

# Review of the Alcoholics and Drug-dependent Persons Act 1968

Discussion Paper



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Drug-dependent Persons Act 1968  
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## Foreword

The Victorian Department of Human Services manages programs that aim to promote and protect the health and wellbeing of all Victorians by reducing death, disease and social harm caused by the use and misuse of licit and illicit drugs. More than 26,000 clients are received each year into 102 alcohol and drug service agencies funded by the Victorian Government.

*The Alcoholics and Drug-dependent Persons Act 1968* (the Act) was introduced when alcohol and drug treatment was in its infancy in Victoria. As alcohol and drug treatment philosophy has matured, it is timely to reconsider the relevance and appropriateness of the Act in the Victorian context.

This discussion paper has been developed to generate debate on the appropriateness of the Act in the current alcohol and drug treatment environment. Responses from the discussion paper will inform the development of government policy.

I invite you to consider the questions posed by the discussion paper, or to raise issues on any aspect of the Act and its operation, and provide a submission to the Department of Human Services. I look forward to your views on the issues raised in this paper and thank you for your interest in this area.

A handwritten signature in black ink that reads "Peter Allen". The signature is written in a cursive, slightly slanted style.

Peter Allen  
Chief Drug Strategy Officer

## 1. About the review

### 1.1 Purpose of the paper

The Department of Human Services Victoria is conducting a review of the *Alcoholics and Drug-dependent Persons Act 1968* to ascertain its relevance in the current drug treatment climate.

The last three decades have seen significant developments in alcohol and drug treatment theory. The *Alcoholics and Drug-dependent Persons Act 1968* was developed with a treatment philosophy which presumed alcoholism and drug addiction to be illnesses that could be treated successfully by confinement of people for involuntary treatment. This premise is now at odds with current thinking, which recognises alcohol and drug dependence as a chronic and relapsing disorder, with successful treatment relying on individuals motivated to change their behaviour.

This discussion paper outlines the interaction of the *Alcoholics and Drug-dependent Persons Act 1968* with Victoria's drug treatment system and seeks submissions from interested parties on the relevance of the Act in the 21st century. This consultation process will inform the development of government policy before any new legislation is drafted. It should be noted that it may be recommended to repeal the Act rather than amend it.

**This paper does not constitute a government policy paper.**

Specific issues and questions are raised in this discussion paper. However, your comments need not be limited to the issues and questions outlined. The department welcomes any comments that people or organisations may have about any relevant matters to the *Alcoholics and Drug-dependent Persons Act 1968*.

### 1.2 Review process and timeline

The review of the *Alcoholics and Drug-dependent Persons Act 1968* is being overseen by a steering committee with membership from the Department of Human Services, Department of Justice and Victoria Police. Additional expert advice has been provided by Moreland Hall, a metropolitan based alcohol and drug treatment agency.

The review is being carried out by the Alcohol Policy Unit within the Drugs Policy and Services Branch, Department of Human Services. The Alcohol Policy Unit reports to the steering committee.

It is planned to put recommendations for the repeal or amendment of the *Alcoholics and Drug-dependent Persons Act* to the Victorian Parliament in 2006/2007.

The proposed timeline for the review is:

- Discussion paper released in August 2005
- Information sessions in the week commencing 29 August 2005
- Responses to discussion paper received by October 2005
- Final policy position by February 2006
- Alcoholics and Drug-dependent Persons Act repeal or amendment Bill to Parliament in 2006/2007

### 1.3 Relevant documents

If you intend to make a submission to the paper you may wish to obtain copies of the *Alcoholics and Drug-dependent Persons Act 1968* and the associated regulations.

This legislation is available from:  
Information Victoria  
356 Collins Street  
Melbourne VIC 3000  
Tel: 1300 366 356  
Website: [www.infovic.vic.gov.au](http://www.infovic.vic.gov.au)

The Victorian Parliament website also contains electronic versions of Victorian legislation. The legislation can be downloaded via the Victorian Legislative and Parliamentary documents homepage at: [www.dms.dpc.vic.gov.au](http://www.dms.dpc.vic.gov.au)

A literature review of outcomes in mandated treatment was undertaken by Turning Point Alcohol and Drug Centre in March 2004. This may provide additional information to inform submissions and can be downloaded at [www.health.vic.gov.au/drugs/alcohol](http://www.health.vic.gov.au/drugs/alcohol)

## 1.4 Further information

Further information on this review is available from:

Rochelle Shaw

Acting Manager, Alcohol Policy  
Alcohol, Tobacco and Koori Drug  
Policy Unit

Drugs Policy and Services Branch

Tel: (03) 9637 4008

Fax: (03) 9637 4744

Email: rochelle.shaw@dhs.vic.gov.au

Members of the Alcohol Policy Unit are also available to discuss issues pertaining to the review. Please contact Rochelle Shaw to arrange a meeting.

## 1.5 Copies of the discussion paper

Further copies of the discussion paper can be obtained from:

Ms Maria Perera

Administrative Assistant  
Alcohol, Tobacco and Koori Drug  
Policy Unit

Tel: (03) 9637 4837

The discussion paper can be found on the Department of Human Services website at [www.health.vic.gov.au/drugs/alcohol](http://www.health.vic.gov.au/drugs/alcohol)

## 1.6 Submissions

If you wish to comment on the matters raised in this paper, you can make a written submission. A template in Microsoft Word listing the questions from the discussion paper is available at [www.health.vic.gov.au/drugs/alcohol](http://www.health.vic.gov.au/drugs/alcohol).

Submissions should be forwarded to:

Ms Rochelle Shaw

Acting Manager  
Alcohol Policy Unit

Drugs Policy and Services Branch

Department of Human Services

GPO Box 1670N

Melbourne Vic 3000

Fax: (03) 9637 4744

Email: rochelle.shaw@dhs.vic.gov.au

**Submissions must be received by 5.00pm on 3 October 2005.**

### Please note:

Unless marked confidential, all correspondence and submissions will be regarded as public documents, and may be made available on the Department of Human Services website, or be accessed by members of the public on request.

Where a request for access is made outside the *Freedom of Information Act 1982* (Vic) (FOI Act) the department may decide to release information of a general de-identified nature. Notwithstanding any such marking, correspondence and submissions to the Department of Human Services may be the subject of a request for access under the FOI Act. The FOI Act includes certain exemptions and, providing your submission attracts an FOI exemption, it will not be released. Certain information on personal affairs, business information and confidential information will be exempt. In certain circumstances where information provided includes personal affairs or business information, you may be consulted with as to the release of information under the FOI process.

## 2. Background and policy context

### 2.1 The Alcoholics and Drug-dependent Persons Act

The *Alcoholics and Drug-dependent Persons Act 1968* (the Act) came into operation in 1975, the seven year delay due to the construction of drug treatment facilities. The Act governs the public provision of drug treatment services in Victoria and is a descendent of the *Inebriates Act 1872*.

