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# Review of the Severe Substance Dependence Treatment Act 2014 (Vic)

## Volume 1

## Report of the Review

**(A literature review that informed this report is included at Volume 2)**

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## 1. EXECUTIVE SUMMARY

This is a report of a review of the *Severe Substance Dependence Treatment Act 2010* (Vic) ('the Act') conducted by DLA Piper Australia for the Department of Health and Human Services ('the Department') in accordance with the requirements of s 41 of the Act.

The Act provides for the detention and treatment of persons with a severe substance dependence who meet certain criteria.

The purpose of the review was to determine—

(a) whether the objectives of the Act are being achieved and are still appropriate; and

(b) whether the Act is effective or needs to be amended.

The review consisted of:

- a review of the literature (presented as a separate volume to this report);
- a detailed analysis of activity under the Act;
- comparison of the Act with other relevant legislation;
- a substantial program of consultation comprising:
    - targeted interviews;
    - stakeholder forums in Melbourne, Ballarat, Shepparton and Traralgon and with the Department of Justice's Koori Caucus;
    - invitations to stakeholders to make written submissions; and
- integration of findings into this report.

Eighty four organisations were invited to participate in the review consultation process. Forty nine individuals participated in interviews and/or forums, and six written submissions were received.

A detailed review of client records was conducted under conditions approved by St Vincent's. There was evidence of a high level of compliance by treatment centre staff with the requirements of the Act.

Twenty three clients were detained and treated at the two declared treatment centres, St Vincent's Hospital Melbourne ('St Vincent's') and Depaul House (co-located with St Vincent's), between 1 March 2011 and 2 February 2015. In total, there were 28 admissions for detention and treatment over that period. Detention and treatment orders ('DTOs') were made in Magistrates' Courts in:

- Melbourne (eight clients)
- other metropolitan areas (nine clients); and
- rural areas (six clients).

Follow-up at six months was available following 25 of the 28 episodes of care. At six months following discharge, in relation to:

- five episodes of care, clients were abstinent;
- two episodes of care, clients had reduced their use;
- three episodes of care, clients had died;
- three episodes of care, clients were lost to follow up and presumed relapsed; and
- 12 episodes of care, clients were known to have relapsed.

It terms of achievement of the Act's objectives, it is clear that:

- provision has been made for detention and treatment of a small number of people with severe substance dependence; and
- the period of involuntary treatment improved the capacity of most clients detained under the Act to make decisions about whether they would continue with voluntary treatment.

For this very complex and ill group of clients, an abstinence/reduced use rate of almost 30% is encouraging.

The client record review also confirmed that clients who were cooperative with ongoing treatment were established on anti-craving medications. Clients with complex social needs and who were homeless received comprehensive case conferencing and, where possible, case management to plan for the delivery of their complex care needs.

While stakeholders recognised the infringement on human rights associated with involuntary detention and treatment and strongly supported the concept that detention and treatment should be a consideration of last resort, they also noted the infringement on safety and dignity experienced by members of the target client group as a result of their severe substance dependence. The vast majority of stakeholders agreed that involuntary detention and treatment remains appropriate for a small group of people with highly complex health and wellbeing needs associated with severe substance dependence. The exception to this was some consumer representatives, who strongly objected to the concept of involuntary detention and treatment.

Stakeholders emphasised that generally poor knowledge of the Act and the complexity of accessing DTOs have resulted in very limited application of the Act, to the disadvantage of some people who would clearly meet eligibility criteria for, and may have an opportunity to benefit from, a DTO.

A number of suggestions to improve the effectiveness and implementation of the Act are included in this report.

Stakeholders suggested that the Act's objectives should be broadened, extending beyond the provision of medically-assisted withdrawal for the purpose of enhanced decision-making to include the provision of multidisciplinary assessment and treatment, care planning, care coordination and transition to high quality care and support services following discharge. There was strong stakeholder representation that if peoples' human rights are to be infringed in the manner enabled by the Act, there is a corresponding obligation to offer them the best possible opportunity to achieve a sustainable health and wellbeing benefit, and this is unlikely to be achieved by focusing solely on medically-assisted withdrawal.

There was stakeholder support for defining the intended client group more clearly and including a 'client benefit' criterion in the Act. There was some support for including the need to protect others from serious harm as a criterion for making a DTO, although other stakeholders suggested this issue is better dealt with through the criminal justice system.

There is significant stakeholder concern about the extensive procedural requirements that must be navigated before a Magistrate can consider an application for a DTO, and delays in treatment associated with those procedural requirements. While the imposition of procedural requirements assists to ensure detention and treatment is a consideration of last resort and to minimise limitations on a person's human rights, stakeholders favoured streamlining procedural requirements to ensure the making of DTOs is not impeded by unnecessary procedural barriers, while ensuring the Act is not inappropriately applied by defining the target client group very clearly.

Stakeholders did not support the existing special warrant process, advising that it is cumbersome and difficult to implement in practice.

There was strong stakeholder support for enabling general practitioners to recommend clients for a DTO, and for implementing similar decision-making processes to those established by the *Mental Health Act 2014* (Vic) ('the Mental Health Act') which authorises initial decision-making by a clinician with subsequent review by the Mental Health Review Tribunal. In the context of the Act, review of clinical decisions could be undertaken by the Magistrates' Court or the Victorian Civil and Administrative Tribunal. Consideration would need to be given to whether review was automatic or only occurred on application, and whether a decision not to detain and treat should be reviewable.

There was also strong stakeholder support for extending the detention and treatment period from 14 days to 28 days. Stakeholders almost universally agreed that 14 days is insufficient to achieve a sustainable benefit for most clients. The difficulty establishing a comprehensive package of services during a 14 day period sufficient to provide clients with necessary support following discharge was noted, as was the need for clients to have adequate supervised time to achieve a stable physical and mental state conducive to making balanced decisions about their future. It was noted that a longer treatment period applies in all other Australian jurisdictions, New Zealand and Sweden.

Stakeholders also supported removing the requirement that a recommendation can only be made after confirming that facilities and services are available for the recommended treatment. Stakeholders suggested that a decision to recommend a client should be made only on the basis of client need, not supply of facilities and services.

There was support for consideration of including an option for community treatment orders in the Act, similar to those enabled by the Mental Health Act.

Stakeholders made a number of suggestions to improve implementation of the Act including:

- providing stakeholder education, to improve awareness of the Act;
- preparing more guidance material to assist stakeholders to better understand the eligibility criteria for a DTO;
- establishing a formal advisory service, separate from the treatment centres, to support potential applicants and prescribed registered medical practitioners ('PRMPs') who are considering making a recommendation under the Act;
- monitoring demand for services, ensuring adequate capacity over time and, if the service system needs to be expanded, declaring a second treatment centre so as to provide an additional geographic option for client management;
- developing secure facilities for better management of the small number of clients at high risk of absconding;
- working with the recently restructured community-based drug and alcohol support sector to ensure clients receive priority access to case management/care co-ordination following discharge;
- collecting an agreed minimum data set, for monitoring and accountability purposes, and publishing an annual report; and
- developing service level agreements between the Department and the treatment provider.

Many stakeholders expressed a desire for access to more information on an ongoing basis about the operation of the Act and the outcomes achieved. Establishment of service level agreements with treatment centres that incorporate minimum data collection requirements would support transparency, accountability and evaluation.

## 2. INTRODUCTION

In December 2014 the Department engaged DLA Piper Australia to review the Act in accordance with the requirements of s 41 of the Act.

The review team included Dr Heather Wellington, Dr Rebecca French and Dr Kelly Shaw. Professor Greg Whelan was a consultant to the review team.

This is the report of the review, which consisted of:

- review of the literature (presented as **Volume 2** of this report);
- a detailed analysis of activity under the Act;
- comparison of the Act with other relevant legislation;
- a substantial program of consultation comprising:
    - targeted interviews;
    - stakeholder forums;
    - invitations to stakeholders make written submissions; and
- integration of findings into this report.

A list of 84 organisations invited to participate in consultation for the review is at **Attachment 1** and a list of individuals and organisations that made submissions to the review is at **Attachment 2**.

Consultation forums were conducted in Melbourne, Shepparton, Ballarat and Traralgon. A list of 49 individuals who participated in targeted interviews and/or attended forums is at **Attachment 3**.

A consultation forum was also conducted with the Koori Caucus, convened by the Department of Justice.

During the review, careful consideration was given to the form and operations of both the Mental Health Act and the *Drug and Alcohol Treatment Act 2007* (NSW) ('the NSW Act'), which were described by many stakeholders as establishing effective models for involuntary detention and treatment.[1] A table comparing the Act with similar legislation in other jurisdictions is at **Attachment 4** and analyses of the Mental Health Act and the NSW Act are included at **Attachments 8** and **11** respectively.

The review was assisted by an expert reference group, the membership of which is listed at **Attachment 5**.

The Self Help Addiction Resource Centre kindly assisted the review by conducting two consumer forums – one with service users and one with family members. Reports of those forums are included at **Attachment 6**.

Subsection 41(3) of the Act requires the Minister to make a report of the review and the Government's response available to the public within 3 months after 1 March 2015.

[1] The review team was advised that the operation of the NSW Act has not been fully reviewed, although there was a pilot of its operation based on a trial for a controlled catchment before it became a State-wide program. That review confirmed that the NSW Act had, "to the extent it has been tested, held up well as a legal document and the trial had demonstrated positive clinical and psychological outcomes for patients during the involuntary period".

## 3. PURPOSE AND SCOPE OF THE REVIEW

The scope of the review is established by s.41 of the Act which provides as follows:

> **41 Review**
>
> (1) The Minister must ensure that a review of this Act is completed by 1 March 2015.
>
> (2) The purpose of the review is to determine—
>
> (a) whether the objectives of this Act are being achieved and are still appropriate; and
>
> (b) whether the Act is effective or needs to be amended.
>
> ...

The objectives of the Act are set out in section 3, as follows (defined terms are shown in ***bold italics***):

> **3 Objectives of the Act**
>
> (1) The objectives of this Act are—
>
> (a) to provide for the detention and ***treatment*** of persons with a ***severe substance dependence*** where this is necessary as a matter of urgency to save the person's life or prevent serious damage to the person's health; and
>
> (b) to enhance the capacity of those persons to make decisions about their substance use and personal health, welfare and safety.

Definitions relevant to the objectives are set out in section 5 (severe substance dependence) and section 6 (treatment).

> **5 Severe substance dependence**
>
> For the purposes of this Act, a person has a ***severe substance dependence*** if—
>
> (a) the person has a tolerance to a substance; and
>
> (b) the person shows withdrawal symptoms when the person stops using, or reduces the level of use of, the substance; and
>
> (c) the person is incapable of making decisions about his or her substance use and personal health, welfare and safety due primarily to the person's dependence on the substance.

> **6 Meaning of treatment**
>
> (1) For the purposes of this Act, ***treatment*** means anything done in the course of the exercise of professional skills to provide medically assisted withdrawal from a severe substance dependence or to lessen the ill effects, or the pain and suffering, of withdrawal.

The Department asked DLA Piper, in undertaking the review, to focus on:

- activity levels;
- the efficiency and effectiveness of the scheme;
- the service model;
- experiences of involved individuals (clients, nominated persons, families, carers, police, courts, health practitioners, Public Advocate etc.); and
- the impact/implications of recent policy and regulatory changes.

## 4. BACKGROUND TO AND SETTING OF THE ACT

Legislation providing for the civil commitment of persons with substance dependence has existed in Victoria for more than a century in the form of a number of 'Inebriates Acts'[2] and, more recently, the *Alcoholics and Drug-dependent Persons Act 1968* (Vic).

The *Alcoholics and Drug-dependent Persons Act 1968* (Vic) authorised and regulated the detention of some alcohol and drug-dependent persons for the purpose of assessment and treatment through a process of civil detention. Section 11 of the Act provided that, upon a complaint by eligible persons,[3] a judge or magistrate could order that a person who appeared to be an 'alcoholic or a drug dependent person' attend and be admitted to an assessment centre for seven days.[4] Section 11 also allowed the court to order that a person 'be retained in the assessment centre for treatment' for an indeterminate period.[5] A person who, so ordered, failed to attend or absconded, may have been arrested by police on a warrant and returned to the assessment centre.[6]

Section 12 provided that a person assessed under s 11 could be committed to a treatment centre where two medical practitioners had certified that the person was an 'alcoholic' or 'drug dependent person' and the medical officer in charge of the centre was of the same opinion. The medical officer in charge must also have been satisfied that the person was 'suitable for treatment in a treatment centre'. This commitment was for an indefinite period.

In November 2007, the then Premier of Victoria established the Ministerial Taskforce on Alcohol and Public Safety to lead the development of an Alcohol Action Plan ('the Plan'). The Plan, which was released in May 2008, outlined various strategies by which the Government intended to reduce the abuse of alcohol in Victoria. In the Plan, the Government noted that it had reviewed the *Alcohol and Drug-dependent Persons Act 1968* (Vic) and was committed to developing new legislation that would continue to provide for short-term involuntary detention of people with a severe alcohol or drug dependence where they are at risk of serious harm to themselves or others. It also committed to

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[2] For example, the Lunacy Statute 1867, *the Inebriates Act 1872*, The *Inebriates Act 1904*, the *Inebriates Act 1915*, the *Inebriates Act 1928* and the *Inebriates Act 1958*.

[3] Including a person's spouse, domestic partner, adult children or siblings, a business partner, police officer or welfare officer: *Alcoholics and Drug Dependent Persons Act 1968* (Vic) s 11(2).

[4] *Alcoholics and Drug Dependent Persons Act 1968* (Vic) s 11(1).

[5] *Alcoholics and Drug Dependent Persons Act 1968* (Vic) s 11(5).

[6] *Alcoholics and Drug Dependent Persons Act 1968* (Vic) ss 11(3); see also s 18.

developing service models that could provide a better service to people affected by the legislation, including more intensive support and aftercare.[7]

The Act was assented to on 10 August 2010 and came into operation on 1 March 2011. It repealed the *Alcoholics and Drug Dependent Persons Act 1968* (Vic). It provides for the detention and treatment of people with severe substance dependence in a treatment centre where this is necessary as a matter of urgency to save their life or prevent serious damage to their health. Detention must be the only means by which treatment can be provided and there must be no less restrictive means reasonably available to ensure the treatment. In addition, the person must be incapable of making decisions about their substance use and personal health, welfare and safety due primarily to their substance dependence. The purpose is to give the person access to medically-assisted withdrawal, time to recover, capacity to make decisions about their substance use and the opportunity to engage in voluntary treatment.

Detention and treatment must be a consideration of last resort. Treatment is limited to 'anything done in the course of the exercise of professional skills to provide medically assisted withdrawal from a severe substance dependence or to lessen the ill effects, or the pain and suffering, of the withdrawal'[8] and the period of detention is limited to a maximum of 14 days.

Section 7 of the Act provides that the Secretary to the Department of Health (now the Department of Health and Human Services) may, by notice published in the Government Gazette, declare a premises at which treatment is to be provided or a service through which treatment is to be provided to be a treatment centre. On 17 February 2011 St Vincent's and Depaul House[9] were declared as treatment centres under s 7(1)(a) of the Act.[10]

## 5. HOW THE ACT WORKS

### 5.1 Overview of procedure for making and implementing a detention and treatment order

The procedure for making and implementing a DTO under the Act is described in a flow chart published by the Department (Figure 1).

A detailed description of the operations of the Act is included at **Attachment 7**.

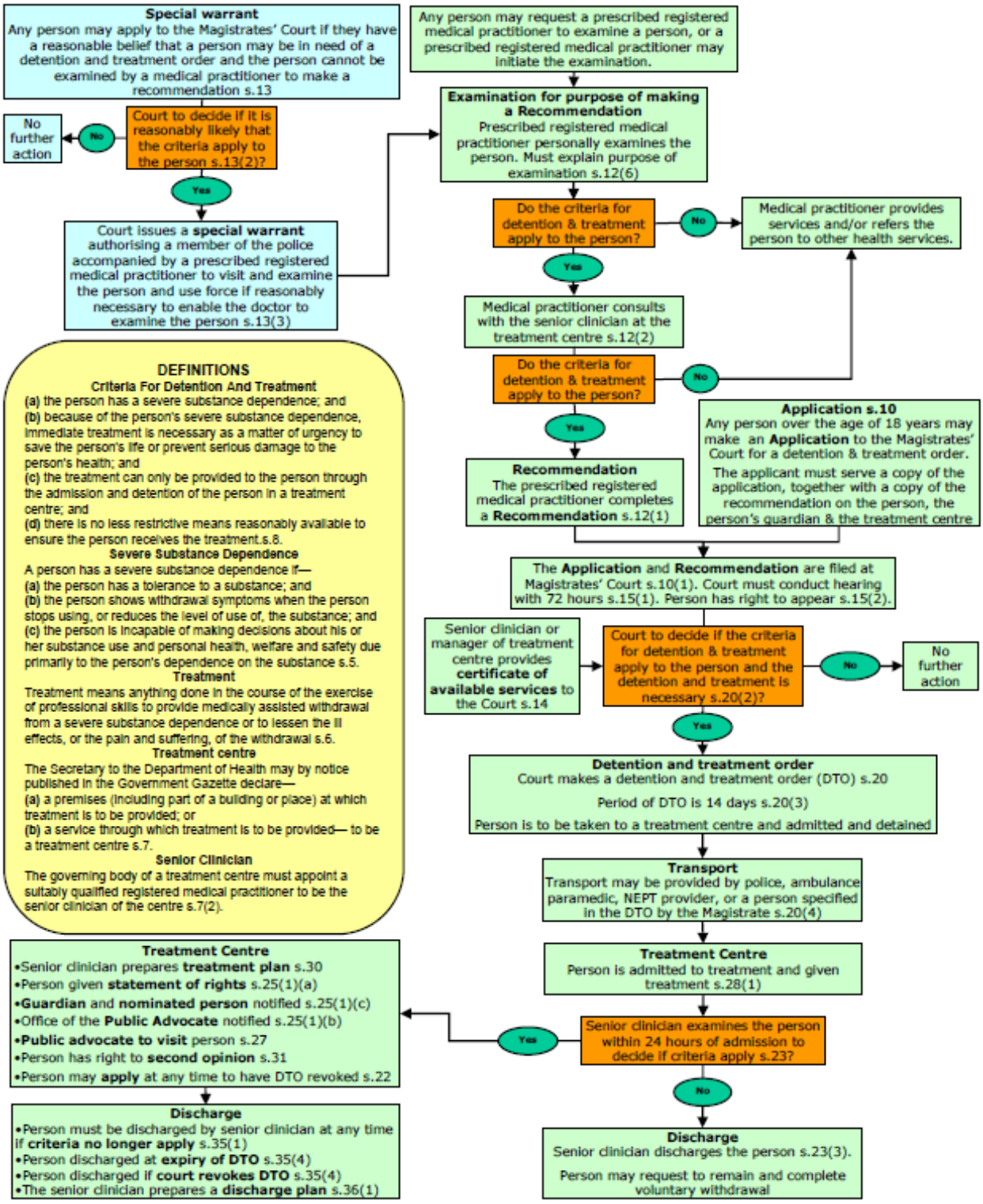
[7] Victorian Government. Victoria's Alcohol Action Plan 2008-2013. May 2008. Page 25.

[8] Section 6(1).

[9] Depaul House is a community based residential withdrawal unit for persons with alcohol and/or drug dependence, operated by St Vincent's.

[10] Victorian Government Gazette. G7. 17 February 2011. Page 281.

**Figure 1: Procedure for making and implementing a DTO under the Act**



## 6. RELATIONSHIP TO THE *MENTAL HEALTH ACT 2014* (VIC)

An overview and flow chart of the operation of the Mental Health Act is included at **Attachment 8**.

A mental illness is defined in s 4(1) of the Mental Health Act as being 'a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory'. This broad definition is expressed as subject to s 4(2), which provides that a person is not to be considered to have mental illness by reason of any one or more of certain listed matters, including (relevantly) 'that the person uses drugs or consumes alcohol': paragraph (l). However, s 4(3) provides that 'Subsection (2)(l) does not prevent the serious temporary or permanent physiological, biochemical or psychological effects of using drugs or consuming alcohol from being regarded as an indication that a person has a mental illness'.

It is clear from this definition that although the Mental Health Act is not targeted at ordinary drug use or alcohol consumption, it can apply where that consumption leads to a significant disturbance or has serious effects of the kind contemplated. Because of this, there is practical overlap between the application of the two Acts. Some groups advised that where they consider that both the Act and the Mental Health Act apply, they prefer to use the Mental Health Act because its process for obtaining a treatment order is more accessible.

However, concern was expressed by stakeholders that medical treatment by mental health specialists and/or in mental health facilities of people with severe drug dependence will not be as effective as medical treatment by addiction specialists in facilities designed for that purpose. This view was consistent with the view expressed in the report of a review conducted in New South Wales which preceded the introduction of its current *Drug and Alcohol Treatment Act 2007* (NSW). That review found that "the detainment of substance dependent people in mental health facilities can be counter-productive as this can harm their wellbeing and that of any clients with mental illness they come into contact with as well as serve as a barrier to their accessing drug and alcohol treatment".[11] Consistent with this statement, stakeholders agreed that where a person's main problem is addiction and they meet the criteria for a DTO under the Act, they should be dealt with under the Act, which is specifically designed for substance dependent persons.

It was also suggested that the application of the two Acts should be more clearly delineated, perhaps by a provision in the Act indicating when it applies in contrast to the Mental Health Act. However, others suggested it is preferable to have both Acts as available pathways, leaving the choice open to clinicians as to which is more appropriate for each client. There are advantages in not being proscriptive about which might be chosen in a particular case.

A minority of those consulted suggested that the provisions of the Act should be incorporated directly into the Mental Health Act.

[11] Report of Review of the Legislation: Drug and Alcohol Treatment Act 2007 (NSW) at p 2.

## 7. THE ST VINCENT'S TREATMENT MODEL

The St Vincent's Addiction Medicine Team provides a broad range of services, including supporting the treatment of clients detained under the Act. It comprises the following positions:

- Addiction medicine consultant (appointed as the senior clinician) - 0.6 FTE
- Addiction medicine consultant - 0.4 FTE
- Addiction medicine consultant - 0.2 EFT
- Registrar (trainee in addiction medicine) – 0.6 FTE
- Registrar (physician trainee, 3 month rotation) - 1.0 FTE
- Clinical nurse consultant - 1.0 FTE
- Counsellor – 1.0 FTE
- Receptionist – 1.0 FTE
- Research assistant - 0.4 FTE
- Forensic counsellor - 0.2 FTE
- Executive assistant (shared with the outpatient department).

In its proposal to the Department to be declared as a treatment centre, St Vincent's described in some detail how it would provide treatment to clients detained under the Act. A detailed description of the current model of care, provided to the review team by the Addiction Medicine Team, is included at **Attachment 9**.

## 8. ACTIVITY UNDER THE ACT

Depaul House has one bed dedicated to the treatment of people detained under the Act, enabling detention and treatment of a maximum of 24 people each year.

Twenty three people in total (an average of approximately 6 per year) were detained and treated under the Act between 1 March 2011, when the service commenced, and 2 February 2015, when client records were reviewed. A small number were detained and treated on more than one occasion. This is fewer than:

- the number expected or considered appropriate by stakeholders consulted during this review; and
- the average of eight recorded episodes of commitment per year, involving an average of six clients per year, that occurred under the *Alcoholics and Drug-dependent Persons Act 1968* (Vic) between 1998 and 2003.[12]

In comparison to Victoria, the NSW Act resulted in the admission for treatment of 93 people in the 12 months to 31 December 2014. This also contrasts with the NSW Act's predecessor, the *Inebriates Act*

[12] Turning Point Alcohol and Drug Centre. The Alcoholics and Drug-dependent Persons Act (AADDPA) 1968: A Review. March 2004. Page 20.

*1912* (NSW)[13], under which there was an average of 19 admissions a year in the 10 years preceding its repeal.[14]

On an adult population basis, 73 admissions annually in Victoria would represent an equivalent admission rate to the NSW admission rate for the 12 months to December 2014 (see population estimates in footnote 15).[15]

### 8.1 Methods

With the approval of St Vincent's, a detailed review of the clinical medical records of all persons with severe substance dependence who had been detained and treated at St Vincent's and/or Depaul House under the Act was conducted on St Vincent's premises in February 2015. A registered medical practitioner personally reviewed each medical record and extracted relevant information, which was de-identified and coded on a Microsoft Excel spreadsheet. No client names or identifiers were retained. The spreadsheet will be destroyed once the final report of the review is approved by the Department.

### 8.2 Characteristics of the client group

Twenty three clients had been treated involuntarily during 28 separate admissions under the Act. Twenty clients had one involuntary admission, two had two involuntary admissions and one had four involuntary admissions. The mean age of clients was 35 years (range 24 to 54 years) and the majority (16 clients) were male.

In 16 clients alcohol dependence led to the admission. The other seven clients reported poly drug use, which included alcohol in all cases. Other substances used by poly drug users were solvents (two clients), cannabis, opioids, benzodiazepines and amphetamines.

The principal place of residence of 11 clients was Melbourne. Six clients were from rural Victoria and six were homeless. Two clients were of culturally and linguistically diverse background and one was of Aboriginal background.

Three clients (two male and one female) are known to have died in the period between their discharge from compulsory detention and treatment and the review. Their ages at the time of involuntary detention and treatment ranged from mid-20s to mid-50s. Two of these clients were admitted for treatment of alcohol dependence and one for treatment of alcohol dependence and abuse/dependence of methadone. The causes of death were not available for review.

In 16 clients a significant mental health comorbid diagnosis including schizophrenia, depression and anxiety, post-traumatic stress disorder, personality disorders and/or attention deficit/hyperactivity disorder was recorded. In addition, intellectual disability thought to pre-date the substance use disorder was recorded in three clients.

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[13] Repealed by the *Courts and Other Legislation Further Amendment Act 2013* (NSW).

[14] Statistics obtained from the Mental Health Drug and Alcohol Office, NSW Ministry of Health.

[15] Based on estimated resident populations of persons aged 18 and over of 4,481,481 in Victoria and 5,738,553 in NSW at 30 June 2013. See the Australian Bureau of Statistics series 3235.0: Population by age and sex, regions of Australia, 2013 at http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3235.02013?OpenDocument

### 8.3 Involuntary admission (s 5 to s 9)

Evidence was provided for all clients of the need for immediate treatment as a matter of urgency to save the person's life or prevent serious damage to the person's health. The severity of the threat to the person's life varied between clients. In the most severe cases clients had presented with acute overdose requiring resuscitation and intensive care management. Six clients required intubation due to respiratory arrest (five relating to excess alcohol consumption). Five clients were engaging in repeated dangerous behaviour whilst intoxicated (e.g. exposure to serious risk of traffic trauma while intoxicated, walking and/or falling asleep on railway tracks while intoxicated) and three clients presented with seizures on withdrawal. The remainder were at risk due to rapid deterioration in physical and/or mental health including acute pancreatitis, encephalopathy, repeated trauma, acute on chronic liver failure and bleeding disorders, including intracranial haemorrhage.

