REGULATION: THE PANACEA FOR PRIVATE REHABILITATION CENTRES

SIMONE HENRIKSEN AND DOMINIQUE MORITZ[†]

Private treatment for substance-related disorders is a critical health and social response to substance misuse in the community. Alcohol and Other Drug (AOD) rehabilitation centres provide a method for treating dependency on licit drugs and illicit drugs. Publicly funded rehabilitation centres cannot always meet the demand for AOD services. Diversity for patients is needed in the sector which is why privately funded rehabilitation centres provide such a vital service to the community.

Private AOD rehabilitation centres are primarily self-regulated in Australia. Use of anecdotal evidence and dishonest attribution of success rates are among the concerns with private rehabilitation centres which current regulation is failing to address. Without national standards governing rehabilitation services, patients may receive inadequate treatment which may adversely affect their recovery. This paper considers how self-regulation of the private industry is failing to facilitate patient protection and maximise health outcomes. Instead, licensing, with national standards, should be imposed on private rehabilitation service providers to address challenges within the Australian rehabilitation industry.

I INTRODUCTION

AOD rehabilitation centres are crucial to support people with substance-related disorders in the community. AOD rehabilitation centres rehabilitate patients with substance-related disorders. Rehabilitation is an intervention strategy designed to optimise functioning and reduce disability in individuals who suffer AOD

[†] Simone Henriksen, PhD Candidate, University of the Sunshine Coast; Dr Dominique Moritz, Lecturer in Law, University of the Sunshine Coast.

dependencies.[1] People who experience AOD dependencies have complex needs which require specialist care.[2] Patients need diversity to access rehabilitation which supports their individual health needs.[3]

AOD rehabilitation centres provide a method for treating dependency on licit and/or illicit substances. Rehabilitation services are available at government funded facilities; patients can pay to use services at private clinics; or they can access non-government organisations for support with substance-related dependencies. The individual rehabilitation centre determines the scope of treatment options for patients. Patients might access inpatient and outpatient services at their facility depending on the centre. All reference to 'rehabilitation centres' or 'rehabilitation services' for the remainder of this article refer to AOD rehabilitation treatment centres.

A variety of AOD services are available to patients seeking treatment for substance-related disorders in Australia. Rehabilitation services for substance-related disorders include a range of health and social services such as counselling, withdrawal management, pharmacotherapy, support and case management, information provision and education.[4] AOD treatment is not restricted to 'traditional' inpatient treatment options, like withdrawal management, and patients can access rehabilitation treatments

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1 World Health Organisation, *Rehabilitation in Health Systems* (2017), 1 <http://apps.who.int/iris/bitstream/handle/10665/254506/9789241549974-eng.pdf;jsessionid=319FBCD7E37F351E24F794CB51841C5F?sequence=1>.

2 David W Best and Dan I Lubman, 'The Recovery Paradigm: A Model of Hope and Change for Alcohol and Drug Addiction' (2012) 41(8) *Australian Family Physician* 593, 595.

3 Antoine Bechara, 'Decision Making, Impulse Control and Loss of Power to Resist Drugs: A Neurocognitive Perspective' (2005) 8(11) *Nature Neuroscience* 1458, 1459; Terry Carney et al, 'Health Complaints and Regulatory Reform: Implications for Vulnerable Populations' (2016) 23 *Journal of Law and Medicine* 650, 651.

4 John Strang et al, 'Drug Policy and the Public Good: Evidence for Effective Interventions' (2012) 379 *The Lancet* 71, 77; Australian Institute of Health and Welfare, *Alcohol and Other Drug Treatment Services in Australia 2014–15 Drug Treatment Series No. 27* (2016), 48 <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129555353>.

without needing to be a live-in patient. People seeking treatment for substance-related disorders can attend AOD rehabilitation centres for treatment.

Public rehabilitation clinics, those which are government funded, are not appropriately resourced to manage the need for AOD dependencies in the community.[5] Private rehabilitation clinics fill an important gap in the market to provide essential services to people with substance-related disorders.

While public rehabilitation centres have governmental regulatory oversight, private centres operate under a self-regulatory model. This paper argues that better regulation of private rehabilitation facilities for the treatment of substance-related disorders in Australia is needed. More specifically, Australia's current arrangement of industry self-regulation of private rehabilitation centres is inadequate to protect the public interest. Private centres each develop their own internal codes of conduct to regulate and enforce behaviour of staff and patients. The power to 'develop, apply and enforce the code of conduct' arises through a contractual arrangement between a clinic and the client when the treatment program commences.[6] One of the challenges, however, is that current self-regulation of the private rehabilitation industry fails to adequately protect consumers and maximise health outcomes. This paper will highlight the shortcomings of the self-regulatory model.

In order to address the challenges of self-regulation of the industry and propose an alternative regulatory model, the paper has four parts. Part II of the paper provides the context of AOD rehabilitation services in Australia by distinguishing between private and public services. Part III considers the current regulatory controls utilised

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5 Alison Ritter et al, 'New Horizons: The Review of Alcohol and Other Drug Treatment Services in Australia' (Final Report, Drug Policy Modelling Program National Drug and Alcohol Research Centre, University of New South Wales, July 2014) 183.

6 Bronwen Morgan and Karen Yeung, *An Introduction to Law and Regulation* (Cambridge University Press 2007) 95.

within the industry, such as self-imposed standards for members of the Australasian Therapeutic Communities Association (ATCA) and the Network of Alcohol and Other Drugs Agencies (NADA), and their application to private rehabilitation clinics.[7] The shortcomings of the current self-regulatory approach will be discussed to highlight the need for greater oversight and governance to protect patients and improve the social and economic burden to Australian communities. Finally, part IV of the paper discusses how the main shortcomings of the current regulation of private rehabilitation centres may be addressed by implementing a licensing regime for entry into the market and uniform national standards for delivery of services supported by enforcement strategies. This alternative model of direct regulation is closely modelled on the system established under the *Health Practitioner Regulation National Law Act 2009* and will be discussed to explain how this will better serve the public. The paper will draw upon regulatory theory to explain why self-regulation of private rehabilitation clinics is not in the community interest.

II ALCOHOL AND OTHER DRUG REHABILITATION IN AUSTRALIA

Substance-related disorders, considered to be substance abuse, refers to harmful or hazardous use of licit and illicit substances.[8] Licit substances include alcohol, tobacco and prescription medication while illicit substances commonly include cannabis, cocaine, amphetamines, heroin and ecstasy. Substance-related disorders[9] are

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[7] Terry Hutchinson and Nigel Duncan, 'Defining and Describing What We Do: Doctrinal Legal Research" (2012) 17(1) *Deakin Law Review* 83, 101; Australasian Therapeutic Communities Association, *Australasian Therapeutic Communities Association Standard For Therapeutic Communities and Residential Rehabilitation Services* (July 2013) <http://www.atca.com.au/wp-content/uploads/2014/09/ATCA-Standard-.pdf>; Network of Alcohol and Other Drug Agencies, *Resources* (2017) <http://www.nada.org.au/media/85569/resources-flyer-2016b-interactive.pdf>.

[8] World Health Organisation, *Substance Abuse* (2017) <http://www.who.int/topics/substance_abuse/en/>.

[9] Substance-related disorders exhibit impaired control, social impairment, risky use and tolerance or withdrawal. They encompass alcohol, caffeine, cannabis,

prevalent in Australia with one in 200 Australians receiving treatment during the 2014-15 period.[10] Polydrug use is prevalent amongst patients who present for treatment for a substance-related disorder with alcohol, cannabis and methamphetamine being the most prevalent.[11]

Substance-related disorders pose a significant social and economic burden upon Australian communities.[12] Mental illness is highly prevalent amongst those who suffer from substance-related disorders.[13] Other adverse health effects include Hepatitis C and HIV.[14] Decision-making of individuals with substance-related disorders is often impaired and impulsive, resulting in this group forming a vulnerable sector in the community.[15] As a result of the

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hallucinogens, inhalants, opioids, sedatives, hypnotics, anxiolytics, stimulants, tobacco and other related substances: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (2013) Psychiatry Online <https://dsm-psychiatryonline-org.ezproxy.usc.edu.au/doi/full/10.1176/appi.books.9780890425596.dsm16>.

10 Australian Institute of Health and Welfare, *Alcohol and Other Drug Treatment Services in Australia 2014–15 Drug Treatment Series No. 27* (2016), vii. <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129555353>;

11 Poly drug use is the combination of different drugs, or taking one drug while under the influence of another drug: Australian Government Department of Health, *Poly Drug Use What You Need to Know About Mixing Drugs* (2014) <https://comorbidity.edu.au/sites/default/files/Polydrug%20Use.pdf>; Pauline Kenny et al, 'Treatment Utilisation and Barriers to Treatment: Results of a Survey Dependent Methamphetamine Users' (2011) 6(3) *Substance Abuse Treatment, Prevention and Policy* 1, 2.

12 Intergovernmental Committee on Drugs, *National Alcohol and Other Drug Workforce Development Strategy* (2015-2018) 1.

13 Debra Rickwood et al, 'A Position Statement Prepared for the Australian Psychology Society' (Position Paper, The Australian Psychological Society Ltd, March 2003) 1, 3; Peter J Kelly et al, 'Study Protocol: A Randomised Controlled Trial of a Computer–based Depression and Substance Abuse Intervention for People Attending Residential Substance Abuse Treatment' (2012) 12(113) *BMC Public Health* 1, 7.

14 Stephen Mugford, 'Licit and Illicit Drug Use, Health Costs and Crime Connection in Australia: Public Views and Policy Implications' (1992) *Contemporary Drug Problems* 351, 353; Nora D Volkow and Julio Montaner, 'The Urgency of Providing Comprehensive and Integrated Treatment for Substance Abusers with HIV' (2011) 30(8) *Health Affairs* 1411, 1412; Rickwood et al, above n 13.

