Submission into Exposure Draft Compulsory Treatment (Alcohol and Other Drugs) Bill 2016

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1. Background

The Mental Health Law Centre Western Australia (MHLC) is a not-for-profit community legal service providing free legal advice and representation for people with a mental illness, including those suffering with drug induced psychosis and people who are involuntary patients in the Western Australian mental health system.

The main areas of law the Centre covers are the *Mental Health Act 2014,* criminal, guardianship and administration matters and criminal injuries compensation. The Centre also has a Telephone Advice Line, where short legal advice or referral for more appropriate assistance is provided to clients. In 2016 MHLC represented and assisted 858 clients.

MHLC also provides legal and community education in all areas of the *Mental Health Act 2014* and CPD presentations for lawyers in the area of mental health. .

MHLCWA welcomes the opportunity to provide feedback and make a submission in regard to the Exposure Draft Compulsory Treatment (Alcohol and Other Drugs) Bill 2016).

This submission is based on the experience of the Centre with laws impacting those with a mental illness, particularly involuntary patients in the mental health system in Western Australia. On this basis, we have restricted our responses to where we have direct relevant experience.

2. Introduction

MHLC welcomes the increased support and funding being directed by the Government of Western Australia towards treating people with severe substance abuse disorders. The Centre also welcomes changing attitudes towards severe substance abuse disorders that encourage rehabilitative, rather than punitive measures to address this issue. Further, we acknowledge there are serious issues regarding substance abuse in Western Australia.

As noted in the Summary Model of Service document, there is likely to be a significant overlap between people with mental health issues and people who may fall under compulsory AOD treatment under the Exposure Draft Bill.

However, MHLC does have a number of concerns regarding the Exposure Draft Compulsory Treatment Bill, which are outlined below.

3. Exposure Draft Bill: Objectives

a) Do the Objectives capture all the key factors in defining the purpose of the proposed legislation?

b) Are there any Objectives you would add, remove or amend?

3.1 Ambiguity of Object (1) (b)

11. *Objects of Act*

(1) The objects of this Act are –

(b) to restore the ability of those persons to make informed decisions about their substance use and personal wellbeing by stabilising their health through the compulsory application of treatment of their severe substance use disorder; and...

The premise of this clause appears to be that the person has lost the ability to make informed decisions about their substance use and personal well-being.

The ability to make decisions is based on the capacity of the individual to make those decisions.

There is nothing in the proposed Bill regarding the capacity of the individual to make decisions; determining capacity to make decisions or how to determine if a person has lost the ability to make informed decisions.

The *Mental Health Act 2014* which does allow for the compulsory treatment of individuals, contains explicit positive statements regarding the capacity of individuals to make decisions unless they are shown not to have that capacity [s.13.(1)] and also about determining capacity to make decisions [s.15]

Without a clear, positive statement regarding the individual's capacity to make decisions, clause (b) is too broad and subjective to be effective.

For example, what is an "informed decision"? A person with a severe drug dependency may be provided with all the facts regarding the negative impact of their drug use and still choose to continue to use their drug of choice. They have made an informed decision. It may not be a decision non-drug users agree with or would make, however, it is still an informed decision.

Likewise, there is no objective measure to determine when a person's capacity to make an informed decision is restored. Is it when they agree with the treating practitioner?

3.2 Positive statement on best treatment and care

It is essential that participation in a compulsory regime does not forfeit the right of the individual to make decisions regarding their care and treatment and with the least possible interference with their rights.

The *Mental Health Act 2014* has a positive statement to this effect as part of its Objects

10 Objects

(1) The objects of this Act are as follows –

(a) to ensure people who have a mental illness are provided with the best possible treatment and care –

(i) with the least possible restriction of their freedom; and

(ii) with the least possible interference with their rights; and

(iii) with respect for their dignity.

These rights should be a positive requirement and a similar provision can be seen in the equivalent Victorian legislation. [1] This creates obligations for consent to treatment and applicable principles to promote the rights of the person.

While 11 (c) of the objects of the Draft Bill mention treatment being provided in the least possible restrictive way, it is the position of MHLC that the Objects should be explicitly strengthened as is in the Victorian legislation.

