

Chapter 5 The evidence on compulsory treatment

... the absence of good literature makes it really hard to make confident statements about where we should go.²¹²

The most important thing I want to say is that there are no different treatments. There are no things to pull out of the hat and say “We can treat drug or alcohol dependence in this way if it were coerced”. We are going to use the existing treatments and the risk is that they will be less effective in coerced individuals than in those who are not coerced.²¹³

In the previous chapter the Committee concluded that the *Inebriates Act* is so archaic, and so open to misuse, that it should immediately be repealed and replaced with an entirely new framework for the involuntary treatment of people with drug and alcohol dependence. In this chapter, the Committee assesses the evidence about the efficacy of compulsory treatment of people with substance dependence, which we see as essential to any consideration of a new system for compulsory treatment. Before examining the available literature and anecdotal information we briefly examine the available treatments for substance dependence and their effectiveness. As the above quote from Professor Mattick of the National Drug and Alcohol Research Centre attests, these same treatments will necessarily be the ones provided in a compulsory setting. Our finding is that the available literature on compulsory treatment does not provide an adequate basis for strong conclusions about the effectiveness of compulsory treatment for non-offenders.

What treatment is available for drug and alcohol dependence?

5.1 In the following section we draw on the evidence of witnesses and the research literature to provide a brief overview of the available treatments for drug and alcohol dependence.

Detoxification

5.2 Ms Tonia Harvey, Area Director of Drug and Alcohol Services, Northern Sydney Health, told the Committee about the typical treatment pathway for people with severe drug or alcohol dependence, which commences with detoxification:

Detoxification, followed by either residential rehabilitation or long-term follow-up on an outpatient basis. Some people, especially those with significant brain injury, may require supervised care in a structured environment and that is because it gives them boundaries by which to build their recovery.²¹⁴

5.3 According to Ms Diane Paul, the manager of the detoxification unit of the Herbert Street Clinic, the detoxification process is crucial for:

²¹² Ms Amy Swan, Research Fellow, Turning Point Drug and Alcohol Centre, Evidence, 28 April 2004, p35

²¹³ Professor Richard Mattick, Director, National Drug and Alcohol Research Service, University of New South Wales, Evidence, 8 April 2004, p9

²¹⁴ Ms Tonina Harvey, Area Director, Drug and Alcohol Services, Northern Sydney Health, Evidence, 4 March 2004, p5

... getting clients to a stage where they can actually make some decisions based on the choices they have in managing their addiction and providing education links to support networks so that they will have the resources to access support in the event of a relapse.²¹⁵

- 5.4** When an individual has become dependent on a substance, the detoxification process will involve physical withdrawal symptoms. This occurs when ‘the drug of dependence is eliminated from the body, and any physical adaptation that has occurred as a consequence of dependent drug use is reversed.’²¹⁶ The severity and nature of the withdrawal symptoms vary according to the type and amount of drugs used. Alcohol withdrawal can entail delirium, seizures and convulsions, while for opioids, symptoms of withdrawal include irritability, anxiety, muscular and abdominal pains, chills, nausea, sweating and insomnia.²¹⁷ Cocaine withdrawal can involve dysphoric mood, fatigue, craving, insomnia or hypersomnia.²¹⁸ Professor Mattick noted the particular seriousness of alcohol withdrawal:

Alcohol dependence is a bit different because it invokes the notion of tolerance to the effects of alcohol, and withdrawal can be quite severe. You can suffer an organic brain syndrome called delirium tremens. Of all the drug dependencies, alcohol withdrawal is the only one that has the potential to cause death. A lot of people do not appreciate that either. The potential of opiate dependence or other dependencies to cause serious harm is minimal. They are very uncomfortable withdrawal states but they do not cause death.²¹⁹

- 5.5** Detoxification, or ‘medicalised withdrawal’, can take place in a variety of settings according to patients’ needs and circumstances. It can be provided on an outpatient or inpatient basis, depending on the severity of dependence, the availability of family support, and the likelihood of complications and health risks. Medications are available to alleviate the symptoms of withdrawal or to prevent complications. For alcohol dependence, benzodiazepines such as diazepam are used to treat or prevent delirium and seizures, and anti-psychotic drugs can be used for treating hallucinations.²²⁰ For opioid withdrawal, patients may be given reducing doses of methadone to minimise withdrawal symptoms. Drugs such as clonidine and lofexident have been found to have less success due to their adverse effects, while buprenorphine has fewer adverse effects.²²¹

- 5.6** While detoxification is an important prelude to treatment, Professor Mattick noted that it does not of itself constitute treatment, it merely addresses the physical adaptation to the drug:

Withdrawal management, or detoxification, is not a treatment for alcohol dependence; it is a way of managing people when they need to detoxify ... It really is not a treatment that will stop heavy drinking, it is a way of managing, particularly for the