15 Bechara, above n 3.

decision-making, criminal behaviour can also occur. Poverty and social inequality can result from ongoing substance use and can impact the family unit as a result of violence, neglect and contact with the criminal justice system.[16]

Substance-related disorders can be treated at AOD rehabilitation centres in Australia. Australian rehabilitation centres fall within the public, private, or not-for-profit system. Public rehabilitation centres are government-funded facilities and financed primarily from taxation.[17] Counselling, withdrawal management and client assessment are the most common treatments provided to patients in public AOD rehabilitation centres to address substance-related disorders.[18] However, the public system also provides inpatient treatment services which offer withdrawal management and detoxification, treatment communities and residential rehabilitation services.[19] Public rehabilitation centres provide government-funded, substance-related rehabilitation services for patients including those who cannot afford to pay for treatment themselves.

Private rehabilitation centres also treat AOD users. Patients pay to use the facilities and services for the private rehabilitation clinics, although some funds are also raised through charitable activities. Not-for-profit organisations delivering AOD rehabilitation services receive government funding indirectly through tax concessions and

[16] Rickwood et al, above n 13; Mugford, above n 14, 381.

[17] Australian Institute of Health and Welfare, *Alcohol and Other Drug Treatment Services in Australia 2014–15*, above n 4, 87.

[18] Australian Institute of Health and Welfare, *Alcohol and Other Drug Treatment Services in Australia 2015-16 Drug Treatment Series No. 29* (2017), vii, 43 <https://www.aihw.gov.au/getmedia/bf851ed5-673c-4f5a-8ff6-49f3a85bd95a/20799.pdf.aspx?inline=true>.

[19] Queensland Health, *Alcohol and Other Drug Services in Queensland* (2018) <https://www.health.qld.gov.au/public-health/topics/atod/services>; New South Wales Government Health, *Drug and Alcohol Treatment* (12 September 2017) <http://www.health.nsw.gov.au/aod/programs/Pages/treatment.aspx>; Victorian State Government, *Alcohol and Other Drug Treatment Services* (2018) <https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services>.

benefits.[20] Not-for-profit organisations will be considered private rehabilitation centres, for the purposes of this paper, as they require patient contribution for treatment services and are self-regulated.

Substance-related disorders are complex and may require treatment by a multidisciplinary team. AOD rehabilitation requires a holistic approach to patient treatment.[21] In order to recover from substance-related disorders, patients need more than just treatment for physical health issues.[22] Treatment may require the engagement of a number of registered and unregistered health professionals. A holistic approach to AOD rehabilitation promotes wellbeing and social functioning by addressing a range of issues which contribute to substance-related disorders such as financial hardship, homelessness and daily tasks.[23] Rehabilitation centres often assist patients to re-integrate into the community by facilitating employment opportunities and encouraging patients to re-establish family and social networks.[24] Treatment programs are especially successful when mental health services are specifically integrated.[25]

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[20] Australian Charities and Not-for-profit Commission, *Factsheet: Charity Tax Concessions Available* (2017) Australian Government <http://www.acnc.gov.au/ACNC/FTS/Fact_ConcAvail.aspx>.

[21] Bridget Roberts and Rebecca Jones, 'Dual Diagnosis Narratives and their Implications for the Alcohol and Other Drug Sector in Australia' (2012) 39 *Contemporary Drug Problems,* 663, 667.

[22] Ibid.

[23] Lara Jackson et al, 'Towards Holistic Dual Diagnosis Care: Physical Health Screening in a Victorian Community-based Alcohol and Drug Treatment Service' (2016) 22 *Australian Journal of Primary Health* 81, 84.

[24] Cori Kautz Sheedy and Melanie Whitter, 'Guiding Principles and Elements of Recovery-oriented Systems of Care: What Do We Know from the Research?' (2009) 9(4) *Journal of Drug Addiction, Education and Eradication* 225, 242.

[25] Effectiveness of treatment is difficult to quantify as substance abuse is characterised as a chronic relapsing condition: Best and Lubman, above n 2, 593; The most studied intervention for substance abuse is opiate substitution treatment (OST): Strang et al, above n 4. A series of Cochrane reviews have shown OST to be most effective in retaining people in treatment but is 'limited in reducing mortality, criminal activity and improving quality of life': Smith LA, Gates S and Foxcroft D, 'Therapeutic Communities for Substance Related Disorder (Review)' (Cochrane Database of Systemic Reviews, Issue 1, Cochrane Library, 2006), 2; Mary F Brunnette et al, 'A Review of Research on Residential Programs for People with Severe Mental Illness and Co-occurring Substance Use Disorders' (2004) 23 *Drug and Alcohol Review* 471, 472.

A *Public AOD Rehabilitation Services*

Public rehabilitation centres have a number of shortcomings with regard to providing AOD rehabilitation services to the community. They are often unable to address the comprehensive needs of patients seeking treatment for substance-related disorders; they may be unable to treat the mental health issues that can co-exist with a substance-related disorder; and funding and resources issues create accessibility barriers for patients needing rehabilitation services. Each of these will be discussed below.

Treatment programs available in the public rehabilitation system are often unable to address the comprehensive needs of those seeking AOD rehabilitation treatment.[26] The chronic nature of substance-related disorders cannot be addressed from short term treatment options and require gradual support through long-term recovery.[27] While some public rehabilitation centres do support long-term recovery, other centres are under-resourced and can only offer short term treatment options that may not adequately support a patient seeking treatment for a substance-related disorder.[28]

AOD rehabilitation often requires a broader strategy than solely treating the patient's substance-related disorder. Up to 90 per cent of patients with a substance-related disorder have other health related concerns such as mental health issues.[29] In Australia, publicly funded AOD services and mental health services are generally 'funded, staffed and located separately'.[30] As such, treatment for substance-

[26] Strang, above n 4, 77.
[27] Best and Lubman, above n 2, 593.
[28] Ritter et al, above n 5, 186.
[29] Charlotte de Crespigny et al, 'Service Provider Barriers to Treatment and Care for People with Mental Health and Alcohol and Other Drug Comorbidity in a Metropolitan Region of South Australia' (2015) 8(3) *Advances in Dual Diagnosis* 120, 120; Australian Institute of Health and Welfare, *Alcohol and Other Drug Treatment Services in Australia 2014–15*, above n 4.
[30] de Crespigny, above n 29, 121; Alison Ritter and Mark Stoove, 'Alcohol and Other Drug Treatment Policy in Australia' (2016) 204(4) *Medical Journal of Australia* 138, 138.

related disorders and mental health is then spread across multiple providers meaning patients cannot receive treatment for all health concerns in a single place.[31] Patients have better treatment outcomes where these services are integrated, yet this is often unachievable in public AOD rehabilitation centres.[32] While better public rehabilitation funding systems have been proposed to allow the development of services for patients, an exploration of the funding system is beyond the scope of this paper.[33]

Access to treatment can be a significant barrier for those seeking rehabilitation.[34] There is a considerable demand for treatment in Australia which is not being addressed in the public system.[35] A 2016 survey of patients seeking treatment in government treatment facilities reported that 14 per cent of patients were turned away or told to wait more than one week before entering treatment.[36] It can take up to eight weeks for a patient's condition to be assessed, with patients waiting up to six months to start AOD rehabilitation programs.[37] Long waiting lists present barriers to treatment because patients may return to substance misuse if they do not receive support when they seek it.[38]

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31 Martin Holt et al, 'Barriers and Incentives to Treatment for Illicit Drug Users with Mental Health Comorbidities and Complex Vulnerabilities' (Monograph Series No. 61, Australian Government Department of Health and Ageing, 2007) 7, 1.4.

32 Sheedy and Whitter, above n 24, 250.

33 Victorian Alcohol and Drug Association, *State Budget Submission* 2018/2019 (1 May 2018), 26 <https://s3-ap-southeast-2.amazonaws.com/arc-vaada/wp-content/uploads/2018/03/29023322/SUB_state-budget-submission-FINAL_22012018-.pdf>.

34 Ritter and Stoove, above n 30, 138.

35 Marion Downey, *Law Enforcement Takes Lion's Share of Illicit Drug Spend* (20 June 2013) University of New South Wales National Drug and Alcohol Research Centre <https://ndarc.med.unsw.edu.au/news/law-enforcement-takes-lions-share-illicit-drug-spend>.

36 Jennifer Stafford and Courtney Breen, *Findings From Illicit Drug Reporting System (IDRS)* (2016) University of New South Wales 6, 95 <https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/national-idrs_2016_finalwith-customs.pdf>.

37 de Crespigny, above n 29, 124.

38 Ibid.

B *Private AOD Rehabilitation Services*

Private AOD rehabilitation centres' treatment modalities are similar to those offered in publicly funded rehabilitation centres. Treatment objectives in private rehabilitation centres are centred around maintaining abstinence and a strong emphasis on improving personal and social functioning.[39] Therapies provided at private centres may include acupuncture, meditation, yoga, art therapy, personal training, fitness and massage.[40] Similar to publicly funded centres, private centres offer outpatient services alongside residential programs to treat substance-related disorders using counselling and group therapy.[41] Residential rehabilitation programs can provide integrated AOD treatment and mental health services which address the complex nature of substance-related disorders.[42]

Private rehabilitation clinics play an important role in the community. While cost may be prohibitive for some patients, the private rehabilitation centres provide timely access to treatment, circumventing the long waiting periods in government treatment programmes.[43] Private clinics offer immediate assessment and access to treatment services avoiding delays which may result in return to drug use and continued health implications.[44] The 'one-stop-shop' approach, allowing access to comprehensive services in a residential setting, can assist patients to overcome their substance-related disorders.[45] Private clinics also provide an alternative to a vulnerable

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[39] Australian Institute of Health and Welfare, *Alcohol and Other Drug Treatment Services in Australia*, above n 4, 2.

