Health
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Musings of an ITLO:

Experiences and learnings from working with involuntary D&A treatment

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Background

- The NSW Drug and Alcohol Treatment Act 2007 provides the legislative basis for the NSW Involuntary D&A Treatment Program
- Trial undertaken from 2009 to 2010
- Independent evaluation undertaken
- NSW IDAT Program commenced 4th September 2012
- Replaced the Inebriates Act 1912, since repealed

Learnings and therapeutic challenges

- Working as a LHD Involuntary Treatment Liaison Officer (ITLO) is a very challenging role
- It is not the patients that are most challenging
- Level of complexity of this group of patients is astounding

Confidentiality / privacy issue

- Pt's are not consenting to treatment
- Not going to sign ROI forms
- The need to engage with NOK / carers is crucial
- The need to collaborate with other stakeholders enhances effective treatment (NGOs, NDIS providers, ambos, police)
- Apply discretion about what information to discuss / disclose to each various stakeholder e.g. need to know principle

Competency/capacity vs autonomy issue

- Impaired **capacity** is a central component of IDAT
- Capacity is the ability to make decisions for oneself

- **Autonomy** – right to make decisions for oneself, even if these decisions appear to be irrational e.g. where a pt. is making a fully informed decision to drink themselves to death; *"you have no right to tell me how to live my life"*

Competency / capacity issue con't.

- Most IDAT pts would like things to be different but change is too difficult or they can't functionally organise themselves enough
- Don't normally undertake formal capacity assessments
- Subjective component exists; some more clear, some less clear
- **Does the person have the capacity/ability to change if they want to?**

Duty of care issue

- The principle of duty of care is that we have an obligation to avoid acts or **omissions** which could be reasonably foreseen to cause injury or harm to pt's
- The term duty of care has limitations and is not always black and white. If we do have a duty of care …….
  - how big or extensive is it? i.e. what does it cover and not cover?
  - where does the duty stop or start?
  - when does is take effect and when is the burden lifted?

Likely to benefit

- How much benefit needs to be gained through the act of taking a person's liberty away?
- There is also the very real prospect that IDAT might do more harm then good i.e. disengagement from services, refuse any further treatment

No other less restrictive treatment is reasonably available

- Really means **“last resort”**
- When is last resort, last resort?
- When is “accessing voluntary treatment” accessing voluntary treatment
- Evidence of a recurring pattern of brief, superficial treatments without any real change

At risk of serious harm

- What is “serious harm” or “risk of” serious harm?
- At what stage do we use IDAT?
- Do we continue to let a pt. deteriorate until their condition is irreparable or life-threatening or intervene earlier?

Therapeutic leverage

- Always aim to use IDAT therapeutically

    - *“We are really concerned about your health and safety”*

    - *“There are all these options of voluntary treatment”*

- Rather than

    - *“List mate, there is the easy way or the hard way”*

- How much “therapeutic leverage” is ethical?

Dealing with the expectations of the various stakeholders

- Patients, family members, ED's/hospitals, MH colleagues, ambos, police, our D&A colleagues
- Sometimes it seems IDAT is treating everybody else's concerns or aimed at mitigating services' perceived level of risk
- Accept that we carry risk, we can't refer every person who is refusing treatment to IDAT
- Consider the motives of referrers
- Need to frequently explain what the Act can and can't do
- Empathy with family members

Unclear patient groups

- Binge / episodic drinkers who put themselves at serious risk when drinking
- Methamphetamine users who use once or twice per week and who have become sensitised to drug induced psychosis

Other issues

- The nature of involuntary treatment and how this fits into the usual clinical processes of the LHD i.e.

  - when does an enquiry from a stakeholder become a referral

  - when to open a treatment episode when pt. is not consenting to treatment

Finally

- IDAT does not necessarily provide an easy or a quick solution
- However, these are pt's that we should be looking after anyway
- If we choose not to refer for IDAT then need to be able to justify/account for why not