Victorian Alcohol and Drug Association

Victorian Alcohol and Drug Association (VAADA)
Position Paper:

Summary of AOD sector feedback on Independent Review of Compulsory Assessment and Treatment Criteria and Alignment of Decision Making Laws

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Background

Victorian Alcohol and Drug Association (VAADA) conducted a 2 hour consultation workshop with members of AOD sector regarding questions raised in the consultation paper titled "The Independent review of compulsory assessment and treatment criteria and alignment of decision-making laws".

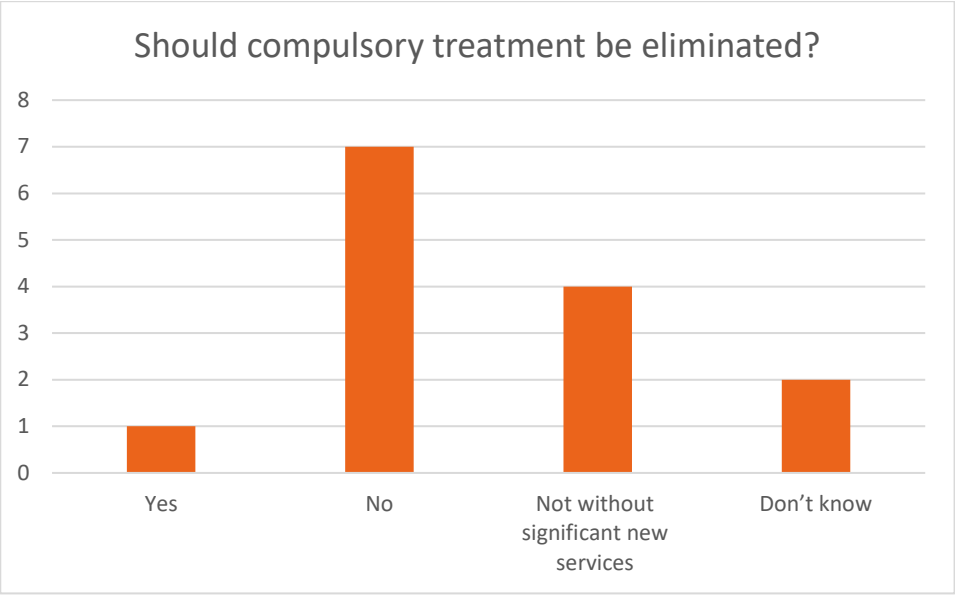
Eighteen participants were involved in the discussion and below is a summary of their feedback.

VAADA acknowledge that;

- People who use substances are often subject to compulsory treatment under the Mental Health Act (although data is not publically available).
- Access to AOD professionals (including LE professionals) for those on compulsory treatment orders is often minimal.
- There is a need to consider the safety and wellbeing of all (individual, family and supporters, workforce) as efforts to reduce the use of compulsory treatment are made.
- The best outcome for individuals presenting to mental health services with AOD needs will be via access to a specialist AOD workforce that can enable intervention across a harm reduction to abstinence spectrum based on an individual's preference and balanced with a 'dignity of risk' lens.

Response to consultation paper questions

1. **There are many different perspectives on compulsory treatment. One of these is that compulsory treatment should be abolished/eliminated entirely. Do you agree with this?**



Half of the participants in our consultation did not agree with the idea that compulsory treatment be completely eliminated and a further 28.5% did not agree with elimination without the implementation of a range of new services to counteract the needs that compulsory treatment currently meet.

Through discussion it was clear that the need to protect the safety of the individual and others (staff, family, community) was foreseen as the main barrier to the elimination of compulsory treatment. It was difficult for participants to envision a system without compulsory treatment unless there were significant changes in several service systems, inclusive of mental health, AOD, housing and a range of other social determinants of health.

Despite these findings, there was support for the reduction of compulsory treatment and the implementation of new mechanisms to better protect an individual's human rights and the nature of the service that compulsory treatment orders will provide.

