KIRKETON ROAD CENTRE
KRC

The Director
Standing Committee on Social Issues
Parliament House
Macquarie Street
Sydney 2000

14th November 2003

Dear Sir/Madam,

On behalf of Dr. Ingrid van Beek and the Medical Unit at Kirketon Road Centre please accept our submission on the issues raised by the terms of reference of the inquiry into the Inebriates Act 1912.

Yours sincerely,

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The Legislative Council Standing Committee on Social Issues

Inquiry into

The Inebriates Act 1912

Dr Hester Wilce
Kirketon Rd Centre
Kings Cross

Contents

Introduction

Compulsory treatment is one of the many approaches that can be used to deal with people with severe alcohol and/or drug dependence.

The Inebriates Act 1912 allows for compulsory treatment of a person habitually using intoxicating liquor or narcotic drugs to excess by either recognizance or mandatory institutionalisation.

This submission addresses the needs of drug users and health service providers in the Kings Cross area and discuses how an updated Inebriates Act may improve outcomes for drug users and the rest of the community.

1. The Inebriates Act 1912 and the provisions of compulsory assessment and treatment under the Act.

Drug users misuse a variety of drugs from central nervous system depressants such as alcohol, opioids and benzodiazepines to psychostimulants such as methamphetamine and cocaine. They often fulfil the DSM IV criteria for dependency (appendix 1) for one or more of the drugs used.

While it is clear from a large body of research that an individual's motivation for change is critical to the success of treatment, it not clear how effective compulsory assessment and treatment is. An individual who recognises that he/she has a problem and actively seeks help or displays readiness for treatment is far more likely to succeed in treatment than someone who feels coerced into treatment.[1,2]

There is little rigorous research in the literature to support compulsory treatment. A recent West Australian study of compulsory *psychiatric* treatment in the community provided mixed results, with no significant improvements in outcome compared with matched controls. [3] A Canadian paper in 2002 looking at compulsory drug treatment stated that 'many questions remain with regard to the current tools of compulsory treatment. The main issue, arguably, is that their true effectiveness and cost-effectiveness remains to be proven'.[4] The authors of an American paper in 1999 reviewed 850 articles on mandatory drug and alcohol treatment and found that 81% of them were opinion pieces, legal interpretations, ethical treaties and not methodologically strong original research articles.[5]

Substance dependence has a high rate of relapse. How relapses will be dealt with in the context of the Inebriates Act 1912 is an issue that has to be considered when contemplating mandatory treatment. Furthermore, it remains unclear to what extent compulsory treatment would affect our current policy of harm minimisation.

Harm minimisation has been an effective tool for working with individuals with drug and alcohol issues and the Australian community has benefited from this approach with much lower levels of HIV and other blood borne infections in the injecting drug using population, compared to other countries that have not embraced this approach. The recently published stated that Australian NSP prevented 25,000 HIV infections and 21,000 HCV infections by 2000 saving $2.3 – 6.9 billion. [6]

Mandatory treatment also has civil liberty implications. There should be clear reasons for compelling individuals to treatment to ensure that we as a community are not merely mandating treatment to punish 'bad behaviour' or as a tool for social control. It could be argued that providing individuals are of sound mind and do not harm others they should retain the right to engage in potentially self destructive behaviour.

2. The appropriateness and effectiveness of the Act in dealing with persons with severe alcohol and/or drug dependence who have not committed an offence and persons with such dependence who have committed offences.

The Act in its current form is neither appropriate or effective.

The Act currently covers the compulsory detainment and treatment of individuals with substance dependence that have committed a crime as well as those who haven't. This creates a dilemma in respect to whether those who have committed a crime be managed by the criminal justice system or by the health system.

An individual who then fails to complete compulsory treatment will be punished doubly for their crime, by being forced into treatment, failing and then being dealt with by the justice system. This in turn will put a huge burden on the criminal justice system.

