Personal Submission. The following represents my personal views and not necessarily those of my employer or colleagues.

Sub #5

11.1.53

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Brief CV:

Current: Clinical Director, Toowoomba Alcohol, Tobacco and Other Drug Service (ATODS)

7 years in total as a Senior Medical Officer in ATODS

3 years General Practice in Toowoomba including addiction management

9 months in Acute Mental Health as Registrar

8 months in Mount Isa and Mornington Island as Registrar and rural Medical Superintendent.

2 years working for Commonwealth Government agencies as medical adviser.

Residual in Queensland Health hospitals as Resident and Registrar.

In my submission I will be arguing that the Mental Health Act 2000 already provides a pathway for the involuntary assessment and treatment of alcohol- and drug-dependent persons.

In summary, my argument is:

1) The Mental Health Act 2000 includes a definition of Mental Illness that includes substance use disorders
2) The exclusion clauses do not exclude substance dependence
3) The mechanisms of assessment and admission are appropriate to use for severe substance use disorders
4) The framework of the Mental Health Act 2000 provides appropriate limits on the admission of persons with severe substance use disorders
5) The Parliament has already recognised the capacity for severe dependence to be managed as a Mental Health condition.

The Mental Health Act 2000 includes a definition of Mental Illness that includes substance use disorders

The definition of Mental Illness in the Mental Health Act 2000 is:

> a condition characterised by a clinically
> significant disturbance of thought, mood, perception or

memory.

There is the additional requirement that:

> On an assessment, a decision that a person has a mental illness must be made in accordance with internationally accepted medical standards.

Substance dependence is characterized by disturbances of thought and memory. The modern science of addiction indicates that the key pathways disturbed are those affecting *incentive salience* and *memory*. In addition, the most severe substance use disorders are associated with alterations of mood and frequently of perception, such as those occurring with *delirium tremens.*

The two most influential international medical standards for mental health diagnosis, the International Classification of Disease, 10th edition (ICD-10) and the Diagnostic and Statistical Manual of the American Psychiatric Association, 4th edition (DSM-4), both include substance use disorders as one class of mental illness.

By using the Mental Health Act 2000 there is no need to further define the diagnosis of severe substance dependence. As diagnostic rubrics change the Act remains current by the requirement that assessment is "in accord with international standards." The Admission criteria (discussed below) ensure that any dependence or substance use disorder is indeed severe before the Mental Health Act 2000 has jurisdiction.

To not include ICD-10 and DSM-4 diagnosable substance use disorders as mental illnesses as defined in the Mental Health Act 2000 would be to go against the very definitions and requirements within the Act itself.

The exclusion clauses do not exclude substance dependence

The Mental Health Act 2000 includes wording that was intended to exclude substance use disorders from coverage under the Mental Health Act, as reported to me in 2002 by the senior Psychiatrist advising. This wording was included in a long list of situations which must not be used as the sole indicator of mental illness.

However in its context the statement that the taking of drugs or alcohol is not sufficient reason for diagnosis of mental illness provides an appropriate safeguard against abuse of the Act while still leaving the way open for substance use disorders to be covered by the Act. This is because substance use disorders require a number of criteria **in addition to** substance use. Substance dependence is much more than "the person takes drugs or alcohol." ICD-10 substance dependence requires three of the following to occur concurrently:

- A strong desire or sense of compulsion to take the substance;
- Difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use;

- A physiological withdrawal state when substance use has ceased or have been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms;
- Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses (clear examples of this are found in alcohol- and opiate-dependent individuals who may take daily doses sufficient to incapacitate or kill nontolerant users);
- Progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects;
- Persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning; efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm.

The additional criteria required for substance use disorders mean that the diagnoses are not "caught" in the various exclusion phrases. The Mental Health Act 2000 states explicitly that "A person may have a mental illness caused by taking drugs or alcohol." One such disorder would be substance dependence, as defined either by ICD-10 or DSM-4.

