The 2022 Revision of the MH Act:

Perspectives from the AOD sector through an integrated treatment lens

Purpose

The purpose of this Issues paper is to;

1. Brief the AOD sector on the changes to the MH Act, and potential implications for the AOD sector
2. Seek feedback from the AOD sector on the proposed Act to inform VAADAs advocacy agenda on behalf of the sector

This Issues Paper offers reflections, from an AOD perspective, on the revised Mental Health Bill, to generate thinking, discussion and space for advocacy. We welcome any thoughts, concerns, differences of opinion on the issues raised and value contributions from all.

Please note that since the drafting of this paper, the Mental Health Bill has been debated in the Victorian Parliament and a request for the following amendment was made: To include the statement "including alcohol and other drug support services and treatment" in objective C, point 7. Once accepted by the Legislative Assembly, the amended Objective will read;

> To provide for Comprehensive, compassionate, safe and high quality mental health and wellbeing services that promote the health and wellbeing of people living with mental illness or psychological distress and that……..Connect and coordinate with other support services to respond to the broad range of circumstances that influence mental health and wellbeing including AOD support services and treatment"

Please email any feedback to *gclark@vaada.org.au*

Background

The Royal Commission into Victoria's Mental Health System found that the existing Mental Health Act (2014) needed to be changed. To achieve this, the Department of Health engaged in a process to gather feedback on features of the new Act including:

- aims and principles
- decision making
- how information can be used and shared
- compulsory treatment
- Seclusion and restraint

The Victorian Government introduced the new Mental Health and Wellbeing Bill to the Victorian Parliament in June 2022. The Bill is currently being debated in Parliament before it is due to be enacted as Law later this year. The Act will come into effect 12 months after it is passed into Law.

The new Act will establish foundations for a redesigned mental health and wellbeing system. This includes people with lived experience in system leadership, as well as the entities needed to enable system accountability and transparency.

The full Victorian Mental Health Bill (2022) may be accessed here:
https://www.legislation.vic.gov.au/bills/mental-health-and-wellbeing-bill-2022

Issues

The AOD sector has not traditionally been covered by the MH Act and there is no desire from the sector this this to change. The requirement for delivery of integrated treatment for people with co-occurring mental health and AOD needs, however, will require part of the AOD sector to operate under, be significantly involved with or possibly governed by this Legislation. These changes provide the opportunity and necessity for consideration of the Bill through an AOD lens. The following section outlines issues from an AOD perspective that VAADA has identified of concern.

Integrated Treatment

Issue #1: The revisions to the MH Bill do not adequately reflect the concept of integrated treatment, care and support

As indicated in Figure 1, the provision of integrated treatment, care and support for people with co-occurring AOD and mental health needs accessing both mental health and AOD services is considered fundamental to the improvement of services delivered as part of a reformed mental health system in Victoria. Further, as indicated by the Commission, in order for integrated treatment, care and support to be realized, a systemic approach is required which embeds integrated treatment throughout all elements of governance, planning, delivery and evaluation.

Figure 1: Integrated Treatment in Mental Health Reform

"The Royal Commission envisaged a future in which people with co-occurring needs and their families and supporters have access to integrated treatment, care and support in a variety of settings, consistent with the intensity of their needs, strengths and preferences" (pg 9)

"Achieving the Royal Commissions vision for people with co-occurring needs, and their families and supporters requires that their needs and perspectives are embedded across all aspects of the reform agenda" (pg 11)

Integrated Treatment, Care and Support for people with co-occurring mental illness and substance use or addiction: Guidance for Victorian mental health and wellbeing and alcohol and other drug services; Victorian Government, July 2022

In spite of these key points, reference to the AOD sector, co-occurring needs, substance use or addiction are rarely mentioned in the revised Bill. The main reference to integrated treatment is contained in the health needs principle and whilst welcome, does not sufficiently highlight the importance of the issue as it is mentioned alongside other 'medical and health needs'.

The lack of inclusion and/or acknowledgment of integrated treatment concepts or principles within the Bill, that is the key service provision framework for the mental health sector, potentially diminishes the acceptance, provision and sustainability of delivery of the Royal Commissions vision.