[40] Sheedy and Whitter, above n 24, 240; Palladium Private, *Drug Rehabilitation* (2017) Palladium Private Health Retreat Programs <http://www.palladium-private.com/drugrehabilitation/>; The Sanctuary Byron Bay, *Treatment Therapies for Addiction and Mental Health* (11 December 2017) < https://www.sanctuarybb.com/therapies/therapies/p/115>.

[41] The Hader Clinic, *We Offer Outpatient Services* (2017) The Ray Hader Clinic <http://www.rayhaderclinic.com.au/intensive-outpatients/>.

[42] Ritter and Stoove, above n 30, 139.

[43] Kenny et al, above n 11, 5.

[44] The Health Retreat, *The Health Retreat Where Recovery is a Reality* (2016) <http://www.thehealthretreat.net.au/>.

[45] Brunette et al, above n 25, 478.

class of people where other services are either inaccessible due to delays or unable to meet patients' needs. As such, their role in the community is a necessary and valuable one.

Private rehabilitation clinics fill a gap in the market for patients seeking treatment for substance-related disorders. Given the similarities in treatment and services between public and private rehabilitation centres, it follows that regulation should be similar as well.

III REGULATING AUSTRALIAN AOD REHABILITATION CENTRES

Regulation of the AOD rehabilitation industry can be considered from two perspectives: health practitioner governance and rehabilitation centre regulation. Health professionals employed in any AOD rehabilitation centre are governed through their professional industry regulation. Rehabilitation centre staff can include medical practitioners, nurses, psychologists, AOD workers, chaplains, counsellors, peer workers and community volunteers. Different regulatory frameworks govern registered and unregistered health practitioners.

Practising health practitioners, including those involved in the delivery of AOD treatment services, are subject to statutory regulation under the *Health Practitioner Regulation National Law Act 2009* (the "*National Law"*). For example, a medical practitioner is subject to minimum registration standards, codes of conduct, guidelines for advertising services and policies concerning social media.[46] Statutory health professional boards regulate the behaviour of individual practitioners through 'rulemaking, monitoring,

[46] Medical Board of Australia, *Codes, Guidelines and Policies* (2017) Australian Health Practitioner Regulation Authority <http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx>.

enforcement and sanctions'.[47] In this way, health practitioners are co-regulated using the *National Law's* statutory framework and industry professionals sitting on National Boards.[48] From the *National Law* framework, the National Boards develop standards for 'education, professional development, quality control and professional conduct'.[49]

Those staff who are not registered health practitioners, are governed in other ways. Unregistered health practitioners, in some jurisdictions, are subject to negative licensing arrangements under the *National Code* which restricts practise if practitioners have contravened minimum standards of practice.[50]

A *Governing Public Rehabilitation Centres*

While there is no difference between health professional regulation in the public and private rehabilitation centres, the rehabilitation centre governance differs considerably. The establishment and operation of public rehabilitation centres are subject to direct government involvement.[51] Statutory rules provide the framework

[47] Margot Priest, 'The Privatization of Regulation: Five Models of Self Regulation' (1997) 29(2) *Ottawa Law Review* 233, 251; Julia Black, 'Critical Reflections on Regulation' (2002) 27 *Journal of Legal Philosophy* 1, 12.

[48] Priest, above n 47, 252; Ian Ayres and John Braithwaite, *Responsive Regulation* (Oxford University Press, 1992) 102.

[49] *Health Practitioner Regulation National Law Act 2009* sch s 25(c); Ahner Akhtar, 'Healthcare Regulation in Low and Middle-Income Countries: A Review of the Literature' (Working Paper Series No 14, The Nossal Institute for Global Health, October 2011) 1, 6.

[50] *Health Complaints Act 2016* (Vic); *Health Care Complaints Act 1993* (NSW); *Health Ombudsman Act 2013* (Qld); *Health and Community Services Complaints Act 2004* (SA).

[51] *Hospital and Health Boards Act 2011* (Qld); *Health Services Act 1997* (NSW); *Health Services Act 1988* (Vic); *Healthcare Act 2008* (SA); *Health Services Act 2016* (WA); *Health Services Act 2017* (NT); *Health Act 1993* (ACT); *Health Act 1997* (Tas).

for policies and standards. Health policy is achieved by implementing minimum standards and guidelines for best practice.[52]

Legislative instruments regulate public rehabilitation centres in each jurisdiction. In Queensland, for example, the *Hospital and Health Boards Act 2011* (Qld) regulates the public sector health system to deliver 'hospital' and 'health services'.[53] Public rehabilitation centres fall within the definition of delivering health services as they improve, restore and manage a client's 'health and wellbeing' in a public-sector health service facility.[54] Equivalent legislation exists in the other states and territories of Australia.[55]

Strict regulatory controls on publicly funded rehabilitation centres are necessary to manage risk and promote health outcomes.[56] As the primary goal of health regulation is to protect the public, regulating healthcare minimises risk whilst balancing benefits to the consumer.[57] For public rehabilitation centres especially, regulating them through statutes enhances consumer protection by reducing the risk of misleading and deceptive conduct.[58] Healthcare professionals operate with a high degree of autonomy within public rehabilitation

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52 Arie Freiberg, *Tools of Regulation* (Federation Press, 2010) 23; Queensland Health, *Health System and Governance* (2017) <https://www.health.qld.gov.au/system-governance>.

53 *Hospitals and Health Board Act 2011* (Qld) s 5(1).

54 Ibid ss 15(1), 17.

55 See, eg, *Hospital and Health Boards Act 2011* (Qld); *Health Services Act 1997* (NSW); *Health Services Act 1988* (Vic); *Healthcare Act 2008* (SA); *Health Services Act 2016* (WA); *Health Services Act 2017* (NT); *Health Act 1993* (ACT); *Health Act 1997* (Tas).

56 Black, above n 47, 9; Therese Saltkjel, Espen Dahl and Kjetil A van der Wel, 'Health Related Social Exclusion in Europe: A Multilevel Study of the Role of Welfare Generosity' (2013) 12(81) *International Journal for Equity in Health* 1, 2.

57 *Health Practitioner Regulation National Law Act 2009* s 3A; Ian Freckelton, 'Regulation of Health Practitioners: National Reform in Australia' (2010) 18 *Journal of Law and Medicine* 207, 208.

58 Jon Wardle, 'Holding Unregistered Health Practitioners to Account: An Analysis of Current Regulatory and Legislative Approaches' (2014) 22 *Journal of Law and Medicine* 350, 355.

centres.[59] As a result, government regulation has been necessary to provide adequate oversight and promote consumer confidence in the healthcare system.[60]

B *Governing Private Rehabilitation Centres*

Unlike the public system, the private rehabilitation industry has no uniformity in standards of treatment or practice between centres.[61] There is no regulatory oversight body or other safeguard to promote transparency. The private rehabilitation clinics are self-regulated and as such, can choose which standards to follow and enforce.

Several voluntary organisations have drafted guidelines for private AOD rehabilitation centre conduct. For example, the Australasian Therapeutic Communities Association (ATCA) have developed standards which assist in managing the quality of services provided, risk assessment and compliance.[62] Members of ATCA are required to comply with the ATCA standards although membership is voluntary for the private rehabilitation clinics.[63] The New South Wales Government and the Network of Alcohol and Other Drug Agencies (NADA) developed another voluntary standard: the *Guidelines for the Treatment of Drug and Alcohol Dependent People in a Residential Setting*.[64] Western Australian Network of Alcohol and

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[59] Chris Moy, 'Code of Ethics Essential to Meet Professional and Community Expectations' (2017) 29(07) *Australian Medicine* 26, 26.

[60] Judith Healy and John Braithwaite, 'Designing Safer Health Care Through Responsive Regulation' (2006) 184(10) *Medical Journal of Australia* 56, 57.

[61] Accreditation Stakeholders Working Group, 'Accreditation for Residential Substance Abuse Treatment Centres: Getting Started' (Canadian Centre on Substance Abuse, December 2015) 9. Very little has been published regarding regulation of private AOD rehabilitation clinics in Australia.

[62] Australasian Therapeutic Communities Association, *Interpretive Guide to the Australasian Therapeutic Association Standard for Therapeutic Communities and Residential Rehabilitation Services* (September 2017), 4 <http://www.atca.com.au/wp-content/uploads/2014/09/ATCA-Standard-Interpretive-Guide-2nd-Edition.pdf>.

[63] Australasian Therapeutic Communities Association, *Ethics and Standards* (2017) <http://www.atca.com.au/contact-about-atca/>.

[64] Mental Health and Drug and Alcohol Office, *Drug and Alcohol Treatment Guidelines for Residential Settings* (February 2007) Ministry of Health New

Other Drug Agencies (WANADA) have developed the *Standards for Culturally Secure Practice* which may be applied to the delivery of AOD rehabilitation services.[65] Similarly to the ATCA standards, these guidelines are not mandatory but 'provide clear practice directions for the delivery of residential rehabilitation services' for those member organisations.[66] Because membership to ATCA or NADA is not mandatory for private AOD rehabilitation centres, non-member organisations are still free to self-regulate through developing their own operating standards.

Private centres have no external or independent method for monitoring and improving the quality and effectiveness of the treatments they provide.[67] No accreditation or auditing process is in place to assess risk or benefit to the consumer. Private centres often equate completion of their treatment program with success.[68] However, treatment success may be more appropriately measured by assessing whether the patient has remained drug free or by reference to a client's goals and treatment priorities.[69]

South Wales Government <http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2007_014.pdf>.

