Sub # 1

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The Health and Disabilities Committee, Queensland Parliament.

Inquiry into severe substance dependence and involuntary detoxification and rehabilitation.

Submission by:

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I note that in undertaking this inquiry, the committee has been directed to:

- Examine initiatives in other Australian and international jurisdictions
- Examine the impact on persons suffering from severe substance dependence and their families, health providers, government and non-government services and the community more generally
- Examine the potential benefits and costs of implementing a model for the involuntary medicated detoxification and rehabilitation of persons with severe substance dependence.

(1) Aims and objectives:

The aims and objectives for 'involuntary medicated detoxification and rehabilitation of persons with severe substance dependence' in Queensland have not been identified. What problems are intended to be solved or ameliorated by involuntary detoxification and rehabilitation?

It is disappointing that consideration is being given to introducing involuntary detoxification and rehabilitation in Queensland without clear identification of the aims and objectives of this proposed intervention.

(2) Basing policies and programmes on evidence:

The Information Paper prepared for this inquiry notes that 'There is limited research evidence about the effectiveness of involuntary treatment for substance dependence' and also that 'A systematic review of the literature in 2008 identified only four studies that met National Health and Medical Research Council guidance for high quality evidence'. It goes on to cite conclusions that 'there was little evidence about the effectiveness of compulsory residential treatment' and 'there is evidence, mainly anecdotal, that civil commitment for short periods can be an effective harm minimisation mechanism'. Great strides have been made in medicine in recent decades. An important advance has been a commitment to evidence-based policy and practices. Medicine is increasingly resisting the introduction of interventions unless there is good evidence for effectiveness and safety. By 'safety' is meant not only a lack of severe side effects, but also a lack of important unintended negative effects. Increasingly, evidence of cost effectiveness is demanded for new pharmaceuticals and other new interventions.

It is disappointing that consideration is being given to introducing involuntary detoxification and rehabilitation in Queensland in an era of evidence-based medicine when there is almost no evidence of the effectiveness, safety and cost-effectiveness of the proposed intervention.

(3) Alcohol and Drug Treatment in context:

Alcohol- and drug-related problems are extremely common in Australia. It is hard to find a family in Australia that has not been severely affected by severe alcohol and drug problems in one or more family members. Yet throughout Australia commitment by commonwealth, state or territory governments to prevention and treatment of alcohol and drug problems is lacking. Despite a strong case for reforming alcohol taxes on both health and economic grounds, there is no commonwealth

government desire to consider this. Despite strong evidence that reducing the density of alcohol outlets and restricting their conditions will reduce the extent of alcohol related problems in Australia, state and territory governments show little desire to consider this. Although voluntary treatment of alcohol dependence has been shown to be effective and cost-effective, it is often very difficult for persons seeking such treatment in Australia to obtain it. It took many decades for Australian governments to begin introducing effective measures to reduce tobacco-related health and economic costs. Commonwealth, state and territory governments still allocate 75% of their expenditure in response to illicit drugs on law enforcement efforts to restrict supply despite limited evidence of effectiveness and impressive evidence of severe unintended negative consequences. In contrast, measures to reduce demand and harm from drugs is well supported by evidence but receives limited funding. For example, methadone treatment is in short supply in Queensland and even more limited for persons detained in correctional centres.

It is disappointing that involuntary detoxification and rehabilitation is being considered for introduction in Queensland when voluntary detoxification and rehabilitation is in short supply in the community and even scarcer for inmates of correctional centres.

(4) Persons with high risk alcohol and drug consumption presenting to the health care system

Few patients presenting to the healthcare system in Australian today with mild, moderate or severe problems resulting from alcohol and drugs are offered detoxification or rehabilitation. Few are offered any assistance for their alcohol or drug problem although the physical, surgical or psychiatric consequences of their high risk alcohol or drug use generally receive excellent care.

It is disappointing that involuntary detoxification and rehabilitation is being considered for introduction in Queensland when the treatment provided today to patients with high risk alcohol and drug consumption presenting to the health care system generally receive assistance which would be considered grossly inadequate for patients with other kinds of health problems.

