children. It operates residential rehabilitation treatment programs from two sites. The site at Lower Plenty has 143 beds available and offers live-in treatment for individuals, couples and parents with their children (aged 0–12 years). The Odyssey House site in Benalla has 15 beds and offers a six-week live-in residential program.

Odyssey House is funded by the Victorian Government, although some funding also comes from Centrelink payments, with clients expected to contribute approximately 80% of their Centrelink payment (although this may vary depending on individual circumstances).

In general Odyssey House informed us that it recommends a minimum stay of four months and that support is provided for those who want to leave at varying times.[101] The program can be completed between 18 and 24 months, but this depends on the individual.[102]

We made the following key observations during our visit.

Facility:

- Male and female clients are housed in separate wings.
- Family rooms are self-contained, modern dwellings. These rooms are separate from the main facility.
- The facility was very clean and well maintained. Clients contribute to the functioning of the community through cooking, cleaning and working on property development and maintenance.
- Disability access is limited.

[100] ATCA 2019, viewed 30 September 2019, <http://www.atca.com.au/referrals/victoria/>.
[101] Odyssey House Victoria 2019, Therapeutic Community Admission, viewed 30 September 2019, <https://www.odyssey.org.au/therapeutic-community-admission/>.
[102] Ibid.

Staffing:

- At least one staff member must always be on duty at the Lower Plenty site. Overnight, there is one staff member present.
- The minimum training requirement for staff is a Certificate IV in AOD treatment.
- Approximately half the staff are 'experts by experience' (they have, themselves, been in the residential rehabilitation program).
- All staff must pass a police check and Working with Children Check (**WWCC**).
- Staff are drug tested if there is a concern they may be taking drugs.
- If a former client wants to apply to become an Odyssey House staff member, a period of 12 months must pass between completing the residential rehabilitation program and working at the facility – the actual duration will depend on factors such as time spent AOD-free.

Clients:

- Some clients will be taken on as part of their bail conditions.
- Violent offenders or sex offenders are generally not permitted.
- Clients are drug tested regularly and subject to random breath tests.
- Clients are subject to a welfare check every two hours.
- There is a high level of trust between staff and clients.
- Clients must complete house duties and office duties as part of the daily running of the facility.
- Clients receive a full medical and psychiatric assessment before entering.

Rules and complaints:

The core rules of the program are:[103]

- No violence or threat of violence.
- No theft.
- No drugs or alcohol.
- No sex.
- Knowledge of these rules being broken must be reported.

A breach of the rules will result in an intervention, the nature of which will depend on the context and severity of the behaviour. For example, if a new client is found to be in possession of drugs on site, the intervention will be different from that imposed if the client has already been in the program for 12 months; a new client in such circumstances is also unlikely to be 'exited' from the program.

There is a comprehensive 'client complaints and grievances' policy and procedure.

Exiting clients:

- A client will not be removed from the facility for breaching the rules unless it is considered safe to remove them.
- When being exited, a client will be put in contact with a family member or a support service. They will also be given money for expenses and, if they are unable to remain on

[103] Odyssey House Victoria 2019, Odyssey House Victoria, Melbourne, viewed 30 September 2019, <https://www.odyssey.org.au>.

the premises due to their behaviour, alternative accommodation is organised.
- A client will not be exited at night due to safety concerns.

Site visit – Provider 1

We visited three sites operated by this provider:
- its head office
- a transitional housing facility – this is the same facility also shown in **Figure 8**
- a residential rehabilitation facility.

We visited the transitional housing facility in March 2019. The visit was approximately 10 months after the photographs in **Figure 8** were taken. Based on our visit, significant improvements appeared to have been effected in that time (see **Figure 10**) – the facility looked relatively clean and seemed to be in much better condition than in the photographs we had been provided. Improvements we observed included the following:
- Bathrooms had been cleaned and there were no visible signs of mould on toilets or in showers.
- The carpets appeared to have been cleaned throughout the facility and had minimal stains.
- Bedrooms were equipped with basic beds and furniture; rooms were average in size, with some rooms large enough room for a double bed and desk.
- There was an industrial-sized kitchen that appeared reasonably clean and well stocked with food.
- It was uncluttered and the facility appeared generally well organised.
- While bedrooms did not have lockable doors, we were informed that this was to ensure client safety and that all outside doors had locks and were locked at night.
- The facility catered for male and female clients, who were housed in separate wings.

The general manager of the facility told us that the provider had generally improved its facilities following the commencement of the 2018 Regulations and that: '*[w]e've made some changes to the facility. Mainly around patient safety, ligature points and making the room safe and have been granted a [*redacted*]-bed prescribed licence.*'

Overall, the facility appeared to be well equipped as a transitional housing facility, although, given the high costs associated with treatment at this facility, there still appeared to be a good chance that, for some clients, there would be an expectation gap regarding what was actually available.

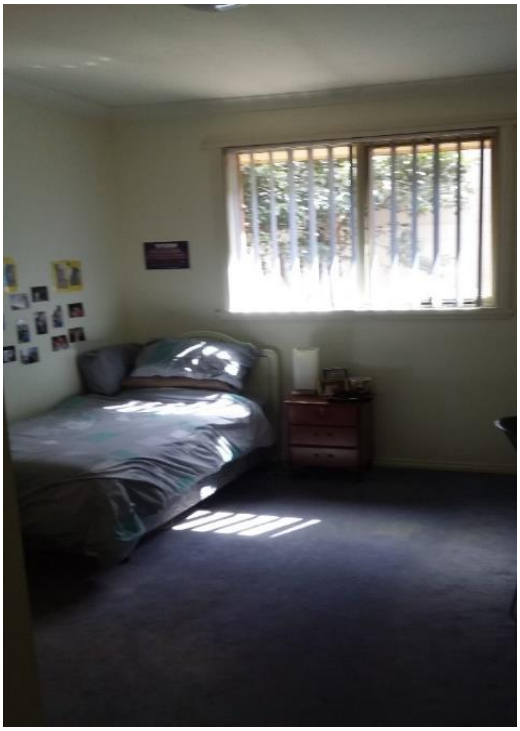
Figure 10: *Photographs from site visit – Provider 1*

Common area
(transitional housing facility)

Kitchen
(residential rehabilitation facility)

Anti-ligature bathroom (withdrawal unit)

Bedroom (transitional housing facility)



Site visit – Provider 2

We visited the residential rehabilitation facility in **Figure 11** in August 2019. By way of context, we had received a complaint about a client's experience at this facility in February 2019 that alleged the facility and services did not align with what client services manager had promised. In addition to her complaint that she had been told a psychologist and doctors were involved in treatment and that she had understood they would be on site, the complainant also stated that the client services manager had shown her a colour brochure with photos of a swimming pool, gym and tennis court, which presented the venue more like a holiday resort than a rehabilitation facility. The basis for the complaint was that:

- There were no doctors on site.
- The pool had been removed.
- The grass and hedges were overgrown.
- Part of the gym roof was missing, insulation was exposed and the general presentation was poor.
- The facility had run out of food and there was only cereal to eat for two days.
- The amount of money they paid did not appear to reflect the services advertised.

Again, we observed significant improvements when we attended this site for a visit.