65 Western Australian Network of Alcohol and Other Drug Agencies, *Standard on Culturally Secure Practice (Alcohol and Other Drug Sector)* (August 2012) < http://www.wanada.org.au/index.php?option=com_docman&view=download&alias=34-standard-on-culturally-secure-practice-alcohol-and-other-drug-sector-1st-edition-august-2012&category_slug=standard-on-culturally-secure-practice&Itemid=265>.

66 Larry Pierce, "Clinical Guidelines for Residential Rehabilitation Settings (2007) 5(1) *Of Substance* 25, 25; Mental Health and Drug and Alcohol Office, *Drug and Alcohol Treatment Guidelines for Residential Settings* (February 2007) Ministry of Health New South Wales Government 1, 4, 1.1 <http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2007_014.pdf>.

67 Accreditation Stakeholders Working Group, above n 61.

68 See, eg, Urban Drug Rehab, *Residential Drug and Alcohol Rehabilitation* (2017) <https://urbandrugrehab.com/>.

69 Rebecca McKetin et al, *Methamphetamine Treatment Evaluation Study (MATES): Three Year Outcome From the Sydney Site* (2010) University of New South Wales National Drug and Alcohol Research Centre <https://ndarc.med.unsw.edu.au/resource/methamphetamine-treatment-evaluation-study-mates-three-year-outcomes-sydney-site>; Valerie Marie Fairbanks, *Developing Patient-Driven Substantive Definition of Office-Based Opioid Treatment Success* (A Dissertation, University of Alaska and Fairbanks and Anchorage, 2016) 1.

Self-regulation can be an effective regulatory tool. Self-regulation, a form of private regulation, involves the profession or industry itself governing the conduct and procedures of members.[70] It is recommended, as a regulatory model, when there is no strong public interest or public safety issues in the discipline's practice; the 'regulatory problem' which the self-regulation seeks to solve is low risk; cost of regulatory compliance is small and the problem can be fixed within the industry itself.[71] Most notably, perhaps, for a self-regulatory model to be effective, the industry needs to be committed to implementing self-regulation[72] and have the expertise and capacity to maintain and enforce professional requirements.[73] There are fiscal advantages for the government from having an independent industry regulator. Depending on the level of self-regulation imposed on an industry, the government is given a monetary reprieve as their responsibility for co-ordinating the regulatory mechanisms lessens.[74] Further, self-regulation has been argued to be responsive to industry needs, flexible, informed, targeted and encouraging of industry compliance.[75]

However, self-regulation has been criticised when used as a regulatory model in healthcare. Using a self-regulatory model for health care has been widely criticised for an apparent pattern of

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[70] Morgan and Yeung, above n 6, 92-3.

[71] ACT Government, 'Best Practice Guide for Preparing Regulatory Impact Statements' (December 2003) 16; Government of South Australia, 'Better Regulation Handbook' (Department of the Premier and Cabinet; Department of Treasury and Finance, January 2011) 32.

[72] NSW Government, 'Guide to Better Regulation' (Department of Premier and Cabinet, November 2009) 32.

[73] Government of South Australia, *Better Regulation Handbook*, above n 71, 32.

[74] John Braithwaite, 'Enforced Self-Regulation: A New Strategy for Corporate Crime Control' (1982) 80 *Michigan Law Review* 1466, 1467.

[75] Robert Baldwin, Martin Cave and Martin Lodge, *Understanding Regulation: Theory, Strategy and Practice* (Oxford University Press, 2nd ed, 2012) 139-46; Julia Black, 'Decentring Regulation: Understanding the Role of Regulation and Self-Regulation in a 'Post-Regulatory' World' (2001) 54 *Current Legal Problems* 103, 115; Neil Gunningham, Peter Grabosky and Darren Sinclair, *Smart Regulation: Designing Environmental Policy* (Clarendon Press, 1998) 50-6.

unacceptable tolerance for unprofessional conduct.[76] Self-regulation can result in the industry being self-serving, having inadequate sanctions and harbouring 'free-rider' problems.[77] Given that private rehabilitation centres provide a health service to vulnerable people in the community, and treat acute and serious health problems, a self-regulatory system in the AOD private rehabilitation industry is concerning because the community should be able to expect a high level of care and safety from a private rehabilitation clinic yet that does not always occur.[78]

There are several problems with the private rehabilitation industry which current regulation is failing to address. Private rehabilitation centres are using anecdotal evidence to entice patients into entering their treatment programs. A number of media examples highlight this concerning trend. For example, the *Get Off Drugs Naturally Foundation* used testimonials that were not provided by genuine patients and the claims of success were not supported by scientific evidence.[79] In another example, Shalom House boasted a 50 per cent 'success' rate despite not having any way to measure success in its program.[80] Such practices raise concerns as they provide false hope

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[76] Ian Freckelton, Regulation of Health Practitioners' in Ian Freckelton and Kerry Peterson (eds), *Disputes and Dilemmas in Health Law* (The Federation Press, 2006) 501; Helen Kiel, 'Regulating impaired doctors: A snapshot from New South Wales' (2013) 21 *Journal of Law and Medicine* 429, 434; Malcolm Parker, 'Embracing the new professionalism: Self-regulation, mandatory reporting and their discontents' (2011) 18 *Journal of Law and Medicine* 456, 466; David Jewell, 'Supporting Doctors, or the Beginning of the End for Self-regulation?' (2000) 50 *British Journal of General Practice* 4, 4-5. See also Thomas A Faunce and Stephen N C Bolsin, 'Three Australian whistleblowing sagas: lessons for internal and external regulation' (2004) 181 *Medical Journal of Australia* 44.

[77] Black, *Decentring Regulation*, above n 75, 115.

[78] Bruce H Barraclough and Jim Birch, 'Health Care Safety and Quality: Where We Have Been and Where Are We Going' (2006) 184(10) *Medical Journal of Australia* 48, 48.

[79] Consumer Affairs Victoria, *Get Off Drugs Naturally Foundation Inc and Dr Nerida James-Enforceable Undertaking* (11 May 2015) <https://www.consumer.vic.gov.au/latest-news/get-off-drugs-naturally-foundation-inc-and-dr-nerida-james-enforceable-undertaking>.

[80] Australian Broadcasting Corporation, 'Breaking Good', *Australian Story*, 10 April 2017; Stephen Bright and Nicole Lee, 'What is "success" in drug rehab?

to prospective patients and promote unreal expectations of the efficacy of the treatment.[81]

Promulgating success rates, or the inability to attribute success, is another concern of the private rehabilitation industry. Victorian Supreme Court Justice Paul Coghlan condemned a rehabilitation facility that 'charged $15 000 for a 28 day program but was unable to provide figures on its success rate'.[82] This example shows the huge sums of money which patients invest in health services. Given the self-regulation of the industry, there is no requirement for rehabilitation services to be supported by clinical evidence. Effectiveness of treatment programs can be difficult to assess.[83] This may reduce patient autonomy around decision-making and may lead to patients relying upon 'spurious and exploitive health practice.'[84]

Regulation of the private rehabilitation industry is necessary. AOD rehabilitation treatment service delivery involves comprehensive skills and specialist knowledge creating an information asymmetry between service providers and patients.[85] Patients who cannot be accommodated in the public rehabilitation system, or who choose to pay for private treatment, may have difficulty discerning which provider would be the most appropriate

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Programs need more than just anecdotes to prove they work', *The Conversation* (online) 13 April 2017 < https://theconversation.com/what-is-success-in-drug-rehab-programs-need-more-than-just-anecdotes-to-prove-they-work-76081>.

81 Ian Freckelton, 'Misplaced Hope: Misleading Health Service Practitioner Representations and Consumer Protection' (2012) 20 *Journal of Law and Medicine* 7, 8.

82 Padriac Murphy, 'Victorian Supreme Court Justice Paul Coghlan Labels Private Drug Rehabilitation Centres "Parasitical"' Herald Sun (Melbourne) 7 September 2016.

83 Matthew E Archibald and Caddie Putnam Rankin, 'Community Context and Healthcare Quality: The Impact of Community Resources on Licensing and Accreditation of Substance Abuse Treatment Agencies' (2013) 40(4) *The Journal of Behavioural Health Services and Research* 442, 443.

84 Ian Freckelton, 'Unscientific Health Practice and Disciplinary and Consumer Protection Litigation' (2011) 18 *Journal of Law and Medicine* 645, 649.

85 John Chamberlain, *Doctoring Medical Governance: Medical Self-Regulation in Transition* (Nova Science Publishers 2009) 55.

to meet their needs.[86] Currently, patients rely upon the centre's website and other marketing tools in order to choose a suitable rehabilitation provider. Because of the self-regulatory system, it is difficult for a patient to determine quality of services, whether complaints have been made about the service or make any other critical evaluation of the service before commencing treatment. As such, a stronger regulatory response is required to prevent harm from occurring.[87] A better regulatory framework for the private rehabilitation industry is necessary to maximise patient outcomes through improving safety and quality of services delivered.[88]

IV REGULATORY RESPONSE TO CURRENT CHALLENGES OF PRIVATE REHABILITATION CENTRES

This paper argues for a licensing model of regulation, reflecting that of the *National Law*, being a more appropriate regulatory model for the private substance rehabilitation industry than the current self-regulatory approach. The *National Law* is a regulatory response designed to protect the public from harm. The *National Law* provides a system of registration and accreditation of health practitioners in Australia.[89] This system of national registration and accreditation protects the public by ensuring that only suitably trained and qualified health practitioners are registered to deliver health services

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86 Ibid.

87 Chamberlain, above n 85; Michael Weir, 'An Ethical Protocol for Complimentary and Alternative Medicine Practitioners in an Orthodox Medicine Regime' (2011) 18 *Journal of Law and Medicine* 728, 736.

