Victorian Alcohol and Drug Association

Victorian Alcohol and Drug Association (VAADA)
Position Paper:

Strategy towards the Elimination of Seclusion and Restraint – Views of the AOD Sector

Contact: Gillian Clark

Mental Health Reform Project Lead

gclark@vaada.org.au

21st July 2023

Background

In response to the request via Engage Victoria for feedback, VAADA coordinated an online consultation session on the 13th July 2023 with workers from the AOD sector to gather their perspective on the questions raised.

The following report details outcomes of this consultation session and highlights the need to routinely incorporate perspectives from the AOD sector and people with lived and living experience of substance use, their families carers and supporters in order to achieve the elimination of seclusion and restraint.

Response to Discussion Paper Questions

DRAFT 'WHY' AND 'HOW' STATEMENTS

1. **Does the 'why' statement reflect everything you feel it should? If not, what else should be included? Does the 'how' statement reflect everything you feel it should? If not, what else should be included?**

Participants expressed no opposition to the draft 'why' and 'how' statements, however some participants expressed concern that without explanation of the process for how these vision statements would be realised, the statements held less meaning.

These concerns were raised in the context of the possibility that seclusion and restraint practices were used primarily in the absence of alternative interventions. It was felt that without this strategy pointing to new 'interventions' and the creation of new approaches, these statements lack strength. This is particularly relevant to appropriately meet the needs of people with co-occurring substance use and mental health needs that attend mental health and wellbeing services with the acknowledgment that not all MH services will have AOD leadership and expertise, culture and services embedded within their service model. Participants expressed their views that without resourcing of alternative strategies and an iterative, 'what is working' approach, the status quo may remain.

Participants shared concerns about the ambiguity of some of the language in the statements. Specifically, reference to the phrases 'a properly resourced system' and 'safety for all' was made. The need for clarification and expansion of the notion of 'the system' was raised with an acknowledgement that it is not just the mental health and wellbeing system that requires resourcing to achieve the elimination of seclusion and restraint. It was reflected that individuals who experience restrictive interventions will have contact with intersecting systems of care, and that if properly resourced these systems could significantly aid in minimisation of the severity of symptoms experienced, support wrap-around models of care (pre and post MHWB intervention) and thus reduce the need for crisis intervention and use of restrictive interventions.

It was also noted that appropriately resourcing and facilitating, through system design, the collaboration and connection between hospital based MHWB and other community support services (AOD, Homelessness, family violence etc.) was essential. Supporting this connection would better enable greater use of allied services and families in de-escalation efforts, defusing trauma-based reactions and advocating for individual's preferences when these are unknown. For example, one participant noted that prior to the use of physical or mechanical restraint within an Emergency Department she worked in, clinicians would contact family, however this practice did not occur for use of chemical restraint. Another participant noted the risk of

individuals leaving mental health and wellbeing services without intervention as no alternatives to restrictive interventions were available. In these circumstances, other appropriately resourced systems of care, that have connection to the individual, can offer community based support and understand potential triggers, could provide essential support at these times.

DRAFT PRINCIPLES: 1. On a scale of 1-5, how important are each of the above principles to include in this strategy? (1 = very important, 2 = somewhat important, 3 = neutral, 4 = somewhat unimportant, 5 = not at all important)? Why have you nominated these as important or less important? Are there any additional principles that should guide the design, implementation and monitoring of this strategy?

It was generally identified that these principles are not adequately reflective of the needs of individuals who use substances, their families, carers and supporters.. This is not in line with the spirit of the Royal Commission for an integrated AOD and MH response.

The following quote from the Royal Commission report was felt to best represent the significance of embedding integrated treatment, care and support within the reimagined mental health and wellbeing sector.

"Integrated care for substance use or addiction will be a core function of mental health and wellbeing services for young people, adults and older adults. It will also be an expectation of Victoria's emergency departments, including the new Mental Health and Wellbeing Crisis Hubs located in each region. For consumers who need to find community or hospital bed-based care, integrated care for co-occurring substance use or addiction will be provided alongside mental health treatments and therapeutic interventions". Page 328, Chapter 22, Volume 3.

Further, the following table taken from the Royal Commission final report illustrates the need for integrated treatment to be included as a core response within mental health and wellbeing services and how, particularly within Emergency Department settings and transportation services, , these settings are very likely to come into contact with people with co-occurring mental health and AOD needs. The quality of their response to AOD presentations, based on capability and capacity, particularly as first responders, will be paramount to any efforts towards minimising harm and triggering any trauma based response.