It is also the recommendation of MHLC the following human rights declarations are enshrined into the Draft Bill:

a) Universal Declaration of Human Rights[2]
Article 3: "Everyone has the right to life, liberty and security of person".

b) International Covenant on Civil and Political Rights[3]
Article 9(1): "Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law".

Article 9(4): "Anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that the court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful".

[1] See for example, *Severe Substance Dependence Treatment Act 2010* (VIC) s.28.
[2] UN General Assembly, "Universal declaration of human rights" (1948) 217 [III] A.
[3] UN General Assembly, "1966 International Covenant on Civil and Political Rights" (1966) 999 UNTS 171.

Article 12(1): "Everyone lawfully within the territory of a Sate shall, within that territory, have the right to liberty of movement and freedom to choose his residence".

c) Convention on the Rights of Persons with Disabilities[4]

Article 25(d): "Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care".

d) Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care[5]

Principle 7(1): "Every patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives".

Principle 7(3): "Every patient shall have the right to treatment suited to his or her cultural background".

Principle 9(1): "Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others".

Principle 9(4): "The treatment of every patient shall be directed towards preserving and enhancing personal autonomy".

Principle 11(9): "Where any treatment is authorised without the patient's informed consent, every effort shall nevertheless be made to inform the patient about the nature of the treatment and any possible alternatives and to involve the patient as far as practicable in the development of the treatment plan".

[4] UN General Assembly, "Convention on the Rights of Persons with Disabilities" (2007) A/RES/61/106.

[5] UN General Assembly, "Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care" (1991) A/RES/46/119.

Recommendation 1

a) *Object 1 (b) should be amended to contain a positive statement regarding the capacity of the individual to make decisions and determining an individual's capacity to make decisions.*

b) The Object of the Bill should include a positive statement on the protection of the person's human rights, including detention and treatment as a consideration of last resort and any limitation on human rights and interference with the dignity and self-respect of the individual kept to an absolute minimum.

4. Exposure Draft Bill: Principles (Clauses 12 – 14)

a) Does this list of Principles capture all the key factors that should be considered in guiding how the legislation is applied?
b) Are there any Principles you would add, remove or amend?

Broadly, MHLC supports the principles outlined in the Bill. However, MHLC is concerned there is no positive obligation to incorporate the Principles when applying the Bill.

Without a positive obligation to take the Principles into consideration, it could potentially create a situation where detention and treatment of the individual occurs in a manner that is contrary to these principles.

The *Mental Health Act 2014,* makes a positive obligation for the Mental Health Care Principles to be considered by any person performing a function under the Act

> ***s.11. Regard to be had to Charter***
> *A person or body performing a function under this Act must have regard to the principles sets out in the Charter of Mental Health Care Principles.*

An example of where there needs to be a positive obligation incorporated into the draft Bill is in Clause 53.

53. Provision of treatment generally

(1) The treating practitioner for a compulsory patient may —

(a) provide any treatment to the patient that the practitioner considers necessary for the treatment of the patient's severe substance use disorder; or

(b) authorise the provision of any such treatment.

(2) The treatment —

(a) may be provided with or without the compulsory patient's consent; and

(b) must be provided in accordance with the compulsory patient's care plan; and

(c) must be provided in a manner that is guided by the 30 principles set out in section 12.

Clause 53, s(2)(c) states that treatment must be provided in a manner that is guided by the 30 principles set out in s.12. There needs to be a stronger obligation than to be simply guided by the principles. Treatment should be provided in accordance with the principles set out in s.12.

Recommendation 2

2.1. There should be a positive statement in the Bill that the principles outlined in Division 2 are to direct the treatment of the individual.

5. Exposure Draft Bill: Proposed Criteria (Clauses 15 – 16)

a) What are your views on the proposed Criteria?

b) What key aspects do you think should define how someone is likely to benefit from treatment?

c) Are there any circumstances where someone should be excluded from participating in the program?

d) Are there any Criteria you would add, remove or amend?

MHLC has a number of concerns with the proposed criteria, particularly the definition of severe substance use disorder.