At the time of our visit, the provider was licensed to provide acute detoxification services, and many of the improvements appeared to have been made to comply with the 2018 Regulations; for example, bathrooms in the acute detoxification unit had the ligature points removed, 24-hour nursing care had been implemented and medication storage units had been installed. As part of our site visit, we were informed or observed that:

- Although there was no medical practitioner or psychologist on site, these services were available off site and there was a 24-hour nurse on site.
- The facility was clean and generally in good repair. There had been a recent fire in a common area fireplace, and this area was being repaired.
- The yard was generally in good repair.
- The kitchen was well stocked with food. There was a kitchen for clients and an industrial kitchen for staff to prepare meals for clients.
- Medication was locked in storage units.
- Medical equipment seemed to be readily available – for example, first aid kits, a needle/sharps disposal container and defibrillators.

Figure 11: *Photographs of site visit to residential rehabilitation facility – Provider 2*

Outside area

Group counselling room

Industrial kitchen

Gym

Medication locked storage unit

Standard bedroom

Site visit – Provider 3

We received information that one private AOD treatment provider was operating from the site of a former brothel and that the facility had not been modified. The complaints we received were made by complainants who wanted to remain anonymous.

We conducted a site visit in June 2019 and observed that:

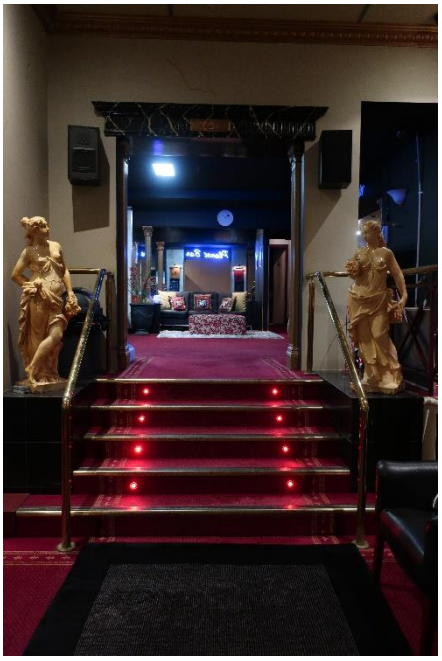
- The facility seemed largely unchanged since it was a brothel. Much of the furniture, signs and memorabilia seemed more relevant to its previous use such as statues of naked women, dancing poles and mirrors on walls and ceilings.
- The facility had fewer clients – four clients at the time of our visit.
- It was clean, although some rooms were cluttered and it was generally very dark.
- The kitchen was stocked with food.
- It was not apparent that treatment programs were being delivered on site.

Figure 12: *Photographs from site visit – Provider 3*

Bedroom (residential rehabilitation)

Kitchen

Stairs leading to main common area



Dance pole in common area

Supporting recommendation 9

It is recommended that all private AOD treatment providers that are not registered under the Health Services (Private Hospitals and Day Procedure Centres) Amendment Regulations 2018 must, as part of any mandatory registration scheme, be regularly and independently audited to ensure they provide AOD treatment that is considered best practice and is safe and effective and that their premises remain clean, safe and fit for purpose.

Staff members

Qualifications

As part of our work in the AOD sector, we were informed that, in some cases, directors and staff members at private AOD treatment services did not have relevant qualifications or misrepresented their qualifications.

Code clause 1(2)(a): Maintain competence
A general health service provider must maintain the necessary competence in the provider's field of practice.

Code clause 9(2)(b): General health service providers not to misinform their clients
A general health service provider must provide truthful information as to the provider's qualifications, training or professional affiliations.

These Code obligations help give effect to the health service principles, specifically principles 4(b) and (c), which require that a health service is safe and of high quality and that it is provided with appropriate care and attention.

To maintain high standards of treatment in the publicly funded AOD treatment sector, DHHS has implemented a minimum qualification strategy.[104] The aims of this strategy are to:

- ensure AOD workers are appropriately and adequately trained and competent to do their jobs
- increase the proportion of workers who have specific AOD or addiction qualifications.

Since 1 July 2006, the minimum qualification strategy has required new workers entering the sector without relevant qualifications to first obtain a specialist qualification in AOD or addiction at the Certificate IV level or higher before being eligible to work in a DHHS-funded AOD service.[105]

While the employment records provided to my office by the two major private AOD treatment providers indicate that they are generally employing people with at least Certificate IV qualifications, they are under no obligation to do so. In some cases a lack of appropriate qualifications has generated complaints to us.

[104] Department of Human Services 2004, *The Victorian alcohol and other drugs workforce development strategy – minimum qualification strategy*, State Government of Victoria, Melbourne.
[105] Ibid.

Case study 11

Two former staff members at a private AOD treatment provider told my office that the director represented themselves as a 'Senior AOD Counsellor', even though they did not have such qualifications (the director also signed emails to HCC staff as a 'Senior AOD Counsellor'). When interviewed the director stated they had a Certificate in Addiction and Treatment, although they were unable to provide us with any evidence to support that claim.

One of the former staff members also alleged the director had published false information about the qualifications of other staff members on the provider's website and had not removed the profiles of previous employees, thereby misrepresenting the level of services available.

Employing people with lived experience

It appears to be common practice in the AOD treatment sector across both publicly funded and privately funded AOD treatment providers to employ people with lived experience of AOD addiction. Often these staff have roles such as AOD counsellors or peer workers. In some cases such workers can comprise up to 50% of staff.[106]

It is understandable that people want to use their experiences to help others experiencing similar addiction issues. However, employing people with a history of AOD addiction can, if not managed well, adversely affect clients if such staff re-engage in AOD-related activities, especially at work. An example of such an instance is set out below under the heading 'Drug use in facilities and practising under the influence'.

As noted above, Odyssey House engages staff who have personally experienced AOD addiction. At Odyssey House there is a general 'stand-down' period of approximately 12 months between completing the residential rehabilitation program and becoming a staff member, depending on individual circumstances. The gap takes into consideration that many people in the residential rehabilitation program will have been AOD-free for 12–24 months before finishing the program. The approach across private AOD treatment providers when employing such people varies. One major provider told us that they generally do not employ former clients but may make an exception if the former client has not used alcohol or drugs for at least 24 months.

Turning Point informed us that the evidence for employing people with experiential knowledge of AOD use, or peers, is well established in the mental health sector and is supported with extensive evidence. Evidence of the use of peers is less extensive in the AOD sector, but the available evidence suggests similar benefits. Models of care using peers is a feature of Victoria's current AOD workforce strategy where comprehensive frameworks based on evidence have been developed around peer support for AOD care. Such peer workers may be paid or volunteers and may be part of a structured workforce or engaged on an ad hoc basis.

[106] For example, Cyrenian House, a Western Australian non-government AOD treatment organisation – Western Australian Association for Mental Health (WAAMH) 2014, *Peer work strategic framework*, WAAMH, West Perth.

Where peers are employed in counselling roles, particularly if they are former clients of a provider, this can present a challenge to the employer, peers and clients, particularly around defining their professional boundaries and roles. It is also important that when former clients are employed as counsellors (as opposed to peer workers), they should have first obtained the requisite qualifications.