Drug users who commit crimes are already being dealt with though the criminal justice system with access to the drug courts; the Inebriates Act should not be applied when the individual has committed an offence for which they will face the criminal justice system.

3. The effectiveness of the Act in linking persons to suitable treatment facilities and how those linkages might be improved.

To our knowledge the Act has not been invoked for quite some years and it would appear to be ineffective in linking people to services. The Act needs updating and refining in order to do this.

Under the Mental Health Act, the Schedule 2 deals with the containment and mandatory treatment for individuals at immediate risk either to themselves or others due to mental illness or mental disorder. It sets out a number of provisos that a person can not be scheduled for expressing or engaging in, or not expressing or not engaging in:

- a particular political, religious, philosophical opinion or belief
- a particular sexual preference or sexual orientation
- a particular religious activity
- sexual promiscuity
- immoral conduct
- illegal conduct
- developmental disability of mind
- antisocial behaviour or
- has taken alcohol or any other drug (unless that use is immediately life threatening).

These conditions may well be useful in limiting the use of the Inebriates Act to the times when it is most likely to be effective.

The service that is set up to contain and treat individuals under the Inebriates Act should have well-defined goals of treatment.

Guidelines should address the following:

- abstinence versus controlled use
- eligibility criteria
- programme length
- where the programme takes place

- dedicated beds
- consequences of not following programme
- established level of tolerance of substance use outside programme
- accountability
- due process and fairness
- effects on civil liberties
- adequate funding
- case load and co-ordination of services across justice and treatment services
- evaluation and ongoing research
- drug and alcohol services should be involved in policy decisions and
- use of physical or chemical restraints.

Finally, there needs to be adequate financial support to enable the effective implementation of the Act. Currently there is no capacity in the tertiary, hospital-based system to deal with this.

In the current Inebriate's Act the individual may themselves enter a 'recognizance'. This states that they agree to abstain from intoxicating liquor and intoxicating or narcotic drugs for the period of up to a year. If they breach this agreement they can then be placed in a State Institution.

The implementation of a 'living will' may be a way to expand this part of the act. In a 'living will' an individual may agree that:

1) he/she will abstain from their drug of misuse or dependence for a given period of time or

2) he/she agree to containment and treatment if they relapse into substance use that puts their life or others' at immediate risk and that this can only occur when the individual is not intoxicated or under any form of duress.

4. Overseas and interstate models for compulsory treatment of persons with severe alcohol and/or drug dependence including Sweden and Victoria.

Sweden introduced mandatory drug and alcohol treatment in the 1970s. There are mixed reports about the effectiveness of the Swedish model. Levels of drug use among young people have risen sharply in the 1990s to levels similar to that of the 1970s, before the strict measures were introduced. Drug overdose death rates in Sweden are amongst the highest in the European Union and more than seven times higher than in the Netherlands. Hepatitis C prevalence is over 90%, the highest in Europe.

In the early 1990s the Swedish economy deteriorated, unemployment rose, funding cuts were made to drug treatment services and the message of 'all drugs are dangerous' led young people to disbelieve government information and left them poorly educated about drugs and their effects. It has been suggested that this may be why levels of drug use and drug related harm have increased in recent years. The Swedish Authorities may well have underestimated the social factors that lead people to use drugs, hoping that enforcement would be enough.

A literature search was unsuccessful in locating any relevant information on the compulsory treatment of persons with severe alcohol or drug dependency in Victoria.

5. Options for improving or replacing the Act with focus on saving the lives of persons with severe alcohol and /or drug dependence and those close to them.

In order to address the issue of harmful drug and alcohol misuse and dependency, it is important to take into account the reasons that individuals use drugs. The Victorian Chief Health Officer Bulletin lists the following risks for factors for harmful drug use.

- Low attachment to one's community
- Community disorganisation
- Detachment from one's school or workplace
- Parental alcohol and drug use
- Family conflict
- Inconsistent parenting
- Marital instability
- Friends engaging in problem behaviours.

