Submission to:

The Youth Treatment Orders Model of Care Public Consultation

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SANDAS is the Peak Body supporting NGOs delivering services in the Alcohol and other Drugs field in South Australia.

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INTRODUCTION

SANDAS is the peak organisation for the non-government alcohol and other drugs sector in South Australia.

SANDAS represents over 35 organisational members that provide a broad range of services including drug and alcohol health promotion, early intervention, treatment, and after-care programs. These community-based organisations operate throughout South Australia. They comprise both large and small services that are diverse in their structure, philosophy and approach to drug and alcohol service delivery.

SANDAS's vision is to lead and strengthen community responses to the harms caused by alcohol and other drugs.

SANDAS facilitates networking, collaboration, research, information sharing, advocacy, training and policy reviews to reduce the harmful impacts of alcohol and other drugs. We are the voice of our members at national and state levels.

SANDAS is governed by a Board of Directors primarily elected from the SANDAS membership

Further information about SANDAS, its programs and services is available on the SANDAS website at www.sandas.org.au.

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Introduction

SANDAS provides the following feedback on the Youth Treatment Orders Model of Care released for consultation on the 10th of November 2020.

SANDAS maintains its position that a Youth Treatment Order system is not an appropriate approach for dealing with young people who are drug dependent. Rather the State should invest the resources identified for this project, with other resources to establish a comprehensive youth treatment system that meets the needs of all South Australian young people who require support and treatment in relation to alcohol and other drug use.

Section 1 and general overview

> *"The Youth Treatment Orders program provides the option of mandatory treatment for children experiencing drug dependency. The Youth Treatment Orders program is a measure of last resort, where all other appropriate and less restrictive means of drug assessment and treatment have been exhausted."*

There is currently an underinvestment in AOD, especially in the youth sector and more particularly in the rural and regional youth space. The Youth Treatment Order system is identified as an intervention of last resort. However, as there is not a systemic approach to youth prevention, early intervention, and acute treatment that meets the needs of all young people affected by AOD, for young people a Youth Treatment Order may be the only intervention they will receive. This does not constitute an intervention of last resort.

Further, the positioning of mandatory treatment in the youth justice system correlates it with criminal activity and identifies the treatment as a criminogenic response. This stigmatises young substances users. There is also a concern that young people in detention are not provided with less restrictive means of accessing treatment. It is unclear from the paper whether a young person in detention could voluntarily opt for treatment and if so, what would that look like. Under the UN Convention on the Rights of The Child a young person should have access to adequate health treatment both in the community and in detention.

> "*Assessment and treatment processes have been informed by the best available evidence for the treatment of children. Special consideration has been given to the provision of trauma informed care and the specific and complex needs of at risk and marginalised groups of children."*

As highlighted in the 50 or so submissions provided to the government by health, legal, human rights and treatment providers, there is limited evidence that mandatory treatment meets the best available evidence-based treatment for young people. In fact, mandatory treatment is, according to the evidence, expensive, stigmatising and often counterproductive.

The Model of Care acknowledges that there is little evidence that mandatory treatment is effective. And whilst an evaluation of the program could contribute to the evidence base either for or against Mandatory Youth Treatment, given the small number of clients likely to be treated under a Youth Treatment Order, there is a likelihood that any evaluation will lack a sufficient power to do so. This is especially true if there is not a control cohort against which to test the outcomes for those under a

Treatment Order. However, that an evaluation is being undertaken before proceeding to Phase 2, young people not in detention is welcomed.

The consultation document is unclear as to the evidence base that the Model is derived from. At one point it says,

> "*Research into the outcomes of substance use treatment in adolescents generally shows small to moderate effects in reducing substance use, with no specific type of treatment emerging as clearly superior to any other, and treatment gains that fade over time"*

At another point the paper cites evidence that family-based therapy is very clearly the most effective form of treatment. However, the Model of Care is not explicit that family therapy will be a significant part of the treatment intervention. Further, the Model also mentions assertive approaches to be effective. Could not these approaches be implemented in the first instance, particularly for young people in detention where there is scope to address family systems issues and provide assertive support without the need for mandating such treatment. There is good evidence that engaging clients in treatment through reward-based reinforcement has good outcomes. Young people could be rewarded with extra privileges for engaging with family therapy or other treatment modalities as opposed to being coerced by law.

