The Alcoholics and Drug-dependent Persons Act (ADDPA) 1968: A Review

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Prepared by

Amy Swan
Silvia Alberti

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- Daniel Harvey, Policy Officer, Alcohol, Tobacco and Koori Drug Policy Unit, Department of Human Services, Victoria
- Sharyn Amos, A&D ABI Clinician Consultant, Western Region Alcohol and Drug Centre (WRAD)
- Roger Brough, Director, Drug and Alcohol Services, South West Healthcare
- Anna Wlazlow, A&D Counsellor, and Rebecca Lorrains, Rural Outreach Diversion Worker, Goulburn Valley Community Health Service
- Karren Chappell, Forensic Services A&D Clinician, Turning Point Alcohol and Drug Centre
- Mike McDonough, Medical Director, DASWEST
- Jackie Shaw, Clinical Withdrawal Services Manager, DePaul House
- Kate Owen, Associate Unit Manager, South West Healthcare
- Secretariat for the Standing Committee on Social Issues Legislative Council, NSW Parliament
- Representative of the NSW Attorney General's Department
- Lisa Farrell, Melbourne Magistrates' Court
- Jillian Crowe, Heidelberg Magistrates' Court
- Representative from Melbourne Magistrates' Court
- Julian MacLeod, Senior Deputy Registrar, Melbourne Magistrates' Court
- Sharyn Newman, Legislative Review Officer, Department of Health and Human Services, Tasmania
- Kevin Lambkin, Director, Corporate Alcohol, Tobacco and Other Drug Services, Queensland Health

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A C R O N Y M S

A&D	Alcohol and drug
ABI	Alcohol-Related Brain Injury
ADDPA	*Alcoholics and Drug-dependent Persons Act 1968*
ADIS	Alcohol and Drug Information System
BBV	Blood Borne Virus
CAP	California Civil Addict Program
COATS	Community Offenders Advice and Treatment Services
DARP	Drug and Alcohol Research Program
DHS	Department of Human Services
DPEC	Drug Policy Expert Committee
DPSB	Drugs Policy and Services Branch
HBV	Hepatitis B
HCV	Hepatitis C
IAG	Implementation Advisory Group, Victoria
IDC	Inter-Departmental Committee, Victoria
NARA	*Narcotic Addiction Rehabilitation Act 1966*
NACC	Narcotic Addiction Control Commission
TASC	Treatment Alternatives to Street Crime
TOPS	Treatment Outcome Prospective Study

1 INTRODUCTION

In December 2003, Turning Point Alcohol and Drug Centre[1] was commissioned by the Alcohol, Tobacco and Koori Drug Policy Unit of the Department of Human Services to undertake a project regarding the *Alcoholics and Drug-dependent Persons Act (ADDPA) 1968.*[2] The project entailed a review of literature pertaining to compulsory treatment outcomes of people (non-offenders) with severe alcohol and drug (A&D) issues. This literature review builds on existing work developed over the years, with a view to providing information about the current state of literature in the field. Consultation with stakeholders of the *ADDPA* were also undertaken to provide feedback on the practical application of the Act.

The current report presents information obtained about the *ADDPA* and compulsory treatment outcomes. It is structured into the following sections: Introduction, Methodology, Literature Review, Civil Commitment in Victoria, Discussion, and Conclusion.

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[1] Hereafter referred to as Turning Point.
[2] Hereafter referred to as the *ADDPA*.

2 METHODOLOGY

2.1 Project design

This project was conceptualised as a literature review of civil commitment legislation and practices in Australia and overseas. A comprehensive search of Australian and overseas literature was undertaken, entailing Library CD Rom and internet searches. There was, however, a dearth of literature pertaining to civil commitment for people with serious alcohol and drug (A&D) problems. Thus, the search was expanded to seek relevant information from a range of fields, inclusive of :

- Voluntary A&D treatment
- Involuntary A&D treatment
- Mandated A&D treatment

Given the limited published literature specific to civil commitment, consultation with a number of stakeholders was also undertaken to supplement the findings of the literature review. Stakeholder interviews provide an opportunity to access information which speaks directly to an intervention and its implementation. As Patton (1990) notes, a stakeholder's close association with an intervention can often provide information which is meaningful and knowledgeable.

Semi-structured interviews were conducted with N=16 stakeholders for this review. Stakeholders included treatment staff and management from agencies that had admitted a section 11 client since mid-2002 (n=8), representatives of the judiciary[3] (n=4), and legislators and policy-makers from several Australian states (n=5). The majority of interviews were conducted by telephone. Interviews focussed on the stakeholder's experience of the *ADDPA*, including management of the order, client outcomes, potential benefits and challenges of the Act. Probes were used when necessary to ensure that fundamental queries were answered and sufficient detail provided. Due to the flexible nature of the interviews, participants had the opportunity to discuss pertinent issues not already raised during the interview. This facilitated a systematic yet flexible approach toward data collection.

The combined approach of a literature review and stakeholder consultation increased the robustness of findings.

2.1.1 ETHICAL CONSIDERATIONS

The inclusion of feedback from stakeholders in this review gives voice to those with experience of the Act. All participants were advised of the confidentiality of information provided, within the legal requirements of the law. All participants signed a consent form to this effect and received a plain language statement.[4]

[3] All Victorian Magistrates were invited to participate in the project.
[4] A plain language statement outlines the project, staffing, timelines and participant role in the project.

3 LITERATURE REVIEW

3.1 Civil commitment

The concept of civil commitment was founded on the 1960s notion that some drug users are motivated for treatment, while others are not. Those who are not motivated for treatment require some lever to facilitate treatment entry. This lever is often referred to as 'rational authority' and entails a mandatory, but not punitive, requirement to attend treatment (Inciardi, 1988). Civil commitment aims to force treatment commencement among involuntary clients and provide an opportunity for therapeutic benefits to take effect (Fagan, 1999, p.250).

Laws relating to civil commitment to treatment have been established in response to a range of particular conditions. Such conditions include 'mental illness, developmental disabilities, sexual and violent offences, some dually diagnosed conditions and A&D use and dependence' (Fagan, 1999, p.250).

3.1.1 DEFINITIONS

A review of the international literature reveals that a range of terminology is used to refer to the involuntary commitment of non-offenders to treatment. Within an A&D context, involuntary commitment is variously referred to as civil commitment, compulsory treatment, coercive treatment, involuntary treatment, and court-ordered treatment. Furthermore, each of these terms may have a different meaning or application. For example, the terms compulsory treatment and civil commitment, as used in a number of U.S. programs and subsequent research publications, are generally used interchangeably and pertain to both offenders and non-offenders, voluntary and involuntary clients.

Leukefeld and Tims (1990) endeavoured to clarify the debate by distinguishing between compulsory treatment and civil commitment. They noted that civil commitment was just one type of compulsory treatment. They recommended that the term 'compulsory treatment' be used, given its reference to a wider range of interventions and use across both offender and non-offender populations. Gostin (1993) restricted the term civil commitment to interventions with non-offenders, where no criminal charge is laid. Committing a 'person already charged with, or convicted of, an offence from indictment, trial or sentencing' to A&D treatment was defined as diversion (p.259).

In Australia and New Zealand, the term civil commitment typically refers to non-offenders, involuntarily committed to treatment. For the purposes of the following discussion, a clear distinction is made between offenders and non-offenders involuntarily committed to treatment. *Civil commitment* refers to non-offenders, involuntarily placed into treatment due to risk of harm to themselves or others, while *mandated treatment* refers to offenders required to attend treatment due to a criminal court or police sanction or status. *Compulsory treatment* pertains to the commitment of both non-offenders and offenders.