Clients with complex medical care needs (as described in Table 1) were comprehensively assessed and managed.

**Table 1: Presenting medical care need for clients detained and treated under the Act**

| Presenting medical care need | Number of clients |
|---|---|
| Seizures and / or loss of consciousness | 10 clients |
| Liver failure | 7 clients |
| Management of traumatic fractures | 6 clients |
| Head injury assessment and management | 5 clients |
| Cachexia | 5 clients |
| Encephalopathy | 4 clients |
| Thrombocytopaenia | 3 clients |
| Pancreatitis | 3 clients |
| Undifferentiated abdominal or chest pain | 3 clients |

In all cases voluntary treatment was not possible (according to the PRMP's recommendations). Reasons included lack of insight into the severity of the person's substance use and consequences of continued use, intoxication and/or cognitive impairment preventing the client from considering treatment.

Evidence of why detention and involuntary treatment was the least restrictive treatment and least intrusive manner of treatment was provided for all clients. Reasons included multiple previous failed attempts at voluntary detoxification (15 clients), absconding and/or discharge against medical advice on previous admissions (13 clients), client refusing treatment even though acutely at risk (14 clients), the presence of cognitive impairment (e.g. intoxication/delerium) and assessment of high risk of absconding from treatment.

All people with co-existing medical and mental health conditions were comprehensively assessed and these conditions were managed during their involuntary treatment. Treatment was provided within St Vincent’s in the emergency short stay unit, a general medical inpatient bed, the mental health inpatient unit and/or the intensive care unit. Clients were treated in designated alcohol and drug treatment beds in Depaul House where possible.

In all cases clients were involved in decisions about their treatment and discharge planning within their capacity to participate. This involvement was comprehensively documented in nursing and medical records. Families and other significant persons were involved in the client's treatment where possible. In three cases this was through a family member being designated as a nominated person. In two cases a family member was the guardian of the client. In other cases medical and nursing staff involved family members with the consent of the client where the client had family to involve. Ten clients had no family or significant others to involve and were very socially isolated.

The average length of involuntary admission of clients was 11.8 days (range of 2 to 14 days). Twelve clients had a recorded involuntary admission of the maximum length of 14 days. All clients met the criteria for severe substance dependence when the order was made.

### 8.4 Detention and treatment orders (s 10 and s 11)

The location of the Magistrates' Courts where DTOs were obtained varied as follows (Table 2):

**Table 2: Magistrates' Courts that issued DTOs**

| Venue | Number of clients |
|---|---|
| Melbourne | 8 |
| Broadmeadows | 2 |
| Frankston | 2 |
| Heidelberg | 2 |
| Ringwood | 2 |
| Dandenong | 1 |
| Geelong | 1 |
| La Trobe | 1 |
| Mildura | 1 |
| Shepparton | 1 |
| Wangaratta | 1 |
| Wodonga | 1 |

In all cases the application and attached documents were in the prescribed form with the prescribed information. According to the client records, the person who was subject to the application and the senior clinician were personally served a copy.

The guardians of the three clients who had a guardianship order in place received a copy of the order within 24 hours of filing according to the client records.

### 8.5 Recommendation for detention and treatment (s 12)

In all cases a PRMP personally examined the person and formed an opinion that the criteria for detention and treatment applied.

All PRMPs consulted with a senior clinician of the treatment centre and provided the senior clinician with the prescribed information. All discussed the option of less restrictive treatment. The senior clinician then confirmed the treatment centre had the facilities/services available to treat the person.

Although an addiction medicine specialist or psychiatrist provided the required information, all clients also had documented evidence of a general practitioner and/or emergency physician who was also in possession of the required information relating to the criteria for detention and treatment and needed for application for involuntary detention.

In all cases the PRMPs recommendation for the detention and treatment, the order and the application were in the form prescribed in the *Severe Substance Dependence Treatment Regulations 2011* (Vic) ('the Regulations').

PRMPs distinguished between facts personally observed from those not personally observed in their recommendations for detention and treatment. In all cases, facts not personally observed were drawn from the client's previous medical records and/or conversation between the PRMP and the client's usual medical practitioner and / or the client's police records.

In accordance with s 12(8), no PRMP who made a recommendation was:

- the applicant for the DTO; or
- a family member of the person subject to the recommendation; or
- the person's guardian; or
- the senior clinician of the treatment centre at the time the application was made.

### 8.6 Special warrant to examine person (s 13)

A special warrant was issued to examine a client in only one case. The clinical record did not contain information regarding who had applied for the special warrant or why the warrant was required (this information is not usually expected to be available in a client's medical record).

### 8.7 Certificate of available services (s 14)

All client records contained a copy of a certificate of available services to the Magistrate's court outlining the facilities and services available at the treatment centre. No other treatment centres were requested to provide a certificate of available services as St Vincent's/Depaul House are the only designated treatment centres under the Act.

### 8.8 Hearing (s 15 to s 20)

Limited information was available in medical records about Magistrates Court hearings. Additional information is likely to be available from the Magistrates Court records, however these were not accessible to the review team.

The medical record did, however, include a copy of relevant documentation of the hearing. This enabled assessment of the timing of the hearing to be made. In 22 of 23 clients the application was heard within 72 hours of filing the application. The reason for a delay in the hearing of the remaining sole application was unclear from the client record.

In all cases the clinical record indicated the order was in the prescribed form, the Court was satisfied the criteria were met and a certificate of available services was available.

### 8.9 Detention and treatment (s 20)

The person who was the subject of the DTO was escorted to the treatment centre by a person who provides non-emergency client transport services (ten clients), police (eight clients), ambulance (two clients) or another person specified in the order (three clients).

### 8.10 Notification to treatment centre and currency of order (s 21)

In all cases the Magistrates Court was recorded as having notified the treatment centre of the order. A copy was available in the client file. A bed was available at the treatment centre when specified in the order and admission was facilitated within seven days of the order being made.

### 8.11 Revocation of order (s 22 and s 35)

In three cases the senior clinician of the treatment centre applied to the Magistrate's Court to have the order revoked. The reason for revoking the order in all cases was the client's willingness to voluntarily participate in treatment - a less restrictive form of treatment.

The application was granted in all three cases and the revocation was served within 24 hours of filing on the person who originally applied for the DTO and (where relevant) the guardian according to the client record. The Public Advocate was notified of the revocation. Where relevant, the nominated person was also notified and notification was documented in the client record.

Details of hearings were not available in clients' medical records.

### 8.12 Initial examination and nominated person (s 23 and s 24)

According to client records the senior clinician of the treatment centre examined each client and reviewed the criteria for detention and treatment within 24 hours of admission. In all cases the criteria for detention and treatment were found to continue to apply, confirming the order.

Five clients nominated another person to protect their interests. In all cases this nomination was accepted by the person nominated and by the senior clinician, who gave effect to the person's nomination. Nominations were made within 24 hours in all cases.

### 8.13 Other actions required within 24 hours of admission (s 25 to s 28)

No client was discharged from their DTO within 24 hours of admission.

Client records indicate that within 24 hours all clients were given a written statement of their rights and entitlements under the Act and that the Public Advocate was informed of the person's admission. Treatment centre staff took active steps to notify the nominated person (where relevant) and guardian (where applicable). A statement of rights was provided to the nominated person (where applicable) and guardian (where relevant).

The written statement of the person's rights was in a standard form which was read to the client by a staff member where required. The statement was a template in the form approved by the Secretary and issued under the Department's logo. It included a statement that the person had the right to obtain legal advice and a second opinion if desired. The plain language statement was written in English, which was not recorded to be a problem for clients from non-English speaking backgrounds.

All clients were recorded as having been given an oral explanation of the written statement. Where the person was unable to understand, or incapable of understanding, the explanation medical, nursing

and/or social work staff members were documented as having made repeated attempts to reinforce the statement of rights when the client's cognitive state allowed.

One client requested assistance to obtain legal advice. This was arranged by nursing staff within 24 hours of admission and provided through Legal Aid.

The Public Advocate visited each person as soon as practicable. For 16 clients this occurred within 24 hours; for one client it occurred within 48 hours; for five clients it occurred within 72 hours and for one client it occurred at four days after admission. The reason for the delay beyond three days was not recorded for this client. In all cases the treatment centre recorded having faxed a notification to the Public Advocate within 24 hours of admission.

### 8.14 Treatment (s 28 to s 33)

Clients admitted to the treatment centre were provided with treatment in accordance with the Act. Although clients were admitted involuntarily, the majority did not show signs of consistently resisting clinical management whilst in treatment. However, three clients resisted active clinical management. For these clients, staff negotiated aspects of treatment that the client was willing to accept. One client requested not to have blood tests or radiological investigations – this request was respected by staff. Preferences regarding medication management of another two clients were respected.

Voluntary treatment was promoted in preference to detention and treatment wherever possible. Ten clients who had serious medical co-morbidities at the time of presentation were comprehensively assessed and provided with medical management. A further six clients had severe co-existing acute mental health conditions that required urgent psychiatric assessment and management. These clients were assessed and managed by specialist psychiatry staff. Clients with undifferentiated psychiatric illness received neuropsychological assessment and, where relevant, a mental health management plan was put in place. Clients with poorly controlled mental health problems were assessed and their mental health management was stabilised where possible.

All clients admitted to the treatment centre under a DTO were examined by the senior clinician.

The senior clinician determined the treatment to be provided in conjunction with other members of the treating team. The person, their families and other significant persons, nominated persons (where relevant) and guardians (where applicable) were involved in treatment decisions affecting the client. Beneficial alternative treatments were not specifically documented but it is not clear whether alternative treatments were available for this group of clients. The acute physical and/or mental health risks associated with not treating the client were documented in the client record.

Treatment was reviewed clinically by medical and nursing staff at least daily and the treatment plan revised in accordance with the client's symptoms and with the wishes of the client, their significant others, their nominated person (where relevant) and their guardian (where applicable).

No client requested a second opinion. There were no transfers to another treatment centre as there are no other declared treatment centres.

No client sought (or therefore obtained) leave of absence.

### 8.15 Apprehension (s 34)

Two clients were absent from the treatment centre without leave granted under s 33 of the Act. In both cases the centre notified the police that the client was under an involuntary treatment order and had absconded. Both clients were located within 24 hours - one presented to the emergency

department and another was brought to the emergency department by police. Neither required an authorised person to enter premises to apprehend the person. In both cases the senior clinician informed the person's nominated person (one client) and the person's guardian (both clients).

### 8.16 Discharge from the DTO (s 35 and s 36)

The senior clinician discharged the person from the order once the order had expired (12 clients) or the criteria no longer applied. The senior clinician notified the Public Advocate in all cases and the Court where required. According to the client records, the nominated person and/or guardian were notified in all cases.

No client was detained at the treatment centre after the DTO had expired or was revoked by the Court.

All clients had a discharge plan outlining follow-up treatment and support to be provided to the person.

The level of detail regarding the discharge plan varied between clients. Seven clients were transferred for residential rehabilitation, two were transferred to inpatient mental health units and the remainder who accepted active treatment after discharge were treated in the community. Two clients actively refused to participate in any form of ongoing treatment after discharge.

Clients were discharged on anti-craving medications. Discharge plans for clients on active treatment also included counselling and additional medication management where required.

The senior clinician took reasonable steps to ensure the person, their nominated person (if relevant), their guardian (if applicable), family members and significant others (where the client consented) and other agencies or services were involved in the discharge planning process and the plan was communicated to them where relevant. A variety of methods was used including case conferences, telephone conversations and/or face to face meetings with the nominated person, guardian, family members, significant others and / or other agencies in addition to written correspondence.

### 8.17 Power of entry (s 37)

One special warrant was issued for a client to be taken to St Vincent's. According to the client notes this client was brought in involuntarily by police. The clinical notes do not describe the process of the authorised person entering the premises as this type of information is not usually contained within a clinical record. The police record is likely to contain this information.

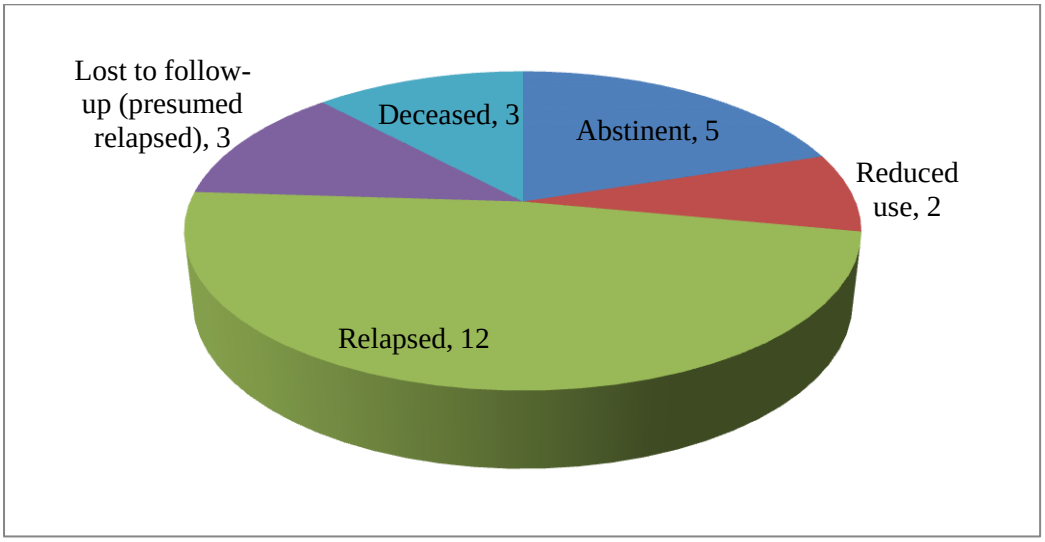
### 8.18 Power to restrain or sedate a person (s 38)

Sedation was not provided to any client under s 38 of the Act. One client who was absent without leave was returned to the treatment centre by police. There was no record in the client file regarding restraint or sedation. No client was recorded as having been frisk searched under s 38.

### 8.19 Outcomes following detention and treatment

St Vincent’s makes efforts to follow up clients for at least six months following discharge to determine their pattern of substance use. Clients detained and treated during twenty five episodes of care have been followed up for six months. The results are shown in Figure 2. Six month follow up is not available for three clients who have not yet been discharged for six months.

**Figure 2: Substance use at six month follow up**




## 8.20 Other matters

Cognitive status was comprehensively assessed by PRMPs and by senior clinicians using a range of techniques, including:

- Glasgow Coma Score (for clients with decreased level of consciousness);
- Mini-Mental State Examination;
- as part of a comprehensive mental state assessment;
- as part of a comprehensive neurological examination;
- through the use of the orientation subscale of the Alcohol Withdrawal Scale; and
- by clinical assessment and direct client observation over the course of taking a client history.

Cognitive assessment was repeated throughout the client admission to re-assess cognitive state. Clinical assessment and direct client observation, together with repeat Alcohol Withdrawal Scale assessments, were used.

The attitude of clients to voluntarily participating in treatment at discharge was generally positive. Three clients actively resisted all clinical efforts to engage them in treatment, including in follow-up treatment at discharge after their DTO had expired. The client records did not include a description of the client's compliance with follow-up care after discharge as the majority of clients received their follow-up care in residential rehabilitation settings, within the community or from clinical and social care providers in their usual residential area.

## 9. PURPOSE AND OBJECTIVES OF THE ACT

The purpose of the Act is to provide for the detention and treatment of persons with a severe substance dependence.[16] The objectives are[17]:

(a) to provide for the detention and treatment of persons with a severe substance dependence where this is necessary as a matter of urgency to save the person's life or prevent serious damage to the person's health; and

(b) to enhance the capacity of those persons to make decisions about their substance use and personal health, welfare and safety.

***Treatment*** means anything done in the course of the exercise of professional skills to provide medically assisted withdrawal from a severe substance dependence or to lessen the ill effects, or the pain and suffering, of withdrawal.[18]

The vast majority of stakeholders consulted for this review advised that continuation of a legislative framework providing for involuntary detention of, and the provision of treatment to, a small group of people with highly complex health and wellbeing needs associated with severe substance dependence is both necessary and appropriate. There was a strong view that the opportunity for improved dignity and safety associated with management of severe substance abuse in the target client group appropriately balances the limitations on human rights and potential interference with dignity and self-respect associated with a DTO. There were varying views amongst consumer representatives, however, about the appropriateness of such legislation (see reports of consumer forums at **Attachment 6**).

A small number of stakeholders suggested that provisions for DTOs for people with severe substance dependence should be included in the Mental Health Act rather than in a separate Act, but most strongly supported retention of the Act as separate legislation, highlighting the unique needs of the intended client group and the specialist nature of their management.

Many stakeholders also strongly advised, however, that the Act's objectives should be broader. The widely-expressed view was that if a person is to be deprived of their freedom and decision-making autonomy, there should be a balancing objective of providing them with a real opportunity of improved health and wellbeing. The narrow focus of the current objectives on medically-assisted withdrawal resulting in enhanced decision-making was seen as inappropriate, with stakeholders emphasising the importance of multidisciplinary assessment and treatment, care planning, care coordination and transition to high quality care and support services following discharge from the DTO. All of these activities are considered necessary to create a reasonable opportunity for client benefit from detention and treatment.

Reference in the objectives to necessity 'as a matter of urgency to save the person's life or prevent serious damage to the person's health' appears redundant as the phrase is already included as one of the criteria for detention and treatment.

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[16] Section 1.

[17] Section 3.

[18] Section 6.

Stakeholders referred with approval to the objects of the NSW Act and the purpose and objectives of the Mental Health Act. Stakeholders generally supported amendment of the Act to include the following concepts:

- The purpose of the Act is to provide a legislative scheme for the involuntary detention, assessment and treatment of persons with a severe substance dependence.
- The objectives of the Act are:
    - to provide for the involuntary detention, assessment and treatment of persons with a severe substance dependence, to protect their health and safety;
    - to facilitate comprehensive assessments of those persons in relation to their dependency;
    - to facilitate stabilisation of those persons through treatment;
    - to enhance the capacity of those persons to make decisions about their substance use and personal health, safety and wellbeing; and
    - to give those persons the opportunity to engage in voluntary treatment.

Stakeholders noted that subsection 3(2) requires the Act to be interpreted, and every function it confers or imposes performed or exercised so that—

(a) detention and treatment is a consideration of last resort; and

(b) any limitations on the human rights and any interference with the dignity and self-respect of a person who is the subject of any actions authorised under this Act are kept to the minimum necessary to achieve the objectives specified in subsection (1).

These are not objectives of the Act. Rather, they are overarching principles of interpretation. Stakeholders strongly supported these concepts and there were no specific suggestions for change.

## 10. DEFINITIONAL ISSUES

### 10.1 Severe substance dependence

Definitions of and concepts relating to substance use disorders have changed significantly over the past decades as a result of various clinical, social, economic and political influences.

In the late 1950s the World Health Organisation promulgated definitions that distinguished between drug addiction and drug habituation. Addiction-producing drugs were characterised by compulsion, tolerance and psychological and physical dependence, whereas habit-forming drugs (including alcohol and tobacco) were characterised by a desire to take the drug for individual wellbeing[19]. Later the term 'dependence' was used in relation to substance use to describe physiological, behavioural and cognitive phenomena that lead to loss of control over use.[20] Dependence on alcohol and tobacco were recognised.

In a recent revision of the Diagnostic and Statistical Manual of Disorders (DSM-5), which is the main system of classification of mental and behavioural disorders used clinically in Australia, there has

[19] http://whqlibdoc.who.int/trs/WHO_TRS_116.pdf

[20] American Psychiatric Association, 2000.

been a movement away from the term 'dependence' to the term 'use disorder'[21]. DSM-5 combines the DSM-IV categories of substance abuse and substance dependence into a single disorder measured on a continuum from mild to severe.

Substance use disorders are defined in DSM-5 in terms of eleven criteria including physiological, behavioural and cognitive elements (Table 3), as well as consequences of criteria, any two of which qualify for a diagnosis.

Table 3: DSM-5 criteria for substance use disorder

| | |
|---|---|
| (1) | Taking the substance in larger amounts or for longer than the you meant to |
| (2) | Wanting to cut down or stop using the substance but not managing to |
| (3) | Spending a lot of time getting, using, or recovering from use of the substance |
| (4) | Cravings and urges to use the substance |
| (5) | Not managing to do what you should at work, home or school, because of substance use |
| (6) | Continuing to use, even when it causes problems in relationships |
| (7) | Giving up important social, occupational or recreational activities because of substance use |
| (8) | Using substances again and again, even when it puts the you in danger |
| (9) | Continuing to use, even when the you know you have a physical or psychological problem that could have been caused or made worse by the substance |
| (10) | Needing more of the substance to get the effect you want (tolerance) |
| (11) | Development of withdrawal symptoms, which can be relieved by taking more of the substance. |

The DSM-5 allows clinicians to specify the severity of the substance use disorder, depending on how many symptoms are identified. Two or three symptoms indicate a mild substance use disorder, four or five symptoms indicate a moderate substance use disorder and six or more symptoms indicate a severe substance use disorder.

The DSM-5 has been criticised for combining the categories of substance dependence and substance abuse. The criticism stems from the view that there is a fundamental difference between substance abuse and dependence/addiction.

The 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10), a medical classification list by the World Health Organization, continues to recognise 'Dependence Syndrome' as:

> "A cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take psychoactive drugs (which may or may not have been medically prescribed), alcohol, or tobacco. There may be evidence that return to substance use after a period of abstinence leads

[21] *Ibid.*

to a more rapid reappearance of other features of the syndrome than occurs with nondependent individuals."

Despite the changes in DSM-5, stakeholders supported retaining the terminology 'substance dependence' in the Act, in preference to 'substance use disorder'. Specifically, stakeholders suggested that the terminology 'severe substance dependence' remains appropriate, despite changes in terminology in the recent revision of the Diagnostic and Statistical Manual of Disorders (DSM-5).

### 10.2 Treatment

'Treatment' is defined narrowly in the Act as "anything done in the course of the exercise of professional skills to provide medically assisted withdrawal from a severe substance dependence or to lessen the ill effects, or the pain and suffering, of the withdrawal".[22]

Stakeholders endorsed the importance of providing high quality care to clients and supported a broader definition of 'treatment'. They observed that persons detained are often homeless and/or unsupported and need immediate and ongoing multidisciplinary care addressing not only their medical problems but also their social and psychological wellbeing. The importance of care planning, care coordination and transition to ongoing integrated health and wellbeing services following discharge from the DTO was emphasised. There was consistent representation that:

- it is pointless returning most clients to their previous social situation after short-term detention and completion of medically-assisted withdrawal alone;
- such an approach 'sets clients up' to repeat the addiction cycle; and
- detention and involuntary treatment is not justified from a human rights perspective if that is all that can be offered.

Stakeholders believe comprehensive, multidisciplinary assessment, care, discharge planning and transition to appropriate community-based services is the only approach that will create a reasonable prospect of sustainable client benefit, sufficient to justify the infringement on human rights associated with detention and involuntary treatment.

It was suggested that it would be appropriate for the Public Advocate to be involved in preparing the discharge plan.

Many stakeholders also pointed out that integrated multidisciplinary treatment, discharge planning and transition to appropriate community-based services cannot be provided effectively within a maximum period of 14 days. There was strong support for extending the period of involuntary detention, which is addressed later in this report.

Further, stakeholders suggested that the focus on medically assisted withdrawal in the Act's definition of treatment requires clients to be discharged once withdrawal has been achieved. This contrasts with broader definitions of 'treatment' in other Acts, which give more clinical flexibility in the medical treatment provided. For example, the definition of 'treatment' for mental illness in the Mental Health Act refers to 'things done to the person in the course of the exercise of professional skills to remedy the mental illness or to alleviate the symptoms and reduce the ill effects of the mental illness'.[23]

[22] Section 6.

[23] It 'includes electroconvulsive treatment and neurosurgery for mental illness'.

Relevantly, the NSW Act refers in its objectives to facilitating the stabilisation of persons with a severe substance dependence 'through medical treatment, including, for example, medically assisted withdrawal': s 3(1)(c). However, its provision for treatment is not limited to withdrawal alone. Section 15 provides (after placing some limits on the administration of medication to the person) that 'an accredited medical practitioner may, subject to this Act, give, or authorise the giving of, such treatment (including any medication) as the practitioner thinks fit for the treatment of the dependent person's substance dependence'.

That contemplates treatment beyond medically assisted withdrawal. In that sense the 'treatment' contemplated under the NSW Act is a broader concept than applies under the Act's narrow definition of 'treatment'. This is also consistent with the detention period under the NSW Act being the longer time of 28 days, in contrast to the Act's 14 days.

Generally, there was strong stakeholder support for broadening the definition of 'treatment' beyond 'medically assisted withdrawal' to include multidisciplinary assessment and care planning, early implementation of case management/care coordination and transition to ongoing integrated and coordinated health and wellbeing services following discharge.

## 11. CRITERIA FOR DETENTION AND TREATMENT

### 11.1 The intended client group

The criteria for detention and treatment are described in section 8 of the Act (reproduced below, with defined terms shown in ***bold italics***):

> **8 Criteria for detention and treatment**
>
> (1) A person must not be detained, or continue to be detained, for ***treatment*** under this Act unless—
>
> (a) the person is 18 years of age or older; and
>
> (b) each of the criteria specified in subsection (2) applies to the person.
>
> (2) The criteria for the detention and ***treatment*** of a person under this Act are that—
>
> (a) the person has a ***severe substance dependence***; and
>
> (b) because of the person's ***severe substance dependence***, immediate ***treatment*** is necessary as a matter of urgency to save the person's life or prevent serious damage to the person's health; and
>
> (c) the ***treatment*** can only be provided to the person through the admission and detention of the person in a ***treatment centre***; and
>
> (d) there is no less restrictive means reasonably available to ensure the person receives the ***treatment***.

A person has a 'severe substance dependence' in accordance with the Act if they:

(a) have a tolerance to a substance; and

(b) show withdrawal symptoms when they stop using, or reduce the level of use of, the substance; and

(c) are incapable of making decisions about their substance use and personal health, welfare and safety due primarily to their dependence on the substance.

