



VICTORIAN ALCOHOL & DRUG ASSOCIATION

*Alcoholics and  
Drug-dependent  
Persons Act  
1968*

Submission to Review

October 2005

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## Acknowledgements

VAADA expresses its thanks to those individuals, agencies and networks whose contributions form the basis of this submission.

VAADA received input from a diverse section of its membership. These individuals, agencies and networks all share an interest in the objective to reduce the harms associated with alcohol and other drugs. These members include:

- alcohol and other drug agencies
- consumer advocacy groups – substance users and their families
- community legal centre
- individual workers – including ABI specialists and dual diagnosis specialists

Written responses from organisations and joint networks were received by VAADA from across six DHS regions – which inform the basis of this response. VAADA also engaged in numerous informal discussions with agencies and individuals who did not have the time to submit comments in a written form.

This submission is therefore based on a diverse range of opinions.

The final views are those of VAADA and may not reflect the individual opinions of those who have generously provided input into VAADA's response.

## **Organisational details about VAADA**

### **Who is VAADA?**

The Victorian Alcohol and Drug Association Inc. (VAADA) is a peak organisation, which aims to reduce the harms associated with alcohol and other drug (AOD) use within the Victorian community.

VAADA's membership comprises agencies working in the AOD field, as well as those individuals who are involved in, or have a specific interest in, prevention, treatment, rehabilitation or research that minimises the harms caused by alcohol and other drugs.

### **What does VAADA do?**

As a peak organisation, VAADA's purpose is to ensure that the issues for people experiencing the harms associated with alcohol and other drug use and the organisations that support them are well represented in policy and program development and public discussion

VAADA seeks to achieve this through:

- Engaging in policy development
- Advocating for systemic change
- Representing issues our member's identify
- Providing leadership on priority issues to pursue
- Creating a space for collaboration within the AOD sector
- Keeping our members and stakeholders informed about issues relevant to the sector
- Supporting evidence-based practice that maintains the dignity of those who use alcohol and other drug services (and related services)

### **Our history**

VAADA became an incorporated association in 1981 and was created as a forum for agencies working in the field of alcohol and other drug issues, as well as those individuals interested in alleviating the harms caused by alcohol and other drugs. VAADA's role was to provide mutual support for its members as well as facilitating planning and development in the AOD field. It was also envisaged that VAADA would have an educative and information role for both its member agencies and the broader community.

### **VAADA membership**

As a statewide peak organisation VAADA's community / constituency is broad. Its membership and stakeholders include 'drug specific' organisations, consumer advocacy organisations, hospitals, community health centres, primary health organisations, disability services, religious services, general youth services, local government and

others (schools, counselling services, correctional/diversion services, legal services) as well as interested individuals.

VAADA's Board is elected from the membership and comprises a range of expertise in the provision and management of alcohol and other drug services and related services.

Member services of VAADA provide a range of services to people experiencing the harms associated with alcohol and other drug use – which include:

- Withdrawal – residential, home-based, outpatient and rural
- Substitute programs – methadone and buprenorphine
- Supported accommodation
- Residential rehabilitation
- Peer support
- Counselling, consultancy and continuing care
- Day programs
- Legal services

## Executive summary

This submission does not respond directly to the questions contained in the Discussion Paper outlining the Review of the *Alcoholics and Drug-dependent Persons Act 1968*. Instead it discusses the Act as a whole piece of legislation and analyses the broader objectives and purpose of the existing legislation. The objectives, as stated on Page 5 of the Discussion Paper, 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
- authorize and regulate the detention of some alcoholics and drug-dependent persons for the purposes of assessment and treatment

The Discussion Paper raises the possibility of the repeal of the Act – yet it does not fully cover the implications of repealing all Sections of the Act.

The focus of the Review, as indicated in the Discussion Paper, relates particularly to the system of authorising and regulating the detention of those with perceived substance dependencies for ‘treatment’ and the monitoring of those services that provide such treatment. VAADA’s submission addresses the issues relating to civil committal:

- when is it used?
- why is it used?
- is existing legislation the best mechanism to respond to the circumstances where civil committal is viewed as the only option?
- are there alternatives?