Issue #2. There is ambiguity about the inclusion of the AOD sector pertaining to governance by new entities covered by the MH Act

The following new entities are included in The Bill;

- Mental Health and Wellbeing Commission
- Mental Health and Wellbeing Regional Boards
- The Victorian Collaborative Centre for Mental Health and Wellbeing
- Youth Mental Health and Wellbeing Victoria

All of these entities have functions that are sanctioned under the MH Bill and include responsibilities such as;

- governance,
- accountability,
- service provision and tendering,
- complaints handling,
- needs analysis and commissioning,
- advocacy,
- Ensuring access and inclusion across the Mental Health and Wellbeing Service System, across the lifespan and across the State.

It is envisioned that these entities will include lived experience leadership and allow the mental health sector to be far more responsive to needs of community, individuals, families and supporters and workforce.

What is unclear, however, is what sectors will be included in their scope?

Example One: An objective of the Mental Health and Wellbeing Commission is "*to ensure the government is accountable for the performance, quality and safety of the mental health and wellbeing system including the implementation of recommendations made by the Royal Commission into Victoria's Mental Health System*". Integrated treatment is a recommendation of the Royal Commission that will be in part delivered by the AOD sector, and its workers. Will the AOD sector therefore be measured for performance, quality and safety as part of this objective?

Example Two: The Collaborative Centre has the responsibility "*to provide or arrange the provision of specialist support services and care for persons who have experienced trauma*" via the Statewide Trauma Service. It is widely accepted that experiences of psychological trauma are a common vulnerability amongst those with AOD and mental health needs. Does this then suggest, that the Collaborative Centre will offer support and oversight to the AOD sector on issues relating to trauma? And if this is the case, will our sector and the needs of those it supports be adequately factored into design, implementation and delivery?

These are just two examples of ambiguity in breadth of scope of these entities. Clarity of scope is urgently required in order to ensure individuals and their families and supporters are afforded the best healthcare possible, across the system.

Reflections: How could the MH Bill better reflect the requirement for integrated treatment for those with co-occurring mental health and AOD needs? How can the AOD needs of individuals and

their families be appropriately embedded into new entities and the AOD sector be supported to operationalize this?

Definitions and scope

There are several definitions within the Bill that are inadequate or missing. Clarity of these definitions may aid in addressing the deficits in scope as outlined previously.

Issue #1: The definition of 'mental health and wellbeing service' is ambiguous particularly given the expectation of integrated treatment provision

Based on the definition, as outlined in Figure 2, one could assume that AOD services were considered mental health and wellbeing services with the notion that they 'improve or support ones mental health and wellbeing', 'assess or provide treatment for mental illness and psychological distress' and their 'families and supporters'.

Figure 2: MH ACT Definition of mental health and wellbeing

mental health and wellbeing service means a professional service—
(a) performed for the primary purpose of—
(i) improving or supporting a person's mental health and *5* wellbeing; or
(ii) assessing, or providing treatment, care or support to, a person for mental illness or psychological distress; or *10*
(iii) providing care or support to a person who is a family member, carer, or supporter, of a person with mental illness or psychological distress; or *15*
(b) that is prescribed to be a mental health and wellbeing service—
but does not include—
(c) a non-legal mental health advocacy service; or *20*
(d) a prescribed professional service;

Issue #2: There is no definition of 'wellbeing' or 'psychological distress'

It is noted that there is no definition of 'wellbeing' or 'psychological distress' in the Bill despite regular use throughout the document. It is suggested that AOD services regularly support people in psychological distress. As part of the broad support network for people in Victoria, the AOD sector could also be seen as supportive of 'wellbeing' as a core component of service delivery for individuals, families and community.

Definitions of these terms in the context of this Bill would assist in interpretation of the Bill for the AOD sector and other similar intersecting sectors.

Issue #3 Potential for inequitable service access and delivery as a result of imbalances in funding. .

