Sisters Inside

Submission on the "Inquiry into severe dependence: a model of involuntary detoxification and rehabilitation."

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Inappropriate use of involuntary detention in the treatment of severe substance dependence.

Involuntary detention is not an effective method of treating individuals with a substance dependence disorder. This model of treatment is counter to the established best practice methods of treating substance use and risks creating a revolving door of patients who are referred by case workers as a risk management strategy. Sisters Inside strongly advocate against the adoption of this model for the following reasons:

No person should be detained against their will

It is a fundamental right of every human being to remain free from arbitrary detention and deprivation of their liberty.[1] We believe that detention and incarceration is an irrational social response to crime and fails to achieve the intended outcome of deterrence or correction. In our society, incarceration and detention is used to punish individuals who are already marginalised. Therefore, we adamantly object to the proposal that detention may be an appropriate response to substance dependence and addiction. Detention of individuals who suffer from a substance dependence disorder is a reactive strategy that undermines their fundamental human rights, without any guarantee of reducing their long term substance use issues.

Lack of empirical evidence

As highlighted in the Information Paper for the current submission, the use of involuntary detention as an effective treatment for individuals with substance dependence is not well supported by empirical evidence.[2] In their review of the literature, the New Zealand Health Services Assessment Collaboration could only find empirical research based on offender populations and at best could only suggest that "there is minimal evidence reporting on the effectiveness of compulsory residential treatment of non-offenders alone."[3] This is far from sufficient evidence to justify a statutory intervention and the deprivation of the liberty of an individual based on an unproven model. Any treatment for substance dependence should be based on best practice and therefore this unproven model should not be accepted or adopted within Queensland.

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[1] United Nations Declaration of Human Rights Article 9

[2] M Broadstock, F Brinson, A Weston (2008) *The effectivenesss of compulsory, residential treatment of chronic alcohol or drug addiction in non-offenders: a systemic review of the literature.* Health Services Assessment Collaboration, university of Cantebury, New Zealand.

[3] Ibid pg iv

Complexity of the treatment of substance abuse

In light of the lack of empirical evidence, the Parliamentary Committee encourages the submissions to comment on "what models of service provision are seen to be most effective." However the specified 'issue for comment' is framed only to invite 'practical approaches to involuntary detoxification and rehabilitation' that are seen as most effective. This disregard for empirical evidence and invitation for anecdotal case studies in support of involuntary detention fails to account for the underlying reason for the lack of empirical support. *Involuntary detention of individuals with substance dependence in the non-offending population is not widely researched because it is counter to the theoretical underpinnings of treatment.* Therefore there is little theoretical or empirical support to justify such an oppressive treatment strategy and would be unethical to trial. Research in the field highlights that substance dependence is a complex disorder to treat and the enforced detoxification of an individual "does not address the underlying disorder, and thus is not adequate treatment."[4]

Further to this, the current theoretical basis for best practise treatment centres around cognitive and behaviouralmodels of change. These models have consistently informed both individual treatment and broader policy on public health, therefore should not be ignored in this instance. These models of change recognise that intrinsic motivation is central to an individual successfully changing an addictive behaviour.[5]Coercion of an individual into detoxification and rehabilitation is not consistent with the stages of change. Coercion may in fact be counter- productive when an individual is in the pre-contemplation stage whereby adverse information about their behaviour may delay their desire to change.The current best practice treatment models work with the models of change through strategies such as motivational interviewing, which will be undermined with involuntary detention. There is a very real risk that coercion will be counterproductive for an individual resistant to change and due to this such a trial is highly unethical.[6]

In addition to the counter-productivity of using coercion when treating an individual for substance dependence, the model suggested also reflects a presumption that substance dependence and addiction can be primarily treated with a medical model. However successful treatment of substance dependence extends well beyond detoxification and requires a comprehensive response that addresses the underlying influences of the "genetic, biological, behavioural and environmental factors."[7] This would require the integration of services that are available as the patient transitions from detoxification and extend well beyond their detention to provide ongoing support. Such a service system would require collaboration between both government and non-government services and need to not only provide services around substance use but also a range of additional services which are outlined in this submission on pages 7-8. While the Queensland Health model includes a plan for such transition of patients, such a comprehensive service delivery system is not currently