3.2 International legislation and practice

The legislative status of A&D dependence varies from country to country. In Australia, although the possession and use of illicit substances, and public drunkenness, are criminal offences, A&D dependence itself is not a crime, nor is it subject to criminal justice system intervention unless associated with an offence. Similarly, in the U.S., A&D-dependent persons are not viewed as offenders, although criminal conduct such as the possession and sale of illicit substances can be prosecuted (Fagan, 1999).

Brown's (1988) review of international A&D legislation reported differences in the legislative basis of compulsory treatment (inclusive of offenders and non-offenders). Some countries worked within mental health legislation and required evidence of 'psychiatric impairment involving threat to others; and/or threat to self; and/or inability to care for oneself' (p.194). Of 43 countries surveyed, 27 legislated for compulsory treatment. Fifteen of these countries provided for compulsory treatment under specific A&D legislation. Under these legislative bases, commitment was dependent on an identified addiction, potential harm to others and the need for treatment. Initiation of compulsory treatment applications could be tendered by one or more of the following parties:

- Family or community members,
- Public or private health care providers,
- Social services organisations,
- Law enforcement or government authorities, and
- The addicted person themselves (Porter, Arif, & Curran, 1986).

In most countries, compulsory treatment applications were accompanied by a medical examination of the individual in question. Applications were typically reviewed by one of three bodies:

- Courts (some countries provide defence counsel for the subject of an order),
- Government agencies (existing or specifically created) with jurisdictional powers, or
- Medical agencies.

The inclusion of treatment details in legislation varied from country to country. Some legislation directed subjects to unspecified rehabilitative treatment, while others listed the range of treatment types available. Some statutes provided details of treatment activities, philosophies and aftercare programs (Porter et al., 1986).

The period of intervention under compulsory treatment legislation varied widely across countries. Length of treatment stay ranged from seven days (Victoria, Australia) to six months (Malaysia, Thailand, Singapore), one year (Finland, Germany), two years (Hungary), three years (Switzerland) and ten years (Russia). Additional periods of commitment could also extend these stays for an additional seven days in Australia, six months in Singapore and one year in Russia. Periodic reviews of an individual's progress and appeals during commitment were also available in several countries (Porter et al., 1986).

Discharge of individuals subject to compulsory treatment legislation typically occurred at treatment completion, or order cessation. Some countries instituted post-treatment supervision of up to two years (Malaysia and Switzerland), and could recall individuals to treatment, should they fail to comply

these processes (Malaysia). The compulsory treatment legislation of nine countries did not specify length of stay, case review, appeals and discharge procedures (Porter et al., 1986).

By 1996, 31 U.S. states and the District of Columbia had statutes allowing compulsory treatment for drug and alcohol dependent persons. Eight of these states excluded A&D issues from mental illness statutes, while some had general statutes for compulsory treatment that included A&D as well as other conditions. Nine states provided for emergency or protective commitment on a short-term basis, generally of five to seven day periods (Kitzmann, 1996).

In the U.S., compulsory treatment legislation was considered constitutional regardless of an individual's legal/non-legal status. Even where individuals had not committed a crime, courts supported the notion that compulsory treatment was 'a valid exercise of the police power because (it was) reasonably necessary to protect the public' (Gostin, 1993, p.232).

3.2.1 COMPULSORY TREATMENT PRACTICES (OFFENDERS AND NON-OFFENDERS)

Compulsory treatment was first proposed in the U.S. in 1914. By 1935 the first 'narcotics farm' was opened in Kentucky, and a few years later in Texas. By the 1980s, there was increasing pressure for the compulsory treatment of intravenous drug users, due to concerns about the spread of the AIDS virus and the offending behaviour that often accompanied drug use. Monitoring and treatment became increasingly important in the response to drug abuse (Fagan, 1999).

Compulsory treatment legislation was also introduced in 1966 at the U.S. Federal level. The *Narcotic Addict Rehabilitation Act (NARA) 1966* targeted non-violent offenders, court-diverted offenders and non-offenders with a drug dependence. Compulsory treatment of non-offenders had two main purposes under the legislation: the protection of society and the rehabilitation of the individual. The majority of non-offenders treated under the *NARA* legislation were self-referred to compulsory treatment. Interestingly, despite this last group committing themselves to A&D treatment, there was no provision for voluntary withdrawal. Participants were obliged to remain in treatment until discharge (Lindblad, 1988; Maddux, 1988).

In the U.S., initiators of compulsory treatment proceedings may be any person, including treatment providers, police, family members or even the drug dependent person themselves (Kitzmann, 1996). Many, but not all, U.S. states require a medical certification of the person's alcohol or drug-dependent status. Eligibility for compulsory treatment entails a dependence on alcohol or drugs and usually requires a person to be a danger to themselves or others, and/or unable to care for themselves. In this sense, compulsory treatment legislation is often similar to that found under mental health statutes (Kitzmann, 1996).

The Narcotic Addiction Control Commission (NACC) was established in New York State in 1966. NACC was to administer a new compulsory treatment program that targeted offenders convicted of a felony or misdemeanour, and non-offenders found to be addicted by a court certification process under the Mental Hygiene Law. The program peaked in 1970, with 24 state A&D facilities employing 5,000 staff and delivering treatment to 6,600 clients (Winick, 1988).

There were six treatment types available under NACC. These included examination, detoxification, residential rehabilitation, halfway houses, temporary and indefinite return. On average, clients were admitted 2.5 times and spent 25 months under NACC control, ten months of which was residential.

The maximum length of stay for offenders was five years, and for non-offenders, three years. Program costs were estimated at one billion dollars between 1966 and 1979. The high cost was attributed to the one to one staff/client ratio, lack of centralised purchasing and the use of prison facilities and staff in the provision of treatment (Winick, 1988).

Inciardi (1988) reported that a range of concerns were raised about the NACC. These included inappropriate program development and design, the misconceived use of correctional facilities as treatment locations, the employment of prison staff in A&D treatment and an associated punitive philosophy. In addition, an inappropriate aftercare component based on a parole model but without adequate supervision, and lack of published outcome data raised questions about the program's effectiveness. By 1971, the NACC had been deemed a failure (Inciardi, 1988, p.555).

At the same time, a shift in drug treatment philosophy had commenced towards a community-based approach (Gostin, 1993; Inciardi, 1988; Winick, 1988). This became the preferred method of dealing with drug users and, together with program concerns about NACC, substantial budget cutbacks took place. NACC ceased operations in 1979 and the following year, New York's compulsory treatment legislation was repealed (Inciardi, 1988, p.555; Winick, 1988).

3.2.2 CIVIL COMMITMENT PRACTICES (NON-OFFENDERS)

Some countries provide specifically for the civil commitment of non-offenders to A&D treatment. Switzerland, Sweden, New Zealand and some states of Australia and the U.S. have legislation in place to provide for the involuntary A&D treatment of non-offenders.

In Europe, Switzerland and Sweden provide for the civil commitment of drug-dependent individuals (non-offenders), when 'the necessary care for these persons cannot be provided otherwise' (Bourquin-Tieche, Besson, Lambert, & Yersin, 2001, p.49). In Switzerland, A&D-dependent persons (non-offenders) can be committed to treatment via civil commitment (Grichting, Uchtenhagen, & Rehm, 2002). Orders can be made by a special authority or by physicians authorised by cantonal[5] regulations. In practice, a referral to treatment is made, and only when this referral is refused is an involuntary commitment order enacted. Most clients are admitted to a psychiatric hospital for A&D treatment, reflecting the order's focus on psychiatric conditions associated with substance-dependence. Appeal processes are available to overturn the Swiss civil commitment order (Grichting et al., 2002).

