



Government of **Western Australia**
Mental Health Commission

Compulsory Alcohol and Other Drug Treatment in Western Australia

Background Paper

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This document describes considerations relevant to the Liberal National Government's policy intentions, but it does not reflect the Government's settled position and it does not indicate a commitment to a particular course of action.

1. Introduction

The State Government is committed to consulting with the community regarding a draft Model of Service and legislation for compulsory alcohol and other drug (AOD) treatment in Western Australia. An Exposure Draft Compulsory Treatment (AOD) Bill 2016 (Exposure Draft Bill)¹ and Summary Model of Service have been developed by the Mental Health Commission (MHC) to assist in consultation with stakeholders, including the community.

This Background Paper provides additional information regarding compulsory AOD treatment models in Australian jurisdictions and New Zealand, and current practice. The Exposure Draft Bill and associated documents are available on the [MHC website](http://www.mhc.wa.gov.au): www.mhc.wa.gov.au.

1.1 Compulsory treatment

The term compulsory AOD treatment refers to a broad range of programs mandated by legislation or Government implemented programs. For the purposes of this paper, compulsory AOD treatment, also referred to as civil commitment, is legally sanctioned, involuntary commitment of an individual into treatment². Compulsory AOD treatment differs from existing diversionary programs in that it is not a requirement that the person come into contact with the criminal justice system to be considered for compulsory AOD treatment. Compulsory AOD treatment is generally an option of last resort. It provides assessment, treatment and management of those with a severe AOD problem; who are at risk of harm to themselves or others; and whose ability to make decisions about their substance use is severely compromised because of their dependency. Compulsory AOD treatment allows for a period of respite for themselves, and their family, and provides support to improve clarity of decision making to facilitate longer term engagement in voluntary treatment.

Those eligible for compulsory AOD treatment programs are some of the most vulnerable people in our community and often have chronic and complex problems including co-occurring mental health illness, cognitive impairment and other health, social and welfare issues such as homelessness.

Western Australia does not have legislation that provides for compulsory treatment of people with a severe AOD problem. As the law currently stands, a person can only be admitted to a service, or provided with treatment, with the informed consent of the individual (or, in some limited situations, with the informed consent of a person who has legal authority to consent on their behalf). To enable the detention and treatment of individuals with a severe AOD problem, legislation is required in Western Australia. If the program is found to be ineffective, the legislation can be amended or repealed.

¹ An Exposure Draft Bill outlines the proposed legislation for open discussion prior to its amendment, finalisation and tabling in Parliament.

² NSW Legislative Council Standing Committee on Social Issues. Report on the *Inebriates Act 1912*. Sydney: NSW Parliament, 2004.

1.2 Developing compulsory alcohol and other drug treatment legislation

The MHC is considering options for the implementation of a compulsory AOD treatment program in Western Australia. Input from an external Steering Committee, Community Advisory Group and public submissions, have been taken into account by the MHC to assist in developing the Exposure Draft Bill, and Summary Model of Service for compulsory AOD treatment. The Exposure Draft Bill has now been released for public comment until 31 January 2017. The Exposure Draft Bill will be refined as much or as little is needed before the Bill is provided to Government for consideration. Consultation will also inform the development of a business case seeking Government approval and funding for a compulsory AOD treatment facility, pending approval of the legislation.

1.3 Current situation for compulsory alcohol and other drug treatment in Western Australia

On 28 November 2016, Cabinet approved the printing and release of the Exposure Draft Bill.

To date and in accordance with actions in the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Better Choices. Better Lives, and the Western Australian Meth Strategy 2016, the MHC has:

- met with key stakeholders in the Northern Territory, New South Wales, Victoria and New Zealand to examine their respective compulsory treatment legislation and applicability to Western Australia;
- considered advice received from a 2012 Expert Advisory Group convened by the then Drug and Alcohol Office, which reviewed compulsory treatment programs in Australia, made recommendations as to the efficacy of implementing compulsory treatment programs in Western Australia, and considered other options;
- considered outcomes of literature reviews undertaken by the National Drug and Research Institute in 2012 and 2015 regarding the effectiveness of compulsory AOD treatment programs;
- released Background and Discussion Papers to facilitate consultations;
- convened the Compulsory AOD Treatment Steering Committee and Community Advisory Group;
- considered advice from the Steering Committee, Community Advisory Group and public submissions in response to the Discussion Paper, to assist in developing the Exposure Draft Bill and Summary Model of Service; and
- released an Exposure Draft Bill and Summary Model of Service for public comment.

