**AMA(SA) Submission on the**
**Controlled Substances (Youth Treatment Orders) Amendment Bill 2018**

The AMA(SA) has significant concerns about proposals for mandatory treatment. This is reflected in our submission earlier this year to the previous Government's proposal to trial a model for mandatory assessment, detention and treatment for adults at extreme and immediate risk as a result of illicit drug use, with the focus being on crystal methamphetamine ('ice'). That submission can be found on our website here: https://ama.com.au/sa/sa-health-mandatory-drug-treatment-consultation-0.

Relevant AMA position statements include:

- AMA Code of Ethics - https://ama.com.au/position-statement/code-ethics-2004-editorially-revised-2006-revised-2016
- Mental health - https://ama.com.au/position-statement/mental-health-2018
- Harmful substance use, dependence and behavioural addiction - https://ama.com.au/position-statement/harmful-substance-use-dependence-and-behavioural-addiction-addiction-2017
- Methamphetamine - https://ama.com.au/position-statement/methamphetamine-2015
- Cannabis Use and Health - https://ama.com.au/position-statement/cannabis-use-and-health-2014

The AMA's position statement on Harmful Substance Use, Dependence and Behavioural Addiction (2017) indicates:

> ***Mandatory treatment***
> *In a number of state jurisdictions there are legislative provisions for mandatory treatment for people deemed to have severe dependence problems.*[1]
> *Although there is some argument that involuntary commitment may save lives in the short term, there is a lack of evidence around the medium and long term efficacy of compulsory residential treatment for non-offenders.*[2] *The unresolved questions about the efficacy of mandatory treatment programs make the evaluation of such programs a matter of priority.*

The desire to act against the toll that drugs such as methamphetamine can take, and assist and protect young people is understandable. The AMA(SA) is extremely concerned about the tremendously damaging effects of methamphetamine and other drug use not only for individuals but families and entire communities. However, patient autonomy is enshrined in the AMA's Code of Ethics, and it is also a core principle of the AMA that treatments should be informed and based on evidence. Mandatory treatment proposals are problematic on both counts. Aside from the concerns about a patient's right to choose, there is a lack of evidence around efficacy.

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[1] For example, The Alcohol Mandatory Treatment Act 2013 (NT) and Severe Substance Dependence Treatment Act 2010 (VIC).

[2] Broadstock, M., Brinson, D., & Weston, A. (2008). The effectiveness of compulsory residential treatment of chronic alcohol or drug addiction in non offenders. Health Services Assessment Collaboration, University of Canterbury. Accessed from: http://www.healthsac.net/downloads/publications/HSAC05%20A&D%20Act%20080708%20FINAL.pdf

In relation to the proposal to provide for mandatory drug treatment programs for children and young people, the references to the child or young person to be assessed or given treatment (Section 54) highlights the paradox of compulsory treatment in this setting. Without the person's active cooperation, there is unlikely to be an accurate assessment, engagement, and effective treatment. People engage in coerced treatment because it may be the preferred option when imprisonment or some other sentence is the other option. It is unclear what the other option might be in this case: detention without treatment, without there being a criminal offence, or a diagnosable mental disorder?

As raised in our earlier submission to the previous state government's proposal for mandatory measures for adults, mandatory measures in general risk further stigmatizing people with mental health and drug-related conditions. They also may undermine the role of psychiatry and addiction medicine specialists, and the doctor-patient relationship, through creating fear and undermining trust. We note that in the model proposed an order can be applied for by a treating medical practitioner: what impact may this have on the trust of young people to divulge truthful information to their doctor?

This proposal seems to be significantly linked to concerns about methamphetamine; however, alcohol or cannabis use is probably more common in this age group. In relation to methamphetamines, treatment evidence is lacking in children and adolescence. In terms of medication, most research relates to adults, not young people, but there are currently no therapeutic agents that support methamphetamine abstinence[3].

There is concern about young people coming to emergency departments in acute psychotic and sometimes violent states associated with the use of methamphetamine who subsequently opt out of support and treatment programs and may end up in an entrenched pattern. However, the response to this issue should be clinically informed and evidence-based. The AMA(SA) recommends seeking expert guidance on the response to this issue from the fields of psychiatry, physicians (addiction medicine) and emergency medicine, such as via the specialist colleges (RANZCP, RACP, ACEM).