In the U.S., Colorado state legislature allows for the court-ordered evaluation and treatment of alcoholics (non-offenders) with serious medical conditions. The three step process of this civil commitment order includes family or medical personnel petitioning the court, an evaluation in an inpatient detoxification ward, and approval and implementation of a drug treatment plan. Clients had typically experienced multiple treatment failures, were unemployed, homeless and lacked effective supports (Steiner, Lezotte, & Gabow, 1995).

Some U.S. literature also exists regarding the use of civil commitment with A&D-dependent pregnant women. In cases where the foetus was at risk due to A&D dependence, civil commitment was seen as preferable to criminalisation. The inclusion of procedural safeguards such as a speedy hearing, and a focus on the health and wellbeing of the mother and child were deemed critical principles in civil commitment of this type (Lichtenberg, 1990).

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[5] A canton refers to a Swiss region.

New Zealand's *Alcoholism and Drug Addiction Act 1966 (ADA Act)* provides for the compulsory treatment of A&D-dependent persons at certified institutions (Webb, 2003). A number of concerns have been raised about the ADA Act including the process of certification of treatment agencies, the right to treat persons against their will and the lack of procedural protections. In addition, contradictions and conceptual confusion, particularly around definitions within the legislation, and inconsistency both internally and externally with other health and welfare legislation in New Zealand were areas requiring attention. Webb (2003) notes, in his recent paper, that many jurisdictions are repealing legislation that allows for the civil commitment of alcoholics, restricting these powers to the commitment of offenders only.

In Australia, the NSW *Inebriates Act 1912* allows for the commitment of a chronically intoxicated person into treatment for up to 12 months (McKey, 1996/7). This legislation, however, has been criticised in recent years for being inconsistent with modern conceptions of A&D treatment. Concerns have been raised regarding the vagueness of the legislation's definitions and its infringement on civil liberties, its functionality and effectiveness. Anecdotal information indicated that the inequitable use of the NSW legislation resulted in economically disadvantaged members of the community being subject to sanctions while more advantaged members were not. In addition, the use of psychiatric hospitals for the treatment of such clients was not considered ideal (MacAvoy & Flaherty, 1990).

Queensland's *Inebriates Institutions Act 1896* was repealed in 1994. There is now no legislation in Queensland that allows for the civil commitment of people with solely A&D issues. Queensland's *Mental Health Act 2000* allows for civil commitment, but only if a person has a mental illness.

3.3 The effectiveness of voluntary A&D interventions

Prior to examining the effectiveness literature regarding compulsory treatment, it is important to briefly review general A&D treatment effectiveness research. In recent years, a number of reviews of treatment effectiveness have been undertaken.

Ritter et al. (unpublished) wrote that any examination of drug treatment should be reviewed in much the same way as other forms of treatment for chronic relapsing conditions. O'Brien and McLellan (1996) reported that fewer than 30% of patients with chronic illnesses complied with medical advice. They compared drug dependence to illnesses such as asthma, hypertension and adult onset diabetes. The development of these illnesses can be influenced in part by patient behaviours which involve choice, such as smoking in the case of asthma. For this condition, lifetime treatment and care is often necessary and relapse to a serious asthmatic episode can occur. Asthma relapse rates vary from 30-50%. Alcohol and drug dependence should be seen in a similar context to such conditions.

Six key treatment goals have been identified through international agreement. Drug treatment should aim to:

- Reduce drug use,
- Reduce Blood Borne Virus (BBV) transmission, including HIV, Hepatitis C (HCV) and Hepatitis B (HBV),
- Reduce drug-related mortality,
- Reduce drug-related crime,
- Enhance social functioning of clients, and
- Improve general health and well being (Ritter et al., unpublished).

Drug treatment has been demonstrated to be effective across a range of treatment modalities. Substantial reductions in illicit drug use, physical and mental health have been reported in major longitudinal outcome studies (for example: Gerstein & Harwood, 1994; Gossop, Marsden, & Stewart, 1998; Hubbard, Collins, Rachal, & Cavanaugh, 1998; Simpson & Sells, 1982; J. Ward, Mattick, & Hall, 1998; M. Ward & Baldwin, 1990).

The US National Institute on Drug Abuse (National Institute on Drug Abuse, 1999) identified a number of key principles of effective treatment. These included that:

- No single treatment is appropriate for all individuals,
- Treatment needs to be readily available,
- Effective treatment attends to multiple needs of the individual,
- An individual’s treatment and services plan must be assessed continually and modified as necessary, and
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness.

For a comprehensive review of effectiveness across various A&D treatment modalities refer to a recent and comprehensive review by Ritter et al. (unpublished).

3.4 The effectiveness of compulsory A&D interventions

A number of researchers have reported on the dearth of effectiveness research regarding the civil commitment of non-offenders with serious A&D problems (Bourquin-Tieche et al., 2001; Brown, 1988; Chavkin, 1991). Chavkin (1991) noted that, in reviewing the literature on addiction, it was 'virtually impossible to disentangle the civil from the criminal' approaches (1991, p.1557). Some programs combined civil and criminal subjects, utilised treatment settings closely resembling prisons, and in some cases housed programs in prisons. As a result, the evaluation of civil commitment (as opposed to criminal/compulsory treatment) has rarely occurred.

In contrast to the limited literature regarding civil commitment, many papers have been published in the last 15 years on compulsory treatment. Wild et al. (2002) conducted a comprehensive review of compulsory A&D treatment literature published since 1988. Of 170 articles, only 18 addressed the effectiveness of the intervention, and 83% of these used non-equivalent comparison group designs. As in previous reviews of compulsory A&D treatment (Fagan and Fagan, 1982, Ward, 1979 cited in Wild et al., 2002), methodological weaknesses in compulsory treatment research have made it difficult to determine treatment effectiveness (Ross, 1993; Wild et al., 2002).

The research findings reported below pertain to interventions for non-offenders (civil commitment) and offenders and voluntary non-offenders (compulsory treatment), as specified.

3.4.1 CIVIL COMMITMENT

Bourquin-Tieche et al. (2001) reported on 17 consecutive cases of civil commitment (of non-offenders) to a Swiss alcohol unit. Cases were typically characterised by complex medical, psychological and social alcohol-related impairments. Risk of death was present in all 15 cases and length of treatment stay was, on average, 29 weeks. Follow-up data were available for ten of the original 15 clients, 18 months post-commitment[6].

The Swiss researchers found that long-term civil commitment for clients dealing with complex physical, psychological and social dysfunction was a life-saving measure. Furthermore, civil commitment contributed to improved health and well-being among the sample. These findings were supported by client feedback, most of whom considered civil commitment to be a completely justified intervention, in retrospect. With eight of the ten clients reporting abstinence from alcohol at follow-up, the authors suggested that the civil commitment intervention had increased the life expectancy of this group (Bourquin-Tieche et al., 2001).

Bourquin-Tieche at al. (2001) also cited two dissertations addressing Swedish civil commitment outcomes (Gerdner, 1998 cited in Bourquin-Tieche et al., 2001; Sallmen, 1999). The theses proposed that significant reductions in alcohol intake were achieved through civil commitment interventions, although overall mortality rates remained high at more than ten times the expected rate.

[6] Note the small sample size and absence of a control group limits the capacity to generalise from these findings.

In Colorado, poor treatment outcomes were reported among non-offenders court-ordered to treatment for serious alcohol-related illnesses. Sixty percent were drinking alcohol six months post intervention (Steiner et al., 1995).[7]

Little can be concluded from the limited research available specifically pertaining to the effectiveness of civil commitment.