2. Evidence base

2.1 Current clinical practice and contemporary trends

Within Australia, compulsory AOD treatment is well established in a number of jurisdictions. Currently, there is no comprehensive national framework on how compulsory treatment programs in their various forms are operated, rather there is a range of national, state and local codes and practices.³

Harm minimisation and evidence based practice

The National Drug Strategy 2010-2015 and the Drug and Alcohol Interagency Strategic Framework for Western Australia 2011-2015 provide the frameworks for AOD policy directions and services development at a national and state level. The strategies recognise that, in order to address the complexities of AOD related problems, there is a need for comprehensive and balanced approaches across the continuum of prevention, treatment and support services.

The national policy framework in Australia is based on a harm minimisation approach: supply, demand and harm reduction. Specialist treatment services are an essential component of these approaches in supporting people to recover from dependence and reconnect with the community.

Internationally, the United Nations Office on Drugs and Crime (UNODC) and the World Health Organisation (WHO) provide policy direction on evidence-based practice and treatment. UNODC and WHO have identified nine principles for the development of services for treatment of drug dependence. The principles are aimed at all Governments and partners, acknowledging that there are differences in local situations in terms of resource availability and treatment system development.⁴

The principles are:

- availability and accessibility of treatment;
- screening, assessment, diagnosis and treatment planning;
- evidence-informed AOD treatment;
- drug treatment, human rights and patient dignity;
- targeting special subgroups and conditions;
- addiction treatment and the criminal justice system;
- community involvement, participation and patient orientation;
- clinical governance of drug dependence treatment services; and
- treatment system based on policy, strategic planning and coordination.

³ Pritchard, E, Mugavin, J and Swan, A (2007). *Compulsory treatment in Australia: a discussion paper on the compulsory treatment of individuals dependent on alcohol and/or other drugs*. ANCD.

⁴ United Nations Office of Drug and Crime and World Health Organization. *Principles of Drug Dependence Treatment*, 2008. <https://www.unodc.org/documents/drug-treatment/UNODC-WHO-Principles-of-Drug-Dependence-Treatment-March08.pdf>

These principles cover the treatment process, governance, structure and system. They address ethics and diversity including special needs groups. They also cover the spectrum of treatment needs and settings.

Diagnostic models

In terms of classifying substance dependence, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), published by the American Psychiatric Association, and the International Statistical Classification of Diseases and Related Health Problems, Tenth Edition (ICD-10), published by WHO, are commonly used tools to assist in diagnosis of mental disorders and substance use disorders. DSM-5 classifies substance use disorder (previously substance dependence) on a continuum from mild, moderate to severe.⁵ Each specific substance is defined as a separate use disorder (for example, alcohol use disorder, and stimulant use disorder); however nearly all substances are diagnosed based on the same overarching criteria. In the DSM-5, a severe substance use disorder diagnosis requires the presence of six or more symptoms from a list of 11. Some examples of criteria used for diagnosis and assessment are:

- recurrent substance use resulting in a failure to fulfil major role obligations;
- tolerance, as defined by a need for markedly increased amounts of the substance to achieve intoxication;
- withdrawal, as manifested by the characteristic withdrawal symptom for the substance; and
- craving or strong desire to use a specific substance.

2.2 Human rights

Similar to mental health legislation, the introduction of compulsory AOD treatment legislation will impact human rights. The UNODC states that short term detention is acceptable where individuals are at serious risk of harming themselves or others, however compulsory clinical interventions should cease once the acute emergency has been avoided and autonomy re-established.⁶ As such, legislation should ensure that the treatment period complies with these human rights principles. In order to ensure the impact on an individual's human rights is minimised consideration should be given to safeguards including, but not limited to:

- a number of separate levels of referral, screening and examination against criteria, which is undertaken by different, appropriately qualified health professionals;
- a right to appeal a decision to make a detention and treatment order;
- strict criteria for the making of a detention and treatment order, including criterion regarding risk and less restrictive options; and
- the performance of functions under the legislation to be undertaken and interpreted so that any interference on human rights is minimised.