The objectives of the Act are to:

- establish the legislative framework for the provision of public drug treatment services, by government or through arrangements with contractors
- monitor the provision of other drug treatment services
- authorise and regulate the detention of some alcoholics and drug-dependent persons for the purposes of assessment and treatment.

The premise underlying the reforms introduced in 1968 was a 19<sup>th</sup> century treatment philosophy that alcoholism and drug addiction were illnesses that could be treated successfully by confinement of people for voluntary or involuntary treatment. This premise is at odds with current thinking, which recognises alcohol and drug dependence as a chronic and relapsing disorder, with successful treatment relying on individuals motivated to change their behaviour.

The shortcomings of the Act have been recognised over the past two decades with the Act reviewed extensively in the late 1980s by an inter-departmental committee; however, amendments were not progressed.

Amendments were made to the Act in 1994 to create the shift in drug treatment to a purchaser-provider model. The amendments also facilitated the closure of the government's centralised drug treatment services, such as Pleasant View, which had been established by the 1968 Act. While the 1994 amendments added a new dimension to the Act, they did not address redundant provisions of the Act, nor its 19<sup>th</sup> century treatment philosophy.

More recent interest in the Act stems from recommendation 4.15 of the Drug Policy Expert Committee in 2000 proposing that the government undertake a review of the Act with a view to removing it from the statute books. This committee noted the difficulties in the operation of the Act, and that it reflected an attitude to drug treatment at odds with accepted contemporary responses<sup>1</sup>.

This discussion paper outlines the interaction of the *Alcoholics and Drug-dependent Persons Act 1968* with Victoria's drug treatment system and seeks submissions from interested parties on the relevance of the Act in the 21st century. This consultation process will inform the development of government policy and potential legislative amendments. Alternatively, the consultation process may also inform a recommendation that the legislation be repealed.

### 2.2 Equivalent legislation in other jurisdictions

In Australia, three other jurisdictions have similar legislation which provides for civil commitment of non offenders – New South Wales, Tasmania and the Northern Territory. The other jurisdictions do not have provisions for civil commitment of alcohol or drug dependent persons who are not offenders.

<sup>1</sup> Drug Policy Expert Committee Stage 2 Report. *Drugs: meeting the challenge*

Table 1. Summary of equivalent legislation in other Australian jurisdictions and New Zealand

Jurisdiction	Equivalent legislation	Details
Australian Capital Territory	No equivalent legislation	
New South Wales	<i>Inebriates Act 1912</i>	Judicial officer can commit an inebriate to a state institution for up to 12 months. Act is under review.
Northern Territory	<i>Liquor Act 2004</i>	Courts can order a prohibition order for persons who use liquor to excess to prohibit the sale or supply of liquor to that person. As part of the order, the court can order an assessment report and a specified program of treatment and rehabilitation.
Queensland	No equivalent legislation	
South Australia	No equivalent legislation	
Tasmania	<i>Alcohol and Drug Dependency Act 1968</i>	Judicial officer can commit a patient to a treatment centre for up to six months. Application for discharge can be made to the Alcohol and Drug Dependency Tribunal. Act is under review.
Western Australia	No equivalent legislation	
New Zealand	<i>Alcoholism and Drug Addiction Act 1966</i>	Judicial officer can commit a patient to treatment for three to six months, or up to two years. Act is under review.

## 2.3 Discussion paper framework

This discussion paper is separated into two sections. Section A discusses civil commitment of non offenders (s. 11 of the Act). If civil commitment powers are retained, it is considered that separate legislation is necessary because such powers are conceptually different from the matters covered by legislation with respect to the provision of health services. As such, Section A discusses the threshold question of retaining the Act.

Section B outlines major provisions of the Act, redundant provisions that may be removed, and provisions that are currently redundant but may be beneficial to redevelop if the Act is retained.

Questions are listed under each heading to assist interested parties to prepare submissions.

## 3. Section A

### 3.1 Civil commitment of non offenders – s. 11 of the Alcoholics and Drug-dependent Persons Act 1968

Section 11 applies to individuals who are ordered by a magistrate or judge to attend a drug treatment assessment centre following complaint and evidence that the individual is an alcoholic or drug-dependent person. The complaint can be made by certain family members, a business partner, police or welfare officer, and evidence is provided in the form of two signed statements by medical practitioners.

The court, if satisfied of the truth of the allegation, may commit the individual to an assessment centre for seven days, which may be extended for a further seven days at the option of the medical officer in charge of the centre. An individual committed to an assessment centre<sup>2</sup> who absconds may be arrested by police on warrant and returned to the centre.

Section 12 provides that once committed, a medical officer in charge, on the advice of two legally qualified medical practitioners, may commit the individual to a treatment centre for an indefinite period.

#### 3.1.1 Definition of civil commitment

Individuals ordered to attend assessment are ‘civilly committed’. Civil commitment refers to **non offenders**. Mandated treatment refers to **criminal offenders** who are required to attend treatment as part of sentencing or pre-hearing. The *Alcoholics and Drug-dependent Persons Act 1968* deals with civil commitment.

Appendix 1 outlines further information on drug treatment options for criminal offenders.

### 3.2 Audit of s. 11 and s. 12 orders in Victoria 1992 to 2004

An audit of s. 11 orders in Victoria between 1992 and 2004 found that an average of **11 individuals per year** are civilly committed under s. 11. The audit could not discern whether individuals were committed on multiple occasions.

Examination of a sample of 31 of these cases found that:

- 23 of the client group were using alcohol, with 15 using alcohol exclusively
- the mean age of all clients was 36 years, with ages ranging between 17 and 69 years
- 12 of the complaints made to the court seeking s. 11 orders were made by a concerned family member, such as a spouse or sibling; 10 were made by Victoria Police; 20 per cent were made by a welfare worker; and three were made by workers from the Acquired Brain Injury Service (ARBIAS).

An audit of s. 12 orders in Victoria between 1992 and 2004 found that no individuals were civilly committed under s. 12.

A breakdown of the numbers of s. 11 orders per year is provided at Appendix 2.

<sup>2</sup> The Act differentiates between assessment and treatment centres. In reality, there are no services currently receiving clients that provide assessment only services.

### 3.3 Case studies of clients committed to treatment

Initial discussions between the Alcohol Policy Unit and a number of drug treatment agencies have identified 31 s. 11 case studies. These cases represent individual case evidence about the operation of the Act. Two cases are outlined below, with further studies outlined in Appendix 3. The majority of these orders were for seven days of treatment.

#### Case 1:

Female client, aged 24, unemployed and single, committed to treatment under a s. 11 order taken out by her mother. General practitioner (GP) specified the client had ‘Increasingly disruptive and self abusive behaviour including one suicide attempt. Drug seeking behaviour. Inability to obtain genuine assistance whilst under the influence’. The client had been prescribed anti-depressant medication by her GP for the last year. Client was involved in alcohol and drug counselling at community health centre.

#### *Outcome of s. 11:*

Withdrawal progressed well in drug treatment facility. Residential rehabilitation was discussed as an adjunct to the withdrawal but was not followed through.