2. What are the implications if compulsory treatment were to be eliminated?

The most significant implication identified by participants relates to lack of alternative options for individuals presenting intoxicated when accessing mental health and wellbeing services. It was identified that currently, many individuals attending emergency departments or in contact with emergency services are placed on compulsory assessment orders and interim treatment orders as a way of providing containment, and at times 'removing' them from more public spaces (e.g. emergency departments) as there are no other options. There are multiple reasons why this pathway is not appropriate as follows;

- Not all mental health services have access to addiction medicine or AOD clinicians to provide the required support to these individuals over a 24 hour.
- The experience of denial of liberty for individuals can cause trauma and may in fact, deter future contact with mental health support services where mental health symptoms are to arise.
- There is limited capacity within inpatient mental health facilities

As a result of these gaps and pressures, if compulsory treatment were to be eliminated, there would be no alternative options for those presenting intoxicated or 'appear' to have a mental illness. Ultimately, if compulsory treatment were to be eliminated or as it is reduced it will be essential to build up alternative options for AOD presentations. To achieve this transparent data and collaborative efforts between all systems (including government and lived experience) of the AOD and MH sectors will be required.

It was identified by one participant and agreed by others that

> "An adequately resourced AOD sector with more capacity for earlier intervention and assertive outreach responses would assist with a reduction in the number of people reaching such crisis states that they might require some sort of compulsory intervention"

This statement is true currently and if compulsory treatment were to be eliminated or as it is reduced the magnitude of this reality would be far more obvious.

To enable the reduction or elimination of compulsory treatment for those with substance use or co-occurring MH and AOD needs, participants identified the following recommendations;

- Connection between Area MHWB services with the 'sobering up' services introduced as part of public intoxication reform
- Increased funding for 'short-stay' model of care options for people presenting to emergency department intoxicated, without evidence of mental illness or significant physical health issue, but requiring or requesting support.
- Increase in the number of AOD clinicians (including peers, addiction specialists, nurses and allied health clinicians) in mental health and wellbeing 'access' points. This would enable access to specialist advice on use of compulsory treatment for people with substance use issues; consumers to access a skilled AOD response when in crisis; support for staff around implementing harm reduction and dignity of risk towards substance use; and create more opportunities for innovation around use of alternative methods of de-escalation for individuals with acute behavioral disturbance as a result of intoxication.
- One participant noted

  "I manage an AOD catchment. I have never had a psychiatrist consult us about a Treatment Order. No psychiatrist or mental health clinician has enquired with us about an individual's AOD treatment history, pattern of use or risk". Increasing the connection and requirement for collaborative care between community AOD services and MH services as part of the process of applying a compulsory treatment order could minimize the use of CT.

  The enhancement of the current Emergency Department AOD initiative in conjunction with the Addiction Medicine Specialist services connected to the Hamilton Centre could begin to meet this gap.
- Ensuring that all hospitals that manage Area mental health and wellbeing services have withdrawal beds. The availability of this service would offer an alternative to compulsory inpatient treatment for substance users, enable pathways to treatment and embed a culture of a health response to AOD use within these institutions.
- Education and support for medical practitioners to admit an individual under a medical duty of care as opposed to requiring an interim treatment order.

Participants noted that the safety and wellbeing of the workforce also needs to be a priority if elimination of compulsory treatment were to be considered. It has been identified that achieving the balance between assuring safety to others (including workforce, family and community) and meeting an individual's basic human rights is the most significant barrier to reduction of compulsory treatment. Working with family, workforce and the broader community to identify the risks and strategies to mitigate these risks will be necessary if compulsory treatment were to be eliminated.

Participants identified the need to support a social determinants of health model across the health and wellbeing spectrum if compulsory treatment were to be eliminated. Ensuring that all individuals who experience mental health and/or substance use issues had their basic needs met will reduce rates of psychological distress which in turn can reduce reliance on substances, mental health symptoms, and enable engagement in community and support. This could include an increase in 'wrap-around' service delivery models to improve connection between housing, legal, financial and family violence services with MH services. Specifically the issue of

safe housing and enabling access to community residential care units (CRCU) for people with substance use issues was identified as a means of reducing the risk of problematic substance use.

3. What do you think the purpose of compulsory treatment should be?

Participant's views on the purpose of compulsory treatment predominantly reflected the current MHWA identified purpose of preventing harm to self or others where there are no less restrictive options available.

From an AOD perspective, the presence of life threatening conditions connected to substance use (e.g. Wernicke's encephalopathy) was identified as a clear reason for the use of compulsory treatment under the MH Act. It was noted that an important step in clarifying purpose of compulsory treatment for people who use substances will be examining the cross-over between the Severe Substance Dependence Treatment Act (SSDTA) and the revised MH Act in terms of which will serve to best meet the needs of individuals with life threatening conditions related to substance use. Process should never be a barrier to ensuring a consumer has access to services yet as referenced in a review of the SSDTA, in situations where either act may apply, practitioners favour the accessibility of the MHA over the SSDTA for its ease of application.