⁵ DSM-5 combines the previous DSM-IV categories of substance abuse and substance dependence into a single disorder.

⁶ United Nations Office on Drugs and Crime (UNODC) (2009) *From Coercion to Cohesion: treating drug dependence through health care, not punishment*. Vienna: UNODC.

2.3 Effectiveness of compulsory treatment

A 2007 Australian National Council on Drugs (ANCD) Research Paper on compulsory treatment in Australia found there is a need to build the knowledge and evidence base regarding compulsory treatment programs.⁷

The findings reported by the ANCD were broadly consistent with those of the National Drug Research Institute (NDRI) that were commissioned by the MHC to review published and grey literature (unpublished) in relation to compulsory treatment programs. While the NDRI concluded that there is a need to undertake further research relating to the efficacy of compulsory treatment, it may serve a short term protective role in emergency situations, to prevent deaths or other harm.

The University of New South Wales is currently undertaking an evaluation of the New South Wales Involuntary Drug and Alcohol Treatment (IDAT) Program. The evaluation aims to determine the effect of the IDAT program on patient outcomes. In addition, the feasibility, appropriateness and the costs of the program will be reviewed. It is understood that the evaluation report will be provided to the New South Wales Ministry of Health by January 2017.

The Western Australian legislation will be supported by a monitoring, evaluation and review framework. The program will be evaluated after three years of operation to review the effectiveness of the legislation, and the program in meeting its objectives.

⁷ Pritchard E, Mugavin, J and Swan, A (2007) *Compulsory Treatment in Australia: a discussion paper on the compulsory treatment of individuals dependent on alcohol and/or other drugs*. ANCD.

3. Models in other jurisdictions

In Australia, compulsory AOD treatment is legislated for in different forms in the Northern Territory, New South Wales, Victoria and Tasmania. The Australian Capital Territory, Queensland and South Australia do not have compulsory AOD treatment legislation. New Zealand has introduced the Substance Addiction (Compulsory Assessment and Treatment) Bill into Parliament. The Bill is intended to replace the *Alcoholism and Drug Addiction Act 1966*. Norway, Sweden and Denmark, and many other international jurisdictions, also have compulsory AOD treatment legislation. The key differences between New South Wales, Victoria, the Northern Territory and New Zealand's compulsory AOD treatment legislation are provided below. Detailed information is set out in the Appendix.

This Background Paper does not consider the Tasmanian legislation in any detail as it is currently under review, and is not aligned to contemporary practice. As such it is rarely used.

Northern Territory: [Alcohol Mandatory Treatment Act 2013](#) (Northern Territory Act)

- Applies to adults taken into police protective custody three or more times in two months, or separately referred to a senior assessment clinician for assessment;
- Applies to persons with severe alcohol issues only, and not other drugs;
- An assessment is undertaken by a clinician who may refer an individual to the Alcohol Mandatory Treatment Tribunal for a determination;
- The treatment order can be for up to three months;
- Treatment is usually provided in secure facilities (modified correctional facility);
- Treatment orders can include a mandatory community treatment order or a mandatory residential treatment order; and
- An aftercare plan must be prepared.

New South Wales: [Drug and Alcohol Treatment Act 2007](#) (New South Wales Act)

- Commenced in 2012 following a two year trial;
- Any medical practitioner may request assessment by an accredited medical practitioner, who may issue a dependency certificate. The dependency certificate must be either confirmed (for the specified time period or a shorter time period) or revoked by a Magistrate;
- Treatment order can be for up to 28 days;
- Treatment includes withdrawal, and medical treatment for concurrent physical and/or mental health issues;
- The program includes longer term intervention, including a community based program on discharge, which provides ongoing assessment, monitoring and case management and access to health and social welfare services; and
- Treatment is provided in a facility with moderate security (high fences, secure access) and is co-located with a hospital.

