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**Review of the Severe Substance Dependence Treatment Act
2014 (Vic)
Volume 2
Literature Review**

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INTRODUCTION

Involuntary treatment of substance use disorders refers to the assessment and management of patients with a substance use disorder where the individual has no choice. This includes treatment for substance dependence with a mandate based in legislation and/or government-implemented programs, such as court-mandated treatment of offenders and the civil commitment of non-offenders.

DLA Piper has been appointed to undertake a statutory review of the *Severe Substance Dependence Treatment Act 2010*. The objectives of the Act are to:

- provide for the 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 to prevent serious damage to the person's health; and
- enhance the capacity of those persons to make decisions about their substance use and personal health, welfare and safety.

This review incorporates peer-reviewed and 'grey' literature and analysed background materials to appraise contemporary evidence regarding involuntary treatment of severe substance use disorders.

This review builds on previous comprehensive reviews and analyses of the literature regarding involuntary treatment of substance use disorders^{1 2 3 4}.

Literature review methods

In the health care literature, the Medical Subject Heading (MeSH) terms 'substance-related disorders', 'coercion', 'mandatory programs' and 'substance abuse treatment centers' were used to search the literature, together with truncated keywords to cover the various subheadings relevant to involuntary treatment of substance use disorders.

These search strategies were used with the international databases PubMed, EMBASE, the Cumulative Index of Nursing and Allied Health Literature (CINAHL) and the Cochrane Library from 2004 until present. The 'grey literature' was also searched using the same keywords and acronyms. 'Google®' and 'Google Scholar®' were interrogated to identify materials of broad relevance. A summary of findings is presented below.

Structure of the current literature review

Drawing on the relevant materials identified, this review describes the policy context for involuntary treatment, definitions of involuntary treatment and international experience with involuntary

¹ Wild T. Social control and coercion in addiction treatment: Towards evidence-based policy and practice. *Addiction* 2006; 101:40-49.

² Urbanoksi K. Coerced addiction treatment: Client perspectives and the implications of their neglect. *Harm Reduction Journal* 2010; 7: 13-23.

³ Broadstock M. A systematic review of the literature. The effectiveness of compulsory, residential treatment of chronic alcohol or drug addiction in non-offenders. University of Canterbury, NZ, 2008.

⁴ Pritchard E. Compulsory treatment in Australia: A discussion paper of the compulsory treatment of individuals dependent on alcohol and / or other drugs. ANCD. Canberra, 2007.

treatment of substance use disorders, evidence of effectiveness of this treatment approach, client perspectives on involuntary treatment, ethical issues and available clinical guidance relevant to involuntary treatment practices.

SUBSTANCE USE DISORDERS

Substance use disorders are serious and complex problems which contribute to increased patient morbidity and mortality, injury, social and family disruption and crime. They are collectively responsible for over five per cent of Australia's burden of disease and impose a heavy financial burden on the Australian community.

Substance use disorders currently affect over 220,000 Victorians. A small proportion of affected people will seek assistance from health professionals for their substance use. The prevalence of severe substance use disorders is difficult to determine as standardised definitions of severe substance use have not been developed.

The treatment of substance use disorders is long-term because substance use disorders are chronic, multi-factorial conditions. Treatment approaches that are most effective incorporate psychosocial approaches matched to patient need and the use of pharmacological agents when clinically indicated.

A description of substance use disorders and their epidemiology is provided at Appendix 1.

A summary of the literature on treating substance use disorders is included at Attachment 2.

A summary of national and state drug and alcohol policy is included at Attachment 3.

A discussion on the *Mental Health Act 2014* (Vic) is included at Attachment 4.

A summary of relevant aspects of the findings of the Inquiry into the Supply and Use of Methamphetamines, Particularly 'Ice' in Victoria is included at Attachment 5.

INVOLUNTARY TREATMENT

Involuntary treatment for alcohol dependence was established in the 1800s in Australia when legislation "embodied the concept of alcoholism as a disease to be treated rather than a crime to be punished"⁵. At this time confinement and rehabilitation (physical and psychological) were viewed as a requirement for the treatment of alcoholism and drug addiction.

Since that time the treatment of alcohol dependence, and subsequently other drug dependence, has evolved significantly.

Definitions of involuntary treatment

There are different definitions of involuntary treatment in the literature. The following definition of involuntary treatment, and the related concepts of civil commitment and coercive treatment, is described here to assist in the interpretation of literature pertaining to involuntary treatment⁶:

⁵ MacAvoy M. Compulsory treatment of alcoholism: the case against. *Drug Alcohol Review*, 1990. 9: p. 267-272.

