TUNA BLUE

Government of **Western Australia**
Mental Health Commission

AOD CRISIS INTERVENTION

Midwest Community Workshop (19th May 2020)

Output Summary Report

CONTEXT

The aim of this Community Workshop was to facilitate engagement with community members to inform development of an AOD Crisis Intervention System Service Model. In particular, it sought to explore what the ideal future of crisis intervention looks like, as well as specific challenges and opportunities relating to service delivery.

OVERVIEW OF ACTIVITIES

Participants considered the following questions during facilitated and self-managed group discussions:

- What should "safe" look like for people experiencing AOD Crisis in the Midwest?
- What are the current challenges and gaps in AOD Crisis Intervention services in the Midwest?
- What additional services or changes to existing services are required to optimise the AOD Crisis Intervention system in the Midwest?
- What are your thoughts on the introduction of compulsory AOD detox and/or treatment in WA?

SUMMARY OF KEY POINTS

The following themes emerged from responses to the questions specified above. A full account of the responses and any associated comments can be found at APPENDIX A.

What should "safe" look like for people experiencing AOD Crisis in the Midwest?

- Wrap around, holistic support based on the health, social and emotional needs of the clients, immediately available and with options / pathways to other services / acuity stages
- Unconditional, non-judgemental and positive regard for clients
- A location based, community 'invented' physical safe space / hub providing a secure bed, safety from any DV, crisis mental health support, a meal and an offer for longer ongoing AOD and mental health support (beyond a 'sobering up' function)
- Greater on-country social and emotional wellbeing programs and involvement of Elder and family models
- Detox options in the region

What are the current challenges and gaps in AOD Crisis Intervention services in the Midwest?

- Lack of non-judgemental, trusted and holistic / non-medical safe places/services for people in crisis (Police and ED are the only options)
- No after hours support
- Limited follow up and integration of AOD and MH services post ED
- Underlying crisis issues are not being addressed, particularly housing and homelessness
- Need for local, on country detox and rehabilitation options with flexible criteria for co-morbidity
- Limited involvement and education of families how they can help and support and encourage wellbeing
- Limited awareness of options in the community

What additional services or changes to existing services are required to optimise the AOD Crisis Intervention system in the Midwest?

- Dedicated pre-crisis and frontline support separate to Police and ED (e.g. Psychiatric Emergency Team, separate crisis areas at hospital)
- A 24/7 safe facility for AOD and MH crisis de-escalation linked to other services and ongoing holistic support (e.g. homelessness, financial, legal, tenancy, mental health, family support, child rearing practices, cultural linkages, employment and training)
- Greater cultural safety in existing services and settings through inclusion of Elders and family, on country services and recognition of the impacts of colonisation and intergenerational trauma
- A local crisis response service with training for local community members to become AOD workers
- Funding required to fill gaps in local, on country detox and rehabilitation services
- Greater integration is required between services (existing and proposed), particularly to address barriers for co-occurring MH and AOD needs

What are your thoughts on the introduction of compulsory AOD detox and/or treatment in WA?

- Short term detox could be beneficial for removing from self harm and risk to others but would need clear criteria and legal checks and balances; longer term treatment may not be effective
- Punishment, removing people's basic human rights and forced change will decreasing the likelihood of help seeking when people are ready to change
- Need for voluntary wrap around supports in the community first; concern that if the rehabilitation options aren't available currently, the clients will end up in jail instead
- Acknowledge the concerns of families and community members and the need to support and educate them

APPENDIX ONE: DETAILED INPUT BY COMMON THEME

The following section provides the detailed input from participants under key theme headings (as identified by the facilitator).

What should "safe" look like for people experiencing AOD Crisis in the Midwest?