While peer worker models vary, best practice when employing peers includes common principles such as consistent and transparent recruitment processes, clear role definition, training and supervision and clarity around confidentiality and disclosure.

What is clear is that the use of peers, either as peer workers or as clinicians, needs to be supported by a robust framework that underpins their engagement, training and supervision. Without these measures, they can pose a significant risk to achieving effective treatment.

Drug use in facilities and practising under the influence

As part of our engagement with the AOD sector we received reports that staff members were engaging in drug use with clients in residential treatment facilities.

Code clause 10: General health service providers not to practise under the influence of alcohol or unlawful substances

(1) A general health service provider must not provide treatment or care to clients while under the influence of alcohol or unlawful substances.

(2) A general health service provider who is taking prescribed medication must obtain advice from the prescribing health practitioner or dispensing pharmacist on the impact of the medication on the provider's ability to practise and must refrain from treating or caring for clients in circumstances where the provider's capacity is or may be impaired.

Not only is it a breach of the Code for a health service provider to practise under the influence of alcohol or unlawful substances, but in the AOD sector, in particular, the harmful effects of such activities are understandably amplified by the particular vulnerability of the clients involved.

Case study 12

Michael was being treated for opiate addiction. He told us that a female staff member had supplied him with heroin on four occasions while he was in treatment:

- The staff member drove him in the work vehicle to meet a drug dealer. They both then used the drugs in the vehicle.
- The staff member walked with him to a public toilet near the facility where they used heroin supplied by the staff member.
- The staff member drove him to a pawn shop and asked him to pawn his jewellery for $150, which Michael then gave her to buy heroin from a dealer.
- The staff member gave Michael heroin while distributing medication to other clients at the facility.

The staff member also had sex with Michael on three sperate occasions after they had used drugs. Michael did not stay in contact with us and we were unable to substantiate his allegations.

Administering medication

Clients receiving AOD treatment often also take medication for various medical and mental health conditions. In some cases this may involve prescription medicines and pharmacy-only medicines. The *Drugs, Poisons and Controlled Substances Act 1981* and the Drugs, Poisons and Controlled Substances Regulations 2017 regulate the possession and use of medicines and poisons in Victoria. As part of the regulatory framework established by these laws, DHHS:

- monitors health practitioners' prescribing habits and pharmacists' dispensing procedures to identify matters that might endanger patients
- monitors procedures to ensure medicines are administered in accordance with the prescriber's instructions at hospitals and residential aged care services
- oversees the supply and use of methadone and buprenorphine in the treatment of patients with an opioid dependency.[107]

In one case, a staff member told us anonymously that while employed as an AOD support worker she had been asked to administer medication to residents with no oversight and had administered medication to residents with mental health issues. In other instances, clients have told us that medications are not stored in secure locations or administered correctly. One client told us that the general manager at a private AOD treatment facility had given her Valium from the manager's personal supply, even though the manager was not a registered health practitioner.

From our review it does not seem uncommon for private AOD treatment providers to have no registered medical practitioners or nurses on site to administer medication. Instead, what some providers appear to do instead is to have 'Webster packs'[108] made up by a local pharmacist and

[107] DHHS 2019, State Government of Victoria, Melbourne, viewed 30 September 2019, <https://www2.health.vic.gov.au/public-health/drugs-and-poisons/drugs-poisons-legislation/drugs-and-poisons-act-regulations>.
[108] Webstercare 2019, *Webster-pak*, viewed 30 September 2019 <http://www.webstercare.com.au/shop/item/community-webster-pak>.

then have staff at the facility supervise the client taking their medication.

The absence of site-based medically trained staff is a concern, especially because, in some cases, anecdotal evidence suggests that AOD workers are administering medication even though they are themselves experiencing AOD addiction issues.

Given these concerns it is important that private AOD treatment providers have clear policies and procedures in place about on-site treatment and self-administering of medication in order to comply with relevant laws and regulations.

Case study 13

Ava told us that her parents had paid $20,000 to admit her to a residential rehabilitation facility for addiction and mental health issues after she had attempted suicide. Ava had previously waited unsuccessfully for months to get into the public system. The provider told Ava they specialised in addiction and mental health.

Ava was concerned that a full medical history was not taken from her, even though she had a significant history of mental health issues. She was not seen by a psychiatrist. She was taken off Suboxone, her Valium intake was reduced and she was put on antidepressants and antipsychotics. Her mental health started to deteriorate. On several occasions the facility manager gave her Valium from a bottle the manager had access to.

Ava self-harmed three times and ambulance services were called on all three occasions. Ava said staff were not trained in dealing with her mental health issues. Given the mismanagement of her mental health and addiction issues and her deterioration she left the facility.

Supporting recommendation 10

It is recommended that, as part of any AOD Worker Registration scheme, 'AOD Workers' must be required to obtain specialist qualifications in AOD treatment.

Specialist qualifications must be to the Certificate IV level or higher as modelled on *The Victorian alcohol and other drugs workforce development strategy – minimum qualification strategy*.

Supporting recommendation 11

It is recommended that all AOD workers with a previous history of AOD addiction ('lived experience') must have 'maintained recovery' for at least 12 months before being permitted to work in the AOD sector.

Where private AOD treatment providers recruit AOD Workers with lived experience, the providers must have processes for providing ongoing on-the-job-training, support and supervision.

Dual diagnosis

In this report, dual diagnosis refers to one or more diagnosed mental health problems occurring at the same time as problematic AOD use.[109] Co-occurring substance use is common rather than exceptional among people with serious mental health problems and disorders.[110] A dual diagnosis condition can include:

- a mental health problem or disorder leading to or associated with problematic AOD use
- a substance use disorder leading to or associated with a mental health problem or disorder
- AOD use worsening or altering the course of a person's mental illness.[111]

Research shows high rates of AOD use among people with severe mental health problems.[112]

The high rates of dual diagnosis present a significant challenge for private AOD treatment providers, as highlighted in case studies 14 and 15.

Code clause 1(2)(a): Maintain competence
A general health service provider must maintain the necessary competence in the provider's field of practice.

Steps a provider should take for clients with dual diagnosis

Turning Point informed us that where a client is identified as having comorbid mental illness, an assessment of their mental state and associated risk is required. This needs to be completed by staff who have the tools and competencies to conduct a mental health assessment. This will include assessing risk, which may involve using a specific risk assessment module. A primary consideration for treatment providers managing dual diagnosis of clients are staff skills and competencies.

In some cases services undertaking intake will act as a 'signpost', and clients may need to be redirected to a more suitable service if psychiatric comorbidity (which is often exacerbated by drug withdrawal) and associated risk is determined to be a management challenge for the service. For example, where assessment reveals a risk of exacerbation of severe mental illness (e.g. psychosis) or suicidal thinking, a referral to another service with capacity to respond to acute mental health symptoms should be considered.