In the second reading of the *Severe Substance Dependence Treatment Bill 2010* (Vic) (the Bill)[24], the then Minister for Health the Hon Daniel Andrews noted that the Bill did not target:

- alcohol-fuelled violence or street drinking; or
- people who use substances at dangerous levels over a long period of time.

Minister Andrews described the intended client group as[25]:

> "...people who have lost all capacity to make decisions about their substance use and personal health, welfare and safety. Typical elements of their situation will include a long history of severe substance dependence, increasingly heavier or more dangerous use of the substance, serious medical and health complications, signs and symptoms of an acquired brain injury, and more recent behaviour that indicates the person no longer has any control over their substance dependence. They will often prioritise their substance use ahead of meeting their other basic needs such as food and self care. Without intervention these people will more likely than not become permanently disabled or die."

Stakeholders emphasised the need to ensure the intended client group is clearly described. They recognise that civil commitment should only be contemplated for a very small group of severely substance-dependent individuals with highly complex needs whose lives are at serious risk in the short- to medium-term. The concept of repeated severe acute-on-chronic episodes of physical or mental ill-health that seriously threaten a substance-dependent person's short- to medium-term survival was discussed.

As noted above, the client group is defined by the following:

- the person is 18 years of age or older; and
- the person has a tolerance to a substance; and
- the person shows withdrawal symptoms when the person stops using, or reduces the level of use of, the substance; and
- the person is incapable of making decisions about their substance use and personal health, welfare and safety due primarily to their dependence on the substance; and
- immediate treatment is necessary as a matter of urgency to save the person's life or prevent serious damage to the person's health; and
- the treatment can only be provided to the person through the admission and detention of the person in a treatment centre; and
- there is no less restrictive means reasonably available to ensure the person receives the treatment.

There is also an important requirement in s 3(2) that the Act must be interpreted, and every function conferred or imposed by it, must be performed or exercised, so that—

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[24] Parliament of Victoria. Parliamentary Debates (Hansard). Legislative Assembly, fifty-sixth parliament, first session. Thursday 10 December 2009. Pages 4583 to 4587.

[25] *Ibid*, page 4583.

(a) detention and treatment is a consideration of last resort; and

(b) any limitations on the human rights and any interference with the dignity and self-respect of a person who is the subject of any actions authorised under the Act are kept to the minimum necessary to achieve the Act's objectives.

Despite this comprehensive definition of the intended client group and the principles that apply to decisions to detain and treat clients, there is clearly confusion about the types of clients intended to be targeted by the Act. Some stakeholders suggested that the current criteria are too narrow to capture the intended client group, while others thought they potentially describe a much larger group of people than appears to have been intended on the basis of the Minister's description, or that could be accommodated and treated within existing resources. There was also a view expressed that "the workforce normalises abnormal pathology unless the person comes in three to four times a week and they become a nuisance and then they get referred". From this perspective, DTOs are often not sought for 'routine' clients who, on objective analysis, would fulfil the criteria for a DTO.

Much of the stakeholder confusion appears to relate primarily to varying interpretations of the terms 'immediate' and 'as a matter of urgency'. Some stakeholders were also confused about whether persons with permanently impaired decision-making capacity, which is prevalent in the intended client group, would be eligible for a DTO. They suggested that the focus in existing Departmental promotional material on recovery of capacity to make decisions suggests, incorrectly, that people with permanently impaired decision-making capacity do not fall within the primary intended client group.

These issues are discussed further below.

***'Immediate' and 'as a matter of urgency'***

Stakeholders provided numerous examples of situations where it was unclear to them whether the 'immediate' and 'as a matter of urgency' criteria for detention and treatment were met. For example, one PRMP thought s 8(2)(b) would be satisfied by a person with acute alcoholic hepatitis who is likely to die if they do not stop drinking immediately. Clinicians distinguished between this and the case of an intoxicated person near a road or railway who could harm themselves by walking across it. It was thought that the urgency and immediacy criterion would not be met in the latter circumstances. The distinction is drawn here between threat to life and health on the one hand and accident or safety consequences on the other hand. However, another clinician considered that if inability to walk safely in traffic happened repeatedly, then the criterion was met. These examples illustrate the confusion in interpreting s 8(2)(b).

For comparison, the following are listed in Table 4:

- criteria for issuing a dependency certificate enabling detention of a person for treatment under the NSW Act;
- criteria for treatment under the Mental Health Act; and
- eligibility criteria for the Multiple and Complex Needs Initiative (MACNI).

A number of stakeholders suggested that the criteria in the NSW Act for issuing a dependency certificate are simpler and easier to understand. Stakeholders also exhibited a clear understanding of criteria for treatment under the Mental Health Act.

There was considerable stakeholder support for modifying the 'immediate' and 'as a matter of urgency' criteria, to describe a concept of necessity of treatment without delay, which stakeholders thought was a more appropriate description of the clinical circumstances of the intended group of

clients. It was also suggested that the Department should produce guidance documentation that includes examples of the types of clients that would meet the criteria. This suggestion is discussed later in this report.

***Decision-making capability***

The requirement that the person be 'incapable of making decisions about his or her substance use and personal health, welfare and safety due primarily to the person's dependence on the substance' is also of practical importance. Neither the DSM-IV nor the ICD-10's diagnostic guidelines for dependence syndrome include decision-making capability as a diagnostic criterion of severe substance dependence. However, the criterion is included within the definition in the Act of 'severe substance dependence' and is similar to the NSW Act's requirement that 'the person has lost the capacity to make decisions about his or her substance use and personal welfare due primarily to his or her dependence on the substance'.

Some PRMPs appear to have taken the view that a person must be currently intoxicated to meet this requirement. A Magistrates Court staff member noted that in one case a client in the custody of Victoria Police was deemed not to meet the Act's criteria because they were sober at the time of examination. He thought the 'incapable of making decisions' criterion should be lessened so it was not necessary to satisfy this before applying the Act.

It was reported that some clients on DTOs agree to receive treatment before the expiry of the detention period. The clinicians at the treatment centre assess these clients to determine whether their apparent acceptance of treatment indicates capability to make decisions about their substance use and personal health, welfare and safety and, therefore, whether they are required to discharge them from the DTO.[26] A clinician described some "really savvy" clients who have agreed to accept voluntary treatment but then left the treatment centre as soon as the DTO is removed. One clinician stakeholder indicated that a comprehensive medical/psychiatric assessment is required to conclude this 'incapable' criterion is no longer satisfied on this basis.

One stakeholder suggested that in section 5(c) the words 'about his or her substance use' should be removed so that the section reads 'the person is incapable of making decisions about his or her personal health, welfare and safety due primarily to the person's dependence on the substance'. It was thought that this wording would be easier to satisfy.

Other stakeholders advised, however, that incapability of decision-making about substance use and personal health, welfare and safety is an inevitable accompaniment of severe physical substance dependence (i.e. dependence associated with tolerance and withdrawal symptoms) that does not resolve as soon as withdrawal is completed, even in clients without overt neurological damage. In their view, impaired decision making inevitably continues for some time after the physical withdrawal process is completed.

In NSW the criterion of having 'lost the capacity to make decisions about his or her substance use and personal welfare due to his or her dependence on the substance' has not been thought problematic.

It is likely that confusion about the 'decision-making capability' criterion could be addressed by the provision of specific guidance documentation, rather than through legislative amendment.

[26] A PRMP at Victoria Police took the same view.

### 11.2 Benefit to the client

Many stakeholders agreed that deprivation of liberty and decision-making autonomy would not be justified without a real likelihood of benefit to the client. They suggested this should be an explicit criterion for detention and treatment.

The NSW Act includes a benefit criterion. The review team was advised that there has been much discussion in NSW of the 'likely to benefit from the treatment' criterion. For instance, questions have been raised whether some people have been too unwell to be likely to benefit.

### 11.3 Potential for harm to others

The potential for harm to others is not part of the current criteria for a DTO. It is a consideration in other jurisdictions and some stakeholders suggested that the criteria should be extended to capture it.

'Harm to others' is also directly relevant in the Mental Health Act. It is included in one of the 'treatment criteria' to be met before a person may be made subject to a Temporary Treatment Order or a Treatment Order. Relevantly, the person must have a mental illness and, under s 5(b):

> because the person has mental illness, the person needs immediate treatment to prevent—
>
> (i) serious deterioration in the person's mental or physical health; or
>
> (ii) serious harm to the person or to another person.

In NSW, Tasmania, the Northern Territory and Sweden 'harm to others' is also directly relevant as a criterion for detention and treatment for substance dependence.[27]

In NSW, in assessing persons for detention, an accredited medical practitioner may have regard to any serious harm that may occur to children in the care of the person, or dependants of the person. It is also relevant to making an order to assess a person. An order for assessment is made by a Magistrate or authorised officer[28] authorising an accredited medical practitioner to visit and assess the person to ascertain whether a dependency certificate should be issued in relation to the person.[29] An order for assessment may only be made if the Magistrate or officer is satisfied of criteria, including that 'the person is likely to be in need of protection from serious harm or others are likely to be in need of protection from serious physical harm'.

There were diverse views, however, about inclusion of a ‘harm to others’ criterion in the Act. A number of stakeholders suggested that a threat of harm to others is better dealt with under the criminal justice system rather than the health care system, noting that medical support for detoxification is also available in the criminal justice system, while others thought that the Mental Health Act criterion of ‘harm to others’ is also relevant in the context of severe substance dependence. This issue requires further analysis if amendments to the Act are contemplated.

There was limited discussion with stakeholders and no submissions were made about the criterion of a minimum age of 18 years. No specific concerns were expressed about this criterion.

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[27] Section 24 *Alcohol and Drug Dependency Act 1968* (Tas), section 10 *Alcohol Mandatory Treatment Act 2013* (NT) and section 13 *Swedish Code of Statutes 1988*. See comparative legislative table attached to this report.

[28] Being an authorised officer within the meaning of the *Criminal Procedure Act 1986* (NSW)

[29] Section 10.

### 11.4 Summary of stakeholder views on criteria for detention and treatment

Stakeholders generally supported:

- amendment of the 'immediacy' and 'urgency' criteria to incorporate a concept of 'need for treatment without delay' to save a person's life or prevent serious damage to their health; and
- inclusion of a 'benefit' criterion.

There was some support for including risk of harm to others as a criterion for making a DTO, although some stakeholders thought this issue should be dealt with through the criminal justice system. Others saw no difference between the inclusion of 'harm to others' as a criterion in the Act, and its inclusion in the Mental Health Act.

Whilst not a legislative issue, stakeholders also supported Departmental development and promotion of additional guidance documentation to support stakeholder understanding of the purpose and objectives of the Act, the criteria for detention and treatment and the meaning of 'incapability of decision-making' in the context of the Act. This suggestion is discussed later in this report.

**Table 4: Criteria for detention and treatment**

| NSW Act | Mental Health Act treatment criteria | MACNI eligibility criteria |
|---|---|---|
| (a) the person has a has a tolerance to a substance; and<br>(b) the person shows withdrawal symptoms when the person stops using, or reduces the level of use of, the substance; and<br>(c) the person has lost the capacity to make decisions about his or her substance use and personal welfare due primarily to his or her dependence on the substance; and<br>(d) care, treatment or control of the person is necessary to protect the person from serious harm; and<br>(e) the person is likely to benefit from treatment for his or her substance dependence but has refused treatment; and<br>(f) no other appropriate and less restrictive means for dealing with the person are reasonably available.<br>The definition of 'severe substance dependence' includes a requirement that the person has lost the capacity to make decisions about his or her substance use and personal welfare due primarily to his or her dependence on the substance. | The *treatment criteria* for a person to be made subject to a Temporary Treatment Order or Treatment Order are—<br>(a) the person has mental illness (defined as a significant disturbance of thought, mood, perception or memory); and<br>(b) because the person has mental illness, the person needs immediate treatment to prevent—<br>(i) serious deterioration in the person's mental or physical health; or<br>(ii) serious harm to the person or to another person; and<br>(c) the immediate treatment will be provided to the person if the person is subject to a Temporary Treatment Order or Treatment Order; and<br>(d) there is no less restrictive means reasonably available to enable the person to receive the immediate treatment. | An eligible person is a person who:<br>• has attained 16 years of age, and<br>• appears to satisfy two or more of the following criteria:<br>  • Has a mental disorder within the meaning of the Mental Health Act 1986;<br>  • Has an acquired brain injury;<br>  • Has an intellectual impairment;<br>  • Is an alcoholic or drug-dependent person within the meaning of the Alcoholics and Drug-Dependent Persons Act 1968; and<br>• has exhibited violent and dangerous behaviour that has caused serious harm to himself or herself or some other person or is exhibiting behaviour which is reasonable likely to place himself or herself or some other person at risk of serious harm; and<br>• is in need of intensive supervision and support; and<br>• would derive benefit from receiving coordinated services in accordance with a care plan under this Act which may include welfare, health, mental health, disability, drug and alcohol treatment services or housing and support services. |

## 12. APPLICATIONS, RECOMMENDATIONS AND DETENTION AND TREATMENT ORDERS

### 12.1 Introduction

A significant number of stakeholders suggested that the procedures for accessing a DTO are poorly understood, cumbersome and time consuming and dissuade people from seeking a DTO even when:

- they know the option exists;
- a client appears to meet the relevant criteria; and
- a DTO appears to be in the client's best interests.

A stakeholder group described the requirements for accessing a DTO as "onerous, a kind of legislative obstacle course". The court process was described as "really tedious", "unnecessarily complex in implementation and nothing like the Mental Health Act". It was observed that the process of seeking a DTO through the Magistrates' Court was slow, taking up to four days, which was inconsistent with the 'immediacy' and 'urgency' requirements of the Act and the needs of individual clients.

While the imposition of extensive procedural requirements assists to ensure detention and treatment is a consideration of last resort and to minimise limitations on a person's human rights in accordance with s 2(b), it also appears to impair achievement of the Act's objective (in s 3) 'to provide for the detention and treatment of persons with a severe substance dependence where this is necessary as a matter of urgency to save the person's life or prevent serious damage to the person's health' and the equivalent criterion for a DTO in s 8(2).

A number of stakeholders pointed out overlap between the criteria for detention and treatment under the Mental Health Act and the Act. In rural and regional Victoria, in particular, stakeholders advised that some people with severe substance dependence who meet the criteria for treatment under both Acts are preferentially treated under the Mental Health Act because the admission procedures are easier to navigate and services can be provided locally. While such decisions are made by clinicians in their clients' best interests, stakeholders suggested that if there were fewer barriers to accessing treatment under the Act it would be strongly preferable to rely on it rather than the Mental Health Act.

In this section, a number of specific issues identified during the review relating to the procedures established by the Act are explained and discussed.

### 12.2 Applications in general

A variety of individuals including health care professionals, police, guardians and family members have made successful applications under the Act (Table 5).

**Table 5: Applicants for detention and treatment orders 1 March 2011 to 2 February 2015**

| Applicant | Number of episodes of detention and treatment |
|---|---|
| Community-based nurses, case managers and support workers | 9 |
| Family members | 8 |
| Members of the police force | 3 |
| Psychiatrist/psychiatry registrar | 2 |
| Pharmacist | 1 |
| Addiction medicine specialist | 1 |
| General practitioner | 1 |
| Guardian | 1 |
| St Vincent's emergency department nurse | 1 |
| Other metropolitan hospital liaison nurse – 1 episode | 1 |
| **Total** | **28** |

The application must be in form prescribed in Schedule 1 of Regulations and contain the prescribed information (which is the information required by the form). The form simply requires details of the applicant and respondent including name, address and contact details and the respondent's date of birth and gender. The application must be accompanied by a recommendation in the prescribed form and containing the prescribed information.[30] Stakeholders observed that making an application is both complex and a lot of work, and creates an inappropriately high administrative and decision-making burden on applicants.

### 12.3 Service requirements

Copies of application documents must be served on the person who is the subject of the application and the senior clinician or manager of the treatment centre. The utility of the requirement of personal service on the person who is the subject of the application, where the criteria are met that the person must be 'incapable of making decisions' and 'immediate treatment is necessary as a matter of urgency to save the person's life or prevent serious damage to' their health, is unclear. Stakeholders advised of circumstances in which a copy of the application was left beside the person who was lying unconscious beside a tree. There was discussion about whether this was adequate service.

An information form (prepared by the Department and available on its website with other material relating to the Act) is to be provided to persons when an application under the Act is served on them. It asks the applicant (amongst other things) to 'read the application and this information sheet', get legal advice from Legal Aid (providing contact numbers) and attend court on the hearing day. Again, if someone fits the incapable criterion, they are unlikely to be capable of reading the form and taking the recommended steps. Having to comply with these service requirements makes the process much

[30] All of these requirements above are in s 12 of the Act, which also imposes some restrictions on PRMPs making recommendations in listed circumstances where they might have a conflict of interest. These are that the PRMP must not make a recommendation if they are also the applicant for the DTO, a family member of the person, their guardian or the senior clinician of the treatment centre: section 12(8).

slower than it should be in circumstances where the criteria are focused on the necessity of treatment to save the person's life or prevent serious damage to their health.

### 12.4 Recommendations by prescribed registered medical practitioners

The category of PRMP for the 23 clients detained and treated to date was a Fellow of the Royal Australian and New Zealand College of Psychiatrists for 17 clients, a Fellow of the Australasian Chapter of Addiction Medicine for five clients and a registered medical practitioner who performed work for Victoria Police for one client.

Many stakeholders are concerned that the categories of medical practitioners prescribed under the Regulations are too narrow. They advised that it is often not practically possible to obtain a recommendation by a PRMP in many regions of Victoria because no PRMPs are available or because PRMPs that may be available are unfamiliar with the Act. Some stakeholders suggested that general practitioners and/or emergency medicine specialists should be included as categories of persons who can undertake examinations and make recommendations. It was also suggested that in rural areas, nurse practitioners specialising in addiction could assume this responsibility. Other stakeholders emphasised the importance of specialist medical assessment to ensure a recommendation is made in the context of a thorough understanding of the very complex health and wellbeing needs of the target client group.

The role of the PRMP under the Act is similar from the clinical perspective to the role of the referring medical practitioner in NSW, who is required to complete a screening and referral form that is then assessed by an accredited medical practitioner at a treatment centre to determine whether there is sufficient information to assess the referred person for a dependency certificate, which is broadly equivalent to a DTO under the Act. If sufficient information has been provided an assessment is made and the accredited medical practitioner can issue a dependency certificate, which allows a person to be involuntarily admitted for treatment. If there is insufficient information, an ITLO works with the referring medical practitioner to undertake further screening and comprehensive assessment of the potential client. In effect, there is a two-step process for the issuing of a dependency certificate in NSW, with any registered medical practitioner able to initiate the referral and the dependency certificate issued by a specialist, accredited medical practitioner.

Under the Mental Health Act any registered medical practitioner or mental health practitioner (that is, a person who is employed or engaged by a designated mental health service and is a registered psychologist, a registered nurse, a social worker or a registered occupational therapist) may make an inpatient or community assessment order, which enables transport of the client to a mental health service for assessment by the authorised psychiatrist.

Under both the NSW Act and Mental Health Act, the decision to authorise involuntary detention and treatment is made by a specialist clinician. Under the Act, authority to approve involuntary detention and treatment is vested in Magistrates. In making their determinations as to the issuing of DTOs, Magistrates rely on assessments undertaken and documentation provided by PRMPs, which establishes a strong justification for the requirement that PRMPs hold specific specialist qualifications. Magistrates also rely on certificates of available service issued by the senior clinician.

If the authority to approve involuntary detention and treatment in Victoria were vested in the senior clinician in Victoria (as canvassed later in this report), it may be appropriate to expand the categories of persons prescribed under the Regulations who may refer persons to the senior clinician for assessment. This would:

- be consistent with the approach established by the Mental Health Act and the NSW Act;
- foster equity of access to involuntary treatment services for potential clients living in areas in which the medical workforce is limited;
- ensure appropriate specialist assessment of the client prior to the order being made; and
- reduce the potential for preferential use of mental health facilities for detention and treatment of clients who are likely to meet the criteria for a DTO.

Stakeholders suggested it would be preferable for a recommendation to be made by a clinician who has a relationship with the client and is familiar with their medical and social circumstances. Such relationships and knowledge are more likely to be held by general practitioners than emergency medicine specialists, who may only see potential clients on a transient basis. Further, many rural and regional areas do not have strong specialist emergency medicine workforces. There was, therefore, support for broadening the categories of practitioners prescribed in the Regulations for the purposes of making recommendations under the Act to include general practitioners.

The prescribed form in Schedule 2 of the Regulations assists in ensuring compliance with the requirements established by s 12. However, it does so incompletely. Further detail on deficiencies in the form is provided at **Attachment 10.** Those deficiencies mean that the Court will lack evidence of the PRMP turning their mind to the missing matters. This is significant as in most cases the practitioner does not give verbal evidence to the Court but simply relies on the written recommendation. Further, whilst there are professional duties binding a registered medical practitioner in making a recommendation in that capacity, the recommendation itself does not take the form of an affidavit or statutory declaration. One Magistrate observed that the recommendations they had considered "haven't quite covered the things needed - maybe a guide or template would assist [doctors] to address the key questions". This issue could be addressed by amending Schedule 2 of the Regulations.

### 12.5 Availability of facilities and services

A PRMP may make a recommendation for a DTO if, amongst other things, they have complied with s 12(2) of the Act, which requires them to consult with the senior clinician of the treatment centre at which it is proposed to detain the person. This is consistent with usual medical practice. As part of that consultation, however, the PRMP must confirm that the treatment centre has facilities or services available to treat the person[31]. This suggests that a PRMP cannot make a recommendation if the senior clinician does not or is unable to confirm the availability of facilities or services, regardless of the needs of a potential client.[32]

The regulatory framework does not specify the factors the senior clinician may take into account in providing this advice. Some stakeholders expressed concern that this provision vests sole control over the allocation of facilities and services in the senior clinician, and suggested that the criteria for availability of facilities and services should be both specified and transparent, and that the availability

[31] Sub-section 12(3)(c).

[32] Note that s 14 contemplates, however, that facilities or services may not be available when a Magistrate is considering an application for a DTO. In those circumstances, the senior clinician must request the senior clinician or the manager of a treatment centre where facilities and services for the treatment of the person are available to provide a certificate of available services to the Magistrates' Court. In practice this section is ineffective as there are no declared treatment centres other than St Vincent's/Depaul House.

of facilities and services should not be a precondition to a recommendation, which should be based on client need.

Under the NSW Act, there is no requirement for a requesting medical practitioner to confirm the availability of facilities or services prior to requesting an accredited medical practitioner's assessment of a person. In NSW, once a referral is received from a medical practitioner a determination is made as to whether there is sufficient information for the accredited medical practitioner to assess the potential client for a dependency certificate. If not, further screening and a comprehensive assessment at the local level will be requested of the requesting medical practitioner and local ITLO.[33] Similarly, the Mental Health Act does not require the registered medical practitioner or mental health practitioner to determine the availability of facilities and services before making an assessment order.

While a requirement to consult with the senior clinician is reasonable, a requirement to take into account the availability of facilities and services before making a referral risks disadvantaging individual clients with high levels of need. Ideally, there would be adequate provision of facilities and services to meet reasonable demand, and checks and balances in the regulatory framework to ensure they are used appropriately.

## 12.6 Magistrates' Court processes

### *Introduction*

Magistrates have an important role in administering the scheme. The Magistrates Court is responsible for issuing special warrants, hearing and determining applications for DTOs and hearing and determining applications for revoking DTOs.

### *Special warrant for PRMP to examine*

Stakeholders criticised the procedure established by the Act for executing a special warrant as impractical, noting that it is very difficult to identify a PRMP who is able to take hours out of their practice to accompany a police officer to locate a person and examine them. In practice, this did not occur and, in at least one case, the police instead brought the person to the hospital. It is not clear whether a special warrant had been issued in that case.

The special warrant provisions are considered by many stakeholders to be a major barrier to facilitating examinations and potential recommendations under the Act. Comparison was drawn with the Mental Health Act, which establishes powers for authorised persons, or protective services officers at designated places, that facilitate taking people to or from a designated mental health service or any other place, or to a registered medical practitioner or mental health practitioner, for an examination for an assessment order in accordance with s 30.[34] Unlike the Act's special warrant provisions, the practitioner is not required to go to the person.

The NSW Act provides for an order for assessment to be made by a Magistrate or authorised officer within the meaning of the *Criminal Procedure Act 1986* (NSW), authorising an accredited medical practitioner to visit and assess the person to ascertain whether a dependency certificate should be issued in relation to the person.[35] Another person (including a police officer) may accompany the

[33] NSW Health. Involuntary Drug and Alcohol Treatment Program Information for Medical Practitioners

[34] Sections 350 to 353.

[35] Section 10.

accredited medical practitioner to assist them in conducting the assessment. Once the order is made, there are powers of entry.

It is rarely likely to be practicable for a clinician to visit and assess a person. It is likely to be more practicable for a client who appears to meet the criteria for a DTO to be taken to a PRMP for assessment and then, if a recommendation is made, taken to the treatment centre for further assessment. Consideration could be given to including relevant authorisations in the Act.

***Making a detention and treatment order***

The Court may make a DTO if satisfied that each of the particular criteria applies (see **Attachment 7**), the order is necessary and there is a place for the person at the treatment centre. The order authorises detention and treatment of the person named in it for 14 days following admission.

A small number of Magistrates responded to the invitation to participate in the consultation for this review. Some said that when the Act had first come into force, they had become aware of it by an internal email. It seems that some had developed a particular interest in the treatment and rehabilitation of drug and alcohol dependent persons and so had informed themselves of the Act's existence.

Magistrates who participated in the consultation process tended to have made orders under the Act and/or have had a special interest in the treatment and rehabilitation of drug and alcohol dependent persons. One Magistrate heard two applications and made orders in both cases, expressing surprise he had not received more applications.

One Magistrate noted that the court process puts lawyers acting for persons the subject of an application in a difficult position, in that it is not easy for them to get coherent instructions from their clients. This is akin to a 'fitness to be tried' issue. This may be another reason why a process akin to the Mental Health Act is more suitable.

In one case reported by an applicant, the Magistrate was not aware of the Act and the matter was stood down. This is consistent with feedback given by one of the Magistrates that, when faced with an application, he had to quickly familiarise himself with the Act. This is unsurprising, given the wide array of legislation Magistrates are required to apply on a daily basis. With fewer than expected numbers of orders being made, widespread knowledge of the Act is unlikely to have developed.

A number of applicants indicated that provision of detailed supporting documentation and explanation by informed applicants (such as the Public Advocate) facilitated the Magistrate’s understanding and enabled DTOs to be made.