3.4.2 COMPULSORY TREATMENT

Wild's (2002) extensive review of compulsory treatment research reported on the general effectiveness of compulsory treatment. Overall, client outcomes were better in relation to referral and retention measures than for voluntary treatment (De Leon, 1988; Heale & Lang, 1999; Hubbard et al., 1998). Compulsory treatment outcomes relating to criminal behaviour and substance use were also comparable with those of voluntary treatment

Mandell and Amsel (1972 cited in Lindblad, 1988) reported on the outcomes of *NARA* clients. They found that length of time in treatment was correlated with positive A&D treatment outcomes, inclusive of decreased drug use, social functioning and crime. Clients who undertook *NARA* aftercare programs also had better outcomes in relation to arrests, drug use, physical and psychological health than those who did not receive aftercare services. However, some concerns were raised about the rigour of the *NARA* research.

The California Civil Addict Program (CAP) operated from the 1960s to early 1970s and targeted offenders and, infrequently, non-offenders. CAP reported reductions in narcotics crime by 22% and property crime by 19%. These outcomes were three times better than those reported for the control group of clients discharged from treatment due to legal errors (Anglin and Hser, 1991 cited in Gostin, 1993). Evaluations of other compulsory treatment programs reported that clients did as well as, if not better than voluntary A&D treatment clients (Anglin, 1988; Leukefeld & Tims, 1988).

Others reported negative outcomes of compulsory treatment. Maier (unpublished thesis) examined the outcomes of drug-dependent persons who underwent enforced detoxification following arrest in Switzerland. In the context of an open drug scene, enforced detoxification was abandoned after a few months due to high post-discharge relapse rates (Maier, 1994 cited in Grichting et al., 2002).

Overall, the limited published literature available has reported that compulsory treatment is an effective intervention in reducing drug use and crime among participants.

3.4.3 GOOD PRACTICE IN COMPULSORY TREATMENT

The majority of research literature regarding good practice in compulsory treatment has originated from the U.S. Thus, recommendations regarding the introduction and operation of compulsory treatment programs are biased towards the management of offenders and self-referring non-offenders. Thus, this literature should be interpreted with caution when applying to a population of non-offenders involuntarily directed to compulsory A&D treatment (as in Victoria).

[7] No control or comparison group was used in this research.

Brown (1988) identified six features required to be present in compulsory treatment practices. They included:

- Appearance of a major risk to the community by a sub-group's inappropriate behaviour,
- Public support for containing those behaviours,
- Capacity to identify/isolate the subgroup,
- A subgroup which is lacking in political support or power of its own,
- Mechanisms available to process, detain and confine members of the subgroup, and
- Belief in the potential to change individuals' inappropriate behaviours to the benefit of all.

Leukefeld and Tims (1990) outlined the benefits and limitations of compulsory treatment in the U.S. Compulsory treatment increased access to A&D treatment, appeared to improve A&D treatment retention and served a preventative function by committing a person to A&D treatment prior to offending. Compulsory treatment was also separate from criminal justice system processes, provided due process, and focused on treatment and containment, rather than punishment. A number of disadvantages of compulsory treatment were also identified. These included delays in processing, potential for exceeding the capacity of A&D treatment facilities, poor client motivation, cost (although cheaper than the criminal justice system), and administrative difficulties (Leukefeld & Tims, 1990).

A set of consensus statements regarding compulsory treatment for offenders and non-offenders were also developed by Leukefeld and Tims (1990).[8] They proposed that:

- Compulsory treatment should target chronic drug abusers, particularly drug-abusing offenders,
- Repeated treatment interventions may be required,
- Length of stay is related to treatment success,
- Urine testing is an important drug use monitoring tool,
- The efficacy of methadone maintenance treatment should be promoted to the criminal justice system,
- The Therapeutic Community is a useful intervention for long term compulsory treatment,
- Treatment places must be readily available, and
- Links between the criminal justice system and the A&D treatment service system should be strengthened.

Porter et al. (1986) made a number of recommendations regarding the processes of compulsory treatment. These included that:

- Individuals should be immediately released following completion of their short-term emergency commitment for incapacitation due to drug dependence,
- Mandated treatment is only justified where effective treatment programs and appropriate facilities are available,
- Length of stay should be limited and subject to periodic review,
- Individuals should be afforded due process rights during committal proceedings, including counsel, standard of proof etc.

[8] Note that these statements have an offender/criminal justice system focus.

Others have stated that:

- Compulsory treatment cannot overcome deficits in services,
- Many treatment types, including aftercare, should be available to manage the chronic relapsing nature of addiction,
- Once treatment is available for which there is evidence of effectiveness, widespread outreach efforts need to be made to induce people to enter treatment voluntarily,
- One can compel attendance but not meaningful participation, and
- If compulsory treatment is to take place, there should be a guarantee of substantive and procedural rights, the involuntary period should be limited and subject to review, and efficacy should be measured (NIDA and WHO cited in Chavkin, 1991).

Thus, a range of recommendations have been proposed regarding the features, benefits and limitations of compulsory treatment. However, this work predominantly focuses on interventions for offenders and its capacity to be generalised to non-offenders is limited.

The need for a range of further research regarding compulsory A&D treatment has been acknowledged. Such research should include treatment outcome studies, replications studies, the development of diagnostic criteria for improved client matching to interventions, service system linkage models, descriptive studies, cost-benefit and epidemiological research, and analysis of secondary data sources (Leukefeld & Tims, 1990).

3.5 The effectiveness of mandated A&D treatment for offenders

In the absence of robust data regarding the effectiveness of compulsory treatment and civil commitment for A&D dependence, this section outlines key literature regarding mandated A&D treatment. While there may be some overlap between mandated clients (offenders) and those on compulsory treatment orders (offenders and non-offenders), there are also distinct differences. The most obvious of these is that some participants in compulsory treatment have not committed an offence.

A great deal of research literature is available pertaining to the use of coerced treatment in diversion. This section provides a brief overview of the range of perspectives offered in the literature.

The literature has widely reported the advantages of mandated treatment, both in Australia and overseas. A number of studies have found outcomes are not significantly different for mandated clients compared to voluntary clients (Brecht, Anglin, & Wang, 1993; De Leon, 1988; Hubbard et al., 1998; Miller & Flaherty, 2000). Mandated treatment has been welcomed for assisting offenders to access treatment where they would not have otherwise done so (Heale & Lang, 1999).

A number of studies have examined the issue of treatment retention among mandated versus voluntary clients. Some found that coerced clients remain in treatment for at least as long as voluntary clients (Heale & Lang, 1999), while others reported that mandated clients stayed in treatment longer (De Leon, 1988; Grichting et al., 2002; Hubbard et al., 1998). De Leon (1988) reported that mandated clients in Therapeutic Community treatment were retained in treatment longer than voluntary clients. A large scale comparative study[9] in the U.S. reported that treatment retention among mandated clients was six to seven weeks longer than among voluntary clients (Hubbard et al., 1998).

Treatment outcomes among mandated clients have also been an area of interest among researchers. Mandated clients have been found to respond well to drug treatment (Brecht et al., 1993; Grichting et al., 2002). One large U.S. outcome study[10] reported that mandated clients did as well as voluntary clients in A&D treatment, demonstrating reductions in crime and improvements in psychosocial status among offenders (Hall, 1997; Miller & Flaherty, 2000). Diversion from prison also reportedly decreased incarceration in the year post-treatment (Hoff, Rosenheck, Baranosky, Buchanan, & Zonana, 1999).