Wrap around, holistic support based on the health, social and emotional needs of the clients, immediately available and with options / pathways to other services / acuity stages

- A wrap around service that holistically meets the health, social and emotional needs of the clients:
- A place that is responsive to needs negotiated by client and service provider taking into account ability of current capacity of service
- Options to up the ante when required – access to extra support when required
- Easy gateway for other services
- A service that is able to be immediately available

Unconditional, non-judgemental and positive regard for clients

- Unconditional positive regard for clients
- To be treated as an equal member of the community regardless
- Trusted
- Feeling welcomed
- A place where a person can go without judgement
- Supportive and non-judgemental
- Needle exchange program for when the machines aren't working

A location based, community 'invented' physical safe space / hub providing a secure bed, safety from any DV, crisis mental health support, a meal and an offer for longer ongoing AOD and mental health support (beyond a 'sobering up' function)

- A literal safe place providing a secure bed, safety from any DV, crisis mental health support, a meal and an offer for longer ongoing AOD and mental health support
- Some form of sobering up shelter
- There needs to be a safe place for people experiencing AOD Crisis that has medically trained people available, ie: not just a 'sobering up centre' that I think should be potentially attached to a health or hospital service and where other community services can access and provide whole of person services, a bit like a hub
- A centre / comfortable inviting environment with trained staff to support client at the vulnerable state they are in
- Free from violence
- Safe place to sleep

- I don't think we know what safe really looks like yet – I think we need to 'invent it'. We need to look at something new that will suit our communities from the coast to the inland. What might benefit those living in regional areas might not work for those living remote. What works in one community won't work in another

Greater on-country social and emotional wellbeing programs and involvement of Elder and family models

- Out bush:
  - On Country Programs such as ABC Foundations "River For Life" re-engage individuals with themselves, their Country and their future. But we simply do not have the quantity and in some cases the quality of one to one service available (or they are fully stretched and doing all they can with large numeric backlogs of individuals requiring assistance). How do we engage the actual cohort that is recognised as needing assistance? Agree with Kate's comments re no services locally for immediate assistance as Chris mentioned at the time most suitable to clients mindset
- Elder support and family
- Culturally safe
- Social and emotional well being

Detox options in the region

- It is inappropriate for people to have to be shunted to the Pilbara, Broome or Perth for detox
- A detox place (because there isn't one here)

What are the current challenges and gaps in AOD Crisis Intervention services in the Midwest?

Lack of non-judgemental, trusted and holistic / non-medical safe places/services for people in crisis (Police and ED are the only options)

- After the death of a woman last year because of a police shooting, we hear that the community is less trusting of calling the police for any AOD intervention which puts them and the community at risk, as well as the person experiencing the crisis
- Police, ED and families are the only crisis intervention service. We need a place to take people in crisis that links in with these options (police take them there, family request it, link to hospital if needed medically)
- Attitude for years in hospital is that you're just a druggie and sometimes not providing services to people because of the belief it is AOD when it is not, ie: non-AOD people being judged
- Overwhelming medical model of engagement at crisis entry
- A PET team would be preferable to police when people experiencing psychosis
- No hub to address the whole of person needs
- There is a massive shortage of crisis services and no funding seems to be allocated for these much needed services
- No hub for our teens to go to / no specialist services
- People on the ground to provide support for people in crisis and their families
- Police are often the first port of call and therefore it sometimes becomes a court issue or the client is back on the streets
- The ED is not an appropriate place for vulnerable people in crisis, and they are often met with negative attitudes from ED staff, especially if they are injecting drug users
- We have no crisis services. If someone is in crisis (AOD or MH) the ED is the only option

No after hours support

- Current model of crisis service delivery is centre based and typically by referral. No or very limited outreach or a response service
- No after hours services. If you need support outside of 8am – 4pm you have to use national hotlines

Limited follow up and integration of AOD and MH services post ED

- The clients that end up in ED over the weekend or of a night time get a mental health referral, but the mental health team can’t see them for weeks / months. When the time comes for that appointment, the client is often reluctant to engage at that point of time.
- Mental health and AOD handballing so people do not get integrated services, chicken and egg style, and therefore more difficult to get integrated services
- More 'joined up services across communities"