Client represented to facility 18 months later and was admitted to the Community Residential Drug Withdrawal Service but discharged herself the following day.

No further contact reported.

#### Case 2:

Male client, aged 64, married and on sickness benefits, committed to treatment under a s. 11 order taken out by his wife. Alcohol was the drug of concern.

#### *Outcome of s. 11:*

Client completed withdrawal program which was beneficial to his home life. Treating service believed it had long-term benefits for the client and that the client’s health and family relationships would have deteriorated without the order.

### 3.4 Evidence to support or reject compulsory treatment for non offenders

There is no available evidence to support or reject compulsory treatment for non offenders. The s. 11 and 12 provisions of the Act have never been evaluated, nor have equivalent provisions internationally or in Tasmania's *Alcohol and Drug Dependency Act 1968* and New South Wales' *Inebriates Act 1912*.

Anecdotal evidence collected from drug treatment services that have received s. 11 clients suggests there are potential benefits and costs for the individual, and for the individual's family and community, in civil commitment.

A literature review undertaken by Turning Point Alcohol and Drug Centre also found the following benefits and costs:

- The major benefit of civil commitment is the short term lifesaving intervention for some individuals who are unaware of the level of self harm they are involved in. Other benefits include client identification, the capacity to capture people at their highest risk and providing 'time out' for individuals from their circumstances in an appropriate treatment setting. A further benefit was the ability of individuals to acknowledge an alcohol or drug problem in an appropriate setting and understand available treatment options for the future<sup>3</sup>. The family of the individual may also benefit from respite from the individual for the period of their committal.
- The costs include the appropriateness of compulsory treatment and deprivation of liberty for individuals who have the right to engage in potentially destructive behaviour provided they do not harm others. There are significant limitations of compulsory treatment for individuals who are not motivated to change their behaviour. Evidence indicates that alcohol and drug treatment is most successful when the client is motivated

to change their behaviour. Another cost is the short term fix that is offered by a seven or 14 day order in a drug treatment facility when evidence recognises that treatment is a multi-faceted process that can last a lifetime for some patients. A further cost is short term treatment does little to identify long term environmental issues that predict a person's recovery in the real world<sup>4</sup>.

Drug treatment agencies have indicated concern about the capacity to detain individuals who are civilly committed and are at risk of absconding from the centre. Some agencies also outlined concerns about the inappropriate use of s. 11 in circumstances such as parents seeking court intervention for their teenage children who may be binge drinkers or social drinkers; older individuals referred by a family member seeking respite from the behaviour of the individual; and referrals that could have been managed as an outpatient rather than an inpatient withdrawal unit.

Other Victorian Acts that may also be relevant to some of this client group are summarised in Appendix 4.

<sup>3</sup> Swan, A. and Alberti S. (2004) *The Alcoholics and Drug-dependent Persons Act (ADDPA) 1968: A Review*, Turning Point Alcohol and Drug Centre, p. 32.

<sup>4</sup> Allen & Clarke (2003) *Review of the Alcoholism and Drug Addiction Act 1966*, commissioned by the Mental Health Directorate, New Zealand Ministry of Health.

## Questions

1. What is your view on civil commitment? Should it be retained or removed from the statute books? Please explain the reasons for your response.
2. Is dependence on alcohol or drugs a significant enough condition for society to intervene to remove an individual's liberty in order to legally enforce assessment, detoxification and treatment?
3. What criteria should be met for an individual to require compulsory treatment?
4. Is it appropriate for people to be compulsorily detained in the interests of their relatives? Please explain the reasons for your response.
5. Is it appropriate for people to be compulsorily detained if they pose a risk of harming others? Please explain the reasons for your response.
6. Is it appropriate for people to be compulsorily detained if they pose a risk to themselves? Please explain the reasons for your response.
7. Which parties should be able to request a compulsory treatment order? Under current legislation, this is restricted to a husband or wife of the person, a parent of the person, a partner in business, a brother, sister, son or daughter of full age, a member of the police force above the rank of senior constable, or by a welfare officer.
8. Should there be a minimum or maximum time for committal under compulsory treatment legislation? What do you believe is an appropriate time period and why?
9. What controls do there need to be to protect individuals who are civilly committed?
10. Should there be a minimum age for individuals subject to civil commitment? What should that age be?
11. Should compulsory treatment also apply to treatment in non institutional settings such as community programs or day programs?
12. Should a rewritten Act include an evaluation of the outcomes for committed individuals? In your view, what aspects of civil commitment need to be evaluated?
13. Do you believe the numbers of orders recorded by the Magistrates' Court under the Act are representative of this client population? If not, what do you believe are the reasons for the discrepancy?

## 3. 5 Additions to the legislation to complement civil commitment provisions

If it is recommended that a system of civil commitment be retained, other changes may be appropriate to complement this provision.

### 3.5.1 Appropriate person/body to commit an individual to alcohol or drug treatment involuntarily

There may be debate about the appropriateness of a magistrate or judge determining an individual's alcohol or drug dependence status. An alternative to this arrangement could be similar to the mental health model whereby an equivalent to a Chief Psychiatrist has the final decision in relation to civil committal. Similarly, the Victorian Civil and Administrative Tribunal makes orders for individuals with cognitive disability under the *Guardianship and Administration Act 1986*.

## Questions

14. Who is the appropriate person/body to commit an individual to drug treatment involuntarily?

### 3.5.2 Appropriate appeals provision

The Act in its current form does not allow individuals to appeal an order to treatment. It would seem essential for individuals to have a right to appeal if they wish to dispute the civil committal order. This appeal could be to the Magistrates' Court or to an alternative body such as the Victorian Civil and Administrative Tribunal or an equivalent of the Mental Health Review Board. With an average of 11 cases each year, it may be unnecessarily costly to establish a new mechanism for review. Further, a balance may need to be struck between the urgency of compulsory treatment for an individual and the time required for a robust appeal system.

#### Questions

15. Should an individual be entitled to appeal against the compulsory treatment order?
16. What appeal mechanisms do you support? Why?

### 3.5.3 Gazetting of institutions

Gazetting refers to the process of the Governor in Council<sup>5</sup> publishing, by notice in the Government Gazette, the appointment of gazetted assessment and treatment centres. Gazetted centres are required to detain civilly committed clients in treatment and have them forcibly returned by police if the client absconds.

The Governor in Council, by notice published in the Government Gazette, may amend or revoke an appointment.

Gazetting of assessment and treatment centres last occurred in the 29 June 1995 edition of the Victorian Government Gazette. This gazettal is out of date and none of the gazetted agencies within the drug treatment system have true custodial capacity such as 'locked' wards. The gazettal has not been updated due to the change in funding of drug treatment services in Victoria in the mid 1990s. The move from drug treatment services provided by government to services provided under contract by external providers complicated the gazetting of appropriate services. Subsequent calls for review of the Act have removed the urgency to update the gazettals.

If civil committal is retained, gazettal may be an appropriate manner in which to prescribe agencies to accept individuals detained under the Act. Retention of civil committal may also require an upgrade to prescribed drug treatment agencies to allow secure detention of individuals ordered to compulsory treatment.