The treatment centre indicated they had had to ‘step’ court registrars through the Act so they could in turn explain it to Magistrates.

There has been some practical overlap between the criminal justice system and the Act. For example, some Magistrates who have made DTOs under the Act did so after persuading the police to bring an application in circumstances where a multiple offender continually returned to their Court on drug and alcohol-related offences. Following the police application made at the Magistrate's suggestion, a DTO was made. One of the Magistrates who had made DTOs in these circumstances noted that where this occurred, the lawyers for the person did not oppose the order and did not demand the application go before another Magistrate.

***Analysis of process as a whole***

There is stakeholder concern that under current processes for making a DTO there is delay which is unacceptable in the context of the immediacy and urgency of the need for treatment. Further, there is concern that many Magistrates are unfamiliar with the Act and with the clinical issues associated with severe substance dependence.

Many stakeholders compared processes under the Act with those established by the Mental Health Act, described in detail at **Attachment 8**, and the NSW Act, described in detail at **Attachment 11**.

The Mental Health Act procedures have some advantages over procedures under the Act. Under the Mental Health Act, the process starts with an assessment order made by a registered medical practitioner or mental health practitioner enabling a person to be compulsorily examined by an authorised psychiatrist (in the community or by taking them to and detaining them in a designated mental health service) to determine if the treatment criteria apply.

Consistent with the immediacy criterion, the Mental Health Act also allows an authorized psychiatrist to make a Temporary Treatment Order for 28 days, which may be revoked by application to the Mental Health Tribunal.[36] Only the Tribunal may make a Treatment Order, which has a longer maximum duration. Thus, if a person meets the immediacy criterion temporary treatment can be obtained promptly on the basis of a clinical decision by a psychiatrist. There is no need for application to and a hearing in the Mental Health Tribunal or the Magistrates Court first, with all the procedural requirements for hearing including service of the application on the person. However, the revocation process still protects the client.

The Mental Health Tribunal is established specifically to protect the rights and dignity of people with mental illness and comprises legal, psychiatrist, registered medical practitioner and community members. It is considered by many stakeholders to be a more appropriate type of body than the Magistrates Court to make decisions with both clinical and social dimensions. The review team was advised that the Mental Health Tribunal and its predecessor have conducted hearings under the Mental Health Act for people who have substance and/or alcohol abuse, as well as mental health, issues.

Many stakeholders also submitted, however, that it would be inappropriate to rely on the Mental Health Tribunal for decision-making about severe substance dependence, because of its existing high workload and a strong stakeholder commitment to recognising the clinical distinction between mental illness and severe substance dependence.

Under the NSW Act, there is also no requirement for a Court or Tribunal to authorise initial detention or treatment. These are clinical decisions, but the Magistrates' Court is responsible for reviewing the issue of dependency certificates and extending them. A person aggrieved by an order or determination of a Magistrate under Part 4 may appeal against the order or determination to the Civil and Administrative Tribunal under Part 4 of the NSW Act.

There was strong stakeholder support for reviewing the processes that lead to a DTO, and aligning them with the Mental Health Act. In particular, consideration could be given to making the initial decision to detain and treat a person for severe substance dependence a clinical rather than a judicial one. As under the Mental Health Act, it would be possible to authorise detention for assessment by a

[36] Section 60.

registered medical practitioner without the need to obtain a special warrant from the court, enabling the person to be taken to the assessing medical practitioner who is a specialist in addiction medicine. The assessor could be given the authority (enforceable by the Act) to make the initial decision to detain and treat. An application to a court or Tribunal would not be required at that point. However, this initial decision to detain and treat should be subject to a second clinical opinion and prompt review by a Court or Tribunal, which might revoke or vary it after a hearing.

If these options were adopted, they would cater for the immediacy or 'without delay' requirement and would enable treatment to be obtained quickly. Implementation of these options would remove significant barriers in the current application process, including the problem of serving the person who is at that stage unlikely to be able to attend Court, let alone fully understand or contribute to the process. The human rights issues would be addressed by availability of the Court or Tribunal review process. As this approach has already been adopted in the Mental Health Act, which is widely accepted by stakeholders, it would not be a radical change.

For the reasons given, it was not proposed that the Mental Health Tribunal conduct the legal review of decisions made under the Act. Further, there may not be enough applications under the Act (at least initially and even if a greater volume is achieved) to warrant establishing a specialist Tribunal dedicated to severe substance dependence.

The Magistrates Court could conduct the review, as occurs in NSW, where there is also a further level of review by the Civil and Administrative Tribunal). Another option would be for the review to be conducted by the Victorian Civil and Administrative Tribunal ('VCAT'). Members who sit in the Human Rights Division of VCAT, in particular the Guardianship List, would be well suited to reviewing decisions made under the Act. They consider issues of capacity and medical treatment on a daily basis and are able to do so flexibly, often by conducting hearings informally and on site in hospitals, including those in regional areas. However, this option has not been raised for discussion with VCAT.

The Magistrates Court would also be able to conduct hearings on a flexible and informal basis. For instance, s 15 of the Act currently provides that (like VCAT) 'the court is not bound by rules or practice as to evidence but may inform itself in any manner it thinks fit'. This provision should be retained if the court is to have the review role in future. The NSW Act contains this provision for its review[37] and also a more general provision that reviews and applications for extensions 'must be conducted quickly and with as little formality and technicality as the requirements of the Act, the regulations and as the proper consideration of the matters before the Magistrate permit'.[38] Consistently with these provisions, in NSW Magistrates have often operated as VCAT members sitting in the Guardianship List would do, conducting hearings very informally in treatment centres. If the Magistrates Court in Victoria is to have the review role, the Act should have a similarly worded general provision for quickness, informality and lack of technicality. If that occurs, then the Magistrates Court would be an appropriate review body.

The need for a two-step review process, as in NSW, where the Magistrates Court decision on review is again reviewable by the Civil and Administrative Tribunal, is questionable. In NSW, there is a

[37] Subsection 37(2).

[38] Subsection 37(1).

right to appeal to the Civil and Administrative Tribunal on a question of law. On any other grounds, an appeal can only proceed with the Tribunal's consent.[39]

Under the NSW Act, an accredited medical practitioner who issues a dependency certificate which leads to a person's detention and treatment, must, as soon as practicable after the certificate is issued, bring the person before a Magistrate for a review of the issuing of a certificate.[40] In contrast to the Mental Health Act process where review is on application, the review by the Magistrates Court is compulsory and not dependent on someone deciding whether to apply. If the application and review processes are redesigned in accordance with the discussion above, consideration would need to be given to whether the review occurs automatically or on application.

If the initial decision to issue a DTO is a clinical one, another question to consider is whether the clinician's decision *not* to issue a DTO should be reviewable. Currently, the Magistrates Court decides as a legal question (based on clinical evidence in the form of a recommendation) whether a DTO should be made, and may decide not to make the order in a particular case. There may be cases where a family member wishes to seek a legal and perhaps also a clinical review (by second opinion) of (say) the senior clinician's decision *not* to detain a person for treatment.

### 12.7 Option for community treatment orders

The review team was informed that most people subject to a Compulsory Treatment Order under the Mental Health Act are on Community Treatment Orders. Under these orders, the clinician at the community-based service manages or coordinates care for the person. There is intensive community-based support if required - for example there may be daily home visits for administration of medication or other matters. For other persons there may be less frequent visits, if their condition is stabilising or responding to treatment.

Some groups consulted referred to this as a potential option for consideration under the Act, allowing a person to be compulsorily treated in the community without the need for detention as an inpatient. They thought this option should be available as an alternative to detention at the treatment centre.

This option would benefit from further consideration. It is unlikely to be suitable for the care of people in the early stages of treatment under a DTO, because of their complexity and high needs, but may be suitable for some people after an initial period of stabilisation in a treatment centre.

## 13. CLIENT ADVOCACY AND REPRESENTATION

Apart from when the Public Advocate specifically takes on a role as applicant in a particular case, the Act provides for involvement of the Public Advocate in each case where a person is admitted to the treatment centre under a DTO.

The Public Advocate and St Vincent's have agreed a protocol to facilitate the Public Advocate's role.

The Public Advocate seeks background information about the skills, capacity and disability diagnosis of the person before they visit, to facilitate their reading of the statement of rights to the person. Access to relevant information prior to a personal visit is also seen as a safety issue for staff of the Office of the Public Advocate. The Public Advocate suggests that the Act should require the application to the Magistrates Court to be provided to the Public Advocate.

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[39] Section 45.

[40] Section 14.

In relation to the initial visit to the person in the treatment centre, the Public Advocate negotiates with the facility to decide whether it is better to visit the person immediately or after they have had some time to allow any immediate effects of substance abuse to abate. In practice, the Public Advocate undertakes to visit any detained person within 72 hours of their detention.[41] If the client is in the Emergency Department, the Public Advocate then considers on a case-by-case basis whether it is appropriate to visit in that setting, after taking advice from the senior clinician.[42]

The protocol also sets out that if the person wants legal representation and/or to seek revocation, the Public Advocate assists them by referring them to and contacting if necessary, Victoria Legal Aid.[43]

The Public Advocate also assists the person when a second opinion is sought. In those circumstances the protocol provides that the facility will compile a list of medical staff which may include addiction specialists and psychiatrists, qualified to provide second opinions. The list includes addiction medicine specialists employed at St Vincent's but not directly involved in the care of client under the DTO and addiction medicine specialists external to St Vincent's. It is to be available to the Public Advocate on request.[44]

Staff of the Public Advocate observed the second opinion is usually given by someone who works within a department of St Vincent's other than Addiction Medicine. According to the Public Advocate, a number of second opinions have been given, although the review of medical records conducted for this review did not reveal evidence of this. Staff of the Public Advocate consider the second opinion should be obtained externally to St Vincent's but acknowledge that this is problematic because of hospital credentialing requirements and a lack of funding.

The protocol contemplates that the Public Advocate might be the guardian of the detained person in some cases and that Public Advocate staff may have supported or made an application for the DTO. The protocol stipulates that the Public Advocate recognises that its roles under the Act open it to a real or perceived conflict of interest in situations where it is the guardian of a person admitted under a DTO. In such cases the Public Advocate will be required under the Act to provide independent advice to the person once they are admitted. The protocol provides that the conflict of interest will be managed by advice being provided to the detained person by a Public Advocate team known as the Intake and Response team, which is separate from those who fulfil the role of guardians in the advocate/guardian program. When the Public Advocate is the guardian of a person admitted to the treatment centre, the Public Advocate will contact Victoria Legal Aid and ask for their attendance and provision of independent advice to the person in addition to the advice provided by the Public Advocate's intake and response team.[45]

The protocol provides that where a detained person requires interpreting assistance 'the facility shall, as a minimum, contact a telephone interpreting service and ensure that the person is advised of their rights under the Act. This may involve having the interpreter read out to the person the information contained in any relevant fact sheets'. The Public Advocate will assist in providing interpreting

[41] Page 3 protocol.

[42] Page 3 protocol.

[43] Page 4 protocol.

[44] Page 4 protocol.

[45] Page 4 protocol.

services when they visit a person who needs them, using a telephone interpreting service where that is the only option, although it acknowledges that this is less desirable than a face to face meeting with an interpreter.[46]

The protocol refers to the discharge plan under section 36 of the Act, noting that where the planning to discharge from the facility may involve a guardianship application, this should only occur where it is likely that the criteria for guardianship can be met in that the person has a disability, is unable to reason of that disability to make reasonable judgments and needs a guardian.[47]

The Office of the Public Advocate has not been involved in an application for revocation although it has supported one person in this process. Detained persons seeking revocation are referred to Legal Aid for this support.

## 14. THE TREATMENT PERIOD

The Act provides for a maximum period of detention and treatment of 14 days following the admission of the person to the treatment centre.[48]

Stakeholders consulted during the review uniformly advised that in their opinion this period is too short to enable effective treatment other than medically-assisted withdrawal. There was strong representation that:

- the administration of treatment on an involuntary basis can only be justified if it offers the best possible likelihood of sustainably improving the detained client's health and wellbeing;
- a 14 day period of detention is insufficient to facilitate withdrawal, stabilisation of health status, service planning and transition to necessary community-based support services; and
- the relatively short detention period creates a high likelihood of relapse immediately following the client's discharge from the DTO.

The limited detention period was noted by some stakeholders as a direct impediment to appropriate discharge planning. For the first part of that period most clients are not able to engage in the discharge planning process. One Magistrate stated that it is "nonsensical" to suggest that a severe alcoholic, who has been arrested for being drunk in a public place and other offences more than 100 times in two years, can shift focus in a two week period. Whilst detention for two weeks creates a 'circuit breaker' the strongly prevailing stakeholder view was that this is insufficient to achieve a sustainable benefit for most clients.

Stakeholders emphasised the complexity of clients detained and treated under the Act, and the time:

- they need to achieve the stable physical and mental state necessary to make balanced decisions about their future; and
- service providers need to make reliable provision for co-ordinated service delivery following discharge.

Maximum detention periods in other jurisdictions are presented in Table 6.

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[46] Page 5 protocol.

[47] Page 5 protocol.

[48] Subsection 20(3).

**Table 6: Maximum periods of detention**

| Jurisdiction | Maximum detention period |
|---|---|
| NSW | 28 days (may be extended on application to a Magistrate to not more than 3 months) |
| Tasmania | 6 months |
| Northern Territory | 16 weeks (*Volatile Substance Abuse Prevention Act 2005* (NT))<br>3 months (*Alcohol Mandatory Treatment Act 2013* (NT))<br>3-12 months (*Alcohol Protection Orders Act 2013* (NT)) |
| New Zealand | 2 years |
| Sweden | 6 months |

The Mental Health Act provides for temporary treatment orders of up to 28 days' duration.

The review team was informed that the 28 day period of detention for management of severe substance dependence has been 'hotly debated' in NSW, and will be examined as part of the full review of the NSW Act to occur in the future. For instance, the Reverend Fred Nile proposed an amending Act (which has not been passed) setting a period of 90 days. The NSW Act's existing power to extend the period to up to three months where the client has cognitive impairment is apparently used quite often. On the other hand, 28 days is reported to be sufficient for people showing an improvement within the first two weeks and a willingness to undergo voluntary treatment.

There is provision in the NSW Act to reduce the 28 day period on review by the Magistrates Court.

Stakeholders consulted for this review generally supported a 28 day detention period as the minimum appropriate period for effective management of the complex clients who are the subject of DTOs.

On the basis of the strong stakeholder representation that a 14 day period is insufficient, and the longer periods provided for in all other legislation, consideration could be given to extending the maximum period of detention to 28 days, with continuing provisions for earlier review by, and with the opportunity for extension on application to, a Court or Tribunal.

## 15. POWER TO RESTRAIN AND/OR SEDATE CLIENTS SUBJECT TO A DTO

Whilst there is security at Depaul House, it is not a locked facility and the detained person is physically able to leave if they choose to do so.

Stakeholders noted that s 38 provides power to restrain or sedate a person in various circumstances, but does not explicitly permit restraint or sedation whilst the client is detained in the treatment centre.

There is concern about the extent of the duty of care to keep clients secure whilst they are under a DTO. While the experience has been that most clients do not seek to leave once they are aware a DTO is in place, a small number of clients have been cared for in St Vincent's secure mental health unit because of an assessed high risk of absconding. This is not ideal for either the client or the other patients accommodated in the mental health unit, and staff of the Public Advocate expressed some concern about this arrangement. Further, some clients have absconded whilst on a DTO, requiring engagement of Victoria Police to locate and return them.

The Mental Health Act authorises bodily restraint to be used in specific circumstances under supervision of the authorised psychiatrist. There is no provision in the NSW Act for restraint or sedation for clients within the treatment centre.

The review team was informed that in NSW both treatment centres are secure facilities, however, with locked doors and barred windows. One facility was an existing detoxification unit and four of 16 beds are designated for involuntary clients under the NSW Act. It was necessary to build a fence around that facility. The review team was advised that security has not tended to be a problem as clients are generally either compliant or too ill to leave.

While clients need to be cared for in the least restrictive environment possible, it may be appropriate for treatment centres to have some capacity for detention in a facility in which client security can be assured to enable safe management. This would obviate the need to use mental health facilities inappropriately for the small number of clients who are assessed as at high risk of absconding but who do not have a mental illness necessitating care in a mental health unit. Consideration would need to be given to the appropriate configuration of such facilities. If a second facility is developed in the future, it may be appropriate to develop it as a facility that enables secure detention.

The use of other forms of physical restraint and/or sedation for the purposes of client detention, however, raises significant issues of clinical risk and human rights. It could not be contemplated without very careful consideration of issues such as the availability and capability of staff to manage clients safely in those circumstances.

## 16. OTHER ISSUES RELATING TO IMPLEMENTATION OF THE ACT

### 16.1 Introduction

During the consultation for this review, stakeholders raised a number of issues relevant to implementation of the Act, which did not fall directly within the terms of reference of the review but are presented below for consideration.

### 16.2 General stakeholder awareness and education

Many people working in relevant fields appear to be unaware of the Act's existence. Stakeholders suggested this has been a significant factor in the low number of applications for DTOs since the Act's inception.

The Addiction Medicine Team considers it is inappropriate for it, as the provider of the service, to actively promote the service, although the senior clinician advises general practitioners and others of the Act's provisions during usual professional interactions and has presented educational sessions on the Act.

If an independent advisory service is established (in accordance with the suggestion below), it could also provide more systematic education about the Act.

While a number of stakeholders expressed concern that if the service were widely advertised there would most likely be insufficient resources to meet demand, it was also suggested that resource limitations should be addressed on their merits and should not be a barrier to ensuring appropriate dissemination of information about the Act and its application. It was suggested that referral pathways currently appear to be distorted, which leads to an incomplete understanding of true demand.

### 16.3 Provision of guidance about the application of the Act

While a summary of the Act, various fact sheets, a flowchart describing the application of the Act and a link to a copy of the Act are available on the Department's website, there is considerable confusion, described earlier in this report, about the circumstances in which a DTO is appropriate.

For instance, it cannot be that the decision-making criteria are only satisfied when a person is presently intoxicated, or that it is no longer satisfied where a person simply asserts that they agree to receive treatment.

It appears that much of that confusion could be addressed through the development and promulgation by the Department of more specific guidance documents that include clear descriptions of the circumstances in which the criteria for DTOs apply, with supporting case studies. These case studies should describe various clinical and social presentations and recognise the complexity of the question as to when a person is incapable of making, and when they regain their capability to make, decisions.

Stakeholders would welcome such guidance documentation.

### 16.4 Management of inquiries under the Act

The senior clinician, his delegate and the Addiction Medicine clinical nurse consultant regularly receive telephone calls from people (for example members of the police force, court registrars, assessing doctors or family members) inquiring about the application of the Act. The substance dependent person's suitability for the treatment centre and whether they meet the criteria for detention and treatment are discussed. On many occasions, the inquirer is referred to the Department's website.

In some cases, potential applicants and/or PRMPs take the interpretations of clinicians at the treatment centre to be definitive such that they do not make an application they might otherwise have made. These decisions about the Act's application do not find their way to the Magistrates Court, instead being made informally by clinicians who are experienced but do not necessarily have the benefit of legal training as to the Act's criteria, and who also may be subject to other considerations such as demand pressures.

While St Vincent's maintains informal records of most inquiries, those records are not in a standard form and St Vincent's could not confirm that all inquiries had been recorded. Available records suggest:

- 36 inquiries (approximately 4 per month) were received during the 10 months of the Act's operations in 2011;
- 30 inquiries (approximately 2.5 per month) were received in 2012;
- 13 inquiries (approximately 1 per month) were received in 2013;
- 20 inquiries (approximately 1.7 per month) were received in 2014;
- 4 inquiries (2 per month) were received during January and February 2015.

No information was available to the review team of the circumstances in which people making inquiries were advised that the potential client would not meet the criteria for a DTO.

In its protocol with St Vincent's, the Public Advocate commits to provide general advice to members of the public about the Act, which includes 'people who are, or might be, subject to detention orders, their friends or relatives, potential applicants for orders, and providers of medical treatment'. A phone number is given in the protocol for the Public Advocate's advice service to be reached. It

seems that this advice service has not been widely advertised or used. Consideration could be given to whether the Office of the Public Advocate might fill the role of an independent advisory service in the future.

In NSW, involuntary treatment liaison officers ('ITLOs') assist in the screening and information gathering required to support a referral by a medical practitioner to an accredited medical practitioner for assessment for a dependency certificate. An ITLO is a doctor or nurse who is trained, has at least five years experience of providing direct drug and alcohol patient care and is skilled to assess and screen persons who may be eligible for a dependency certificate under the NSW Act. In liaison with the medical practitioner, treatment centre and accredited medical practitioner, an ITLO conducts screening, triage and assessment to determine if a person should be recommended for referral for assessment by an accredited medical practitioner for a dependency certificate.[49]

Stakeholders suggested establishment of a formal advisory service, separate from the treatment centre(s), to support potential applicants and PRMPs who are considering making an application or recommendation under the Act. The Drug and Alcohol Clinical Advisory Service ('DACAS') was suggested as potentially suitable to assume this advisory role, noting, however, that it would need additional support to develop capacity and provide such a service. Others felt that it would be appropriate for an advisory service to include persons with both legal and relevant clinical training. Further, it was agreed that it would be appropriate, for accountability and evaluation purposes, for the treatment centres to be required to maintain standard records of all inquiries they receive and advice they provide. This could be included as an accountability requirement in a service level agreement.

### 16.5 The number and locations of treatment centres

There are two declared treatment centres - St Vincent's, and Depaul House, which is collocated with St Vincent's. While only one bed is allocated in Depaul House to the management of clients under DTOs, the Addiction Medicine Team advised that if another bed is required urgently one will be found.

The lack of a more distributed service system has been identified as a problem for people in rural areas, both in terms of access to family and local service providers whilst they undergo treatment and the risks of transporting sick people long distances to the treatment centre.

Some stakeholders suggested that every hospital with a drug and alcohol service should be authorised to detain people under the Act, to meet demand locally as far as possible. Others emphasised the importance of supervision of care by addiction medicine specialists, however, who are unavailable in most rural and regional areas of the state.

The program delivered in accordance with the NSW Act is state-wide, although there are only two treatment centres operating under that Act. One is in the metropolitan area at the Herbert Street Clinic in the Northern Sydney District at Royal North Shore Hospital. The other is located at Bloomfield Hospital in Orange, Western New South Wales. One has eight beds and the other has four.[50] It is apparently an issue in NSW that there are only two treatment centres, requiring many people to travel considerable distances.

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[49] NSW Health. The Involuntary Drug and Alcohol Treatment Program. Referral and Screening Process. Factsheet available at http://www.health.nsw.gov.au/mhdao/Factsheets/Factsheets/idat-rs.pdf, accessed on 23 February 2015.

[50] Discussion with Mental Health Drug and Alcohol Office, NSW Ministry of Health.

Stakeholder reported that if the Act becomes more widely known, unnecessary barriers to accessing DTOs are removed and more DTOs are made, more resources may be needed in the Victorian treatment system. The treatment system capacity will need to be monitored and may need to be expanded if demand increases. If that occurs, it may be appropriate to declare and fund a new treatment centre so as to provide an additional geographic option for client management. It may also be appropriate to develop any new centre as a secure facility, to cater for the small number of clients who are at high risk of absconding.

The proposition that any addiction treatment facility should be permitted to manage patients under the Act raises compliance concerns. The compliance obligations established by the Act are, rightly, significant, and those providing the service need to be appropriately trained in the Act and its implementation. This would be very difficult to achieve with a distributed service system with multiple providers providing very small service volumes.

### 16.6 Provision of ongoing care

Stakeholders strongly suggested that access to case management/care co-ordination services should be provided as a priority for clients who have been detained and treated under a DTO.

The senior clinician is required to prepare a discharge plan if a detention order expires, is revoked or discharged. The discharge plan must outline follow-up treatment and support that is to be provided to the person: s 36(1).

Stakeholders expressed concern that despite this provision, appropriate community-based support has not been accessible to many clients following discharge from a DTO. Stakeholders agreed that the most appropriate option for many clients following withdrawal is residential rehabilitation, which is rarely if ever available. Further, while treatment centre staff make every effort to identify and coordinate a 'package' of ongoing care and support using existing funding streams in the community, they have limited opportunity within a 14 day period to arrange an appropriate package of services. The review team was advised that ongoing community-based care for clients who have been subject to a DTO is often difficult to access, fragmented, poorly coordinated and generally inadequate.

The general stakeholder view was that if a person's autonomy and liberty are infringed, there is an obligation to ensure provision of appropriate longer term care and support following discharge to give them the best chance of long term benefit.

Many stakeholders commented on the complex and challenging social circumstances of many clients, which need to be addressed if good long term outcomes are to be achieved. One Magistrate noted that "homelessness is fundamental to overcome before you can successfully engage in rehabilitation".

The review team was advised that brokerage arrangements in place in NSW are considered effective.

The new structure of non-residential adult community-based services may offer opportunities for effective partnerships between the treatment centre(s) and appropriate gateway services. Stakeholders advised that following the recent recommissioning of the non-residential adult alcohol and other drugs treatment sector, there is a new suite of services provided by consortia, a new funding model and new catchments. Twenty treatment types have been collapsed into six. Stakeholders suggested that clients who have received treatment under the Act should be identified as complex, high needs clients and have priority access, through direct referral to intake and assessment units, to case management/care coordination services.

### 16.7 Accountability and evaluation issues

Treatment for substance dependence is complex and many people who eventually recover suffer repeated relapses before doing so. Evaluation of outcomes is challenging, because there have been few clients detained and treated under the Act, long term follow up of clients is often not possible and there are few agreed client-based outcome measures.

Many stakeholders suggested it would be desirable to collect more information about the operations of the Act and client outcomes. Staff of the Office of the Public Advocate advised they would be interested in knowing when applications for orders are rejected by the Magistrates' Court, feedback on the outcomes of Legal Aid referrals and whether requested second opinions are obtained. The Magistrates Court does not, however, have dedicated fields in its computerised case management system to enable provision of complete statistical information about the applications on which orders are made and those which are struck out. One Magistrate indicated she and a colleague would like more follow-up as to how DTOs are implemented and what is done after an order is made. Another Magistrate indicated a desire to receive feedback on the outcomes of DTOs.

A number of stakeholders suggested research on short- and long-term client outcomes would assist to ensure an appropriate model of care that balance client interests with human rights, and to inform future evaluations.

Robust monitoring, evaluation and accountability are all extremely important in the context of involuntary detention and treatment. A minimum data set with a compliance and an outcome focus could be maintained to inform future evaluations. Depending on the future role of the Magistrates' Court, it could be approached to determine if relevant data can be collected prospectively.