Victoria: [Severe Substance Dependence Treatment Act 2010](#) (Victorian Act)

- An adult can apply to a Magistrates Court for another person to be placed on a detention and treatment order;
- The application must be accompanied by a recommendation for detention and treatment made by a prescribed registered medical practitioner;
- The detention and treatment order can be for up to 14 days;
- Treatment focus is on short term medically assisted withdrawal, however there is an opportunity to access further voluntary treatment;
- A discharge plan must be prepared, outlining follow-up treatment and support that is to be provided to the person; and
- Treatment is provided in a facility which is co-located with the hospital, but it is not a locked facility.

New Zealand: [Substance Addiction \(Compulsory Assessment and Treatment\) Bill](#) (New Zealand Bill)

- Introduced into Parliament in December 2015; the NZ Bill is intended to replace the *Alcoholism and Drug Addiction Act 1966*;
- Applies to people in a situation where: the person has a severe substance addiction; the person's capacity to make informed decisions about treatment for that addiction is severely impaired; compulsory treatment is necessary; and appropriate treatment for the person is available;
- The Bill can apply to children subject to additional safeguards;
- Any adult can apply to the Director of Area Addiction Services to have a person assessed.
- An Approved Specialist conducts a specialist assessment and can sign a compulsory treatment certificate.
- The Family Court or District Court must review the person's compulsory status within ten days.
- Involuntary treatment for up to 56 days - may be extended by an additional 56 days (total of approximately four months);
- Treatment is provided at treatment centres, intended to be a specialised residential AOD treatment centre or medical detoxification facility (an inpatient hospital bed).

3.1 Common features of compulsory AOD treatment legislation

Legislation in the Northern Territory, Victoria and New South Wales, and proposed legislation in New Zealand suggests that compulsory AOD treatment may provide a short term protective role, an opportunity for people to undergo safe drug withdrawal, and an opportunity of participants to engage in further treatment. A summary of common key features of these jurisdictions' compulsory AOD treatment legislation is outlined in the table below.

Table: Common Features of New South Wales, Victoria, Northern Territory and New Zealand Legislation

Area	Features
Legislation	<ul style="list-style-type: none"> • Stand-alone legislation
Objectives	<ul style="list-style-type: none"> • Protect from harm • Restore decision making capacity • Stabilise health through medical treatment and assessment • Provide opportunities for voluntary treatment
Criteria	<ul style="list-style-type: none"> • Aged 18 years and over (except in New Zealand) • 'Severe' dependence • At risk of immediate harm to themselves • Lack capacity to consent to treatment • Treatment likely to be of benefit • No less restrictive option (option of last resort)
Treatment	<ul style="list-style-type: none"> • Short term (ranging from 14 days to three months) • Option to extend beyond initial treatment period in some situations • Includes medical withdrawal
Protections	<ul style="list-style-type: none"> • Right to have the order reviewed • Community visitors program or similar advocacy support • Explanation of rights and responsibilities to individual and at least one other person (such as their next of kin)
Other	<ul style="list-style-type: none"> • Key decisions made by people with qualifications specified in the Act • Treatment centres declared under legislation

3.2 Western Australian diversion programs and mental health legislation

Diversion programs

A range of police and court diversion programs are currently available in Western Australia.

Police diversion programs have an early intervention focus and aim to divert offenders to education or treatment. They include:

- Cannabis Infringement Requirement for minor cannabis offences; and
- All Drug Diversion for minor offences involving illicit drugs other than cannabis.

Court diversion programs are available to most offenders appearing in court who have drug-related problems, depending on the seriousness of the offence. These programs are voluntary and in most cases the offender is required to plead guilty during their court appearance. Diversion court programs include a range of treatment intervention programs in the Magistrates and/or Children's Courts. The range of programs provide opportunities for people apprehended or charged with criminal offences to engage in specialist AOD treatment services. Programs include:

- Drug Court;
- Pre-sentence Opportunity Program;
- Young Persons Opportunity Program;
- Diversion Programs for Aboriginal People;
- Supervised Treatment Intervention Regime; and
- Youth Supervised Treatment Intervention Regime.

Whilst diversion programs can be coercive, they do not operate along the same way as compulsory treatment programs. This is because the offender always has the choice as to whether or not to participate (i.e. a participant needs to have agreed to opt into the program), albeit failure to comply may be reflected in imposed sanctions or sentencing. In addition, opting into a diversion program does not guarantee 'active' participation.