⁶ Dore G. Involuntary treatment of drug and alcohol dependence in New South Wales: an old Act and a new direction. *The Medical journal of Australia*, 2013. 198(11): p. 583-5.

Involuntary treatment refers to commitment to treatment where the individual (offender or non-offender) has no choice. This includes treatment for substance dependence with a mandate based in legislation and/or government implemented programs, such as court-mandated treatment of offenders and the civil commitment of non-offenders.

Civil commitment is a process undertaken outside the criminal justice system and refers to the “legally sanctioned, involuntary commitment of a non-offender into treatment [for drug or alcohol dependence]”. In Australia, civil commitment legislation for substance dependence exists in New South Wales, Victoria and Tasmania, while the Northern Territory has involuntary treatment orders for alcohol and volatile substance dependence. Sweden and New Zealand also have civil commitment legislation. A detailed description of jurisdictional legislation relating to civil commitment is provided in the companion document accompanying this literature review.

Coercive treatment is considered to be a form of involuntary treatment. Coercive treatment occurs when an individual “is given the choice to choose between an opportunity to comply with addiction treatment or receive the ‘alternative consequences’ prescribed by the enforcement of the law, policy or agency” (e.g. prison or probation, loss of child custody, loss of employment or benefits). This includes court diversion programs.

According to these definitions, the St Vincent’s Hospital Melbourne treatment program under the Severe Substance Dependence Treatment Act is a form of civil commitment.

Trends in involuntary treatment worldwide

Israelsson and Gerdner (2012) conducted a comprehensive international analysis of trends in compulsory commitment to care for substance misuse. Their analysis included 90 countries worldwide, approximately 82 per cent of which had some laws on compulsory commitment⁷. The majority were compulsory commitment laws that were of a coercive rather than civil commitment nature.

The authors observed the following trends across countries:

- since the year 2000 the number of countries worldwide that use **any type of compulsory care** for the treatment of people with substance use disorders has decreased;
- the use of compulsory **civil commitment** to care for people with substance use disorders has decreased worldwide and the maximum time an individual can be mandated to receive care has decreased;
- since 1990 there has been a worldwide increase in the use of compulsory care within **criminal justice legislation** and the maximum time an individual can be mandated to receive care has increased substantially; and
- for a subset of European countries with available data, the number of people mandated to receive care for substance use disorders increased significantly (between the years 2002 and 2006).

⁷ Israelsson M. Compulsory commitment to care of substance misusers: international trends during 25 years. *European Addiction Research* 2012; 18: 302-321.

Room (2011) also conducted a study that examined trends in compulsory treatment for substance use disorders. The author analysed data from 147 countries worldwide⁸. A total of 42.5 per cent of countries were found to have laws or 'special legislation' for the compulsory treatment of substance use disorder. A further 20.5 per cent were found to have drug courts and 52.2 per cent have programs for compulsory diversion to treatment.

The interpretation of the data contained within this report, and comparison with the findings of Israelsson et al. is problematic as the report by Room does neither specify which countries the author found to have each of these legal features. Further, the report does not provide legislative texts or clear definitions of 'special legislation on compulsory treatment' or drug courts.

Evidence of effectiveness of involuntary treatment

The majority of studies of involuntary treatment relate to coercive treatments provided via the criminal justice system. Studies of civil commitment, similar to the program offered at St Vincent's Hospital Melbourne under the Act, are more limited^{9 10 11 12}.

Reviews of the literature have generally concluded that^{13 14}:

- most research and evidence on the effectiveness of involuntary treatment relates to offenders who are coerced and referred via the criminal justice system;
- short term involuntary treatment can provide improved patient outcomes for some people at least some of the time;
- there is little evidence relating to the effectiveness of involuntary treatment in rehabilitating or achieving long-term behavioural change; and
- while substance use disorders are chronic conditions, acute emergency situations that are life-threatening do occur. Involuntary treatment may be used in these acute situations to prevent death and minimise harm.

Evidence of effectiveness of involuntary treatment generally considers involuntary treatment that is legally mandated. However, some policy documents and opinion pieces draw conclusions about the effectiveness of involuntary treatment from other sources of evidence, particularly the social control literature (described below). A limitation of all available evidence about involuntary treatment is that

⁸ Room R. Policy and legislation; in ATLAS on substance use 2010, 2011: Geneva.

⁹ Pritchard E. Compulsory treatment in Australia: A discussion paper of the compulsory treatment of individuals dependent on alcohol and / or other drugs. ANCD. Canberra, 2007.

¹⁰ Hall W. Advocates need to show compulsory treatment of opioid dependence is effective, safe and ethical. Bulletin of the World Health Organisation 2013; 91: PMC3605012.