5.1 Severe Substance Use Disorder

a) Definition

The definition of severe substance use disorder s.4 of the draft Bill has a number of potential difficulties:

i) It is a disorder that manifests as a continuous or intermittent condition. There is no definition of intermittent which could lead to ambiguity. For example, does a person who uses substances every three or four weeks and during this period craves the substance and is unsuccessful at controlling their use of the substance fall within the definition of having a severe substance use disorder?

According to the definition that is given, the person could be diagnosed with such a disorder. The individual may have simply made an informed decision to go on a bender because of a number reasons.

ii) The use of the term "neuro-adaptation" as one of the defining features is also ambiguous and difficult to determine. How does a person determine if another individual has neuro-adaption to a substance? If neuro-adaptation can be demonstrated, what level of adaptation is required to constitute a severe substance use disorder?

iii) Craving for the substance is also a subjective term. Craving often depends on the physiology of an individual and can only be subjectively determined by the individual who experiences the craving.

Hence the definitions under the Bill are subjective and difficult to apply with any objectivity. To compulsory detain a person for treatment on the basis of subjective characteristics is problematic at the very least.

A diagnosis for a severe substance use disorder under DSM 5 requires a person has six or more symptoms of diagnosis associated with substances, including symptoms of impaired control, social impairment, risky use and pharmacological criteria.

If the goal of the Bill is to provide for the treatment of people who have substance induced disorders it would be effective to have the definition in the Bill more closely aligned with diagnostic tools such as DSM-5 which specifically deal with the diagnosis and treatment of substance induced disorder.

The definition for severe substance use disorder given in s.4 of the Bill should be amended to more closely reflect the criteria outlined in DSM 5.

b) Capacity of the person to consent to treatment

There is nothing within the definition of severe substance use disorder given in the Bill which implies a person has lost the capacity to make decisions. Section 4(a) refers to compulsive use of a substance. However, a person may use a substance compulsively and still have the capacity to make decisions, including the decision to compulsively use the substance.

A person may be diagnosed with a severe substance use disorder, yet retain their capacity to make decisions and still be compulsory detained for treatment.

This makes the Bill significantly more restrictive than the *Mental Health Act 2014*, where patients may only be made involuntary if they lack capacity to make decisions.

In NSW the legislation refers to persons having "lost the capacity' and in VIC of persons being "incapable of making decisions."[6]

The current Bill appears to disregard the capacity of the person to make a decision about their own treatment when providing compulsory AOD treatment.

It is also ambiguous how the provision of "unsuccessful efforts to control the use of the substance" would be satisfied.

The issue of capacity to make decisions needs to be addressed under the Bill.

[6] *Drug and Alcohol Treatment Act 2007* (NSW); *Severe Substance Dependence Treatment Act 2010* (VIC)

c) Causality

There is no explicit link between limbs of s.4 (a) and s.4 (b) of the definition of severe substance use disorder. As a result, it appears a person may not need to prove the issues of severity in (b) have been caused by the compulsive substance use in (a).

If it is not explicit, it allows for the potential misuse and the risk of a person being detained to 'protect them' against their will.

Under the *Mental Health Act 2014*, it is explicitly stated a person can only be made involuntary "*only of all the criteria are satisfied*" [s.25 (1)].

Other similar Acts in Australia have avoided this issue with clear language. Both legislative schemes in NSW and VIC directly refer to causality in their criteria; in NSW capacity must primarily be reduced due to the severe substance dependence and in VIC the definition of severe substance dependence includes incapability to make decisions about substance abuse due to their substance dependence.[7]

The question of causality in the definition needs to be addressed to ensure that both (a) and (b) limbs of the meaning apply.

Recommendation 3

The current definition of severe substance use disorder to include:

a) the disorder meets the criteria outlined in the DSM;
b) the disorder has damaged the capacity of the person to consent to rehabilitative measures; and
c) direct reference to causality between limbs (a) & (b).

d) Significant Risk of Causing Harm

The consideration of significant risk of causing harm to oneself or to others is a wide threshold. This is both in relation to its definition generally and its applicability to causality.

As detailed in the Background Paper on the Exposure Draft Bill, UNDOC states that short term detention is acceptable where individuals are at serious risk of harming themselves or others and interventions should cease once the acute emergency has been avoided and autonomy re-established.