The following are seen to be protective factors.

- Culture of co-operation and tolerance among individuals, between institutions and diverse groups in society
- A sense of belonging to family, to school, to one's workplace, to one's community, good relationships within and outside the family
- Positive achievements
- Stability and security

These issues should continue to be addressed at many levels in many different ways. The Inebriates Act can in no way address the myriad of risk factors for drug use and the benefit of mandatory treatment and its effects on tolerance and co-

operation should be questioned. It can, however, be one of many options used to improve outcomes for certain drug users.

In Appendix 2, two case studies are presented that highlight when mandatory containment and enforced treatment may have benefited the individual and our community as a whole. It should be noted that among 150,000 attendances for clinical services provided by the Kirketon Road Centre (KRC) in the last three years, there were only 2 cases where the Inebriates Act may have been useful.

These case studies illustrate the challenges in addressing serious health risk among chaotic drug users. In case one, LT repeatedly visited numerous services asking for assistance. She was acutely delirious and a danger to herself and to others. While she was admitted under the Mental Health Act on one occasion, little was achieved from that admission as she was reassessed 12 hours later and found quite correctly, not to be 'mentally ill' as per the Act's definition.

Delirium caused by cocaine is short-lived, lasting a matter of hours, however, she continued to be cocaine dependent, unable to stop or curtail her cocaine use, which led to continued cocaine use, recurring psychotic symptoms and continued risk to herself and others. Appendix 3 outlines information about the Kirketon Road Centre (KRC) and the services it provides and gives some details about the recent problems with cocaine injecting drug users.

A revised Inebriates Act may have been useful, containing LT for some days to weeks to allow her to stabilise and control her cocaine use and allow adequate treatment of her concurrent medical problems. This case may have had a better outcome given that she repeatedly attended for help and wanted to change her behaviour but was unable to do that without containment.

The second case is more problematic as JM was for the most part an unwilling participant in treatment. He did ask for in-patient detoxification on one occasion and it may be that this brief window of opportunity could have been effectively used to help him make some changes to his drug use.

The Act may best be implemented if only invoked by adequately trained registered medical practitioners or by the individual themselves. The application by a medical practitioner could only be made if the individual's life was at immediate risk, due to their substance misuse or dependence. Ideally this would occur with the individual's consent and active involvement. If it was considered that the individual's life was at immediate risk, a Schedule under the Act would then be completed, giving the state the responsibility to contain that individual in a safe environment for days to weeks, to allow the individual to go through detoxification. This Schedule could be devised in a similar manner to the Schedule 2 under the Mental Health Act.

The Police Service currently employs Section 24 of the Mental Health Act to contain individuals behaving "bizarrely or dangerously" in the community. It would appear that this power is adequate fro the police and the Act may not need to include police as applicants to compel inebriates to treatment.

Conclusion

The Inebriates Act has not been effectively used for many years. Written in 1912 it reflects societal norms of its time. With careful updating the Act may become an effective tool to help manage those in our community with significant life-threatening drug and alcohol issues, for which existing approaches have been ineffective. The criteria for implementation of the Act will require further investigation.

While the Inebriates Act has traditionally been directed at those with alcohol dependence, it does include 'a person who habitually uses intoxicating liquor or intoxicating or narcotic drugs to excess', both in the case where no offence has been committed and in situations where an offence has been committed. The Inebriates Act should be revised and implementation only be considered where the individual's life is at immediate risk. Criminal offences should be dealt with separately.

There are a small number of clinical situations that are only occasionally encountered by clinical staff working in the drug and alcohol field where implementation of an updated Inebriates Act might improve the outcomes for individuals and the community at large. While the Inebriates Act may not cure an individual's alcohol or substance dependence, it may contain them for a period of time while they are in crisis and their life is in immediate danger due to their alcohol and drug use.