¹¹ Urbanoksi K. Coerced addiction treatment: Client perspectives and the implications of their neglect. Harm Reduction Journal 2010; 7: 13-23.

¹² Hall W, Lucke J. Legally coerced treatment for drug using offenders: ethical and policy issues. Crime Justice Bull. 2010;144:1-12.

¹³ Wild T. Social control and coercion in addiction treatment: Towards evidence-based policy and practice. Addiction 2006; 101:40-49.

¹⁴ Broadstock M. A systematic review of the literature. The effectiveness of compulsory, residential treatment of chronic alcohol or drug addiction in non-offenders. University of Canterbury, NZ, 2008.

no studies control for other treatment strategies that may be in place in conjunction with involuntary treatment and that may affect the effectiveness of involuntary treatment.

Literature reviews that have appraised evidence regarding involuntary treatment have generally concluded that research on the efficacy is inconsistent and inconclusive^{15 16 17 18 19}. This is in part because these literature reviews do not always distinguish between different forms of involuntary treatment in conducting their analyses of outcomes.

In aggregate, the findings of studies where patients feel 'legally pressured' to participate in treatment are generally that some form of legal pressure is associated with better outcomes than voluntary treatment in terms of treatment retention and post-treatment drug use^{20 21 22 23}. Legal pressure is associated with longer retention in treatment^{24 25 26 27 28 29}. Studies have also found that clients who enter treatment under legal pressures show comparable or better short-term treatment responses (e.g.,

¹⁵ Urbanoksi K. Coerced addiction treatment: Client perspectives and the implications of their neglect. *Harm Reduction Journal* 2010; 7: 13-23.

¹⁶ Broadstock M. A systematic review of the literature. The effectiveness of compulsory, residential treatment of chronic alcohol or drug addiction in non-offenders. University of Canterbury, NZ, 2008.

¹⁷ Wild T. Social control and coercion in addiction treatment: Towards evidence-based policy and practice. *Addiction* 2006; 101:40-49.

¹⁸ Klag S. Development and initial validation of an instrument to measure perceived coercion to enter treatment for substance abuse. *Psychology of Addictive Behaviours* 2006; 20:463-470.

¹⁹ Stevens A. Quasi-compulsory treatment of drug dependent offenders: An international literature review. *Substance Use and Misuse* 2005; 40:269-283.

²⁰ Copeland J. Cannabis treatment outcomes among legally coerced and non-coerced adults. *Biomed Central Public Health* 2007; 7:111-118.

²¹ Kelly J. Substance use disorder patients who are mandated to treatment: Characteristics, treatment process, and 1- and 5-year outcomes. *Journal of Substance Abuse Treatment* 2005; 28:213-223.

²² McCormick R. Commitment to assessment and treatment: comprehensive care for patients gravely disabled by alcohol use disorders. *The Lancet* 2013; Published online April 19,2013.

²³ Sweeney T. Civil commitment for substance use disorder patients under the Florida Marchman Act. *Journal of Addictive Diseases* 2013; 32: 108-15.

²⁴ Vickers-Lahti M. The relationship between legal factors and attrition from a residential drug abuse treatment program. *Journal of Psychoactive Drugs* 1995; 27:17-25

²⁵ Leukefeld C. Compulsory treatment of drug abuse: Research and clinical practice. Rockville, MD: US Department of Health and Human Services; 1988. (NIDA Research Monograph No. 86)

²⁶ Young D. Impacts of perceived legal pressure on retention in drug treatment. *Criminal Justice and Behavior* 2002; 29:27-55.

²⁷ Brecht M. Coerced treatment for methamphetamine abuse: Differential patient characteristics and outcomes. *American Journal of Drug and Alcohol Abuse* 2005; 31:337-356.

²⁸ Knight K. Legal pressure, treatment readiness, and engagement in long-term residential programs. *Journal of Offender Rehabilitation* 2000; 31:101-115

²⁹ Copeland J. Cannabis treatment outcomes among legally coerced and non-coerced adults. *BMC Public Health* 2007; 7:111

reductions in substance use, criminal activity) compared with others in treatment^{30 31 32 33 34 35 36 37 38}
³⁹

On this basis, it is anticipated that clients of the St Vincent's Hospital Melbourne treatment program who are treated under the Act could have longer treatment retention and may have reduced post-treatment drug use. However, some studies that suggest civil commitment of a similar nature to the St Vincent's involuntary treatment program may produce equivalent rather than superior outcomes to voluntary clients for post-program treatment retention and post-program crime, including re-arrest^{40 41 42}. Further, in some studies voluntary treatment is associated with better outcomes than mandatory treatment, including treatment retention, days incarcerated and drug-free discharge^{43 44}.