> *"The Youth Treatment Orders program does not replace the voluntary drug assessment and treatment services. The program is not a punishment and balances the need to respect the rights and autonomy of children and the special obligation of the community to care for and protect children."*

The paper fails to describe any voluntary treatment available to young people in detention. It cites an intention to compare voluntary and non-voluntary treatment outcomes but does not establish a voluntary model in the detention centre. Without voluntary treatment to compare with, the efficacy of the model cannot be tested. Comparing the mandatory treatment in detention to treatment prior or post detention would not be valid as there are too many confounding influences on retention in treatment in the community versus retention in the program. The implementation of a rewards based incentivisation program would provide a comparative model. Then only young people who had failed to engage would become mandatory clients. The imposition of a mandate would then qualify as a 'last resort' and the outcomes could be tested against the voluntary engagement cohort.

Inherent throughout the paper is an implicit assumption that young people will transition to community-based services on release. How will young people living in the community access youth specific treatment services when there is a dearth of such services across the state, especially in rural and remote areas. In many locations the only option would be to engage with mental health services that do not specialise in AOD nor AOD youth treatment.

Whilst the Model of Care cites the ICD-10 diagnostic criteria it at no point describes them in full, this requires a person commenting on this Model to either know or find this information themselves. The ICD 10 requires explanation and contextualisation for the reader if it is the basis of a treatment order.

Whilst It does not appear to be the sole basis of the treatment order, we would suggest a link to a resource is included in the final version of the Model of Care. It will be important for anyone seeking to refer a young person to understand the requirements. The alternative may be to include it as an appendix with a plain English interpretation.

Section 1.4 of the document identifies co-occurring issues that are related to substance misuse. However, the treatment model that will be introduced into the detention centre, whilst trauma informed, does not appear to address co/multiple morbidities. How will mental health, educational, disability (e.g., issues such as ADHD, ASD, educational disengagement, family violence, sexual assault, childhood neglect, FASD etc) be addressed? Will it be in the drug treatment setting or are there parallel programs on offer? The paper does not describe existing therapeutic interventions for these other issues or how these different programs may intersect. An indication of the primacy of treatment interventions may be of value in clarifying the relationships (is trauma, neglect, mental health or AOD treated first?).

The paper states:

> *'Assessments should be developmentally and culturally appropriate and occur in a culturally safe setting.* [3]*'*

but does not indicate how this will be done. Nor how assessment of culturally safety may be effected or measured other than by employing Aboriginal and CALD staff. Will there be Aboriginal and CALD professionals (addiction medicine, psychiatric, psychological, paediatric, counselling, etc) involved in the assessment and treatment processes? Will the Aboriginal and CALD staff be justice workers or independent practitioners coming in from outside. Existing workers taking on such roles often have a conflict of interest.

The document uses many terms which have multiple meanings. The Model of Care would benefit from a comprehensive glossary/list of definitions as many of the terms have specific meaning in the context of the Model or are not terms in common usage. It may also be of value to the lay reader to have a flow chart of the key processes/steps involved in the application for and implementation of an order.

Section 2 Governance

Section 2.1 describes the key agencies facilitating the Youth Treatment Orders Program. This section does not cite the non-government treatment sector as key agents. However, later on there is an indication that the program may be delivered in conjunction with non-government specialist alcohol and drug treatment organisations.

Section 2.4 How does a service seek accreditation to work with young people in this system? It is unclear if services would be deemed accredited if funded by the state or federal government to deliver drug and alcohol services. Will a service have to undergo a Youth Treatment Orders service providers audit? Currently organisations need to meet criteria in relation to receiving funding but there is no specific accreditation system for alcohol and other drug services. The paper does mention compliance with the National Quality Framework, if a service meets these requirements is this sufficient. Whilst this may be clarified in any procurement process undertaken as part of the implementation it would be helpful to include a brief clarification. The paper does outline requirements for staff qualifications for those delivering services which is appropriate and helpful.

Whilst Section 2.5.5 establishes the evaluation process it does not adequately describe it. Will the evaluator be engaged early enough to be able to establish base line data such as:

- how many young people would meet the definition of dependence on entering the facility?
- had they previously attempted to and failed to access treatment, accessed treatment but withdrew, not had access to treatment and if so, why not?
- given that most young people who are detained for a period would not have access to drugs whilst in detention and therefore may not meet the criteria for dependence, will this only apply to newly detained young people?
- will young people have access to voluntary treatment if it is thought they would benefit, without meeting the criteria for dependence?
- will there be a control group established (that is young people who voluntarily engage in treatment) or will data on previous residents be used to build a picture of the pre/no treatment intervention?
- what are the ethical considerations of the evaluation and where appropriate how will ethics clearance be achieved? Given the small number of young people likely to be engaged in the programme the issue of privacy and identification becomes significant considering the requirement for public reporting on the scheme. Mentioned in S8 but not fully addressed.