Drug users are a very vulnerable population in our community and often have serious mental health issues and personal histories of severe abuse and neglect. They are a difficult group to engage and have often learnt through bitter experience not to trust others. While there may indeed be a few occasions where mandatory treatment may have a positive outcome, the Act should not become a tool to impose community views based on moral dilemmas around drug use and should be limited to extreme cases.

Appendix 1 DSM criteria for dependency

- Substance taken in larger amounts or over longer period than the person intended
- Persistent desire or one or more unsuccessful efforts to cut down or control substance use
- A great deal of time spent in activities necessary to get the substance
- Frequent intoxication or withdrawal symptoms when expected to fulfil major role obligations at work, home or school, or when substance use is physically hazardous
- Important social, occupational or recreational activities given up or reduced because of substance use
- Continued substance use despite knowledge of social, psychological or physical problem that is caused or exacerbated by the use of the substance
- Marked tolerance, need for markedly increased amounts of the substance in order to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount
- Characteristic withdrawal symptoms
- Substance often taken to relieve or avoid withdrawal symptoms

Appendix 2 Case studies

Case study 1 Delirium associated with cocaine dependence

Ms LT

A 27 year old woman

- street-based sex worker in the Kings Cross area since age 13
- chronic homelessness
- childhood sexual assault
- first seen age 16 in 1991 at the Kirketon Road Centre
- injecting drugs since her early teens with daily heroin use and heavy cocaine binges
- high risk needle sharing
- hepatitis C positive
- recurrent episodes of cellulitis secondary to injecting
- methadone maintenance treatment at a number of clinics and does quite well for short periods of time
- repeated unsuccessful attempts to detoxify from drugs
- unsafe sex with partners and clients
- repeated episodes of sexually transmitted infections including chlamydia, human papilloma virus and syphilis
- perpetrator of domestic violence; violent behaviour towards animals and friends
- repeated convictions and short prison sentences

Presented to KRC in early 2001 acutely distressed with psychotic thoughts, visual hallucinations, paranoid delusions and suicidal thoughts associated with cocaine use, over the ensuing 3 weeks she was seen repeatedly by different agencies on 21 occasions with little effective resolution to her condition.

4 June 2001 Released from Mullawa Correctional Facility, on methadone treatment and recommenced injecting cocaine and heroin on release.

6 June 2001 After altercation with parents self-mutilated inflicting deep laceration on left wrist, admitted to Royal North Shore Hospital for 2 days, laceration sutured, self discharged.

11 June 2001 Presented to St Vincent's Emergency Department (SVH ED), felt at risk of harming her partner and cut open sutured laceration.

13 June 2001 Presented with father to KRC in crisis, reported using 'as much cocaine, heroin and benzodiazepines as I can get'. Laceration infected, at significant risk of self-harm. St Vincent's Mental Health team called to do assessment. LT attended mental health team while intoxicated. She was told to return following day as they felt assessment was not possible while she was intoxicated.

14 June 2001 Presented to KRC in distress, appointment made to see St Vincent's Mental Health team15 June 2001.

16 June 2001 Presented to Sydney Medically Supervised injecting Centre (MSIC), displaying psychotic features. Became increasingly drowsy and ambulance called. LT became verbally abusive and the ambulance refused to take her. She left the MSIC and returned ½ hour later. Staff called a taxi and took her to the SVH ED. While being assessed in the ED, she became aggressive and left.

20 June 2001 Presented to KRC outreach. Accompanied to Sydney Hospital by staff. Waited several hours to be seen, before she gave up and left.

21 June 2001 Presented to Sydney Hospital, become agitated after waiting 3 hours; asked to leave by security staff.

22 June 2001 Presented distressed, febrile, laceration open, infected, with pain extending to fingers, unable to fully extend or flex fingers. Displaying psychotic features, visual hallucinations, agitated. Taken by KRC staff to SVH ED, Schedule 2 under the Mental Health Act completed. Seen by surgical registrar, who refused to insert a cannula for intravenous antibiotics due to LT's past history of violence in the ED, admitted overnight under schedule.