(5) Persons unable to manage self care in the community presenting to the health care system

A small number of patients unable to manage self-care in the community present to hospitals requiring prolonged admission. The vast majority of these patients have severe cognitive impairment resulting from excessive alcohol consumption. These patients are often too well for hospital but are too difficult to place in the community. The main reason for the difficulty in placing these patients is the lack of supported accommodation in the community. These lengthy and inappropriate hospital admissions are disliked intensely by staff and the patients themselves, are expensive and a waste of scarce health resources. The overwhelming majority of the admissions to the Nepean Hospital in Sydney during the recent two year trial of involuntary detoxification and treatment in NSW involved such patients. Note that very few admissions to the Nepean Hospital during this recent trial involved patients who had been taking illicit drugs.

It is disappointing that involuntary detoxification and rehabilitation is being considered for introduction in Queensland when there is a much greater need for increasing supported accommodation beds in the community.

(6) Perverse incentives

When the voluntary system for alcohol and drug treatment in both public and private is grossly inadequate, there is a very high risk of creating perverse incentives by introducing an involuntary system. That is people who seek help but are unable to do obtain it on a voluntary basis, may then deliberately make their condition worse in order to obtain involuntary treatment. Note that this risk remains high as long as the voluntary treatment sector remains inadequate. The voluntary treatment sector is likely to remain inadequate as long as it is accepted that 'there are no votes in alcohol and drug treatment.'

There is a very high risk of creating perverse incentives by introducing involuntary detoxification and rehabilitation in Queensland.

(7) Compulsory treatment and ability to manage in the community

It is fair to say that varying degrees of coercion exist in the health care system today. Examples include family members threatening the patient with dire consequences if they do not accept the need for treatment or the legal system offering treatment as the only alternative to incarceration. Also, patients with severe cognitive impairment who are considered unable to manage in the community are detained by the health care system today. In New South Wales, health practitioners can apply to an independent official body (the Guardianship Tribunal) under these circumstances. The Guardianship Tribunal may accept responsibility for the patient including management of their finances. It is impossible to prevent informal degrees of coercion by family members and others. Coerced treatment may be preferable to incarceration for the individual, their family and the community.

Few would criticise the detention of an individual with severe cognitive impairment who is unable to safely manage in the community. But the discussion of involuntary detoxification and rehabilitation in Queensland (or New South Wales) does not require as a minimum that the detained patient has severe cognitive impairment and is unable to safely manage in the community. Would involuntary detoxification and rehabilitation in Queensland be imposed on cognitively intact persons perfectly capable of managing in the community simply because they are considered to be drinking alcohol, smoking tobacco, taking prescription drugs or consuming illicit drugs at high-risk? Would Sir Winston Churchill, who is said to have drunk a bottle of spirits a day for most of his adult life, have been detained if he had visited Queensland? The late Christopher Hitchens is said to have drunk copious quantities of spirits and smoked heavily. He died of cancer of the oesophagus at the age of 62. There is little doubt that Hitchen's premature death was caused by his high risk drinking and smoking. Would Christopher Hitchens have been detained for involuntary detoxification and rehabilitation if he had visited Queensland? Is this intervention only to be considered for persons consuming illicit drugs? How is any doctor going to determine that an individual is at high risk of severe adverse consequences? This may seem perfectly obvious to a lay-person but is a difficult if not impossible task for even specialist doctors. The Discussion Paper notes the importance of respecting patients' autonomy. Where is the over-riding benefit which can justify ignoring patients' autonomy.

The introduction of involuntary detoxification and rehabilitation in Queensland should only be considered for persons with severe cognitive impairment who are unable to safely manage in the community.

What practical approaches to involuntary detoxification and rehabilitation are considered most effective?

 # Involuntary detoxification and rehabilitation could be practical if the patient has severe cognitive impairment and is unable to safely manage their own life in the community.

Models for involuntary detoxification and rehabilitation

 # Involuntary detoxification and rehabilitation is implemented widely in several countries in Asia including China, Malaysia and Vietnam. Involuntary treatment centres in Malaysia and Vietnam are now being closed as voluntary treatment (especially methadone treatment) is being expanded.