Figure 22.7: Estimated number of people who used mental health-related services and alcohol and other drug services who also accessed ambulance services and emergency department services, Victoria, 2014–15 to 2018–19

Sources: Department of Health and Human Services, Integrated Data Resource, Client Management Information/ Operational Data Store, Victoria Emergency Minimum Dataset, Victorian Ambulance Minimum Dataset, Victorian Alcohol and Drug Collection 2014–15 to 2018–19; Australian Bureau of Statistics, Australian Demographic Statistics, June 2020, cat. no. 3101.0, Canberra.

Note: In this instance, mental health consumers includes consumers who accessed mental health services in the public specialist system, private hospitals and emergency departments.

Figure 1: Taken from Royal Commission into Victoria's Mental Health System Final Report, Volume 3, Chapter 22

These direct excerpts support the strongly held views by participants that this strategy should include a principle relating to co-occurring mental health and AOD.

Participants noted the explicit reference by the Commissioners that co-occurring mental health and AOD needs are to be considered an expectation rather than an exception and felt that not including this as a principle for this strategy risks limiting the ability for an integrated treatment response for those presenting with high risk behaviours and the elimination of seclusion and restraint practices amongst those for example, presenting with intoxication. It was reinforced by the group that it is inappropriate to provide a mental health response to an AOD problem, yet without alternative options, this is often the only measure available to health practitioners.

It is noted that the discussion paper identifies that the strategy needs to have consistency with the principles outlined in the Mental Health Act. Upon reflection it was noted that some of the principles listed were strongly consistent with those in the Act, whereas others from the Act were omitted. Specifically the principle of a 'health led response' within the Act is essential within this Strategy. This principle sets the expectation for a culture within these settings that enables health and wellbeing at all times. As reflected by several participants, the criminisaltion of substance use continues to be a barrier to a health-led response and arguably not including it in this strategy minimises the need to address this barrier. One participant shared an experience of having to call a CATT team to an individual accessing treatment in a community AOD treatment setting. Police attended with the CATT team and immediately handcuffed the individual - 'just to be safe'. Whilst it is acknowledged that in a future state, it will Ambulance Victoria rather than Police attending with CATT teams, Police and security guards within the settings listed will remain and it is

restrictive interventions such as this that may be overlooked if a principle of a 'health led response' is not included in the strategy. The health-led principle is also strongly interconnected with the principles of safety for all and human rights.

Human Rights Principle

Participants noted significant challenges in prioritising the principles for fear that those principles not ranked highly would be missed or minimised For example, one participant noted that a principle of human rights is essential and should be expected as a legislative requirement and overarching principle for all mental health and wellbeing work. It was felt that ranking it against other principles minimises the necessity as an overarching principle. Further, there was some concern that some principles (e.g. human rights) should be able to be expected as a result of legislation. Participants felt there was risk, of minimising the significance of this overarching right through a prioritisation process. Similarly some participants felt that a Lived and Living Experience principle was a priority however questioned whether this should be a policy of inclusion of this notion as opposed to having to include it as a principle.

The description of this principle would be strengthened if there was a particular reference to 'dignity of risk'. From a human rights perspective, all healthcare workers must accept that it is the right of any individual to take risks and make choices, including choices about substance use. This notion, and a working understanding of how it can be upheld in practice, will be essential in minimising use of restrictive interventions as there is a shift in the culture regarding risk that is currently driving a lot of mental health and wellbeing practice.

Transparency Principle

Several participants noted the importance of the principle of 'Transparency' as key to success. Ironically, data on the diagnoses or prevalence of substance use amongst those who are secluded or restrained has not been made publically available. Anecdotally, substance users are restrained and secluded regularly within mental health and emergency department settings and multiple participants shared stories describing these experiences

One participant noted that, *"These practices have existed for so long because they are invisible."* And this sentiment was reflected further by participants agreeing that it is very difficult to change what is unknown. Without transparency of data, processes, successes and failings, the changes necessary will be difficult to achieve.

Appropriately Resourced System Principle

There was some discussion amongst participants of the importance of the principle of an 'appropriately resourced system' to enable the elimination of seclusion and restraint highlighting the potential for a range of different perspectives. Firstly, participants noted the importance of realizing that the 'system' should not be narrowly defined and in order to be able to eliminate seclusion and restraint. Greater support options needs to be available within the community to prevent the need for crisis care. This would include appropriately resourcing the AOD treatment sector to limit waiting lists for treatment and resourcing the harm reduction sector to minimize harms associated with substance use. These would likely help reduce the burden on EDs and other settings and reduce the number of incidents potentially requiring seclusion and restraint.

