3rd October 2005

Ms Rochelle Shaw
Acting Manager
Alcohol Policy Unit
Department of Human Services
GPO Box 1670N
Melbourne, Vic. 3000.

Dear Ms Shaw

Re: Review of the Alcoholics and Drug-dependent Persons Act 1968

The Office of the Public Advocate is pleased to make a submission to this review and welcomes the opportunity for further input if requested.

Yours truly,

Dr David Sykes
Acting Public Advocate

Submission to the Review of the

Alcoholics and Drug-dependent Persons Act (1968)

3rd October 2005
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This submission is endorsed by the Acting Public Advocate, Dr David Sykes.
This submission does not contain any confidential material.

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Executive Summary

The Public Advocate welcomes the opportunity to make a submission to the Review of the Alcoholics and Drug-dependent Persons Act (1968) in response to the consultation paper.

The key issues this submission will focus on are:

1) The intent of the Act
2) Current issues and problems with the Act
3) Civil Commitment
4) Making an application
5) Accountability

Summary of Recommendations

Intent of the Act

1. The Public Advocate believes that the primary intention of this Act should be to provide for immediate access to drug and alcohol treatment centres to ensure the safety and wellbeing of the drug or alcohol-affected individual. This may have the additional effect of reducing risk to others from alcohol or drug-affected individuals.

2. The Act should be amended to have s.11 cover both admission and treatment.

Current issues and problems with the Act

3. That guardianship is not an appropriate mechanism to admit persons, with a cognitive impairment, and a drug or alcohol related problem to a facility for the purpose of an assessment or ongoing care.

4. The provisions of s.11 to be strengthened so that treatment and residency can be enforced for the period of the Order and that the existing power in the Act for the Victoria Police to return the person to the facility be enforced.

5. If coercive sanctions are to be included within the revised Act, the same coercive sanctions must apply for anyone subject to the Act regardless of whether not the individual has a cognitive disability. Coercion should not occur through the use of any other Act.

Problems with the service system

6. Follow-up support services designed to support the transition of people with cognitive impairment into the community after detoxification (medical, accommodation and medium term rehabilitation and case management) need to be made available.

7. Education and training about guardianship and cognitive impairments in the D&A sector.

8. Drug and Alcohol treatment centres capable of housing people subject to s.11 orders should also be located in rural and regional areas.

Civil commitment

9. Civil commitment (detention in a drug and alcohol treatment facility) under section 11 of this Act should be retained.

Applications

10. The group of people who can make applications should continue to be limited to minimise the number of people to whom this is an option. However, Guardians and medical practitioners should be able to make applications under s.11.

11. One of the two medical practitioners who certifies to someone's alcohol and/or drug dependency should be from a Drug and Alcohol Treatment agency.

12. Criteria should be developed as the basis for civil commitment under section 11 along the lines of the *Mental Health Act*. These could include:
    - Evidence of sustained negative impact and / or self-neglect caused by D&A dependency.
    - Attempts at voluntary treatment have proven unsuccessful
    - Treatment would be beneficial to the individual
    - Dependency constitutes a danger to self and / or others

All of these criteria should be satisfied before any civil commitment is considered.

Accountability

13. There must be accountability in the civil commitment process with appropriate independent, transparent and accountable appeal and review processes. Applications should be made to the Victorian Civil and Administrative Tribunal rather than the Magistrate's Court so that an appropriate appeal process can be built into the system, which is potentially more accessible to the client group than the current arrangement which would necessitate an appeal to the County Court.

14. If locked treatment centres were to be established, a review process based on the Community Visitor model would be required.

1. Introduction

The Public Advocate welcomes the opportunity to make a submission to the Review of the *Alcoholics and Drug-dependent Persons Act* (1968) in response to the consultation paper. The Public Advocate made a submission to the Department of Human Services in relation to the possible review of the *Alcoholics and Drug-dependent Persons Act* (1968) in June 2004. This submission draws on that 2004 submission.

The key issues this submission will focus on are:

1) The intent of the Act
2)Current issues and problems with the Act
3) Civil Commitment
4) Making an application
5) Accountability

2. About the Public Advocate

The Public Advocate in Victoria is appointed by the Governor in Council pursuant to the *Guardianship and Administration Act* 1986 (Vic). The Office of the Public Advocate (OPA) represents the interests of people with a disability, aiming to promote their rights and dignity and to strengthen their position in society. It is a statutory office, independent of government and government services, and can highlight situations in which people with disabilities are exploited, neglected or abused.