Mental Health Act 2014

The *Mental Health Act 2014* provides for involuntary detention and treatment of people experiencing mental illness in certain circumstances, including where there is a co-occurring AOD problem or where mental illness has been precipitated by AOD use.

While there is often a relationship between mental illness and AOD use, assessment and treatment of these two cohorts are quite different. In addition, not all people with severe AOD problems have a mental illness. Therefore, the objectives of compulsory AOD treatment legislation cannot be achieved by relying on mental health legislation.

4. Key issues for consideration

Some of the key elements for review and discussion relating to the proposed compulsory AOD treatment legislation are detailed in this section.

4.1 Objects and principles of the legislation

In reviewing compulsory AOD treatment legislation in Australia, the ANCD report recommends that compulsory AOD treatment legislation contain an objects section that clearly states the intended outcomes of the legislation.⁸ The objects of the Victorian Act relate to the provision of detention and treatment of persons with severe substance dependence where this is necessary as a matter of urgency to save the person's life or prevent serious damage to the person's health; and to enhance the decision making capacity of those persons. The objects of the Victorian Act are narrower than the New South Wales Act which contains the following objects:

- (a) to provide for the involuntary treatment of persons with a severe substance dependence with the aim of protecting their health and safety;
- (b) to facilitate a comprehensive assessment of those persons in relation to their dependency;
- (c) to facilitate the stabilisation of those persons through medical treatment, including, for example, medically assisted withdrawal; and
- (d) to give those persons the opportunity to engage in voluntary treatment and restore their capacity to make decisions about their substance use and personal welfare.⁹

4.2 Prerequisites for compulsory AOD treatment

Appropriate criteria to determine if a person can be issued a compulsory AOD treatment order are crucial to ensure that the intended cohort of people can be issued a compulsory AOD treatment order, and conversely that the criteria is not too broad that it can capture people for whom the compulsory AOD treatment legislation is not intended. The Victorian Act requires that immediate treatment must be necessary to save life or prevent serious damage to health.¹⁰ The New South Wales Act is slight broader, and contains the following prerequisites:

- is 18 years or older;
- has a severe substance dependence;
- care, treatment or control of the person is necessary to protect the person or other persons from serious harm;
- the person is likely to benefit from treatment for his or her substance dependence but has refused treatment; and
- no less restrictive means are reasonably available.¹¹

In addition, the accredited medical practitioner may have regard to any serious harm that may occur to children in the care of the person, or dependants.¹²

⁸ Pritchard E, Mugavin, J and Swan, A (2007) *Compulsory Treatment in Australia: a discussion paper on the compulsory treatment of individuals dependent on alcohol and/or other drugs*. ANCD, Canberra.

⁹ s3 NSW Act.

¹⁰ s6 and s8(1)(2) Victorian Act

¹¹ s9(3) NSW Act

¹² s9(4) NSW Act

The New Zealand Bill proposes to include children within the scope of the Bill, with additional safeguards.

4.3 Pathway to compulsory AOD treatment

The way in which a person can be referred for assessment for compulsory AOD treatment differs between jurisdictions.

In the Northern Territory there are two main pathways to assessment. First, where a person has been taken into police protective custody three or more times within two months, they are automatically referred to a senior assessment clinician (SAC) for assessment. Second, a health practitioner may refer the person to a SAC. Unless the SAC decides that the person would be best treated under mental health legislation, the SAC must make an application to the Alcohol Mandatory Treatment Tribunal (AMTT), specifying whether or not the person meets the criteria for a mandatory treatment order. The AMTT may make a mandatory treatment order.

In New South Wales any medical practitioner may request an accredited medical practitioner (AMP) to assess a person for detention and treatment. After assessing the person, the AMP may issue a dependency certificate, stating that the person may be detained for treatment. If the AMP is unable to access the person to conduct an assessment, an authorised Court Officer (including a Magistrate) may make an order authorising the AMP to visit and assess the person, with or without the assistance of a police officer. If a dependency certificate is issued the person may be detained. Dependency certificates are reviewed by a Magistrate, who may confirm the dependency certificate or discharge the person from the treatment centre.

In Victoria an adult can make an application to the Magistrates Court for a detention and treatment order to be made in respect of another person. The application must be accompanied by a recommendation for detention and treatment made by a prescribed registered medical practitioner. The Magistrates Court may then make an order that the person be admitted to a treatment centre, detained, and provided with treatment.