#### Questions

17. Do you believe gazettal of drug treatment services by the Governor in Council is the best way to prescribe the services that are required to accept individuals for compulsory treatment?
18. What alternative options would you propose to prescribe the services that should accept individuals for compulsory treatment?

<sup>5</sup> Governor in Council is a meeting of the Governor of Victoria and representatives of Cabinet. The Government, through Cabinet, will recommend the institutions to be gazetted and, at a meeting of the Governor in Council, the council will generally consider and endorse the recommendations of Cabinet.

## 4. Section B

### 4.1. Major provisions

#### 4.1.1 Title of the Act

The existing title of the Act may not be considered appropriate in today's alcohol and drug treatment context. The inter-departmental committee in 1989 recommended that the title of the Act be changed to the Substance Abuse Act.

#### Question

19. Do you believe the Act should be renamed? If so, what is a more appropriate title and why?

#### 4.1.2 Definition of alcoholic and drug-dependent person

The Act defines an 'alcoholic' as a person who habitually uses intoxicating liquor to such an extent that he has lost the power of self-control with respect to the use of intoxicating liquor or to such an extent as to endanger the health safety or welfare of himself or other persons.

A 'drug-dependent person' is defined as a person who habitually uses drugs of addiction to such an extent that he has lost the power of self-control with respect to the use of drugs of addiction.

If the Act is rewritten, these definitions may play a pivotal role in determining the right of the state to order someone to a drug treatment service against their will. The definitions, in their current form, focus more on the presence or absence of 'self control' rather than on the current government policy to reduce harm associated with drug use.

A rewritten act may also rely on **criteria** for an individual to be admitted and detained in an approved drug treatment service. This is the case for the admission and detention of clients under the *Mental Health Act 1986*. Appendix 5 gives an outline of the criteria used by the *Mental Health Act 1986*.

#### Questions

20. Are the existing definitions appropriate in today's drug treatment settings? If not, what other elements would you recommend?

21. If you were to specify criteria for the admission of clients to compulsory treatment, what criteria would you recommend?

### 4.2 Redundant provisions of the Act

The Act has a number of redundant provisions that should be repealed if the Act is retained and rewritten. These provisions are outlined below.

#### 4.2.1 Assessment/treatment centres

As footnoted in Section A of this paper, the Act currently differentiates between assessment and treatment centres, however, in the current system there are no services receiving clients that provide assessment only services. If the Act is rewritten, it may be recommended that this distinction be removed.

#### 4.2.2 Committal to detention centres (s. 14)

Section 14 of the Act makes reference to a magistrate's ability to commit a person to a detention centre for six months to three years, rather than prison, if they are convicted of public drunkenness or an offence related to drug addiction more than three times in the preceding three months. In circumstances where a person was convicted of an indictable offence where drunkenness or drug addiction contributed, the magistrate can also take this path.

This provision is redundant as no centres were ever appointed as detention centres under the Act. If the Act is rewritten, it may be recommended that this section be removed.

It is believed that s. 14 should have been repealed when the *Sentencing Act 1991* was revised to include s. 13 of the *Alcoholics and Drug-dependent Persons Act*. Section 13 of the *Alcoholics and Drug-dependent Persons Act* (now repealed) used to enable magistrates to consider offering prisoners treatment programs for alcohol and drug addiction as part of their sentence.

### 4.3 Redundant provisions that may be retained in a rewritten Act

The Act also has provisions which are currently redundant but which may be appropriate if the Act is retained and rewritten. These are outlined below.

#### 4.3.1 Voluntary admission to a centre (ss. 9 and 10)

Sections 9 and 10 of the Act deal with voluntary admissions to either assessment or treatment centres. Section 9 enables a person to apply at an assessment centre for admission. If admitted, the person may be held there for up to two days after he/she makes a written application to the medical officer in charge to be released or, in the absence of an application, until such time as the medical officer in charge thinks he or she should be released.

Under s. 10, a person may voluntarily seek admission to an appointed or licensed residential centre but must undertake to stay in the centre and may be held there for a period of three months after his/her admission. While the admission is voluntary, the person appears to have no capacity to leave during the three-month period.

However, given the high rate of exit outlined in the case studies (Appendix 3), and given that the existing drug system is predicated on voluntary entry, these provisions may not be required.

#### Questions

22. If civil commitment is to be retained, should voluntary committal form part of this system?
23. What is the benefit of an individual voluntarily committing themselves into compulsory treatment?
24. What are the costs/dangers of an individual voluntarily committing themselves into compulsory treatment?
25. How do we ensure that persons voluntarily committing themselves are not 'queue jumping' normal processes in order to get a bed more quickly?
26. Is it appropriate to accept the consent of a guardian, in cases of individuals with cognitive disabilities, to commit an individual to voluntary committal?

#### 4.3.2 Official visitors (s. 8)

Under s. 8 of the Act, the Governor in Council may appoint fit and proper persons (not being employees in the public service or medical officers of the department) for a period of five years, to be official visitors to any treatment centre and may remove any person so appointed. Official visitors have the power to visit treatment centres as often as they wish, and at least once per month. They can inspect all parts of the centre and make any inquiries about a person or persons detained in the centre. No appointments, however, are currently in place, nor have any official visitors ever been appointed pursuant to the Act.

The Victorian *Mental Health Act 1986* provides for the appointment of community visitors by the Governor in Council. The role of the community visitor is, amongst other things, to inquire into the adequacy of assessment and treatment services for people with a mental disorder, the appropriateness of accommodation and recreation facilities, and to respond to any complaints by clients within these services.

The *Intellectually Disabled Persons Services Act 1986* also provides for the appointment of community visitors by the Governor in Council. These visitors have a similar role to community visitors under the *Mental Health Act 1986*.

#### Questions

27. Do you see any benefits in appointing official visitors to visit drug treatment facilities? Please explain these benefits.
28. To whom should official visitors report their findings if action is required to be taken against a drug treatment facility?
29. Should the official visitors have the ability to report on all drug treatment facilities, or just those facilities that accept civil committals? Why?

### 4.3.3 Inspector of Treatment Centres (s. 19)

The role of the Inspector of Treatment Centres is central in the administration of the current Act and attracts wide powers. The Act requires that the inspector be a legally qualified medical practitioner appointed by the Governor in Council. The Act authorises the inspector to enter any assessment or treatment centre appointed or licensed under the Act at any reasonable time, with or without assistance, to determine compliance with the Act's provisions, regardless of whether there has been a complaint. The inspector also has the power to investigate a complaint relating to a service which is not funded by the government.

In addition to powers of inspection, the inspector has a role in any procedures which may lead to the revocation of a licence. The inspector may order the discharge of a person detained at a treatment centre, or the further treatment and detention of a detained person who is going to be discharged.

The inspector has a supervisory role in the granting of trial leave and has the power to order the transfer of a person from one residential treatment centre to another or to a mental hospital.