The Public Advocate delegates his authority to his staff, who may be advocates, investigators or guardians. The office also coordinates the Private Guardian Support Program, the Community Guardians Program, the Community Visitors Program and the Independent Third Person Program in Victoria. Further material on the role of the Office can be provided if required by consulting OPA's website: www.publicadvocate.vic.gov.au.

3. Intent of the Act

OPA supports the retention of the Act and particularly the provision enabling civil commitment of non-offenders for assessment (s.11). People with cognitive disabilities often lack the capacity to understand the consequences of their behaviour and the risk their substance abuse may pose to themselves and/or to others. Generally, they are also unable because of their disability to make a decision to seek treatment voluntarily with a view to modifying their behaviour. They are therefore vulnerable to abuse and neglect (including self-abuse and neglect). Without the possibility of detaining someone for the purpose of treatment, some people with cognitive disabilities affected by serious substance abuse would be at serious risk of significant harm.

The Public Advocate has experience as being appointed by the Victorian Civil and Administrative Tribunal as guardian for many people who have an alcohol related

brain injury. For example, in 2003/04 approximately 50% of OPA cases where the client had an Acquired Brain Injury (ABI) were due to alcohol abuse. In some of these instances the person required detoxification and ongoing care.

There are a wide variety of reasons that a guardian may be sought to place a person with a cognitive disability in a detoxification facility. These include:

1. Life saving When the situation has reached crisis point for a person with an ABI admission to a facility for detoxification can be a way of saving the person's life if they are considered to be at significant risk.

2. Crisis: Admission for detoxification can be a way of defusing the pressure of the situation. This can often be in response to requests to exert some level of social control in order to remove the person from those who are distressed by the person's behaviour. This can be contrary to the interests of the person with ABI who may operate best in a familiar environment.

3. Assessment: To enable assessments to be carried out once the person is no longer intoxicated. These assessments may be important to plan for the future accommodation and support needs of the person. These assessments can include:- neuropsychological, mental health, aged care and physical health.

4. Carer respite: Admission can provide important respite for carers or service providers under stress who often have few alternatives to seeking a period of respite.

5. Access to services: In order to gain access to accommodation and/or support programs it may be necessary to have the person admitted for detoxification before they can be accepted into these services.

6. Restraint: Guardianship may also be sought to keep the person in detoxification because services believe that the *Alcoholics and Drug dependent Persons Act* (1968) does not authorise them to be able to keep the person in the facility. Alternatively the facility may not be secure and so guardianship is sought to try and keep the person in a place where they cannot be compulsorily held for care.

Sally

Sally is 30 and has been an alcoholic since 16. Sally has a diagnosis of personality disorder, elements of an obsessive-compulsive disorder (OCD) as well as a marginal acquired brain injury (ABI). She completed Year 11 and did office work for several years before her lifestyle deteriorated to the point where she could no longer maintain employment or stable accommodation. At 24 she had a son who has alcohol foetal syndrome. He lives with his father and Sally is not permitted to see him unsupervised. Sally used to live at an SRS before it closed and then moved to another SRS. She had case management from SANS but wore out their workers. In cycles she will drink methylated spirits, causing her to lose consciousness and frequently be brought to hospital.

A Guardianship order was made to allow hospital to engage security to keep her at the detoxification facility. In this case according to the interpretation of the Magistrates'

Court s11 of the *Alcoholics and Drug dependent Persons Act* (1968) allows a person to be taken to a D&A treatment centre but does not provide for a person to be prevented from leaving.

Whilst the *Alcoholics and Drug dependent Persons Act* (1968) does have provision through section 11 for someone to be placed into a detoxification facility the experience of the OPA is that Guardianship tends to be used more frequently by services to enable the client to be admitted to a detoxification facility.

The Public Advocate believes that the primary intention of this Act should be to provide for immediate access to drug and alcohol treatment centres to ensure the safety and wellbeing of the drug or alcohol-affected individual. This may have the additional effect of reducing risk to others from alcohol or drug-affected individuals.