4.4 Duration of detention and treatment

In line with the object of the new legislation (see 4.1), compulsory AOD treatment should be long enough to ensure that the person is properly assessed, fully withdrawn (detoxified) from the drug(s) of dependence, their health is stabilised, and they have regained capacity to make sound decisions regarding their AOD use. A person must not be detained for an unjustifiable time period; to do so risks breaching fundamental human rights.

Some studies have found that longer treatment periods have been demonstrated to be a consistent predictor of positive therapeutic outcomes in offender based literature.¹³ Conversely, there are views that a shorter period of up to 14 days with an option to extend an additional 14 days, similar to the Victorian model, is adequate, and ensures protection of

¹³ Broadstock M, Brinson D, Weston A (2008) *The effectiveness of compulsory, residential treatment of chronic alcohol or drug addiction in non-offenders*. Christchurch, Health Services Assessment Collaboration, 2008.

human rights.¹⁴ The New Zealand Law Commission Review of *The Alcoholism and Drug Addiction Act 1966* (Review), after consultation with the treatment sector, recommends an initial maximum detention period of six weeks. However, the Review also found that a period of 28 days, in line with the New South Wales model is considered to be sufficient to enable withdrawal, and to encourage the individual to be motivated to engage with AOD treatment.¹⁵

Following extensive consultation, and taking into account the Review, the New Zealand Bill proposes an initial maximum period of 56 days (two months), with the option to extend for an additional 56 days if the person has an acquired brain injury as a result of AOD use.

While the New South Wales Act does not mandate the individual to engage with services upon discharge from the compulsory treatment order, there is a requirement that the AMP must take all reasonable steps to liaise with agencies providing services to the person, including residential rehabilitation services and specialist community services.

4.5 Treatment environment

The location and type of facility are dependent on the availability of an existing facility, demand, and the availability of funds to construct or refurbish a facility.

Persons meeting the criteria for compulsory AOD treatment in Australia have a severe substance use dependence and therefore are likely to present significant risks to their life and health, particularly in the medical withdrawal (detoxification) stage. As a result, in both Victoria and New South Wales, compulsory AOD treatment is provided in centres adjacent to or within a hospital. Treatment centres vary in their level of security, ranging from fully locked facilities to community based treatment settings.

4.6 Continuity of care

As discussed above, according to international Human Rights covenants and principles, compulsory treatment is only acceptable for a short period of time to protect the person from harm, and to restore their capacity. Following a short period of compulsory treatment, the provision of ongoing treatment either in residential rehabilitation or in the community on a voluntary basis is likely to be more effective in producing long-term benefits for the person. While this is legislated for, some compulsory treatment legislation, including the New South Wales Act, requires that in planning the discharge of a person, the AMP must take all reasonable practicable steps to consult with agencies involved in providing relevant services and to provide the person and the person's primary carer with appropriate information about follow-up care.¹⁶ In addition, the New South Wales model includes a community based program on discharge that provides ongoing assessment and monitoring and case management.

¹⁴ New South Wales Legislative Council Standing Committee on Social Issues (2004). *Report on the Inebriates Act 1912*. Sydney.

¹⁵ New Zealand Law Commission (2010) *Compulsory Treatment for Substance Dependence: A Review of the Alcoholism and Drug Addiction Act 1966*, Wellington.

¹⁶ s25(2)(33) NSW Act

4.7 Rights, recourse and other safeguards

The inclusion of safeguards is essential to ensure that the proposed compulsory AOD treatment legislation has the minimum possible impact on human rights and aligns with the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights. In New South Wales, the Northern Territory, Victoria and New Zealand, a qualified health professional will screen the individual against the criteria for inclusion. If a person is recommended for a compulsory AOD treatment program, this is reviewed by either the Court (New South Wales, Victoria and New Zealand) or a Tribunal (Northern Territory), which will then confirm or revoke the compulsory AOD treatment order or dependency certificate.

Additional safeguards that are incorporated into mental health legislation and/or compulsory treatment legislation in Australia include:

- key decisions and orders must be recorded in clinical notes;
- the facility must notify another person (such as a family member, guardian, or another nominated person) of certain matters;
- legal rights must be explained before search and seizure processes are undertaken;
- treatment must be explained before being provided, including side effects;
- the right to a second opinion; and
- the right to make a complaint.