[4] C P O'Brien & A T McLellan (1996) "Myths about the Treatment of Addiction" 347 The Lancet 237
[5] G De Leon (1996) "Integrative Recovery: A StageParadigm" 17 Substance Abuse 13
[6] G Corey (1996) Theory and practice of counselling and psychotherapy (5th Edition) Pacific Grove, CA: Brooks-Cole.
[7] Note 4 pg 347

available in Queensland and until such time as it is available then it cannot be expected that involuntary detoxification and rehabilitation will successfully reduce substance dependence for individuals on a long term basis. Sisters Inside advocates that Government resources would be better invested in establishing a holistic wrap-around model of service delivery for individuals who voluntarily seek help.

Potential costs associated an ineffective system

Currently in Queensland there is limited facilities for detoxification and withdrawal for voluntary patients. Individuals wishing to enter these facilities face wait lists which are months long. Following this, there is limited support and follow up available for out-patients. The lack of services is exacerbated in regional, rural and remote areas. As highlighted above, involuntary detoxification and rehabilitation will not successfully impact on an individual's substance dependence unless it is followed up by adequate treatment and access to a range of services. The introduction for an involuntary model of detoxification and rehabilitation will have quantifiable costs for the health system in assessment, referral and treatment as well as the legal system in hearings and appeals. Without empirical evidence to support the effectiveness of the model, it is cannot be expected that the model will in fact be successful in reducing substance dependence amongst the target group. At best it will provide a temporary solution to the concerns of case workers and family members about the risk taking of substance dependent individuals. At the conclusion of the solution, the proposed model will return individuals to all the risk factors which created the substance dependence. There is also the risk that positive relationships between the individual and their support network who referred them will have been undermined by the coercive nature of the forced detoxification.

The likelihood of relapse is high in this population if the risk factors for substance use are not addressed following detoxification. This will create a revolving door of individuals within the system at a high cost to the community with no foreseeable benefit based on current knowledge. Sisters Inside believe that the resources required to establish and implement such a system would be better invested in improving the current AOD service delivery options to voluntary patients who are on extensive wait lists for detoxification, rehabilitation and out-patient services already.

Interpretation of "decision making capacity" is too discretionary

The information paper highlights that one of the purpose of the Queensland Health model is to restore decision making capacity of an individual. It is not clear whether the assessment of a person's decision making capacity will be based on a legal or medical test. The current accepted legal test in Australia is based on whether an individual understands both the short and long term physical, emotional and spiritual consequences of their decision.[8] For this test to be satisfied, an individual must be able to communicate their understanding of both their decision to use substances and their decision to refuse treatment. The fact that they also have a physiological addiction to a substance which may influence their decision does not necessarily equate to a loss of decision making capacity under the legal test. Therefore, an individual may continue to use substances and refuse treatment with a full understanding that their continued use may lead to physical injury, impact on their relationships and interfere with day to day functioning. This does not reflect a lack of decision making capacity, although it may reflect the physiological addiction. Therefore there is a

[8] "Marion's Case" Secretary, Department of Health and Community Services (NT) v JWB and SMB (1992) ALJR 300

temptation and risk that a person's decision making capacity will not be interpreted with the legal test of the 'capacity to make a decision,' rather it may be interpretedas whether the individual is willing to make 'the right decision.' Clearly the 'right decision' in this circumstance would require an individual to accept treatment and reduce or cease their use of substances. Therefore this could become a mechanism to coerce individuals into detoxification and rehabilitation against their will, rather than to truly restore their decision making capacity. Sisters Inside strongly advocate against such an incursion on the free will of an individual and maintain that coercion and detention are not appropriate strategies for addressing addiction and substance use.