There is currently no service level agreement between the Department and St Vincent's. St Vincent's collects activity data and regularly provides it to the Department. Service level agreements with the treatment centre(s) could specify the centre(s)' obligations to the Department including provision of treatment in accordance with a documented model of care, collection and submission of data and, to improve overall knowledge of the regulatory scheme and its outcomes, publication of annual reports. They would enhance program transparency and accountability.

## 17. ATTACHMENT 1 – STAKEHOLDER ORGANISATIONS INVITED TO PARTICIPATE IN THE REVIEW

Senior representatives from the following organisations were sent a written invitation to make a submission or attend a forum:

Ambulance Victoria – Grampians
Anglicare Victoria
Arbias
Australian Community Support Organisation (ACSO)
Bairnsdale Regional Health Service
Ballarat and District Aboriginal Co-operative
Ballarat Community Health
Ballarat Health Services
Ballarat Police Station
Barwon Health
Bass Coast Health
Bendigo & District Aboriginal Co-operative
Bendigo Community Health Services
CatholicCare Melbourne
Central Gippsland Health Service
City of Greater Bendigo
City of Greater Geelong
City of Melbourne
Colac Area Health
Drug and Alcohol Nurses of Australasia
Eastern Access Community Health Inc. (EACH)
Eastern Health Alcohol and Drug Service
EDAS MonashLink Community Health Service
Family Drug Help
Fitzroy Legal Service
Gippsland & East Gippsland Aboriginal Co-operative
Gippsland Lakes Community Health
Gippsland Southern Health Service
Grampians Community Health Centre/Palm Lodge, Horsham
Grampians Medicare local
Greater Shepparton City Council
Great South Coast Medicare Local
Gunditjmara Aboriginal Cooperative
Hepburn Health Service
ISIS Primary Care – Voyage Alcohol and Other Drug Service
Jesuit Social Services

Justice Connect (formerly PILCH)
Kardinia Network, Salvation Army
Lake Tyers Health and Children's Services
Latrobe City Council
Latrobe Community Health Service
Latrobe Regional Hospital
Law Institute Victoria
Mallacoota District Health and Support services
Mallee District Aboriginal Services
Mental Health Legal Centre Inc.
Mind Central Office
Moogji Aboriginal Council
Networking Health Victoria
Njernda Aboriginal Corporation
Omeo District Health Service
Orbost Regional Health Service
PenDAP, Frankston Integrated Health Centre
Peninsula Health – Frankston and Mornington Drug and Alcohol Service
Portland District Health Salvation Army Australia – Bridgehaven
Ramahyuck District Aboriginal Corporation
Salvation Army
South Gippsland Hospital
South West Healthcare
Stepping Up Consortium
UnitingCare Ballarat
Victorian Legal Aid
Wathaurong Aboriginal Co-operative
Western Health DASWest
Western Health, Drug Health Services
West Gippsland Healthcare Group
Wimmera Health Care Group
Winda-Mara Aboriginal Corporation
WRAD & Great South Coast Drug and Alcohol Treatment Services Consortium
Yarram District Health Service
Youth Support and Advocacy Service (YSAS)

Senior representatives of the following organisations were sent a written invitation to participate in a consultation session with the consultants, attend a forum or make a submission

Aboriginal Health Unit, Department of Health

Association of Participating Service Users

Burnet Institute

Federation of Community Legal Centres

Harm Reduction Victoria

Koori Justice Unit, Department of Justice

Turning Point Alcohol and Drug Centre

Uniting Care ReGen

Victorian Aboriginal Community Controlled Organisation

Victorian Aboriginal Health Service

Victorian Aboriginal Legal Service

Victorian Alcohol and Drug Association

YouthLaw

## 18. ATTACHMENT 2 - SUBMISSIONS RECEIVED

Dr Rodger Brough, Addiction Medicine Specialist

Dr Mike McDonough, Addiction Medicine Specialist

Dr Benny Monheit, Addiction Medicine Specialist

South West Healthcare

Uniting Care ReGen

Victorian Alcohol and Drug Association

## 19. ATTACHMENT 3 – INDIVIDUAL AND ORGANISATIONAL PARTICIPANTS IN INTERVIEWS AND FORUMS

Ms Mary Baker - Mallee District Aboriginal Services

Dr Rodger Brough - Addiction Medicine Specialist, South West Healthcare, Warrnambool

Ms Linda Bryant - Youth Justice Mental Health Initiative, Goulburn Valley Health

Ms Charlotte Byrne - Victoria/Tasmania Representative, Drug and Alcohol Nurses Australasia

Mr Paul Burke - Ambulance Victoria

Mr Brett Cain - State Coordinating Registrar, Melbourne Magistrates Court

Mr Matthew Carroll - President, Mental Health Tribunal

Ms Jenny Collins – Department of Health and Human Services, Grampians Region

Dr Ruth Collins - Consultant Addiction, Psychiatrist/Drug and Alcohol Services, Barwon Health

Ms Shelley Cross - General Manager, Stepping Up

Ms Liz Dearn - Senior Policy and Research Officer, Office of the Public Advocate

Ms Maria De Grazia - Ballarat Community Health

Ms Kerry Donaldson - Manager Community Programs, YSAS Bendigo

Mr Neil Duggan – Manager, Mental Health and Ageing, Department of Health and Human Services Loddon Mallee Region

Ms Meghan Fitzgerald - Fitzroy Legal Service

Dr Matthew Frei - Head of Clinical Services, Turning Point Alcohol and Drug Centre

Ms Eleanore Fritze - Senior Lawyer, Mental Health and Disability Advocacy

Ms Ann Hamden - Manager, Drug Treatment Services, Latrobe Community Health Service

Professor Margaret Hamilton - Melbourne University

Mr Paul Hurnall - Loddon Campaspe, Southern Mallee Dual Diagnosis Consultant, Psychiatric Services Professional Development Unit, Bendigo Health

Mr Rod Jackson – Chief Executive Officer, Wathaurong Aboriginal Co-operative

Dr Paul Lee, Clinical Director Mental Health, Latrobe Regional Hospital

Ms Debra Little - Service Development Officer of Territorial, AOD Unit, The Salvation Army

Dr Martyn Lloyd-Jones – Senior Clinician, St Vincent's Hospital Melbourne

Ms Anne Malloch - Team Leader, City Issues, City of Melbourne

Ms Megan McDonald - Area Manager, Loddon Mallee, Mind Australia

Ms Claire McNamara - Office of the Public Advocate

Mr Eugene Meegan - Manager of Youth and Primary Mental Health Services, Bendigo Health

Ms Jillian Michaelski – Goulburn Valley Health

Ms Chantelle Miller - Manager, Drug and Alcohol Strategy Unit, Victoria Police

Mr Edward Morgan - Senior Police Custodial Medical Officer, Victoria Police

Mr Allan Muntz - Practice Leader, Child Protection, Goulburn East Division, Department of Health and Human Services

Deputy President Genevieve Nhill - Head of Human Right Division, Victorian Civil and Administrative Tribunal

Dr Ed Ogden, Addiction Medicine Consultant, St Vincent's Hospital Melbourne

Ms Helen O'Neill - Clinical Nurse Consultant, Department of Addition Medicine, St Vincent's Hospital Melbourne

Ms Josephine Parkinson - Senior Policy and Projects Officer, Civil Justice, Victoria Legal Aid

Ms Maria Plakourakis - Senior Policy Officer, City Safety, City of Melbourne

Deputy Chief Magistrate Jelena Popovic, Melbourne Magistrates' Court

Ms Rosie Rand, Connect Team Leader, ACSO

Ms Sonia Rowe – Care and Recovery Clinician, Drug Treatment Services, Latrobe Community Health Service

Mr Glenn Rutter - Manager - Court Support and Diversion Services, Melbourne Magistrates' Court

Ms Claire Ryan - AoD and Refuge Services Team Leader, Ballarat Community Health

Ms Maggy Samaan - General Counsel - Ambulance Victoria

Mr Rod Soar - Federation Training

Ms Cheryl Sobczyk, Senior Manager, Alcohol and Other Drugs Services, Bendigo Community Health Services

Ms Raelene Stephens - Manager Social & Emotional Wellbeing Program, Mallee District Aboriginal Services

Ms Jenny Strauss - Regional Assessor, ACSO

Magistrate Stella Stuthridge - Melbourne Magistrates Court

Mr Peter Treloar - Emotional Wellbeing Nurse, Ballarat and District Aboriginal Co-operative

## 20. ATTACHMENT 4 – COMPARISON WITH RELEVANT LEGISLATION

Acts Referred to:

| | |
|---|---|
| **Victoria** | *Severe Substance Dependence Treatment Act 2010* (Vic) |
| **New South Wales** | *Drug and Alcohol Treatment Act 2007* (NSW) |
| **Tasmania** | *Alcohol and Drug Dependency Act 1968* (Tas) |
| **Northern Territory** | *Volatile Substance Abuse Prevention Act 2005* (NT) (**VSAP Act**)<br>*Alcohol Mandatory Treatment Act 2013* (NT) (**AMT Act**)<br>*Alcohol Protection Orders Act 2013* (NT) (**APO Act**) |
| **New Zealand** | *Alcoholism and Drug Addiction Act 1966* (NZ) |
| **United Kingdom** | *Mental Capacities Act 2005* (UK) |
| **Sweden** | *Swedish Code of Statutes 1988: 870* (Sweden) |

## 20.1 Objects of the Legislation

| Victoria | New South Wales | Northern Territory | United Kingdom | Sweden |
|---|---|---|---|---|
| To provide for the detention and treatment of persons with a severe substance dependence where this is necessary as a matter of urgency to save the person's life or prevent serious damage to the person's health (s 1(a)).<br>To enhance the capacity of those persons to make decisions about their substance use and personal health, welfare and safety (s 1(b)). | To provide for the involuntary treatment of persons with a severe substance dependence with the aim of protecting their health and safety<br>To facilitate a comprehensive assessment of those persons in relation to their dependency.<br>To facilitate the stabilisation of those persons through medical treatment, including, for example, medically assisted withdrawal<br>To give those persons the opportunity to engage in voluntary treatment and restore their capacity to make decisions about their substance use and personal welfare<br>(s 3(1)) | **VSAP Act**<br>The objects of this Act are to support child, family and social welfare and improve the health of people in the Territory by providing a legislative framework for (s 3):<br>• the prevention of volatile substance abuse<br>• the protection of persons, particularly children, from harm resulting from volatile substance abuse<br>**AMT Act**<br>The objects of this Act are to assist and protect from harm misusers of alcohol, and other persons, by providing for the mandatory assessment, treatment and management of those misusers with the aim of (s 3):<br>• stabilising and improving their health; and<br>• improving their social functioning through appropriate therapeutic and other life and work skills interventions; and<br>• restoring their capacity to make decisions about their alcohol use and personal | The UK equivalent legislation does not contain objects, but rather principles. They are as follows (s 1):<br>• A person must be assumed to have capacity unless it is established that he lacks capacity.<br>• A person must be assumed to have capacity unless it is established that he lacks capacity.<br>• A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success<br>• A person is not to be treated as unable to make a decision merely because he makes an unwise decision<br>• An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests<br>• Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action | The Swedish equivalent legislation does not contain objects, but rather guiding principles which are set out in Swedish social services legislation as follows:<br>• The stated objectives of society's social services should provide guidance for all care that aims to help individuals to get away from the abuse of alcohol, drugs or volatile solvents. Care must be based on respect for individual autonomy and integrity and shall, so far as possible, be designed and implemented in consultation with the individual (s 1).<br>• Care within the social given an addict in agreement with him or her under the provisions of the Social Services Act (2001: 453). An addict must, however, be given the care irrespective of its agreement, subject to the conditions set out in this Act (compulsory) (s 2).<br>• Compulsory treatment should be aimed at by the necessary efforts motivate the addict so he or she can be assumed to be in a position to voluntarily contribute to the continued treatment and receive support to get away from their addiction. *Act (2005: 467)* (s 3) |

| Victoria | New South Wales | Northern Territory | United Kingdom | Sweden |
|---|---|---|---|---|
| | | welfare; and<br>• improving their access to ongoing treatment to reduce the risk of relapse.<br>**APO Act**<br>No objects/principles section | | |

**Note: Tasmania and New Zealand Acts do not contain an objects/principles section.**

## 20.2 Key definitions

| Defined Term | Victoria | New South Wales | Tasmania | Northern Territory | New Zealand | United Kingdom | Sweden |
|---|---|---|---|---|---|---|---|
| **Court** | ***Court*** means the Magistrates' Court (s 4) | A Magistrate must hold an inquiry in relation to a person brought before the Magistrate in accordance with section 14 (s 34(1)). | ***Tribunal*** means the Alcohol and Drug Dependency Tribunal established under section 7 (s 2(1)). | **VSAP Act**<br>***Court*** means the Local Court. (s 4)<br>**AMT Act**<br>***Tribunal*** means (s 5):<br>(a) generally - the Alcohol Mandatory Treatment Tribunal established by section 102; or<br>(b) in relation to a particular proceeding – the Alcohol Mandatory Treatment Tribunal as composed under section 109<br>**APO Act**<br>*Court, Tribunal etc* is not defined in the Act | District Court (s 9). The District Court is the equivalent to the Magistrates' Court of Victoria. | Court of Protection (s 45(1)). | Administrative Court decides on the preparation of compulsory treatment. The Act (2009:800) (s 5).<br>The Social Welfare Board is the social welfare board of the municipality which according to the *Social Services Act 2001*, has the responsibility to the individual receiving the support (s 47) |
| **Severe substance /**<br>**Substance /** | Substance is not defined in the Act. | ***substance*** is defined as substances listed in Schedule 1 of the Act (s 5). This includes: analgesics, sedatives & | ***alcohol*** means any form of alcohol or any liquid containing any form of alcohol, and includes any | **VSAP Act**<br>***volatile substance*** means:<br>(a) plastic solvent, adhesive cement, cleaning agent, glue, | ***Alcohol*** is defined by the *Sale and Supply of Alcohol Act 2012* (NZ).<br>That Act provides a | Substance, alcohol drugs, etc are not defined in the Act. (N/A) | Substance, alcohol drugs, etc are not defined in the Act. (N/A) |

| Defined Term | Victoria | New South Wales | Tasmania | Northern Territory | New Zealand | United Kingdom | Sweden |
|---|---|---|---|---|---|---|---|
| **Drugs and/or Alcohol** | | hypnotics; stimulants and hallucinogens and volatile solvents. Schedule 1 includes various sub-forms of these substances and includes the commonly referred to name. Eg. cocaine (including Coke). | spirituous or fermented liquors, methylated spirits, and any mixture containing any such liquor or spirits; (s 2(1)) The Governor can make an order that a drug is a drug under the Act. (s 4(2)) | nail polish remover, lighter fluid, petrol or any other volatile product derived from petroleum, paint thinner, lacquer thinner, aerosol propellant or anaesthetic gas; or (b) a substance declared under section 5 to be a volatile substance (s 4 ). **APO Act** ***alcohol*** means: means a liquid that contains more than 1.15% by volume of ethyl alcohol (s 4) **AMT Act** *Severe substance, substance, Drugs, alcohol etc* not defined in the Act | scientific definition of alcohol by (s 2). | | |
| | A person has a severe substance dependence if - | ***severe substance dependence***, in relation to a person, | For the purposes of this Act a person shall be regarded as suffering from | **VSAP Act** ***abuse***, of a volatile substance, means the | ***alcoholic*** means a person whose persistent and excessive indulgence | Not defined in the Act. (N/A) | Dependence is if a person , as a result of continuous abuse of alcohol, drugs or |

| Defined Term | Victoria | New South Wales | Tasmania | Northern Territory | New Zealand | United Kingdom | Sweden |
|---|---|---|---|---|---|---|---|
| **Dependence** | (a) the person has a tolerance to a substance;<br>(b) the person shows withdrawal symptoms when the person stops using, or reduces the level of use of, the substance; and<br>(c) the person is incapable of making decisions about his or her substance use and personal health, welfare and safety primarily due to the person's dependence on the substance.<br>(s 4) | means the person:<br>(a) has a tolerance to a substance, and<br>(b) shows withdrawal symptoms when the person stops using, or reduces the level of use of, the substance, and<br>(c) has lost the capacity to make decisions about his or her substance use and<br>personal welfare due primarily to his or her dependence on the substance<br>(s 4). | alcohol dependency if he consumes alcohol to excess and<br>(a) is thereby dangerous at times to himself or others or incapable at times of managing himself or his affairs; or<br>(b) shows prodromal signs of becoming so dangerous or so incapable. (s 3).<br>For the purposes of subsections (2) and (4), dependency means a condition of a person arising from the taking of a substance that is manifested by<br>(a) an interference with his bodily or mental health; or<br>(b) an interference with his capacity to engage in ordinary relations with other persons or to earn his own livelihood | misuse of the substance by deliberately inhaling it to become intoxicated. (s 4).<br>**APO Act**<br>*Dependence* or some other like concept not defined in the Act<br>**AMT Act**<br>*Dependence* or some other like concept not defined in the Act | in alcohol is causing or is likely to cause serious injury to his health or is a source of harm, suffering, or serious annoyance to others or renders him incapable of properly managing himself or his affairs (s 2).<br>This Act shall apply, in the same way as it applies to an alcoholic, to any person whose addiction to intoxicating, stimulating, narcotic, or sedative drugs is causing or is likely to cause serious injury to his health or is a source of harm, suffering, or serious annoyance to others or renders him incapable of properly managing himself or his affairs (s 3). | | volatile solvents, needs to be removed away from their addiction and if failure to remove them will:<br>(a) subject his/her physical/mental health to grave danger;<br>(b) run an obvious risk to ruin her life, or<br>c) are liable seriously to harm himself or someone close. (s 4). |

| Defined Term | Victoria | New South Wales | Tasmania | Northern Territory | New Zealand | United Kingdom | Sweden |
|---|---|---|---|---|---|---|---|
| **Dependence** | | | or to undertake any duties or perform any functions that he might reasonably be expected to undertake or perform. ( 4(1))<br>For the purposes of this Act a person shall be regarded as suffering from drug dependency if he takes drugs to the extent that -<br>(a) he is thereby dangerous at times to himself or others or incapable at times of managing himself or his affairs; or<br>(b) he shows prodromal signs of becoming so dangerous or so incapable. (s 4(4)) | | The Act applies in the same way to drug addicts as it applies to alcoholics (s 3). | | |
| **Medical Practitioner / Assessor** | ***registered medical practitioner*** means a person registered under the Health Practitioner Regulation National | ***accredited medical practitioner***<br>A medical practitioner appointed by the Director-General | ***responsible medical officer***, when used in relation to a patient liable to be detained in a treatment centre, | **VSAP Act**<br>***assessor***<br>An assessor must be:<br>(a) a health practitioner; or<br>(b) a person who | ***medical practitioner*** means a health practitioner who is, or is deemed to be, registered with the Medical Council of | Not defined in the Act. (N/A) | Not defined in the Act. (N/A) |

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| | Law to practise in the medical profession (other than a student) (s 4). | (s 7). | means the medical practitioner in charge of the treatment of the patient (s 4). | holds a qualification approved under subsection (5).<br>(3) An assessor must exercise and perform his or her powers and functions in accordance with assessment guidelines issued by the Chief Health Officer. (s 32(2))<br>**APO Act**<br>Not defined in the Act<br>**AMT Act**<br>***decision maker,*** for a person, means a decision maker (as defined in section 3 of the Advance Personal Planning Act) for the person who has authority for matters relating to the assessment, treatment and management of the person under this Act (s 5)<br>***health practitioner*** | New Zealand continued by section 114(1)(a) of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of medicine (s 2). | | |

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| | | | | means a person registered under the Health Practitioner Regulation National Law to practise in a health profession (other than as a student) (s 5)<br>***senior assessment clinician*** means a person holding an appointment as a senior assessment clinician under section 131(1) (s 5) | | | |
| **Treatment definition** | Treatment means anything done in the course of the exercise of professional skills to provide medially assisted withdrawal from a severe substance dependence. (s 6(1)) | Treatment, care, medical care, etc. is not defined in the Act, nor does Part 2 of the Act (which covers involuntary detention and treatment from assessment to discharge) contains no information about what is done to treat the patient.. | ***medical treatment*** includes nursing, and also includes care and training under medical supervision (s 4). | **VSAP Act**<br>A ***treatment program*** is a program of treatment or intervention appropriate for a person at risk of severe harm (s 31A(1))<br>**APO Act**<br>Not defined under the Act<br>**AMT Act**<br>***treatment*** means therapeutic, health, | Treatment, care, medical care, etc. is not defined in the Act. | ***Mental Health Act Matters***<br>"Medical treatment", "mental disorder" and "patient" have the same meaning as in that Act. (s 28)<br>(following extracts from Mental Health Act 1983):<br>"medical treatment" includes nursing, psychological intervention and specialist mental health habilitation, | Treatment provided by direction of - *statens institutions styrelse* (State Institutions Board of Directors) "LVM home", that is specifically designed to provide care under this Act. The Act (2001: 464) (s 22).<br>Compulsory treatment shall cease as soon as the purpose of health care is achieved and |

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| | | | | diversionary, educational or other intervention or treatment aimed at remedying or reducing a person's misuse of alcohol (s 5) | | rehabilitation and care (but see also subsection (4) below) (s 145(1)). | no later than when care has been going on for six months (length of stay) (s 20). |
| **Treatment Centre** | A ***treatment centre*** may be declared by the Secretary and may be a premises; or a service through which treatment is to be provided. (s 4) | ***treatment centre*** is that which is declared until section 8 of the Act. (s 4) Section 8 states which premises may be a treatment centre, which is to be declared by the Director-General and published in the Gazette. | On the recommendation of the Secretary, the Governor may, by order, declare any premises or part of any premises (being premises or a part of any premises at which mental health services are provided) to be a treatment centre for the purposes of this Act. | **VSAP Act** Treatment centre is not defined in the Act. **APO Act** Treatment centre is not defined in the Act. **AMT Act** ***treatment provider*** means a community treatment provider or residential treatment provider (s 5) ***treatment centre*** means premises declared to be a secure residential treatment centre under section 128 - ie. *Gazzetted* by the CEO (s 5) | ***Institution*** means a certified institution under this Act. (s 2). ***Certified institutions*** (1) Where any person or body of persons (whether incorporated or not) is desirous of establishing or maintaining an institution under this Act, the Governor-General may by Order in Council, on the recommendation of the Minister made on the application of that person or body, and if satisfied in respect of the fitness of the institution and | ***Care home*** has the meaning given in section 3 of the *Care Standards Act 2000 (c. 14)*. (s 38 (6)) | Treatment takes place in "LVM homes" (which is not defined in the translation of the Act). For users who need to be under especially close supervision, there shall be LVM homes that are suited for such supervision. Act (1993: 3). (s 23). The care should be initiated in hospital, if the conditions for hospital treatment are met and deemed appropriate with regard to the planned care in general. (s 24) |

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| | | | | | of that person or body, certify the institution as an institution under this Act. (s 5). | | |

## 20.3 Criteria for detention and treatment

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| • the person must be 18 years old (s8(1)); and<br>• Have a severe substance dependence; and<br>• because of the person's severe substance dependence, immediate treatment is necessary as a matter of urgency to save the person's life or prevent serious damage to the person's health; and<br>• the treatment can only be provided to the person through the admission and detention of the person in a treatment centre; and<br>• there is no less restrictive means reasonably available to ensure the person receives the treatment. (s 8(2)) | A person may have a dependency certificate issued against them if:<br>• the person has a severe substance dependence; and<br>• care, treatment or control is necessary to protect the person from serious harm; and<br>• the person is likely to benefit from treatment for his or her substance dependence but has refused treatment; and<br>• no other appropriate and less restrictive means for dealing with the person are reasonably available.<br>(s 9(3)) | An admission application may be made in respect of a patient on the grounds -<br>(a) that he/she is suffering from alcohol dependency or drug dependency to a degree that warrants his detention in a treatment centre for medical treatment; and<br>(b) that it is necessary in the interests of his health or safety or for the protection of other persons that he be so detained. (s 24)<br>Period of detention in place of safety:<br>Where a person has been conveyed to a place of safety under this Part he/she may, during the period of 72 hours following that conveyance, be detained in any place of safety, and during that period may be | **AMT Act**<br>The following are the criteria for a mandatory treatment order in relation to a person:<br>(a) the person is an adult;<br>(b) the person is misusing alcohol;<br>(c) as a result of the person's alcohol misuse, the person has lost the capacity to make appropriate decisions about his or her alcohol use or personal welfare;<br>(d) the person's alcohol misuse is a risk to the health, safety or welfare of the person or others (including children and other dependants);<br>(e) the person would benefit from a mandatory treatment order;<br>(f) there are no less | No person in respect of whom an order for detention is made under the foregoing provisions of this Act shall be detained under that order in any institution or institutions under this Act for more than 2 years altogether after his first reception in an institution pursuant to the order.<br>Subject to the provisions of this Act, every such person shall be detained until he is discharged pursuant to this Act.<br>(s 10) | (4) For the purposes of this section D restrains P if he—<br>(a) uses, or threatens to use, force to secure the doing of an act which P resists, or<br>(b) restricts P's liberty of movement, whether or not P resists.<br>(5) But D does more than merely restrain P if he deprives P of his liberty within the meaning of Article 5(1) of the Human Rights Convention (whether or not D is a public authority).<br>There are further provisions in the legislation about the extent of detention power.<br>(s 6) | The Social Welfare Board would in ordinary circumstances apply to the Court for a decision to be made as to the compulsory treatment (s 5), however, where the Court's decision cannot be waited for:<br>Social Welfare Board may decide that a user immediately be detained if<br>1. it is likely that the abuser may be provided with care under this Act, and<br>2. the Court's decisions about care cannot be awaited because the abuser are likely to have their health seriously impaired if he or she does not receive immediate care, or because there is an imminent risk to the abuser as a result of their condition will |

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| | | conveyed from one place of safety to another by a police officer or a welfare officer. (s 60) | restrictive interventions reasonably available for dealing with the risk mentioned in paragraph (d).<br>(s 10)<br>**APO Act**<br>An officer may issue, or if it is not practicable for the officer to do so, the officer may authorise a police officer to issue, an alcohol protection order to an adult if:<br>(a) the adult has been arrested, summonsed or served with a notice to appear in court in respect of an alleged qualifying offence; and<br>(b) the officer believes that the adult was affected by alcohol when the adult did the thing that caused the arrest of the adult, or the service of the summons or the giving of the notice to appear to the adult (s 6)<br>**VSAP Act** | | | seriously injuring themselves or a loved one (ie. waiting for a decision by the Court will be detrimental to that person's health)<br>The Social Welfare Board can make an immediate decision to detain, or, if they cannot, such a decision may be made by the Board Chairman or any other member Board. The decision must be presented at the next meeting of the Board.<br>When the Social Welfare Board has applied for involuntary treatment may also be right on any of the grounds specified in the first paragraph decide that the user immediately be detained.<br>(s 13) |