The correlation between use of assessment and temporary treatment orders and management of acute behavioral disturbance requires further exploration. Holding someone on a compulsory treatment order only to administer medication to reverse acute behavioural disturbance is unnecessary and unethical. Alternative options should be trialed and resourced to ensure service responses for people presenting intoxicated are provided without the need for compulsory mental health treatment.

The type of 'support' received if someone were to be subject to compulsory treatment was also raised as an important consideration regarding purpose. There are multiple examples of individuals who have been on compulsory treatment orders who have been vilified for their perceived 'lack of compliance with treatment'. It is suggested that this narrative and stigmatizing notion should be turned 'upside down' and that where consideration of forced treatment is made, it is done so because the service response has not been successful. If this rhetoric were to be followed, it would suggest that those subject to compulsory treatment would receive an elevated service response. Mental health services would then be responsible for seeking specialist advice, accessing multidisciplinary support and or wraparound service models as a result of an individual being placed on a compulsory treatment order. Further, compulsory treatment may be a trigger for a full review of the individual's history by professionals with expertise in the presenting symptoms, collectively with the individual and their family or supporters that prioritize achieving a balance between dignity of risk and use of treatment.

The connection between the purpose of compulsory treatment and other potential changes to its application were also suggested. One participant noted that compulsory treatment only be enacted if it was indicated in the persons advanced statement or values statement. Another that the decision making capacity criterion should be included and therefore no individual who

is deemed to have the capacity for decision making should be subject to compulsory treatment.

4. What should supported decision making in mental health treatment look like?

In discussion regarding supported decision making the importance of a principled care system was identified by participants. Ensuring that an individual felt they were heard, provided with a suite of options, empowered to make decisions through conversations with peers and qualified professionals, supported in the context of their family and environment were noted of importance.

In order to appropriately support principled care in practice the time for engagement and understanding in the context of an individual's specific cultural, spiritual, psychosocial and decision making capacity are vital. One participant commented on the need to support people through a social determinants of health lens, identifying that ones' capacity for supported decision making can be greatly impacted upon by other stressors such as access to safe housing and food. If individuals were to be supported to meet their basic needs, it would strengthen engagement with the provider, provide essential information about decision making capacity and enable supported decision making. Arguably the decision to assign a substitute decision maker for a person should only be made following interventions such as these which would also meet a trauma informed approach at ensuring sense of safety before any decision making.

The use of AOD professionals in a supported decision making approach is essential. Stigma remains a barrier to individuals seeking support for their AOD needs. Ensuring that an individual has access to an AOD professional (including lived experience) prior to assigning a substitute decision maker would, through the provision a non-judgmental, harm reduction framed intervention, support the individual to make informed choices regarding substance use that impacts on their mental health. The services providing the 'opt-out' non legal advocacy service, implemented as a result of the new MH Act will require expertise in advocacy regarding substance use alongside mental health needs.

5. What are the implications of having a values statements as an additional option for consumers?

Generally participants were in favour of the introduction of a values statement with one participant stating "It should be core business and part of everyday practice or at least offered". In order for a values statement to be meaningful however, participants' identified the following necessary process considerations;

- Development of a values statement would be best supported if the client had an established relationship with a clinician
- Particularly helpful for individuals with trauma histories that can regain a sense of control over any treatment interventions.
- Should be made collaboratively with people that the consumer identifies as their supporters.
- Consent should be sought to share the values statement with any health services and professionals and routinely reviewed with individuals.
- In terms of substance use a values statement could aid as a communication tool to express preferences for treatment interventions at times of crisis (i.e. I prefer oral

medications to manage acute behavioral disturbance or I am aware that Olanzapine is not sufficient to manage intoxication.)

- Where an individual is a poly substance user, a values statement that is held by the individual, may aid in contextualizing any identified mental health or substance use risk.
- From a harm reduction perspective, a values statement will allow for individuals who use multiple substances to identify their preferences about abstinence, reduction of use or no intervention.
- Need to ensure dignity of risk is upheld and service providers, family and supporters are supported to take a balanced approach to the writing and implementation of a values statement that take into account any risk of coercive control.
- The necessary environment and culture that would be required to ensure that the individual felt safe enough to disclose a preference for continued use in a values statement would be necessary.
- The necessary supports (both capability and personally) for the workforce to enact values statements that may be contradictory to the criminalization of drug use.
- That the 'opt-out' non legal advocacy service supporting individuals is skilled in AOD related advocacy alongside mental health advocacy and works with a harm reduction framework.