Opponents of mandated treatment generally believe that it is unethical. Some claim that the criminal justice system should not endeavour to correct behaviours by referring offenders to treatment, but should focus on punitive responses to offending (Chick, 1998). The diversion of offenders into treatment is a response that extends beyond the criminal action itself and tends to factors that contribute to criminal behaviour (Belenko, 1998). Despite this, the World Health Organisation (WHO) supported the legal and ethical justification of diversion, provided due process is adhered to, treatment is effective and humane (Porter et al., 1986).[11]

Some concerns have been made about forcing unwilling and/or unsuitable participants into treatment (Hall, 1997). In the case of mandated treatment, offenders typically have a choice between regular criminal justice system processes and diversion (Bean, 1999; Miller & Flaherty, 2000; Porter et al.,

[9] This entailed a comparison of the Treatment Outcome Prospective Study (TOPS) with the Treatment Alternatives to Street Crime (TASC) study.
[10] These studies included the Drug Abuse Reporting Program (DARP) and TOPS.
[11] For a comprehensive discussion of ethical issues relating to diversion refer to Heale and Lang (1999).

1986). It is noted that many voluntary clients enter treatment due to informal pressures such as that of family, and that this can be perceived as more coercive than legal pressure (Chick, 1998; Hall, 1997). In the case of civil commitment, Victorian clients are truly forced to attend A&D treatment, with no choice in the decision-making processes of the court.

Some warn that the potential benefits of A&D treatment should not be overstated (Hall, 1997). Mandated A&D treatment is not the panacea for offending behaviour, BBV transmission and other drug-related problems. At its most basic level, mandated treatment provides an alternative to the ineffectiveness and costliness of imprisonment. Even if the success rate of mandated treatment is not high, it is worthy of exploration (Hall, 1997).

To sum up researchers have found that the outcomes of mandated clients were as good as those of clients who entered treatment voluntarily.

4 CIVIL COMMITMENT IN VICTORIA

4.1 Legislation and practice

Legislation relating to the involuntary treatment of A&D-dependent people began in Victoria with the *Lunacy Statute 1867*. The *Lunacy Statute* was replaced by the *Inebriates Act 1872*, which was later replaced by the *Inebriates Act 1958*. With the repealing of the *Inebriates Act 1958*, the *Alcoholics and Drug-dependent Person's Act (ADDPA) 1968* took on the legislative function of providing for the civil commitment of people with severe A&D problems. It was operationalised in 1975 following the establishment of treatment facilities (ADDPA Reference Group, December 2003).

The *ADDPA* 'provides for the detention of alcoholics and drug-dependent persons on a voluntary and involuntary basis for assessment and treatment' (ADDPA Reference Group, December 2003) Its objectives are to:

- 'Establish the legislative framework for the provision of public drug treatment services,
- Monitor the provision of other drug treatment services, and
- Authorise and regulate the detention of some substance-dependent people for assessment and treatment' (ADDPA Reference Group, December 2003, p.3).

The *ADDPA* is essentially defined by section 11 of the legislation, which authorises a court to order a person to be involuntarily committed to an A&D assessment centre for seven days. A range of people can make a complaint to the court seeking a section 11 order, including a spouse or parent, business partner, adult child or sibling, police member or welfare officer. The court requires evidence from a registered medical practitioner attesting to the alcohol or drug dependency of the person. Following the seven day confinement, the individual who is subject to the order can be confined for an additional seven days as directed by the treatment centre, for a period as directed by the court, or committed by section 12 of the Act to attend treatment (ADDPA Reference Group, December 2003).

Since its operationalisation, the *ADDPA* has been amended many times (28 times in total). Despite significant reforms occurring in 1981 and 1994, the original intent of the *ADDPA* has remained the same as that enacted in the 1872 statute. Those original intentions distinguish themselves from the contemporary treatment philosophies advocated today by both the Government and A&D treatment sector. Early treatment philosophies considered that A&D dependency was a disease of the will, and should be treated through confinement. This philosophy is no longer endorsed by Government and the broader A&D field, raising questions about the Act's legislative status (ADDPA Reference Group, December 2003).[12]

[12] For a detailed review of the ADDPA see the background briefing paper prepared for the *ADDPA* Reference Group (*ADDPA* Reference Group, December 2003)

4.1.1 PREVIOUS REVIEWS OF THE *ADDPA*

A number of reviews of the Act have been conducted over the years. These included a review by an Inter-Departmental Committee (IDC) established by the Minister for Health and the Attorney-General, which made 73 recommendations in their December 1987 report. An Implementation Advisory Committee (IAG) assessed these recommendations in a 1990 report and shortly after a Committee was convened to finalise the review of the Act. However, the review was never completed and it was not until a recommendation in the Drug Policy Expert Committee (DPEC) Stage 2 Report (November 2000) that it came under further scrutiny. The DPEC recommendation that the Act be repealed from the statutes was approved by the Social Development Cabinet Committee in 2001 and the Act was earmarked for review the next year. This review aimed to determine whether the *ADDPA* should be re-written or if portions of it should be relocated. The outdated treatment approach and limited use of the Act was also noted at this time. While a background paper was written in anticipation of the forthcoming review, the review was not completed (ADDPA Reference Group, December 2003).

The Alcohol, Tobacco and Koori Drug Policy Unit of the Department of Human Services took on the role of completing the *ADDPA* review in January 2003. An *ADDPA* Reference Group was convened and a range of documents were developed to support the review process (ADDPA Reference Group, December 2003). This literature review represents one of the documents that will inform Reference Group discussion regarding the future of the *ADDPA*.

4.1.2 IMPLEMENTATION OF SECTION 11

A review of the use of the section 11 order draws on Alcohol and Drug Information System (ADIS)[13] data recorded between the financial years 1998/99 and 2002/03 (inclusive). Across these five financial year periods, a total of 39 section 11 episodes of care[14] were recorded across a total of 32 clients. Some individual clients are subject to multiple section 11 episodes across time, accounting for the higher episodes of care figure. The yearly figures for section 11 orders between 1998 and 2003 thus equate to an average of eight recorded section 11 episodes per year and an average of six clients per year state-wide.[15]

Section 11 clients are required to attend for assessment at an A&D treatment agency. In recent years, (2002/03) six agencies have recorded the provision of a section 11 episode of care. However, two of these six agencies did not provide actual withdrawal treatment, but outreach/support services before, during and/or after a section 11 client was admitted to another agency for withdrawal.[16] Agencies were metropolitan and regionally-located. A breakdown of services and their throughput of section 11 episodes of care and clients for 2002/2003 is outlined below in Table 1.

[13] ADIS records data provided by treatment agencies to the Drugs Policy and Services Branch (DPSB), DHS regarding funded service provision.
[14] An *episode of care* refers to a period of A&D treatment. In the case of inpatient withdrawal treatment for a civil commitment, an average episode of care spans seven days. Henceforth, it is referred to as ‘episode(s)’.
[15] Average figures are subject to rounding. Actual averages are 7.8 episodes of care/year and 6.4 clients/year.
[16] These outreach/support services were provided by two regional agencies: Goulburn Valley Community Health Service and Western Region Alcohol and Drug Centre (WRAD).

Table 1: A&D treatment agency, location and throughput of section 11s (2002/03)

A&D Agency	Location (metro/regional)	# Episodes of care	# Clients
DAS West, Western Hospital	Footscray (metro.)	3	3
Salvation Army	St. Kilda (metro.)	4	1
DePaul House	Fitzroy (metro.)	1	1
South West Healthcare	Warrnambool (regional)	1	1

*Client-based data is provided in section 4.2, below.

As shown by Table 1, above, section 11 orders have been rarely imposed in Victoria in recent years.[17] Where they are implemented, previous reviews have identified that absconding clients are not apprehended by Police or other authorised persons for return to treatment. This was considered to be due to a lack of police resources and/or knowledge of the Act and the perceived low priority of such cases (ADDPA Reference Group, December 2003).