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| | | | The Chief Health Officer may decide to apply for a treatment order in relation to the relevant person if satisfied all of the following circumstances apply:<br>(a) the person has been assessed as being at risk of severe harm;<br>(b) a treatment program has been recommended for the person;<br>(c) the person has not participated in a treatment program since the assessment report was made;<br>(d) a treatment order will be in the best interests of the person;<br>(e) the person cannot be adequately protected from severe harm in any other way; (s 35) | | | |

## 20.4 Who may apply for an order?

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| A person who is 18 years of age or older may file an application at the proper venue of the Magistrates' Court requesting that the Court make a detention and treatment order in respect of a person. (s10(1)). | A medical practitioner may request an accredited medical practitioner to assess a person for the purpose of making a recommendation for detention and treatment (s9(1)).<br>If a medical practitioner does not request an accredited medical practitioner to undertake an assessment or the accredited medical practitioner is not able to, an order may be applied for which compels assessment so that a dependency certificate may be ordered. (s 10) The Act does not specify who can apply for an order. | Application for a treatment order may be made by:<br>• the patient themselves (called a personal application)<br>• a relative of the patient<br>• a welfare officer (s23(2)).<br>Note: A patient may seek treatment on a voluntary basis which is provided for in the same way as treatment ordered under the Act. | **VSAP Act**<br>An application may be made by:<br>• a police officer or authorised person (s33(1)(a))<br>• an employee approved under section 65 (s33(1)(b))<br>• a health practitioner (s33(1)(d)<br>• in relation to a child believed to be at risk of severe harm - a responsible adult for the child (s33(1)(c))<br>An "authorised person" is a person declared as such by the Minister for Health (s60).<br>An "approved employee" is a person declared as such by the Minister for Health (s 65).<br>**AMT Act**<br>uses the word "applicant" but does not state who that term | Application for treatment may be made by:<br>• the patient themselves (s8(1))<br>• a relative (s9(1))<br>• a constable or any other reputable person.<br>Note: An application made by a person who is not a relative must contain a statement as to why it is made by the applicant instead of by a relative (s9(2)). | N/A | Any authorities who come into contact with dependents must refer them to the Social Welfare Board (s6). |

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| | | | encompasses<br><br>**APO Act**<br>A Police officer, who is of or above the rank of sergeant, issues an alcohol protection order (s 6) | | | |

## 20.5 What is required to make an application?

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| **Form of Application** | An application must:<br>• be in prescribed form and contain prescribed information; and<br>• have attached a recommendation for the detention and treatment of the person who is the subject of the application made by a prescribed medial practitioner that is current at the time of filing the application.<br>(s 10) | In NSW, an application is not made to a court unless an accredited medical practitioner is unable to make an assessment.<br>If an assessment is not made an application needs to be made to Court, an order may only be made if evidence on oath is adduced that once the person has been assessed a dependency certificate may be issued (viz, the person making the application deposes that they fulfil the criteria to be treated) (s 9(2)). | An application must:<br>• be in prescribed form, specify the treatment centre sought and be addressed to the superintendent of the treatment centre (s 23(3))<br>• State the relationship the applicant has to the patient (s 23(4)<br>• Only be made if the applicant has seen the patient within the past 14 days (s 23(5))<br>An application may be made with respect to a patient who is already in a treatment centre but not liable to being detained (s 23(6)). | **VSAP Act**<br>An application must be in the prescribed form (s 64).<br>**[Note: We cannot get the prescribed form.]** | An application must be in the form prescribed by s 9(1). Which includes:<br>• the name, address and occupation of the applicant<br>• the reasons that the applicant believes the person is a drug or alcohol addict<br>• the relationship of the applicant to the person<br>• if the application is made by someone who is not a relative, why the application is not made by a relative (Reg 3(3)). | N/A | Not specified. |

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| | An application must have attached a recommendation for the detention and treatment of the person who is the subject of the application made by a prescribed registered medical practitioner that is current at the time of the filing of the application. (s 2(b)) | If an accredited medical practitioner is not able to examine a dependent a person and issue a dependency certificate, a Magistrate or authorised officer may make an order authorising an accredited medical practitioner to visit and assess the person (s 10(1)). | An admission application shall be founded on the recommendation of a medical practitioner made in accordance with this Part, and such a recommendation is in this Act referred to as a medical recommendation. (s 24(3)) | **VSAP Act**<br>An application must include an assessment report conducted by an assessor (s 33(3)(b)) in accordance with s 34(1).<br>**APO Act**<br>No Medical Report needed<br>**AMT Act**<br>An application to Tribunal (under s 22) must be accompanied by an assessment report<br>An assessment report is a clinical assessment of the person by a senior assessment clinician (s 19) - no medical report required per se | If the application is not a voluntary application, two medical practitioners must examine the alleged alcoholic. (s 9(4)). | Section 49<br>(2) The court may require a report to be made to it by the Public Guardian or by a Court of Protection Visitor.<br>(3) The court may require a local authority, or an NHS body, to arrange for a report to be made.<br>(4) The report must deal with such matters relating to P as the court may direct.<br>(6) The report may be made in writing or orally, as the court may direct.<br>(7) In complying with a requirement, the Public Guardian or a Court of Protection Visitor may, at all reasonable times, examine and take copies of—<br>(a) any health record,<br>(b) any record of, or held by, a local authority and compiled in connection with a social services function, and | Upon completion of the Social Welfare Board's investigation, a doctor must issue a certificate in accordance with s 9 of the Act. The requirements of the contents of the certificate are not known (s 11). |

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| **Steps after making application** | Within 24 hours of filing the application the applicant must take all reasonable steps to:<br>• personally serve a copy of the application, together with a copy of the recommendation and any other documents filed with the application on the person who is the subject of the application; and (s8(3)(a))<br>serve a copy of the application, together with a copy of the recommendation and any other documents filed with the application on the senior clinician or the manager of the treatment centre at which it is proposed to detain the person (s8(3)(b)). | If a dependency certificate (under s 9(2)) is issued in relation to the person assessed, the person may be detained in accordance with the certificate for treatment under the Act<br><br>If a dependency certificate is not issued, the practitioner must, if appropriate, give advice on alternative options available for treating the person | N/A | **AMT Act**<br>As soon as practicable after make an application the applicant must give notice to the person at risk and the assessor.<br>The notice must include the persons who are required to attend the hearing of the application, and the persons who are able to attend the application. (s 31)<br>As soon as practicable the senior assessment clinician must take reasonable steps to ensure the following persons are given notice of that action:<br>(a) the assessable person;<br>(b) the assessable person's primary contact;<br>(ba) the assessable person's guardian (if any); | N/A | N/A | If an application is made and on the basis that the person at risk needs immediate care (before a court order) (s 13), that person must receive their file and be informed of their right to:<br>(a) request a hearing before the court; and<br>(b) the right to receive public assistance (s 16) |

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| | | | | (bb)the assessable person's decision maker (if any);<br>(c) the assessable person's representative (if any);<br>(d) any person nominated by the assessable person<br>(s 23(1))<br>Additionally, the clinician must give a copy of the application and assessment report to the assessable person and any person nominated by the assessable person<br>(s 23(2))<br>**VSAP Act**<br>As soon as practicable after make an application the applicant must give notice to the person at risk and the assessor.<br>The notice must include the persons | | | |

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| | | | | who are required to attend the hearing of the application, and the persons who are able to attend the application (s 38)<br>**APO Act**<br>No Steps | | | |

**20.6 What coercive powers are granted under the act to compel assessment for the purpose of making a recommendation, take a dependent person to detention, and/or enforce a treatment order?**

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| **Special warrant to examine person** | In order for an order to be made, a prescribed medical practitioner must examine the person and make a recommendation that they be given treatment under the Act. If a person cannot be located for the purposes of being examined, any person may make an application for a special warrant (s13(1)).<br>In order to issue a special warrant, evidence on oath (s13(2)) must be adduced to show:<br>• the Magistrate must be satisfied that the criteria for detention and treatment applies; and (s13(1)(a) | If an order is made under s 10 (because an assessment could not be performed by an accredited medical practitioner) , the authorised person (including a police officer) may assist the accredited medical practitioner in conducting the assessment (s 10(4)).<br>If the Magistrate or authorised officer makes an order to conduct an assessment, a person who takes action under the order must give written notice of what action has been taken to comply with the order to the person | N/A | Nothing specifically analogous in NT Acts<br>**AMT Act**<br>When an assessable person is taken to an assessment facility, a senior assessment clinician must admit the assessable person to the facility and detain the assessable person for the purpose of an assessment (s 14)<br>**APO Act**<br>Not Applicable<br>**VSAP Act**<br>Not Applicable | If a District Court judge is satisfied that an alleged alcoholic has refused to undergo an examination by two medical practitioners the judge may issue a warrant for the alcoholics arrest and to undergo the tests (s 9(5)). | N/A | A doctor requires a certificate to examine under section 9. |

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| | • a prescribed medical practitioner is unable to examine the person for the purposes of making a recommendation under s12. (s13(1)(b))<br>The special warrant allows a police officer and registered medical practitioner to enter premises specified in the warrant (s13(3)(a)); and<br>use reasonable force necessary to allow the registered medical practitioner to make a recommendation. (s13(3)(b)).<br>The special warrant remains valid for 7 days (s13(4)). | who made the order (s 10(7)).<br><br>Note: It is not necessary for a police officer to attend. | | | | | |
| **Power of Entry** | A person is authorised to enter premises if:<br>• they have a | An accredited medical practitioner (and any other person authorised) | The court may issue a warrant to transport a person to a treatment centre or | **AMT Act**<br>Not Applicable | N/A | N/A | N/A |

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| | warrant issued under s13; or<br>• there is a detention and treatment order to take a person to a treatment centre; or<br>• someone is absent from a treatment centre without permission (under s34)<br>(s37(1))<br>Before they enter premises they must:<br>• announce they are authorised to enter the premises<br>• state the basis of that authority<br>• give anyone at the premises an opportunity to permit entry to the premises<br>(s37(2)).<br>If permission is not given, a police officer may use reasonable force to enter (s37(3)). | may enter premises, if need be by force, to carry out the assessment.<br>(s 10(5)) | take them into custody if sworn evidence is given of the location of the dependent person and that entry to the premises has been refused. (s 59)<br>A commissioner may order the superintendent to bring a patient before the commissioner for examination for the purpose of an appeal. (s 55(2)) | **APO Act**<br>Not Applicable<br>**VSAP Act**<br>A Magistrate may issue a treatment warrant that authorises an authorised officer:<br>(a) to enter, at any reasonable time, a place where the officer reasonably believes the person specified in the warrant may be found; and<br>(b) to search the place in order to find the person; and<br>(c) to remain at the place for as long as the officer considers reasonably necessary to find the person; and<br>(d) if the person is found – to apprehend the person and take the person to the place specified in the | | | |

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| | Upon entry the person for treatment must identify themselves & be given a copy of the warrant or the detention and treatment order (s37(4)). | | | warrant to participate in the component of the treatment program as specified in the warrant. (s 41B) | | | |
| **Power to transport person / Power to restrain or sedate a person** | A police officer or ambulance paramedic may use reasonable force to restrain or sedate a person if:<br>• a person is to be taken to a treatment centre; or<br>• a person is to be transferred to another treatment centre; or<br>• a person is granted leave of absence is to be taken to or returned from a medical facility; or<br>• a person who is absent without | A transport officer (a member of NSW Health Service, a police officer, or a prescribed person) may:<br>• use reasonable force in exercising functions under the Act; (s 20(2)(a))<br>• restrain the dependent person in any way necessary in the circumstances (s 20(2)(b))<br><br>A police officer may also assist an accredited medical | As above. | **AMT Act**<br>An authorised person may use reasonable force to restrain a person who is detained at an assessment facility or treatment centre if necessary to:<br>(a) enable a senior assessment clinician to conduct an assessment of the person; or<br>(b) enable the person to be detained at the facility or centre; or<br>(c) prevent a risk of imminent harm to the person or any | A person may be detained for the purposes of transport under the Act (s 15). | N/A | Immediate custody is permitted under sections 13 - 19, which set out the decision process for detaining someone in immediate custody, and the review process for such a decision. |

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| | leave from a treatment centre is to be taken to a treatment centre.<br>(s 38) | practitioner. (s 23) | | other person; or<br>(d) maintain the good order and security of the facility or centre<br>(s 75)<br>If a person is required to be taken to an assessment centre or a treatment centre, A transport officer is authorised to take the person to or from the assessment facility or treatment centre<br>(s 137(1), (2))<br>If necessary to enable the person to be taken to or from the assessment facility or treatment centre safely, a transport officer may use reasonable force to restrain the person. (s 137(3))<br>**APO Act**<br>Not Applicable<br>**VSAP Act**<br>As above (s 41B). | | | |

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| **Power to search/ confiscate** | A police officer may frisk search a dependent person before returning them to treatment centre (s 38(4)). | A transport officer may frisk search a dependent person if they believe they may possess a dangerous item or an item that would assist in escape from custody. (s 20(3)-(5)). | N/A | **VSAP Act**<br>A responsible person may search an apprehended person and must remove any valuable items for safekeeping until release (s 25)<br>**AMT Act**<br>A transport officer may carry out a frisk search or ordinary search of the person if the officer reasonably suspects the person is carrying anything:<br>(a) that would present a danger to the officer, the person or any other person; or<br>(b) that could be used to assist the person to escape from the officer's custody<br>(s 137(4))<br>**APO Act** | N/A | N/A | If necessary, it may be cared for under this Act frisked or superficial body inspected, upon arrival at the LVM home, to check that he or she does not carry anything that may not be held there. The same applies if, during the stay in the home arises suspicion that such property be found in him or her. All of the account as circumstances permit shall be observed when physical searches and surface body examination. Where possible, a witness present. (s 32) |

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| | | | | A police officer who reasonably believes that an adult is subject to an alcohol protection order and that the adult may be in possession of alcohol may, without warrant:<br>(a) search the adult; and<br>(b) seize any container in the possession of the adult that the police officer reasonably believes contains alcohol | | | |
| **Power to apprehend dependent person absent from treatment** | A dependent person who is absent from a treatment centre without leave may be apprehended (s 34). | If a dependent person is absent from the treatment facility without permission they may be apprehended by:<br>• an accredited medical practitioner<br>• a person authorised by the director of | The court may issue a warrant to transport a person to a treatment centre or take them into custody if sworn evidence is given of the location of the dependent person and that entry to the premises has been refused. (s 59) | As above (s 41B). | If a patient is absent from treatment without permission they may be arrested without a warrant (s 16). | N/A | The head of the hospital unit where the addict staying shall ensure that the social welfare committee or National Board of Institutional notified immediately if the addict wants to leave or have already left the hospital. The |

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| | | the centre<br>• a police officer. (s 22) | | | | | operations manager will decide that the addict must be prevented from leaving the hospital during the time necessary to ensure that the addict can be transferred to an LVM home. Act (s 24) |

## 20.7 What is involved in the detention and treatment itself under the Act?

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| **Initial examination** | As soon as practicable after a person is admitted to a treatment centre under a detention and treatment order, but not more than 24 hours after the admission, the senior clinician of the treatment centre must examine the person. (23(1))<br>The senior clinician must then review whether the criteria is applicable (23(2)).<br>The clinician must then either confirm that the criteria apply, or that it does not apply, and confirm the order or discharge the person respectively. | N/A | N/A | N/A | N/A | N/A | N/A |
| **Other action required immediately upon admission** | As soon as practicable after a person is admitted to a treatment centre | The dependent person must be given an or oral and written explanation of their | N/A | **VSAP Act**<br>Not Applicable<br>**AMT Act** | N/A | N/A | N/A |

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| | under a detention and treatment order (but within 24 hours) the senior clinician or manager must ensure the person is given a written statement of their rights, the public advocate is informed of the person's admission, and all reasonable steps are taken to notify the persons nominated person and if applicable the person's guardian.<br>The senior clinician or manager must also ensure that the statement of rights and entitlements under the Act is given to the person's nominated person and if applicable the person's guardian. (s 25). | rights and entitlements as soon as practicable after the dependency certificate is given. (s 16) This includes specifically the right to appeal. (s 18) | | As soon as practicable after the person is admitted to the treatment centre, the senior treatment clinician must give the person:<br>(a) a rights statement; and<br>(b) an oral explanation of the rights statement<br>(s 55)<br>**APO Act**<br>Not Applicable | | | |
| **Treatment Plan** | The senior clinician of the treatment centre must determine the | Not Applicable | Not Applicable | **VSAP Act**<br>A treatment plan may be developed which can include | Not Applicable | Not Applicable | Compulsory treatment is provided though a home that is |

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| | treatment to be provided to the person and prepare a treatment plan<br>In determining the treatment to be provided to the person and preparing the treatment plan, the senior clinician must take into account each of the following:<br>(a) the wishes and preferences of the person as far as they can be ascertained<br>(b) the views of:<br>(i) the person's nominated person<br>(ii) if applicable, the person's guardian<br>(c) with the person's consent, the views of any family member of the person<br>(d) any beneficial alternative treatment available<br>(e) the nature and degree of any | | | any of the following:<br>(a) treatment for withdrawal, stabilisation, rehabilitation or aftercare;<br>(b) therapeutic, health, diversionary or educational intervention;<br>(c) any other type of treatment or intervention intended to alleviate the severe harm;<br>(d) a combination of any treatment or intervention mentioned in paragraphs (a) to (c).<br>(s 31A)<br>**AMT Act**<br>Treatment must be given in accordance with the principles of the Act and a treatment plan be prepared by the senior treatment clinician and the treatment plan must | | | specifically designed to provide care under the act (s 22)<br>The care should be initiated in hospital; if the conditions for hospital treatment are met and deemed appropriate with regard to the planned care in general (s 24)<br>Before care begins, the Social Welfare Board, in consultation with the inmate and the National Board of Institutional, establish a plan for continued care (s 28)<br>Social Welfare Committee shall activiely work with the individual after hospitalisation to make sure they get personal support or treatment to permanently get |

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| | significant risks associated with the proposed treatment or alternative treatment<br>(f) the consequences to the person if the treatment is not provided<br>(g) any second opinions obtained<br>(h) any prescribed matters<br>The senior clinician or a member of the treating team must discuss the plan or any revision of the plan with:<br>(a) the person; and<br>(b) the person's nominated person<br>(c) if applicable, the person's guardian<br>The senior clinician must review the treatment plan on a regular basis and revise the plan as required | | | be reviewed by the senior treatment clinician on a regular basis and amend it as required (s 56)<br>**APO Act**<br>Not applicable | | | away from their addiction (s 30)<br>National Board of Institutional shall follow up activities under the Act (s 30a) |

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| | (s 30) | | | | | | |
| **Time period for treatment** | 14 days<br>(s 20(3)). | Not more than 28 days<br>(s 14(a)). | 6 months from the date of admission<br>(s 27(1)). | **VSAP Act**<br>A period set by the court not exceeding 16 weeks<br>(s 41(2)(d)).<br>**AMT Act**<br>A period not exceeding 3 months<br>(s 49(2)(b))<br>**APO Act**<br>An alcohol protection order issued to an adult is in force:<br>(a) if it is a first order for a period of 3 months;<br>(b) if it is a second order for a period of 6 months;<br>(c) if it is a later order a period of 12 months from the later of the date on which is was issued and the date on which the latest of the previous alcohol protection orders | No more than 2 years after admission<br>(s 10(1)). | N/A | Maximum 6 months<br>(s 20). |

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| | | | | were issued to the adult ceases to be in force<br>(s 7(1)) | | | |

## 20.8 What additional safeguards does the Act contain to protect the rights of the detained person?

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| **Objects** | All of the objects of the Act must be performed so that detention and treatment is a last resort; and<br>human rights and any interference with the dignity and self-respect of a person who is the subject of any actions authorised under this Act are kept to the minimum necessary. (s 4) | A person must not be detained in a treatment centre under this Act unless an accredited medical practitioner has issued a dependency certificate in relation to the person (s 7) | N/A | **VSAP Act**<br>Not Applicable<br>**AMT Act**<br>Not Applicable<br>**APO Act**<br>Not Applicable | N/A | (1) The following principles apply for the purposes of this Act.<br>(2) A person must be assumed to have capacity unless it is established that he lacks capacity.<br>(3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.<br>(4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.<br>(5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be | Care must be based on respect for individual<br>autonomy and integrity and shall, so far as possible, be designed and implemented in consultation<br>with the individual. (s 1) |

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| | | | | | | done, or made, in his best interests.<br>(6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.<br>(s 1) | |
| **Information for Dependent /**<br><br>**Interpreter** | The dependent person must be given an oral and written explanation of their rights and entitlements. (s 26) This includes specifically the right to legal advice. (s 26) | The dependent person must be given an or oral and written explanation of their rights and entitlements. (s 16) This includes specifically the right to appeal. (s 18)<br>The accredited medical practitioner must arrange for an interpreter if the person cannot communicate adequately. (s 11) | N/A | **VSAP Act**<br>Any information or request that a police officer or authorised person is required to give to or make of a person under this Part must be given or made in a way the person is likely to understand and, if possible, in a language the person is able to understand. (s 11) | N/A | N/A | In connection with a decision on immediate custody is subject to the right social welfare committee shall, if possible, let the patient get some of the file and inform him of his right to:<br>1. make written representations to the court within a specified time,<br>2. request a hearing |

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| | | | | **AMT Act**<br>If an affected person is unable to communicate adequately in English but is able to communicate adequately in another language, the Tribunal must, to the extent that is reasonably practicable, permit the person to have access to an interpreter to assist the person:<br>(a) to prepare for the hearing; and<br>(b) when appearing at the hearing<br>As soon as practicable after the person is admitted to the treatment centre, the senior treatment clinician must give the person:<br>(a) a rights statement; and<br>(b) an oral | | | before the Court, and<br>3. the right to receive public assistance.<br>The Social Welfare Board shall also inform the individual that the right may give judgment even if not given an opinion. (s 16) |

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| | | | | explanation of the rights statement<br>If the assessable person is unable to communicate adequately in English but is able to communicate adequately in another language, the senior assessment clinician must, if practicable, arrange for the oral explanation to be given in the other language (s 15)<br>**APO Act**<br>Not applicable | | | |
| **Dependants/Children** | N/A | The accredited medical practitioner may have regard to any serious harm that may occur to children or dependents of the dependent person. (s 9(5)) | N/A | **VSAP Act**<br>The welfare of any child who may be affect by the exercise of power under the Act is to be the paramount consideration (s 18).<br>**AMT Act**<br>Criteria for mandatory treatment order includes the | N/A | The dependent persons' children must be notified of a decision to register an enduring power of attorney on behalf of the dependent person (s 6(1)). | Not specified. |

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| | | | | person's alcohol misuse is a risk to the health, safety or welfare of the person or others (including children and other dependants) (s 10(d))<br>**APO Act**<br>Not Applicable | | | |
| **Treatment** | (a)voluntary treatment must be promoted in preference to detention and treatment wherever possible;<br>(b)the person must be given the best possible treatment based on best evidence;<br>(c)treatment must be provided in the least restrictive environment and least intrusive manner that will enable treatment to be effectively given | The person who authorises treatment must recommend only necessary treatment and prescribe minimum medication required with full regard to effects of prescribed care. (s 15) | A person who mistreats a patient in detention is guilty of an offence (s 63). | Where an order have been made under the AMT Act, a person at risk does not need to comply with a treatment order to the extent the mandatory treatment order makes it not reasonably practicable to do so. (s 41D). | N/A | N/A | Compulsory treatment shall cease as soon as the purpose of health care is achieved and no later than when care has been going on for six months (length of stay) (s 20). |

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| | and identified risks to be effectively managed;<br>(d)if the person has a coexisting medical condition or mental disorder, the person must be appropriately assessed and referred to relevant welfare, health, mental health or disability services, and treatment must be coordinated with services provided by those other service providers;<br>(e)the person must be involved in decisions about his or her treatment and discharge planning and must be given sufficient information and supported where necessary, to enable this to occur;<br>(f)the age-related, gender-related, religious, cultural, | | | | | | |

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| | language, and other special needs of the person must be taken into consideration;<br>(g)the role of families and other persons who are significant in the life of the person must be considered and respected. (s 28(3)) | | | | | | |
| **Visiting and examination** | The Public Advocate must make arrangements to visit the dependent person in the treatment centre as soon as possible after they are detained (s 27). | The Minister may appoint official visitors who are medical practitioners. An official visitor is appointed to:<br>(a) to refer matters relating to any significant alcohol or drug dependency issues or patient safety or treatment issues to the principal official visitor or any other appropriate person or body,<br>(b) to act as an advocate for patients about issues arising in the alcohol or drug | N/A | **VSAP Act**<br>Not Applicable<br>**AMT Act**<br>Not Applicable<br>**APO Act**<br>Not Applicable | N/A | N/A | A person who cared for under this Act in an LVM home has the right to make and receive<br>phone calls and receive visits as far as conveniently may be. The inmate may be denied phone calls and visits it may jeopardize the health or order at home. (s 33) |

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| | | dependency treatment system, including issues raised by the primary carer of a dependent person,<br>(c) to inspect treatment centres as directed by the principal official visitor and in accordance with this Part,<br>(d) any other function conferred on official visitors under this or any other Act. (s 27)<br>A dependent person may request to see an official visitor. (s 32) | | | | | |
| **Carer / Guardian / Advocate** | A dependent person's guardian must be served a copy of an application for an order within 24 hours (s 11(3)).<br>A dependent person's guardian may appear and makes submission in Court (s 18(3)). | A dependant person may nominate a primary carer under the Act. They may exclude or revoke nominations at any time. (s 13)<br>An accredited medical practitioner must give notice of the dependent person's detention (to their primary carer) within 24 hours (unless | N/A | **VSAP**<br>If a child is released into care at a place of safety or into the care of a responsible adult who is not<br>the child's parent or guardian, the police officer or authorised person must, if practicable, inform a parent or<br>guardian of the child | N/A | Appointment of independent mental capacity advocates<br>(1) The appropriate authority must make such arrangements as it considers reasonable to enable persons ("independent mental capacity advocates") to be | N/A |