Comparison with other exclusion clauses suggests that the section is primarily concerned to ensure that non-illnesses subject to disapproval by some sections of society are not sufficient for a mental illness diagnosis. It is entirely appropriate that these requirements be in place, but even more important when it is understood that substance use disorder is included in the possible diagnoses. It ensures that the appropriate criteria must be met for diagnosis. For example, heroin use is almost universally regarded as aberrant behaviour, but simple use does not meet criteria for dependence and is clearly excluded by the Mental Health Act 2000.

The mechanisms of assessment and admission are appropriate to use for severe substance use disorders

The Mental Health Act 2000 sets out a variety of processes by which a person may be brought involuntarily for assessment of their mental health. One of the most commonly enacted is that of an Emergency Examination Order by a Police Officer. In many of these cases the question is whether a person found in a disturbed state of mind has a mental illness. In many of these cases the disturbance will be due to substance use, and in some of these cases criteria for a substance use disorder will be met. The existing mechanism is used to require the person to be assessed by an Authorised Mental Health Practitioner or a doctor. There has never been a suggestion that the Authorised Mental Health Practitioner or doctor would not be able to undertake this type of assessment. Where the assessment cannot be completed the Authorised Mental Health Practitioner or doctor may require the person to remain for up to 72 hours for involuntary assessment. Many persons so admitted will be found to have substance use disorders ranging from simple intoxication to substance-induced psychosis.

The open recognition that the Mental Health Act 2000 includes the possibility of involuntary treatment for substance use disorders would provide a second option for management of persons assessed in the

existing way. It clarifies that these persons could be treated involuntarily, provided appropriate treatment was available at the Authorised Mental Health Service.

The intake procedures under the Mental Health Act 2000 are suitable for substance use disorders, and so are the mechanisms for review and management. The **least restrictive treatment** requirement prevents punitive extensions of admission, while the Mental Health review tribunal provides a robust check on the approach to treatment. It can be expected this will be particularly so regarding substance use disorders.

Considering the proposed alternatives to medical assessment, assessment by a Magistrate before or after admission, both ultimately derive from the Inebriates Act 1872 of Victoria, the first of its kind in any British Dominion. The provisions of that Act (and the heavily-dependent Queensland Inebriates Institutions Act 1896) reflect a time before motor vehicles, a time when it was considered reasonable for police officers to check on the wellbeing of mental health patients in private dwellings, and a time when a Justice of the Peace could be expected to hear cases in a Magistrate's Court. It should be borne in mind that the Queensland Insanity Act 1884 also required review by two JPs before either admission or discharge from an Insane Asylum.

The Magisterial approach to commitment has been criticized by the Queensland Parliament (in the Inebriates Institutions Act 1896 repeal debate) and by the Australian National Council on Drugs "Compulsory Treatment in Australia" report (Pritchard, Mugavin and Swan, 2007).

The framework of the Mental Health Act 2000 provides appropriate limits on the admission of persons with severe substance use disorders

The Mental Health Act 2000 provides a strong framework to prevent abuse of powers of involuntary admission.

In order to be involuntarily treated a person must meet **all** the following criteria:

> (a) the person has a **mental illness**;
> (b) the person's illness requires **immediate** treatment;
> (c) the proposed treatment is **available** at an authorised mental health service;
> (d) because of the person's illness—
> (i) there is an imminent risk that the person may cause **harm to himself or herself or someone else**; ***or***
> (ii) the person is likely to suffer **serious mental or physical deterioration**;
> (e) there is **no less restrictive way** of ensuring the person receives appropriate treatment for the illness;
> (f) the person—
> (i) **lacks the capacity** to consent to be treated for the illness; ***or***
> (ii) has **unreasonably refused** proposed treatment for the illness.

(emphasis mine)

Considering a case of severe substance dependence, a person would need to not merely have a diagnosis of substance dependence, such as alcoholism or heroin addiction, but would need to meet criteria for *immediate need for treatment, availability of treatment* and *imminent risk of harm*. There would need to be *no less restrictive treatment* and the person would need to *lack capacity* or *have unreasonably refused.*

These criteria will only be met by extremely severe cases.