The approach to dual diagnosis will depend on the type of treatment offered. For example, there are different risk considerations for a short-term detoxification admission compared with residential rehabilitation. In the former, acute risk issues will be the primary concern in dual diagnosis clients. In the latter, the ability to offer maintenance treatment will be important. In a

[109] DHHS 2013, State Government of Victoria, Melbourne, viewed 30 September 2019, <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/specialist-responses/dual-diagnosis>.
[110] Ibid.
[111] Ibid.
[112] Ibid; Lubman, D, Manning, V and Cheetham, A 2017, *Informing alcohol and other drug service planning in Victoria*, Turning Point, Victoria.

residential rehabilitation setting, where the commitment to treatment usually involves stays of more than one month, the ability of the client to remain engaged in treatment and have their mental health needs attended to will need to be assessed.

The information we have indicates that some AOD treatment providers have little or no competency or capacity to effectively treat serious mental health conditions as part of an AOD treatment plan.

Case study 14

Sam was admitted to a private AOD residential rehabilitation facility to treat his addiction to ice, marijuana, alcohol and Valium. Sam also had a borderline personality disorder. One reason this provider had been chosen was because it advertised that it specialised in treating dual diagnosis clients. This was specifically discussed with the general manager, who stated that the provider was equipped to treat Sam. The treatment cost $25,000. Sam's family told us that:

- The provider did not have a psychologist or psychiatrist on site.
- The provider did not appropriately manage Sam's medication. The medication was changed without the family's knowledge; Sam was not given his usual medication (Prozac) but taken to a GP instead and prescribed olanzapine (an antipsychotic). This was problematic because Sam was addicted to antipsychotic medication.
- The provider temporarily exited Sam from the program on several occasions for his behaviour. Sam's family was given little notice of these events and were told Sam would be dropped at a train station within an hour. Given the potential risk to Sam if left to travel alone on the train, Sam's family had to arrange for him to be picked up and brought home at considerable expense.
- Sam had told them another male client had held Sam down and had slapped him in the face with his penis.
- The provider called them to say Sam was being discharged because they were unable to manage his behaviour and mental health concerns.
- In a letter written for Sam's court appearance the provider stated that Sam had been noncompliant with all aspects of the AOD treatment program.

Some publicly funded residential rehabilitation services, such as Odyssey House, will help clients to engage with mental health services that provide complementary treatment for issues of dual diagnosis within a shared care framework. If at intake or initial screening a complex or serious mental health issue is identified, the client will be referred for further specialist mental health or psychiatric assessment.

However, a dual-track approach does not appear to align well with the business model adopted by those private AOD treatment providers that run residential rehabilitation facilities given that, where a potential client is referred to a mental health service, they are unlikely to later return to the provider for AOD treatment. This has been confirmed by private AOD treatment providers who informed my office that a shared treatment model would be counterproductive given the potential loss of the client. Instead, private AOD treatment providers appear to be more likely to try to secure a contract with the client and to treat them themselves.

Case study 15

Olivia suffered from AOD addiction as well as post-traumatic stress disorder, borderline personality disorder and an eating disorder. She was admitted for a 30-day detoxification and rehabilitation program at a private AOD treatment facility at a cost of $12,200.

Before her admission Olivia's mother informed the provider of Olivia's mental health issues. The provider independently assessed Olivia and recorded her addiction and mental health issues. The provider assured Olivia's mother that they could deal with these issues.

Olivia's mother told us that because Olivia was not appropriately medicated she became sleep-deprived and her mental health issues worsened. Nineteen days into the program the provider arranged for Olivia to see a GP because there were no doctors on site. The GP was so concerned about Olivia that they recommended she withdraw from the program and move into psychiatric care. Olivia withdrew from the program.

Olivia's mother felt she had been misled by the provider into believing they had the necessary expertise to manage and treat the complexities of Olivia's dual presentation of AOD addiction and mental health issues. Olivia's mother told us that '*[n]o one at [the provider] asked for [Olivia's] medical records, a letter from her treating psychiatrist or GP, or even to speak with her GP or treating psychiatrist*'.

As part of the investigation an independent expert opinion was sought. The independent expert found gaps in the preadmission process and questioned the appropriateness of the treatment provided to Olivia. The independent expert highlighted the importance of:

- quality frameworks that incorporate, among other factors, minimum qualifications in clinical staff in dual diagnosis
- addiction medicine or addiction psychiatrist input and support in treatment programs of complex clients, clear systems of clinical governance and access to on-call medical support
- evidence-based treatments such as opioid pharmacotherapies in cases such as Olivia's, despite the onerous nature of daily dispensing from community pharmacies.

Staff and treatment

Turning Point informed my office that staffing and treatment requirements will depend on the severity and acuity of the mental health issue, how well managed the condition is, and how long the condition has been stable. Many public AOD services have staff with the qualifications and training to treat clients with dual diagnosis such as counsellors who have received formal dual diagnosis training and registered psychiatric nurses and psychologists. A staff profile that includes clinicians from one of these groups would be expected in services that cater for low-severity mental health disorders such as those with stable depression or psychosis. However, where staff within a service do not have dual diagnosis capability, psychiatric or generalist medical support, consideration needs to be given instead to admitting the client to a dual diagnosis–capable facility.

If the provider decides not to treat dual diagnosis

According to Turning Point:

- Depending on the severity and assessed risk related to a client's psychiatric comorbidity, options such as crisis psychiatric services and telephone support lines may need to be considered.
- In the medium term, a provider should facilitate referral to an appropriate service.
- It is a reasonable expectation, as a duty of care, that a provider follows up the outcome of the referral/transfer to an appropriate service to ensure the client has been responded to.
- Clinical staff at the assessing service should liaise with the client's referrer and/or GP and communicate with the referrer on any plans that were implemented.

Supporting recommendation 12

It is recommended that all private AOD treatment providers that offer treatment to persons with 'dual diagnosis' (i.e. patients with one or more diagnosed mental health concerns occurring concurrently with AOD addiction) must either:

(a) have access to appropriately experienced, trained and competent staff or contractors to provide AOD treatments to such clients, or

(b) take reasonable steps to assist such clients (or potential clients) to find an alternate, suitable health service provider such as a recognised provider of mental health services.

Sexual misconduct

The nature of AOD addiction means that consumers seeking treatment are often physically and emotionally vulnerable. Some of the complaints and information we have received has raised concerns about the way in which relationships between clients and providers are managed including concerns about inappropriate behaviours that cross professional boundaries.

Sexual misconduct, in particular, is an abuse of the relationship of trust between a provider and client and can cause significant and lasting harm to clients. Code clause 13 aims to protect consumers from such harm.

Code clause 13: General health service providers not to engage in sexual misconduct

(1) A general health service provider must not engage in behaviour of a sexual or close personal nature with a client.
(2) A general health service provider must not engage in a sexual or other inappropriate close personal, physical or emotional relationship with a client.
(3) A general health service provider should ensure that a reasonable period of time has elapsed since the conclusion of the therapeutic relationship before engaging in a sexual relationship with a client.