The Act allows, but does not require, such appointments to be made. At present no appointments are in place for Inspector of Treatment Centres. This position has been vacant since 1986.

#### Questions

30. What benefits do you believe there are in appointing inspectors to inspect drug treatment facilities?
31. Do you believe the role of inspector should be restricted to medical professionals? Why?
32. To whom should inspectors report their findings if action is required to be taken against a drug treatment facility?
33. Do you think there is a role for both inspectors and official visitors? Which of these two positions do you believe would be more effective and why?

### 4.3.4 Special Magistrates (s. 15)

The Act makes provision for the appointment, by the Governor in Council<sup>6</sup>, of a stipendiary magistrate as a Special Magistrate (s. 15) to review the continued detention of any person resident in a treatment centre. This provision relates to s. 12 of the Act, which allows a person's order for civil commitment to be extended. It is noted in Appendix 2 that there have been no recorded s. 12 orders considered in the Magistrates' Court in the last 12 years.

Under the Act, any person who has been resident in a treatment centre for more than six months may, once per month, request the medical officer in charge of the treatment centre to send a certificate regarding their physical and mental state to a Special Magistrate. The medical officer must do this within 48 hours.

Upon receipt of these documents, the Special Magistrate must inquire into the question of the person's discharge immediately, and may order the discharge of that person after discussions with the Inspector of Treatment Centres. In conducting the inquiry, the Special Magistrate can visit the centre, examine any documents relating to that person, conduct interviews – either in person or through official visitors – and require the medical officer in charge to show cause why that person should not be discharged. In relation to a request from a resident of a treatment centre for release, the Act transfers the onus of proof to the treatment centre to show why the person should not be discharged. There is no record of any Special Magistrates being appointed under the Act.

The appointment of Special Magistrates may have been designed as a quasi appeals system. The discussion around an appropriate appeals process in section 3.5.2 may also cover this issue.

#### Questions

34. Do you believe a Special Magistrate or its equivalent could be beneficial in determining appeals of individuals compulsorily committed to drug treatment facilities? Please explain the reasons for your response.

<sup>6</sup> Governor in Council is a meeting of the Governor of Victoria and representatives of Cabinet. The Government, through Cabinet, will recommend the appointment and the Governor in Council meeting will generally consider and endorse the appointment.

### 4.3.5 Listing

All services whose primary purpose is the 'care, treatment or rehabilitation of alcoholics or drug-dependent persons' and are not funded by the Department of Human Services must apply for listing by the Secretary. Failure to apply attracts a penalty of not more than \$2000.

Applications for listing must contain:

- the aims of the service
- the premises or place where the service will be conducted
- the kind of care, treatment or rehabilitation that will be provided by the service.

Listing was introduced in 1981 to enable identification of organisations involved in the care or treatment of alcoholics and drug-dependent persons and to require those organisations to provide the (then) Health Commission with statistical information on the number and range of treatment services provided.

The requirement to be listed appears to serve no useful purpose as a mechanism for monitoring or controlling alcohol and drug services, as the department is required to 'list' all organisations or bodies that apply to be listed and there is no provision for removal of listed status at the instigation of the department. Indeed, it is considered that listed status may be exploited by agencies to convey an impression that the department somehow endorses the quality of their service. This is further complicated by the availability of funding from a variety of bodies, such as the Commonwealth Government, State Government or local council or the Alcohol Education and Rehabilitation Foundation, and the quality measures each funding body requires.

### Questions

35. Do you believe there is any benefit to requiring alcohol and drug services to be listed? Please explain these benefits.
36. Should listing be used as a control measure for the sector? How would you propose this work?
37. Do you consider that listing may assist the function of the official visitor or inspector roles outlined above? In what respect?

## Appendix 1 Drug treatment programs for criminal offenders

Stage	Service
Pre-arrest:	<ul style="list-style-type: none"> <li>• Cannabis Cautioning – ‘Cautious with Cannabis’ Education</li> <li>• Illicit Drug Diversion Cautioning</li> <li>• Rural Outreach Diversion Worker (under 25)</li> <li>• Collaboration, Care and Innovation (CCI) Program</li> </ul>
Point of arrest/bail:	<ul style="list-style-type: none"> <li>• Rural Outreach Diversion Worker (Under 25)</li> <li>• Custodial Health Alcohol &amp; Drug (CHAD) Nurses</li> <li>• CREDIT (Court Referral Evaluation and Drug Intervention Treatment) Bail Diversion</li> <li>• Criminal Justice Diversion Program</li> <li>• Salvation Army Chaplains</li> </ul>
Deferral of sentence:	<ul style="list-style-type: none"> <li>• Deferred Sentencing (17–25 years)</li> <li>• Children’s Court Clinic Drug Program</li> </ul>
Sentencing options: Non-custodial Part custodial	<ul style="list-style-type: none"> <li>• Bond with undertaking for drug education – FoCIS Program for first offenders only; illicit drugs other than cannabis</li> <li>• Community-based order (CBO)</li> <li>• Community-based orders with drug treatment conditions (ICO)</li> <li>• Drug Treatment Order (DTO)</li> <li>• Alcohol or drug driving conviction – Victorian Accredited Driver Education Programs – Drink Driver Program and Drug Driver Program</li> <li>• Mixed prison/community based sentence – Custody and Community Treatment Order (CCTO)</li> </ul>
Custodial	<ul style="list-style-type: none"> <li>• Adult prison sentence – range of in-prison education and treatment</li> <li>• Juvenile Justice drug treatment</li> </ul>
Post-prison:	<ul style="list-style-type: none"> <li>• Parole with drug treatment conditions (adult and juvenile)</li> <li>• Post-prison release services (adult and juvenile) – short-term intensive counselling and case management</li> </ul>

## Appendix 2 Total numbers of orders made in the Magistrates' Court\*

Year	Section 11 orders	Section 12 orders
1992	2	0
1993	3	0
1994	4	0
1995	6	0
1996	9	0
1997	14	0
1998	34 (+2 refused/struck out by Magistrate)	0
1999	20 (+3 refused/struck out by Magistrate)	0
2000	23 (+4 refused/struck out by Magistrate)	0
2001	9 (+2 refused/struck out by Magistrate)	0
2002	13 (+2 refused/struck out by Magistrate)	0
2003	5 (+2 refused/struck out by Magistrate)	0
2004	8	0
<b>TOTAL</b>	<b>150</b>	<b>0</b>

\*Reported by Courtlink, Magistrates Court, Department of Justice

## Appendix 3 Case studies for clients civilly committed under s. 11

\*Cases 1 and 2 are in the body of the discussion paper on page 9.

### Case 3

Male, aged 46, never married, on pension benefits under s. 11 order initiated by ARBIAS<sup>7</sup> worker. Extensive history of alcohol abuse and paranoid schizophrenia.

#### *Outcome of order:*

Client completed episode and referred back to ARBIAS. The client did not report for any additional treatment. The treating service reported that the order was considered beneficial in this case.