However, OPA contends that the distinction between assessment (s.11) and treatment (s.12) in an alcohol and drug facility is artificial and since no orders have been made under s.12, the Act should be amended to have s.11 cover both admission and treatment.

4. Current issues and problems with the Act

The experience of the Office is that the Drug and Alcohol service system tends to be inadequate in its capacity to respond effectively to the needs of clients with a cognitive impairment. Unlike other clients they may require some level of restriction to ensure that they receive adequate care.

4.1. Problems with current service system

OPA's previous submission highlighted the difficulties of containing persons with cognitive impairments in the current service system. A fundamental issue is the extent to which the current range of services available in the Drug and Alcohol field adequately address the needs of clients who have a cognitive disability. The majority of people addicted to drugs and alcohol do not have a brain injury and are capable of making decisions for themselves. However the current approach to treating addiction that relies upon the person voluntarily seeking out treatment can be problematic for clients who lack insight as a direct result of their disability. Consequently the use of guardianship or s11 of the *Alcoholics and Drug dependent Persons Act* (1968) is contrary to the belief that people should take responsibility for their lives. It is often difficult for someone to be admitted to detoxification under a guardianship order. Drug and alcohol professionals are wary of guardians trying to arrange rehabilitation rather than the person themselves.

The reliance upon cognitive behavioural approaches in the treatment of addiction also means that this can be of limited benefit to a person with cognitive disability. In fact

for many people with a cognitive disability the approach required is not related to treatment or rehabilitation but rather care and management of behaviours.

Jan
Jan a 47 year old woman who was a chronic alcoholic, drinking two flagons of wine per day. Jan had been a very successful business woman. She was suffering end stage liver disease and the prognosis was that she would be dead in five months. Following a period in detoxification Jan now lives in a Supported Residential Service where she has controlled access to alcohol and there is also a strong partnership with the local police.

This lack of familiarity by drug and alcohol professionals with clients who have cognitive impairment leads to a number of difficulties. Most people following detoxification do not require supported accommodation or supports other than provided by community drug and alcohol counsellors. However people with drug and alcohol problems in addition to disability frequently use or demand community support services far in excess of what is available which may cause services to withdraw completely. Indeed homelessness can be a significant problem amongst this group. Related to this is the lack of case management for these clients which can create a problem for achieving a co-ordinated response. This is further exacerbated by the fragmented nature of the service system. For example it is not possible to plan entry to detoxification in conjunction with a placement in a rehabilitation program following detoxification. A further problem is the lack of detoxification facilities in rural areas which means that the person needs to be transported long distances to a detoxification centre.

Since the *Alcoholics and Drug dependent Persons Act* (1968) was proclaimed a significant number of related legislation has been enacted which needs to be considered in how they relate to the *Alcoholics and Drug dependent Persons Act* (1968). These include the *Mental Health Act* (1986), *Children and Young Persons Act (*1989) and *Guardianship and administration Act* (1986). It is the experience of the Office that there is a lack of education and training about the intersection of drug and alcohol, mental health and guardianship legislation, which exacerbates the problems discussed here.

4.2. Section 11 Orders

Currently Section 11 of the Act enforces admission to Drug and Alcohol (D&A) Treatment Centres, but does not enforce treatment or residency. If people are committed under section 11 and abscond the police are able to return them, but experience suggests that this responsibility is not always a high priority for the Victoria Police. There is concern that individuals subject to a guardianship order would be subject to these coercive sanctions to a far greater extent than other individuals subject to s.11. To subject only people with disabilities to coercive sanctions because of their cognitive incapacity would be discriminatory and against the principles of the *Guardianship and Administration Act* (1986), which requires that a guardian only be appointed where it is in the person with the disability's best interests **and** there is a need for a guardian to make a decision **and** all less restrictive options have been tried first.

If coercive sanctions are to be included within the revised Act, the same coercive sanctions must apply for anyone subject to the Act regardless of whether the individual has a cognitive disability. Coercion should not occur through the use of any other Act.