88 John F Mayberry, 'The Need to Develop a Regulatory Body for the Practice of Al-Hijama' (2016) 24 *Journal of Law and Medicine* 35, 38.

89 *Health Practitioner Regulation National Law Act 2009* (Qld) s 3; *Health Practitioner National Law* (NSW) s 3; *Health Practitioner Regulation National Law* (ACT) *Act 2010* (ACT) s 3; *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) s 3; *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA) sch 2 s 3; *Health Practitioner Regulation National Law* (WA) *Act 2010* s 3; *Health Practitioner Regulation (National Uniform Legislation) Act 2010* (NT); *Health Practitioner Regulation National Law (Tasmania) Act 2010* (TAS).

to the Australian public.[90] Further, the *National Law* facilitates the access and delivery of health services by registered practitioners in the interests of the health and safety of the public.[91] A similar regulatory model would be appropriate for the private substance rehabilitation industry as it provides a proactive approach to public health and safety by setting minimum standards, accreditation requirements and compliance strategies to manage behaviour that falls below the required standard of care.

The proposed licensing model, reflecting *National Law* regulation, would require a statutory licensing authority governing industry bodies to provide governance and education to the industry.[92] A number of regulatory mechanisms would be necessary to achieve the goals of protecting the health and safety of the public and would require a co-ordinated approach from service providers within the industry as well as government intervention.[93] A regulatory approach consisting of the following elements may be beneficial to regulating private rehabilitation centres:

a) A licensing body;
b) Minimum standards for granting of the licence;
c) Accreditation and revalidation; and
d) Compliance strategies.[94]

A *Licensing*

Licensing is a regulatory tool used to grant access to a market under specified conditions.[95] Licensing controls entry into, and out of, a

[90] Ibid.
[91] Ibid.
[92] Ayres and Braithwaite, above n 48.
[93] Ritter and Stoove, above n 30, 139.; Cary Coglianese and Evan Mendelson, 'Meta-Regulation and Self-Regulation' (Research Paper No 12-11, University of Pennsylvania Law School, (2010)) 1, 22.
[94] Freiberg, *Tools of Regulation,* above n 52*,* 145; David Cousins, 'Using Licensing to Protect Consumers' Interests' (Research Paper No 9 Consumer Affairs Victoria, November 2006) 13.
[95] Arie Freiberg, *Regulation in Australia* (Federation Press, 2017) 304.

market by ensuring entry requirements are met.[96] For private rehabilitation centres, a licensing scheme would require individual centres to hold a licence in order to accept patients for treatment. Legal remedies would allow enforcement options if rehabilitation treatment centres delivered treatment services without a licence. Centres would need to demonstrate minimum standards in order to be granted a licence by the licensing body. Centres which did not achieve those standards would be unable to provide healthcare services to patients. For example, the regulatory body could use conditions on a licence to control and force certain desired behaviour.[97] Licensing is an appropriate regulatory tool as it is a way to protect patients and the public from harm.[98] Licensing would shift the responsibility for determining quality from patients to government.[99] Adherence to the minimum standards would address the safety and quality of services provided by private rehabilitation centres.

Safety and quality of health services are significant concerns in healthcare.[100] Regulation of healthcare in the private rehabilitation sector is important as it provides oversight for safety and quality of patient care by ensuring treatment providers meet minimum standards of practice and competence.[101] Regulation would address unprofessional conduct and professional misconduct by providing a disciplinary structure for providers falling short of acceptable

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96 Colin Scott, 'Licensing as a Tool of Regulation and Governance' (2014) 36(2) *CASS Journal of Law* 35, 38.

97 Freiberg, *The Tools of Regulation,* above n 52, 143, 146.

98 Ibid 143; John Wardle, Amie Steel and Erica McIntyre, 'Independent Registration for Naturopaths and Herbalists in Australia: The Coming of Age of an Ancient Profession in Contemporary Healthcare' (2013) 25(3) *Australian Journal of Herbal Medicine* 101, 102.

99 Anthony I Ogus, *Regulation: Legal Form and Economic Theory* (Hart Publishing, 2004) 216.

100 Parker, above n 76, 460.

101 Ian Freckelton, 'Regulation of Health Practitioners: National Reform in Australia' (2010) 18 *Journal of Law and Medicine* 207, 208; Ian Freckelton, 'Regulating the Unregistered' (2008) 16 *Journal of Law and Medicine* 413, 413.

standards.[102] Standards for practice and competence ensure healthcare providers are competent in delivering AOD health services and promote consumer confidence.[103] Regulation of healthcare through standards of practice, codes of conduct and disciplinary processes provides 'guarantees to the public in relation to status, currency and fitness to practice of healthcare providers.'[104] As such, a licensing scheme for private rehabilitation centres promotes those minimum standards of practice and competence by preventing unsuitable organisations from attaining a licence to provide rehabilitation services for patients.

Licensing would serve to address the information asymmetry that currently exists between providers of private drug rehabilitation services and patients. A licensing scheme would allow patients to compare centres.[105] Private rehabilitation centres granted a licence would be required to comply with rules and conditions of the licence which would ensure that a centre operated within the scope of the licence.[106] They would also need to demonstrate a minimum standard of competency in relation to the delivery and management of AOD rehabilitation services.[107] Through this process, patients would be assured that licensed centres have the necessary skill and competency to deliver rehabilitation services.[108] The licence indicates verification of the skill required to deliver rehabilitation services, thereby addressing information asymmetry.[109]

There would be a number of steps involved to create a licensing system for private rehabilitation centres. This includes establishing a

[102] Freckelton, 'Regulation of Health Practitioners: National Reform in Australia' above n 101.
[103] Freckelton, 'Regulating the Unregistered' above n 101.
[104] Freckelton, 'Regulation of Health Practitioners: National Reform in Australia' above n 101, 213.
[105] Archibald and Rankin, above n 83.
[106] Freiberg, *The Tools of Regulation,* above n 52, 143.
[107] Archibald and Rankin, above n 83, 446.
[108] Freiberg, *Regulation in Australia,* above n 92.
[109] Scott, above n 96, 42.

licensing body, provision for mandatory reporting, conditional licences and a 'fit and proper person' test.

A statutory licensing body would be required to administer the licensing system for private rehabilitation centres. Uniform legislation between states and territories would ensure the most effective licensing system. Uniform legislation would promote jurisdictional consistency in the regulation of the private rehabilitation industry across Australia. The *National Law* provides a relevant example of uniform legislation which creates consistency between jurisdictions and the proposed licensing scheme would model the interjurisdictional framework established in the *National Law*.

Under a licensing model, private rehabilitation centres would be required to apply for a licence to practice. Private rehabilitation centres would undertake an application process, managed through the licensing body, and the licensing body would then control entry into the private rehabilitation industry.[110] Licensing would serve to prevent patients from being exposed to unnecessary risk of harm by ensuring minimum standards of competency have been met prior to commencing operation.[111]

Licensing would involve mandatory reporting requirements by private rehabilitation centres to promote compliance with minimum standards.[112] Health professionals registered under the *National Law,* who are working within private rehabilitation centres, are subject to mandatory reporting of practice that threatens patient safety.[113] However, private rehabilitation centres can employ health professionals who do not need registration, such as peer workers, providing an opportunity for regulatory failure due to lack of mandatory reporting. Instances of behaviour relating to 'notifiable

[110] Ibid 38.
[111] Ogus, above n 99, 214.
[112] Scott, above n 96, 42.
[113] *Health Practitioner Regulation National Law Act 2009* s 141.

conduct' as defined by the *National Law* may go unreported, placing patients' safety at risk.[114] This licensing model would ensure unregistered health care workers, employed in private rehabilitation centres, would be subject to the same mandatory reporting requirements as registered health practitioners to promote patient safety and welfare.[115]

The licensing system would also allow for conditions of practice. Conditions may be placed upon licences to minimise risk to the public.[116] Conditions placed upon a licence would limit or influence the activities of a private rehabilitation centre. Where a centre is found to have operated outside their scope of practice, or in a way which placed a patient at risk, conditions may be imposed to prevent this from happening in the future.[117] This would prohibit a centre from providing services that they are not competent to deliver, thereby protecting the public from harm.[118]

A public register of licences should be maintained. A public register would be important for the licensing scheme to allow prospective patients to access details about the rehabilitation centre including to check its licensing status and whether conditions have been imposed on its practice. A register would serve to inform patients of those centres that have attained the required standard for delivering care whilst also allowing patients to exercise informed consent about whether or not to attend the centre for treatment.

Licensing would enhance consumer protection by limiting entry into the private AOD rehabilitation industry.[119] A 'fit and proper person' test should be applied to individual *proprietors* entering into

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[114] Ibid s 140.
[115] Parker, above n 76, 460.
[116] Freiberg, *The Tools of Regulation,* above n 52, 146.
[117] Gregory Treverton Jones, Alison Foster and Saima Hanif, *Disciplinary and Regulatory Proceedings* (Jordan Publishing, 2015) 265.
[118] Ibid.
[119] David Cousins, 'Using Licensing to Protect Consumers' Interests' (Research Paper No 9 Consumer Affairs Victoria, November 2006) 15.

the private AOD rehabilitation industry as part of the licensing application.[120] Conditions of the 'fit and proper person' test could include background checks on criminal history and character.[121] This would minimise the risk of harm to patients by ensuring that only proprietors of good character are able to operate.[122] The benefit, other than consumer protection, is that the licence serves as a screening tool to limit entry to those proprietors committed to delivering the health benefits of AOD rehabilitation rather than those who see it as a pure economic proposition.[123] Criminal history checks for the unregistered health professionals working in the rehabilitation centres would not, necessarily, be appropriate given peer workers' criminal history might exclude them from assisting their peers.