²¹⁵ Ms Diane Paul, Manager, Detoxification Unit, Herbert Street Clinic, Evidence, 4 March 2004, p8

²¹⁶ Australian National Council on Drugs, *Evidence Supporting Treatment: the Effectiveness of Interventions for Illicit Drug Use*, Research Paper 3, (hereafter referred to as ANCD Research Paper), p16

²¹⁷ ANCD Research Paper, p22

²¹⁸ ANCD Research Paper, p28

²¹⁹ Professor Mattick, National Drug and Alcohol Research Centre, Evidence, 8 April 2004, p1

²²⁰ National Alcohol Strategy, *The Treatment of Alcohol Problems: A Review of the Evidence*, June 2003, pp 31-33

²²¹ ANCD Research Paper, pp23-24

severe end of alcohol withdrawal, for epileptic seizures or delirium tremens, an organic brain syndrome that can eventually cause death. The thing that New South Wales and Australia lost over the last 15 years is that detoxification used to provide very good shelter and humane care. It gave people a place to have a shower, to get away from wet boarding houses or other environments for some time.

Systematically over the 1990s those detoxification facilities were not supported and some closed. Some have reopened. They play an important role in terms of shelter and humanitarian care. It can be provided on an outpatient and inpatient basis, medicated and non-medicated. The most important point that the Committee needs to understand is that the international literature is quite clear; providing detoxification does not change people's drug use or alcohol use. It provides some health gains, potentially, and may be an entree into further treatment. The episode of detoxification, per se, is not a treatment for altering drinking or drug use. It is the way of simply managing the individual for a brief time ...

I think proclaimed places and detoxification are very important. That should be supported, but we have to recognise that it is not a treatment and then provide other treatments. That is my first point.²²²

- 5.7** Following detoxification, psycho-social therapies and/or pharmacotherapies such as naltrexone and acamprosate are typically used. Research into treatment of substance dependence reveals that a number of different interventions can be effective, to a greater or lesser degree. Common treatments are briefly described below.

Psycho-social therapies

- 5.8** **Cognitive-behavioural therapy** is based on a view of addiction as being:

learned, maladaptive habit patterns acquired through the interactive processes of classical conditioning, instrumental learning and cognitive mediation ... From this point of view, addictive behaviours are maladaptive coping responses when they become the central means individuals use to cope with the stress of life's demands.²²³

- 5.9** Addiction is considered to be the result of multiple factors, including biological (such as genetic vulnerability and substance-induced physiological changes), psychological and sociocultural factors.²²⁴ Cognitive-behavioural therapy therefore seeks to 'replace addictive behaviours with new and more adaptive coping skills', and to help clients 'meet life's demands without resorting to the excessive use of alcohol and its associated problems.'²²⁵

- 5.10** Professor Mattick provided a broad outline of cognitive-behavioural therapy:

We have a range of cognitive behavioural therapies for alcohol dependence. They are essentially skills training and development of better communication methods and

²²² Professor Mattick, National Drug and Alcohol Research Centre, Evidence, 8 April 2004, pp 3-4

²²³ Parks GA, Marlatt GA and Anderson BK, 'Cognitive-behavioural Alcohol Treatment', in N Heather and T Stockwell (eds), *Treatment and Prevention of Alcohol Problems*, John Wiley and Sons, Chichester, 2004, pp69-86, pp70-71

²²⁴ Parks et al, 'Cognitive-behavioural Alcohol Treatment', pp70-71

²²⁵ Parks et al, 'Cognitive-behavioural Alcohol Treatment', p72

better relationships within the family. The social skills training involves behavioural self-management to set limits for alcohol consumption, cognitive restructuring, cue exposure - which helps people to cope with cravings for alcohol - and interventions for families and couples. There are also self-help guides and self-help materials. The international literature is clear that these interventions reduce drinking. It is quite convincing. They are not unavailable in Australia, but they could be more available.²²⁶

- 5.11** Therapists use a variety of interventions differing in intensity and duration, depending on the severity of dependence or abuse, cognitive or neurological impairment, and whether there are other psychiatric conditions present.²²⁷ Interventions include social skills training, community reinforcement, behavioural contracting, aversion therapy, relapse prevention and cognitive therapy, as briefly outlined below.
- 5.12** Social skills training aims to address deficits in people's coping and life skills that are believed to be behind their substance abuse. It focuses on an individual's particular vulnerabilities and seeks to improve communication skills that will enhance social relationships. Skills training can concentrate on areas such as interpersonal relationships, dealing with stressors and coping with substance cues.²²⁸ One treatment handbook notes that the evidence for the efficacy of this intervention as part of a treatment package is strong.²²⁹ This type of intervention is considered particularly appropriate for severely dependent persons.
- 5.13** Studies have shown the community reinforcement approach to assist in maintaining abstinence and employment in alcohol dependent people in inpatient or outpatient situations. This approach seeks to enhance patients' access to 'positive activities and makes involvement in these activities contingent on abstinence'.²³⁰ The success of community reinforcement lies, apparently, in its combination of different behavioural approaches and in involving patients in rewarding activities that do not involve drinking.²³¹
- 5.14** In behaviour contracting, the client and therapist identify and make a 'contract' about particular drinking goals. This intervention is useful for providing alternatives to drinking, and has been evaluated as providing consistently positive results.²³²
- 5.15** Aversion therapies seek to generate an aversion to alcohol by 'establishing a conditioned response to cues associated with drinking'.²³³ While conditioning through electric shocks has not been shown to be very effective, nausea aversion therapy, in which medications are used to induce nausea when alcohol is consumed, and covert sensitisation through 'imaginal techniques' have shown short-term success.²³⁴