Australian perspectives

The NSW Drug and Alcohol Treatment Act (2007) was drafted with a treatment model that incorporated involuntary, short-term inpatient treatment to individuals with severe substance

³⁰ Anglin M. Pre-treatment characteristics and treatment performance of legally coerced versus voluntary methadone maintenance admissions. *Criminology* 1989; 27:537-557

³¹ Leukefeld C. Compulsory treatment of drug abuse: Research and clinical practice. Rockville, MD: US Department of Health and Human Services; 1988. (NIDA Research Monograph No. 86)

³² Brecht M. Coerced treatment for methamphetamine abuse: Differential patient characteristics and outcomes. *American Journal of Drug and Alcohol Abuse* 2005; 31:337-356.

³³ Copeland J. Cannabis treatment outcomes among legally coerced and non-coerced adults. *BMC Public Health* 2007; 7:111.

³⁴ Collins J. Legal coercion and retention in drug abuse treatment. *Hospital and Community Psychiatry* 1983; 34:1145-1149.

³⁵ Brecht M. Treatment effectiveness for legally coerced versus voluntary methadone maintenance clients. *American Journal of Drug and Alcohol Abuse* 1993; 19:89-106.

³⁶ Kelly J. Substance use disorder patients who are mandated to treatment: Characteristics, treatment process, and 1- and 5-year outcomes. *Journal of Substance Abuse Treatment* 2005; 28:213-223.

³⁷ Grichting E. Modes and impact of coercive inpatient treatment for drug-related conditions in Switzerland. *European Addiction Research* 2002; 8:78.

³⁸ Perron B. The influence of legal coercion on dropout from substance abuse treatment: results from a national survey. *Drug Alcohol Depend* 2008; 92:123-131.

³⁹ Burke A. Substance abuse treatment outcomes for coerced and non-coerced clients. *Health and Social Work* 2007; 32:7-15.

⁴⁰ Schaub M. Comparing outcomes of 'voluntary' and 'quasi compulsory' treatment of substance dependence in Europe. *European Addiction Research* 2010; 16:53-60.

⁴¹ Schaub M. Predictors of retention in the 'voluntary' and 'quasi-compulsory' treatment of substance dependence in Europe. *European Addiction Research* 2011; 17:97-105.

⁴² Prendergast M. Influence of Perceived Coercion and Motivation on Treatment Completion and Re-Arrest among Substance-Abusing Offenders. *J Behav Health Serv Res* 2008.

⁴³ Beynon C. Trends in drop-out, drug free discharge and rates of re-presentation: A retrospective cohort study of drug treatment clients in the north west of England. *BMC Public Health* 2006; 6:205-214.

⁴⁴ Desmond D. Compulsory supervision and methadone maintenance. *Journal of Substance Abuse Treatment* 1996; 13: 79-83.

dependence. The clinical model is similar to the St Vincent's Melbourne clinical model, however NSW legislation provides for detention for treatment for up to 28 days or up to three months if the person has alcohol-related brain injury.

A trial of the Act commenced in February 2009. Patients receive medicated withdrawal treatment for 5 to 7 days, followed by post withdrawal inpatient residential treatment and discharge/care planning. Community aftercare is an important component of the model of care, noting that patients take it up on a voluntary basis upon discharge. The aftercare framework aims to manage the high risks of relapse and adverse events following discharge from involuntary care, as well as restoring the person's capacity to make decisions about their substance use and personal welfare.

An evaluation by KPMG found the new system of care was more effective than treating severe substance dependent persons under the existing systems. The new system provided for the delivery of appropriate treatment, including supervised withdrawal, medical and nursing treatment of severe medical co-morbidities and also supportive aftercare. The trial demonstrated positive clinical and psychosocial outcomes for patients during the involuntary period including:

- providing the opportunity for medical conditions and physical health to be properly assessed and addressed and enabling patients to complete an extended period of abstinence that they would not be able to complete as voluntary patients;
- improved social relationships;
- slight reduction in symptoms of mental illness such as depression; and
- 80% of involuntary patients take up post-discharge voluntary aftercare.

A Queensland study of mandatory treatment for non-custodial offenders with substance use disorders examined the relationship between substance use patterns, treatment-seeking behaviours and treatment outcomes. Outcomes assessed included helping the person to stop using substances, using less alcohol and / or drugs for a while, using substances safely, improving mental and physical health and improving relationships with family, partners and friends. This mixed methods study of 480 people found that people with severe substance use disorders are more likely to recognise they have a substance use disorder but are not more likely to decide to enter treatment than those with less severe substance use. Further, once in treatment, people with severe substance use disorders do not perceive they perform any better or worse in treatment than those with less severe substance use. The performance of people who have undergone involuntary treatment did not differ significantly to those who had undergone voluntary treatment alone⁴⁵.