In light of the requirement for integrated, treatment care and support within the AOD sector, VAADA envision two streams of the future AOD workforce as outlined below:

Table 1: Division of AOD workforce according to MH ACT

AOD services operating as part of a mental health and wellbeing service	**Party to MH Act?**
AOD services operating outside of the mental health and wellbeing system	**Not party to MH ACT?**

The implementation of integrated treatment will effectively spread AOD professionals across the spectrum of intensity of need of mental health and AOD and associated service streams. It is assumed that the MH sector will require workers from the specialist AOD workforce in order to provide integrated treatment. Further, based on current workforce capacity and employment conditions, it is probable that these workers will be procured from existing AOD organisations. At this stage, there is however, no growth funding for the AOD sector outside of mental health. With this prospective loss of workforce in an environment of high demand and limited resourcing for the community AOD sector, the development of an inequitable treatment system is feared.

For the individual accessing AOD support it is integral that access is equitable irrespective of the stream of funding and associated legislative requirements that the service operates under. An imbalance in resourcing for associated sectors will manifest in increased demand for MH and acute health services coupled with greater preventable community harm.

In order for this to be realized, funding for the AOD services operating outside of the mental health sector needs to be commensurate to that of services provided as part a mental health and wellbeing service. This need is further highlighted through reference in the MH Bill objectives to ensure the provision of broad and accessible voluntary treatment options to reduce reliance on coercive treatments and greater demand for acute health services. This encapsulates the vision of a reformed mental health system to provide community based services with the aim of preventing acute care needs.

As the AOD sector workforce peak body, VAADA will continue to have a role to play in supporting workers in both of these systems and in turn advocating for their needs and the needs of the individuals that they support. We are however, strongly committed to ensuring that the integrity of the current AOD sector is not diminished as a result of this unbalanced funding.

Reflections: What improvements can be made to definitions in the Bill to reflect integrated treatment requirements?

How can the AOD sector maintain integrity whilst harnessing opportunity for growth?

How can the AOD sector grow and add value to the vision of the Commission through continued work in the community?

Elimination of seclusion and restraint

Issue #1: Ensuring everyone's human rights are considered

As with any legislation, the rights of all potentially impacted need to be considered equally to achieve a balanced outcome. We acknowledge, as has been identified in multiple Royal Commission submissions, the often permanent negative effect that use of seclusion and restraint practices have had on some individuals accessing the mental health treatment system. As a human right, it is essential that all measures are taken to ensure that no individual accessing any care or treatment service experiences traumatic events.

We also acknowledge that, as an unintended consequence of illness or behaviors, the often permanent negative effect that witnessing or being victim to violence or aggression as a healthcare worker can have. As a human right, it is essential that all efforts are taken to ensure that no worker experiences traumatic events whilst at their place of employment.

VAADA acknowledges that both situations occur, often daily within the current system and both need a complex array of solutions to affect change. With the potential for growth of the AOD workforce within mental health and/or hospital settings, VAADA is committed to working collaboratively to find these solutions to achieve the best outcomes for all.

Issue #2: **Who is secluded and restrained, and how can we use this data to reduce restrictive interventions? Including common vulnerabilities and context of restraints.**

The MH Bill specifically outlines a vision for the elimination of use of seclusion and restraint and as outlined above, VAADA supports this vision with the provision of meeting the human rights of all.

VMIAC have indicated that data relating to the correlation between diagnosis and seclusion was not released by the Department of Health, however, multiple other pieces of evidence (Figure 3) suggest a high rate of seclusion and restraint amongst those presenting with substance use issues.

Figure 3: Evidence that is suggestive of high rate of substance using individuals who may be secluded or restrained

- 53.6% of mental health related ED presentations had a principle diagnosis of mental health and behavioural disorders due to psychoactive substance use [1]
- Most likely to be secluded if you are between 25-44 years of age and identify as male, these demographics correlate with prevalence data regarding high risk populations for substance use disorder[2]
- In the 5 years from 2014-15 to 2018/19 approximately 29,571 consumers accessed both MH and AOD services. Of this group, nearly 42% had been admitted to a public specialist bed based mental health service an average of 3 times and had an average stay of 44 days.[3]
- 26.8% of methamphetamine users were secluded after admission[4]
- Consumers who use both AOD and MH services are 25 times more likely than the overall population to use an ambulance [5]
- A substantial proportion of mental health consumers who use Bed Based services are also living with substance use or addiction or have been diagnosed with 'substance use disorder'[6]
- Consumers accessing both mental health and AOD services are 48 times more likely to go to an emergency department for reasons relating to suicidal ideation and 40 times more likely to go to them for reasons relating to self-harm[7]

[1] https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-content/about

[2] VMIAC. (2022). How safe is my hospital? The Seclusion Report #3. Version 2.2. Victorian Mental Illness Awareness Council (VMIAC). Available at: www.vmiac.org.au/vmiac-seclusion. https://www.aihw.gov.au/reports-data/health-welfare-services/alcohol-other-drug-treatment-services/overview

[3] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Volume 3: Promoting inclusion and addressing inequities, Parl Paper No. 202, Session 2018–21 (document 4 of 6).