²²⁶ Professor Mattick, National Drug and Alcohol Research Centre, Evidence, 8 April 2004, pp4-5

²²⁷ Parks et al, 'Cognitive-behavioural Alcohol Treatment', p75

²²⁸ Brown JM, 'The Effectiveness of Treatment', in N Heather and T Stockwell (eds), *Treatment and Prevention of Alcohol Problems*, John Wiley and Sons, Chichester, 2004, pp9-20, p11

²²⁹ Brown, 'The Effectiveness of Treatment', p11

²³⁰ Brown, 'The Effectiveness of Treatment', p11

²³¹ Brown, 'The Effectiveness of Treatment', p12

²³² Brown, 'The Effectiveness of Treatment', p12

²³³ Brown, 'The Effectiveness of Treatment', p12

²³⁴ Brown, 'The Effectiveness of Treatment', p12

- 5.16** Relapse prevention is a behavioural approach that seeks to reduce the cues that can cause relapses, including stress, specific emotions and cravings. The treatment teaches patients to cope with these cues, and has had success in preventing relapses and assisting individuals to recover from relapses.²³⁵

Psychological interventions also deal with situations where a risk of relapse is high. This is an important area that also has a good evidence base in the international literature. It is called relapse prevention. It recognises that alcohol and other drug-use disorders are chronic relapsing disorders and that these interventions identify factors likely to cause relapse and help people to develop strategies to overcome those situations. They can be used in a number of settings.²³⁶

- 5.17** The Committee heard that relapse is common, and should not be considered as evidence of failure of the treatment. As Ms Harvey told us when we visited the Herbert Street Clinic at Royal North Shore Hospital:

It is important to recognise that relapse is part of the journey for a percentage of clients. What is important are the gains made in between those relapses and, hopefully, a realistic expectation is that the length of sobriety will extend over time. As clients build new skills in dealing with how they feel - other than using substances - there is an opportunity there for them to make significant life changes. We accept that it is part of the process.²³⁷

Brief interventions and motivational interviewing

- 5.18** Brief interventions – which can be as short as a few minutes or a few sessions – aim to assist the patient to recognise their substance abuse problem, to become committed to change and seek to provide skills training. They have some success in reducing alcohol consumption. Motivational interviewing is often used during such interventions, and aims to initiate a person's motivation to change, by providing information about risk and harm, and using 'encouragement and empathy' to help overcome the client's hesitation to change.²³⁸

- 5.19** Professor Mattick briefly explained motivational interviewing to the Committee:

Motivational interviewing is a more recent intervention. It introduces the notion of stages of change; that is, drinkers are at different stages in their desire to change their drinking. Some people are not really thinking about it and some people think they should but have not thought it through. Others are ready to change and some are trying to. The motivational interviewing process, which feeds back the health effects to the drinker, allows for the individual to engage in changing his or her motivation to stop drinking or using drugs.²³⁹

²³⁵ Brown, 'The Effectiveness of Treatment', p12

²³⁶ Professor Mattick, National Drug and Alcohol Centre, Evidence, 8 April 2004, pp4-5

²³⁷ Ms Harvey, Northern Sydney Health, Evidence, 4 March 2004, p8

²³⁸ Brown, 'The Effectiveness of Treatment', pp10-11

²³⁹ Professor Mattick, National Drug and Alcohol Research Centre, Evidence, 8 April 2004, pp4-5

- 5.20 Brief interventions and motivational interviewing are appropriate for people who are abusing alcohol rather than those who are dependent on it.²⁴⁰

Self-help groups

- 5.21 Studies suggest that evidence of the effectiveness of self help groups such as Alcoholics Anonymous and Narcotics Anonymous in preventing relapse is limited and mixed.²⁴¹ Nevertheless, a number of practitioners including Mr Owen Brannigan, Manager of the Phoenix Unit residential rehabilitation program with Northern Sydney Health explained to the Committee that self-help group therapy is useful for some patients:

Alcoholics Anonymous and Narcotics Anonymous, any of the self-help groups, can be a useful adjunct to our services because people who are severely dependent would rarely still be living in the world they used to live in, so they would have lost a great deal of things. They would have caused sometimes irreparable damage to their social and family relationships. They can experience a tremendous sense of isolation. So linking them into self-help groups to let them know that they are not the only person who has suffered from this problem, to let them know that there are people who have had to fight similar battles, that can be useful for those people and can benefit them greatly. At the Phoenix Unit, of which I am the manager, we have a consumer group.²⁴²

Medications

- 5.22 Pharmacotherapy – the treatment of a disease through medication – is available for drug and alcohol dependence. The Committee heard from Dr Stephen Jurd, an addictions psychiatrist and Area Medical Director of Drug and Alcohol Services with Northern Sydney Health that a number of new medications have become available in recent years:

Addiction medicine in general is a new specialty. The College of Physicians has only recently organised a chapter of addiction medicine that is only 18 months or two years old. Drug and alcohol dependent people in the past have largely been treated as social, not really clinical. There were not many specific medications. When I started in drug and alcohol back in 1983, basically there were only two medications that were used and that was valium for withdrawal and methadone for people with opiate dependence, provided that you do not call vitamin B1 a medication. But now there is an increasing number of medications ... There is more on the market, and so now we are beginning to have a field that is more consistent with other fields, and so we are in a better position.²⁴³

- 5.23 Early medications for alcohol dependence were **aversion therapies**, and included drugs such as disulfiram that sought to provide a deterrent by inducing disagreeable physical reactions

²⁴⁰ Brown, 'The Effectiveness of Treatment', pp10-11

²⁴¹ ANCD Research Paper, p73

²⁴² Mr Owen Brannigan, Manager, Phoenix Unit Residential Rehabilitation Program, Evidence, 4 March 2004, p7

²⁴³ Dr Stephen Jurd, Area Medical Director and Addictions Psychiatrist, Drug and Alcohol Services, Northern Sydney Health, Evidence, 4 March 2004, p7

after alcohol had been consumed. The reactions include flushing, headache, nausea, and tightness in the chest.²⁴⁴ Studies revealed that disulfiram had only limited success in improving abstinence, though this increased if compliance with taking the medication was supervised. There is limited evidence that disulfiram, when combined with buprenorphine or methadone maintenance, may reduce cocaine use in people who are also opioid dependent.²⁴⁵

5.24 The Committee was told that **anti-craving medications** can be useful in reducing ‘the dysphoria associated with people’s ruminations about the substance they have been using’.²⁴⁶ Acamprosate is one such medication that has been seen to have success in treating alcohol dependent persons. The literature reveals that acamprosate treatment:

typically [enhances] completed abstinence by some 20% above the rate achieved in the placebo group (ie approximately doubling the proportion of complete abstainers) for up to 1 year ... These studies also found that the cumulative total of days of abstinence was significantly greater in the acamprosate-treated patients.²⁴⁷

5.25 The Committee heard that acamprosate is available in Australia under the Pharmaceutical Benefits Scheme (PBS):

Acamprosate has been the subject of 12 randomised clinical trials involving 3,800 patients in eight countries. The trials began in the 1980s and it was approved in 1999 and listed on the PBS in the same year.²⁴⁸

5.26 Opioid antagonists such as naltrexone are considered ‘**blocking agents**’ and work by displacing opioids from receptor sites, thus blocking the effects of the opioid. Naltrexone is also believed to reduce cravings for opioids. Although naltrexone is more commonly known as a treatment for opioid addictions, it also can be an effective treatment for alcohol dependence (in combination with psychological therapy). Opioid antagonists are believed to interfere with the endorphin transmission in the brain, which in turn reduces the ‘rewarding’ effects of alcohol consumption. The effects of naltrexone make it useful in reducing ‘catch-up’ drinking or drug use that can occur during relapses after periods of abstinence.²⁴⁹ The Australian Therapeutic Goods Authority [TGA] approved naltrexone in January 1999, and it was PBS listed in February 2000.²⁵⁰

5.27 The literature suggests some success for treatment with naltrexone. Three double-blind randomised controlled studies have shown that detoxified alcohol dependent patients in an outpatient program taking naltrexone have a reduced risk of relapse over a three month period.