The use of retention as a measure of the efficacy of involuntary treatment has been criticised on the basis that people may remain in treatment while “going through the motions” without engaging meaningfully in the treatment process^{46 47}. This is supported by the findings of Knight et al. (2000) who showed legal mandates were positively related to treatment retention but unrelated to treatment

⁴⁵ Crime and Misconduct Commission. Mandatory treatment and perceptions of treatment effectiveness. Research and Issues Paper Number 7, October 2008.

⁴⁶ Wild T. Social control and coercion in addiction treatment: Towards evidence-based policy and practice. *Addiction* 2006; 101:40-49.

⁴⁷ Urbanoksi K. Coerced addiction treatment: Client perspectives and the implications of their neglect. *Harm Reduction Journal* 2010; 7: 13-23.

engagement⁴⁸. Similarly, Marshall and Hser (2002) found that involuntary treatment was associated with lower treatment engagement than voluntary treatment⁴⁹.

Social pressures: Social pressure may be used as an alternative to involuntary treatment for some patients. Social pressure is not legally mandated but is considered coercive and is therefore of relevance to understanding the effectiveness of non-voluntary substance use treatment. Social pressure is therefore mentioned in brief here.

The main form of social pressure used is to require participation in addiction treatment as a condition of receiving social assistance. Most studies have focussed on women and single mothers receiving welfare assistance in the US. These studies generally report positive impacts of treatment on substance use and employment outcomes, including job rates and earned wages^{50 51 52 53 54}. However, few studies compare this treatment with a comparison group of non-compulsory or untreated individuals. One study that did compare people referred to treatment through the welfare system with self-referred people found no difference in rates of treatment completion⁵⁵.

Complementary strategies: Involuntary treatment may occur in conjunction with other complementary treatment strategies.

Informal social networks may have a role in pressuring problem drinkers to change their behaviour and/or enter treatment, regardless of the involuntary component of treatment^{56 57}. In clinical studies, family and friends are among the most common sources of pressures to enter alcohol and drug treatment^{58 59}.

⁴⁸ Knight K. Legal pressure, treatment readiness, and engagement in long-term residential treatment programs. *Journal of Offender Rehabilitation* 2000; 31:101-115.

⁴⁹ Marshall G. Characteristics of criminal justice and noncriminal justice clients receiving treatment for substance abuse. *Addictive Behaviors* 2002; 27:179-192.

⁵⁰ Metsch L. Welfare and work outcomes after substance abuse treatment. *Social Service Review* 2003; 77:237-254.

⁵¹ McLellan A. One-year outcomes from the CASAWORKS for Families intervention for substance-abusing women on welfare. *Evaluation Review* 2003; 27:656-680.

⁵² Morgenstern J. Improving 24-month abstinence and employment outcomes for substance-dependent women receiving temporary assistance for needy families with intensive case management. *American Journal of Public Health* 2009; 99:328-333.

⁵³ Wickizer T. Employment outcomes among AFDC recipients treated for substance abuse in Washington State. *Milbank Quarterly* 2000; 78:585-608.

⁵⁴ Morgenstern J. Effectiveness of intensive case management for substance-dependent women receiving temporary assistance for needy families. *American Journal of Public Health* 2006; 96:2016-2023.

⁵⁵ Brizer D. Treatment retention of patients referred by public assistance to an alcoholism clinic. *American Journal of Drug and Alcohol Abuse* 1990; 16:259-264.

⁵⁶ Room R. Sources of informal pressure on problematic drinkers to cut down or seek treatment. *Journal of Substance Use* 2004; 9:280-295.

⁵⁷ Hasin D. Treatment/self-help for alcohol-related problems: Relationship to social pressure and alcohol dependence. *Journal of Studies on Alcohol* 1994; 55:660-666.

⁵⁸ Marlowe D. Multidimensional assessment of perceived treatment-entry pressures among substance abusers. *Psychology of Addictive Behaviors* 2001; 15:97-108.

Intervention methods involving family and friends and aimed at encouraging or inducing a loved one to enter treatment have been developed and tested. Some studies show that informal pressures, ranging from encouragement to organised interventions to prompt treatment entry, are associated with higher rates of treatment completion and a greater likelihood of regular attendance at 12-step meetings and methadone treatment^{60 61}.

Evidence of harm from involuntary treatment

Few studies have comprehensively assessed the empirical relationship between involuntary treatment and patient harm^{62 63}.

