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RACP Submission to the South Australian Department of Health and Ageing's consultation paper titled *Considering a model for mandatory assessment and/or treatment of those at extreme and immediate risk, based on the Victorian Severe Substance Dependency Treatment Act 2010*

February 2018

Introduction

The Royal Australasian College of Physicians (RACP) and its Australasian Faculty of Addiction Medicine (AChAM) wish to thank the South Australian Department of Health and Ageing for the opportunity to provide feedback on its consultation paper titled *Considering a model for mandatory assessment and/or treatment of those at extreme and immediate risk, based on the Victorian Severe Substance Dependency Treatment Act 2010.*

The RACP is the largest specialist medical college in Australasia, and trains, educates and advocates on behalf of over 15,000 physicians and 7,500 trainee physicians across Australia and New Zealand. The RACP represents physicians from a diverse range of disciplines including addiction medicine physicians and public health medicine physicians. RACP members see first-hand the many and varied harms caused by addiction when treating their patients in Australia's addiction clinics, rehabilitation centres, liver clinics, cancer wards, and hospital emergency departments.

This submission

The RACP and the AChAM understand that the South Australian Department of Health and Ageing is looking to implement a trial model for mandatory assessment and/or treatment of those at extreme and immediate risk, based on the Victorian Severe Substance Dependency Treatment Act 2010 as part of the South Australian Ice Action Plan. As outlined in the consultation paper provided for this consultation, the South Australian model would have the same objectives as those of the Victorian Act, namely to:

- provide for the detention and treatment of persons with a severe substance dependence where this is necessary as a matter of urgency to save the person's life or prevent serious damage to the person's health; and
- enhance the capacity of those persons to make decisions about their substance use and personal health, welfare and safety.

The evidence regarding the effectiveness of mandatory drug treatment is limited; a 2016 systemic review found that the current evidence does not suggest improved outcomes in general while some studies showed potential harms.[1] However, the evidence for mandated treatment is problematically presented in the literature due to the various definitions of mandatory treatment being used. For example, treatment is not the same as incarceration and some of the programs studied in the literature do not provide 'treatment' as we would interpret the word to mean. Conflating the evidence of the outcomes of vastly differing processes is problematic. However, whilst more research and evidence is needed, there appears to be emerging evidence of positive outcomes for some specific programs.[2] One of our Fellows, Dr Lee Nixon, FAChAM, has provided information about his experience as a senior addiction medicine specialist at the New South Wales' Involuntary Drug and Alcohol Treatment (IDAT) Unit at Bloomfield in Orange. This includes some emerging findings of positive outcomes from this particular program which Dr Nixon credits to the level of support provided by the unit and the very committed staff working there. Further information about IDAT and Dr Lee Nixon's experience has been included in the Appendix of this submission.

The RACP and the AChAM's view is that involuntary treatment for individuals with severe substance use disorders should only ever be used for a very small number of severely sick and high risk vulnerable individuals as a last resort once all other treatment options have been exhausted. In addition, it should always be led by specialist clinicians who have the clinical training and expertise required to assess the potential risks and benefits of different treatment options for a given individual.

Specific feedback on the proposed model for mandatory assessment and/or treatment as outlined in the South Australian Department of Health and Ageing's consultation paper

The RACP and the AChAM have significant concerns regarding this model being implemented for individuals with a severe substance dependency to methamphetamine in South Australia based the Victorian Act which are outlined below.

The RACP and the AChAM are concerned that **the Act does not allow for sufficient time assigned for treatment** (up to 14 days) and that **its narrow focus on providing medically-assisted withdrawal to enhance an individual's decision-making ability is inadequate** to sustainably improve the health, welfare and safety of these individuals. Both the insufficient time assigned for treatment and the narrow focus of the Act on medically-assisted withdrawal fail to acknowledge the complex needs of individuals suffering from severe drug addiction. Individuals with severe substance use disorders need holistic and comprehensive care which includes multidisciplinary assessment and treatment, care planning, care coordination and transition to high quality care as well as support services following discharge. On that basis, **the RACP and the AChAM do not agree that the objectives of the Act justify depriving an individual of their liberty to treat them against their will given the likely outcome that the condition will not change substantially due to the insufficient time assigned for treatment and the narrow focus on medically-assisted withdrawal.**

We are concerned that whilst medical opinions and assessments are used to inform the decision of the Magistrate's Court under the Victorian Act, the Court holds the authority to mandate initial detention or treatment of individuals with severe substance use disorders. This is inadequate, **treatment decisions regarding the involuntary initial detention or treatment of individuals with severe substance use disorders should be led by specialist clinicians**. Specialist clinicians are best placed to make those treatment decisions based on their clinical training and expertise which includes assessing the potential risks and benefits of different treatment options for individuals to ensure the best treatment outcomes. In New South Wales, under the IDAT program,[3] specialist clinicians lead these decisions with legal oversight after the admission and treatment of the individual has commenced, rather than as a first step to determine treatment. Legal processes should play the role of protecting the rights of patients whom specialist clinicians have assessed as requiring involuntary treatment when required (as is the case under Mental Health Acts) rather than making determinations that involuntary treatment must be applied. We would recommend the Department gives much greater consideration to a model such as exists in NSW with the legal oversight provided, after the admission and treatment of the individual has commenced, rather than as a first step to determine treatment.