It can be very difficult to have success with applications under s.11 and there seems to be a perception that rather than making a s.11 application, these difficulties can be avoided by applying for the appointment of a guardian in the hope that admission to treatment will be achieved. There seems to be a lack of awareness of the processes and underlying principles of the *Guardianship and Administration* Act and it would be beneficial if workers in the drug and Alcohol services field undertook some training in this area. This also suggests that A&D legislation is so difficult to bring into effect that other legislation is being used inappropriately. This highlights the need to revise the A&D Act so that use of s.11 is more effective. Guardianship should not be used as a means of bypassing other legislation. It is a last resort and all less restrictive options should be used prior to a guardianship order being sought. A guardian's role should be to initiate an application and follow up post-treatment rather than taking measures to enforce treatment.

OPA submits that is more appropriate for the provisions of s.11 to be strengthened so that treatment and residency can be enforced for the period of the Order and that the existing power in the Act for the Victoria Police to return the person to the facility be enforced.

Currently there are no locked facilities which would make possible enforced treatment. Within the discussion paper reference is given to a preference for a harm minimisation approach to D&A treatment, and OPA recognises that client voluntarism forms an important component of this ethos, yet the Public Advocate believes that there is a place for small-scale locked treatment facilities.

5. Civil Commitment

The Public Advocate is of the view that civil commitment (detention in a drug and alcohol treatment facility) under section 11 of this Act should be retained. However, some changes are recommended:

- The period of involuntary treatment is currently 7 days, but OPA agrees with the recommendations of treating agencies that the period be extended. At a Dept. of Human Services consultation meeting held with representative agencies on the 6th of September 2005, the initial position was that this should be extended to 14 days.

- After 14 days the Section 11 order will automatically lapse unless an application is lodged for extension. It would be incumbent upon agencies to apply for an extension if they believed there is a clinical need.

6. Making an Application

6.1. Who can make an application?

The group of people who can make applications should continue to be limited to minimise net-widening effects.

- The definition of welfare officer needs to be clarified to make the application process more workable. The current list of applicants is deficient due to uncertainty about who is considered to be a 'welfare officer' within the meaning of the Act.

- Currently guardians are not part of the small group with the authority to make applications under s.11. The Public Advocate contends that it is appropriate for guardians to make applications. However, the ability of a guardian to bring a complaint under s.11 should not be used as an excuse for making a guardianship application to the Victorian Civil and Administrative Tribunal-Guardianship List in order for a s.11 complaint to be brought.

- The Public Advocate should be included. This inclusion will facilitate options less restrictive than guardianship, in cases where it is appropriate to make an s.11 application rather than appointing a guardian.

- Family members should be included.

- Medical practitioners currently cannot bring a complaint and the Public Advocate believes that medical practitioners should be able to bring a complaint.

- Business partners should not be included.

These recommendations aim to create a balance between maintaining restrictions on the range of people allowed to make s.11 applications and improving ease of application process so that legislation better serves the purpose for which it was designed. It is proposed that the imminent creation of Neighbourhood Justice Centres as outlined in the Attorney-General's Justice statement, with co-location of courts and community services such as Drug and Alcohol services may also assist the process of making an application.

6.2. The Application Process

Currently the application requires evidence of D&A dependency in the form of signed statements by two medical practitioners. OPA supports the proposal that one of these should be from a doctor at a D&A agency. This would ensure that specialist knowledge informs the application, which will aid the Magistrate's decision-making.

Assessment by a specialist agency would enable the consideration of all available treatment options prior to progressing a complaint under section 11 of the Act. This would ensure that less restrictive options are explored first. To ensure ease of access for non-professionals, the second doctor could be the individual's GP.

6.3. Application Criteria

The earlier OPA submission suggested that criteria should be developed as the basis for civil commitment under section 11. Reference was made by analogy to the criteria under the *Mental Health Act* (1986). It is suggested that criteria under this Act follow along similar lines:

- Evidence of sustained negative impact and / or self-neglect caused by D&A dependency.
    - Currently, description of living circumstances is provided (by Occupational Therapist, for example), generally with an emphasis on danger to self.
    - "Sustained": definition of alcoholic or drug-dependent person (contained in discussion paper). In this way individual must "appear to be an alcoholic or drug dependent person."

- Attempts at voluntary treatment have proven unsuccessful
- Treatment would be beneficial to the individual
- Dependency constitutes a danger to self and / or others

If all the criteria are satisfied evidence will be tendered to a Magistrate who retains the formal legal authority to find the section 11 application proven.

