

Sub # 4



11.1.5.3

Health and Disabilities Committee,
Parliament of Queensland.

Submission to the inquiry into severe substance dependence: a model for involuntary treatment and rehabilitation.

Queensland Health's proposal to use involuntary treatment orders for detoxification and rehabilitation of people enduring severe substance disorder raises many questions about how mental health, drug and alcohol policy should be constructed. QCOSS, The Queensland Alliance, coalface workers in the multi-disciplined workforce, their peer groups and consumers might well have questions about:

1. Capacity for voluntary care.
2. Choices prioritised, resourced and funded across sub-acute, acute and rehabilitative stages.
3. The impacts for human and community costs through disconnection with family, work and community.
4. The absence of comparative data from similar common law jurisdictions such as Canada, New Zealand and the United Kingdom.
5. The absence of evidence on the effectiveness of treatments.
6. Absence of clarity around the delivery of front-line services, priorities, resources and funding arising from cultural and structural change in Queensland Health due 1/7/2012.
7. The failure to understand that legislative based systems, cultures and structures should be anchored by principles, values, purposes and other explicit parameters of operation. An evidence-based system requires multiple knowledge and skill sources drawn from areas such as research, theory, practice wisdom, consumer leadership and participation.
8. The effectiveness and appropriateness of treating persons subject of this proposal in a mental health or other secure facility may not be enhanced due to concerns about personal, cultural, familial or other matters. We need to consider where, when, how and why a person in need may consent, commit and rehabilitate through being motivated and accepting responsibility.

A major concern here is the inconsistency of the treatment (eligibility) criteria with those of the Mental Health Act 2000 which distinguishes between "appearance for assessment" and "diagnosis for involuntary treatment". In the latter a major requirement is that the standard of care meet and satisfy the health principle of least restrictive care. In addition both domestic law and Treaty law for people with disabilities requires access to assistance, advocacy and legal representation and by implication that consent needs to be renegotiated at each intervention. Any attempt to limit the Allied Person role denies a person their human rights and is inconsistent with Treaty obligations and domestic disability law.

Garnishing professional and community support for this proposal at a minimum should require a consistent whole of government approach from a rehabilitative focus with limited periods of involuntary detention, assessment and treatment.

Priorities around population health issues, community of interest and especially socially excluded communities will need to be retained and realigned as primary, secondary and tertiary services adopt new systems and structures as a consequence of regional decision-making under the National Health Reform Agenda. Confidence and capacity in both service delivery and service improvement requires a full partnership where consumer and community-based inputs continue to be fully respected, co-operative and apply mature relationships.

One medium should be representative regional consultative committees established or re-established on the basis of shared responsibilities and leadership capacity. These Committees should be anchored by approaches that are integrated, principled, valued and inclusive. Essential is the balancing and harmonising of competing values; human rights, ethics, efficiency, effectiveness, empowerment and equity. Inter-related mental, psychological, emotional and physical aspects of health care normally should promote key lifespan issues of quality of life, self-determination, opportunity and choice. Substance dependence should be a question of rehabilitation and recovery.

In this proposal by Queensland Health we are offered a biological or symptom abatement response without consideration of psycho-social factors. This approach appears inconsistent with both the principles of the Mental Health Act (2000) and Disability Act (2006) which provide a statutory basis for working with people in a holistic manner. Best practice and sound legislative standards on consistency and clarity require a plain English statement of both review and appeal processes and jurisdictions together with respect for Rule of Law principles within our Common Law rights. One should therefore see in the legislation explicit provisions for legal or other appropriate representation and advocacy. I have in mind here either their Allied Person or the person working with them on their care plan.

Arguably, other fundamental issues such as demonstrating respect and dignity for their journey towards positive health include the silent issues of:

1. Re-negotiating the shifting nexus of capacity and consent at varying addiction and intervention levels.
2. The social consequences of functional impairment and participation restriction (psycho-social disability).
3. Impacts on spousal, family, community, work and other key relationships.
4. Disconnection and/or reconnection of their capacity to enhance self-esteem, motivation and acceptance of responsibility should not be overlooked or ignored.
5. Significant at any level of care should be the individual and partnership arrangements accessible from the above or other identified key relationships. Involuntary Treatment Orders and their accompanying processes and procedures may not assist the capacity, ability or willingness of the helping function.

If involuntary treatment is to be considered necessary and appropriate this should be evidence-based and inclusive of expected and achieved outcomes and treatment history. All relevant factors including medication, therapy, care planning and contributing and/or underlying factors should be balanced and harmonised to ensure no person is restricted longer than is necessary and appropriate when balancing individual and community well-being.

The first hurdle is that no agreed definition of severe substance dependence exists. Accordingly the symptoms abatement approach seeks guidance from the World Health Organization definition and a range of indicators in the DSM. This approach is a population health bio perspective and fails to address the triple bottom line of bio-psycho-social recovery-based systems where the journey not the outcome is king.

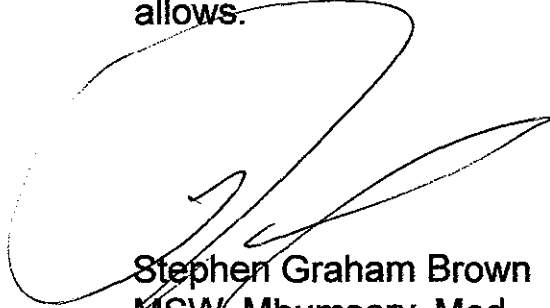
Consequently, the Queensland Health proposed model and choice is one anchored on the New South Wales Drug and Alcohol Treatment Act which is a statutory basis for a trial project. A key component therein is that: "There is no appropriate and less restrictive means reasonably available". How then do we apply this to a dual diagnosis mental health client who is already entitled to the "Least restrictive Care" principle?

A clear and reasonable alternative is the Victorian model which with its inherent Charter of Human Rights offers better outcomes of personal autonomy through empowerment of individuals, family, community and others. Common law rights emphasise explicitly the place and nature of care and a basis of being voluntary and enjoying choice and self-determination across the varied stages of prevention, sub-acute, acute and post-care when responding to particular and specific factors of the addiction phase. Guardianship rights, through access to information, advocacy and legal representation, empower fair and equitable outcomes. In this model the initial gatekeeper is a magistrate rather than a clinician chosen by the health authority. A more impartial assessment of the need, appropriateness, brevity and other factors of the treatment order can be considered. It is presented that this produces cost effectiveness and savings in both the mental health and judicial systems.

I prefer risk harmonisation rather than a blunt risk management strategy as seen in the treatment of mental illness. Funding of continuity of care with a community interface involving participation and partnership between the person, workplace, family, community, medical practitioner should be inclusive of brokered access to service providers (government or non-government) by choice.

Summary.

I support the use of involuntary treatment orders that are purposeful, meaningful and relevant. These orders must be anchored by necessary, sufficient and relevant Legislated protections, be last resort, least restrictive, evidence-based and accompanied by a comprehensive negotiated and consented care plan developed and revised as the shifting nexus of consent allows.



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