### Case 4

Male, age unknown, single, disabled pensioner under s. 11 order initiated by Victoria Police. Long-term chronic abuse of alcohol and heroin with numerous previous admissions to the drug treatment system. Order was made due to continuing arrests for public drunkenness, concerns held for client's personal health and safety as well as the safety of the community as a result of the client's threatening behaviours.

#### *Outcome of order:*

Client completed order. Service noted that the order was appropriately accommodated in their facility, though also noted no perceivable benefits.

### Case 5

Male, 23, single and unemployed, under s. 11 order initiated by his father. Heroin was drug of concern with the client agreeable to the order as motivated to withdraw from addiction.

#### *Outcome of order:*

Client absconded three times during stay in residential unit. Completed order and discharged on day 7.

### Case 6

Male, 19, single, unemployed, under s. 11 order initiated by a drug and alcohol worker. Heroin was drug of concern, and order due to concerns about client's safety and potential for harm within the community.

#### *Outcome of order:*

Client completed order but wanted to discharge himself on two occasions. Attended group sessions and involved himself in unit activities. Discharged himself on day 7.

### Case 7

Female, 69, widow, on pension, under s. 11 order initiated by a support worker. Drug of concern was heroin.

#### *Outcome of order:*

Client completed order. Client returned voluntarily, but then left against advice. Service was concerned about physical and mental health deterioration of client.

### Case 8

Female, 36, single, on disability pension, under s. 11 order initiated by welfare worker. Drug of concern was alcohol.

#### *Outcome of order:*

Service reported they felt the order was appropriately accommodated in their facility. The program was completed with no further follow up. The service noted that, in the absence of the order, the client's general health would have deteriorated.

### Case 9

Female, 20, defacto relationship, unemployed, under s. 11 order initiated by mental health service. Drug of concern was alcohol, and poly-drug use.

#### *Outcome of order:*

The service noted that the client completed the program and had two additional admissions, with referrals and support link up. In the absence of the order, service noted that the physical and mental health of the client would have deteriorated further.

### Case 10

Male, 17, single, unemployed, under a s. 11 order initiated by his father. Drug of concern was opiates and poly-drug use.

#### *Outcome of order:*

The service noted that the client completed the program and had outpatient follow-up.

<sup>7</sup> Acquired Brain Injury Service

**Case 11**

Male, 22, single, on pension, uncertain who initiated s. 11 order. Drug of concern was alcohol and benzodiazepines.

*Outcome of order:*

The service noted the client was unable to stop drinking and left the service without completing the order. No benefits recorded of order.

**Case 12**

Female, 29, married, home duties, under a s. 11 order initiated by her husband. Drug of concern was alcohol.

*Outcome of order:*

Service noted minimal withdrawal symptoms whilst in unit with the client feeling positive and grateful for facing alcohol issue. Discharged on day 7 and on waiting list for residential rehabilitation.

**Case 13**

Female, 44, defacto, employed, under a s. 11 order initiated by her partner. Drug of concern was alcohol.

*Outcome of order:*

Service noted client attended all aspects of program, and discharged on day 7. Staff concerned for client upon discharge as partner moving interstate. No record of further contact.

**Case 14**

Female, 43, married, home duties, under a s. 11 order initiated by her husband. Drug of concern was alcohol.

*Outcome of order:*

Service noted client as vague and medication seeking. Refused referral to ARBIAS for psychiatric assessment as husband concerned about brain damage due to drinking. Discharged on day 7.

**Case 15**

Female, 48, married, pensioner, under a s. 11 order on two separate occasions initiated by her husband. Drugs of concern were alcohol and cannabis.

*Outcome of order:*

Service noted client dealt with many issues during initial residential stay. Client undertook discharge planning with staff and was discharged on day 11. Client relapsed after eight months of sobriety and was the subject of the second order. Discharged on day seven to supported accommodation.

**Case 16**

Female, 44, marital and employment status unknown, uncertain who initiated s. 11 order.

*Outcome of order:*

Service noted order not completed with client absconding on day 4.

**Case 17**

Female, 49, separated, unemployed, under s. 11 order initiated by husband (separated). Drug of concern was alcohol and benzodiazepines.

*Outcome of order:*

Service noted client completed withdrawal. Accommodation arrangements being made for client on discharge but client left prior to arrangements being finalised.

No further contact.

**Case 18**

Male, 20, single, unemployed, under s. 11 order initiated by his sister. Drugs of concern were heroin and cannabis. Previous s. 11 order also recorded.

*Outcome of order:*

Service noted family took out s. 11 to bypass waiting list. Client difficult to contain, leaving service repeatedly. Returned by mother and completed order. Service noted client's behaviour as demanding, aggressive and drug seeking. No further contact.

**Case 19**

Male, 26, single, unemployed, unclear who initiated s. 11 order. Drug of concern was alcohol. Indigenous client.

*Outcome of order:*

Service noted client completed order with an uneventful withdrawal. Support provided by a Koori Drug and Alcohol Resource Service. No further contact.

**Case 20**

Male, 25, single, unemployed, under s. 11 order initiated by his mother. Drug of concern was poly-drug use.

*Outcome of order:*

Service noted some past interaction with drug treatment with counselling and outpatient detoxification. Client absconded on day 2. No record of service contacting police. Service noted order to be inadequate in this instance.

**Case 21**

Female, 50, divorced, unemployed, unclear who initiated s. 11 order. Drug of concern was alcohol.

*Outcome of order:*

Service noted client completed program. Service considered program improved health of client.

**Case 22**

Male, 39, divorced, unemployed, under s. 11 order initiated through Victoria Police. The drugs of concern were alcohol, cannabis, poly-drug use.

*Outcome of order:*

The service noted that the client had a history of voluntary admissions to the inpatient withdrawal unit for alcohol detoxification, as well as two outpatient withdrawal admissions. The client had also been received twice as an involuntary inpatient in an acute mental health service.

The service noted that the lack of a locked facility meant they relied heavily on the police to return the client when he absconded on multiple occasions.

The service believed that the order was beneficial in allowing the client to receive acute care for multiple health problems in a safe environment. Once sober, the client asked for referral to a residential rehabilitation program. The service believed that, in the absence of the order, the client would have died within a few days or weeks.

**Case 23**

Male, 48, single, pensioner, under s. 11 order initiated by ARBIAS case manager. Drug of concern was alcohol.

*Outcome of order:*

The service noted that the client had past treatment at Pleasant View in the late 1980s and several admissions to a hospital emergency department.

The client completed withdrawal and the service believed the order to be beneficial due to the health benefits to the client. The service noted that, in the absence of the order, the client's health would have seriously deteriorated.

**Case 24**

Male, 29, married, employed, under s. 11 order initiated by Victoria Police. The drug of concern was alcohol and poly-drug use.

*Outcome of order:*

The service noted that the client completed the program which minimised the risk of self harm in the short term.

**Case 25**

Female, 31, single, pensioner, under s. 11 order initiated by mental health service. The drug of concern was alcohol.

*Outcome of order:*

The service noted that the client completed the program which minimised risk of self harm in the short term.