23 June 2001 Assessed by Psychiatric registrar at SVH, no evidence of mental illness, Schedule revoked, discharged.

24 June 2001 Presented to outreach staff, laceration grossly infected, accompanied to Sydney Hospital by staff, and waited some hours to be assessed; left before assessment.

26 June 2001 Dressing done at KRC. Laceration still infected, taking antibiotics daily.

27 June 2001 Dressing, laceration slowly improving.

2 July 2001 Presents with dystonic reaction, no sleep for more than 3 days, denies cocaine use in last 48 hrs.

Laceration healed with significant scarring over next 2-3 months.

Case study 2 life threatening poly drug use.

Mr JM

26 year old male from Perth

- first started injecting age 15
- hepatitis C positive
- depression
- multiple drug overdoses
- homelessness
- street sex working
- using heroin, cocaine, benzodiazepines, amphetamines, inhalants/petrol sniffing
- victim of multiple physical assaults, and domestic violence
- multiple presentations for infections abscesses and superficial thrombophlebitis related to the injecting of temazepam gelcaps
- Several attempts to stabilise opioid use, treated with methadone and naltrexone in the past.

10 December 2002 Commenced on methadone treatment at KRC, concerns among staff regarding chaotic drug use and high risk of overdose.

12 December 2002 Opioid overdose witnessed at KRC, successfully resuscitated.

17 December 2002 Seen at KRC after physical assault, very intoxicated, denied any drug use, methadone dose withheld.

18 December 2002 Intoxicated, methadone dose withheld.

7 January 2003 NSW ambulance service called to see JM with opioid overdose on street.

7 January 2003 Admitted to the SVH ED after second overdose of alcohol and 500mg diazepam (Valium).

9 January 2003 Grave concerns about JM's safety, with recent history of multiple serious drug overdoses and continued chaotic polydrug use. Staff attempted to organise benzodiazepine reduction regimen through St Vincent's Alcohol and Drug Team without success.

10 January 2003 Options for inpatient detoxification explored, no local services able to take on his care, unable to be referred out of area as he lives in South-East Sydney Area. JM presented to KRC requesting help with detoxification after being witnessed using inhalants, very intoxicated, agitated, aggressive with physical evidence of recent opioid use (pinpoint pupils, drowsy). Staff attempted to organise inpatient treatment, however, refused as there are no inpatient beds at St Vincent's hospital and the St Vincent's Detoxification unit is non-medicated and therefore not appropriate for detoxification from benzodiazepines. Sydney Hospital refused to admit him for inpatient care due to polydrug use. JM's methadone dose was reduced and split daily dosing introduced to reduce risk of overdose.

13 January 2003 Split dosing continued. JM considering leaving Sydney.

16 January 2003 Reviewed after physical assault, mildly intoxicated.

17 January 2003 Overdosed on street, seen by NSW ambulance service, resuscitated, refused transfer to ED.

20 January 2003 Presented to KRC intoxicated, asked not to use and to return later in the day for further assessment before methadone dose. Returned 6 hours later still very intoxicated, methadone dose withheld.

21 January 2003 Decision made to completely withdraw JM from methadone treatment over 4 days as risk of overdose remained too high. JM encouraged to see St Vincent's Team for benzodiazepine reduction regimen. JM unhappy with this, threatened to go out and use heroin and overdose, if not given methadone.

24 January 2003 JM unhappy with management plan, wanted to sue KRC for unfair treatment. Exit form for methadone faxed to PSB.

10 July 2003 Presented to KRC very intoxicated, declined naloxone (Narcan). Angry and aggressive, denied drug use, left the building.