Whilst these concerns may be more relevant to the evaluation model it may be helpful if they were touched on in the Model of Care.

Section 3 Overview

The Model does not indicate, other than through appeal, what the consequences for non-compliance might be. How will the program manage a young person who has appealed against an order, failed in that appeal and still refuses to engage?

Section 4 Principles

The Principles set out in Section 4. are comprehensive and consistent with other such principles. However, there are some concerns:

- these principles should apply to all children in detention
- what is the ordinary length of a detention order for a young person? Will a treatment system be able to implement mandatory treatment services in a timely way?
- given the range of ages of young people (10-17) who may be in detention at any one time and there are likely to only be a few in Youth Treatment Order treatment, how will their different needs be addressed? The same concerns exist in relation to cultural safety.
- Whilst consumer (presumably the young person) and family engagement is incorporated in the principles it is not defined here or elsewhere in the Model.

Section 5 Case Coordination

Section 5 indicates that a comprehensive case management system will be incorporated in the Model of Care. The development of a comprehensive post incarceration case coordination system is welcome. However, it is hard to understand why such services are not available to the general detention centre population, many of whom have complex social and emotional issues. It is

important to note that the delivery of drug and alcohol treatment interventions should be undertaken by non-centre staff as there are significant conflicts when custodial staff are also providing counselling. Given the over-representation of Aboriginal children in the system, the Model of Care should be fully consulted on with therelevant Aboriginal community controlled organisations.

Section 6 Assessment Orders

Section 6.1 cites the enabling legislation requirements around costs in relation to an appeal against a Mandatory Treatment Order:

"…. Such a costs order cannot require Crown or the child subject of the Application to pay."

However, the document does not clarify who should pay. Given that appeals could require significant funding if they are to higher courts, how will they be funded and resourced.

Section 6.3 describes the process for developing a report on the outcomes of the treatment. However, despite the principles citing consumer and family engagement the model does not appear to include scope for the child or their family to contribute to the report. Whilst the principles reflect the best interests and child centred practice, the assessment procedure lacks a sufficient engagement with the young people and their family. In the case of Aboriginal and Torres Strait Islander and culturally and linguistically diverse young people the definition of 'family' should be extended to include key community members where appropriate.

Section 7 Treatment Order

Section 7.8 is not clear if an application by child or parent to revoke a mandatory treatment order will be supported with funding for legal representation up to and including a Supreme Court challenge.

7.7 deals with relapse and aftercare and the sector welcomes a commitment to supporting young people post treatment. Due consideration will need to be given to how such young people may be prioritised in an already challenged system.

Section 8 Monitoring and Reporting

Section 8 presumes that the system will be continued beyond its trial as there is no requirement to detail failings of the model. The requirement is described as 'identifying areas of high performance and areas for improvement'. Consideration should be given, based on the evidence for mandatory treatment as to possible systems failures, including causes, impacts and any possible remediations. A report should include "recommendations on the performance and continuation or cessation of the Youth Treatment Orders program in South Australia".

In describing the evaluation report for the program, it is unclear as to whether the independent evaluation report will be presented in full (with any potentially identifying content redacted). Given the complexities and challenges of implementing the Model of Care, the evaluation should be fully independent, and the final evaluation report presented as a public document, whilst ensuring that the identity of program participants is protected.

Section 9 Statement of Rights

Section 9.1 document the Statement of Rights for a young person. It describes the process and implementation of a Treatment Order. However, it does not document what happens if a young person refuses to engage with treatment nor is it explicit as to whether a person has the right to refuse and what are the consequences of refusal.

Conclusion

SANDAS welcomes the opportunity to provide feedback on the Youth Treatment Orders Model of Care. Whilst much work has been undertaken to develop the Model and it has seen improvements from its original conception, there are still concerns as indicated above.

To address these concerns SANDAS would like to see significantly more consultation with the alcohol and other drug treatment sector on how the model will be implemented. This is particularly important in relation to the engagement of NGO AOD services both in the Training Centre and after a young person's release. The consideration of budget implications for delivering the Model is still unclear. If delivery is to go ahead there needs to be a clear commitment to expanding the funding for treatment services to ensure access to voluntary treatment commensurate with need. We remain committed to the principle that if implemented this intervention should be a last resort. We maintain the position that the most effective response to drug and alcohol issues in young people is a considerable investment in the development of a comprehensive state-wide treatment model for young people and further investment in prevention and early intervention. It is important that any such invest,ment target those most at risk of being engaged by the system including Aboriginal children, families and communities, young eople in the out of home care system, and those disengaged from education and employment.