Likewise, appropriately resource the public intoxication reforms may have a similar benefit. Accountability for allocation of funds towards AOD specific interventions in mental health settings is also required to ensure that any systemic measures implemented are effective and meaningful Further, participants also noted the importance of the 'resourcing' to be specific to need. One participant shared the experience of an individual with co-occurring mental health and AOD needs that was routinely treated by Police and Ambulance Victoria, bought into Emergency Departments for treatment only to be discharged following crisis resolution as a result of no service willing to provide AOD treatment with an interpreter. This type of 'specific needs based resourcing' should be enabled based on community need in order to reduce the 'revolving door' experience.

Lived Experience Lead Principle

This principle does not adequately incorporate AOD lived experience, nor the value of voices of people 'living' with mental illness, psychological distress or substance use and addiction. The strategy would be strengthened by a definition of lived and living experience specific to this strategy in an appendix of definitions.

Collaboration and Communication Principle

There is a need for collaboration with key intersecting systems of care that routinely support people who may be secluded or restrained. There could be opportunities for partnership via AOD peak bodies, for example, that could ensure ready access to evidenced based practice, ease of engagement with community AOD sectors and an avenue for shared advocacy where needs of individuals are not appropriately met by the reformed system.

This principle does not contain any reference to improved communication. Appropriate, person centred, non-judgmental and non-stigmatising communication is essential when managing instances of crisis, distress, emotional dysregulation or behaviour as a result of neurobiological changes. The need for strong communication extends beyond the individual and is particularly important between hospital departments, within multidisciplinary teams and with families as well as cross- sectoral communication to enhance community service responses to individuals who may be secluded or restrained.

Evidence based practice principle

Participants reflected on the multiple and varied reasons that could lead to an individual being secluded or restrained and overwhelmingly supported the need for mental health and wellbeing services to embrace a biopsychosocial and preventative lens to any data collection and research. It was shared during the consultation that there are common vulnerabilities amongst individuals that are subject to restrictive interventions such as substance use, trauma, family violence, communication difficulties, including having English as a second language and cognitive limitations. Without data collection and research into these vulnerabilities, the ability to implement best practice will be short-sighted and risk only focusing on interventions at the time of crisis rather than preventative interventions to minimise risk of behavioural disturbance or behaviours that may result in use of restrictive interventions.

To this effect there is a specific need for evidence based practice to manage intoxication and withdrawal within all these service settings. Significant learnings can be gained through reflecting on practice change that occurred within many of these settings following the increase in presentations relating to use of methamphetamines such as acute behavioural disturbance guidelines development. Examining the usefulness, sustainability of these measures without AOD

leadership, and potential for applicability to other substance use presentations is essential in addressing the needs of people with co-occurring mental health and AOD needs.

It was also shared that evidence used to support this strategy should be focussed on individual clinical journeys and examination of factors that led to the use of seclusion and restraint, alongside rates based data. All of these settings collect clinical information of the people they see. Some of these settings will have significant information of an individual's service access history, story, current and historical personal information that could be used in a reflective and preventative way to shift practice. Several participants supported the idea that between now and 2031, all services in the settings in scope for this strategy should have resources to support the independent review of every instances of seclusion and restraint. This should be conducted where possible with the individuals and family and supporters involved and summarised findings shared across sector to promote learning. If done, this process should be conducted with a 'learning and quality framework' rather than a punitive one, therefore promoting change and striving towards best practice. Further, in instances where AOD use is a factor in the presentation, AOD expertise should be routinely incorporated into the review.

One participant noted her experience of working with the MACNI model and often discovering that it was not until multiple services came together to support an individual, examine their history, presentation and take time to consider what has worked and what hasn't that options for support that meets the individuals needs come to light.

Family inclusive principle

This statement could be strengthened by broadening the concept of 'family' in relation to people who use substances. There is also no mention of recognising the needs of family and supporters separate to the needs of their loved one. A family inclusive principle should also include acknowledgement of the role that family play in reducing restrictive interventions. Services have a responsibility to ensure that family are enabled to support services to reduce the use of restrictive interventions.

DRAFT PILLARS

1. **Are the pillars proposed the right priority areas for the strategy? If yes, should the strategy identify any additional priority areas in order to create the greatest impact and help us achieve our vision? If no, which priority areas are needed in order to create the greatest impact and help us achieve our vision?**

Participants expressed a strong view that in order to ensure that the needs of individuals with co-occurring AOD and MH needs were adequately met and considered in the strategy that instead of listing this group as a 'cohort', the strategy should include a new column, labelled 'Co-occurring mental health and AOD needs alongside the Lived Experience and cultural safety columns.