What criteria should apply to involuntary treatment?

The criteria should be: (i) evidence of effectiveness; and (ii) a lack of serious side effects. Evidence of cost –effectiveness is also important. The risk of perverse incentives and loss of patient autonomy are also important considerations.

The Queensland Health model proposes the same criteria for involuntary treatment as in the New South Wales Drug and Alcohol Treatment Act 2007 (the NSW Act). The NSW Act is the statutory basis for a trial project of involuntary treatment that commenced in parts of NSW in 2009. The criteria are:

the person has a severe substance dependence

 # This only makes sense if applied to legal and illegal drugs as in Australia legal drugs account for >95% of drug related mortality and > 85% of the economic costs of psychoactive drugs.

care, treatment or control is necessary to protect the person from serious harm

 # Though it is not difficult to predict for groups, it is very difficult to predict which individuals consuming psychoactive drugs at high risk will develop severe health , social or economic problems.

the person is likely to benefit from treatment of substance dependence but has refused treatment

 # Predictions regarding which individuals are likely to benefit from treatment are unreliable.

there is no appropriate and less restrictive means reasonably available.

 # As it is usually assumed that there are few votes in providing alcohol and drug treatment, there may be no appropriate and less restrictive means reasonably available. But this is a choice made by governments.

The purpose of involuntary detoxification and rehabilitation varies between models. The Queensland Health proposal is to provide short term care, comprehensive assessment, medicated withdrawal, support to restore decision making capacity, and support to find suitable accommodation and services after detoxification and withdrawal.

 # The objectives of treatment should be to reduce deaths, disease, social or economic costs of a condition. Providing 'short term care, comprehensive assessment, medicated withdrawal, support to restore decision making capacity, and support to find suitable accommodation and services after

detoxification and withdrawal' may be worthy means to achieve objectives but they are not objectives in themselves.

The focus of the recently commenced Victorian scheme appears to be harm minimisation. There is some anecdotal evidence that involuntary detoxification and rehabilitation may be effective to prevent death and minimise harm, while the evidence of longer term effectiveness is unclear.

 # Again this does not make it clear what the specific objectives are. It is disappointing that anecdotal evidence appears to be given some weight. Policy and practise should be based on more rigorous evidence than anecdote. Why are anecdotes even considered as evidence? If involuntary detoxification and rehabilitation *are considered to reduce the risk of death, why is this not considered evidence of long-term benefit?*

What purpose should a model of involuntary detoxification and rehabilitation have? For example, should the main objective be to protect people with severe substance dependence from harm to themselves, or harm to others?

 # The benefits of health treatment for an individual should generally be the only consideration. Any benefits to others should be considered a bonus. There may be exceptions to this but great care should be exercised when attempting to benefit the community from healthcare given to an individual.

Should the objectives include restoring decision making capacity and encouraging people to voluntarily participate in rehabilitation?

 # Restoring decision making capacity can only be an objective if the loss of decision making capacity was a requirement for initial entry into involuntary detoxification and treatment. Loss of decision making capacity has not been stipulated before as an entry criterion.

Are there other objectives that should be considered in developing a model for involuntary detoxification and rehabilitation?

 # The objectives should be a reduction in deaths, a reduction in the extent of complications from psychoactive drugs, an improvement in social functioning, an ability to manage safely in the community, indefinite abstinence from psychoactive drugs, progress towards abstinence from psychoactive drugs and a reduction in financial costs.

The Queensland Health proposal is for involuntary detoxification and rehabilitation of up to 28 days. Victoria has a limit of 14 days for detention, with no extension. Under the NSW Act, involuntary treatment may be for 28 days, and this may be extended to three months. Under the NSW Inebriates Act 1912 (which is in effect in locations other than a trial of a new model of involuntary treatment), a person can be ordered to a facility for up to 12 months.

 # Little can be achieved clinically in just 14 days in patients with severe alcohol dependence and severe cognitive impairment. The degree and frequency of independent oversight is more important than the specified maximum duration of detention.