²⁴⁴ Chick, ‘Pharmacological Treatments’, in N Heather and T Stockwell (eds), *Treatment and Prevention of Alcohol Problems*, John Wiley and Sons, Chichester, 2004, pp 53-68, p54

²⁴⁵ cited in ANCD Research Paper, p55

²⁴⁶ Mr George Klein, Behavioural Scientist, Centre for Drug and Alcohol Medicine, Nepean Hospital, Evidence, 7 April 2004, pp54-55

²⁴⁷ Chick, ‘Pharmacological Treatments’, p61

²⁴⁸ Professor Mattick, National Drug and Alcohol Research Centre, Evidence, 8 April 2004, pp4-5

²⁴⁹ Chick, ‘Pharmacological Treatments’, p57

²⁵⁰ Professor Mattick, National Drug and Alcohol Research Centre, Evidence, 8 April 2004, pp4-5

For example, in one study cited by Chick, the relapse rate for patients completing naltrexone treatment was 25%, compared to 53% for the placebo group.²⁵¹

- 5.28** One disadvantage with naltrexone appears to be a high level of patient drop-out, with various studies showing between 22.5% and 58% of participants leaving treatment within the first week, and between 39% and 74% leaving by the end of the second week.²⁵² One study indicated that less than 20% of patients remain in treatment for more than six months, which compares unfavourably with a 60-80% retention over 12 months for methadone maintenance treatment.²⁵³
- 5.29** **Substitution treatment** for opioid dependence has been available for some years. This type of treatment 'entails the prescription of a drug with a similar action to the drug of dependence, but with a lower degree of risk'.²⁵⁴ The main aim of substitution is to stabilise the health and social situation of users as a stepping-stone to further treatment.
- 5.30** Methadone maintenance is the most commonly used opioid substitute and works by preventing withdrawal symptoms, thus decreasing the frequency of use of opioids.²⁵⁵ Research cited in the Australian National Council on Drugs literature review suggests that methadone maintenance 'substantially reduces but does not eliminate heroin use' amongst clients, and is 'more effective than no treatment or placebo in reducing rates of imprisonment, reducing heroin use, retaining clients in treatment, and supporting employment or return to further education'.²⁵⁶ Alternative opioid substitution treatments include buprenorphine and Levo alpha acetyl methadol (LAAM).²⁵⁷
- 5.31** When combined with psychosocial therapies such as regular counselling, social work, family and employment counselling and contingency management interventions, the effectiveness of methadone maintenance increases.²⁵⁸

How successful is treatment for substance dependence?

- 5.32** Mr Klein of the Centre for Drug and Alcohol Medicine at Nepean Hospital told the Committee that treatment for drug and alcohol dependence generally (that is, for both voluntarily-accessed and compulsory treatment) has success over time:

As a working clinician I see that the impact of treatment - you could say that this is a kind of convenient clinical fiction that I am creating to justify my own position. But after a quarter of a century what I see is that the impact of treatment is cumulative: people get better at recovery, and sometimes it takes them a long time. The reason it

²⁵¹ Chick, 'Pharmacological Treatments', pp58-59

²⁵² cited in ANCD Research Paper, p42

²⁵³ cited in ANCD Research Paper, p30

²⁵⁴ ANCD Research Paper, p30

²⁵⁵ ANCD Research Paper, p30

²⁵⁶ ANCD Research Paper, p35

²⁵⁷ ANCD Research Paper, pp36-39

²⁵⁸ cited in ANCD Research Paper, p59

takes them such a long time is the way that psychoactive substance use impacts on decision making.

... My view is that people become better at recovery and that treatment provides people with a gradually increasing repertoire of internal defences against the compulsion to take their substance ... After a quarter of a century, it is my understanding that people do not decide to give up taking drugs or taking alcohol. Rather, they get better at accepting opportunities not to take these substances. They get better at saying yes to alternatives.²⁵⁹

- 5.33** An important point made by inquiry participants is that any evaluation of treatment success is dependent on the definition of success. While abstinence is the goal of treatment for people with severe dependencies,²⁶⁰ participants such as Dr Richard Matthews of NSW Health suggested that total abstinence is not a realistic measure of success:

... we need to define “success”. If success is abstinence, then there are fairly poor results for most types of dependence ... There is good evidence, for instance, about the effectiveness of methadone maintenance in reducing crime, reducing seroconversion and reducing death, if they are your outcome measures. But if abstinence is your outcome measure, there is not terribly good evidence around about anything much. It is a question of the definition of success.²⁶¹

- 5.34** Professor Mattick cautioned against unrealistic expectations about treatment outcomes:

We have another problem when we think about drug dependence as a community. That is, that we would like to cure it. We do not think of curing necessarily other diseases such as diabetes, schizophrenia, depression or hypertension. Unless the community can get out of the notion that we will cure this disorder and only manage the other ones we will be left in a situation where we are always looking for a therapeutic ideal. It is a real problem in this area. We want cure and we are not going to get it. We have good methods of management as we do for other disorders. This has been said before, and you have probably heard it here before, but it is an important point. It is a subtle point that people miss - they slip back into it, but if we can only get them to stop.