The complex procedural requirements of the Victorian Act make it difficult to enact. This issue was highlighted in the review of the Victorian Act commissioned by the Victorian Government which noted that "there is significant stakeholder concern about the extensive procedural requirements that must be navigated before a Magistrate can consider an application for a DTO [Drug Treatment Order], and delays in treatment associated with those procedural requirements."[4] The review further noted that "while the imposition of procedural requirements assists to ensure detention and treatment is a consideration of last resort and to minimise limitations on a person's human rights, stakeholders favoured streamlining procedural requirements to ensure the making of DTOs is not impeded by unnecessary procedural barriers, while ensuring the Act is not inappropriately applied by defining the target client group very clearly." [5]

Whilst the RACP and the AChAM understand that this mandatory treatment trial has arisen from the South Australian Government's "Stop The Hurt South Australian Ice Action Plan", we do not support the narrow focus of the proposed South Australian model which is to be applied solely to individuals with severe methamphetamine substance use disorders. We are concerned that the particular focus on methamphetamine may create the impression that this measure is likely to make a significant public health impact and that it will provide a solution to issues of crime, general anti-social behaviour and night-time violence associated with methamphetamine use; this is clearly not the case for the reasons outlined in this submission and also due to the very small number of individuals who would be subject to the Act. **In addition, any Act should encompass alcohol and a range of illicit drugs as individuals presenting with severe substance use disorders are likely to use multiple substances and there are questions over equitable access to treatment for high risk individuals with other severe substance use disorders if this Act singles out individuals with severe methamphetamine use disorders.**

Finally, in the context of addressing severe substance use disorders in vulnerable individuals, it is important to note that **alcohol and other drug treatment services in Australia are chronically underfunded and overstretched, despite compelling evidence of their cost effectiveness**. The funding currently provided for alcohol and other drug treatment services is not commensurate with the needs of the population. A review in 2014 found that alcohol and other drug treatment services in Australia met the need of fewer than half of those seeking the treatment.[6] Whilst we note that additional funding was provided to the drug treatment sector under the National Ice Action Strategy, it is disappointing that this funding has not generally addressed the key needs of the drug and alcohol sector as its use is restricted under the terms of the funding agreement. Within

this context, this proposed trial represents a significant opportunity cost as its effective implementation requires a large patient population and enough qualified staff to justify it unless it can be attached to an existing treatment service.

Access to quality treatment, delivered by a suitably trained workforce, is fundamental to address the complex needs of individuals struggling with addiction; this should be the main priority of all levels of government when considering policy development and investment in this area.

Appendix: The New South Wales Involuntary Drug and Alcohol Treatment (IDAT) program

Background information on the NSW IDAT program

The New South Wales Involuntary Drug and Alcohol Treatment (IDAT) Program is a "structured drug and alcohol treatment program that provides medically supervised withdrawal, rehabilitation and supportive interventions. The IDAT Program provides short term care, with an involuntary supervised withdrawal component, to protect the health and safety of people with severe substance dependence who have experienced, or are at risk of, serious harm and whose decision-making capacity is considered to be compromised due to their substance use.

The IDAT Program is a structured drug and alcohol treatment program that provides medically supervised withdrawal, rehabilitation and supportive interventions for Identified Patients (IPs).

The NSW Drug and Alcohol Treatment Act 2007 (DAT Act) provides the legislative basis for IDAT. The DAT Act "provides for the health and safety of persons with severe substance dependence through involuntary detention, care, treatment and stabilisation".

The DAT Act aims to ensure that involuntary treatment is only used when it will be in the best interests of the individual and when no other less restrictive means for treating them are appropriate. The DAT Act also protects the rights of people while they are undergoing involuntary treatment.

Under the IDAT program, a Dependency Certificate, which allows a person to be involuntarily admitted, may only be issued if the Accredited Medical Practitioner (AMP) at the Treatment Centre is satisfied the person meets the following criteria:

- *The person has a severe substance dependence, meaning they:*
  - *have a tolerance to a substance*
  - *show withdrawal symptoms when they stop or reduce levels of its use*
  - *do not have the capacity to make decisions about their substance use and personal welfare primarily because of their dependence on the substance AND*
- *The care, treatment or control of the person is necessary to protect the person from serious harm, AND*
- *The person is likely to benefit from treatment for his or her substance dependence but has refused treatment, AND*
- *No other appropriate and less restrictive means for dealing with the person are reasonably available.*

An AMP can issue a dependency certificate detaining the person for treatment under the Act for up to 28 days in the first instance. There is an option to extend the Dependency Certificate for up to a total treatment period of three months, in extreme circumstances, where withdrawal, stabilisation and discharge planning may take longer."