Licensing reflects the relationship of trust needed between a health carer and patient. Compulsory licensing should not be viewed as an opportunity to create a monopoly by restricting entry into the private AOD rehabilitation market.[124] Rather, the licensing, which is contingent upon achieving and maintaining accredited status, should reflect the special relationship of trust that exists between the patient and the centre.[125] A power imbalance exists between the patient and the rehabilitation provider due to the knowledge and expertise held by the healthcare provider.[126] Patients are heavily reliant upon healthcare professionals for advice as services are individualised.[127] The level of reliance creates a trust relationship that requires healthcare providers to have a professional responsibility towards their client, as they are required to make complex clinical decisions.[128] Regulating private rehabilitation centres, using a

[120] Ibid.
[121] Freiberg, *Regulation in Australia,* above n 95, 308.
[122] Ibid 307.
[123] Cousins, above n 119.
[124] Freiberg, *The Tools of Regulation,* above n 52, 143.
[125] Andra le Roux-Kemp, 'The Making of a Health Profession: A South African Case Study' (2017) 24 *Journal of Law and Medicine* 707, 710; Freckelton, 'Regulation of Health Practitioners: National Reform in Australia' above n 101.
[126] Priest, above n 47, 254
[127] Jon Wardle, 'Defining Deviation: The Peer Professional Opinion Defence and its Relationship to Scope Expansion and Emerging Non-medical Health Professions' (2016) 23 *Journal of Law and Medicine* 662, 664.
[128] Chamberlain, above n 85, 55.

licensing scheme, promotes consumer confidence by providing accountability and transparency.[129]

Cost is a significant factor in establishing a licensing body. Stronger regulatory control over entry into and out of the private rehabilitation industry may reduce the costs to the patients and the community but increase the cost to the government.[130] Patients and families may face considerable financial loss where private rehabilitation centres fail to deliver services as promised because of exploitive practices or poorly defined services. Licensing could ensure that patients are fully informed about the rehabilitation centre's practices before paying for treatment. Indirect costs to the community may be reduced by minimising the possibility of a person returning to drug use by ensuring patients undergoing treatment are exposed to those centres that hold the requisite qualifications.[131] Individuals would be assured of a greater level of consumer protection under the licensing arrangement, as they could be confident that a centre holding a licence has acquired the necessary skill and competency to deliver AOD rehabilitation services.[132]

However, a licensing system would impose a considerable financial burden on the government. Establishing a licensing body, evaluating licensing applications and ongoing compliance monitoring (discussed in C) would be a substantial government cost. AOD use also causes considerable costs to the government and community. The cost of substance use to the Australian economy is also significant. The human cost of substance use during 2011 was estimated at $3161 million and included medical costs due to hospitalisation, drug treatment costs, loss of productivity of drug users whilst in treatment and the cost of drug related deaths.[133]

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[129] Ibid 57; Freckelton, 'Regulation of Health Practitioners: National Reform in Australia' above n 101.

[130] Ibid.

[131] Ogus, above n 99, 228.

[132] K F Mackie, 'Occupational Licensing in Tasmania' (1977) 5 *University of Tasmania Law Review* 288, 289-90.

[133] Australian Institute of Criminology, *Drug Abuse* (14 April 2015) <https://aic.gov.au/publications/rpp/rpp129/drug-abuse>.

Human costs represent only a small proportion of the true cost of substance use. Societal costs of substance use have risen over time with these costs estimated at $55.2 billion in 2004-2005 compared with $34.4 billion in 1998.[134] These costs represent the value that would have been available to society had no substance use occurred both now and in the future.[135] By ensuring greater efficacy in rehabilitation centre operations and regulation, the economic cost of AOD use would lessen, balancing the regulatory burden of a licensing system.

B *Standards*

Another helpful regulatory change for the private rehabilitation industry is for centres to maintain minimum standards of conduct and operation. Fragmentation of the private rehabilitation industry has resulted in treatment being 'poorly defined in terms of clinical features and overall service design'.[136] This is evident by the lack of systematic implementation of standards by private rehabilitation clinics across Australia. Standards for delivery and management of services specific to rehabilitation centres operating in a residential setting should apply to all centres, such as the voluntary ATCA standards discussed earlier in this paper.[137] Standards for the delivery and management of private rehabilitation services would help patients better assess the quality and costs of care that a provider may be offering.[138]

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[134] David Collins and Helen Lapsley, 'Counting the Cost: Estimates of the Social Costs of Drug Abuse in Australia in 1998/9' (Monograph Series, No 49, Commonwealth Department of Health and Ageing, 2002) ix; David Collins and Helen Lapsley, 'The Cost of Tobacco, Alcohol and Illicit Drug Abuse to Australian Society in 2004/05' (Commonwealth Department of Health and Ageing, 2008) xi.

[135] Ibid 7.

[136] Pierce, above n 66.

[137] Australasian Therapeutic Communities Association, *Australasian Therapeutic Communities Association Standard For Therapeutic Communities and Residential Rehabilitation Services* (July 2013) <http://www.atca.com.au/wp-content/uploads/2014/09/ATCA-Standard-.pdf>.

[138] Akhter, above n 49, 5.

Information asymmetry is a significant issue for patients seeking treatment for AOD rehabilitation. Private rehabilitation centres asserting claims around the effectiveness of treatments contribute to a power imbalance between the centre and patients.[139] This imbalance arises from a number of factors including lack of knowledge regarding addiction, 'treatment options and personal preferences'.[140] Uniform standards may reduce the potential for information asymmetry in the industry because not only would standards be promulgated but they would apply, uniformly, across centres.[141]

Government intervention into AOD rehabilitation encourages industry participation. When the New South Wales Government endorsed the voluntary NADA standards, there was a better adoption of the standards across New South Wales than in other states and territories without government involvement or endorsement.[142] This presents a strong argument for government intervention in the regulatory control of the private rehabilitation industry because it demonstrates that private centres are more responsive to government endorsed standards.

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[139] Anne-Maree Farrell et al, *Health Law Frameworks and Context* (Cambridge University Press, 2017) 30.

[140] Ibid.

[141] Information asymmetry occurs when consumers 'have inadequate information about the substance, quality, cost and provider incentives to make informed choices': Erin C Fuse Brown, 'Resurrecting Health Care Rate Regulation' (2015) 67 *Hastings Law Journal* 85, 94; Freckelton, 'Unscientific Health Practice and Disciplinary and Consumer Protection Litigation' above n 84, 647.

[142] The Network of Alcohol and Other Drug Agencies in New South Wales has approximately 100 members; Network of Alcohol and Other Drug Agencies, *Resources* (2016), 1 <http://www.nada.org.au/media/85569/resources-flyer-2016b-interactive.pdf>; Queensland Network of Alcohol Drug Agencies has 47 members: Queensland Network of Alcohol Drug Agencies, *What We Do* (2017) <http://www.qnada.org.au/566/what-we-do>; Western Australian Alcohol and Other Drug Agencies has 55 full members: Western Australian Alcohol and Other Drug Agencies, *Members* <http://www.wanada.org.au/about/members.html>.

A regulatory framework should involve principles based regulation and standard setting.[143] An organisation such as NADA may be utilised at each state and territory level to develop and implement a uniform set of standards in the private rehabilitation industry. The professional industry body should develop principles based regulatory goals directed at risk prevention and promoting accountability and transparency within the industry.[144] These regulatory goals need to be consistent with those already in place at public rehabilitation centres rather than the private interests of the private rehabilitation industry.[145] Once the regulatory goals have been designed, an assessment process would need to be undertaken to identify and prioritise areas that pose a high risk to patient safety.[146] Once safety risks have been identified, risk assessment standards may be developed addressing best practice, 'benchmarks, performance indicators and quality control'.[147] Principles based regulation would be most appropriate as it would encourage private rehabilitation centres to manage risk by going beyond minimum standards rather than taking a 'box-ticking' approach to compliance.[148] Principles based regulation would address the variations in the type of services offered by private AOD rehabilitation clinics.[149] It would further allow private rehabilitation clinics to choose how they might comply with a standard in order to achieve the regulatory goal.[150]

Regulatory principles would need to be formulated into standards that may be implemented into practice. Standards would need to clearly articulate the regulatory goals as ambiguity may allow private rehabilitation centres to circumvent standards.[151] Fragmentation of

[143] Baldwin, Cave and Lodge, above n 75, 297, 300.
[144] Ibid 301.
[145] Coglianese and Mendelson, above n 93.
[146] Sarah Scobie et al, 'Measurement of Safety and Quality of Health Care' (2006) 184(10) *Medical Journal of Australia* 51, 54.
[147] Chamberlain, above n 85, 70.
[148] Baldwin, Cave and Lodge, above n 75, 303.
[149] Ogus, above n 96, 216.
[150] Freiberg, *Regulation in Australia,* above n 95, 236.
[151] Mark Davies, 'The Future of Medical Self-regulation in the United Kingdom-Renegotiating the State-profession Bargain?' (2014) 14(4) *Medical Law International* 236, 247.

the private rehabilitation industry has resulted in treatment being 'poorly defined in terms of clinical features and overall service design'.[152] Industry fragmentation has limited the implementation of uniform standards to date and currently few restrictions are in place for the delivery and management of care despite the private rehabilitation centre assuming a position of primary carer once a patient enters treatment. [153] Industry consensus would be necessary for the standards to effectively define the scope of practice for the private rehabilitation industry.[154] Once the scope of practice has been defined, individual centres may identify compliance issues where they may be operating outside the permitted scope of practice and determine systems for integrating compliance within their operations.[155] Employees with previously non-defined roles would be guided by the standards when delivering services. [156] Compliance with the standards needs to actually achieve the regulatory goals of harm prevention and promotion of accountability and transparency within the industry.[157] Implementing the standards, and the ongoing regulatory requirements, needs to be cost effective for the private rehabilitation centre.[158] A failure to achieve the regulatory goals and excessive regulatory costs for compliance will see private rehabilitation centres view the regulatory scheme as over regulation and unreasonable.[159] This would be detrimental to the success of the regulatory scheme.