Underlying crisis issues are not being addressed, particularly housing and homelessness

- Housing is being used by some people using AOD by charging 'homeless people' a lot of their money and individuals and families are then being exposed to drug use
- Housing is a huge issue for people with serious MH issues – they very easily become isolated from their families and regular support network
- Underlying issues fuelling the fire – poverty, DV, homelessness, inter-generational trauma, negative role modelling, etc

Need for local, on country detox and rehabilitation options with flexible criteria for co-morbidity

- We have no detox. There's no real (as in evidence-based) rehab either. Hospital puts barriers up for clients with both mental health and AOD issues.
- Long distance from Perth with no specialist services
- Community has to go off country for treatment
- No crisis service no long term treatment / rehab service
- These are ongoing challenges, that have been observed over a good number of years. The challenge is how many more consultations need to occur before any actions are undertaken. Sobering up centre, Detox service / options
- Retention of appropriate staff

Limited involvement and education of families how they can help and support and encourage wellbeing

- There is a requirement for help for family and/or friend who support the person with information and education how they can help and support and encourage wellbeing.
- Partners of people in jail 'forced' to get drugs into prison with obvious results for these partners
- Challenge with youth we see is that for many AOD is a normalized family experience

Limited awareness of options in the community

- Not enough health information in the community as there is home baking with the reduction in drug supplies due to coved boundary restrictions
- The community – friends and families are often unaware of services and how best to contact them for advice
- We have a good number of programmes available in community around AOD and contributing factors, but not the specialty ones that have been highlighted.

What additional services or changes to existing services are required to optimise the AOD Crisis Intervention system in the Midwest?

Dedicated pre-crisis and frontline support separate to Police and ED (e.g. Psychiatric Emergency Team, separate crisis areas at hospital)

- Support for people before they reach crisis, as 000 service workers, Police and Ambulance are regularly involved at escalation point
- Psychiatric Emergency Team 24hours a day
- Support for frontline workers, particularly Police.
- Co-response teams
- Separate area from police emergency

A 24/7 safe facility for AOD and MH crisis de-escalation linked to other services and ongoing holistic support (e.g. homelessness, financial, legal, tenancy, mental health, family support, child rearing practices, cultural linkages, employment and training)

- The service should allow for family connections once the immediate crisis is dealt with. People do fall out of rehab when there need for family connection is stronger than their need for treatment, so a facility must be family friendly and allow for contact
- We need a 24hr facility that is linked to other services that can provide help with eg: homelessness, financial, legal, tenancy, mental health, family support, child rearing practices, cultural linkages, employment and training, etc
- A service that has self referral, available 24 hours a day, not a hospital setting but a health centre that is welcoming and supports clients emotionally, spiritually and culturally to seek services they need
- One of the best models in the world I have read about is the Trieste model in Italy for mental health support and AOD – 24 hrs, outside of hospital system, viewed as a health Centre capable of dealing with severe conditions and of supporting clients in their daily life with a view towards recovery and social inclusion. Staffed with nurses and social workers trained in mental health and AOD. This is the type of service missing for Midwest:
  - This is the Hope Springs model, but this has not proved to be effective in Geraldton
- In the Trieste model people have a bed with the service that is safe for a limited period of time, allows for de-escalation and then planned support
- A place that also accommodate their partner and their children
- Creating a Therapeutic Community Service with a holistic approach to improving a client's self-worth in all aspects of life
- Department of Communities – Housing have a role to play in holistic service delivery

Greater cultural safety in existing services and settings through inclusion of Elders and family, on country services and recognition of the impacts of colonisation and intergenerational trauma

- Greenough Regional Prison used to provide for elders from more remote towns and communities to bus into GRP to talk with prisoners from their communities. A Geraldton

facility should have funding available to provide for elder visits if there is not a local treatment facility in places like Meekatharra / Wiluna / Burringurrah, etc.