Source: NSW Health website[1]

The New South Wales' Involuntary Drug and Alcohol Treatment (IDAT) program is currently being reviewed independently by the National Drug and Alcohol Research Centre at the University of New South Wales. However, there is emerging evidence of positive outcomes from this program.

A study by Dore et al[7] presented findings from 40 alcohol-dependent patients admitted to the Northern Sydney Local Health District IDAT program. This study found that a quarter of the patients admitted to this IDAT unit were abstinent and living in the community at 6 months and 17.5% had notably reduced alcohol use; an outcome "not dissimilar to the findings for patients treated voluntary for alcoholism". [8]

[1] http://www.health.nsw.gov.au/aod/programs/Pages/idat-gi.aspx [Last accessed 31.01.2018]

Dr Lee Nixon is a senior addiction medicine specialist working at the IDAT Unit at Bloomfield in Orange; a unit which has 8 beds. Dr Nixon and his team have conducted a study of the first 135 patients to be admitted to this unit over a two-year period from September 2013 to February 2016.

The patients admitted at the unit tend to be very unwell, presenting with severe cirrhosis, endocarditis, cardiomyopathy. Of these patients, 80% were using alcohol as their primary drug and the remaining 20% were split between using opioids and methamphetamine as their primary drug. This study was able to report on 131 of 135 patients at six months post-discharge which exemplifies the level of engagement patients had with staff while at the unit. In terms of outcomes, 30% of these patients had maintained abstinence 6 months post-discharge and 24% continued to show improvements in function and quality of life.

Dr Nixon reports that the majority of patients attending the unit express gratitude by the time they leave and acknowledge that it was something they needed despite often being negative on arrival. He also states that it is not uncommon for ex-patients to voluntarily request readmission and that they have a number of ex-patients visiting the unit to keep contact with staff and express gratitude.

Dr Nixon credits these positive outcomes to the level of support provided by the unit and the very committed staff working there. These include a senior addiction specialist for 3 days per week, a full-time career medical officer, a full time Nurse Unit Manager, usually 3 nurses on the floor, a full time social worker, a full-time drug and alcohol clinician, an occupational therapist (0.4 FTE), a clinical psychologist (0.5 FTE, does cognitive assessments as well as groups and 1:1 e.g. anxiety management) and a full time allied health assistant. The Unit also links in well with general hospital medical services which enables patients attending the Unit to access required medical treatments in a timely manner.

References

[1] Werb D, Kamarulzaman A, Meacham MC, Rafful C, Fischer B, Strathdee SA, Wood E. The effectiveness of compulsory drug treatment: A systematic review. International Journal of Drug Policy. 2016 Feb 29;28:1-9.

[2] Dore, Glenys, Barbara Sinclair, and Robin Murray. "Treatment Resistant and Resistant to Treatment? Evaluation of 40 Alcohol Dependent Patients Admitted for Involuntary Treatment." *Alcohol and Alcoholism* 51.3 (2015): 291-295.

[3] NSW Government, NSW Health, The Involuntary Drug and Alcohol Treatment (IDAT) Program: http://www.health.nsw.gov.au/aod/programs/Pages/idat-gi.aspx [Last accessed 29.01.18]

[4] DLA Piper, Review of the Severe Substance Dependence Treatment Act 2014 (Vic) Volume 1, Report of the Review. 2015, p.2. Available online: https://www2.health.vic.gov.au/alcohol-and-drugs/aod-policy-research-legislation/aod-legislation/severe-substance-treatment-act-ssdta/review-of-the-act [Last accessed 29.01.18]

[5] DLA Piper, Review of the Severe Substance Dependence Treatment Act 2014 (Vic) Volume 1, Report of the Review. 2015, p.2. Available online: https://www2.health.vic.gov.au/alcohol-and-drugs/aod-policy-research-legislation/aod-legislation/severe-substance-treatment-act-ssdta/review-of-the-act [Last accessed 29.01.18]

[6] Ritter, Alison, and Mark Stoove. “Alcohol and other drug treatment policy in Australia.” Med J Aust 2016; 204 (4): 138.

[7] Op. Cit. Dore, Glenys, Barbara Sinclair, and Robin Murray (2015).

[8] Op. Cit. Dore, Glenys, Barbara Sinclair, and Robin Murray (2015).