Targeting of Aboriginal and Torres Strait Islander and other marginalised groups

Aboriginal and Torres Strait Islanders, as well as individuals who are homeless or have low socio-economic status have a higher rate of substance use.[9] Therefore it is likely that this model will increase the rate of detention for these groups that are already over represented in other forms of detention.[10] This is particularly significant for Aboriginal and Torres Strait Islander population where research consistently highlights the detrimental effects of removal and detention of these population.[11] There is also arisk that the model will be used to facilitate or justify the removal of Aboriginal and Torres Strait Islander homeless individuals from public spaces, as has been seen with the move-on powers.[12]

[9] Australian Human Rights Commission (2008) A statistical overview of Aboriginal and Torres Strait Islande peoples in Australia. Aboriginal and Torres Strait Islander Social Justice
[10]L Behrendt (2011) Deaths in custody still haunt indigenous communities. National Times
[11]House of Representative, Standing Committee on Aboriginal and Torres Strait Islander Affairs (2011) Doing time - Time for doing: Indigenous youth in the criminal justice system. Australia.
[12] CMC (2010) Police move-on powers: A CMC review of their use. Crime and Misconduct Commission: Queensland

Involuntary detention model suggestions

In the event that the involuntary detention model is adopted as a reaction to severe substance dependence, Sisters Inside believe that the model must include strict safeguards to the rights of the individuals who are subject to a referral. These safeguards should include:

Clinical and legal threshold met before involuntary detention

Sisters Inside advocates the need to ensure a high threshold is met before a person is detained involuntarily and forced to undergo medical treatment for the substance dependence. This threshold should comprise of both a clinical and legal criteria to ensure that a person's liberty is revoked only when absolutely necessary to prevent serious injury or loss of life.

The NSW criteria is not appropriate for the Queensland model as it is based on refusal to accept treatment, rather than the capacity to make a decision. As discussed above, if an individual has the legal capacity to make a decision then their refusal to accept treatment should not be interpreted as lack of decision making capacity. As the involuntary order is based on both clinical and legal tests, it should be a two stage process which requires the assessment to be made by both a medical practitioner and Magistrate in their respective fields of expertise. The following criteria is advocated:

Stage One – Medical Assessment

An accredited Medical Practitioner makes an assessment to ascertain:

1. The individual meets the DSM-IV criteria for substance dependence; and
2. The substance dependence appears to be severe as it threatens to cause physical injury or death to themselves if treatment is not administered; and
3. Treatment can only be administered as an in-patient.

If the above criteria is satisfied then a Severe Dependency Certificate is issued.

Stage Two – Legal Assessment

A specialist court or Magistrate determines that

1. A Severe Dependency Certificate has been issued; and
2. The individual's substance dependence has resulted in the inability to understand the long and short term physical, emotional and spiritual consequences of their substance use; and
3. There is evidence that involuntary detoxification and rehabilitation will restore their decision making capacity; and
4. There is no less restrictive means of treatment or response available; and

5. A Certificate of Available Services has been obtained from the treatment centre proposed for the person's involuntary treatment.

Right of legal representation and appeal

While the Queensland Health model does not mention access to legal representation in their proposal, Sisters Inside believe that it is imperative that anyone who is potentially subject to an order of detention has the opportunity to appear at their hearing and access legal advice and representation. The individual should have also have the opportunity to have a support person present during their initial assessment by a medical practitioner. These rights must be included in the legislation. In addition to this, there must be the right to appeal the decision. These rights to appeal should encompass both the decision by the medical practitioner and the decision by the Magistrate. In the event that an individual does appeal the decision, they should not be detained until the conclusion of the appeal process.

No detention for assessment.

The Queensland model allows for individuals who do not undergo a voluntary assessment to be detained for up to 3 days to allow for assessment by a medical practitioner. In both New South Wales and Victoria detention for the purpose of assessment is not permitted. Sisters Inside strongly objects to detention of assessment being included in the model and advocate for the adoption of the processes used in either New South Wales or Victoria. In addition to this, once a decision is made by a medical practitioner, the case must be brought before a Magistrate as soon as possible. In the event that the case does not proceed to a Magistrate then the Certificate of Severe Dependence should expire within 7 days, to ensure that individuals are not detained based on an out-dated medical assessment in the future.