[4] McKenna, B, McEvedy, S, Kelly, K, Long, B, Anderson, J, Dalzell, E, Maguire, T, Tacey, M, Furness, T (2016) Association of methamphetamine use and restrictive interventions in an acute adult inpatient mental health unit: A retrospective cohort study; International Journal of Mental Health Nursing; 26:1

[5] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Volume 3: Promoting inclusion and addressing inequities, Parl Paper No. 202, Session 2018–21 (document 4 of 6).

[6] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Volume 3: Promoting inclusion and addressing inequities, Parl Paper No. 202, Session 2018–21 (document 4 of 6).

[7] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Volume 3: Promoting inclusion and addressing inequities, Parl Paper No. 202, Session 2018–21 (document 4 of 6).

It is also suggested that there may be common vulnerabilities amongst individuals that are more likely to be secluded or restrained, such as experiences of trauma that may be re-triggered when in hospital environments or when an individual perceives loss of control. Consideration of how best to mitigate these vulnerabilities should be considered as part of this process.

This data highlights the need to have a shared and transparent understanding of whom is likely to be secluded and restrained. Without this evidence, any measures to reduce seclusion and restraint will be ill informed, not person centered and potentially unsuccessful.

VAADA feel it is imperative to gain a better understanding of the individuals for whom seclusion and restraints are likely to be used, particularly from an AOD perspective. To understand the myriad issues that may result in the perceived need for seclusion or restraint and the factors that are likely to underpin these circumstances.

Issue #3: The need to learn from other sectors and take a 'whole of system' approach to seclusion and restraint.

VAADA feels it is important to acknowledge the use of restraint is not a mental health issue alone and in fact issues of restraint have been raised in Aged Care and Disability Settings also with a 'reduction premise'.

In attempting to solve the problem it is best to truly understand the context, characteristics, purpose, impact, outcome and resources required. Of particular relevance is ensuring that environment is considered in this exploration. We know that restraint is used by emergency services/first responders, within emergency department settings, during ward transfers and in units outside of mental health. It can be assumed that each of these different environments will provide different contexts, different professionals with different legislative requirements, experience and values. The only way in which the use of restraint can be reduced is through understanding the specific context of each occasion that it is used in alongside any broader systemic issues that potentially preclude the need for restraint,

This will require;

- Improved and transparent data collection on each instance of restraint seclusion
- Investigation of code grey and code black calls within hospital environments
- Exploration of occasions when someone is bought into hospital under Section 351
- Correlations with any complaints made in these situations by individuals and their families and supporters.

Taking a whole of system approach to this complex issue, may require more time, difficult conversations and fine attunement, however will undoubtedly result in a better outcome for all and consequently allow us to evolve our healthcare standards towards excellence.

Issue #4: Understanding the difference between chemical restraint used as a means of 'restraint' versus a 'medication for the purposes of treatment' when considering substance intoxication and withdrawal?

The inclusion of 'chemical restraint' as a form of 'restraint' is welcome in the new Bill, however the operationalization of the definition within the Bill requires significant cross-sector thinking and exploration to again ensure the rights of all are balanced in the outcome. As the below examples will illustrate, the rights and protections of individuals with substance use issues are paramount in this discussion.

Example One: Since the insurgence of methamphetamine use within Australia, significant work has been conducted to improve the care of individuals who present with methamphetamine intoxication to Emergency Departments and Mental Health Services. Specifically, the use of medications to reverse the effects of methamphetamine intoxication were heavily researched both as a means to reducing risk to self and others and providing 'treatment' to the individual. These medications are now widely accepted best practice within Victorian Hospitals to positive effect.