While the section 11 order pertains to a seven day civil commitment for the purposes of assessment only, in practice it typically includes A&D withdrawal treatment provision. The order specifically provides for detoxification to the exclusion of other A&D treatment modalities. While civil commitment for treatment purposes is specifically addressed in section 12 of the Act, this order is very rarely used. Under the existing service system, all Victorian A&D agencies provide both assessment and treatment,[18] thus, the legislative distinction between assessment and treatment may be unnecessary. The IAG review (1990) recommended that this distinction should be abolished and treatment redefined to include 'initial assessment, subsequent treatment and ongoing case review' (ADDPA Reference Group, December 2003, p.13).

Other issues raised in reviews of the Act pertain to the currently unfilled roles of Inspector of Treatment Centres and Official Visitors.[19] The former has remained unfilled since 1986. The IDC (1987) also recommended that the legislation's title should be revised to the 'Substance Abuse Act', reflecting the contemporary inappropriateness of terms such as 'drug-dependent persons' and 'alcoholics'. These terms reflect the previous notion of blame and labelling and fail to embody the current culture of harm minimisation (ADDPA Reference Group, December 2003).

[17] Section 11 throughput data prior to 1998 was not available.
[18] The only exclusion to this is the Community Offenders Advice and Treatment Service (COATS), which provides assessment/referral only to correctional/mandated clients.
[19] For further discussion of the roles of Inspector of Treatment Centres and Official Visitors, refer to (ADDPA Reference Group, December 2003).

4.2 ADDPA client profile

An understanding of the client group for which the section 11 order is being used is critical to any discussion of the future of the Act. By learning about this client group, and understanding their needs, we can better inform any discussion about the role of the Act within the broader A&D service system, as well as other service systems such as mental health, corrections and intellectual disability services. This section provides information about the client group that has been subject to a section 11 order since 1998. The data source for this information is ADIS, as recorded by treatment agencies and stakeholders.

A total of 32 people were subject to a section 11 order between 1/7/98 and 30/9/03. Of this group 56% were males and 44% were female. The mean (average) age of males was 34 years and of females, 40 years.[20] The mean age of all clients was 36 years, with ages ranging between 17 and 69 years. Clients aged between 41 and 50 years of age represented the greatest proportion of the sample (29%), almost double the proportion of other age categories of 17-21, 22-25, and 31-40 years (16% each). Three clients (9%) were aged 61 years or older. Table 2, below, outlines gender and age information for the sample.

Table 2: Gender and age breakdown for section 11 clients (1/7/98-30/9/03)

Gender	Proportion (%) (N=32)	Mean age (Range) (n=31)[20]
Male	56%	33.5 years (17 to 64 years)
Female	44%	39.9 years (19 to 69 years)
Male and Female	100%	36.4 years (17-69 years)

Other demographic information available for the client group relates to employment and accommodation status, drug use, previous A&D treatment history, and complainant seeking the section 11. Note that data for these variables are incomplete and analysis has been conducted on only those data available.[21]

The majority of clients (87% of n=29) were unemployed at admission to treatment. Of this group, 37% were receiving a pension allowance. Thirteen percent of clients were employed and 7% were engaged in home duties. One-third of clients (34% where n=29) reported being homeless/transient at treatment entry and 10% (of n=29) reported living alone.

The majority of the client group (76% of N=32) was using alcohol at treatment entry and 48% of clients were using alcohol exclusively. The significant proportion of alcohol users in the group may reflect the high visibility of this client group combined with the absence of mechanisms for treatment, support or diversion to treatment for licit substance use. This contrasts with the range of Federal and state-

[20] Age data is based on n=31. Data for one client was missing.
[21] Data for all variables is not available for every client. This may be due to changes to ADIS recording requirements over time and recording error.

funded treatment, support and diversion options that focus on illicit substances such as heroin. Heroin/opiate use was recorded for 21% of the sample, and benzodiazepine use recorded for 19%. Use of two substances or more (polydrug use) was recorded for almost half of the sample (43%).

Data regarding previous A&D treatment were recorded for 15 clients. Of these, two clients (18%) had previously been subject of two section 11 orders each and two clients (18%) had been the subject of one section 11 order in the past. Previous voluntary A&D treatments were recorded for three clients (27%) with 'numerous' voluntary treatment episodes recorded for two clients (13%). Numerous hospital accident and emergency admissions were also recorded for four clients (27%), with high rates of admission for some e.g. five admissions in the last week, eight in the last month, 37 admissions in previous 18 months.

Stakeholders noted that clients subject to a section 11 order were quite distinct from the mandated clients (i.e. offenders). Section 11 clients were more likely to be alcohol-dependent with an Alcohol-Related Brain Injury (ABI) and had experienced multiple recent police, ambulance and hospital contacts. The group was generally considered to be easier to manage than a mandated client group, which was typically characterised by illicit drug use, baseline anti-social traits and difficult behaviours. Mandated client treatment was typically focussed on managing legal as well as therapeutic issues.

A range of client responses to treatment were reported by stakeholders across section 11 clients. Some were compliant, while others were rebellious and disruptive, acting out and displaying difficult behaviours.

4.3 Stakeholder feedback

This section provides a discussion of the key issues associated with the practical implementation of the *ADDPA* 1968 in Victoria. Data were primarily drawn from interviews with stakeholders, including A&D treatment providers, members of the judiciary, civil commitment and compulsory treatment legislators and policy makers from other Australian states. Key issues are divided into process, operational and other issues. Client benefits identified by stakeholders are also discussed.

4.3.1 PROCESS ISSUES

Awareness

The low throughput of section 11 orders under the *ADDPA* 1968 is directly related to a lack of awareness across the A&D treatment, medical, welfare, police, legal and judicial sectors. Anecdotal evidence suggests that very few Magistrates and A&D treatment providers are aware of the powers of this legislation. Several stakeholders reported that they had not been aware of the section 11 order until they had dealt with it. Others suggested that low throughput was a result of the perceived ineffectiveness of the order. Some stakeholders reported advising potential court applicants against the initiation of section 11 proceedings.

Extensive education is required regarding civil commitment legislation. Dissemination of information could occur via forums such as A&D service provider conferences, the Royal Australian College of General Practitioners (RACGP) or the Law Institute. Court advice staff and police also play an important role in providing advice to potential section 11 applicants. Informing relevant parties of civil commitment legislation is likely to increase awareness and utilisation of the order.

Assessment

The exclusion of treating agencies from pre-court client assessment processes means that inappropriate referrals can occur. Stakeholders reported that, on occasion, clients were admitted for inpatient withdrawal treatment (the only treatment legislated for under section 11) when A&D problems could be managed on an outpatient or home-based withdrawal basis. One agency returned to court to have an order amended to manage a detoxification on an outpatient, rather than inpatient basis.

Two stakeholders proposed a process similar to that used in the *Mental Health Act 1986*. In that Act, the treating agency is involved in a pre-court client assessment process and provides a treatment plan to court. Treating agency involvement in potential section 11 cases will ensure that appropriate cases are referred to withdrawal treatment.

Referral

A number of issues were raised by stakeholders regarding section 11 referrals. These included the use of section 11 to bypass treatment waiting lists and as respite care for families and carers.

Stakeholders reported that, on occasion, the section 11 order was utilised as a method of bypassing A&D treatment agency waiting lists. The expedited admission procedure available under the Act was seen by some complainants (typically family members of the client) as a way to avoid a three week wait for a detoxification bed. Others reported that such admission processes placed undue pressure

on agency admission and waiting lists. In some cases, agencies were forced by the court order to prioritise section 11 clients over emergency care cases.