6. Are there any compulsory treatment criteria that are particularly problematic?

Participants identified the following problematic criteria for **assessment orders;**

- The use of the term 'appears to have a mental illness' as defined by the MHWA is too ambiguous. Symptoms of substance intoxication can easily be misidentified as symptoms of mental illness and the treatment pathways will be different dependent on the cause of symptoms.
- The notion of 'treatment' is ambiguous. Sedation and sleep should not be considered 'treatment'. Many services do not have adequate resources to 'treat' substance use or dependence and therefore no guarantee can be given that the 'right' treatment will be provided. There should also be clear guidance regarding the use of harm reduction and a dignity of risk approach regarding substance use as opposed to an 'abstinence only' model.
- One participant noted "rather than go straight to an assessment order why not wait until the person is sober and discuss it with them". Consideration of a time period of observation before someone is placed on an assessment order should be considered. This would also allow for the collection of collateral information from friends, family, supporters and health professionals external to the mental health service.
- The function and need for 'assessment' has been discussed at length as part of the development of an Access Policy for AMHWB and LMHWB services. A full comprehensive mental health assessment, which would currently be completed upon service access, is not always necessary, can be long and repetitive and trigger traumatic memories. Thus the third criterion "the person can be assessed if made subject to an assessment order" need reconsideration or different terminology to differentiate between medical examinations versus comprehensive mental health assessment. Any invention for individuals presenting

in crisis should be first and foremost be to protect life, arguably this does not require full assessment but rather mitigation of life threatening risks.
- In regional areas, assessment orders are often used to enable transport from smaller hospitals to the designated mental health facility in the region. From an AOD perspective, this would be less necessary if all hospitals had access to beds for people experiencing acute behavioral disturbance as a result of substance use and pathways to AOD treatment.
- The use of assessment orders are enmeshed issues of seclusion and restraint and any adaptations to criteria should be cross- referenced with actions to eliminate seclusion and restraint.

Participants identified the following issues with the criteria **for compulsory treatment and temporary treatment orders**;

- There remains ambiguity about the scope of 'mental illnesses as defined in the new MHWA in relation to substance dependence. It is noted that individuals who have used substances, across the spectrum of use, abuse or dependence can present with significant disturbance of thought, mood, and perception of thought, and according to these criteria would meet criteria for compulsory treatment. Further the Diagnostic Statistical Manual V (DSM5) lists substance dependence as a mental illness. In spite of Recommendation 35 of the Royal Commission for all mental health services to provide integrated mental health and AOD treatment, this requirement does not assure the provision of AOD treatment alone. If an individual who uses substances, and has no other comorbid mental health issues were to be subject to a compulsory treatment order based on the current criteria, they would not be able to access an AOD treatment directly.

7. What changes could be made to the assessment and/or treatment criteria?

- The definition of 'mental illness' needs to specifically identify that individuals presenting with substance use and no other mental health symptoms cannot be subject to compulsory treatment.
- Where there is uncertainty about the cause of presenting symptoms of an individual (unconsciousness, inability to communicate, sedation) a checklist of criteria could be developed to ensure due diligence is taken prior to consideration of compulsory treatment. This may include contact with external service providers and family, friends and supporters or assessment by an Addiction Medicine Specialist.
- Alternative services could be established across all designated mental health services to safely support the needs of individuals who present intoxicated (e.g. short stay, sobering services) as an alternative to the need for mental health treatment
- Clear guidance should be provided to clinicians regarding the suitability of 'assessing' someone who presents intoxicated. Suitable timelines should be installed as criteria to prevent the use of assessment orders on people that present intoxicated.
- Further education and support should be provided to staff on recognizing trauma based responses. There are circumstances where individuals may be placed on treatment orders as a result of behaviors that are deemed 'inappropriate', 'aggressive' or 'harmful to others'. Behaviour alone should not be sufficient to warrant use of compulsory treatment and a focus on increasing capability of staff to recognize trauma based responses would reduce the need for orders based on behavior.

8. Should the compulsory assessment and treatment criteria include a decision-making capacity criterion? What are the considerations?