If you move away from substance disorders to something like panic disorder, which is an anxiety disorder. We do not feel that we have failed if the panic attacks reduce but someone has one or two every month instead of one or two a day. We feel we have succeeded. With alcohol or other drug disorders if they return to drug use we feel we have failed. It is an issue of management more than cure. There is a need for repeated treatment episodes as there is for blood pressure problems and diabetes when people are not compliant with their medication. There is a need for the avoidance of unrealistic expectations of a therapeutic ideal of cure. That is not an ideal that is applied to other disorders. We are on an uneven playing field here. It actually has quite negative consequences in the drug and alcohol field because the area is criticised if we do not achieve the therapeutic ideal.²⁶²

²⁵⁹ Mr Klein, Nepean Hospital, Evidence, 7 April 2004, pp54-55

²⁶⁰ Professor Mattick, National Drug and Alcohol Research Centre, Evidence, 8 April 2004, pp6-7

²⁶¹ Dr Richard Matthews, Acting Deputy Director General, Strategic Development, NSW Health, Evidence, 11 December 2003, p20

²⁶² Professor Mattick, National Drug and Alcohol Research Centre, Evidence, 8 April 2004, p2

5.35 Similarly, Dr Wilce from the Kirketon Road Centre noted:

I want to comment on what we consider success is. For me with the case studies that I have talked about, success in a way is keeping them alive and trying to give them a safe breathing space for a short period of time.²⁶³

5.36 According to a literature review by Ms Amy Swan and Ms Sylvia Alberti of the Turning Point Alcohol and Drug Centre, prepared for the review of the Victorian compulsory treatment legislation, there are six key goals of drug treatment:

- reduced drug use
- reduced blood borne virus transmission
- reduced drug-related mortality
- reduced drug-related crime
- enhanced social functioning
- improved general health and wellbeing.²⁶⁴

5.37 The authors reported that a range of studies had demonstrated that treatment for drug dependence is effective across various treatment modalities, with reductions in drug use and improvements in health and wellbeing evident.²⁶⁵

The effectiveness of compulsory treatment

5.38 Unfortunately, the Committee was unable to find significant evidence of the efficacy or otherwise of compulsory treatment of individuals with drug or alcohol dependence. That there is a dearth of available evidence is confirmed by the findings of the literature review by Turning Point Alcohol and Drug Centre conducted for the review of Victoria's *Alcoholics and Drug Dependent Persons Act 1968*. Ms Amy Swan, Research Fellow at Turning Point told the Committee:

... there is very little good research about the effectiveness of compulsory treatment and outcomes. I suggest there is some in relation to drugs and crime issues, but in relation to civil commitment we can't make any conclusions about the effect of interventions because there is very little research. And what does exist warrants further research.²⁶⁶

5.39 Ms Swan noted that much of the literature dealing with compulsory treatment of non-offenders fails to provide insight about the effectiveness of this treatment mode:

One of the problems with all of this literature is the lack of good research. In terms of the broader area of compulsory treatment, there was a review of all research done by Wyle et al. (2002). They reviewed 170 publications in relation to compulsory

²⁶³ Dr Hester Wilce, Medical Practitioner, Kirketon Road Centre, 7 April 2004, p6

²⁶⁴ Amy Swan and Silvia Alberti, *The Alcoholics and Drug-dependent Persons Act 1968: A Review*, March 2004, p12

²⁶⁵ Amy Swan and Silvia Alberti, *The Alcoholics and Drug-dependent Persons Act 1968: A Review*, March 2004, p12

²⁶⁶ Ms Amy Swan, Research Fellow, Turning Point Alcohol and Drug Centre, Evidence, 28 April 2004, p26

treatment. Only 18 of those pertained to effectiveness, and 83% of those were methodologically unsound. That tells you very little about the effectiveness of compulsory treatment – and that is an area about which plenty has been written.²⁶⁷

5.40 Only a handful of useful studies were found during the literature review, and these revealed mixed outcomes:

In terms of civil commitment, we came up with four studies. Two of these were Swedish PhDs that we were not able to access, but had some cited material about. One of the key studies was a Swiss outcome study by Bourquin-Tieche et al in 2001. Seventeen consecutive cases were admitted to an alcohol unit. These people had complex medical, social and psychological alcohol related problems, and there was a risk of death in 15 of 17 of those cases. They stayed in treatment on average 29 weeks and they were followed up after 18 months - and 10 of them could be followed up. So we are talking about really small case numbers here.

Bourquin-Tieche et al found that civil commitments of this group were a lifesaving measure, and they found increased health and wellbeing. Eight of the 10 reported abstinence at eight months, and a leap was made that abstinence equals increased life expectancy, thus the positive outcomes.

The two Swedish dissertations by Solomon in 1999 and Gerdner in 1998 reported significant decreases in alcohol intake, but they still had high mortality rates - much higher-than-expected mortality rates.