The section 11 order has also been used as respite care for both clients and their family/carer. Some stakeholders felt that respite care was a valid use of the order, giving 'clients time out from trying to cope and survive' and allowing family and carers to begin 'to think more clearly'. Others felt that this use of the order was heavy-handed and denied clients their rights. In the 1980s, Feldstead (1984) reported that staff of the Gresswell Centre in Victoria were reporting inappropriate section 11 applications by some to 'rid' themselves of family members and tenants.

Data recording

A range of issues have been identified in the recording of section 11 orders. Some problems have been identified in data coding and entry on the DHS ADIS database. Education and training is required for A&D treatment providers to ensure that satisfactory data recording processes occur.

Current court recording of section 11 orders is also problematic. Court records do not distinguish between section 11 applications and orders, and other generic orders. Should improved data collection methods be required, a unique identifying code could be allocated to civil commitment applications and orders, and a practice direction issued to courts. This would allow improved monitoring of section 11 order throughput under the *ADDPA*.

Accountability

The limited accountability built into the *ADDPA* was raised as an area of concern. Suggested improvements focussed on providing basic treatment outcome reports back to the ruling magistrate. Onerous reporting should be avoided to increase the likelihood of completion of any such requirement. Treatment agencies could potentially utilise a reporting format consistent with that required by the ADIS database. Other stakeholders felt that a case report back to the referring medical practitioner should be included in the legislation.

The absence of the appointment of an official visitor under the *ADDPA* was an issue raised in Victorian documentation (ADDPA Reference Group, December 2003). An official visitor has the capacity to inspect treatment centres and enquire about persons committed under the Act. However, no official visitors have been appointed since the implementation of the *ADDPA*.

Finally, stakeholders reported that the addition of a civil commitment review panel, as available under the *Mental Health Act 1986*, would be a welcome addition to the order. This would allow individuals subject to the order to appeal against civil commitment.

4.3.2 OPERATIONAL ISSUES

Treatment setting

A range of stakeholders reported concerns regarding the inability of A&D treatment agencies to satisfactorily detain section 11 clients in non-secure treatment settings. Only one agency could effectively detain clients (in hospital delirium rooms) to prevent premature departure. Stakeholders claimed that the A&D service system lacked the capacity to detain clients as required under the

ADDPA. Many clients reportedly walked out of treatment centres, jumped back fences, rejected medical advice and staff insistence to remain. Ethical, clinical and occupational, health and safety dilemmas associated with such incidents were reported by some.

Issues were raised regarding inconsistent police follow-up of absconded clients, which reportedly contributed to the ‘toothlessness’ of the Act. Some stakeholders felt that a lack of police follow-up meant that some clients absconded without consequence or sanction. Overseas literature has also reported that warrants for absconding clients were given low priority (New York) (Winick, 1988). In Victoria, even when police did locate and return clients to agencies, some clients continued to abscond repeatedly during the seven day commitment order.

On return from absconding, clients were typically A&D-affected. There were concerns that such behaviour impacted negatively on other treatment participants. Some discontent had been articulated by other residents, given the different ‘rules’ that applied to section 11 clients. In an environment in which regular clients were typically asked to leave the withdrawal unit upon detection of unprescribed drug use, the return of an A&D-affected client to the unit may be perceived as a double-standard by some. Treatment providers may also struggle with this contradiction in treatment practice.

Not all clients were absconders. Stakeholders reported that once clients were no longer drug-affected/intoxicated, some were happy to remain in treatment. The benefits of a treatment stay which attended to the therapeutic, nutritional, accommodation and social needs of clients may have been welcomed by some.

One agency reported that their withdrawal unit had to be closed to other clients during the treatment of section 11 clients. This was due to the complexity of problems with which the section 11 client presented and the intensive care required by the client.

Term of civil commitment

Some stakeholders reported that the seven day length of stay under section 11 of the Act is sufficient. The provision of a further seven days, under the direction of the medical officer of the assessment centre, is available for those participants requiring ongoing treatment. An additional period of detention at a treatment centre is also available under section 12 of the Act.

Others proposed that a longer period of civil commitment was required to make an impact on clients and that a rehabilitative component beyond the seven day withdrawal stay was necessary. Stakeholders proposed an extended withdrawal treatment period, via case review to determine the need for further treatment or by creating linkages with, and referrals to, post-withdrawal support services (Feldstead, 1984). Two stakeholders suggested that a non-prescriptive civil commitment of up to 12 months would be beneficial for clients requiring long-term treatment and support across the full spectrum of A&D treatment modalities.

In practice, it appears that some treatment agencies already utilise their discretion to retain clients in treatment beyond the initial seven day period, as dictated by their treatment needs. In one instance, a client was retained in treatment for a month to enable a meaningful psychiatric assessment from an external provider to occur.

Health and welfare needs

Some stakeholders were concerned about the lack of attention to the broader health and welfare needs of clients. In most instances, clients were returned to the same environment, despite these being unsuitable. Within a longer-term rehabilitative framework, some stakeholders proposed that the inclusion of aftercare provisions in the legislation would allow workers to address some of the ongoing lifestyle problems faced by clients, including housing, nutrition, and hygiene. Living skills development could attend to a range of issues, such as cooking, cleaning and managing finances (e.g. Centrelink payments), while long-term case management processes could address health, ABI, psychiatric and other issues.

Within a crisis intervention framework broader health and welfare issues should be managed through the processes of referral to, and assertive follow-up from, mainstream support services. It is noted, however, that these services are founded on the principle of voluntary treatment and support, and where clients lack motivation, referral and follow-up may be challenging.

Finally, some stakeholders reported that the current *ADDPA* was not flexible enough to meet the needs of clients with an ABI. These clients, who were often subject to civil commitment orders, required different assessment, treatment, rehabilitation and support services to regular withdrawal clients.

4.3.3 OTHER ISSUES

Civil liberties

The issue of whether civil commitment infringed on clients' civil liberties was discussed at length in the literature. Fischer (2002) noted:

> An emerging fundamental debate is characterised by the question of whether compulsory treatment is a more reasonable approach (i.e. from a public health perspective) given its offer of the opportunity for treatment rather than just punishment, or whether it now subordinates the patient/offender to a wider, thinner and potentially more coercive net of social control (Fischer et al., 2002, p.53).

Civil libertarians oppose any form of compulsion to treatment based on a number of reasons. Some propose that the availability of a compulsory treatment option results in a greater number of people being drawn into the treatment system. This occurs to the potential detriment of many more motivated, treatment-seeking individuals on waiting lists. Others believe that drug use is voluntary and does not directly harm others, that there exists the potential for the inappropriate commitment of some people, and that the punitive nature of involuntary commitment is inconsistent with the non-offender status of some individuals (Gostin, 1993; Sowers & Daley, 1993).

Rosenthal (1988) reported that legislation regarding the involuntary commitment of opiate-dependent persons was challenged shortly after its introduction in the U.S. Substantive challenges were made based on the constitutionality of the legislative power to commit involuntarily, while procedural challenges argued that the absence of procedural safeguards invalidated state or federal laws. Some argued against the commitment of people to an A&D treatment of unproven effectiveness. Others suggested that drug-dependent individuals should be committed to treatment no more than those with, for example, heart conditions, given both are 'at-risk' communities with short life expectancies.

The issue of civil commitment was never satisfactorily resolved for some. Rosenthal (1988) reported that, in upholding laws regarding the involuntary commitment of opiate addicts, the U.S. Supreme Court failed to adequately address the central issue of substantive power.

While the issue of civil liberties was a common theme in the literature, it was raised in only one stakeholder interview. This stakeholder felt that civil libertarian concerns were overstated: 'As a caring community, we should be involved'.

Legislation

One stakeholder advocated the benefits of the *Mental Health Act 1986*. This Act provides for agency involvement in pre-commitment client assessment and a review panel. This legislation was deemed a good model on which to base amendments of the existing *ADDPA* or a new piece of legislation.