**Patient characteristics**

In terms of patient group characteristics, this group would be very complex, characterised by high rates of psychiatric co-morbidity (other mental health conditions). Common problems would include high prevalence disorders, particularly social anxiety, PTSD and mild depression, and personality disorders. There would be high rates of young people in this group (around or more than 50%) who have had exposure to significant adverse childhood events that would be unmasked and require a therapeutic response (this could be an opportunity for treatment, or harmful to those not ready if the skills of the service are lacking). Among this group there would likely be suicide attempts, family dysfunction, and forensic problems. Social disadvantage would be over-represented as well. This group would usually abuse many substances (ie polydrug abusers), not just methamphetamine, and usually are impulsive by temperament. The characteristics described above apply both to methamphetamine users and heavy alcohol and illicit drug users.

**Treatment milieu**

This stigmatising treatment approach would have to deal with all of the problems mentioned above, with awareness of educational requirements also. A service would require a high level of treatment expertise, rather than goodwill of reformed users or the for-profit private sector. It would need to be led by specialists in psychiatry (child, youth and addiction), and addiction medicine (although noting the latter tend to take a biological approach versus the psychosocial treatments in the young sector and in addictions). Other input from the fields of social work, forensics and education would be

[3] AMA Position Statement on Methamphetamine (2015) https://ama.com.au/system/tdf/documents/Methamphetamine-2015-AMA-Position-Statement_2.pdf?file=1&type=node&id=42634

vital. It is already challenging to appropriately staff drug and alcohol and psychiatric services; there is the question of where staff would be found for this 24/7 service.

A building for inpatients would have to be secure — keeping people in and people out, and preventing drugs coming in (challenging and not successfully accomplished even in prison facilities). It has also been raised in our feedback that whatever treatment is made available, does not bring together groups of young people who are all in the same situation, as bringing troubled young people together can exacerbate the problem due to normalization of substance use behaviours. We received feedback that care should be taken to ensure they are treated on an individual basis away from peers in the same situation, and definitely away from adults with concurrent substance use issues.

**Research**

If adopted, there would need to be ethics consideration for this treatment approach, as it is experimental; and evaluation. A proper systematic literature review would be required, and a proper implementation approach that is scientifically rigorous, involving clinicians, carers, consumers and experts. In relation to the previous mandatory model proposed (for adults, for a period of up to two weeks) the AMA(SA) advocated that should a mandatory program be adopted, it should be a trial only: a randomized controlled trial with similarly resourced intervention and control arms, coordinated by an external academic institution, with an obligation to report to Parliament. This would present opportunity costs which should be considered.

**Context**

The AMA(SA)'s overwhelming preference is for well-resourced voluntary treatment, and more early support, education and intervention. Drug and alcohol services are already under resourced and under-funded, and the AMA(SA) would want to see that funding directed to where it will be most effective. There is already a lack of mental health beds and insufficient services for those in need of treatment. Where would the people captured under this measure be placed? We note with concern reports in *The Advertiser* that a report from the Victorian Alcohol and Drug Association found that "SA had the lowest number of residential treatment beds per head of population at just one for every 35,000 people" versus in WA, NSW, Tasmania and Queensland there was a bed for every 10,000 people, based on 2016 information.

This proposal would be expensive, and, as we noted in our earlier submission regarding mandatory measures for adults, more would be achieved through funding existing tertiary services with evidence-based treatments, and providing more drug and alcohol services at the points of presentation. A new proposal would need new funding, not a redirection of funding from existing services. This treatment program, even though conceived as a last resort, would be expensive, and unless additional funds are provided, the AMA(SA) is concerned it would result in a displacement of voluntary clients from the treatment system.

If a mandatory option did proceed, the medical opinion would need to be the most important factor in the assessment decision. Any model would need to be guided and informed by expert input from the relevant medical specialties; we would recommend this be done through the specialist medical colleges. The Association also advocates that policy decisions affecting children and young people should also involve, and include meaningful consultation with, organisations and authorities representing children and young people. The Bill itself is problematic in a number of respects – we have not commented here on all the issues in relation to specific clauses and wording, focusing rather on the problematic and challenging premise, principles and context. Suffice it to say that should this contentious proposal gain support to proceed, the Bill itself would need revision and much closer consideration, informed by expert health, medical, legal, rights and ethics input.