In Colorado there was a study by Steiner et al in 1995, which was an acute alcohol treatment at a general hospital, and they had a sample of 99 - a decent-sized patient quota - and these again were consecutive patients. This study found poor treatment outcomes regarding alcohol use, with 60 per cent of the group drinking again six months post intervention.²⁶⁸

5.41 The Kirketon Road Centre's search for literature on compulsory treatment of non-offenders identified two research papers. The Centre's submission cited a 2002 Canadian paper focusing on compulsory drug treatment that concluded that 'the main issue, arguably, is that their true effectiveness and cost-effectiveness remains to be proven'.²⁶⁹ The other paper cited in the submission is an American study which looked at 850 articles on mandatory alcohol and drug treatment and concluded that 81% of them were opinion pieces, legal interpretations, or ethical treatises rather than methodologically sound, original research pieces.²⁷⁰

5.42 Asked by the Committee whether there is a sound enough evidence base to indicate that compulsory treatment can actually be of benefit, Professor Wayne Hall of the University of Queensland, and one of the few Australian academics to have published on compulsory treatment responded:

²⁶⁷ Ms Swan, Turning Point Alcohol and Drug Centre, Evidence, 28 April 2004, pp30, 32

²⁶⁸ Ms Swan, Turning Point Alcohol and Drug Centre, Evidence, 28 April 2004, pp30, 32

²⁶⁹ Fischer B, Roberts JL, Kirst M, 'Compulsory treatment in Canada: historical origins and recent developments', *European Addiction Research*, 2002, 8, p61-68, cited by Dr Hester Wilce, Submission 30, Kirketon Road Centre, p4

²⁷⁰ Wild TC, 'Compulsory substance user treatment and harm reduction: a critical analysis', *Substance Use and Misuse*, 1999, 34(1), pp83-102, cited in Submission 30, Dr Hester Wilce, Kirketon Road Centre, p4

I think the short answer would have to be “no”. I think there is somewhat better evidence for coerced treatment than there is for civil commitment, if we use that in the sense of drug dependent people being committed for their own good rather than because they have committed an offence.

I do not know of any controlled studies of civil commitment, certainly with alcohol. There was some work done in California in the 1960s, the civil commitment addict program there, although a lot of those people in fact were committed because they had committed offences rather than because they were simply using opiates and were dependent on them.

There was a recent update of the review which I did in 1997, which is now seven years old. There was a recent paper in the European *Addiction Research Journal* reviewing the literature since then, which comes to broadly the same conclusion: that there is not a lot of strong evidence for efficacy and it is almost all in the area of coerced treatment ... With regard to the civil commitment addict program, I do not know of any evidence that would support that.²⁷¹

- 5.43** Given that Sweden has made significant use of compulsory treatment for over 90 years, the Committee had hoped that that country would be a source of useful evaluative material. However, as Dr Matthews, who visited Sweden to collect information to inform New South Wales policy in relation to treatment of offenders, pointed out, this is not the case:

In other jurisdictions where similar legislation applies - and the most notable example would be Sweden - we have been unable to find through a literature search any scientific evaluation or research in relation to their legislation which I think has been in force since 1913 in a country where there are something like 4,000 secure beds for a population of 6 million. There is a very strong belief that it works, but no evidence.²⁷²

I have to comment that Swedish society is somewhat different to ours. They, as a community, have accepted that the State has a degree of responsibility for the individuals that we, as a nation of somewhat rugged individualists, possibly would not accept. So there is a difference in philosophy within the community in Sweden. In answer to your question, no, I do not really have any basis on which I can make an assessment. Until fairly recent times they have also been one of the most homogenous communities on the planet and that is another factor. Within our society as well, we have a great number and growing difference in cultural views about alcohol that would also need to be taken into account in relation to treatment programs and that, in itself, is a tricky issue.²⁷³

- 5.44** The literature about compulsory treatment of non-offenders leaves us with many unanswered questions, and the Committee considers that it is an inadequate basis on which to draw any safe conclusions in relation to effectiveness. As Ms Swan, one of the authors of the literature review noted:

²⁷¹ Professor Wayne Hall, Professorial Fellow and Director, Office of Public Policy and Ethics, Institute for Molecular Bioscience, University of Queensland, Evidence, 29 April 2004, pp2-3

²⁷² Dr Matthews, NSW Health, Evidence, 11 December 2003, p17

²⁷³ Dr Matthews, NSW Health, Evidence, 11 December 2003, p19

... the literature is really bare. Lots of it is discursive and descriptive. That was one of the things that we were really clear about when we did the review; that there is not a lot to draw on that's hard and good data, so we should be cautious about it.²⁷⁴

Anecdotal evidence on effectiveness

- 5.45** In the absence of rigorous research on the outcomes of compulsory treatment, the Committee obtained the views of a number of practitioners. The submission from Kirketon Road Centre, while noting the absence of research on the outcomes of compulsory treatment, commented:

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 is 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.²⁷⁵

- 5.46** Professor Mattick also observed that motivation is important in successful treatment outcomes:

I think the answer is that [if] people are disinterested in altering their drug use behaviour - they won't. What you can do, however, is deal with their physical problems and then, through that process, I think it is very important to capture that you can actually get those individuals to become more motivated ... So I think engaging people that way is likely to be helpful. Diverting resources from the health care sector to deal with people who do not want to be in treatment and trying to make them change is likely to get less good outcomes than leaving the money where it is.²⁷⁶

- 5.47** Dr Glenys Dore, an addictions psychiatrist and Deputy Medical Superintendent at Macquarie Hospital, noted that there are some people who do not wish to access treatment, as well as others for whom there are no successful treatment:

The difficulty is that this patient group do not want those services. They do not want to go to detox, or they do not want to go to rehabilitation, or they do not want to go on methadone programs, or they do not want to go on [acamprosate]. They would prefer to be using drugs and alcohol. The services are there, but they either do not want to use them or in some cases they have gone to all those programs and they are still not succeeding.

There are some patients for whom we simply do not have treatments that will be successful. There are cases of individuals that we just do not have adequate treatment services for or they do not exist. We do not know when we will have them. We do not have medication that controls everyone's addiction. So there are individuals who will not survive their problems with addiction and who we will not be able to help, unfortunately, with the best treatment services in the world.²⁷⁷

²⁷⁴ Ms Sylvia Alberti, Manager, Forensic and Clinical Services and Senior Research Fellow, Turning Point Alcohol and Drug Centre, Evidence, 28 April 2004, p32

²⁷⁵ Submission 30, Kirketon Road Centre, p3

²⁷⁶ Professor Mattick, National Drug and Alcohol Research Centre, Evidence, 8 April 2004, p14

²⁷⁷ Dr Glenys Dore, Addictions Psychiatrist and Deputy Medical Superintendent, Macquarie Hospital, Evidence, 4 March 2004, p11

- 5.48** While supportive of compulsory treatment, Ms Diane Paul of the Herbert Street Clinic noted a number of challenges associated with imposing treatment on unwilling patients:

While staff are skilled in using strategies such as motivational interviewing and working with clients to assist them in making changes to their lifestyle this is not always successful. In fact, I found the most challenging group of clients to manage are those who feel that they have been pressured into the treatment facility by others, such as family members, case managers or probation officers.

On the other hand, many clients who are initially lacking motivation for treatment do manage to complete the program and choose to go into rehabilitation post-detoxification. Our main challenge is to get clients through the first three days, get them through the withdrawal process so that we can actually have a chance to work with them.²⁷⁸

- 5.49** Ms Alberti advised the Committee that compulsory treatment can be valuable for some individuals:

the people who actually participate in it report back - or a large number of them have reported back - that they found it useful or lifesaving. And the field, regardless of where they come from, whether they be police or magistrates or health practitioners, are saying that for a very, very small number of people this can be a very beneficial intervention.²⁷⁹

- 5.50** Similarly, Professor Hall noted some benefits:

If one were to look at the more positive side of the *Inebriates Act*, there is certainly an important harm reduction function that was served in the wards that I worked in. We did clean people up and got them into much better shape, and by the end of the week they were looking a lot better, before they were shipped off to Bloomfield Hospital in Orange, often for six months at a time.²⁸⁰

- 5.51** This was reflected in the Swiss study referred to earlier, in which:

The usefulness of residential civil commitment of certain severely impaired alcohol dependent patients is underscored. This study suggests that civil commitment not only may save the lives of endangered patients but could also be a health-promoting measure that may sometimes allow for recovery from dependence. Unexpectedly, this measure was retrospectively well accepted by many patients, who considered the commitment decision as having been justified and useful.²⁸¹

²⁷⁸ Ms Paul, Herbert Street Clinic, Evidence, 4 March 2004, pp8-9

²⁷⁹ Ms Alberti, Turning Point Alcohol and Drug Centre, Evidence, 28 April 2004, p31

²⁸⁰ Professor Hall, University of Queensland, Evidence, 29 April 2004, p5

²⁸¹ Bourquin-Tieche, D, Besson J, Lambert H, Yersin, B, 'Involuntary treatment of alcohol dependent patients: a study of 17 consecutive cases of civil commitment', *European Addiction Research*, Vol 7 No 2, 2001, pp48-55, p48

Conclusion

5.52 In this chapter the Committee has briefly overviewed the broad range of treatments available for drug and alcohol dependence, and noted the varying success rates for them. We have also documented the available literature, along with anecdotal information, on the effectiveness of compulsory treatment. What is clear from the information before the Committee is that the evidence relating to the efficacy of compulsory treatment of non-offenders is scant. The few methodologically sound studies that have been published had equivocal findings, with mixed outcomes for those subject to coercion. Anecdotal evidence relayed to the Committee was similarly variable. In the Committee's opinion, the absence of any substantial evidence base for benefits of compulsory treatment raises serious questions about the ethics and cost-effectiveness of instituting a compulsory treatment regime.