4.3.4 CLIENT BENEFITS

Despite the issues outlined above, many stakeholders reported that section 11 affords some important benefits for people with serious A&D problems.

Identification

Stakeholders reported that the *ADDPA*, specifically section 11, ensured that a mechanism existed by which vulnerable members of the community could be identified, assessed and assisted. One of the benefits of the section 11 order was its capacity to catch people at their highest risk of harm. For some clients, this meant conducting a formal assessment of their unmet needs, providing detoxification treatment, educating them about harm minimization and health issues, and working towards the point of engaging in a therapeutic relationship with withdrawal staff, and other support services.

Time Out

For many clients, imposed A&D treatment provided some important time out from their circumstances. This is most likely to be beneficial where the client is not too aggrieved at being removed from their environment. Time out in treatment provided an opportunity for some to withdraw from A&D, wash, eat three healthy meals a day, have safe lodgings and improve their physical health. Time out in treatment was seen as highly preferable to incarcerating clients.

Client outcomes

Civil commitment provided some clients with an opportunity to acknowledge an A&D problem. This did occur, on occasion, with stakeholder reports of clients voluntarily remaining in treatment beyond the length of the order, showing interest in pursuing further treatment options, and even maintaining a level of sobriety upon treatment departure. Others reported clients who had turned their lives around entirely to be productive members of the community. Even a small or temporary change in A&D use behaviours was seen as a positive outcome which may prompt people to access treatment in the future.

5 DISCUSSION: CONSIDERATIONS FOR FUTURE DIRECTIONS

There are many factors to consider when thinking about the value of a civil commitment intervention. Upon exploration of this area, it is clear that there are different views and diverse experiences to take into account when rendering judgement about the worth of this type of intervention. The purpose of this discussion is to draw out some of the key factors for consideration when determining the future direction of civil commitment intervention.

5.1 Society and culture

At the broadest level, a civil commitment intervention is embedded within the culture and fabric of society. Given the level of diversity across and within societies, consensus varies in regards to the place of an intervention such as this one. What is acceptable, understood and desirable in one society is not necessarily the case in another. For example, in some countries, legislation such as this is used to compel individuals with problematic A&D use to long term rehabilitation. In other countries, it is used as crisis intervention to provide 'time out' for an individual, while in others, civil commitment is regarded as an outdated and unnecessary intervention which infringes on a person's civil rights.

Prior to determining the future of the *ADDPA*, consideration should be given to national and local contexts. It is important to examine the original impetus for this legislation, its evolution over time and the environment in which it operates. It is critical also to consider the value that individuals, families and stakeholders place on the availability of this option and the impact of civil commitment on those who have experienced it.

5.2 Context and definition

The place of civil commitment within the broader A&D service system is worthy of attention. The role and function of such an intervention should be clearly defined and examined in the context of a range of A&D treatment services provided to voluntary and mandated clients. The development in recent times of a range of diversion and compulsory A&D treatments adds an additional element of complexity to the existing voluntary A&D service system. The place of civil commitment on the continuum between voluntary and mandated/diversion services and its potential role as a gateway to treatment should be examined. Civil commitment should also be considered in terms of the range of pressures experienced by A&D treatment clients, including the informal pressures of family, friends and self through to the formal pressures of the criminal justice system. Clarifying the place of civil commitment in the current A&D service system will facilitate greater understanding about the intervention.

At its simplest level, civil commitment refers to non-offenders, involuntarily placed into A&D treatment due to risk of harm to themselves or others. The individual has no role in the decision-making processes of an *ADDPA* order. In contrast, mandated treatment refers to offenders required to attend

A&D treatment due to a criminal court or police sanction or status. Offenders typically have a choice regarding their involvement in mandated treatment/diversionary processes, although these are often influenced by the formal pressures/threat of alternative sanctions (i.e. imprisonment). Voluntary treatment refers to individuals who attend treatment voluntarily. It is recognised, however, that voluntary clients may be subject to a range of informal and other pressures (pending criminal, family court hearings) which motivate them to attend A&D treatment.

5.3 Purpose

One of the most critical factors to consider in any review of the *ADDPA* is the purpose of the intervention. What do we seek to achieve through the *ADDPA*, specifically section 11 of the Act? In some countries, A&D commitment interventions are utilised to encourage or enforce 'rehabilitation'. As a result of this goal, time in treatment is generally long-term and accompanied by comprehensive due process and certification practices, as well as opportunities for client review.

In other countries, A&D commitment is used as a 'protective' mechanism. This facilitates intervention in an individual’s life where they are at an extremely high level of risk and need, and are unable to initiate change on their own. In these instances, treatment periods tend to be shorter and aim to provide 'time out' to stabilise and recuperate to a safer level of risk and need (i.e. eat well, sleep, have required medical and health input). These practices are consistent with the stabilisation efforts undertaken in mental health fields.

Diverse views about the purpose of A&D commitment have been cited in the literature and across stakeholders. Until the goal of the intervention is clarified, it is not possible to address the range of structural, operational and philosophical issues, including the appropriateness of the current treatment modality (a seven day withdrawal episode). In practice, it appears that the Victorian section 11 order has been established and utilised as a 'time out' type of intervention. Integration of individuals into other forms of A&D treatment have rarely occurred.

5.4 Intervention

The A&D treatment literature purports that treatment length is a critical determinant of positive client outcomes. While this may be true, it is clear that premature departure from treatment undermines the effectiveness of any intervention. This is true not just for the A&D field, but across a range of sectors that provide treatment to clients lacking in motivation and commitment to change their behaviours. The value and impact of treatment on a client’s health and well being is diminished where treatment is terminated prior to completion. Therefore, consideration should be given to a) the required period of treatment to achieve the desired aim and b) maximising the capacity for the individual to remain engaged for that period of time.

Where the purpose of civil commitment is to provide 'time out' for the individual, then an appropriate treatment period is at the shorter end of the spectrum (i.e. up to approximately 14 days with additional follow-up). A longer period would be required for rehabilitation.

5.5 Criteria for inclusion

Having considered fully the purpose and type of intervention to be provided, addressing the criteria for inclusion should follow. Inclusion criteria should be supported by systems of accountability that ensure appropriate checks and balances are in place. These might include court examination of the circumstances of order initiation, assessment of the reliability of the complainant and the individual potentially subject to an order, and review of the appropriate documentation accompanying an order. While the criteria for inclusion should be clearly defined, the capacity for flexibility and responsiveness is also important.

5.6 Treatment setting and client retention

The impact of the treatment setting in which a section 11 is operationalised is an issue requiring consideration. The A&D service system cannot currently contain clients who choose to discharge themselves or abscond from treatment. If civil commitment is to be effective, greater capacity is required for engaging clients for the duration of their treatment episode. This will allow some benefits to be achieved from their commitment. Increasing capacity may entail the provision of greater security and supervision, and a swift police response upon early termination.

Consideration should also be given to the impact of section 11 clients on other people in the treatment unit. Non-compliant individuals can be disruptive to a treatment unit and impact negatively on other clients.

6 CONCLUSION

Civil commitment is a complex concept. Operationally, it is challenging to implement. Despite this, both the literature and stakeholders in the field have identified the benefits of this type of option for people with severe A&D problems. Achieving the right balance between the potential benefits and challenges of such an option is critical when considering the future direction of the *ADDPA*. It is also important to increase legislative and service system capacity in order to maximise the benefits of A&D treatment during the period of the section 11 order.

This review has identified a number of areas for further consideration. These include consideration of society and culture, definitions and context of the legislation, purpose of the Act, appropriateness of the intervention, inclusion criteria, and treatment setting and retention.

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