The critical legal and practical bottleneck to involuntary treatment of substance use disorders is *availability of treatment at an Authorised Mental Health Service*. If this bottleneck was removed, through provision of treatment within existing Authorised Mental Health Services or through Authorisation of one or more dedicated substance use disorder facilities, the current Mental Health Act 2000 stands ready and able to provide an appropriate framework for involuntary admission of patients with severe substance use disorders.

There is the risk that attempts may be made to force persons to engage in treatment against their will and despite failure to meet Mental Health Act 2000 criteria. The Mental Health Act 2000 exclusion criteria make it clear that one **or more** of the criteria are not sufficient. A person cannot be involuntarily treated, for example, simply because they are a poor person of an Aboriginal nation carrying out an antisocial act while consuming alcohol. On the other hand these facts would not in themselves disprove the diagnosis of substance dependence nor the Admission Criteria.

Mental Health Act coverage of severe substance dependence recognised by Parliament

For many the suggestion that the Mental Health Act would cover substance use disorders will appear strange. However that is exactly the bipartisan position taken by the Queensland Parliament when the Inebriates Institutions Act 1896 was repealed in 1993.

The (Government) Member for Fitzroy, Mr Pearce, stated in the Parliamentary debate "Long-term heavy use of alcohol and some other drugs can also cause brain damage, with the consequent impairment of a person's ability to think and behave in a manner conducive to the maintenance of his or her health. Therefore provisions for compulsory treatment are still required for people suffering from these alcohol and drug-induced conditions. Upon repeal of the Inebriates Institutions Act 1896, the working party recommended that the Mental Health Act 1974 be used to provide compulsory treatment at designated drug and alcohol agencies, general hospitals and psychiatric hospitals throughout Queensland." Hansard 1993 p6521

Dedicated facilities required

Within the context of an Authorised Mental Health Service there is no place for a long-stay Inebriates Institution. Certainly some persons will be found to have neurological damage precluding functioning in broader society. These will be managed under Guardianship. On the other hand mere "detox" – medicated withdrawal management – is a precursor to treatment and not treatment in itself. Rehabilitation of the psychoeducational style is most attractive and could be delivered in a relatively brief 28 days, however many patients will require ongoing anticraving medication or maintenance

therapies such as buprenorphine or methadone. The use of minimally restrictive practices and community-based treatment orders may be appropriate.

Beyond any trial dedicated facilities for rehabilitation will be required, of a minimum size for cost-effectiveness and presumably located throughout the State. The withdrawal facilities could be co-located within existing medical wards but with restrictions on patient movement. Staff training in managing co-occurring behavioural and medical disorders could enable these units to also manage medically compromised patients with other mental illnesses. This may ultimately reduce staffing costs as currently these patients are managed on open medical wards with one-on-one nursing.

The goals of involuntary rehabilitation must include:

1) Initial sobriety: return of non-intoxicated neurological functioning
2) Resolution of medium-term withdrawal symptoms
3) Treatment with appropriate anticraving or maintenance medications
4) Psychoeducation, and education regarding drug effects including addiction
5) The voluntary opportunity to undertake much longer rehabilitation programs
6) Detailed assessment for physical and psychiatric illness

Recommendations:

1) The existing provisions within the Mental Health Act 2000 be utilised for involuntary assessment and treatment of severe substance use disorders.
2) That facilities for the management of medically compromised mental health patients, including patients undergoing substance withdrawal management, be located on medical wards at all major hospitals, with additional physical restrictions on patient egress.
3) That dedicated rehabilitation facilities, designated as Authorised Mental Health services, be created at 2 or 3 locations in the State.
4) That the goal of involuntary treatment of substance use disorders be that of involuntary mental illness management: the rapid re-establishment of patient self-determination through effective management of the disorder.

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