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[152] Pierce, above n 66.

[153] Ritter and Stoove, above n 30; Wardle, 'Defining Deviation: The Peer Professional Opinion Defence and its Relationship to Scope Expansion and Emerging Non-medical Health Professions' above n 127, 670.

[154] Wardle, 'Defining Deviation: The Peer Professional Opinion Defence and its Relationship to Scope Expansion and Emerging Non-medical Health Professions' above n 127, 671.

[155] Christine Parker, 'Evaluating Regulatory Compliance: Standards and Best Practice' (1999) 7 *Trade Practices Law Journal* 62, 71.

[156] Karen M Neuman and Margaret Ptak, 'Managing Managed Care Through Accreditation Standards' (2003) 48(3) *Social Work* 384, 385.

[157] Benedict Sheehy and Donald Feaver, 'Designing Effective Regulation: A Normative Theory' (2015) 38(1) *University Of New South Wales Law Journal* 392, 400; Marina Nehme, 'Australian Charities and Not-for-profits Commission: Enforcement Tools and Regulatory Approach' (2017) 45 *Australian Business Law Review* 159, 177.

[158] Nehme, above n 157.

[159] Ibid.

Standards may be used to restrict advertising practices to protect the public. Private clinics rely upon testimonials to promote their programs.[160] Testimonials are based upon a third party's positive experience in order to promote a clinic.[161] Testimonials are an advertising technique used by clinics to 'persuade the reader to engage in particular health behaviours'.[162] Being highly emotive in nature, testimonials readily gain the trust of the reader.[163] The effectiveness of testimonials arises from the reader's ability to identify with the individual providing the account and the vividness of the information provided.[164] Information delivered in this format influences behaviour as it is more persuasive than abstract information and has been shown to have a stronger effect on behaviour.[165] Testimonials provided by private clinics portray 'atypical positive results', as they only describe the favourable aspects of an individual who has been successful in overcoming their substance misuse.[166] These testimonials can be deceptive as they overestimate the positive effects of the treatments provided.[167]

Adverse consequences can arise from a person relying upon a testimonial from a private rehabilitation centre.[168] Testimonials may include inaccurate or incomplete information resulting in inappropriate choice of treatment by consumers, which is not in the

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[160] See, eg, The Hader Clinic, *Testimonials* (2017) The Ray Hader Clinic <http://www.rayhaderclinic.com.au/testimonials/>; Urban Drug Rehab, *Drug Rehabilitation Testimonials* (2017) <https://urbandrugrehab.com/drug-rehab-testimonials/>.

[161] Hwa Meei Liou, 'Endorsements and Testimonials in Advertising in the Perspective of Competition Law' (2016) 19(1) *Journal of Legal, Ethical and Regulatory Issues* 79, 80.

[162] Amanda J Dillard and Jackie L Main, 'Using a Health Message with a Testimonial to Motivate Colon Cancer Screening: Associations with Perceived Identification and Vividness' (2013) 40(6) *Health Education and Behaviour,* 673, 673.

[163] Liou, above n 161.

[164] Dillard and Main, above n 162, 674.

[165] Ibid.

[166] Ahmed E Taha, 'Selling the Outlier' (2015) 41 *The Journal of Corporation Law* 459, 461.

[167] Ibid.

[168] Ibid 469.

interest of public health.[169] Failure rates or negative experiences of treatment are not discussed nor is follow-up data of patients, post treatment, giving little indication of the true success rate of the programs. False expectations regarding outcomes are created by testimonials, as they do not include information concerning risks or adverse effects of treatment.[170]

The promulgation of a standard preventing the use of testimonials would prevent the risks associated with this form of advertising. Currently the Australian Competition and Consumer Commission may take action for advertising that is found to be misleading or deceptive.[171] Often a regulatory response will only occur following a consumer complaint, meaning the harm has already occurred.[172] A standard prohibiting the use of testimonials would minimise harm to patients and form the basis of an education program providing private rehabilitation centres with the tools to understand their obligations with respect to advertising requirements.[173]

C *Compliance Strategies*

To achieve minimum standards in the licensing scheme of private rehabilitation centres, compliance strategies should accompany the regulatory approach.[174] In order to maximise patient protection, risk

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[169] Australian Health Practitioner Regulation Agency, '*Guidelines for Advertising Regulated Health Services*' (May 2014) <http://www.ahpra.gov.au/Publications/Advertising-resources/Legislation-guidelines/Advertising-guidelines.aspx>.

[170] Del Wilmington, 'Hospitals Should End the Use of Testimonial Advertising' (2016) *The News Journal* A.9.

[171] *Competition and Consumer Act 2010* (Cth) sch 2, s 18.

[172] Parker, above n 155, 63; Consumer Affairs Victoria, *Get Off Drugs Naturally Foundation Inc and Dr Nerida James-Enforceable Undertaking* (11 May 2015) <https://www.consumer.vic.gov.au/latest-news/get-off-drugs-naturally-foundation-inc-and-dr-nerida-james-enforceable-undertaking>.

[173] Australian Health Practitioner Regulation Agency, Submission to Therapeutic Goods Administration, *The Regulatory Framework for Advertising Therapeutic Goods,* 21 December 2016, 5.

[174] John Braithwaite, 'Regulating Nursing Homes: The Challenge of Regulating Care for Older People in Australia' (2001) 323 *British Medical Journal* 443, 445.

prevention and harm prevention, behaviour consistent with the regulatory strategy, that is to achieve minimum standards of conduct and operation in rehabilitation centres, should be encouraged and/or enforced.[175] Without a means for the regulatory body to ensure compliance with standards, and penalties for non-compliance, the regulatory body would be relying on voluntary compliance.

Voluntary compliance with standards is not an appropriate strategy for private rehabilitation centres. Private rehabilitation centres may be disinclined to adopt voluntary standards for a number of reasons. Allowing voluntary compliance may cause a financial cost to private rehabilitation centres as they may need to change their policies and procedures to accommodate the industry standards.[176] Further, private rehabilitation centres may not perceive a benefit in implementing standards if there is no mandatory uptake.[177] In Queensland, only 12 private drug rehabilitation centres are members of ATCA, of which only one is a certified therapeutic member meaning that their standards have been certified against the ATCA standards.[178] Despite Queensland private rehabilitation centres being offered the option of adopting standards, voluntary compliance has not been popular and therefore does not address the regulatory disparity which currently exists in the industry. As such, mandatory standards with associated compliance requirements are necessary.

An effective compliance strategy to uphold minimum standards in private rehabilitation could utilise sanctions to encourage compliant behaviour.[179] To deter private rehabilitation centres from contravening standards they must perceive the probability of getting

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[175] Christine Parker, above n 155, 66.

[176] Vicky Comino, *Australia's Company Law Watchdog ASIC and Corporate Regulation* (Lawbook Co, 2015) 103.

[177] Ogus, above n 99, 91.

[178] Australasian Therapeutic Communities Association, *Queensland* (2017) <http://www.atca.com.au/referrals/queensland/>; Australasian Therapeutic Communities Association, *Australasian Therapeutic Communities Association Membership Categories* (2016), 2 <http://www.atca.com.au/wp-content/uploads/2016/09/Membership-kit.pdf>.

[179] Nehme, above n 157, 180.

caught by the regulator as real and there must be consequences for non-compliance.[180] Optimal compliance will be achieved by using deterrence strategies, as private rehabilitation centres will be inclined to balance the likelihood of being caught contravening a standard against the cost of being caught.[181] A threat of sanctions being imposed for non-compliance could ensure that the licensing scheme is successful in ensuring compliance with standards.[182]

Compliance with the proposed regulatory scheme could be achieved where the licensing body imposes sanctions which are responsive to the rehabilitation centre's behaviour. The idea of regulators prescribing rules based on the conduct of those it regulates, and deciding on an interventionist strategy when needed, is known as 'responsive regulation'.[183] That is, regulation 'responsive' to the industry. An enforcement pyramid can utilise multiple sanctions responsive to the industry which escalate in the event of breaches in compliance.[184] The *National Law* regulatory model is an example of an enforcement pyramid structure which the private rehabilitation clinics can mirror as the *National Law* offers a range of sanctions for the National Boards to use depending on the seriousness of the breach.[185]

Private rehabilitation centres could encourage compliance using responsive regulation. If private rehabilitation clinics use an enforcement strategy modelled on the *National Law's* enforcement structure, first offences or less serious breaches may involve a warning or enforceable undertaking.[186] Warnings and other similar sanction strategies encourage a culture of compliance within the

[180] Nick Kotzman, 'The Cartelist's Dilemma: Leniency Policies and Game Theory' (2017) 25 *Australian Journal of Competition and Consumer Law* 22, 23.
[181] Ogus, above n 99, 91.
[182] Kotzman, above n 180.
[183] Ayres and Braithwaite, above n 48, 4.
[184] Ibid 35.
[185] See, eg, *Health Practitioner Regulation National Law Act 2009* s 178.
[186] Nehme, above n 157, 173, 174.

industry rather than taking an immediate punitive approach.[187] They also have an educative role by identifying an issue and providing feedback on how a provider may better address an issue in the future.[188] Encouraging cooperation between the regulator and rehabilitation centre encourages innovation in the delivery of health care as continuous improvement is fostered.[189] However, for persuasion techniques to result in compliance, the regulator must be able to use punitive measures as an option for rehabilitation centres that breach standards.[190]