4.8 Methamphetamines

Reviews of New South Wales, Victoria and Northern Territory models show that the overwhelmingly highest proportion of people referred to the program have alcohol as their primary drug of concern, with only a very minimal number of people with a severe methamphetamine problem entering into the program.

This may be as a result of the prerequisites and classification of severe substance dependence, which generally requires years of drug problems to begin to impair the ability of a person to the extent that it can be demonstrated that they are unable to make decisions about their substance use. However, referral mechanisms may also impact on the cohort of people who are referred to the program.

4.9 Evaluation, monitoring and review framework

The development of an evaluation framework will be important to enable assessment, review and monitoring of the effectiveness (in the short, medium and long term) of the proposed legislation. A minimum of three years operation is considered appropriate to facilitate an assessment of the model.

However, after three years of operation, only short term outcomes (for example, reduced risk of immediate harm) can be assessed. If the program continues for more than three years, the medium and long term outcomes (for example, reduced AOD consumption) can be monitored and evaluated, as part of the ongoing assessment and improvement of the legislation and the compulsory AOD treatment program.

The evaluation and monitoring of the program may include a mix of qualitative and quantitative measures pre, during and post treatment such as data linkage and qualitative measures such as the Living in the Community survey, the Your Experience Survey, and the Health of the Nation Outcome Scales (HoNOS) Survey.

Appendix -compulsory AOD legislation in other jurisdictions

Feature	New South Wales Act	New Zealand Bill	Victorian Act	Northern Territory Act
Objects	<ul style="list-style-type: none"> provide for involuntary treatment to protect the health and safety of individuals with severe substance dependence; facilitate comprehensive assessment; facilitate stabilisation through medical treatment, including medically assisted withdrawal; and provide individuals with the opportunity to engage in voluntary treatment; and restore capacity to make decisions about substance use and personal welfare. 	<ul style="list-style-type: none"> protection from harm; facilitate comprehensive assessment; stabilise health through provision of medical treatment (including medically managed withdrawal); protect individual's dignity; restore capacity to make informed decisions about treatment and further substance use; facilitate planning for ongoing treatment and care on a voluntary basis; and provide opportunities to engage in voluntary treatment. 	<ul style="list-style-type: none"> detention and treatment of individuals with a severe substance dependence where this is necessary as a matter of urgency to save the person's life or prevent serious damage to the person's health; and to enhance the capacity of those individuals to make decisions about their substance use and personal health, welfare and safety. 	<ul style="list-style-type: none"> assist and protect individuals from harm; stabilise and improve health; improve social functioning; restore capacity to make decisions about alcohol use and personal welfare; and improve access to ongoing treatment to reduce relapse.
Eligibility / criteria	<ul style="list-style-type: none"> adult; severe substance dependence; care, treatment or control is necessary to protect the individual from serious harm (includes harm to their children and dependants); has refused treatment; likely to benefit from treatment; and no less restrictive option is reasonably available. 	<ul style="list-style-type: none"> severe substance addiction; impaired capacity to make informed decisions regarding treatment for the addiction; compulsory treatment is necessary (i.e. if voluntary treatment is unlikely to be effective); and appropriate treatment is available. 	<ul style="list-style-type: none"> adult; severe substance dependence; immediate treatment is necessary to save the individual's life or to prevent serious damage to the person's health; the treatment can only be provided through admission and detention of the person in a treatment centre; and no less restrictive option reasonably available. 	<ul style="list-style-type: none"> adult; misusing alcohol; lost the capacity to make decisions about their alcohol use or personal welfare; risk to the individual or others (including children or other dependants); the individual would benefit from a mandatory treatment order; and no less restrictive option reasonably available.