The Medical Board of Australia's *Guidelines: sexual boundaries in the doctor–patient relationship* explains that breaching sexual boundaries is always unethical and usually harmful for the following reasons:[113]

- *Power imbalance:* The doctor–patient relationship is inherently unequal. The patient is often vulnerable and in some clinical situations may depend emotionally on the doctor. To receive health care, patients must reveal information that they would not reveal to anyone else and may need to allow a doctor to conduct a physical examination. A breach of sexual boundaries in the doctor–patient relationship exploits this power imbalance.
- *Trust:* Patients place trust in their doctor. They have a right to expect that examinations and treatment will only be undertaken in their best interests and never for an ulterior, sexual motive.
- *Safety:* Patients subjected to sexual behaviour from their doctor may suffer emotional and physical harm.
- *Quality:* A doctor who sexualises patients is likely to lose the independence and objectivity needed to provide good-quality health care.
- *Public confidence:* Members of the community should never be deterred from seeking medical care, permitting intimate examinations or sharing deeply personal information because they fear potential abuse.

Risk of sexual misconduct while receiving treatment

The potential for sexual misconduct towards a client by an AOD treatment provider is exacerbated by:

- the physical and psychological effects of AOD addiction on the client
- the proximity of clients to providers, especially in residential treatment settings.

[113] Medical Board of Australia 2018, *Guidelines: sexual boundaries in the doctor–patient relationship*, Medical Board of Australia.

Case study 16

Isla sought treatment for alcohol and methamphetamine addiction in a residential rehabilitation program run by a private AOD treatment provider.

Isla formed a sexual relationship with Henry, a staff member employed by the provider who lived in a cabin on the facility grounds. Henry was a former client.

Although Henry's role was to maintain the facility, clients would regularly be put in his care and he would attend therapeutic sessions. At some of these sessions Isla shared her childhood experiences of sexual abuse and family violence. Isla said Henry 'would always try to sleep with [her] when [she] just wanted someone to talk to'.

About a month into Isla's treatment she and Henry started a sexual relationship that lasted several weeks and Isla fell pregnant. She met with a manager and the director of the facility and told them about her relationship with Henry. They told Isla she should abort the pregnancy and to say that the sexual conduct had occurred during a weekend Isla was away from the facility. Five weeks into her pregnancy Isla miscarried and had to be referred to a hospital for treatment. The matter remains under investigation.

In our view, all AOD treatment providers should have policies in place to safeguard against inappropriate relationships with clients and clear processes to address events when they occur. For many clinicians in the AOD treatment space, unprofessional conduct such as inappropriate relationships will also attract regulatory oversight by a professional body (e.g. Ahpra).

Case study 17

Claire was being treated at a private AOD residential rehabilitation facility. The director of the facility made sexually inappropriate comments and gestures to her and about her to other clients. These included explicit sexual references, openly referring to fantasies about the client and touching the client's knee on several occasions. The matter remains under investigation.

Health service providers also need to have complaints mechanisms in place and an ability to impartially investigate complaints or incidents when they arise. In addition, in-house policies and complaints mechanisms and supervision/management protocols should be supplemented with training on minimum professional standards (similar to cultural sensitivity training) for all client-facing staff.

What constitutes a ‘reasonable period of time’

Clause 13 prohibits a general health service provider from engaging in a sexual relationship with a client unless a ‘reasonable period of time’ has passed since the conclusion of the therapeutic relationship.

Case study 18

The director of a private AOD treatment provider started a personal and sexual relationship with a client, Sofia. Sofia had a complex history of AOD addiction, mental health issues and sexual abuse and attempted suicide several times during her treatment. The director told staff to tell the residents Sofia was on suicide watch and had to sleep in the director’s room at the facility. The relationship started shortly after Sofia was admitted, even though the director had told staff that at least 12 months had to pass after treatment before a relationship could commence.

A ‘reasonable period of time’ is not defined in the Code or the Act. However, by way of guidance, we note that the Australian Psychological Society’s *Code of ethics* states that ‘psychologists [must] not exploit people with whom they have or had a professional relationship’ and if they ‘wish to engage in sexual activity with former clients [it must be] after a period of **two years** from the termination of the service’[114] [emphasis added].

The Australian Counselling Association’s *Code of ethics and practice* similarly prohibits counsellors from ‘sexual activity with all current and former clients for a minimum of **two years** from cessation of counselling’[115] [emphasis added].

Supporting recommendation 13

It is recommended that all private AOD treatment providers take all reasonable steps to ensure that their AOD Workers, staff, contractors or any other person engaged in the private AOD treatment facility does not, while the client is receiving AOD treatment within the facility and for a reasonable period of time after treatment has ceased, engage in any conduct that involves:
(a) behaviour of a sexual or close personal nature with a client; or
(b) a sexual or other inappropriate close personal, physical or emotional relationship with a client.

[114] Australian Psychological Society 2007, *Code of ethics*, APS, Melbourne.
[115] Australian Counselling Association 2019, *Code of Ethics and practice of the association for counsellors in Australia*, ACA, Grange, Queensland.

Adverse events

The Code also requires general health service providers to have a sound understanding of any possible adverse interactions between the therapies and treatments being provided and medications or treatments the client is taking and to advise the client accordingly (Code clause 1(2)(h)).

Code clause 5: General health service providers to take appropriate action in response to adverse events

(1) A general health service provider must take appropriate and timely measures to minimise harm to clients when an adverse event occurs in the course of providing treatment or care.

(2) Without limiting subclause (1), a general health service provider must:
- (a) ensure that appropriate first aid is available to deal with any adverse event; and
- (b) obtain appropriate emergency assistance in the event of any serious adverse event; and
- (c) promptly disclose the adverse event to the client and take appropriate remedial steps to reduce the risk of recurrence; and
- (d) report the adverse event to the relevant authority, where appropriate.

Some of the information we received included events that put clients at risk of harm, mainly due to a lack of oversight. Examples include suicide attempts and self-harm.

Case study 19

An AOD client told us:

'There were some girls that were cutting themselves in [the residential treatment facility] and we had to deal with them because there weren't any support staff around.

'One resident had to deal with two girls cutting themselves in one day, there was blood everywhere and she had to deal with it all on her own, she was really overwhelmed. The support workers were in the office, this girl saw it happening on the security footage and ran to help one of them. There was no ambulance called, it was just dealt with in house. One girl had used part of her ceiling fan and the other [girl used] a broken mirror to self-harm. The resident who found them had to take them to the office where the support workers were, they just dressed the wounds and that was it.'

Policies and procedures – limitations on access to high-risk medications and mitigating risk of suicide

We sought specific advice from Turning Point on this issue. In summary:

- Policies and procedures to ensure client safety should be apparent in all service settings and should meet current accreditation standards. Such processes should be supported by a

well-articulated system of governance, as well as safety, risk and compliance with relevant laws and regulations.

- The risk of inadvertent toxic overdose from high-risk medications (e.g. potent opioids and benzodiazepines) can be reduced by complying with the rules around prescribing these substances.
- Agencies should monitor (e.g. through audits) their practices involving high-risk drugs to ensure they comply with local policies and guidelines, that are in turn consistent with overarching jurisdictional and national regulations.
- Governance plays a key role in overseeing the prescribing conduct of individual practitioners. Governance structures intersect with risk management through informing evidence-based policy, supervision of individual practitioners and investigations of adverse events or incidents where there is, for example, aberrant prescribing.
- Self-harm from medication is a recognised risk in AOD treatment populations. However, other risk mitigation measures in community settings are also integral to quality systems including designs that eliminate ligature points.