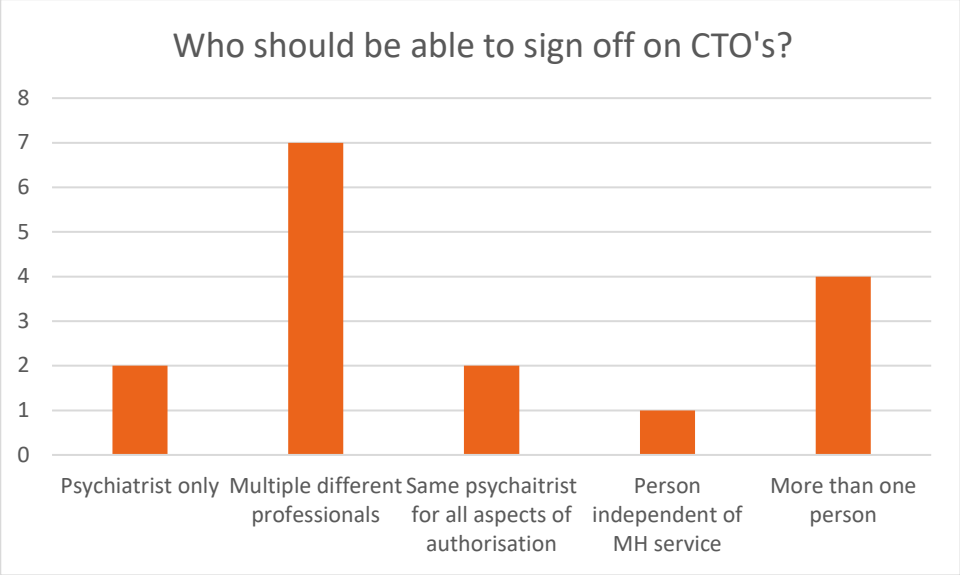
From an AOD perspective, participants felt that the presence of a decision-making capacity criterion as part of the criterion for compulsory treatment warrants consideration. Aside from this provision better enabling human rights of people with mental illness, as outlined in the consultation paper, it would also better align with other decision making laws.

It was acknowledged that the ability for decision making, according to the legal definition, may be impaired in different ways as a result of substance use. Firstly an individual may meet this criteria for a short period as a result of intoxication. Secondly, decision making capacity could be permanently altered following long term substance dependence, consequences of overdose or conditions arising as a result of substance use. These distinctions have implications for the duration, purpose and means of determining decision making capacity.

The following processes could be considered in these circumstances to ensure appropriate determination of decision making capacity;

- Consultation with an individual's AOD service provider to understand patterns of use in relation to decision making capacity and evidence of capacity for making decisions outside of those relating to substance use
- Use of addiction medicine specialists in a multidisciplinary team to determine decision making capacity. Determining whether an individual is substance dependent should be considered when determining decision making capacity. Substance dependence should not be suggestive of an inability for decision making capacity, but rather as a context similar to other co-occurring physical conditions.
- Incremental testing of decision making capacity during the first 48 hours of an individual's presentation to measure the impact of intoxication on decision making capacity.
- The importance of ensuring that the assessment of decision making capacity was completed by a culturally competent multidisciplinary team.
- It was identified that the criteria noted in the consultation paper would require specificity regarding mental health/ substance use to be fit for purpose. For example, where a person presents with co-occurring substance use and mental health symptoms, their decision making capacity regarding mental health treatment should be separate to decision making capacity regarding substance use. This would enable greater assurance of dignity of risk and possibly assist in engaging individuals in mental health treatment without compromising their right to choose to use substances.
- That decision making capacity be determined in conjunction with the 'opt out' independent advocate
- Decisions on decision making capacity should not be determined by a single professional

9. **Who should be able to sign off on an assessment order, temporary treatment orders, treatment orders?**



Whether different professionals or individuals, it was identified by the group that ensuring that more than one person signs off on a compulsory treatment order is preferred. The group specifically discussed the potential for any individual with co-occurring substance use and mental illness to have any order signed off by an addiction medicine specialist alongside other members of a specialist treating team. Providing this expert oversight would ensure that all other options are considered and discussed with the individual prior to an order being put in place. Further it would also ensure that individuals with substance use were being supported by experts in addiction as opposed to experts in mental health alone.