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| | | discharged within 24 hours) (s 17)<br>If the dependent is absent without permission, discharged or an application is made to extend the dependent's period of detention the carer must be informed. (s 19) | | of that action. (s 21)<br>**AMT Act**<br>A senior assessment clinician must ensure each of the following occur as soon as practicable after the assessable person is admitted:<br>(a) the following persons are notified that the assessable person has been admitted to the assessment facility:<br>(i) the assessable person's primary contact<br>(ii) the assessable person's guardian (if any);<br>(iii) the assessable person's decision maker (if any)<br>A person who is detained at an assessment facility may nominate a person to be the person's primary contact under this | | available to represent and support persons to whom acts or decisions proposed under sections 37, 38 and 39 relate. (s 35) | |

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| | | | | Act and may revoke or vary the nomination at any time (s 30(1))<br>**APO Act**<br>Not Applicable | | | |
| **Leave of absence** | A senior clinician or treatment centre manager may grant a dependent person leave of absence on medical or compassionate grounds and may impose any relevant conditions. (s 33) | A dependent person may be granted a leave of absence from a treatment centre on medical or compassionate grounds. (s 21) | The responsible medical officer may allow a leave of absence and impose any relevant conditions. (s 45) | **AMT Act**<br>A senior assessment clinician at the assessment facility or the senior treatment clinician for the treatment centre may permit the person to be absent from the facility or centre on any conditions considered appropriate by the clinician<br>(s 76(2))<br>**VSAP Act**<br>Not Applicable<br>**APO Act**<br>Not Applicable | A patient may be absented from detention for the purpose of medical or dental treatment (s 22). | N/A | Not specified. |
| **Discharge** | A dependent person must be discharged if they no longer fulfil the criteria for | An accredited medical practitioner may discharge a dependent person if they believe | A patient may apply to the Tribunal to be discharged while | **VSAP Act**<br>Not Applicable<br>**AMT Act**<br>The senior treatment | A patient who has been detained can be discharged at | N/A | The decision to discharge vests in the National Institutional Board, |

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| | detention. (s 35) | detention will not achieve the intended result. (s 24(1))<br>A dependent person must be discharged if they no longer fulfil the criteria for detention. (s 24(2)) | in detention (s 29) | clinician must release the person from the treatment centre immediately on:<br>(a) the expiry of the period during which the mandatory residential treatment order remains in force; or<br>(b)on the revocation or suspension of the order<br>(s 58(b))<br>**APO Act**<br>Not Applicable | any time by order in writing (s 17).<br>A patient may apply for discharge after they have served 6 months during their first stay at detention (s 18). | | who may determine to discharge the patient into an alternative LVM home (s 25) or discharge into the community (s 20)). |
| **Appeal / Revocation / Second Opinion** | A person who is the subject of a detention and treatment order may at any time apply to the Magistrates' Court, in the prescribed form, for the order to be revoked (s 22).<br>A person detained in a treatment centre under a detention and treatment order | Appeals to the New South Wales Civil and Administrative Appeals Tribunal are expressly provided for in the legislation (s 45).<br>The dependent person must be advised of these rights by the accredited medical practitioner (s 18). | An order of the Tribunal may be appealed to the Supreme Court by the patient (s 53). | **VSAP Act**<br>Not Applicable<br>**AMT Act**<br>A person who is entitled to be given an information notice may appeal to the Local Court against the decision stated in the notice. The appeal may be made in relation to a question of law only. (s 51(1) and | Appeals against an order of the District Court Judge are specifically provided for in the legislation. The patient may lodge an appeal within 3 weeks of the order (s 23) | Rights of appeal<br>(1) Subject to the provisions of this section, an appeal lies to the Court of Appeal from any decision of the court.<br>(2) Court of Protection Rules may provide that where a decision of the court is | The decision by the National Board of Institutional under this Act may be appealed by the individual at the administrative court, the decision<br>1. The terms of the transfer or the denial of discharge pursuant to § 25,<br>2. restricts the particular case of |

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| | is entitled to obtain a second opinion from a registered medical practitioner with relevant expertise in severe substance dependence and its treatment (s 31). | | | (2))<br><br>The decision remains in force until the Local Court decides the appeal (s 51(4))<br><br>Mandatory Treatment order is suspended while the person is subject to an order under the Mental Health Act and is of no effect while suspended (s 52)<br>**APO Act**<br>An adult to whom an alcohol protection order has been issued may apply for a reconsideration of the decision to issue the alcohol protection order. The application must:<br>(a) be made in writing; and | | made by—<br>(a) a person exercising the jurisdiction of the court by virtue of rules made under section 51(2)(d),<br>(b) a district judge, or<br>(c) a circuit judge, an appeal from that decision lies to a prescribed higher judge of the court and not to the Court of Appeal.<br>(s 53) | the right of every person staying in the home that according to § 33 a transfer telephone calls or receive visits,<br>3. The case of health in solitude or seclusion according to § 34, or<br>4. apply loss or sale of property pursuant to § 36.<br>Leave to appeal is required to appeal to the Appeal.<br>Other decisions under this Act by the National Board of Institutional may not be appealed.<br>Decisions about medical examination in accordance with § 9 or § 11 third paragraph may not be appealed.<br>Decisions on disposal according to § 13 first or |

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| | | | | (b) state the reason why the adult believes that the decision to issue the alcohol protection order should not have been made; and<br>(c) be lodged at a police station not later than 3 days after the date on which the order was issued<br>(s 9)<br>A senior office will reconsider an application lodged within 2 days (s 10)<br>An adult whose alcohol protection order has been confirmed by a senior officer may apply to the Local Court for a review of the merits of the senior officer's decision (s 11) | | | second paragraph may not be appealed. Appeals against the Court's decision on disposal according to § 13 third paragraph is not restricted to a certain time. The Act (2009: 800). (s 44) |
| **Confidentiality** | The Court may order that an application | [The Court may order that an application be | N/A | **VSAP Act**<br>The Court may | All applications made for an | N/A | N/A |

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| | be heard in closed Court and may make non-publication orders (s 19) | heard in closed Court and may make non-publication orders (s 37) | | order that proceedings not be published (s 59).<br>It is an offence to disclose the identity of an informer (s 55)<br>**AMT Act**<br>A person commits an offence if they:<br>(a) obtain information in the course of performing functions connected with the administration of the act; and<br>(b) engages in conduct that results in the disclosure of that information<br>(s 141)<br>**APO Act**<br>Not Applicable | order are to be heard in closed court (s 35(1)). | | |

## 20.9 What are the requirements/options under the act following discharge from the treatment facility?

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| **On-going treatment plan** | The senior clinician must prepare a discharge plan outlining follow-up treatment and support that is to be provided to the person. (s 36). The plan must include:<br>(a)the person being discharged from the treatment centre;<br>(b)the person's nominated person;<br>(c)if applicable, the person's guardian;<br>(d)with the consent of the person—<br>(i) any family member of the person;<br>(ii) any agencies or services which will be involved in providing services to the person as part of the discharge plan. | There are no specific requirements about treatment following discharge. However, an accredited practitioner must take all reasonable steps to ensure the dependent person and their carer are consulted are the dependent's discharge (s 25(1)). | N/A | **VSAP Act**<br>N/A<br>**AMT Act**<br>An aftercare plan must be prepared for a person who receives treatment under a mandatory treatment order for a person receiving treatment at a treatment centre – by the senior clinician for the centre (s 65(1)(a))<br><br>The aftercare plan must:<br>(a) specify the follow-up treatment the person is required to receive after the expiry of the period specified in, or the revocation of, the mandatory treatment order; and<br>(b) specify the period | N/A | N/A | National Board of Institutional shall, as soon as possible in view of the scheduled treatment, decide that the prisoner shall be allowed to stay outside the LVM home for care in another form.<br>The Social Welfare Board shall ensure that such care is provided.<br>If there is no longer preconditions for care in another form, the National Board of Institutional decide that the addict must be retrieved back to home. (s 27)<br>Before care in another form begins, the Social Welfare Board, in consultation with |

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| | | | | during which the treatment is to be received which must end not less than 3 months or more than 6 months after the expiry of the period specified in, or the revocation of, the mandatory treatment order; and<br>(c) be in the form approved by the CEO<br>(s 65(2))<br>The senior treatment clinician or community treatment provider must take reasonable steps to ensure the following persons are consulted in the preparation of the aftercare plan and receive a copy of the final aftercare plan:<br>(a) the person to whom the plan relates;<br>(b) the person's | | | the inmate and the National Board of Institutional, establish a plan for the continued care. Act (2005: 467). (s 28) Social Welfare Committee shall actively work to the individual after hospitalization having housing and work or training, make sure he or she gets personal support or treatment to permanently get away from their addiction. Act (s 30) National Board of Institutional shall follow up the activities under this Act. This monitoring shall include the time, both during and after completion of treatment. The Social Welfare Board shall submit to the National |

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| | | | | guardian if any;<br>(ba) the person's decision maker (if any);<br>(c) any person who would, under the aftercare plan, be involved in providing treatment or support to the person<br>(s 65(3))<br>An aftercare plan must be lodged with the Tribunal:<br>(a) as soon as practicable after an application for the revocation of the mandatory treatment order that applies to the person is made;<br>(b) if no such application is made – at least 7 days before the mandatory treatment order expires<br>(s 66(1)) | | | Board of Institutional provide the information concerning individuals of Institutional needs to fulfill the obligation under the first paragraph. (s 30a) |

## 21. ATTACHMENT 5 – MEMBERSHIP OF THE EXPERT REFERENCE GROUP

Ms Judith Abbott - Director Drugs, Primary Care and Community Programs, Department of Health and Human Services

Ms Pauline Ireland - Director Health Review and Regulation, Department of Health and Human Services

Ms Kathryn Johnston - Director of Legal Services - Health, Department of Health and Human Services

Mr Peter Lamb – Director, Courts Policy, Department of Justice and Regulation

Prof Dan Lubman – Director, Turning Point Alcohol and Drug Centre

Ms Heather Pickard – Chief Executive Officer, Self Help Addiction Resource Centre

Ms Leanne Beagley - Director, Mental Health, Wellbeing and Ageing, Department of Health and Human Services

Professor Greg Whelan - consultant to review team

## 22. ATTACHMENT 6 – REPORTS OF CONSUMER FORUMS

### 22.1 Forum 1 – Service users

**Present: 5 service users, a facilitator and a recorder**

**Method: Participants were asked to consider the numbered issues (bolded below). Responses are included below each issue.**

1. **Whether it remains appropriate to have legislation that provides for compulsory detention and treatment of people with severe substance dependence in specific, limited circumstances.**

   1 participant felt it was appropriate, others felt it depended on an individual's circumstances. Most felt that there are more issues than just the addiction to deal with in this situation i.e. housing, family, continued support etc.

2. **The types of clients that should be the subject of compulsory detention and treatment orders. The legislation is not intended to capture everyone with a severe substance dependence. It is intended to be a mechanism of last resort to help a small number of people who are so severely affected by their substance dependence that compulsory detention and treatment is justified urgently, as a life-saving measure or to prevent serious health damage. We would be interested in consumer views as to how the target group should be described so that it is appropriately identified and not too broad.**

   There was much discussion around who was defining an individual's "severity" of dependence and whether they were suitably qualified to make this decision, or if indeed anyone at all was qualified to make that decision.

   It was also felt that the fact that this whole process could be conducted behind the person's back could never be a helpful thing and would only add to the distress i.e. a policeman arresting anyone who had no idea it was going to happen would be distressing for anyone let alone someone who may already be in crisis.

   It was felt that perhaps individuals should be taken on a case by case basis, as no clear parameters could be given for describing the target group.

3. **Whether the legislation should have a specific objective of providing a health and wellbeing benefit to the individuals who are detained and treated. At present, the focus is on enabling people detained and treated under the act to achieve a state of improved decision-making, so they can make decisions about their ongoing substance use and care. Some stakeholders have suggested that the legislation should also have an objective of longer term health benefit to people who are subject to its provisions.**

   The general consensus was that the client would be in no way capable of making any improved decisions after only 7 to 14 days of detoxing. This led to discussion around the fact that the group felt there was little to no clear pathway back into the community including the support needed. It was also felt that it wasn't realistic to force a client into making decisions about their wellbeing at such a time, but making them aware of their options could be more beneficial than using more force.

4. **How detention and treatment should be activated. At present, a detention and treatment order is issued by the magistrates' court. Gaining an order is a complex process that takes time, in circumstances where the client may be very ill. Some stakeholders have suggested that a more streamlined access process involving specialist doctors but not the courts approving detention and treatment, similar to what happens in the mental health system, may be more appropriate, followed by a more independent process of review of the decision.**

   The group strongly felt that not just any GP should be able to be consulted regarding the "severity" of a client's substance dependence, but an addiction specialist. Also moving away from the Courts making these decisions to an addiction specialist with much more knowledge on the subject was felt would be greatly beneficial.

5. **Whether the focus on withdrawal over a period of up to 14 days is appropriate. Some stakeholders have suggested that a longer period of detention and a requirement to commence rehabilitation as well as completing withdrawal would be more appropriate, while others have suggested that the period of compulsory detention and treatment should remain very limited, to limit the impingement on human rights that is associated with compulsory detention and treatment. Some other jurisdictions have longer periods of detention and treatment - for example, NSW legislation provides for detention and treatment for a period of up to 28 days.**

   The group agreed that from their experiences there seemed to already be a lack of resources for any stays of up to 14 days, and it was felt that 14 days was nowhere near long enough. It was felt that 14 days wasn't long enough because helping clients in crisis was not just about abstaining for a certain period, learning skills was also necessary. It was felt that detox was merely a start, a step in the right direction, and that there was a serious shortage of places to go for after care. These clients then often end up in crisis accommodation which may not be conducive to recovery.

6. **The extent of the systems' responsibility to provide a pathway of care, beyond withdrawal. At present, efforts are made to link clients into ongoing care and rehabilitation after withdrawal, but it can be difficult to access appropriate services. Some stakeholders have suggested that if clients are to be detained and treated involuntarily, there is an obligation on 'the system' to ensure they have access to a fully integrated 'package' of care and rehabilitation.**

   100% of the group agreed that there was a definite responsibility to provide a pathway of after care. The group felt that there should be Dept funded beds as part of this Act as part of the follow through actions of after care and support.

7. **Whether a single treatment centre is sufficient. At present, St Vincent's is the only declared treatment centre. Some stakeholders have noted it is difficult for people from rural and regional Victoria to access a metropolitan centre and there should be more centres available in regional Victoria, while others have noted the lack of drug and alcohol specialists in rural and regional Victoria and have suggested it would be difficult to provide quality services in many rural and regional centres.**

   The group felt that regardless of the low number of people having been detained under this Act, clients would benefit from access to local services and feel more "at home" in their own community. It was also raised that risk of harm would increase should a client choose to

leave a detainment facility and be in a completely unfamiliar environment eg a client from a rural area suddenly finding themselves in an unfamiliar city.

It was also raised that there could be a risk of inferior treatment in rural areas since the Act has only been enforced in a very limited capacity. Despite this, the group felt it would make sense to at least have some options available for rural clients.

It was also raised that a single case worker should be assigned to each client for the sake of continuity

**8. Whether any changes are needed to ensure limitations on human rights and interference with the dignity and self-respect of persons subject to any actions authorised under the Act are minimised.**

It was raised that it wasn't clear exactly who the consumer advocates were and where they were from. Were they attending in the first 48 hours and what sort of information are they giving the client? Are they told that they are able to leave? This was felt to be very important as it was a basic human right.

It was also felt that at the moment there seemed to be no continuity – this was also felt to be very important, preferably with an independent advocate.

**9. Any other relevant comments about the Act or its operation/implementation.**

There seems to be no continuity – one support person to follow through with the client's journey was felt to be beneficial.

There seems to be no clear scale of "severity" and confusion around who exactly is making this assessment. It was felt that this should be a professional addiction specialist.

It was felt that getting the process out of the court system should be looked at – this would also help streamline the process.

The group felt they needed clearer information regarding who the client advocate is, where they are from, what they can do for their client, how often they can see them etc.

The group felt that a learning skills component was absolutely necessary as part of after care – without it there is definitely increased risk of harm after leaving the detox including overdose.

### 22.2 Forum 2 – Family members

**Present:** Facilitator and family member
Recorder and family member
6 other family members

1. **Whether it remains appropriate to have legislation that provides for compulsory detention and treatment of people with severe substance dependence in specific, limited circumstances.**

   The majority of the group felt that if the situation with the client was life or death, then yes the Act was appropriate, albeit in very limited circumstances. However, 2 participants felt quite strongly that it was not appropriate at all, and 1 was unsure, but was leaning towards yes.

2. **The types of clients that should be the subject of compulsory detention and treatment orders. The legislation is not intended to capture everyone with a severe substance dependence. It is intended to be a mechanism of last resort to help a small number of people who are so severely affected by their substance dependence that compulsory detention and treatment is justified urgently, as a life-saving measure or to prevent serious health damage. We would be interested in consumer views as to how the target group should be described so that it is appropriately identified and not too broad.**

   Again, the majority of the group felt that the criteria should stay quite broad, as it is now, except for the participants that were not in favour of the act to begin with.

3. **Whether the legislation should have a specific objective of providing a health and wellbeing benefit to the individuals who are detained and treated. At present, the focus is on enabling people detained and treated under the act to achieve a state of improved decision-making, so they can make decisions about their ongoing substance use and care. Some stakeholders have suggested that the legislation should also have an objective of longer term health benefit to people who are subject to its provisions.**

   The group felt that the scope of the Act should ***only*** be around "clearing the fog" for the client for those 14 days. They also felt that there could be an option given of moving onto additional after services, but that was not really what the scope of the Act should cover.

4. **How detention and treatment should be activated. At present, a detention and treatment order is issued by the magistrates' court. Gaining an order is a complex process that takes time, in circumstances where the client may be very ill. Some stakeholders have suggested that a more streamlined access process involving specialist doctors but not the courts approving detention and treatment, similar to what happens in the mental health system, may be more appropriate, followed by a more independent process of review of the decision.**

   5 participants were in favour of keeping the court component but involving an addiction specialist or experienced AOD prescriber rather than GPs. 3 participants were in favour of the courts not being involved at all, these participants also agreed that addiction specialists should be involved instead of GPs.

5. **Whether the focus on withdrawal over a period of up to 14 days is appropriate. Some stakeholders have suggested that a longer period of detention and a requirement to commence rehabilitation as well as completing withdrawal would be more appropriate,**

**while others have suggested that the period of compulsory detention and treatment should remain very limited, to limit the impingement on human rights that is associated with compulsory detention and treatment. Some other jurisdictions have longer periods of detention and treatment - for example, NSW legislation provides for detention and treatment for a period of up to 28 days.**

5 participants felt that the Act adhered to the scope of being purely for withdrawal purposes, then 14 days was long enough.

1 participant felt 14 days was too long, and 2 felt that the treatment period should be up to 28 days with more room for care and support after the detox period.

6. **The extent of the systems' responsibility to provide a pathway of care, beyond withdrawal. At present, efforts are made to link clients into ongoing care and rehabilitation after withdrawal, but it can be difficult to access appropriate services. Some stakeholders have suggested that if clients are to be detained and treated involuntarily, there is an obligation on 'the system' to ensure they have access to a fully integrated 'package' of care and rehabilitation.**

   All the participants felt that some sort of long term after care plan should be available to clients beyond withdrawal, but with appropriately qualified staff. It was also felt that there should be funding for this after care should the client choose to continue down that pathway – the funding should go with the client post withdrawal and prioritisation of these cases was a must. There was also a suggestion that some Govt funded beds in private rehab centres for the clients of this Act would be beneficial.

7. **Whether a single treatment centre is sufficient. At present, St Vincent's is the only declared treatment centre. Some stakeholders have noted it is difficult for people from rural and regional Victoria to access a metropolitan centre and there should be more centres available in regional Victoria, while others have noted the lack of drug and alcohol specialists in rural and regional Victoria and have suggested it would be difficult to provide quality services in many rural and regional centres.**

   It was generally felt that the single treatment centre was sufficient given the low number of clients being detained under this Act, but there was a suggestion made of perhaps each detox centre in each catchment area should have a bed available for this use. This would give regional clients better access.

8. **Whether any changes are needed to ensure limitations on human rights and interference with the dignity and self-respect of persons subject to any actions authorised under the Act are minimised.**

   Participants made the following suggestions:

   > The statement of rights that the Public Advocate gives to the client must be easily understood and clear in its breadth. Being easily understood may mean it being re-presented to the client when they are not intoxicated – it must be provided to the client when they are best able to comprehend it.
   >
   > It must be considered how any records are kept, how they are accessible and how they could affect a client at a later date.
   >
   > The clients must be made aware of any recourse they have if they believe they have been wrongly detained.

The appropriateness of the Public Advocate must be ensured – preferably it would be an AOD professional who could continue with the client on their aftercare journey, or at least be aware of the need for client education around skills required after detoxing and easing back into the community.

**9. Any other relevant comments about the Act or its operation/implementation.**

One participant had strong concerns that the Act would become a way of "managing" challenging members of society e.g. homeless people

There was a clear range of views by the participants – some felt that the Act shouldn't exist at all, some felt that it definitely should, and some were still undecided.

## 23. ATTACHMENT 7 – DETAILED DESCRIPTION OF PROCEDURES UNDER THE ACT

### 23.1 Procedures for making an order

Any person who is 18 years of age or older make apply to the Magistrates' Court for a DTO to be made in respect of a person under the Act.[51] The application must be accompanied by a current recommendation of a PRMP, who in accordance with regulation 6 of the Severe Substance Dependence Treatment Regulations 2011 must be:

(a) a person who is a fellow or affiliate of the Royal Australian and New Zealand College of Psychiatrists; or

(b) a person who is a fellow of the Australasian Chapter of Addiction Medicine; or

(c) in relation to a person in custody at facilities operated by the Victoria Police—

  (i) a registered medical practitioner who, in the course of work for the Victoria Police, provides medical care to that person at those facilities; or

  (ii) a person referred to in paragraph (a) or (b).

In making a recommendation the PRMP must have personally examined the person within the last 72 hours, formed the requisite opinion as to the criteria applying, and consulted with the senior clinician of the treatment centre where the person is to be detained. In so consulting, the PRMP must give information about the nature of the severe substance dependence, the nature of the urgent risk to the person's life or health and any previous efforts to treat their severe substance dependence. He or she must also discuss if there are any less restrictive options available for treatment and confirm that the treatment centre has the facilities or services available to treat the person.[52]

The recommendation must specify the facts on which the opinion that each of the criteria applies is based and distinguish the facts personally observed by the practitioner from facts not personally observed. If a PRMP relies on facts additional to his or her own observations, he or she must have reasonable grounds for relying on those facts.

The Act contemplates that it might be difficult to personally examine someone. If a prescribed registered medical practitioner is unable to examine the person for the purposes of determining whether or not to make a recommendation under s 12, a special warrant must be obtained from the Magistrates Court to facilitate the examination. A special warrant authorises and directs a member of the police force accompanied by a PRMP to enter the specified premises and to use such force as may be reasonably necessary to enable the PRMP to examine the person named in the warrant for the purposes of determining whether or not to make a recommendation under s 12. The special warrant only remains in force for seven days so the police officer and PRMP must act quite quickly. If they are unable to execute the warrant by the expiry date (i.e. within seven days), it must be returned unexecuted to the Court.

Section 14 requires a certificate of available services to be provided to the Magistrates Court by the senior clinician or manager of the treatment centre where the person is to be treated. There is no form

[51] Section 10

[52] Section 12.

of certificate in the Regulations although section 14(2) specifies that the certificate *'must give an outline of the facilities and services available at the treatment centre for the treatment of the person who is the subject of the application'.*

The applicant must have taken reasonable steps to personally serve a copy of the application on the person, and to serve a copy on the senior clinician or manager of the treatment centre.[53]

The Magistrates Court must hear the matter within 72 hours of filing.[54] The person the subject of the application has the right to appear and is entitled to be represented by a lawyer or (if the applicant is a police officer) a police prosecutor. A guardian also has the right to appear and make representations to the court.[55]

The applicant must give evidence of satisfaction of the service requirements on the person and the guardian or if not, the steps taken to serve the application on them, so the court can decide whether all reasonable steps have been taken.[56] If the court is satisfied that all reasonable steps have been taken to effect personal service on the person or (if applicable) their guardian, an order may be made in their absence where *'it would be detrimental to the person's health to delay hearing the application'.*[57] However, the Court has broad discretion to adjourn the hearing to enable the person the subject of the application to get legal advice and legal representation, or for their guardian to be served.

The Court may make a DTO if satisfied that each of the particular criteria applies (see section 0 below), the order is necessary and there is a place for the person at the treatment centre. The order authorises detention and treatment of the person named in it for 14 days following admission. The detained person who is the subject of the order may at any time apply to the Court for it to be revoked.[58] The person's nominated person or guardian may make an application on their behalf. The Court must hear that application within 48 hours of its filing.

Within 24 hours of filing, the application must be personally served on the person proposed to be detained and served on the senior clinician/manager of the treatment centre. Reasonable steps must be taken to serve the person's guardian within 24 hours of filing (after, if necessary, obtaining their contact details from VCAT).[59]

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[53] Section 10

[54] Section 15

[55] Section 15 and 18

[56] Section 16

[57] Subsection 16(3)(b)(ii)

[58] Section 22

[59] Section 11. VCAT's Guardianship List does not recall receiving any such queries, probably because in most cases the applicant will know who the guardian is.

### 23.2 Taking the detained person to the treatment centre

The detained person may be taken to the treatment centre by a police officer, an ambulance paramedic, a person providing non-emergency client transport services or anyone else specified in the order.[60] Each of those persons is given the power to enter any premises where they reasonably believe the person may be found, for the purposes of taking the person to the treatment centre.[61]

The Act also provides for powers of restraint or sedation in taking the person to and from the treatment centre, or (as set out below) transferring them or returning them there. The Act authorises police officers and ambulance paramedics to use reasonable force to restrain a person being transported in this way, and registered medical practitioners to administer sedation to enable the person to be moved (without limiting the power of an ambulance paramedic or a nurse to administer sedation within the ordinary scope of his or her practice). There are also powers of police officers, the senior clinician or manager of the treatment centre or a person employed or engaged by it to frisk search or ordinary search the detained person.[62]

If the detained person is not admitted to the treatment centre within seven days of the order being made, the order lapses[63], unless the applicant has applied for an extension within seven days after the order is made and the Court has extended the order by another seven days.