- Overall Australia still has not acknowledged where much of the pain and suffering be it via mental health or drug and alcohol abuse is inherited from – Our country does not acknowledge our true history as yet. Therefore, creating safety and culturally appropriate service for mine is simply recognising a human being in need, not a race or creed
- Culturally and age appropriate services for young people experiencing and/or living with AOD:
  - And on Country

A local crisis response service with training for local community members to become AOD workers

- A local response service would be ideal with cross agency collaborating
- Training for local community members who want to become AOD workers but don't want to leave their community to do it
- Information to community to de-mystify the issues

Funding required to fill gaps in local, on country detox and rehabilitation services

- We require more than the initial response and support – that appears as occurring for people however it is once the specific case is identified the lack of intermediate and longer term local facilities / HR to address individual's needs at that specific time. It has been long recognised and data collected that indicates and demonstrates that Geraldton and the Midwest Gascoyne as a whole suffers from many mental health and AOD issues. The lack of onsite facilities in our hinterland and regional cities / towns is sadly lacking. How do we collectively and collaboratively build the case for a 24 hour facility connected to all other elements of clients' needs can be interwoven and PRESENT that case to government?
- Funding now
- We just need funds to be able to run local detox services, local rehab services and other missing support services. These services need to be culturally appropriate
- Yes, cutting the red tape is common sense.

Greater integration is required between services (existing and proposed), particularly to address barriers for co-occurring MH and AOD needs

- We are instigating a no wrong door approach with amalgamation of Midwest Mental health and CADS services. There is an opportunity to open the Step Up Step down facility for both AOD and MH clients. CADS do provide a limited youth service in partnership with Headspace – needs extending:
- The Mental Health Commission and State (and Federal?) funding to Mental Health services in Midwest (based at Geraldton campus – to serve the region) needs to have AOD responses for crisis and management imbedded – this is the Step Up step down – beds need to be allocated for co-current clients

What are your thoughts on the introduction of compulsory AOD detox and/or treatment in WA?

Short term detox could be beneficial for removing from self harm and risk to others but would need clear criteria and legal checks and balances; longer term treatment may not be effective

- I think compulsory detox is a good idea, but only used as one part of a huge support system for a client
- Yes great, but needs to have wrap around services included
- I support it even if it gives family a rest time to regroup In saying that forcing rebab has low positive outcomes because they are not ready themselves
- Compulsory treatment is more vexed than detox. I personally do not support compulsory treatment when government has so much work to do in providing voluntary treatment services in the first instance
- I really don't know – it is something I fundamentally disagree with, but... if done right could it bring about meaningful change for the AOD user
- Would be beneficial in removing from self harm and risk to others
- Short term with very clear criteria. There also needs to be a funded legal service to ensure that all compulsory AOD detox is not misused. For example, people that are being held involuntarily are able to access the Mental Health:
  - Sorry, the Mental Health Law Centre
- It does present a possible opportunity, and it has been done through the prison system, but how has that step impacted individuals and communities' lives

Punishment, removing people's basic human rights and forced change will decreasing the likelihood of help seeking when people are ready to change

- I strongly dislike the idea of compulsory AOD treatment. Research shows people struggling with AOD don't recover until they're READY. Forcing someone into compulsory treatment will build a negative association between the user and support services and decrease their likelihood of reaching out when they are ready
- Currently people are being punished enough, without the support, where to begin, to find some balance in their lives.
- Peoples basic human rights need to be respected above all – I agree we should have localized services to provide supports at a local level
- Nope... people still have human rights, regardless of whether they are using alcohol and other drugs. There should be alternatives before we get to this level of intervention

Need for voluntary wrap around supports in the community first; concern that if the rehabilitation options aren't available currently, the clients will end up in jail instead

- More wrap around holistic support would work better, then the heavy handed approach of orders, believe me I know
- If it goes ahead then what guarantee will there be that the person will be supported afterward? There must be community supports in place before this could go ahead
- If there are no treatment places, I fear people will be held in jails