This example, highlights the important question: How do we determine when chemical restraint is used as a means of 'restraint' versus a medication for the 'purpose of treatment', particularly in relation to substance dependence, intoxication and withdrawal?

Example Two: The use of benzodiazepines within inpatient mental health settings we believe also requires significant exploration in terms of chemical restraints versus medication. The limitations and dependence potential of benzodiazepines are more widely accepted now, however concerns exist about the reliance on these medications by some health professionals within inpatient mental health settings.

For example, individuals may be prescribed PRN doses of benzodiazepines at their request or psychiatrist recommendation whilst in hospital, to manage anxiety, distress, sleeplessness, other mental health symptoms, or as a means of chemical restraint. It is not uncommon, however, that prescriptions for this medication may be discontinued prior to discharge. This pattern raises the question of need and efficacy of this medication in the first place. Surely, if an individual is distressed in a supposedly safe and contained environment and provided with 24/7 professional care, yet still require benzodiazepines, does it not suggest that in the community, a more high stimulus environment, where there are multiple triggers for distress, that an individual may also require medication for support?

Conversely, the use of benzodiazepines as part of a withdrawal management algorithm has been long practiced, however as a result of increasing awareness of risk associated with this medication, some individuals undergoing withdrawal in inpatient mental health settings may be under-medicated.

How do we know that the use of benzodiazepines is not with the intention of chemical restraint and how do we ensure that a balanced approach to use of any drugs of dependence is taken within mental health settings?

Reflections: How can the AOD needs of individuals who are secluded and restrained be appropriately understood and addressed to enable the elimination of seclusion and restraint?

How can we better understand the use of drugs of dependence as a form of chemical restraint and/or sedative medications as a means of treatment versus chemical restraint?

How can we assure that this issue and strategy towards the elimination of seclusion and restraint balances the rights of all and is based on evidence to support the preclusion of its use?

Compulsory Treatment

Issue #1: The need to ensure that the AOD needs of those on compulsory treatment orders are adequately met without an expectation of abstinence.

The use of mandated treatment for substance use and dependence has shown to have limited efficacy within the AOD system. As outlined in a systematic review "evidence does not, on the

whole, suggest improved outcomes related to compulsory treatment approaches, with some studies suggesting potential harms". However the use of compulsory treatment orders for individuals with co-occurring MH and AOD needs is not uncommon and thought to be of significance across all compulsory MH treatment provisions (Assessment Orders, Inpatient and Community Treatment Orders).

Issue #2: What are the circumstances in which compulsory treatment for individual with co-occurring mental health and AOD needs would be appropriate? How can we learn from the Severe Substance Dependence Treatment Act (SSDTA)?

VAADA acknowledge that the there are multiple scenarios in which compulsory treatment options are called upon and a complex array of costs and benefits need to be factored into each instance of its use.

For example, some may argue that the use of compulsory inpatient treatment for individuals with co-occurring needs may provide an otherwise unrealized opportunity for a person to have an extended period in a 24/7 monitored environment to allow for assessment of mental health and cognitive functioning whilst substance free. Even in these circumstances, however in order for the gain to outweigh the risk, the support required for this individual would have to be holistic, multidisciplinary (including access to medical withdrawal supports, peer workers, AOD counselling and specialist dual diagnosis interventions), non-judgmental and offer some choice and power for the individual. Further if undertaken, in consideration of the principle of 'dignity of risk', harm minimization principles should be accommodated noting that abstinence is not a realistic nor chosen outcome for many individuals. Any individual who is held on a treatment order must understand that the goal is not to 'enforce' abstinence.

The Severe Substance Dependence Treatment Act was introduced in 2010 and allows for the detention and treatment of an individual with 'severe substance dependence' for up to 14 days. This Act follows similar vision regarding 'least restrictive practices' however treats a significantly lower proportion of the substance use community compared to the MH Act. Further, despite co-occurring mental illness being recognized as a reason for complexity under this Act, mental illness is not alone sufficient to detain someone under the SSDTA, which invariably then places clinicians in having to rely on the mental health Act for compulsory treatment. Given individuals with co-occurring mental health and AOD needs could be subject to either Act, the need to further explore the intersections, appropriateness, efficacy and purpose of both in relation to substance using individuals, it is suggested, would be helpful in better understanding the risks and benefits of compulsory treatment.