Case study 20

Tim, an AOD client with an eight-year history of serious drug use, told my office:

'I was really depressed when I first went in because I had been using a lot of meth as well. I had asked for an extension cord for my electronic music sequencer on the second day I was there … On the third night there, I tried to hang myself with the extension cord on the bedroom door handle. I tried a couple of times that night and passed out a few times. The next night I tried to hang myself again and came relatively close.'

Tim told another resident about these events, who informed the facility management staff. Tim told my office that when the latter called him into their office:

'I said I was ok and they didn't really seem to care. They didn't ask me what I had used to try and hang myself. That was it, there was no more follow up about me feeling depressed or suicidal, no one ever came and took the extension cord off me. It was in my room for the rest of the time I was there.'

It is clear that practice guidelines and policies that inform clinician practices as part of a quality framework will improve client safety and that associated mechanisms to escalate monitoring of high-risk patients based on specific flags (e.g. policies on the frequency of nursing observations) will also mitigate the risk to clients from unintended or deliberate harm associated with community residential treatment, such as withdrawal management.

Case study 21

Adam was a client at an AOD residential treatment facility. A new client, Luke, arrived. Luke was on bail for a violent offence. Luke stated he was only at the facility to avoid prison and was very aggressive towards Adam. On one occasion Luke got into an argument with another client, went to the kitchen and returned with two knives. Luke's behaviour was reported to a support worker and he was subsequently removed from the facility.

In our view, to be effective an AOD provider's governance framework should be such that adverse events should prompt audit and review processes, including investigations of serious events to identify opportunities to correct gaps in the treatment structure that may expose clients to risk/adverse events. For smaller services, or those outside the public sector oversight framework, clients' risk exposure may be more pronounced unless robust and effective risk management processes are maintained.

Supporting recommendation 14

It is recommended that private AOD treatment providers must only be permitted to employ people who are appropriately trained to provide emergency assistance. At a minimum, suitably qualified staff must be available on-site during operational hours with the following qualifications and skills:

(a) Certificate IV in Alcohol and Other Drugs Work (part of this qualification involves a first aid component – first aid certificates must be kept up to date).
(b) training in 'Suicide and Self Harm Assessment and Response' and 'Managing Difficult or Aggressive Clients'.

Children in adult residential rehabilitation

One complaint we received about a private AOD rehabilitation service providing residential rehabilitation related to a 15-year-old who was placed in the same facility as adult clients. Although this was the only matter of this type raised with us, it enabled us to identify two important issues that arise when treating adolescents in adult residential rehabilitation facilities:

- the vulnerability of minors to the negative influence of adult residents
- that the treatment of minors with complex AOD addiction adds an additional level of complexity that private AOD treatment providers are unlikely to be well placed to manage.

It is not uncommon for adults in AOD rehabilitation facilities to have complex mental health issues. In some cases these factors are further complicated by criminal histories, active criminal proceedings against them or bail conditions. Where minors are placed in such environments, their youth and vulnerability means that their risk exposure is significantly amplified beyond the risk levels already present for adult clients – this includes the potential of being introduced to

criminal conduct that they would otherwise not be exposed to.
Treating AOD addiction in minors is already complex and requires specific training and support mechanisms. As one counsellor at a private AOD rehabilitation facility told us, youth programs need to be very different from adult residential programs. She was concerned the provider she worked for was not equipped to treat young people.

Code clause 1(2)(b): Safe and ethical treatment

A general health service provider must not provide a health service of a type that is outside the provider's experience or training, or provide services that the provider is not qualified to provide.

Case study 22

Martin, aged 15, was admitted for residential rehabilitation treatment. The program cost $32,700. There were no other children at the facility and Martin's counsellor at the facility told his parents the facility was 'the wrong place for [him] and that he would be exposed to adult prisoners and bikies on parole'. The counsellor also told the facility director it would be inappropriate to treat children because staff did not have WWCCs. She continued to work with Martin because she wanted to keep her job.

Martin left the facility twice with an adult client to search for magic mushrooms. Each time he was found he appeared drug-affected. The first time he was given a warning; the second time he was exited from the facility.

Child Protection then became involved with his care and he was placed on an interim accommodation order that required him to return to the provider to participate in a 10-day detoxification program. Martin was readmitted but was subsequently removed by Child Protection for self-harming and was placed in another private AOD treatment facility.

Children in the public system

Victoria's AOD program guidelines for public AOD facilities limits younger clients' eligibility to access adult services. These guidelines allow persons aged 16 years or older to access adult AOD rehabilitation services if 'developmentally appropriate'.[116] Odyssey House also recognises the difficulty in treating children in an adult environment and does not admit children to its adult residential facilities because they are more susceptible to isolation and the negative influence of older clients.

Working with Children Checks

On 3 April 2006, WWCCs were introduced to prevent those who pose a risk to the safety of children from engaging in work that involves children.[117] The *Working with Children Act 2005*

[116] DHHS 2018, *Alcohol and other drugs program guidelines Part 1: overview*, State Government of Victoria, Melbourne.
[117] Department of Justice and Community Safety 2019, State Government of Victoria, Melbourne, viewed 30

makes WWCCs mandatory for everyone in Victoria who undertakes child-related work, even on a volunteer basis.

We found that many private AOD treatment providers do not require staff to have WWCCs. Although generally these services are not providing health services to children, as **Case study 22** demonstrates, children may end up as clients if no other treatment options are available to them. Similarly, providers' clients may have children of their own or be visited by children, which again may place staff members in contact with minors.

In the public AOD treatment sector it is a requirement for staff to have a WWCC if they may come into contact with children. Further, some public organisations have a blanket policy that requires all staff and volunteers to have a valid WWCC, even if they are not working with children directly.

The policy on WWCCs in the private sector, on the other hand, lacks uniformity. While the larger providers generally require AOD workers to have a WWCC, the requirements for other staff seem to be less rigorous.

Supporting recommendation 15

It is recommended that all private AOD treatment providers that treat minors in residential facilities must ensure all minors are housed and treated separately from adult residents or treated in a youth-specific facility.

As part of the mandatory registration/licensing scheme all staff employed in residential facilities must have a valid Working with Children Check.

Supporting recommendation 16

It is recommended that all AOD workers involved in treating minors or employed by private AOD treatment providers that treat minors must:
(a) be appropriately skilled at treating the complexities of AOD addiction specific to minors
(b) have a valid Working with Children Check.

September 2019, <http://www.workingwithchildren.vic.gov.au/>.

Discharging clients

Some clients informed my office that they were discharged from treatment in circumstances that were unsafe and unethical.

Case study 23

Sarah was in a 30-day treatment program for ice addiction. She was asked to leave early and before she had detoxed. The provider took Sarah to a local train station and gave her $20 for her expenses to get home. Sarah's parents were only notified of her situation after she had been ordered from the facility and was on the train. Sarah's father believed the provider had acted negligently and had placed Sarah in a vulnerable and dangerous situation.

In what circumstances is it appropriate to discharge a client early?

Discharging a client early needs to be properly planned, taking into account the potential vulnerability of a client who is being discharged before their treatment is complete.