- We can't address this situation in current setting due to lack of services and "places for clients" availability. IF we were to make this compulsory where would ALL of the cases go? Perth and others across the nation are already full and with long waiting lists seldom if ever matched to the client's immediate desire to address their issues. This could force the issue for government to have even greater recognition of the issue but will not immediately address the significant lack of 'places" available nor the budgetary requirements to address these in each location or region
- There is no point if there aren't enough local rehabs for people to go to afterwards

Acknowledge the concerns of families and community members and the need to support and educate them

- Often requested by the family cohort, has been in the media and politics in the past
- Risky behaviour and safety of community and family, however if it is not their time psychologically they will not be effective other than providing them with underpinning knowledge for when they are ready

APPENDIX A: RAW GROUPMAP OUTPUT

Title	*Comments*
What should "safe" look like for people experiencing AOD Crisis in the Midwest?	
I don't think we know what safe really looks like yet - I think we need to 'invent it'. We need to look at something new that will suit our communities from the coast to the inland. What might benefit those living in regional areas might not work for those living remote. What works in one community won't work in another	
A wrap around service that holistically meets the health, social and emotional needs of the clients	REMOVED
It is inappropriate for people to have to be shunted to the Pilbara, Broome or Perth for detox	
Unconditional positive regard for clients	
A place that is responsive to needs negotiated by client and service provider taking into account ability of current capacity of service	
A literal safe place providing a secure bed, safety from any DV, crisis mental health support, a meal and an offer for longer ongoing AOD and mental health support	
Options to up the ante when required - access to extra support when required	
Needle exchange program for when the machines aren't working	
Some form of sobering up shelter	
Out bush	On Country Programs such as ABC Foundations "River For Life" re-engage individuals with themselves, their Country and their future. But we simply do not have the quantity and in some cases the quality of one to one service available (or they are fully stretched and doing all they can with large numeric backlogs of individuals requiring assistance). How do we engage the actual cohort that is recognised as needing assistance? Agree with Kate's comments re no services locally for immediate assistance as Chris mentioned at the time most suitable to clients mindset
There needs to be a safe place for people experiencing AOD Crisis that has medically trained people available, ie: not just a 'sobering up centre' that I think should be potentially attached to a health or hospital service and where other community services can access and provide whole of person services, a bit like a hub	
Elder support and family	
A detox place (because there isn't one here)	
Easy gateway for other services	
A centre/comfortable inviting environment with trained staff to support client at the vulnerable state they are in	
To be treated as an equal member of the community regardless	
Trusted	
Feeling welcomed	
Free from violence	
Safe place to sleep	
A place where a person can go without judgement	

Culturally safe

Supportive and non-judgemental

A service that is able to be immediately available

Social and emotional well being

What are the current challenges and gaps in AOD Crisis Intervention services in the Midwest?