Including integrated treatment or co-occurring AOD and MH as a core consideration (with a dedicated column) within all the pillars would significantly strengthen them. For example, if AOD and MH needs were a core consideration of the Leadership and Culture pillar it would enable an authorising environment for organisations to implement specific AOD expertise

within their leadership teams, which would support shifts in culture towards meeting the Royal Commissions expectation regarding provision of integrated treatment.

It was felt, that the gains from including AOD and MH needs as a core consideration as opposed to a specific cohort far outweigh the risks for this strategy. Anecdotal evidence regarding the rate and impact of seclusion and restraint amongst those with co-occurring mental health and AOD needs, discussed in the consultation, highlighted that many of the challenges exist for this group as a result of the culture, capability, resource availability and stigma. Not embedding an AOD/MH response will risk the possibility of implementation of strategic measures to address these barriers.

It was also reflected by participants that including co-occurring AOD and MH needs as a 'cohort' potentially fuels the misconception that a health response to substance use is only required at the point of dependence or 'addiction'. Acknowledging the significant role that mental health services can play in reducing harms associated with substance use amongst people with mental health issues could be lost and as a consequence the aim to reduce the need for acute care could be compromised.

A best practice model of integrated treatment should include many more things than specific treatment pathways and in fact enabling integrated treatment requires a 'whole of service', 'whole of systems' approach. Again, the notion of early intervention and viewing the elimination of seclusion and restraint from a social determinants lens was raised as essential in achieving the end goal.

SUGGESTED ACTIONS AND ENABLERS

Participants identified a range of potential actions and enablers based on the vision, principles and pillars. We have grouped suggestions into areas dependent upon what part of the system they would influence or be connected to as follows;

Whole of Community/ Government/ Departmental action	Early intervention and social determinants lens to be applied
	Increased funding for AOD community sector to better support individuals with AOD needs who may develop mental health conditions. This would enable increased wrap-around support, for individuals who are likely to be subject to restrictive interventions, enable treatment pathways to prevent repeat crisis presentations, and support need for AOD expertise within settings in scope.
	Targeted stigma campaign to minimise stigma towards AOD and MH and encourage help seeking behaviour earlier in presentation of troubling symptoms. This should include support for families to intervene early in their loved ones substance use journey.
	Embedded AOD expertise and leadership across all governing bodies in the mental health and wellbeing sector to enable appropriate AOD responses to reduce the use of restrictive practices.
Systemic action	Include an integrated treatment, care and support principle
	Enabling AOD sector to access psychiatric consultations to enable improved access to mental health treatment for individuals who are using substances

	Greater connection between community and hospital services to enable stepped care and early intervention
	New MH and wellbeing commission to establish a mid-review point and evaluation/ outcome measures for this strategy to ensure success and accountability
	Requirement for settings in scope to undergo independent review of all cases of use of seclusion and restraint that includes full review of consumer history to prevent further use of seclusion and restraint.
	Establishment of process that reviews and identifies common vulnerabilities amongst individuals subject to restrictive interventions.
	Creation of guidelines on substance use risk and supporting 'dignity of risk' amongst people who use substances to support the Access Policy for MHWB
	Inclusion of health-led response principle
	Requirement for all settings to have clinical guidelines on; Management of intoxication Management of withdrawal Integrated treatment and embedded expert AOD leadership in place to support to support These guidelines to be implemented in a biopsychosocial framework that enables harm reduction.
Organisational/service action	Embedded AOD clinicians in the ED including expansion of EDAOD clinicians initiative
	Employment of AOD peer workers in MHWB services
	Enabling changes to minimum qualifications for working in hospitals
	Resourced cross-sector communities of practice to better support those at risk of being secluded and restrained to enable early intervention in the community
	Embedded AOD and Addiction leadership within the settings in scope to ensure evidence based expertise in the implementation of interventions for this population.
	Connection with Specialist Trauma Practitioners, dual diagnosis clinicians (e.g. VDDI clinicians) and family violence specialist advisors to support services to develop appropriate responses to common vulnerabilities

Individual worker action	Access to trauma informed care, motivational interviewing skills and other AOD skill sets for all mental health clinicians and vice versa in AOD services
	Greater access to worker well-being, reflective practice and supervision to minimise the impact of involvement within individuals that may present with challenging behaviours.

Summary

The AOD Sector supports the strategy to work towards the elimination of seclusion and restraint practices as part of Victoria's Mental Health Reform. It is believed that in order to achieve this goal whilst adequately meeting the needs of individuals with substance use issues, their family carers and supporters cannot be achieved without the inclusion of an integrated treatment overlay.

The success of this strategy will rely on targeted interventions at government, system, organisation and worker levels reflective of best practice in AOD treatment, care and support, AOD principles, AOD leadership, intersecting and connected AOD and MH systems and AOD and integrated treatment practice.