Another key objective of the Act is that which Section 4 essentially covers – that is, to establish the legislative framework for the provision of public drug treatment services. Notably this objective has not been addressed in the Discussion Paper. VAADA’s submission will also touch upon the issue of the legislative basis for the AOD sector – which the repeal of the Act would have implications for.

VAADA invited all member agencies and individuals to contribute their opinions and views to the response that VAADA is submitting. It received input from:

- alcohol and other drug agencies
- consumer advocacy groups – substance users and their families
- community legal centre
- individual workers – including ABI specialists and dual diagnosis specialists

In view of the short timelines to respond to the Discussion Paper on the Review of the *Alcoholics and Drug-dependent Persons Act 1968*, VAADA did not undertake extensive consultations. It instead sought input from its constituency through written contributions

and through verbal discussions and was particularly keen to ensure input from its rural members and members representing consumer interests.

The position formed by VAADA in this submission does not reflect any one individual response – but rather an analysis of the broader sector response. VAADA's response, therefore, forms a sector / service system perspective and addresses the issues of civil committal, the legislative framework of AOD services and the monitoring of agencies that provide treatment to those individuals civilly committed.

The key concerns raised by VAADA's constituents in regard to the Act include:

- the Act's contemporary relevance in the context of current frameworks that underlie responses to people experiencing issues with their substance use
- the current inability to define an 'alcoholic' or a 'drug dependent person'
- the potential for abuses of the civil rights of individuals who fall under the provisions of the Act
- the capacity for the service system to comply with the legislative requirements of the Act
- the capacity for agencies to ensure measures in workplaces that don't put employees at risk of committing an offence under the Act

When the current reasons that prompt use of the legislation (particularly Section 11) were considered, however, it was evident that there is a small, yet extremely vulnerable, population group where civil committal is at times deemed necessary. More often than not, this applies to individuals who misuse substances, are considered cognitively impaired and incapable of making important decisions about risks to life. There was a view put to VAADA that for these individuals 'treatment' sometimes offers the possibility of harm minimisation.

The service system, however, is not adequately resourced to work holistically and in the most effective ways with these individuals. VAADA advocates for the Victorian Government to commit itself to strategise on methods for more effectively addressing the issues that arise for these individuals with permanent or temporary cognitive impairments misusing substances.

This submission argues for the repeal of the Act – but on the grounds that there are measures put in place to improve the responses to this vulnerable population group through:

- exploring the scope for using existing legislation more effectively – including the *Guardianship and Administrative Act 1986* and the *Mental Health Act 1986* – to respond to individual's with cognitive impairments who misuse substances and are unable to make important decisions about life threatening situations
- introducing more effective responses to this vulnerable population group – including assertive outreach options and AOD specialist assessment in emergency departments at public hospitals
- exploring the evidence with regard to the effectiveness of treatment responses when individual's have been civilly committed

VAADA also argues that more detailed consideration be given to the legislative framework for public drug treatment services – particularly in the context of the potential repeal of the Act.

VAADA's recommendations have been influenced by the range of viewpoints provided to the peak body and policy considerations for the current AOD service system and related sectors.

Several of VAADA's members have chosen to submit individual responses to the Review in addition to contributing their views to the broader sector response.

In light of the responses received by VAADA, the following sections outline in greater detail the rationale underlying the argument to repeal the Act and the need for further examination of alternatives and the implications of repeal.

While the legislation itself may appear archaic and outdated – the complexity of the issues experienced by the vulnerable group that tend to fall within the provisions of the current Act continue to affect these individuals and to provide challenges to those responding to their needs.