One study of the impact of compulsory drug detention on the subsequent avoidance of healthcare among injecting drug users was conducted in Thailand with 435 people who were intravenous drug users. Exposure to compulsory drug detention was associated with avoidance of healthcare and the experience of shame associated with one's drug use⁶⁴. Social, cultural and legal differences between Thailand and Australia make interpretation of these findings problematic.

Duration of involuntary treatment

The length of time an individual can be detained for involuntary treatment varies widely internationally. Although the majority of countries have legislation in place that enables involuntary treatment to be provided for a period of weeks, in some countries people with substance use disorders are detained in locked treatment facilities for several years^{65 66}.

Evidence is lacking from which to conclude an ideal duration for continuation of involuntary treatment. The appropriate length of time for involuntary treatment will depend on factors such as the substance type, the type of physical and / or mental harm that the patient is at immediate risk from and the length of time that is required to enable the patient to be properly assessed and fully detoxified from their drug(s) of dependence⁶⁷.

⁵⁹ Cunningham J. Alcohol and drug abusers' reasons for seeking treatment. *Addictive Behaviors* 1994; 19:691-696.

⁶⁰ Miller W. Engaging the unmotivated in treatment for alcohol problems: A comparison of three strategies for intervention through family members. *Journal of Consulting and Clinical Psychology* 1999; 67:688-697.

⁶¹ Gyarmathy V. Individual and social factors associated with participation in treatment programs for drug users. *Substance Use and Misuse* 2008; 43:1865-1881.

⁶² Broadstock M. A systematic review of the literature. The effectiveness of compulsory, residential treatment of chronic alcohol or drug addiction in non-offenders. University of Canterbury, NZ, 2008.

⁶³ Pritchard E. Compulsory treatment in Australia: A discussion paper of the compulsory treatment of individuals dependent on alcohol and / or other drugs. ANCD. Canberra, 2007.

⁶⁴ Kerr T. The impact of compulsory drug detention exposure on the avoidance of healthcare among injection drug users in Thailand. *The International Journal on Drug Policy* 2014; 25: 171-4.

⁶⁵ Israelsson M. Compulsory commitment to care of substance misusers: international trends during 25 years. *European Addiction Research* 2012; 18: 302-321.

⁶⁶ International Harm Reduction Association, 2010

⁶⁷ Reynolds A. Compulsory treatment of alcoholism. New South Wales, October 1988.

Short-term involuntary treatment (up to two weeks) may be useful to reduce the risks associated with severe substance use, to enable the patient to improve their decision-making capacity and to provide the opportunity to motivate the patient to continue treatment on a voluntary basis⁶⁸.

If there is evidence of an enduring physical health disorder or a persistent cognitive impairment that reduces the individual's capacity to give consent or make informed decisions, then a period of up to two weeks is unlikely to have lasting positive effects on the patient's substance use disorder. In these circumstances, other legal instruments may need to be put in place to ensure effective guardianship for the patient⁶⁹.

Client perceptions of involuntary treatment

Studies incorporating client perceptions of involuntary treatment into evaluations of addiction treatment are limited.

Rourke et al. (2014) conducted an evaluation of client perceptions about legal mandates to enter residential alcohol and other drugs treatment in Australia⁷⁰. Across 114 clients surveyed, being legally mandated to enter treatment and perceived coercion did not independently predict treatment engagement or relate to treatment retention. Instead, predictors of treatment engagement were that client's motivation, self-efficacy and the presence of peer support. These findings were interpreted by the authors as demonstrating coercion did not have a negative impact on treatment.

Katsakou (2006) conducted a review of studies that assessed patient perspectives on involuntary treatment⁷¹. According to the review findings, patients beliefs regarding their need for hospital admission and treatment in general indicate between 33 and 68% of patients rate their admission as correct or necessary. When the percentage of patients explicitly expressing negative views is reported, 28 to 48% of patients believe that they did not need hospital admission. Studies specifying both positive and negative views indicate that the number of participants viewing their admission positively is higher than those with negative views.

This review also assessed patients view about clinical improvement as a result of treatment. When patients were specifically asked at three weeks post-discharge to report whether they thought they had clinically improved after receiving involuntary treatment, 68 to 76% of them state that they feel

⁶⁸ Pritchard E. Compulsory treatment in Australia: A discussion paper of the compulsory treatment of individuals dependent on alcohol and / or other drugs. ANCD. Canberra, 2007.

⁶⁹ Law Commission, New Zealand. Compulsory Treatment for Substance Dependence: A review of the Alcoholism and Drug Addiction Act 1966. September 2010.

⁷⁰ Rourke P. Legal mandates and perceived coercion in residential alcohol and other drug treatment. *Psychiatry, Psychology and Law* 2014; <http://dx.doi.org/10.1080/13218719.2014.986839>.