Punitive approaches may be necessary to address non-compliance. Severe or repeated breaches of standards may require the use of more punitive approaches such as fines, conditional licences, licence suspensions or licence revocation.[191] The *National Law* utilises all of these sanctions proportionately to the seriousness of the contravention.[192] Instances where patient safety has been severely compromised or where a breach has been deliberate may require the use of punitive measures.[193] Penalties of this nature would serve to punish a non-compliant centre whilst sending a message of deterrence to the industry that the licensing body will not tolerate severe or repeated breaches.[194] Punitive measures would have a deterrent effect necessary to ensure optimal compliance. For deterrence strategies to work effectively there must be a real possibility private rehabilitation centres will be detected as non-compliant and there must be consequences for being caught.[195] Resistance to the introduction of statutory regulation of the industry may be overcome by the use of persuasion to achieve compliance as

[187] Ayres and Braithwaite, above n 48, 39; Healy and Braithwaite, above n 60.
[188] Healy and Braithwaite, above n 60, 58.
[189] Braithwaite, 'Regulating Nursing Homes: The Challenge of Regulating Care for Older People in Australia' above n 174; Comino, above n 176, 117.
[190] Comino, above n 176, 115.
[191] Ayres and Braithwaite, above n 48, 38.
[192] See, eg, *Health Practitioner Regulation National Law Act 2009* ss 178, 196.
[193] Rhett Martin, 'Victorian Ecologically Sustainable Forest Management: Pt III – Regulatory Theory and Modality' (2017) 34 *Environmental and Planning Law Journal* 209, 219.
[194] Kotzman, above n 180.
[195] Ibid.

this may reduce the 'compliance burden' on private rehabilitation centres.[196]

Compliance strategies would cause a considerable burden for private rehabilitation centres, the licensing body and the government. In order to ensure licensing and standards compliance, ongoing evaluation and assessment of a centre's clinical performance would be warranted. This would be an onerous but necessary task to ensure the licensing system continues to operate effectively.

D *Accreditation and Revalidation*

The regulatory approach of a licensing system for private rehabilitation centres will require accreditation. The licensing body would be responsible for the development and enforcement of minimum standards of practice.[197] It would also provide a system for patient complaints against a centre. Accreditation will be required to assess the practices of a private rehabilitation centre against the minimum standards of practice adopted by the licensing body. Accreditation would promote reliability of the quality of services offered by holding providers accountable to minimum standards of practice.[198]A compliance program would require self-assessment and review by the private rehabilitation centre and an external accreditation process. Performance assessment against competency standards via external accreditation would provide the patient with the level of confidence and trust that should be expected from a provider delivering services relating to drug and alcohol rehabilitation. [199] The development of the *Guidelines for the Treatment of Drug and Other Alcohol Dependent People in a Residential Setting* by NADA were designed to form part of a formal accreditation process for private rehabilitation centres to be

[196] Nehme, above n 157, 178.
[197] Ibid.
[198] Archibald and Rankin, above n 83.
[199] Bruce H Barraclough and Jim Birch, 'Health Care Safety and Quality: Where We Have Been and Where Are We Going' (2006) 184(10) *Medical Journal of Australia* 48, 48; Healy and Braithwaite, above n 60, 58.

undertaken by the Quality Improvement Council of Australia.[200] To date, this formal accreditation process has not been undertaken.[201]

Accreditation would require centres to be assessed against the standards and guidelines for practice to ensure a minimum level of care is achieved.[202] The licensing model with accreditation would promote ongoing consistency, reliability and quality of services provided by private rehabilitation centres.[203] Accreditation will be necessary to 'monitor, assess and review' adherence to standards by a private rehabilitation centre.[204] Compliance with a minimum set of standards provides quality assurance for the industry.[205] Further, accreditation equips a consumer with the information to determine the quality of services provided by a private rehabilitation centre.[206]

Accreditation conducted externally to the private rehabilitation centres is vital. External accreditation is preferred over self-assessment as it provides an objective assessment of skills and performance of the private rehabilitation centre.[207]An industry body such as NADA or ATCA would be suitably placed to conduct the accreditation process, as they would possess the necessary skill and industry experience to evaluate the effectiveness of compliance across a diverse range of practices.[208]

Compliance with standards would require monitoring and assessment to achieve transparency and accountability. Transparency and accountability is more likely to be achieved where an independent regulatory body conducts accreditation as the focus is

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200 Pierce, above n 66.

201 Quality Improvement Council, *Alcohol and Other Drug Services* (2017) Quality Innovation and Performance <http://www.qip.com.au/find-the-right-accreditation/for-community-organisations/alcohol-and-other-drug-services/>.

202 Parker, above n 155, 72.

203 Archibald and Rankin, above n 83.

204 Parker, above n 155.

205 Parker, above n 76, 463.

206 Freiberg, *The Tools of Regulation,* above n 52, 152.

207 Ibid.

208 Parker, above n 155, 72.

protecting the interests of the public rather than the interests of the private rehabilitation industry.[209] An independent accrediting body is more likely to be objective when assessing the centre against the required standards. In considering the standards monitoring process in nursing homes, Braithwaite noted that regulation was more effective when conversations could be conducted with residents.[210] This approach would be particularly relevant to private rehabilitation centres where an independent assessment may be undertaken involving outcomes from a patient perspective. An independent assessor may be more readily able to ask patient orientated questions without having to consider the interests of the centre.

Revalidation of accreditation would be important to promoting public interest and preventing risk.[211] Revalidation would require private rehabilitation centres to satisfy requirements for continued suitability to provide AOD rehabilitation services to the public.[212] Under revalidation, private rehabilitation centres would be required to make a commitment to continuous improvement through education and training.[213] To ensure accountability and compliance, the regulatory body should undertake inspections. This approach would prevent complacency by private rehabilitation centres between accreditation periods and secure greater compliance, further promoting public interest goals.[214]

A licensing system should respect the valuable role private rehabilitation centres provide to the community. The regulatory approach needs to manage the patient's expectations with private rehabilitation centre needs. As already outlined, private rehabilitation centres fulfil a crucial community role as they provide diversity in access to AOD treatment for patients. A shortfall of the licensing scheme is that it may restrict access to the market for some private rehabilitation centres. If some private centres cannot compete in the

[209] Wardle, Steel and McIntyre, above n 98, 103.
[210] Braithwaite, above n 174.
[211] Neuman and Ptak, above n 156; Davies, above n 151, 247.
[212] Davies, above n 151.
[213] Braithwaite, above n 174.
[214] Ayres and Braithwaite, above n 48, 19.

market, competition is reduced as private rehabilitation centres may choose to forego a licence or not be granted one.[215] If clinics choose to practice without a licence, the same industry problems will still exist in the new system. If clinics choose to close because the regulatory burden is too great, access to private rehabilitation services will decrease in the community meaning greater accessibility issues for patients. A reduction in the availability of private rehabilitation clinics would also, potentially, increase the cost of the services making those services inaccessible to patients. It will be necessary to effectively manage the costs associated with compliance and enforcement for the regulatory scheme to be effective.[216] If the costs of compliance dissuade private rehabilitation centres from operating, this will have a negative impact on access to services.[217] However, reducing access to treatment would undermine the important role private rehabilitation centres currently play in the community. The regulatory scheme should not be excessive but needs to be balanced against the requirement to prevent harm to the patient and provide social benefits to the community.[218]

V CONCLUSION

This paper has examined the nature of AOD rehabilitation services in Australia. In particular, despite public and private rehabilitation centres both delivering health services to the community, private rehabilitation centres are self-regulated while public rehabilitation centres are subject to governmental regulation under a statutory scheme. The regulatory disparity between public and private rehabilitation centres raises a number of challenges for the community. A patient entering public AOD rehabilitation treatment is afforded superior consumer protection as a result of the stricter regulatory controls in place. However, a person seeking private treatment for a substance-related disorder is exposed to a much

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215 Freiberg, *The Tools of Regulation*, above n 52, 148.

216 Akhter, above n 49, 7.

217 Ibid.

218 Malcolm Voyce, 'Regulating Alternative Health' (1994) 19 *Alternative Law Journal* 132, 134.

higher risk because of the self-regulated environment. Patients are not assured of a minimum standard of care in a private rehabilitation centre as there is currently no requirement to implement or maintain minimum standards of service delivery. There are no controls in place to regulate who may operate a private drug rehabilitation clinic, which means entry into the market is unrestricted. Finally, no accreditation or revalidation systems are in place to ensure that providers entering the market provide minimum standards of care on an ongoing basis.

Private rehabilitation centres serve an important role in the community. Private rehabilitation centres address many of the shortcomings of public centres such as lengthy wait times and provide diversity for patients seeking treatment for substance-related disorders. Private centres deal with the complex needs of those suffering substance-related disorders by offering integrated mental health services with AOD treatment. Because of their important role in the community, regulatory reform is needed to ensure treatment is delivered in a safe and effective manner, promoting positive health outcomes for the consumer and the community.

A licensing model of regulation is proposed as the most appropriate regulatory approach. While there is currently infrastructure already in place, such as the standards provided by NADA and the health complaints process in each state and territory, a licensing scheme should be introduced to control entry into and out of the market. The licensing model would provide superior consumer protection to that currently in place. For the regulatory scheme to be successful it will be necessary to ensure the practice standards are designed to achieve harm prevention and promote accountability of the private rehabilitation industry. Implementation and compliance of the proposed scheme may impose a significant burden upon individual private rehabilitation centres, however, this is necessary because of the risk of consumers being exposed to poor or exploitive practices. Co-operation between the licensing body, professional industry bodies and individual rehabilitation centres will encourage success.

A failure to address the current inadequate level of regulation in the private rehabilitation industry is at odds with the current harm minimisation policy adopted by the government. The issue of substance misuse should be viewed as a social issue with broad reaching effect if not adequately managed. Regulation of the private rehabilitation industry is necessary to manage risk as well as managing the social effect of failing to adequately address substance-related disorders.