The paper is structured in the following way:

- Analysis of the *Alcoholics and Drug-dependent Persons Act 1968*
- Alternatives to the Act
- Conclusion and recommendations

## **Objectives of the Act**

As outlined in the Discussion Paper on page 5, the objectives of the *Alcoholic and Drug-dependent Persons Act 1968* 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

### **Objective 1 – legislative basis of the AOD sector**

A key objective of the *Alcoholics and Drug-dependent Persons Act 1968* – according to the Discussion Paper (p.5) – is to ‘establish the legislative framework for the provision of public drug treatment services, by government or through arrangements with contractors’.

Section 4 is the critical Section of the Act that outlines this.

#### Section 4

It is important to consider what the implications of modifying or repealing or re-positioning Section 4 might be for the alcohol and other drug treatment sector. This section has significance in forming the legislative basis of the AOD sector. The comment at the end of Section 2.1 of the Discussion Paper (p.5) that ‘the consultation process may also inform a recommendation that the legislation be repealed’ – provides good reason to prompt discussion about what this might mean for the legislative framework for AOD services.

While the review of the Act opens the discussion regarding the potential repeal of the *Alcoholic and Drug-dependent Persons Act 1968*, the discussion paper provides little analysis or discussion regarding the implications for this legislative framework if the Act were to be repealed.

What are the potential alternatives for the legislative basis for services? Might they be incorporated into the *Health Services Act 1988*? What would this change mean? Or would the legislative basis for AOD services be removed? And, if so, what would be the implications?

There are, perhaps, simple answers to these questions – but it is critical that some degree of discussion is undertaken with regard to this issue of the legislative framework.

## **Objective 2 – monitoring of services**

### Sections 8, 15 and 19

Sections 8, 15 and 19 are the relevant components of the Act that appear to relate to the monitoring of services that are gazetted to provide a response under a system of civil committal.

These Sections relate to:

- Official visitors
- Special magistrates
- Inspectors of treatment centres

Apart from the role of the special magistrate – the roles of official visitors and inspectors of treatment centres are outmoded. All three roles are not filled and do not provide the protections and monitoring that they were designed to.

In the context of a system that legislates for civil committal – these roles, while currently outdated, could conceivably be reviewed and redeveloped in order to provide appropriate safeguards for the system.

The key question, however, is not about the retention of these mechanisms – but whether civil committal to compulsory treatment for individuals with ‘substance dependence’ should exist as stand alone legislation.

If it is deemed that an Act is necessary to legislate for civil committal to compulsory drug treatment – then it is critical that there are sound mechanisms for monitoring services that provide the response.

In the event that there is any system of civilly committing individuals to compulsory drug treatment (through one Act or through other legislative measures) – VAADA would argue for adequate mechanisms for monitoring services and for ensuring due process through the system.

VAADA argues for the repeal of the Act and for the introduction of alternative strategies for working with those individuals who misuse substances and are cognitively impaired and / or co-morbid. Any alternative arrangements should include inbuilt mechanisms for monitoring the services that provide treatment and that ensure services are operating according to approved standards.

### **Objective 3 – voluntary and compulsory civil commitment**

Sections 5-6, 8A-12, 14, 16-18, 20-27, 30-31

The objectives of these sections are to authorise and regulate the detention of those defined as alcoholics and drug-dependent persons for the purposes of assessment and treatment.

This objective raises several issues that VAADA seeks to address in this section:

- the argument that a serious health concern – ie, substance ‘dependency’ – provides a rationale for compulsory civil committal
- the inconsistency of the Act with current harm minimisation approaches
- the argument that ‘time out’ and respite for families is a rationale for denying human rights and civil liberties
- the implicit assumption that there is an accepted definition of what constitutes an alcoholic or drug-dependent person
- the issue of an individual’s right to engage in self-destructive behaviour and their right to refuse / deny medical treatment
- the sector’s commitment to providing services that are evidence-based
- the inadequacy of the current service system to fully implement a system of civil committal

#### **Human rights and civil liberties**

Consideration of current human rights frameworks in which society operates more broadly is vital when reviewing the *Alcoholics and Drug-dependent Persons Act 1968*. It is not possible to divorce the issue of substance use and substance dependency from broader arguments relating to human rights issues. Indeed, protecting the rights of vulnerable groups, such as those experiencing harms associated with their (mis)use of substances, is particularly critical.