15 September 2003 Seen at KRC to make phone call to family in Perth.

Appendix 3 The Kirketon Road Centre, delirium and psycho-active substances

The Kirketon Road Centre (KRC) is a primary health care facility of the Sydney and Sydney Eye Hospitals and South Eastern Sydney Area Health Service located in Kings Cross which is involved in the prevention, treatment and care of HIV/AIDS and other transmissible infections among 'at risk' youth, sex workers and injecting drug users (IDUs). KRC offers medical, nursing, counselling and social welfare services, a methadone access programme, an outreach and needle syringe programme (NSP).

In 2000-2001 there was a shortage of heroin in Australia while led to a change in the pattern of drug use. Cocaine, meth-amphetamine and temazepam gelcaps have become increasingly popular and have led to increased injecting related harm. The clinical syndromes associated with these drugs are great challenges to the services working with this group of the community.

Cocaine injecting drug users (CIDUs) can be particularly chaotic and difficult to access due to the nature and frequency of their drug use and have a wide range of significant health and social welfare needs.

Most health and social welfare agencies in the Kings Cross/Darlinghurst area reported an increase in cocaine use and associated harms between 2000 and 2001. The NSW Ambulance Service identified that cocaine use had led to an increase in call-outs for acute psychosis, paranoid states, aggression, self-harm and cocaine induced psychosis was the main concern cited by all services.

In response to this, staff at KRC developed clinical protocols to help manage these issues. Of particular relevance to the inebriates act, a protocol for the management of

delirium in the presence of cocaine and other psycho-stimulant use was created. (This protocol was a finalist in the 2003 Baxter NSW Health awards).

Delirium is a clinical presentation characterised by a disturbance in consciousness and cognition of acute onset. The person has difficulty with attention and may manifest a variety of psychomotor, perceptual and emotional disturbances; this presentation can fluctuate over minutes to hours. They may present with decreased level of consciousness or drowsiness or with acute agitation or excitability. They may see or hear things that are not there, they may feel paranoid and worry that people are trying to kill them. They find it difficult to concentrate and misinterpret their surroundings; their speech and thoughts can be incoherent or difficult to understand. They can be aggressive and unpredictable. A person with delirium from whatever cause may pose a serious risk of harm to themselves or to others and should therefore be regarded as a medical emergency.

Delirium can be caused by many medical conditions, from infection to head injury to low blood sugar to drug intoxication or withdrawal. Its presentation in the Kings Cross area is often in the context of psycho-stimulants and polydrug use. However it can be difficult to assess the cause of the delirium in the community setting. Due to the dangerous nature of the condition, individuals presenting with the symptoms need immediate containment and treatment at an Emergency Department (ED). However, due to the individuals decreased level of cognition, they may be unwilling or unable to attend the ED. For this reason they need to be escorted, against their will if necessary, to ensure their safety and best treatment.

This protocol was written in consultation with other local services and has been implemented in the South-Eastern area of Sydney. It has been very successful in helping deal with this issue, however, adequate treatment remains problematic, as it

is difficult to get these individuals to the Emergency Department where they need to be seen and treated.

The protocol suggests using the Mental Health Act to ensure mandatory containment and assessment. Under the mental health act a person maybe deemed mentally disordered 'if the persons behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary: a) for the person's own protection form serious harm; or b) for the protection of others from serious harm.'

Under the Mental Health Act a doctor in the community setting can invoke the act and complete the schedule 2 which ensures that the person will be taken to a prescribed hospital for assessment. This is done with the aid of the police and the ambulance service. The problem with invoking this act is that the person will often be taken to a psychiatric hospital and not the ED of a general hospital where their condition is best assessed and managed. While a psychiatric hospital has medical staff, they are not set up to assess people that are medically unwell.

It may be possible under the Inebriates Act to ensure that acutely unwell 'inebriates' be taken to an ED rather than a psychiatric hospital.

It should also only be implemented where the individual's or another's life is seriously at immediate risk. Furthermore, it must be clear that implementation of the Act will result in positive outcomes. The act can only be effectively implemented with meaningful financial support, good follow up and support to the patient and staff involved.

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