### 23.3 Examination and treatment

Once the detained person is admitted into the centre, they must be examined initially within 24 hours by the senior clinician.[64] The 'senior clinician' is defined in the Act as follows:

> ***senior clinician***, of a treatment centre, means—
>
> (a) the registered medical practitioner appointed by the governing body of the treatment centre under section 7(2) to be the senior clinician of the centre; or
>
> (b) a registered medical practitioner or nurse practitioner who is exercising the powers and functions of the senior clinician delegated to him or her under section 7(3) by the person referred to in paragraph (a).

In this examination the senior clinician reviews whether the criteria for detention and treatment still apply. If they do not, the person must be discharged.

Interim treatment may be provided to the person before they are examined within 24 hours if there are reasonable grounds for doing so as a matter of urgency.[65]

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[60] Section 20

[61] Subsection 20(5)

[62] Section 38

[63] Subsection 21(4)

[64] Section 23

[65] Section 29

The person is treated whilst they are in the centre for withdrawal from their severe substance dependence. Treatment may be provided without their consent. The Act specifies that certain principles apply to the treatment and preparation of a discharge plan for the person. These include that treatment be provided in the least restrictive environment and least intrusive manner that will enable treatment to be effectively given and identified risks to be effectively managed.[66]

The senior clinician prepares a treatment plan for the person in accordance with legislative requirements.[67]

The detained person has the opportunity to access a second opinion from a registered medical practitioner with relevant expertise in severe substance dependence.[68] If that medical practitioner thinks one or more of the criteria no longer apply, the senior clinician of the treatment centre must examine the person without delay and decide whether or not those criteria continue to apply. If the senior clinician is of the opinion that each of the criteria continues to apply, the order remains in force and the senior clinician notifies the Public Advocate of that as soon as practicable. For instance if the detained person wishes to apply for the order to be revoked, the Public Advocate may assist them with that. If the senior clinician forms the opinion following examination that one or more of the criteria no longer apply, he/she must discharge the detained person from the DTO.

### 23.4 Other protections of detained person's rights

Other protections of detained persons' rights are established by the legislation. They can nominate a person to protect their interests.[69] Within 24 hours after admission, they must receive a written statement of their rights and entitlements under the Act, from the senior clinician or manager of the treatment centre. Within 24 hours after admission, the senior clinician or manager of the treatment centre must ensure that the Public Advocate has been informed of the admission. This is not required if the person is discharged from the DTO within 24 hours after admission.

Upon being so informed, the Public Advocate must arrange with the manager of the treatment centre to visit the person as soon as practicable. The Public Advocate's role is to make representations on the person's behalf or act for them, to provide advice to them as to their rights and entitlements under the Act and, where required, to assist them in arranging legal representation or obtaining a second opinion or applying for eradication of the DTO: s 27.

The senior clinician must notify the Public Advocate if he discharges the person from the treatment centre,[70] or if the court revokes the DTO.[71] Under its protocol with St Vincent's, the Public Advocate asks to be advised of planned discharge in advance.

### 23.5 Transfer or leave of absence

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[66] Section 28

[67] Section 30

[68] Section 31

[69] Section 24

[70] Section 35.

[71] Section 35.

The detained person may be transferred to another treatment centre or have a leave of absence from the treatment centre for particular purposes. If they are absent without leave, they may be apprehended and returned to the treatment centre.[72] Powers of entry apply to enable authorised persons to apprehend detained persons who are absent from the treatment centre, so they may be returned.[73]

### 23.6 Discharge from the treatment centre

The senior clinician must discharge a person from the DTO if he/she is of the opinion that one or more of the criteria for detention and treatment no longer apply to them. In making that decision, he/she must have regard to any second opinion obtained in respect of the person.

In discharging a person, the senior clinician must notify the Court, the Public Advocate, the detained person's nominated person and (if applicable) guardian.[74]

The senior clinician must prepare a discharge plan outlining follow up treatment and support to be provided to the detained person. The senior clinician must consult with the detained person, their nominated person, guardian and (with the person's consent) any family members or agencies which will be involved in providing services to them.[75]

[72] Section 34

[73] Section 37

[74] Section 35

[75] Section 36

## 24. ATTACHMENT 8 – *MENTAL HEALTH ACT 2014* (VIC)

Broadly, the key relevant provisions in the Mental Health Act process are as follows.

The 'treatment criteria' for a person to be made subject to a Temporary Treatment Order or a Treatment Order are set out in s 5 as:

(a) the person has mental illness; and

(b) because the person has mental illness, the person needs immediate treatment to prevent—

  (i) serious deterioration in the person's mental or physical health; or

  (ii) serious harm to the person or to another person; and

(c) the immediate treatment will be provided to the person if the person is subject to a Temporary Treatment Order or Treatment Order; and

(d) there is no less restrictive means reasonably available to enable the person to receive the immediate treatment.

There are some parallels between these criteria and those under the Act. There are requirements of 'immediacy', 'no less restrictive means' and that the intervention is needed to prevent 'serious' deterioration/harm. A notable difference is that the risk of serious harm need not be only to the person, but might be to another person.

Procedures established by the Mental Health Act start with an assessment order made by a registered medical practitioner or mental health practitioner[76] enabling a person to be compulsorily examined by an authorised psychiatrist[77] to determine whether the treatment criteria apply (a community assessment order), or taken to, and detained in, a designated mental health service and examined there by an authorized psychiatrist to determine whether the treatment criteria apply (an inpatient assessment order).[78] Some criteria apply for the making of the assessment order, which are linked to the treatment criteria.[79] There are requirements for making an assessment order directed at protecting the person's human rights, such as informing the person of the examination and explaining its purpose, prior to its conduct. The examination must also have occurred within the 24 hours before the order is made.[80] There are also requirements, directed at protecting human rights, for informing various persons after the assessment order has been made.[81]

A person subject to an inpatient assessment order must be taken to a designated mental health service as soon as practicable but no later than 72 hours after the order is made.[82] The Mental Health Act

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[76] Defined in s 3 as a person employed or engaged by a designated mental health service who is a registered psychologist, registered nurse, social worker or registered occupational therapist.

[77] Defined in s 3 as a person appointed as an authorized psychiatrist for a designated mental health service under s 150.

[78] Section 28.

[79] In short, these are that the person appears to have a mental illness, and because of that, they appear to need immediate treatment to prevent serious deterioration in their mental or physical health or serious harm to them or to another person, if the person is made subject to an assessment order they can be assessed, and there is no less restrictive means reasonably available to enable them to be assessed. Section 28.

[80] Section 30 for requirements.

[81] Section 32.

[82] Section 33.

establishes powers for authorised persons or protective services officers that facilitate taking people to or from a designated mental health service or any other place, or to a registered medical practitioner or mental health practitioner, for an examination for an assessment order in accordance with s 30: see ss 350 to 353. Unlike the Act's special warrant provisions, the practitioner is not required to go to the person, which is considered by many stakeholders to be a major barrier to facilitating an examination and potential recommendation under the Act.

Although the court may make court assessment orders, there is a different process for that.[83]

The assessment order itself only lasts for specified time periods, not exceeding 72 hours.[84] An authorized psychiatrist must examine a person subject to an assessment order as soon as practicable after it is made or the person is received at the designated mental health service. He or she must immediately revoke the order if satisfied the treatment criteria do not apply to the person or it naturally expires at the end of the time periods specified.[85] Again, various persons must be informed.[86]

In keeping with the immediacy criterion, after assessing the client under an assessment order an authorized psychiatrist may make a Temporary Treatment Order that enables the person to be compulsorily treated in the community (Community Temporary Treatment Order) or compulsorily taken to, and detained and treated in, a designated mental health service (Inpatient Temporary Treatment Order).[87] This is after examining the person and being satisfied that the treatment criteria apply to them. They take into account the views of the person and others (including guardians and carers)[88] and they must determine whether the order is a Community Temporary Treatment Order or an Inpatient Temporary Treatment Order, again taking into account those views.[89] After the order is made the authorized psychiatrist must take reasonable steps to inform the person, explain the order and give them a copy of it and the relevant statement of rights.[90] The authorized psychiatrist must notify the Mental Health Tribunal the order has been made, and ensure reasonable steps are taken to inform other persons, including guardians and carers.[91] Unless revoked or it expires, a Temporary Treatment Order remains in force for 28 days.[92]

The Mental Health Tribunal may make a Treatment Order, which enables a person who is subject to it to be compulsorily treated in the community (a Community Treatment Order) or taken to, and

[83] In Div 2 Part 4.

[84] Section 34.

[85] Section 37.

[86] Section 37.

[87] Section 45.

[88] Section 46.

[89] Section 48.

[90] Section 50.

[91] Section 50.

[92] Section 51.

detained and treated in, a designated mental health service (an Inpatient Treatment Order).[93] The Tribunal must conduct a hearing to determine whether to make a Treatment Order in relation to a person who is subject to a Temporary Treatment Order, and must do so before the expiry of that Temporary Treatment Order.[94] The Tribunal is required to take into account the views of the person and others (e.g. guardian and carer) as part of this hearing process. The duration that may be specified in the Treatment Order is (for people over 18 years) maximums of 12 and 6 months under a Community Treatment Order and an Inpatient Treatment Order respectively.[95] There is provision for variation and revocation of these orders. Whilst the variation process is subject to some oversight by the Tribunal of variations made by an authorized psychiatrist[96], a revocation is obtained by application to the Tribunal.[97]

There is a process for a second opinion to be obtained. A second psychiatric opinion may be obtained by a person who (relevantly here) is subject to a Temporary Treatment Order or a Treatment Order: ss 78 to 89.

Community Treatment Order can be made under the Mental Health Act, allowing a person to be compulsorily treated in the community without the need for detention as an inpatient. Most people on compulsory Treatment Orders under the Mental Health Act are on Community Treatment Orders.[98]

The Mental Health Act makes detailed provision (ss 68 to 77) for when a person does and does not have the capacity to give informed consent and in what circumstances certain treatment may be given without informed consent, or without consent.

[93] Sections 52 and 53.

[94] Section 53.

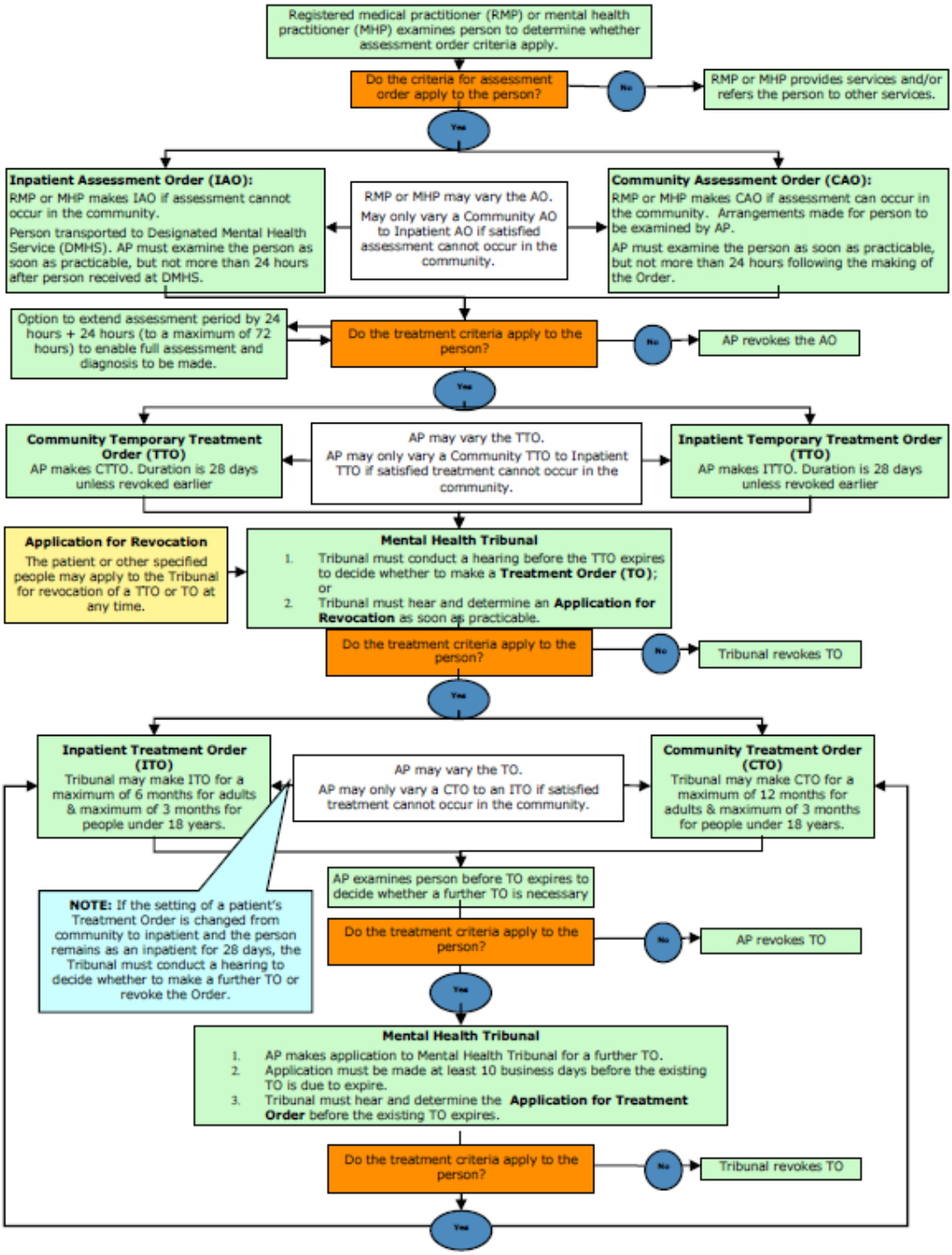
[95] Section 57.

[96] Section 58.

[97] Section 60, for both Temporary Treatment Orders and Treatment Orders.

[98] Discussion representative of Mental Health Tribunal.

## 24.1 Mental Health Act Treatment Orders flow chart



## 25. ATTACHMENT 9 – MODEL OF CARE FOR INVOLUNTARY CLIENTS

Clients detained and treated under the Act generally are cared for by the senior clinician and/or the 0.2FTE addiction medicine consultant, and the clinical nurse consultant, in collaboration with a treating team in an inpatient medical unit, the mental health unit or Depaul House.

Clients are generally transported to St Vincent's by members of the police force or ambulance service, a friend or a family member. In the experience of the Addiction Medicine Team, clients are often under the influence of a substance on arrival. All clients, regardless of the referral source or their immediate state of health, are initially managed in the emergency department, with emergency department clinicians assuming responsibility for their immediate care.

The legislated assessment by the senior clinician or his delegate is conducted in the emergency department within 24 hours and, unless exceptional circumstances apply, during usual business hours. The senior clinician or his delegate is rostered on-call and is available if needed at weekends or overnight.

No special security arrangements for these clients apply in the emergency department and there is no specific protocol to ensure clients do not leave. Members of the Addiction Medicine Team advised that once a DTO is made, clients generally cooperate with treatment and most do not seek to leave. The practice has been to ensure they are cared for in a location that is in direct view of emergency department staff, so they can be observed closely. A 'Code Grey'[99] alert is called if a client becomes violent, non-compliant or indicates an intention to leave, and efforts are made to calm the client, de-escalate the situation and gain the client's cooperation. The Addiction Medicine Team believes that if the client is medically compromised to the extent that a common law duty to provide emergency care arises St Vincent's can prevent them from leaving, but that there is no power under the Act to do so. If the client leaves the hospital, however, the practice has been to seek the assistance of police to apprehend and return them.

Where possible, the client is assessed by the Addiction Medicine Team collectively. The senior clinician, in consultation with the Addiction Medicine Team, decides the most appropriate treatment and treatment setting, and prepares a treatment plan in accordance with the requirements of the Act. To date, all clients have presented with a primary problem of alcohol dependence, therefore initial management has focussed on this condition.

There is no documented standard suite of investigations or approach to immediate treatment, but the Addiction Medicine Team advises that:

- a full blood examination, urea, electrolyte, calcium, magnesium, phosphorous and Vitamin D levels and liver function tests are ordered for most clients;
- a coagulation screen is performed if deemed necessary; and
- emergency department staff usually insert an intravenous cannula, commence administration of intravenous thiamine and diazepam and monitor the client on an alcohol withdrawal scale.

The clinical nurse consultant, either personally or through the registrar ensures:

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[99] Part of a standardised response to incidents of violence or aggression. See the Department's publication: *Better responses, safer hospitals* at http://docs.health.vic.gov.au/docs/doc/D8C0E089893FD00FCA257CED0081DBA6/$FILE/Code%20Grey%20Standards_May%202014.pdf

- each client is offered an opportunity to nominate a person under s.24 of the Act;
- each client is given a written statement of their rights and entitlements under s.25(1)(a) of the Act and further explanation in accordance with ss.26(2)-(4) of the Act;
- all reasonable steps are taken on request of the client to assist them to obtain legal advice in accordance with s.26(5) of the Act and/or a second opinion in accordance with s.31(3) of the Act;
- the Public Advocate is informed in accordance with s.25(1)(b) of the Act; and
- reasonable steps are taken to nominate and contact the nominated person and, if applicable, the client's guardian.

If clients are accompanied by persons who are not their guardians or nominated persons, usual privacy and confidentiality protocols are applied.

Alcohol withdrawal is managed in accordance with a policy that applies generally in St Vincent's Hospital[100] and contains clear management guidelines for assessment, non-medicated management and medicated management. The alcohol withdrawal scale is used to monitor the progress of the alcohol withdrawal syndrome and as a guide to the employment of pharmacotherapy. The specified aim of treatment is to decrease symptom severity and reduce the likelihood of the development of withdrawal-associated complications.

The review team was not provided with protocols for the management of clients' withdrawal from other substances.

All clients other than those admitted to the mental health unit (see below) are managed in a non-secure environment. The practice has been to allocate a nurse to exclusively support each client during the first 24-48 hours of admission, following which the need for a 'special' nurse is reassessed. These nurses tend to be drawn from St Vincent's nurse bank and usually do not have specialist drug and alcohol expertise.

Some clients are admitted directly to Depaul House, while others are transferred there following a period of care on medical or mental health wards. If clients are medically unwell they are admitted for medical care under the supervision of a general or specialist physician, with members of the Addiction Medicine Team providing consulting advice and overseeing contemporaneous management of the client's severe substance dependence. A small number of clients who would otherwise be suitable for care in Depaul House but have been assessed to be at high risk of absconding have been admitted to St Vincent's Hospital secure mental health extra care unit, under the bedcard of a psychiatrist. The Addiction Medicine Team provides consultation support in relation to the client's substance withdrawal, as for clients admitted under medical units.

In Depaul House, management proceeds in accordance with the agreed treatment plan and treatment is administered by Depaul House staff in accordance with their usual policies and procedures. Members of the Addiction Medicine Team maintain regular contact with the client, liaise with Depaul House staff and plan the client's discharge in collaboration with local service providers. In accordance with section 36 of the Act an individualised discharge plan is prepared for each client and efforts are made to link the client into suitable ongoing supports and services.

[100] St Vincent's Hospital Melbourne. Alcohol Withdrawal Syndrome. Endorsed April 2014.

Although documentation on client rights[101], which is authored by the Department and provided to clients by St Vincent's, advises that clients will be assisted by a care coordinator for up to six months after the order finishes, in reality there is no specific care coordination or case management funding available for these clients and the Addiction Medicine Team advised that they do not always have access to post-discharge care coordination unless an existing service can be resumed or a care coordinator can be identified through another funded program.

St Vincent's has developed the following documents to support performance of its role under the Act:

- Proforma - Certificate of Available Service
- Severe Substance Dependence Treatment Act Checklist (which serves as an aid to compliance with the Act)
- Data Collection Form
- Notice of Admission under Severe Substance Dependence Treatment Act (for provision to the Public Advocate)
- Notice of Discharge/Absconding Client under Severe Substance Dependent Treatment Act (for provision to the Office of the Public Advocate)
- Severe Substance Dependence Treatment Act 2010 Section 24 Nominated Person (including checklist)
- Notice of Discharge (to the Magistrates' Court of Victoria.

[101] Mental Health, Drugs and Regions Division, Department of Health. Your rights: detention and treatment orders. February 2011.

## 26. ATTACHMENT 10 – DEFICIENCIES IN THE PRESCRIBED FORM IN SCHEDULE 2

The prescribed form in Schedule 2 of the Regulations prompts the PRMP to specify for each of the criteria in s 8(2), the facts on which their opinion is based. The form contains a prompt for the criterion in s 8(2)(d) (regarding no less restrictive means), to distinguish between facts personally observed and facts communicated to them by another person. However, this prompt should also have been inserted for each of the criteria, as that is what s 12 requires. For the criterion in s 8(2)(a) the prompt to specify the facts on which the opinion is based is only inserted for the aspect of the person being incapable of making decisions. It should be extended to consideration of whether the person has tolerance to the substance and shows withdrawal symptoms, being the other two parts of this criterion. Further, in relation to the distinction between facts personally observed and facts not personally observed, the form could more helpfully refer to the requirement in s 12 that if the practitioner relies on facts additional to his or her own observations he or she must have reasonable grounds for relying on those facts. There is again a useful prompt in the form to require the practitioner to state that they have consulted with the senior clinician at the centre who has advised that there are facilities and services available. However there is no reference to the other requirements of consultation in s 12(3).[102]

[102] The side-notes in the Department's recommendation form found on its website do not appear to rectify this.

## 27. ATTACHMENT 11 - *DRUG AND ALCOHOL TREATMENT ACT 2007* (NSW)

A model similar to the Mental Health Act is the NSW equivalent of the Act, the *Drug and Alcohol Treatment Act 2007* (NSW). The objects of this NSW Act are set out above. It has a similar definition of 'severe substance dependence'. Its starting point is a general restriction on involuntary detention in s 6, which provides that 'a person must not be detained in a treatment centre under this Act unless an accredited medical practitioner has issued a dependency certificate in relation to the person'.

Like the Mental Health Act , the decision to detain a person in the first instance is a clinical one, made by a medical practitioner. The person may be detained and treated initially under a certificate without the need to wait for a formal application to and order by, a court. The process is that a medical practitioner may request an accredited medical practitioner (an AMP) to assess a person for detention and treatment under the NSW Act. After assessing the person, the AMP may issue a 'dependency certificate' in a form set out in Schedule 2, stating the person may be detained for treatment under the NSW Act for the period stated in the certificate.[103]The criteria for the issue of that certificate are[104]

> (a) the person has a severe substance dependence, and
>
> (b) care, treatment or control of the person is necessary to protect the person from serious harm,and
>
> (c) the person is likely to benefit from treatment for his or her substance dependence but has refused treatment, and
>
> (d) no other appropriate and less restrictive means for dealing with the person are reasonably available.

The AMP may have regard to any serious harm that may occur to children in the care of the person or dependents of the person. Importantly, under s 9(5), if a dependency certificate is issued 'the person may be detained in accordance with the certificate for treatment under this Act'.[105] Therefore the certificate gives the authority to detain.

Whilst the criteria above are similar in some respects to those in the Act, a key difference is that there is not the 'immediacy and urgency' criterion found in s 8(2)(b) of the Act. Instead, there are two much simpler criteria - the 'serious harm' and 'benefit' criteria. These are arguably more consistent with the detention period being the longer period of 28 days (as opposed to 14) and for treatment being potentially broader than simply for medically assisted withdrawal (see discussion of 28 day period and 'treatment' below). If the AMP cannot access the person to conduct the assessment , a Magistrate or an authorised officer within the meaning of the *Criminal Procedure Act 1986* (NSW) may, by order, authorise the AMP to visit and assess the person to ascertain whether a dependency certificate should be issued in relation to them.[106] Another person (including a police officer) may be required to assist the AMP in conducting the assessment to accompany the AMP. Once the order is made, there are powers of entry. The criteria for making this order are slightly different from the criteria for

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[103] Section 9.

[104] Section 9.

[105] And the same applies if an order is made for assessment, following which a dependency certificate is issued: s 10(6).

[106] Section 10.

making the assessment order which leads to detention and treatment. This order may only be made if the Magistrate or officer is satisfied, by evidence on oath, that:

> (a) the person is likely to have a severe substance dependence, and
>
> (b) the person is likely to be in need of protection from serious harm or others are likely to be in need of protection from serious physical harm, and
>
> (c) because of physical inaccessibility, the person could not, but for the making of the order under this section, be assessed, and
>
> (d) the person is likely to benefit from the treatment.

Notably, whilst protection from serious harm to others is not a criterion of issuing an assessment order, it is a criterion of issuing an order for assessment. This may be because a person who submits to assessment without the need for an order is unlikely to be of serious harm to others, whereas if an order is required to assess, that may well be the case.

The maximum period for which a dependency certificate may be issued is 28 days, although this is subject to reduction or extension for up to three months, by the Magistrates Court on the review. [The extension for up to three months is on application by an AMP if satisfied that there is a drug and alcohol related acquired brain injury and additional time is needed to carry out treatment and plan the person's discharge.[107]]

There is provision for 'transport officers' to take dependent persons to or from a treatment centre, powers of search and apprehension, and for police assistance take dependent persons to and from a treatment centre.[108]

An AMP must, as soon as practicable after the certificate is issued, bring the person before a Magistrate for a review of the issuing of a certificate.[109] The review by the Magistrates Court here is compulsory and not dependent on someone deciding whether to apply. This contrasts with the Mental Health Act process, under which a person subject to a Temporary Treatment Order (made by an authorised psychiatrist) or a Treatment Order (made by the Mental Health Tribunal), may apply to the Mental Health Tribunal for the order to be revoked.[110] The Temporary Treatment Order under the Mental Health Act is the equivalent of the dependency certificate under the NSW Act in that each are made by a clinician and lead to detention and treatment in the first instance.

At the Magistrates Court hearing under the NSW Act, the Magistrate must consider relevant information in deciding whether a person meets the criteria in s 9, including consider the reports and recommendations of the AMP who has examined the person, any proposed further treatment for the person, the likelihood the treatment will be of benefit to them, the person's views, and any cultural factors relating to the person that may be relevant to the determination.[111] The Magistrates Court

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[107] Sections 35 and 36.

[108] Sections 20, 22, 23.

[109] Section 14.

[110] Section 60 *Mental Health Act 2014*.

[111] Section 34.

decision may be appealed to the Civil and Administrative Tribunal.[112] However, it is not known whether such an appeal has ever been made.

There are various human rights protections built into the NSW Act, for instance in relation to the information to be given to the dependent person and their carer, which broadly mirror the kinds of protections provided for in the Act. Whereas the Act provides for the Public Advocate to visit and have a role, the NSW Act provides for official visitors, whose role seems to be that of a general inspector and advocate for client issues in the system as a whole.

[112] Section 45.