[7] *Drug and Alcohol Treatment Act 2007* (NSW); *Severe Substance Dependence Treatment Act 2010* (VIC)

However, the Draft Bill considers "significant risk" as opposed to "serious", which appears to be a lower threshold. It also does not require an "acute emergency" or a "lack of autonomy" to be established at any point.

Additionally, to consider as an element a significant risk of causing harm, without showing it is related in some significant way to the severe substance disorder, creates a provision with a large scope. This provision could be used to detain a person incidental to a substance disorder, as opposed to, for the primary purpose of addressing their disorder.

15. Criteria for compulsory treatment

A person (whether or not an adult) may be provided with compulsory treatment under this Act only if —

(a) the person has a severe substance use disorder; and

(b) the person is at significant risk of causing serious harm to —

(i) the person's life or health; or

(ii) any other person's life or health;

and

(c) the person is in need of treatment; and

(d) the person is likely to benefit from treatment; and

(e) there is no less restrictive means reasonably available for the treatment than through the person's admission 33 and detention in a treatment centre.

MHLC notes the Victorian legislation has a much higher threshold, "*necessary as a matter of urgency to save person's live or prevent serious damage to person's health.*"

The Centre believes the protocol by UNDOC reflects a higher threshold to allow short term detention of individuals. If there is no element of causality between the first limb of severe substance abuse disorder and the second limb of significant risk of causing harm, then there must be a higher threshold to justify the restriction on liberty.

Recommendation 4

The severe substance use disorder is of such severity that it has causes or primarily causes serious danger to the person or another.

OR

Changing the threshold to "urgency to save person's life or prevent serious damage" if there is no causality link involved.

e) Relationship with *Mental Health Act 2014 (MH Act 2014)*

MHLC believes it is appropriate for the *MH Act 2014* to be considered before the treatment outlined in the Draft Bill, as currently drafted.

However, care needs to be exercised as the Bill may capture, in its ambit, some people who have had orders under the *MH Act 2014* and are susceptible to being further detained under the Draft Bill once the *MH Act* orders have expired.

The Centre is concerned the Draft Bill will allow people who have both mental health and drug dependency issues to be detained for compulsory AOD treatment once they are released from an order under the MHA. This has the potential for a person to be forcibly detained by the State for an extended period of time despite not having committing a crime.

Recommendation 5

In order to protect the interest of people who have been detained or treated under the *MH Act 2014* and are also assessed as requiring compulsory AOD treatment to be screened/assessed by a mental health expert to determine whether or not they are suitable for such a program.

Or require a Tribunal determination.

MHLC supports the use of the Mental Health Advocates and Mental Health Tribunal as outlined in Part 5 - Division 3 & Division 5.

However, it is important to note that not all people who may be diagnosed as having a *severe substance use disorder* have a mental health issue and may find it problematic being visited by a Mental Health Advocate or being seen by the Mental Health Tribunal.

It may be necessary to find a more generic name for the Advocates and Tribunal or include "AOD" in their titles – e.g., Mental Health & AOD Tribunal and Mental Health & AOD Advocates.

As the Tribunal has jurisdiction to review compulsory treatment orders as outlined in section 97 of the draft Bill it makes it more important for the definition of severe substance use disorder requiring compulsory treatment to at least conform to accepted diagnostic criteria such as in DSM 5 rather than the meaning given in section 4 of the draft Bill.

Recommendation 6

To include the term "AOD" in the title of the Mental Health Tribunal & Mental Health Advocate or to change the name of the entities to a more generic name that allows for the incorporation of matters under the proposed Bill.

f) No less restrictive means s.15 (e)

The "no less restrictive means" criteria mentioned in this section is ambiguous.

The language of the Bill implies detention is a key component of treatment, however this section seems to imply there is provision for compulsory AOD treatment to be imposed, which would require the person to attend certain treatments and therapies but not require detention.

This could effectively allow persons to be provided treatment similar to a Community Treatment Order under the *MH Act 2014*.