7. Accountability

The application model proposed above ensures accountability in the civil commitment process. This is achieved through:

- Maintaining restrictions on who is able to make applications
- Using D&A specialists to provide evidence that non-voluntary treatment is necessary
- Having a Magistrate, with legal authority to commit people to hear and decide upon the evidence.

In addition, as discussed below, this process will ensure that an appropriate independent, transparent and accountable appeal and review process exists.

7.1. Review and Appeal Processes

There is currently no appeal process. The Public Advocate recommends that:

- Applications be made to the Victorian Civil and Administrative Tribunal rather than the Magistrate's Court. This would enable an appropriate appeal process to be built into the system.

An accessible appeal process must be established for any process through which an individual has his or her liberty removed. Considering the needs and resources of people who may be subject to section 11 of D&A Act, the process of making appeals against Magistrates' decisions through the County Court may not be accessible and therefore is not appropriate. However, as there are judicial members of VCAT, an appeal process could be established whereby these judicial members could preside over appeals against the decisions of other Tribunal members.

- Re-hearing after the 14 day period.
  - The application automatically lapses on the fourteenth day after approval, unless the original applicants requests that it be re-heard.
  - There must be provision in the Act for the matter to be re-heard before this time, however. In these cases, a judicial member from VCAT should preside over the review.

7.2. Monitoring Processes

Provision for "Inspectors / Official Visitors" exists in original Act (s 8) but no "Inspector / Official Visitors" have ever been appointed.

The Public Advocate strongly believes that if locked treatment centres were to be established, a review process based on the Community Visitor model, which currently exists in the disability, mental health and health services legislation, would be required.

8. Recommendations

Intent of the Act

1. The Public Advocate believes that the primary intention of this Act should be to provide for immediate access to drug and alcohol treatment centres to ensure the safety and wellbeing of the drug or alcohol-affected individual. This may have the additional effect of reducing risk to others from alcohol or drug-affected individuals.

2. The Act should be amended to have s.11 cover both admission and treatment.

Problems with the Act

3. That guardianship is not an appropriate mechanism to admit persons with a drug or alcohol related problem to a facility for the purpose of an assessment or ongoing care.

4. the provisions of s.11 to be strengthened so that treatment and residency can be enforced for the period of the Order and that the existing power in the Act for the Victoria Police to return the person to the facility be enforced.

5. If coercive sanctions are to be included within the revised Act, the same coercive sanctions must apply for anyone subject to the Act regardless of whether not the individual has a cognitive disability. Coercion should not occur through the use of any other Act.

6. Follow-up support services designed to support the transition of people with cognitive impairment into the community after detoxification (medical, accommodation and medium term rehabilitation and case management) need to be made available.

7. Education and training about guardianship and cognitive impairments in the D&A sector.

8. Drug and Alcohol treatment centres capable of housing people subject to s.11 orders should also be located in rural and regional areas.

Civil commitment

9. Civil commitment (detention in a drug and alcohol treatment facility) under section 11 of this Act should be retained.

Applications

10. The group of people who can make applications should continue to be limited to minimise net-widening effects. However, Guardians and medical practitioners should be able to make applications under s.11.

11. One of the two medical practitioners who certifies to someone's alcohol and/or drug dependency should be from a Drug and Alcohol Treatment agency.

12. Criteria should be developed as the basis for civil commitment under section 11 along the lines of the *Mental Health Act*. These could include:
    - Evidence of sustained negative impact and / or self-neglect caused by D&A dependency.
    - Attempts at voluntary treatment have proven unsuccessful
    - Treatment would be beneficial to the individual
    - Dependency constitutes a danger to self and / or others

Accountability

13. There must be accountability in the civil commitment process with appropriate independent, transparent and accountable appeal and review processes. VCAT should be used rather than the Magistrate's Court so that an appropriate appeal process can be built into the system.

14. If locked treatment centres were to be established, a review process based on the Community Visitor model would be required.

9. References

Office of the Public Advocate (2004) *OPA submission to the Review of the* ***Alcoholics and Drug-dependent Persons Act* (1968).**
OPA, Melbourne.