In responses received by VAADA, concerns were expressed about the potential abuse of human rights contained within the Act and the lack of safeguards for protecting civil liberties. One response specifically noted the potential contradiction that retaining the Act might present in the context of a future Human Rights Charter – if introduced by the Victorian Government.

Unlike other similar legislation for compulsory health treatment, currently there are no mechanisms within the *Alcoholics and Drug-dependent Persons Act 1968* to ensure assessment and ‘complaints’ processes adequately protect the rights of individuals. Furthermore, those safeguards that do exist are not operational and – in the current context of our health and community services – are not appropriate.

Section 11 stipulates that:

- Upon complaint made to the Supreme Court, to the County Court or the Magistrates' Court that a person is an alcoholic or a drug-dependent person and upon evidence (including at least one certificate in the prescribed form from a registered medical practitioner who has examined such person within forty-eight hours prior to such complain) making it appear to the court that such person is an alcoholic or a drug-dependent person the court may make an order directing that the person complained against do attend at and be admitted to an assessment centre and there remain for a period of seven days and, if the medical officer in charge of the assessment centre so directs, for a further period of seven days after such first-mentioned period.

Within the Act, there is no definition of 'complaint'. The actions or circumstances that might form the basis of a complaint against an individual who misuses substances are unclear and potentially limitless.

Section 16 stipulates that:

- A registered medical practitioner who signs a medical certificate support any complaint or committal to be made under this Act or for any other purpose provided in this Act shall specify therein the facts upon which he has formed his opinion that the person to whom the certificate relates is an alcoholic or a drug-dependent person (as the case requires) and shall distinguish in the certificate facts observed by himself from facts communicated to him by others and no order shall be made under this Act upon a certificate which purports to be founded only upon facts communicated by others.

In the absence of a uniform, agreed upon definition of 'dependency' – considerable room exists for discretion (by both the medical professional and the magistrate) that might enable one complaint to be taken further, yet another not.

Again, determining the 'facts' of the case is open to discretion by the medical professional (with no apparent assessment processes).

Furthermore, the legislation makes no reference to how the individual concerned can be medically assessed by coercion in order to formalise a complaint through the courts.

## Assessment

A fundamental concern underlying the legislation is what forms the basis of a 'complaint', thereby enabling an individual to be civilly committed. This raises a range of issues in regard to the process of assessment. What processes exist to determine the circumstances where a person may be assessed as requiring coerced drug treatment through involuntary civil commitment? What is the rationale for compulsory treatment for a substance dependent person?

Key considerations include:

- The lack of consistent agreement about how 'dependent' is defined

- The ethics of making an assessment that an individual is suitably substance dependent to an extent that justifies detention against their will (with no criminal offence having been committed)
- The ethics of detaining an individual for a serious health condition such as substance dependency. What would prevent us from extending this rationale to detain individuals for a range of dependencies that might be considered harmful to their health and the health of others around them?
- How do we consider the issue of cognitive impairment and the inability to make informed and important decisions about the need for medical treatment for serious health conditions (of which the misuse of alcohol and other drugs is one such condition)?
- Should the Act exist entirely to enable those with cognitive impairment to be appropriately assessed, monitored and treated for their AOD use (which may be co-morbid)? In this instance – should those checks and balances contained within the Act be to undertake assessment in a manner that doesn't deprive a person of their liberty, yet ensures their right to adequate health care?

To what extent can we determine that it is appropriate to deprive individuals of their liberty and human rights on the basis of their substance use? Presently the Act has the power to do this. Do we seek to retain legislation that does not contain adequate safeguards for the rights and liberties of individuals?

A clear message from a majority of the responses received from VAADA is that substance dependency itself cannot form the basis for civilly committing individuals to coerced treatment.