10. **Are there exceptional circumstances in which community treatment orders are appropriate?**

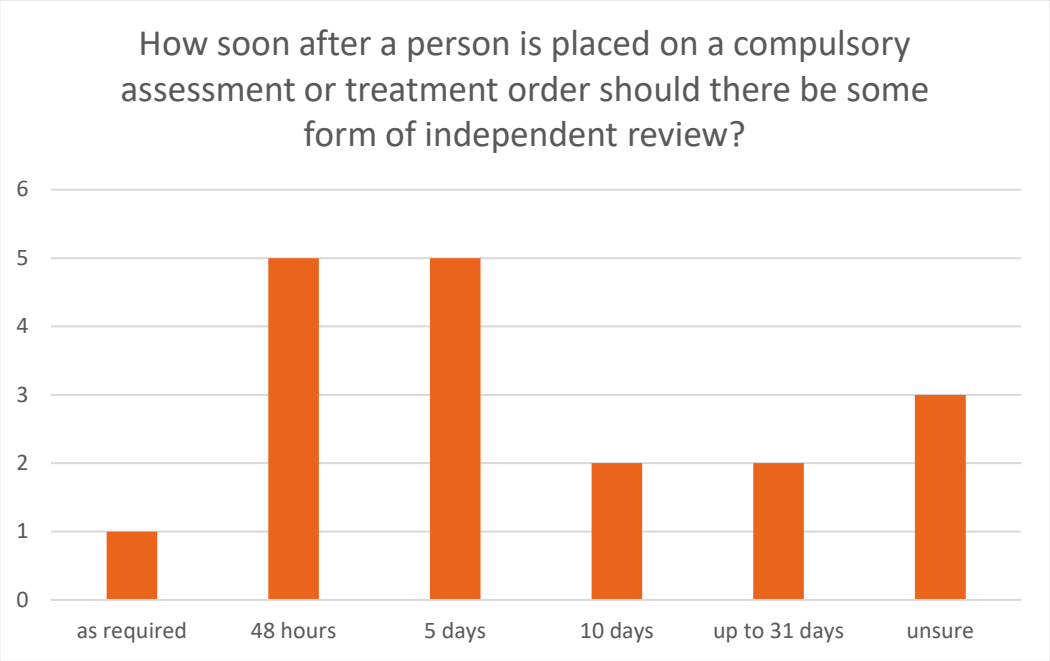
The statistics contained in the consultation report regarding rates of community treatment orders within Victoria and efficacy rates are alarming and certainly indicate the need for an alternative approach. Despite this, participants indicated that there may still be the need for community treatment orders in cases where individuals present at high risk of harm to self or others and treatment has not been successful. If community treatment orders were utilized, it was felt that they should only be used with strict protections in place for the individual and access to the best treatment options and professionals.

One participant stated that “use of community treatment orders should be consistent with the AOD sector harm reduction approach to keep people alive and as healthy as possible”.

The limited evidence of the effectiveness of community treatment orders should prompt a question around the purpose and access to support and services of such orders. If community treatment orders granted extra or more intensive access to services and support for individuals or a different type of response from practitioners, the outcome may be more favorable. This may be particularly true for individuals who have been on a cycle of community treatment orders without change. In terms of interventions for people with co-occurring needs on CTOs, there may need to be consideration of purchased AOD treatment beds for rehabilitation and/or withdrawal.

For those currently on community treatment orders a review process with a multidisciplinary panel should be implemented as an initial step towards reducing compulsory treatment rates. Conducted in a systemic way, this could provide vital information to inform thinking on implications and alternative options for compulsory treatment. Any information gathered from this review should be made publicly available to enable all intersecting systems to identify possible implications for their practice and system and a collective project should be established to action any outcomes.

11. How soon after a person is placed on a compulsory assessment and/or temporary treatment order should there be some form of independent review?



Whilst there was no consensus as to an appropriate time period for independent review of compulsory assessment or treatment, there was a preference for a smaller timeframe for review in comparison to the current standard of up to 31 days.

For those with co-occurring AOD and MH needs there may be extra considerations for appropriate time frames for review. For example the absence or presence of mental health symptoms once intoxication has resolved could be a significant decision making point about a individuals treatment, need and decision making capacity. Without a smaller timeframe for independent review, there is inherent risk in prolonging compulsory treatment without just cause and inadvertently increasing the risk of an individual experiencing psychological harm as a result.

Conclusion

It is hoped that the need for independent review may be lessened as the vision of the Royal Commission is realized. The implementation of other suggested measures in this paper such as values statements, increased AOD service options, changes to compulsory treatment criteria in conjunction with implementation of other Royal Commission recommendations such as changes to access and triage functions and policy, integrated treatment and Local MHWB services will collectively aid in reduction of the need for compulsory treatment.