**Case 26**

Male, 39, separated, unemployed, under s. 11 order initiated by Victoria Police and drug treatment service. Drug of concern was alcohol. One previous s. 11 recorded.

*Outcome of order:*

The service noted that the client had serious health problems and had a four-week period of crisis interventions involving the police, the hospital emergency department and the drug treatment service crisis intervention. Long history of interaction with drug treatment services including multiple voluntary presentations at residential rehabilitation, and drug and alcohol supported accommodation without resulting behaviour change.

During the order, due to the client's behaviour, the service had to close the withdrawal unit for all other clients. The service gained a referral to a residential rehabilitation facility but the client discharged himself. Last recorded movement of the client reported his being in a diabetic coma at hospital.

The service felt the use of s. 11 was appropriate as an intervention was necessary to reduce harm to self and the impact that was being felt by the police and health services. However, the service reported that the intervention was beneficial for the short term but failed in the long term.

**Case 27**

Male, 34, separated, unemployed, under s. 11 order initiated by Victoria Police. Drug of concern was alcohol.

*Outcome of order:*

Service noted that the client had a history of drunk and disorderly charges and presentations to the hospital emergency department for intoxication. Client had multiple voluntary episodes of care for voluntary alcohol withdrawal.

The service noted the order was appropriate as the client was at risk of death in the short term from his alcohol consumption. The client disengaged at the end of the order and recommenced problematic drinking which resulted in his death.

**Case 28**

Male, 32, single, student, under s. 11 order initiated by Victoria Police. Drug of concern was alcohol.

*Outcome of order:*

Service noted that client had multiple presentations to the hospital emergency department. The client had numerous interactions with withdrawal programs within drug treatment services. No record of whether client completed order and whether any benefits resulted.

**Case 29**

Male, 31, separated, pensioner, under s. 11 order initiated by Victoria Police. Drug of concern was alcohol and benzodiazepines.

*Outcome of order:*

Service noted the client completed program, resulting in improved relationship with family.

**Case 30**

Female, 53, widow, employed, unclear who initiated s. 11. Drug of concern was alcohol.

*Outcome of order:*

The service noted that the client completed the program, and attended rehabilitation.

**Case 31**

Female, 19, single, unemployed, under s. 11 order initiated by Victoria Police. Drug of concern was inhalants.

*Outcome of order:*

Service noted client required special security during her entire admission due to behavioural problems and to deter her from absconding. Client did not participate in ward activities and refused most medical and psychiatric investigations. Client discharged on day seven.

## Appendix 4 Other Acts that may involve the client population of the Alcoholics and Drug-dependent Persons Act 1968

Victoria's *Mental Health Act 1986*, *Guardianship and Administration Act 1986* and the *Human Services (Complex Clients) Act 2003* may also be of interest in preparation of a submission.

### Mental Health Act

The *Mental Health Act 1986* outlines a process for making Involuntary Treatment Orders (ITO). This is a brief overview of the actions taken to initiate involuntary treatment of a person under this Act. Further information is available at [www.mhrb.vic.gov.au](http://www.mhrb.vic.gov.au)

For a person to receive involuntary treatment under an ITO, two documents are usually completed first:

- *Request for person to receive involuntary treatment from an approved mental health service.* This document can be completed by any person over the age of 18.
- *Recommendation for person to receive involuntary treatment from an approved mental health service.* This document can only be signed by a medical practitioner who expresses the opinion that the person meets the following five admission criteria:

1. the person appears to be mentally ill

#### and

2. the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order

#### and

3. because of the person's mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public

#### and

4. the person has refused or is unable to consent to the necessary treatment for the mental illness

#### and

5. the person cannot receive adequate treatment for the mental illness in a manner less restrictive of the person's freedom of decision and action.

The ITO is then made by either a medical practitioner or mental health practitioner. The making of this order is then reviewed by an Authorised Psychiatrist who examines the person to ensure the criteria for involuntary treatment are met. This examination must occur within 24 hours and results in either discharge of the patient or confirmation of the status if the psychiatrist considers they satisfy the five criteria outlined above.

Involuntary treatment can be provided in a mental health service on an inpatient basis or in the community on a Community Treatment Order.

The patient has the ability to appeal to the Mental Health Review Board at any time against their involuntary patient status.

The Mental Health Review Board also automatically reviews the status of involuntary patients within eight weeks of the initial placement on an ITO.

### The Guardianship and Administration Act

*The Guardianship and Administration Act 1986* allows the Victorian Civil and Administrative Tribunal to appoint a guardian to make personal and lifestyle decisions for an adult with a disability. The Act defines disability as intellectual impairment, mental disorder, brain injury or physical injury. The decisions guardians may take may include medical treatment, accommodation, employment and access to services.

Any person may apply to the Victorian Civil and Administrative Tribunal for an order appointing a guardian for a person over 18 years with a disability. The guardian then has the decision making authority which a parent would have in relation to a child. In making decisions, a guardian must act in the best interests of the represented person. A guardian cannot require that an agency provides a particular service or treatment but can consent to a treatment or service as if they were that person. While additional enforcement powers may be added to a guardianship order to ensure the person complies with the decision of the guardian, there are significant practical limits to the efficacy of these enforcement provisions.

After an order of guardianship has been made, the represented person or a person entitled to notice of the order may apply for a rehearing of the application. The Victorian Civil and Administrative Tribunal may then decide to affirm the order, vary the order or set aside the order.

The Victorian Civil and Administrative Tribunal must also conduct a reassessment of a guardianship order within 12 months after making the order and at least once every three years.

### The Human Services (Complex Needs) Act

*The Human Services (Complex Needs) Act 2003* establishes powers for a new approach to planning service delivery for some of Victoria's most vulnerable community members. This service response targets individuals 16 years and over with multiple and complex needs. It is centred on a time limited specialist intervention that aims to stabilise housing, health, social connection and safety issues; pursue planned and consistent therapeutic goals for each individual; and provide a platform for long-term engagement in the service system.

The eligibility criteria for the Multiple and Complex Needs Initiative is stringent. An eligible person is a person who:

- has attained 16 years of age

**and**

- appears to satisfy two or more of the following criteria:
  - i. has a mental disorder within the meaning of the *Mental Health Act 1986*
  - ii. has an acquired brain injury
  - iii. has an intellectual impairment
  - iv. is an alcoholic or drug dependent person within the meaning of the *Alcoholics and Drug-dependent Persons Act 1968*

**and**

- has exhibited violent and dangerous behaviour that has caused serious harm to themselves or some other person or is exhibiting behaviour which is reasonably likely to place himself or herself or some other person at risk of serious harm

**and**

- is in need of intensive supervision and support and would derive benefit from receiving coordinated services in accordance with a care plan under this Act that may include welfare services, health services, mental health services, disability services, drug and alcohol treatment services or housing and support services.

A referral to the Multiple and Complex Needs Initiative may come from any source, including existing service providers working with the individuals, self referrals, family members or significant others.