Feature	New South Wales Act	New Zealand Bill	Victorian Act	Northern Territory Act
Referral process	Doctor requests that accredited medical practitioner (AMP) assesses individual. AMP considers criteria, may issue dependency certificate. AMP arranges review by Magistrate. Magistrate may confirm the dependency certificate. The AMP is a specialist in addiction medicine.	Adult applies for assessment. Must have medical certificate from doctor who has examined person, or have attempted to arrange examination. Authorised officer determines whether there are reasonable grounds to suspect the individual meets the criteria. Approved specialist assesses the person and can sign a compulsory treatment certificate. Family Court or District Court can make compulsory treatment order.	Adult applies to Magistrate Court for an order. Application must include a recommendation from a prescribed registered medical practitioner (Fellow or affiliate of the Royal Australian and New Zealand College of Psychiatrists or a Fellow of the Chapter of Addiction Medicine). Magistrate considers criteria and application, and obtains certificate of available services from the relevant treatment centre. Magistrate may make detention and treatment order.	Automatic referral of a person who is taken into police protective custody three or more times in two months. Alternatively, health practitioner can refer an adult to a senior assessment clinician for assessment. Only the Alcohol Mandatory Treatment Tribunal (AMTT) can make a mandatory treatment order.
Order for assessment	If AMP cannot access the individual, a Magistrate or an authorised officer under the <i>Criminal Procedure Act</i> may make an order for assessment. May require police assistance.	Authorised officer may take all reasonable steps to take the individual to an assessment. May require police assistance.	Police officer or any adult can apply to Magistrate for special warrant to have person examined. May require police assistance.	An individual can be detained in a designated assessment facility to await an assessment.
Length of order	Initial order – up to 28 days. Magistrate may extend, maximum total length of order – 3 months.	Initial order – up to 8 weeks. Court may extend for up to another 8 weeks if the person has a brain injury.	14 days.	Up to 3 months. AMTT may extend, maximum total length of order – 6 months.
Treatment	<ul style="list-style-type: none"> • treatment prescribed by AMP; • have regard to possible effects of medication; • minimum medication consistent with proper care; • includes withdrawal, medical treatment for co-occurring physical conditions or mental illness, and longer term intervention including health, social and welfare services • includes community based program. 	<ul style="list-style-type: none"> • treatment that the responsible clinician thinks fit; • have regard to possible effects of medication; • minimum medication consistent with proper care; • in accordance with treatment plan; • includes detoxification, care, counselling, rehabilitation and interventions to alleviate or prevent the worsening of the symptoms or manifestations of severe substance addiction. 	<ul style="list-style-type: none"> • anything done in the course of the exercise of professional skills to provide medically assisted withdrawal from a severe substance dependence or to lessen the ill effects, or the pain and suffering, of the withdrawal • in accordance with treatment plan; • consider views of person and their support persons; • consider alternatives, risks and consequences of not providing treatment. 	<ul style="list-style-type: none"> • in accordance with treatment plan; • alcohol testing; • assessment and withdrawal phase, followed by longer period of treatment.

Feature	New South Wales Act	New Zealand Bill	Victorian Act	Northern Territory Act
Safeguards	<ul style="list-style-type: none"> • right to explanation of legal rights; • nomination of primary carer; • access to interpreter, if required; • access to official visitor; • right of appeal to Civil and Administrative Tribunal. 	<ul style="list-style-type: none"> • right to explanation of legal rights; • notifications to principal caregiver, guardian and nominated person; • right to information about treatment; • right to independent advice from approved specialist; • access to interpreter, if required; • right to legal advice; • right to make a formal complaint; • right to visitors and communication with others; • additional safeguards for children who are on a compulsory treatment order; • right to apply to Court for urgent review of status. 	<ul style="list-style-type: none"> • statement of rights; • notifications to Public Advocate, nominated person and guardian; • right communications in form and terms that the person is most likely to understand; • right to a second opinion; • right to a discharge plan; • right to request legal advice; • right to appeal to Magistrate's Court for revocation of order. 	<ul style="list-style-type: none"> • statement of rights and oral explanation of rights; • nomination of primary contact; access to interpreter, if required; • access to community visitor; • right to appear and be represented before the AMTT; • right to appeal to Local Court on a question of law.
Treatment facilities	Can be detained in a facility that has been declared as a treatment centre.	Can be detained in a treatment centre operated by an approved provider.	Can be detained in a declared treatment centre.	Three kinds of facilities declared as: <ul style="list-style-type: none"> • assessment centres – for withdrawal; • secure facilities – treatment centres; and • community services – for treatment.