#### Need for 'time out' and respite

The needs of families of those individuals who misuse substances are an important consideration. Providing support roles for people with issues relating to substance misuse are critical and need to be recognised.

Responding to these needs, however, would best occur in a policy context – as opposed to a legislative framework. What are the needs of those providing support? How are they being met? Are they being met?

It is not possible to disregard the human rights of a population group at risk in order to provide respite. If it is considered that this is the only avenue – then it indicates that there are some serious shortcomings with regard to the needs of supporters and families of individuals who use substances.

It is critical to note, however, that these needs ought to be addressed at a policy level as opposed to a legislative level.

VAADA recommends that the Victorian Government further investigate the needs of those people and families who live with / care for individuals who misuse substance. In particular, such a research project or review might consider the need for earlier

intervention for families and raise awareness in regard to the options available for individuals and families to understand their role.

### Compulsory treatment – need for evidence-base

There is a clear lack of evidence regarding the effectiveness of compulsory treatment – particularly with regard to civil commitment, those with co-morbid conditions and those with cognitive impairments.

This is a significant shortcoming in the context of a service system that operates on a strong evidence base.

VAADA recommends that further research be conducted into the effectiveness of coerced treatment to determine whether there is an evidence-base for this approach to treatment. Such evidence is important in the context of a service system that operates on the basis that individuals need to be motivated to change their behaviour for treatment to be successful.

### Service design

In the context of the current legislation – it is critical to consider the capacity of the current AOD service system to adequately detain those individuals civilly committed. Currently, the AOD service system is not designed to enable the detention of individuals in treatment services.

There are implications regarding the inability to detain individuals according to the requirements of the Act. Section 18(2), for example, stipulates:

- Any person employed in an assessment centre or treatment centre who through willful neglect or connivance permits any person detained in the centre under the provisions of this Act to quit or escape from such centre or to be at large without authority under this Act or who secretes or abets or connives at the escape of any such person shall be guilty of an offense against this section.

Workers in drug treatment services could conceivably be found guilty of offences under the Act and imprisoned for 3 months.

Such offences are unlikely. Yet in view of the service system not being adequately equipped to detain individuals who are civilly committed – Section 18(2) does raise issues for workers, agencies and government.

## Alternatives to the ADDP Act

A clear message came through in the responses received by VAADA's constituency regarding the Review of the *Alcoholics and Drug-dependent Persons Act 1968*. This message indicated that there is a section of the community where the Act is currently the only tool for providing an effective response. While it was recognised that the Act may not be the appropriate approach – it demonstrates that there is a need to seriously consider how we respond to this vulnerable group of individuals whose substance misuse intersects with their cognitive function to the extent that it impacts on their capacity to make decisions in life threatening situations.

There are 3 key considerations that form the basis of VAADA's views on alternatives to the *Alcohol and Drug-dependency Act 1968*.

1. For a small minority of individuals who are cognitively impaired and who misuse substances – there will be occasions when they are not able to make important decisions when they are putting their lives and the lives of others at risk. The conclusion cannot be ignored in such circumstances that these individuals might not be the best judge of their own interests and their substance misuse may be exacerbating their incapacity for decision making. At such times, there may need to be mechanisms to ensure that people who are permanently or temporarily cognitively impaired are able to receive appropriate treatment.
2. Substance 'dependency' itself cannot be the grounds for being declared incompetent and causing commitment to treatment.
3. Where an individual is declared cognitively impaired and committed for treatment, it is essential that there is a mechanism whereby an independent third party would be appointed to consider whether the individual's interests are given proper weight. It is not adequate to rely entirely on medical opinion to make these determinations.

Alternatives suggested by individuals, agencies and consortiums in the AOD sector have contributed to the recommendations for alternative models that VAADA is recommending. These include the following proposals.

### Civil committal through other existing legislation

In view of the existence of the *Guardianship Act 1986*, the *Mental Health Act 1986* and the *Human Services (Complex Needs) Act 2003* – VAADA considers that there is scope to explore opportunities to more effectively enact these pieces of legislation to respond to the treatment needs of individuals whose substance misuse is severely impacting on cognitive functioning and the ability to make important decisions.