A similar proposal was made under the report assessing the scheme in Victoria.[8]

If the Exposure Draft Bill does allow this, it would potentially increase the number of people who could be assisted under compulsory AOD treatment and allow for people to have more autonomy where appropriate.

Recommendation 8

Include an option of compulsory AOD treatment that does not require detention and can be provided in the community. This would allow persons, remained within their community where appropriate and attend treatment when required.

It could be similar to home detention rather than using Treatment facilities.

[8] Review of Severe Substances Dependence Treatment Act 2014 (VIC) – page 5

6. The application, screening and referral process

a) Is the proposed application pathway appropriate?
b) Are the sources of referral (concerned person, health professional, police) appropriate?
c) How can people wanting to make an application best be supported in this process?
d) The legislation details the qualifications and requirements for the screening role (AOD Liaison Officer) and the person who can issue an order (Approved Specialist). What kinds of health professionals should be considered for the roles of screening and assessment?
e) What are the most important issues to consider when screening and assessing potential participants for the program?
f) Is there anything in the application, screening and referral processes that you would add, remove or amend?

a) Application for Assessment

S.18 (1) *Any of the persons specified in subsection (2) who has reasonable grounds to suspect that another person is suffering from a severe substance use disorder may apply for the assessment of the other person under this Act*

MHLC believes this clause is ambiguous and too wide in its scope.

The basis for an application for assessment for a person to be compulsorily detained is *reasonable ground of suspicion.*

The reasonable grounds are not defined. The people who may make an application under s.18(2) are a police officer, a health professional or a concerned individual. The reasonable grounds which a concerned individual may use are likely to be different from that of a police officer or health professional.

There is no strong basis for making application to assess another person to be compulsorily detained on the basis of suspicion. The *Mental Health Act 2014* s.25 sets out a clear criteria of five conditions that all have to be met before a person can be declared involuntary,

Under the proposed Bill all that is required is reasonable grounds to suspect the person has a severe substance use disorder and a medical certificate. [s.19 (1) (d) (f)].

s.20 Supporting Medical Certificate

A supporting medical certificate must –

(c) State that the medical practitioner has reasonable grounds to believe that the person proposed to be assessed meets the criteria for compulsory treatment; and

This clause is also problematic for the following reasons:

a. The medical practitioner only has to have *reasonable grounds to believe.* A person's private medical practitioner may know the individual enough to have reasonable grounds to make an assessment. However, the draft Bill allows for any medical practitioner to make an assessment. If the medical practitioner does not know the individual, on what basis are they going to have reasonable grounds?
b. Problems with s.15 Criteria for compulsory treatment have already been discussed. However, there are further ambiguities using this clause for the supporting medical certificate.
    - S,15 (d) states the person *is likely to benefit from treatment.* As a threshold criteria for compulsory treatment this is too low because most people are likely to benefit from treatment. Just because someone is likely to benefit from treatment is no reason to compulsorily detain them for treatment.
    - S.15 (e) states *there is no less restrictive means reasonably available for the treatment.* It is debatable if and how a medical practitioner will know there is a less restrictive means for treatment reasonably available.

b) Sources of Referral

Clause 18(2) has a wide scope of persons who can apply for the assessment of another person under the Act, including a police office, health professional or a concerned individual.

MHLC recommends a higher threshold for the "concerned individual" to include knowing a person for a minimum of 6 months; or being a family member and/or carer to further protect individuals for spurious and vexatious nominations.

There is also the consideration that applicants should be able to willingly nominate themselves under the compulsory treatment scheme.

While this may seem counterintuitive, there are people who want and seek rehabilitation and are concerned about their own lack of control. Persons who nominate in this manner, have more autonomy and are more likely to have positive therapeutic benefits when there is a clear interest in rehabilitation.

Recommendation 9

1. S.18 & s.20 need to be redrafted to remove ambiguity and provide a definition of reasonable grounds for an application to be made for compulsory treatment.

2. S.18 (2), a higher threshold is required than simply a "concerned individual". It should be a family member and/or carer or a concerned individual who has known the person for at least 6 months.