According to Turning Point, the consent process for residential AOD treatment should include a 'behavioural agreement' (sometimes also called a 'treatment contract' or a 'statement of client rights and responsibilities'). Under such an agreement, client responsibilities would include expectations by the treatment provider around client behaviour and the potential consequences of behaviours that interfere with the treatment or safety of the client, other clients, visitors or staff. Treatment agreements need to be as clear as possible, given that in some cases the consequence of inappropriate behaviour may include being exited early and losing some or all of any prepaid treatment fees.

Reasonable grounds for exiting a client early might include:

- where the client presents a risk or danger to other clients or staff (e.g. trafficking drugs in a residential unit)
- where a client's behaviour interferes with treatment, is violent, threatening or otherwise behaves outside acceptable guidelines for the service (e.g. sexually inappropriate actions, culturally insensitive language, refusal to take part in treatment activities).

Other reasons supporting an early discharge decision may relate to the capacity of the service provider to treat the client – for example, where the person's conditions or complications are such that the service cannot effectively manage them. In such cases it is important that the provider ensures the client is transferred to, or receives, appropriate care.

It seems clear therefore that an exit decision should only be made in the context of a provider's broader quality framework and duty-of-care obligations and should be a last resort rather than an 'easy option' to remove difficult/resource-intensive clients who exhibit behaviours that are consistent with the very challenge of battling AOD addiction.

Process for discharging a client

Given addiction is a chronic, relapsing and remitting condition, post-discharge planning should be an integral part of any treatment program.

Turning Point advised us on the proper procedure for discharging and exiting clients. A discharge summary should be provided to the client's referrer and/or GP. Discharge planning should include very clear steps to follow post-treatment and may involve organising a GP review, ongoing counselling or engagement in an aftercare program.

Discharge support also encompasses planning in the event of relapse, such as re-entry to the program, or review by other community-based services. Where available, clients leaving a service should be given phone numbers of support lines. In the case of previous engagement with 12-step programs, details of local meetings should be provided.

The process of exiting a client before completing the treatment program will depend on the grounds for discharge. In all cases a risk assessment should be undertaken, which may prompt the clinician(s) implementing the exit to organise an urgent or immediate response such as a police welfare check or psychiatric crisis team review. Lower intensity measures such as appointments with a GP or AOD counsellor may also be indicated based on the assessed risk level at discharge. Further, the reasons for discharge need to be communicated clearly and in a timely manner to the referrer and/or the client's GP.

Where discharge is due to clinical deterioration or where escalation of treatment is needed, Turning Point advised that providers have a duty of care to provide referral and facilitate transport to a setting with capacity to manage the client (e.g. organising an ambulance transfer to an emergency department).

Further, options for re-entry to treatment at the service should also be provided to clients unless the service is deemed a 'poor fit', in which case other suitable options should be provided.

Supporting recommendation 17

It is recommended that all private AOD treatment providers develop a discharge policy that requires them to only discharge clients in a safe and ethical manner. As a minimum, any such policy must include:

(a) clear steps for a client to follow after they are discharged such as GP review, ongoing counselling or engagement in an aftercare program
(b) discharge support that encompasses planning in the event of relapse, such as re-entry to the program, or review by other community services.

If a discharge relates to the capacity of an AOD treatment provider to effectively treat a client, the AOD treatment provider must exercise its duty of care to ensure the client is transferred to, or receives, appropriate care.

Health records

A common concern raised with my office is that private AOD treatment providers are not collecting enough health information before treatment begins.

In some cases the allegation is that AOD treatment was provided even though a full medical history was not taken by the AOD treatment provider or the medical practitioners employed by them. As a result, some clients have felt their treatment was not adequately tailored to their needs.

Code clause 15: General health service providers to keep appropriate records

(1) A general health service provider must maintain accurate, legible and up-to-date clinical records for each client consultation and ensure that these are held securely and not subject to unauthorised access.
(2) A general health service provider must take necessary steps to facilitate clients' access to information contained in their health records if requested.
(3) A general health service provider must facilitate the transfer of a client's health record in a timely manner when requested to do so by the client or the client's legal representative.

What matters should be specifically recorded for AOD treatment?

Treating addiction is similar to treating any other health condition and requires clearly documented assessments, treatment needs, a management plan and progress notes. Case notes should follow quality principles based on guidelines and local or organisational policies. Within detoxification settings, purpose-designed proformas should be used for record keeping and should include:

- severity of withdrawal (based on a validated scoring tool)
- doses of drugs prescribed and amounts of drugs prescribed
- assessment of risk, particularly risk of self-harm
- physical and mental state examination findings.

Collection and confidentiality of health information

The Health Records Act regulates the use and disclosure of health information in Victoria. Health information should be collected with a client's consent and used or disclosed for the primary purpose it was collected, or for a directly related and reasonable secondary purpose.

Health information can only be used or disclosed for a non-related purpose in some circumstances such as when there is a serious risk to someone or the information is needed to evaluate the service a client received.

Any service provider collecting health information must ensure the information is up to date and relevant to their work. They must also store, transfer and dispose of health information securely to protect client privacy.

Where a health service provider moves premises or closes down, they must post a public notice about what will happen with their records and how clients can access their health records.

These obligations are listed under the Health Privacy Principles in Schedule 1 of the Health Records Act :

- HPP 1 – Collection
- HPP 2 – Use and Disclosure of Health Information
- HPP 3 – Data Quality
- HPP 4 – Data Security and Data Retention
- HPP 5 – Openness
- HPP 6 – Access and Correction
- HPP 7 – Unique Identifiers
- HPP 8 – Anonymity
- HPP 9 – Transborder Data Flows
- HPP 10 – Transfer or Closure of the Practice of a Health Service Provider
- HPP 11 – Making Information Available to Another Health Service Provider.

They are further supported by the obligations in Code clause 14, which requires general health service providers to comply with relevant privacy laws including the Health Records Act, the *Privacy and Data Protection Act 2014* and the *Privacy Act 1988* (Cwlth).

Case study 24

A private AOD treatment provider ceased operating during our investigation. We asked the provider for health information in relation to a client. The office administrator told us that all the health records were in boxes and that she would be unable to process this request for one to two weeks because the business had closed. When asked what would happen to the records, the office administrator stated the boxes of records would be going with her.

The office administrator did not seem to understand the importance of ensuring that health records were securely stored and retained for seven years after the last date a health service was provided. We wrote to the provider to remind them of their obligations under the Health Records Act.

Supporting recommendation 18

It is recommended that all private AOD treatment providers introduce clear records management systems that document and include a client's assessment, treatment needs, management plan and progress to ensure compliance with the AOD treatment provider's legal obligations in relation to health information under the *Health Records Act 2001*.

Access to the Code

Code clause 17 requires general health service providers to make a copy of the Code and information about making a complaint to my office available to their clients or to bring these documents to their clients' attention.

Code clause 17: General health service providers to provide access to code of conduct and other information

(1) A general health service provider must bring each of the following documents to the attention of, or make available a copy of each of the following documents to, the clients of the general health service provider when providing or offering to provide a general health service:
  (a) a copy of this code of conduct;
  (b) a document that gives information about the way in which clients may make a complaint to the Commissioner.