What is the appropriate maximum period for involuntary detoxification and rehabilitation? Should an extension of involuntary treatment be possible, and if so, in what circumstances?

 # Involuntary detention should mainly be reserved for patients with severe alcohol dependence, severe cognitive impairment and an inability to manage in the community. In many such patients, considerable functional improvement (and even considerable structural improvement on CT scans) takes place slowly over 1-2 years. Some patients will relapse back to drinking no matter how long they are detained. But some do remain abstinent.

Who should make a decision that a person is detained for involuntary detoxification and rehabilitation? For example, should the decision be made by a medical practitioner and confirmed by a magistrate, or should the initial decision be made by a magistrate?

 # The decision to detain a patient can only be made initially by a medical practitioner but should soon be reviewed by a magistrate. A magistrate would find it very difficult to make decisions about what are essentially clinical questions.

What treatments should be provided for involuntary detoxification and rehabilitation?

 # There are different views about the meaning of the term 'detoxification'. Some consider that detoxification means 'the process of removing toxic substances or qualities', more specifically, the safe and comfortable withdrawal from psychotropic substances. Others consider that detoxification means 'medical treatment of an alcoholic or drug addict involving abstention from drink or drugs'. Medicated forms of detoxification generally provide a safe and comfortable withdrawal from depressant drugs (e.g. alcohol, heroin, benzodiazepines) but are less successful for stimulant drugs (e.g. cocaine, amphetamine). There are many different forms of treatment for different kinds of alcohol and drug dependence.

What would be required to implement a best practice approach to involuntary detoxification, assessment, and support to restore decision making capacity?

 # Abstinence from mood altering drugs is critical to allow recovery from any cognitive impairment. In the case of alcohol-related impairment, large quantities of thiamine should be given because of the possibility that a specific form of alcohol-related brain damage (Wernicke-Korsakoff syndrome) may be contributing to the cognitive impairment. There is no other treatment which can speed up recovery from alcohol related cognitive impairment. Sever cognitive impairment does not occur directly from illicit drugs but can occur indirectly (e.g. anoxic brain damage from drug overdose).

How could a model for involuntary detoxification and rehabilitation best support people to enter voluntary rehabilitation after discharge from involuntary treatment?

 # Entry to voluntary treatment is more likely if attractive treatments are provided by humane and caring staff and is less likely after a period of involuntary treatment. Financial incentives are likely to increase the number of people entering voluntary treatment but may not be feasible politically.

What are the costs and benefits of implementing a model for involuntary medicated detoxification and rehabilitation?

 # The discussion rightly emphasises the high costs of mood altering drugs to the community. However the discussion fails to point out that it is the legal drugs, alcohol and tobacco, which account for most of these health and financial costs. The discussion also fails to note that effective prevention and treatment measures are known for psychoactive drugs but these are usually poorly funded. Most government expenditure in response to illicit drugs is allocated to supply control

measures (customs, police, courts and prisons) which are relatively ineffective, often counter-productive and generally expensive. Funding involuntary medicated detoxification and rehabilitation, for which there is almost no evidence of effectiveness or cost effectiveness, is consistent with the tendency to choose high cost-low impact interventions for mood altering drugs.

Notes about the author:

Dr Alex Wodak is a physician and has been Director of the Alcohol and Drug Service at St. Vincent's Hospital, Sydney, since 1982. Working with colleagues, Dr Wodak helped to establish the National Drug and Alcohol Research Centre (1987), the NSW Users AIDS Association (NUAA) (1989), the Australian Society of HIV Medicine (ASHM) (1989) and, when both required civil disobedience, Australia's first needle syringe programme (1986) and the first medically supervised injecting centre (1999). Dr. Wodak is President of the Australian Drug Law Reform Foundation and was President of the International Harm Reduction Association (1996-2004). He often works in developing countries on HIV control among injecting drug users. Dr Wodak has published over 270 scientific papers. He has been a Short Term Consultant to the World Health Organisation, UNAIDS, UNODC and the World Bank. Dr Wodak was awarded an AM in 2010.