3. An individual who believes they have a severe substance use disorder should be able to apply for assessment themselves.

c) Application, screening and referrals process to add, remove or amend

32. Inquiries to be made before making compulsory treatment order

(2) The matters are -

(a) whether the assessed person can be provided with appropriate treatment and support at the proposed treatment centre; and

(b) in the case of an assessed person who is under 18 years of age –

(i) whether the person can be provided with appropriate treatment and support at the proposed treatment centre having regard to the person's age, maturity, gender and cultural or spiritual beliefs; and

(ii) whether the person can be provided with treatment in a part of the proposed treatment centre that is separate from the part where adults are provided with treatment.

MHLC believes that Clause 32(2)(b)(i), regarding appropriate treatment and support regarding age, maturity, gender and cultural or spiritual beliefs should be taken into consideration for adults as well as individuals under 18 years of age.

Recommendation 10

Inquiries to be made before compulsory AOD treatment to include:

- Appropriate treatment and support is assessed for an individual according to their specific needs..
- Consideration regarding age, maturity, gender and cultural or spiritual believes is taken into account for all persons;
- A person (or their guardian under the GAA) under compulsory AOD treatment can refuse to go to a designated facility where the facility promotes a religious ethos or doctrine the person objects to. If under 17, a parent or guardian can refuse additionally on their behalf.

7. Safeguards and Protections for Participants

a) Are the proposed safeguards appropriate?
b) Are there any other safeguards or protections you would add, remove or amend?

Part 5 – Protections for compulsory patients of the draft Bill need to be strengthened in the following ways:

a) There is nothing in this section which states that a patient must have their rights explained to them. This positive obligation is enshrined in the *MH Act 2014* s.244 – *the person responsible under s246 must ensure that the person is provided with an explanation, as described in the regulation of the persons' rights under this Act.*

The draft Bill should contain a positive statement of the responsibility of treating staff to explain patients' rights to the person.

b) Given the rights under the draft Bill are not absolute and can be revoked where the treating practitioner believes it is necessary. There is no obligation on the treating practitioner to report and be accountable for where the rights of the patient are infringed. Under the *MH Act 2014,* a psychiatrist has to report to the Chief Advocate where a treatment decision has been made that requires the patients' rights to be infringed. MHLC believes a similar requirement should be enshrined in the draft Bill for treating practitioners.

c) The draft Bill is also lacking in recognizing the rights of family members and carers of people who have severe substance use disorder. The draft Bill should have a provision for protecting the rights of family members and carers to be involved in the person's treatment and care.

Recommendation 11

Part 5 – Protections for compulsory patients of the draft Bill need to be strengthened in the following ways:

a) The draft Bill should contain a positive statement of the responsibility of treating staff to explain patients' rights to the person.

b) A treating practitioner should be required to report to the Chief Advocate where a treatment decision has been made that requires the patients' rights to be infringed or suspended for a period of time.

c) The draft Bill should contain a positive statement recognizing the rights and involvement of family members and carers

8. Summary Model of Service: Designated Treatment Centres

a) Other Factors, Locations and Type

MHLC is concerned the draft Bill may adversely affect persons in rural areas, particularly:

A. People who are nominated for the program but are unable to be found a treatment centre due to their location, or put in a substandard facility due to their location;
B. People who are nominated for the program but are found a treatment centre that is far from their home location – compulsory AOD treatment in this scenario may become a forced removal.

We would recommend these factors be taken into account during the screening and assessment process.

Recommendation 12

Where a person is being screened and assessed to have compulsory AOD treatment, consideration should be given to their location and how that will affect their ability to receive treatment. Potential considerations to include, but not limited to:

- Will they receive the same level of quality or care.?
- What the treatment impact will be for the person if they are required to receive compulsory AOD treatment in a different location to their home?
- The ability to access family and community support both while undergoing compulsory AOD treatment and afterwards; and
- How the distance and location would impact once the patient was a voluntary patient.

9. Conclusion

While the Mental Health Commission is to be commended for considering treatment options that encourage long term rehabilitation MHLC does have concerns regarding the draft Bill, particularly safe guarding human rights of the person and the justification and method of detaining them.

However, a scheme which has true rehabilitative elements, respect for the individual and assisting the person to have AOD treatment and then to progress toward rehabilitation will have a positive impact.