⁷¹ Katsakou C. Outcomes of involuntary hospital admission – a review. *Acta Psychiatrica Scandinavica* 2006;

better^{72 73}. Further, between 46 and 73% of patients report to be satisfied with the treatment they received^{74 75 76}.

Qualitative evidence from focus groups conducted by the Association of Participating Service Users (APSU), a peer-based advocacy organisation, shows that when seeking treatment for substance use disorders, patients require respect and dignity to their overall wellbeing. APSU state compulsory treatment supersedes these values and that available evidence on the effectiveness of involuntary treatment 'is grossly inadequate for such a compromise to civil liberty'⁷⁷.

Self-determination and involuntary treatment

Criticism of involuntary treatment is often based on the assumption that internal motivation (motivation from within the individual, independent of external contingencies) is essential for effective treatment and those pressured into treatment are less likely to be motivated⁷⁸. Evidence generally supports the view that internal motivation is important for treatment to be effective and is positively associated with treatment engagement⁷⁹.

Autonomous motivation at admission has been shown to be associated with:

- increased session attendance^{80 81};
- longer retention^{82 83}; and
- lower rates of in-treatment drug use^{84 85}.

⁷² Kjellin L. Ethical benefits and costs of coercion in short-term inpatient psychiatric care. *Psychiatr Serv* 1997; 48:1567–1570.

⁷³ Kjellin L. Coercion in psychiatric care – patients and relatives experiences from four Swedish psychiatric services. *Nord J Psychiatry* 2004; 58:153–159.

⁷⁴ Spensley J. Patient satisfaction and involuntary treatment. *Am J Orthopsychiatry* 1980; 50:725–729

⁷⁵ Kjellin L. Ethical benefits and costs of coercion in short-term inpatient psychiatric care. *Psychiatr Serv* 1997; 48:1567–1570.

⁷⁶ Kjellin L. Coercion in psychiatric care – patients and relatives experiences from four Swedish psychiatric services. *Nord J Psychiatry* 2004; 58:153–159.

⁷⁷ The Association of Participating Service Users. *Forced Treatment: The Severe Substance Dependence Treatment Bill 2009*. Undated.

⁷⁸ Urbanoski K. Coerced addiction treatment: client perspectives and the implications of their neglect. *Harm Reduction Journal* 2010; 7: 13.

⁷⁹ Wild T. Social pressure, coercion, and client engagement at treatment entry: a self-determination theory perspective. *Addictive Behaviors* 2006; 31:1858-1872.

⁸⁰ Zeldman A. Motivation, autonomy support, and entity beliefs: Their role in methadone maintenance treatment. *Journal of Social and Clinical Psychology* 2004; 23:675-696.

⁸¹ Ryan R. Initial motivations for alcohol treatment: Relations with patient characteristics, treatment involvement, and dropout. *Addictive Behaviors* 1995; 20:279-297.

⁸² *Ibid*

⁸³ De Leon G. Circumstances, motivation, readiness, and suitability (the CMRS scales): Predicting retention in therapeutic community treatment. *American Journal of Drug and Alcohol Abuse* 1994; 20:495-515.

⁸⁴ Zeldman A. Motivation, autonomy support, and entity beliefs: Their role in methadone maintenance treatment. *Journal of Social and Clinical Psychology* 2004; 23:675-696.

In contrast, controlled motivation has been shown to be associated with:

- poorer session attendance among clients in methadone maintenance treatment⁸⁶; but
- longer retention in outpatient counselling and therapeutic community settings^{87 88}.

In studies incorporating post-discharge outcomes, admission levels of autonomous motivation have also been associated with lower frequency of drinking months after discharge from alcohol treatment⁸⁹.

In studies focusing on legal pressure and motivation, some demonstrate that involuntary treatment is associated with lower motivation than voluntary treatment^{90 91 92}. Others have found no difference between involuntary and voluntary treatment in motivation^{93 94} or that involuntary treatment is associated with higher levels of motivation than voluntary treatment⁹⁵.

Overall, these studies suggest the importance, separate from the application of any social controls or pressures, of fostering and supporting autonomous motivation for achieving positive outcomes.

Nolan and Thompson (2009) conducted a study that assessed psychological similarities and differences between involuntary and voluntary Australian participants in alcohol and drug treatment⁹⁶. The results showed that voluntary and involuntary cohorts were more similar than different. At programme entry participants were the same on measures of psychological distress and dysfunction, empathy and perspective taking and on three of four stages of change. At five weeks,

⁸⁵ Downey L. Sources of motivation for abstinence: A replication analysis of the Reasons for Quitting Questionnaire. *Addictive Behaviors* 2001; 26:79-89.