(2) Copies of these documents must be made available in a manner that makes them easily accessible to clients.

Some providers make information about my office available on their websites, feedback forms or policy documents; however, this has generally not included a copy of the Code and overall my office observed varying compliance with Code clause 17. A lack of awareness and/or understanding of the Code and its obligations appears to be the predominant reason for this shortcoming.

On one of our site visits HCC staff noticed that the Code was made available to clients; however, it is hard to determine if this was for the benefit of our visit or if this information would be readily available to clients at other times.

Supporting recommendation 19

It is recommended that all private AOD treatment providers must comply with the 'General code of conduct in respect of general health services' as set out Schedule 2 of the *Health Complaints Act 2016.*

As part of the mandatory registration/licensing scheme, AOD treatment providers must be required to include an education program for staff on rights and obligations under the 'General code of conduct in respect of general health services'.

Complaints management

A key driver for complaints to my office about private AOD treatment providers seems to originate in poor complaint management by providers.

In some cases this may be because of a deliberate position taken by some providers on issues such as refunds or exiting clients. In other cases it seems that complaints are made to my office because the provider in question lacked an effective, internal complaint handling process.

By way of example, the private AOD treatment provider that was the subject of just over a third of the private AOD treatment-related complaints has consistently refused to offer refunds under any circumstances. For the reasons already outlined, that then gives rise to complaints to my office that focus mainly on refund requests.

Supporting recommendation 20

It is recommended that all private AOD treatment providers must develop a complaint handling policy which complies with the minimum requirements of the complaint handling standards as set out in the *Health Complaints Act 2016.*

- Information about complaint handling processes must be readily available to clients.
- Providers must inform clients that if they are not satisfied with the provider's response, the client may make a complaint to the Health Complaints Commissioner.

Policies and procedures

As part of our engagement with private AOD treatment providers, we routinely asked them to provide us with copies of their policies and procedures. The quality of these was highly varied and, notably, the providers that have since ceased operating were unable to produce any substantial policy or procedure documents.

There were often also gaps in the policy documents provided to my office by private AOD treatment providers. In some cases these documents did not cover all aspects of the provider's practice or were still being developed.

Two of the major providers informed my staff that they had developed in-depth policies and procedures following the commencement of the 2018 Regulations as part of their registration obligations. Another was in the process of developing further documents, which we have requested copies of to understand what they cover and how they will be implemented.

However, this same level of process improvement does not appear to have translated to smaller, private AOD treatment providers who have not sought registration under the 2018 Regulations – their policies and procedures often seem to only cover a part of the treatment services or adverse events.

Supporting recommendation 21

It is recommended that all private AOD treatment providers must have comprehensive, written policies and procedures that provide a minimum set of standards of service relevant to the type of AOD treatment being provided that are regularly reviewed and updated. Copies must be easily accessible to clients and potential clients.

- Applicable policies will form part of the mandatory registration/licensing scheme.

Conclusion

Many of the issues identified in the private AOD treatment sector would be mitigated by regulating private providers in a similar method to those that receive public funding.

Clients and their families are in a vulnerable position, either dealing with AOD addiction themselves or the addiction of a family member. Long wait times to access services in the public system have facilitated the expansion of the private sector and clients are engaging with these services because they are unable to access other forms of treatment.

Some private AOD treatment providers are taking advantage of this vulnerability by charging high fees for treatment, requiring payment upfront and not appropriately explaining or misrepresenting what treatment involves.

The intersection between undersupply, the vulnerability of clients and the for-profit model of treatment is the space where poor consumer outcomes occur and that, by and large, generates the most complaints to my office. Unfortunately, the high cost of treatment does not necessarily correspond to better outcomes.

The unregulated nature of the private sector has allowed numerous operators to open AOD treatment services without the necessary competence, skills or experience to meet client needs or expectations and exacerbates many of the issues in the private sector.

Private providers are frequently not informing clients that they are entitled to make a complaint to my office. As such we are unable to gauge the breadth of the issues that face the private AOD treatment sector.

The amendments made by the 2018 Regulations to the Health Services (Health Service Establishments) Regulations 2013 that require all private operators offering AOD withdrawal/detoxification services to be registered as a private hospital has had a positive impact. The changes have forced operators who want to provide detoxification services to improve to meet the strict requirements of registering as a private hospital or cease offering those services. When the 2018 Regulations commenced, we saw a drop in complaints; however, these requirements are only applicable to the detoxification phase of treatment and do not expressly cover other treatment programs offered by AOD treatment providers. To make significant improvements to the sector, regulation needs to be expanded to include all phases of AOD treatment.

My office will continue to monitor the complaints it receives, undertake investigations when necessary and work with complainants and private AOD providers on a case-by-case basis. However, a framework that implements a mandatory registration/licensing scheme is imperative to set a standard the Victorian public can and should expect from private AOD services. At minimum that standard should align with the quality of publicly funded AOD services.

Definitions, abbreviations and legislation

Definitions

2018 Regulations	The Health Services (Private Hospitals and Day Procedure Centres) Amendment Regulations 2018 made amendments to the Health Services (Health Service Establishments) Regulations 2013 to require all private residential acute withdrawal (detoxification) services to be operated in a registered private hospital.
Act	*Health Complaints Act 2016*
Acute detoxification	The treatment and care of patients undergoing the acute phase of withdrawal from alcohol and/or other drugs on which they are physically dependent, involving medical supervision where the patient is admitted overnight (Health Services (Health Service Establishments) Regulations 2013).
AOD treatment	Health services that assist people to overcome addiction to alcohol and other drugs, including detoxification, rehabilitation and counselling services.
Code	The code of conduct for general health service providers set out in Schedule 2 of the Health Complaints Act.
Health service	An activity that meets the definition in s.3 of the Health Complaints Act.
Private AOD treatment providers	Privately funded health service providers that offer alcohol and other drug rehabilitation and counselling services in Victoria. These services do not receive public funding.

Abbreviations

AA	Alcoholics Anonymous
ACCC	Australian Competition and Consumer Commission
ACL	Australian Consumer Law
Ahpra	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
AOD	alcohol and other drugs
ATCA	Australasian Therapeutic Communities Association
CBT	cognitive behaviour therapy

DHHS	Department of Health and Human Services (Victoria)
GP	general practitioner
HCC	Health Complaints Commissioner
IPO	interim prohibition order
NA	Narcotics Anonymous
National Law	Health Practitioner Regulation National Law
PO	prohibition order
WWCC	Working with Children Check

Legislation

Drugs, Poisons and Controlled Substances Act 1981

Drugs, Poisons and Controlled Substances Regulations 2017

Health Complaints Act 2016

Health Records Act 2001

Health Practitioner Regulation National Law

Health Services Act 1988

Health Services (Health Service Establishments) Regulations 2013

Health Services (Private Hospitals and Day Procedure Centres) Amendment Regulations 2018

Privacy and Data Protection Act 2014

Public Health and Wellbeing Act 2008

Working with Children Act 2005

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Level 26, 570 Bourke Street
Melbourne Victoria 3000

Complaints line: 1300 582 113
DX: 210182

hcc@hcc.vic.gov.au
hcc.vic.gov.au