VAADA is of the understanding that each of these Acts has limitations in its current form (or current usage) for the circumstances that arise for those individuals with co-morbid and cognitive impairment conditions.

VAADA therefore recommends that all legislation relevant to the vulnerable population groups currently captured by the *Alcoholics and Drug-dependent Persons Act 1968* is reviewed. Such a review would investigate the working effectiveness of other legislation intervening in cases of individuals with cognitive impairments who misuse substances and are perceived to require drug treatment for life-saving purposes.

It might also involve raising awareness for those professionals who are most likely to use the legislation.

#### More effective linkages and partnerships through the acute care health system

Individuals engaging in high-risk substance use have a high likelihood of presenting at emergency departments in public hospitals. If the Victorian Government fostered the development of more effective partnerships across acute health care and specialist AOD programs, there might be the potential to more effectively engage with individuals about their substance use, health and cognitive impairment implications.

VAADA advocates for the effective resourcing of specialist AOD responses within emergency departments in the public hospital system. Such responses would be designed to strategically intervene in cases where individuals present with substance related injuries and health conditions that might benefit from comprehensive assessment, treatment plans, and appropriate linkages to specialist services and referral pathways.

#### More comprehensive early intervention and prevention for at risk groups

VAADA recommends that the Victorian Government support the development of more effective assertive treatment intervention programs for individuals who, despite access to treatment, continue to misuse substances (in particular, alcohol) in ways that are dangerous to their health. Such a program would enable AOD workers to develop skills and AOD agencies to devise programs to explore assertive outreach and treatment interventions that might support these individuals.

This might occur in partnership with the Royal District Nursing Service – or could potentially be modelled on the outreach approach used by the Homelessness Persons Program of the RDNS.

## Conclusion and Recommendations

In considering the views of those individuals, agencies and networks that provided input, VAADA concludes that alternatives to the Act need to be seriously considered and, if introduced, adequately resourced.

VAADA makes the following recommendations in regard to the Review of the *Alcoholics and Drug-dependent Persons Act 1968*.

1. That the *Alcoholics and Drug-dependent Persons Act 1968* be repealed and that mechanisms to civilly commit those individuals with cognitive impairments who misuse substances and are unable to make important decisions about life threatening situations is comprehensively accounted for in other legislation.
2. That the effectiveness of using other legislation – specifically the *Guardianship and Administration Act 1986* and the *Mental Health Act 1986* – to assist the individuals noted in Recommendation 1 is comprehensively reviewed to account for circumstances where substance misuse is severely impacting on cognitive ability and the capacity for decision-making.
3. That consumers and consumer advocacy groups are consulted in regard to their views on civil commitment and compulsory treatment – in particular, those most likely to be affected by the legislation.
4. That substance dependency itself does not form the grounds for being declared incompetent and causing commitment to treatment.
5. That the Victorian Government pilot an assertive outreach treatment program to engage and monitor that vulnerable population group whose substance misuse is seriously damaging to their health and cognitive functioning.
6. That emergency departments in the public hospital system be more effectively resourced through specialist AOD responses designed to strategically intervene in cases where individuals present with substance related injuries and health conditions that might benefit from comprehensive assessment, treatment plans, and appropriate linkages to specialist services and referral pathways.
7. That an evidence base be developed to determine the effectiveness of compulsory treatment through civil committal.
8. That the specific needs of rural and remote communities are given consideration in the policy development of alternative programs for vulnerable populations – in particular, the implications of distances for assertive outreach programs and the difficulties in accessing health and treatment services.

9. That the Victorian Government further investigate the needs of those individuals and families who support substance users. In particular, such a research project or review might consider the need for earlier intervention for families, the options this might include and the need to raise awareness in regard to the options available for individuals and families to understand their role.
10. That further analysis of the implications of modifying, repealing or re-positioning the legislative framework for public drug treatment services is undertaken.