Short time frame for maximum period of detention

The period of detention recommended by the Queensland Health model is 28 days, however the Victoria model only allows for 14 days with a 7 day extension on application to Magistrate. As a trial model which is not supported by empirical evidence, Sisters Inside strongly advocate against a 28 day detainment and advocate for the shortest time frame possible. The time frames within the Victorian model are more reasonable for a trial than a 28 day detention. The option of a 7 day extension with application to a Magistrate will give enough flexibility to allow the safe completion of the detoxification process where necessary, while ensuring individuals are detained for the minimum amount of time possible.

Additional services

In addition to these legal safeguards, Sisters Inside advocate for a more responsive system that will ensure individuals subject to an involuntary detention order are given the best opportunity to successfully overcome their substance use. While the model suggests that Queensland Health and the Department of Communities will work with NGOs to transition the individuals and address social risk factors, there is little evidence that the sector is adequately resourced to achieve this. As these social issues are risk factors for substance dependence it is likely that these individuals have already been failed by the lack of existing services. Therefore Sisters Inside highlight the need for the model

to include increased funding and resources for the NGO sector to support the transition of these individuals.

Factors such as low-socio economic status and lack of family or social support have been identified as serious risk factors for relapse.[13] Therefore Sisters Inside would like to highlight the need for increased funding to services that can support individuals in the following areas:

Provision of supported accommodation for individuals at risk of or experiencing homelessness. Lack of access to adequate housing increases the stress of individuals which increases risk of relapse, which is particularly pronounced for individuals with co-morbid mental health issues.[14] Therefore it is imperative that individuals subject to an involuntary detoxification and rehabilitation order are provided with adequate support to maintain appropriate housing in low-risk neighbourhoods.

Provision of education and training to assist individuals to engage in meaningful employment. Both lack of education and lack of a challenging professional career have been identified as risk factors for relapse.[15] Therefore as part of any model to reduce the risk of relapse, individuals who have been ordered to undergo an involuntary detention for the purpose of detoxification and rehabilitation should be provided with both educational and meaningful work opportunities. If this is to occur through the current Department of Education and Training or Job Skills Australia services, then they should be appropriately resourced to provide adequate services to this unique group which takes account of their substance use challenges and provides additional ongoing support to ensure they can maintain educational activities and employment.

Treatment and support of co-morbid mental health issues. Research into relapse prevention highlights that "clients with co-occurring disorders are highly prone to relapse to substance abuse, even after they have attained full remission."[16] Therefore it is essential that these individuals receive adequate treatment for their mental health issues, as well as their substance use. Furthermore, this treatment should be provided by practitioners who are skilled in working with mental health issues that are co-morbid with substance use. This treatment should be delivered in a way that is both collaborative and integrated with other allied health and support services required by the individual.

Provision of free counselling for an individual and their family members to address the underlying causes of substance dependence. Particularly for women, it is claimed that child sexual and physical abuse is one of the largest and most unacknowledged underlying causes for women's substance abuse and triggers for relapse.[17] In these instances substance abuse can be utilised as coping mechanism to deal with the trauma and when this coping mechanism is removed then new coping skills must be developed to avoid relapse. It is also important for individuals and their family to

[13] B e Havassy, D Wasserman, S M Hall (1995) Social relationships and cocaine use in an American treatment sample. 90 Addiction 699

[14] R R Bebout, R E Drake, H Xie et al (1997) Housing status among formerly homeless, dually diagnosed adults in Washington D C. 48 Psychiatric Services 936

[15] D Snow & C Anderson (2000) Exploring the factors influencing relapse and recovery among drug and alcohol addicted women. 28 Journal of Psychosocial Nursing & Mental Health Services 7

[16] R E Drake, M A Wallach, M P McGovern, (2005) Future directions in preventing relapse to substance abuse among clients with severe mental illness. 56(10) Psychiatric Services 1297 at p 1297

[17] E Young (1990) The role of incest issues in relapse. 22 Journal of Psychoactive Drugs 249

understand the nature of their substance use, its connection with their trauma history,[18] as well as acknowledge the current impact on their life.

[18] Ibid