After the death of a woman last year because of a police shooting, we hear that the community is less trusting of calling the police for any AOD intervention which puts them and the community at risk, as well as the person experiencing the crisis	
Police, ED and families are the only crisis intervention service. We need a place to take people in crisis that links in with these options (police take them there, family request it, link to hospital if needed medically)	
The clients that end up in ED over the weekend or of a night time get a mental health referral, but the mental health team can't see them for weeks/months. When the time comes for that appointment, the client is often reluctant to engage at that point of time.	
Housing is being used by some people using AOD by charging 'homeless people' a lot of their money and individuals and families are then being exposed to drug use	
There is a requirement for help for family and/or friend who support the person with information and education how they can help and support and encourage wellbeing.	
Housing is a huge issue for people with serious MH issues - they very easily become isolated from their families and regular support network	
Not enough health information in the community as there is home baking with the reduction in drug supplies due to coved boundary restrictions	
We have a good number of programmes available in community around AOD and contributing factors, but not the specialty ones that have been highlighted.	
Have tried for months to get a meeting with AOD management to discuss mental health/AOD issues, however they have not responded	Give me a call or email - Liz Lockyer - elizabeth.lockyer@health.wa.gov.au 99561963
Underlying issues fuelling the fire - poverty, DV, homelessness, inter-generational trauma, negative role modelling, etc	
Partners of people in jail 'forced' to get drugs into prison with obvious results for these partners	
A PET team would be preferable to police when people experiencing psychosis	
These are ongoing challenges, that have been observed over a good number of years. The challenge is how many more consultations need to occur before any actions are undertaken. Sobering up centre, Detox service / options	
Challenge with youth we see is that for many AOD is a normalized family experience	
Current model of crisis service delivery is centre based and typically by referral. No or very limited outreach or a response service	
No after hours services. If you need support outside of 8am - 4pm you have to use national hotlines	
No hub to address the whole of person needs	
The community - friends and families are often unaware of services and how best to contact them for advice	
Attitude for years in hospital is that you're just a druggie and sometimes not providing services to people because of the belief it is AOD when it is not, ie: non-AOD people being judged	
Overwhelming medical model of engagement at crisis entry	

There is a massive shortage of crisis services and no funding seems to be allocated for these much needed services

Retention of appropriate staff

No hub for our teens to go to/ no specialist services

We have no detox. There's no real (as in evidence-based) rehab either. Hospital puts barriers up for clients with both mental health and AOD issues.

People on the ground to provide support for people in crisis and their families

Police are often the first port of call and therefore it sometimes becomes a court issue or the client is back on the streets

Long distance from Perth with no specialist services

Mental health and AOD handballing so people do not get integrated services, chicken and egg style, and therefore more difficult to get integrated services

The ED is not an appropriate place for vulnerable people in crisis, and they are often met with negative attitudes from ED staff, especially if they are injecting drug users

Community has to go off country for treatment

No crisis service no long term treatment/rehab service

More 'joined up services across communities"

We have no crisis services. If someone is in crisis (AOD or MH) the ED is the only option

What additional services or changes to existing services are required to optimise the AOD Crisis Intervention system in the Midwest?

Greenough Regional Prison used to provide for elders from more remote towns and communities to bus into GRP to talk with prisoners from their communities. A Geraldton facility should have funding available to provide for elder visits if there is not a local treatment facility in places like Meekatharra / Wiluna / Burringurrah, etc

Yes, cutting the red tape is common sense.

Support for people before they reach crisis , as 000 service workers, Police and Ambulance are regularly involved at escalation point

Overall Australia still has not acknowledged where much of the pain and suffering be it via mental health or drug and alcohol abuse is inherited from - Our country does not acknowledge our true history as yet. Therefore creating safety and culturally appropriate service for mine is simply recognising a human being in need, not a race or creed.

A place that also accommodate their partner and their children

Psychiatric Emergency Team 24hours a day

We require more than the initial response and support - that appears as occurring for people however it is once the specific case is identified the lack of intermediate and longer term local facilities/HR to address individual's needs at that specific time. It has been long recognised and data collected that indicates and demonstrates that Geraldton and the Midwest Gascoyne as a whole suffers from many mental health and A&OD issues. The lack of onsite facilities in our hinterland and regional cities/towns is sadly lacking. How do we collectively and collaboratively build the case for a 24 hour facility connected to all other elements of clients needs can be interwoven and PRESENT that case to government?

Support for frontline workers, particularly Police.