Referrals are made through a Department of Human Services Regional Coordinator. There is one Regional Coordinator based in each region of the Department of Human Services. If a referral appears to meet the eligibility criteria and the region is satisfied that all relevant support options have been explored, are insufficient or cannot be agreed, the individual subject to the referral will be notified about the region's intent to refer them to the Multiple and Complex Needs Panel. If the individual does not refuse to be referred to the panel, the relevant regional director will endorse the referral and forward it to the panel.

The Multiple and Complex Needs Panel is a statutory body established under the *Human Services (Complex Needs) Act 2003*. This panel is responsible for determining eligibility of the individual for a Multiple and Complex Needs service response; authorising a referral to the specialist multidisciplinary service to undertake a comprehensive individual assessment and the development of a draft Care Plan; considering the recommendations made in a draft Care Plan prepared by the multidisciplinary assessment service; determining a Care Plan; appointing a Care Plan coordinator; allocating brokerage funds where appropriate; and reviewing Care Plans as required.

The Care Plan outlines:

- the areas of the individual’s life which have been identified as a priority
- priority goals for the individual
- strategies to engage the individual
- services and supports and their roles and responsibilities
- a crisis intervention plan specific to the individual
- when and how the Care Plan will be monitored and reviewed
- the Care Plan coordinator.

*The Human Services (Complex Needs) Act 2003* is voluntary and makes no provision for the compulsion of individuals to participate in a service response. For example, while the Multidisciplinary Assessment Service may negotiate a draft Care Plan that includes the provision of detoxification services for an alcoholic or drug dependent person, the Act, in itself, cannot require the individual to comply with the Care Plan.

## Appendix 5 Excerpt from the Mental Health Act 1986

### 8. Criteria for involuntary treatment

(1) The criteria for involuntary treatment of a person under this Act are that-

- a) the person appears to be mentally ill; and
- b) the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order; and
- c) because of the person's mental illness, involuntary treatment of the person is necessary for his or her health and safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and
- d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and
- e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.

Note: In considering whether a person has refused or is unable to consent to treatment, see section 3A.

(1A) Subject to sub-section (2), a person is mentally ill if he or she has a mental

illness, being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.

(2) A person is not to be considered to be mentally ill by reason only of any one or more of the following –

- a) that the person expresses or refuses or fails to express a particular political opinion or belief;
- b) that the person expresses or refuses or fails to express a particular religious opinion or belief;
- c) that the person expresses or refuses or fails to express a particular philosophy;
- d) that the person expresses or refuses or fails to express a particular sexual preference or sexual orientation;
- e) that the person expresses or refuses or fails to express a particular political activity;
- f) that a person engages in or refuses or fails to engage in a particular religious activity;
- g) that a person engages in sexual promiscuity;
- h) that a person engages in immoral conduct;
- i) that a person engages in illegal conduct;

- j) that the person is intellectually disabled;
- k) that the person takes drugs or alcohol;
- l) that the person has an antisocial personality;
- m) that the person has a particular economic or social status or is a member of a particular cultural or racial group.

3) subsection 2 k does not prevent the serious temporary or permanent physiological, biochemical or psychological effects of drug or alcohol taking from being regarded as an indication that a person is mentally ill.

## Appendix 6 List of issues for comment

### Questions

#### Section A

1. What is your view on civil commitment? Should it be retained or removed from the statute books? Please explain the reasons for your response.
2. Is dependence on alcohol or drugs a significant enough condition for society to intervene to remove an individual's liberty in order to legally enforce assessment, detoxification and treatment?
3. What criteria should be met for an individual to require compulsory treatment?
4. Is it appropriate for people to be compulsorily detained in the interests of their relatives? Please explain the reasons for your response.
5. Is it appropriate for people to be compulsorily detained if they pose a risk of harming others? Please explain the reasons for your response.
6. Is it appropriate for people to be compulsorily detained if they pose a risk to themselves? Please explain the reasons for your response.
7. Which parties should be able to request a compulsory treatment order? Under current legislation, this is restricted to a husband or wife of the person, a parent of the person, a partner in business, a brother, sister, son or daughter of full age, a member of the police force above the rank of senior constable, or by a welfare officer.

8. Should there be a minimum or maximum time for committal under compulsory treatment legislation? What do you believe is an appropriate time period and why?
9. What controls do there need to be to protect individuals who are civilly committed?
10. Should there be a minimum age for individuals subject to civil commitment? What should that age be?
11. Should compulsory treatment also apply to treatment in non institutional settings such as community programs or day programs?
12. Should a rewritten Act include an evaluation of the outcomes for committed individuals? In your view, what aspects of civil commitment need to be evaluated?
13. Do you believe the numbers of orders recorded by the Magistrates' Court under the Act are representative of this client population? If not, what do you believe are the reasons for the discrepancy?

#### Section B

14. Who is the appropriate person/body to commit an individual to drug treatment involuntarily?
15. Should an individual be entitled to appeal against the compulsory treatment order?
16. What appeal mechanisms do you support? Why?
17. Do you believe gazettal of drug treatment services by the Governor in Council is the best way to prescribe the services that are required to accept individuals for compulsory treatment?
18. What alternative options would you propose to prescribe the services that should accept individuals for compulsory treatment?
19. Do you believe the Act should be renamed? If so, what is a more appropriate title and why?
20. Are the existing definitions appropriate in today's drug treatment settings? If not, what other elements would you recommend?
21. If you were to specify criteria for the admission of clients to compulsory treatment, what criteria would you recommend?
22. If civil commitment is to be retained, should voluntary committal form part of this system?
23. What is the benefit of an individual voluntarily committing themselves into compulsory treatment?

24. What are the costs/dangers of an individual voluntarily committing themselves into compulsory treatment? compulsorily committed to drug treatment facilities? Please explain the reasons for your response.
25. How do we ensure that persons voluntarily committing themselves are not 'queue jumping' normal processes in order to get a bed more quickly? 35. Do you believe there is any benefit to requiring alcohol and drug services to be listed? Please explain these benefits.
26. Is it appropriate to accept the consent of a guardian, in cases of individuals with cognitive disabilities, to commit an individual to voluntary committal? 36. Should listing be used as a control measure for the sector? How would you propose this work?
27. Do you see any benefits in appointing official visitors to visit drug treatment facilities? Please explain these benefits. 37. Do you consider that listing may assist the function of the official visitor or inspector roles outlined above? In what respect?
28. To whom should official visitors report their findings if action is required to be taken against a drug treatment facility?
29. Should the official visitors have the ability to report on all drug treatment facilities, or just those facilities that accept civil committals? Why?
30. What benefits do you believe there are in appointing Inspectors to inspect drug treatment facilities?
31. Do you believe the role of Inspector should be restricted to medical professionals? Why?
32. To whom should Inspectors report their findings if action is required to be taken against a drug treatment facility?
33. Do you think there is a role for both Inspectors and official visitors? Which of these two positions do you believe would be more effective and why?
34. Do you believe a Special Magistrate or its equivalent could be beneficial in the determining appeals of individuals