Issue #3: What is the rate of individuals with substance use issues that are subject to assessment orders and or temporary treatment orders whilst intoxicated only to be discharged when the intoxication resolves?

The MH Bill allows for the use of assessment orders on individuals where the following criteria are met;

- the ***person appears to have mental illness,*** and
- because ***the person appears to have mental illness***, they appear to need immediate treatment to prevent:
    - serious deterioration in their mental or physical health, or
    - serious harm to themselves or another person, and

It is asserted that many individuals under the influence of AOD may meet the above criteria. Further, whilst data is not available, it is assumed that many individuals with substance use issues held on

Inpatient Treatment Orders following an assessment order will be discharged from mental health care once their intoxication had resolved.

Whilst the use of assessment orders may be warranted based on an individual's inability at the time to provide information to make an appropriate assessment, or to protect them from or others from perceived risk, the use of such orders for people under the effect of AOD, only for the purposes of containment in a mental health inpatient facility arguably does not meet the principles of the new Bill, wastes limited resources and is unnecessarily traumatizing for the individual, staff and other patients.

The rate at which Assessment Orders and Temporary Treatment Orders are used for individuals who are discharged 24-48 hours later with substance use issues needs to be identified. Finding alternative, humane and evidence based means of supporting this cohort of individuals through development of new models of care similar to those in ED AOD/MH hubs must be prioritized.

Issue #4: Assuring the principle of 'dignity of risk' when considering substance use?

One of the principles that the Act is based on includes "dignity of risk" and this notion is particularly pertinent to anyone with co-occurring substance use and mental health issues that is subject to involuntary treatment. The AOD sector strongly premise all treatment provided on a notion of 'readiness to change' and therefore the use of involuntary treatment as a means to address a persons' substance use is dissonant with current evidence based AOD treatments. With this in mind, we feel that the use of compulsory treatment orders for people with substance use issues should be done so, only with clear guidance and expectations of service providers, and the mental health tribunal. Further, it should be framed around the 'dignity of risk' principle that does not suggest that abstinence nor AOD treatment is a requirement to cease compulsory treatment.

Reflections: How can the AOD needs of individuals be appropriately managed in situations where compulsory treatment is used?

How can we better understand the impact that compulsory treatment has had on those with substance use issues?

How can we assure a harm minimization approach is taken for anyone under compulsory treatment orders?

What can we learn from the Severe Substance Dependence Treatment Act? How can be intersect the two?

Considering the needs of all individuals with complex needs

Issue #1: The need to adequately meet the needs of individuals with co-occurring needs and high risk profiles who do not meet criteria for the Mental Health Act.

It is important to note that there is a population of 'high risk', vulnerable people that access hospital environments and may undergo mental health assessment that do not meet criteria for mental health treatment under the MH Act, or deny need for same. Whilst we do not support the notion of extending the Act to meet the needs of these people, it is important to identify this population, their needs and how they are supported without legislation.

These insights could significantly aid in the reduction of reliance on legislation to support those with mental health issues. They could also identify the need for alternative strategies to be implemented

across all acute healthcare systems to support everyone that is vulnerable at the time of access of care, not just those that are deemed at risk to themselves or others as a result of mental illness.

Reflections: Not all individuals with complex AOD and MH needs will meet criteria for treatment under the MH Act?

How do services ensure the rights of these individuals?

How can we improve treatment access and ensure that they can have access to Statewide or specialist services without treatment under the MH Act?

Summary

Over the next 10 years of implementation of the recommendations of the Mental Health Royal Commission the mental health sector, and supporting sectors such as the AOD sector, will undergo significant change. On the background of high demand and workforce pressures, this change may be overwhelming for many and at times seem irrelevant in comparison to immediate needs of those with AOD issues and their families.

Despite this, the changes will occur and VAADA seek to ensure that the voice of our sector and those we aim to support are heard continuously over this change period. You can help us hear your voice by commenting on this paper or reaching out to us with your thoughts, feelings and concerns so that together we can assure the future of our sector and high quality AOD care and support for anyone who desires it.

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