Creating a Therapeutic Community Service with a holistic approach to improving a client's self-worth in all aspects of life

Department of Communities - Housing have a role to play in holistic service delivery

The service should allow for family connections once the immediate crisis is dealt with. People do fall out of rehab when there need for family connection is stronger than their need for treatment, so a facility must be family friendly and allow for contact	
Information to community to de-mystify the issues	
Funding now	
We just need funds to be able to run local detox services, local rehab services and other missing support services. These services need to be culturally appropriate	
Culturally and age appropriate services for young people experiencing and/or living with AOD	And on Country
A service that has self referral, available 24 hours a day, not a hospital setting but a health centre that is welcoming and supports clients emotionally, spiritually and culturally to seek services they need	
A local response service would be ideal with cross agency collaborating	
Training for local community members who want to become AOD workers but don't want to leave their community to do it	
We need a 24hr facility that is linked to other services that can provide help with eg:, homelessness, financial, legal, tenancy, mental health, family support, child rearing practices, cultural linkages, employment and training, etc etc etc	
Co-response teams	
Separate area from police emergency	
In the Trieste model people have a bed with the service that is safe for a limited period of time, allows for de-escalation and then planned support	
One of the best models in the world I have read about is the Trieste model in Italy for mental health support & AOD - 24 hrs, outside of hospital system, viewed as a health Centre capable of dealing with severe conditions and of supporting clients in their daily life with a view towards recovery and social inclusion. Staffed with nurses and social workers trained in mental health and AOD. This is the type of service missing for Midwest	This is the Hope Springs model, but this has not proved to be effective in Geraldton
We are instigating a no wrong door approach with amalgamation of Midwest Mental health & CADS services. There is an opportunity to open the Step Up Step down facility for both AOD & MH clients. CADS do provide a limited youth service in partnership with Headspace- needs extending	The Mental Health Commission and State (& Fed?) funding to Mental Health services in Midwest (based at Geraldton campus- to serve the region) needs to have AOD responses for crisis & management imbedded - this is the Step Up step down - beds need to be allocated for co-current clients
What are your thoughts on the introduction of compulsory AOD detox and/or treatment in WA?	
https://www.tunablue.com.au/aod-survey	
It does present a possible opportunity, and it has been done through the prison system, but how has that step impacted individuals & communities lives	
I think compulsory detox is a good idea, but only used as one part of a huge support system for a client.	
Yes great, but needs to have wrap around services included	
Currently people are being punished enough, without the support, where to begin, to find some balance in their lives.	
Peoples basic human rights need to be respected above all - I agree we should have localized services to provide supports at a local level	
I support it even if it gives family a rest time to regroup In saying that forcing rebab has low positive outcomes because they are not ready themselves	
More wrap around holistic support would work better, then the heavy handed approach of orders, believe me I know	

I strongly dislike the idea of compulsory AOD treatment. Research shows people struggling with AOD don't recover until they're READY. Forcing someone into compulsory treatment will build a negative association between the user and support services and decrease their likelihood of reaching out when they are ready.

If it goes ahead then what grantee will there be that the person will be supported afterward? There must be community supports in place before this could go ahead

If there are no treatment places, I fear people will be held in jails

Nope... people still have human rights, regardless of whether they are using alcohol and other drugs. There should be alternatives before we get to this level of intervention

Often requested by the family cohort, has been in the media and politics in the past

We can't address this situation in current setting due to lack of services and "places for clients" availability. IF we were to make this compulsory where would ALL of the cases go? Perth and others across the nation are already full and with long waiting lists seldom if ever matched to the client's immediate desire to address their issues. This could force the issue for government to have even greater recognition of the issue but will not immediately address the significant lack of 'places" available nor the budgetary requirements to address these in each location or region

Risky behaviour and safety of community and family, however if it is not their time psychologically they will not be effective other then providing them with underpinning knowledge for when they are ready

There is no point if there aren't enough local rehabs for people to go to afterwards

Compulsory treatment is more vexed than detox. I personally do not support compulsory treatment when government has so much work to do in providing voluntary treatment services in the first instance

I really don't know - it is something I fundamentally disagree with, but... if done right could it bring about meaningful change for the ado user????

Would be beneficial in removing from self harm or ans

Short term with very clear criteria. There also needs to be a funded legal service to ensure that all compulsory AOD detox is not misused. For example, people that are being held involuntarily are able to access the Mental Health

Sorry, the Mental Health Law Centre