⁸⁶ Zeldman A. Motivation, autonomy support, and entity beliefs: Their role in methadone maintenance treatment. *Journal of Social and Clinical Psychology* 2004; 23:675-696.

⁸⁷ Ryan R. Initial motivations for alcohol treatment: Relations with patient characteristics, treatment involvement, and dropout. *Addictive Behaviors* 1995; 20:279-297.

⁸⁸ De Leon G. Circumstances, motivation, readiness, and suitability (the CMRS scales): Predicting retention in therapeutic community treatment. *American Journal of Drug and Alcohol Abuse* 1994; 20:495-515.

⁸⁹ Staines G. Predictors of drinking outcomes among alcoholics. *American Journal of Drug and Alcohol Abuse* 2003; 29:203-218.

⁹⁰ Wild T. Social pressure, coercion, and client engagement at treatment entry: a self-determination theory perspective. *Addictive Behaviors* 2006; 31:1858-1872.

⁹¹ Kelly J. Substance use disorder patients who are mandated to treatment: Characteristics, treatment process, and 1- and 5-year outcomes. *Journal of Substance Abuse Treatment* 2005; 28:213-223.

⁹² Marshall G. Characteristics of criminal justice and noncriminal justice clients receiving treatment for substance abuse. *Addictive Behaviors* 2002; 27:179-192.

⁹³ Schaub M. Comparing outcomes of 'voluntary' and 'quasi compulsory' treatment of substance dependence in Europe. *European Addiction Research* 2010; 16:53-60.

⁹⁴ Schaub M. Predictors of retention in the 'voluntary' and 'quasi-compulsory' treatment of substance dependence in Europe. *European Addiction Research* 2011; 17:97-105.

⁹⁵ Gregoire T. The relationship of legal coercion to readiness to change among adults with alcohol and other drug problems. *Journal of Substance Abuse Treatment* 2004; 26:35-41.

⁹⁶ Nolan J. Psychological Change in Voluntary and Legally Coerced Clients of a Residential Drug and Alcohol Treatment Programme. *Psychiatry, Psychology and Law* 2009; 16: 458-72.

voluntary versus involuntary status did not differentiate those staying or leaving treatment and the pattern of change on the self-report measures over the intervening three to four weeks were the same. For those staying in treatment up to 10 to 11 weeks, voluntary and involuntary clients showed the same pattern of change on all measures other than two scales of stages of change (contemplation and maintenance).

Ethics and involuntary treatment

It is a fundamental ethical and legal principle that medical treatment cannot be imposed upon a competent adult without that person's consent. Involuntary treatment is not justifiable when a patient has capacity to make choices about ongoing substance use. The corollary is that involuntary treatment may potentially be justifiable when⁹⁷:

- a person's dependence has seriously impaired their capacity to make choices about ongoing substance use and personal welfare;
- care and treatment is necessary to protect the person from significant harm;
- no other less restrictive means are reasonably available for caring for the person;
- the person is likely to benefit from the treatment; and
- the person has refused treatment.

Society defines the role of the clinician in terms of our professional responsibilities to patients. The ethical principles of medical practice include the principle of non-maleficence - the clinician's duty to "do no harm". Clinicians can avoid harming patients by showing respect for their autonomy i.e. by allowing patients to make their own decisions regarding whether to accept or reject recommended medical care⁹⁸.

Clinicians are also bound by a professional obligation to help patients. This duty is prescribed by the ethical principle of beneficence which requires that clinicians provide services to patients that will benefit the patient. Where clinicians encounter patients in need of treatment yet who refuse to receive care, the clinician faces the challenge of weighing their professional obligations of non-malevolence and beneficence in deciding whether to hospitalise patients against their wishes⁹⁹.

When an individual is suffering from a clinical condition where their judgement may be impaired, which may be the case for patients with severe substance use disorders, the individual is not truly autonomous, and the weighing of ethical obligations for the clinician may be difficult. Individuals with substance use disorders have illnesses that pose a high risk of morbidity and may be associated with increased mortality. As a patient group they have been characterised as having a high degree of treatment reluctance and refuse treatment even when necessary for their survival. However, patients with substance dependencies do not demonstrate clear evidence of thought disorder, perception of reality or an inability to comprehend the seriousness of their illness and its consequences¹⁰⁰.

⁹⁷ Crime and Misconduct Commission. Mandatory treatment and perceptions of treatment effectiveness. Research and Issues Paper Number 7, October 2008.

⁹⁸ Grace P. Ethical issues: when a patient refuses assistance. *Am J Nurs.* 2008; 108:36–38.

⁹⁹ *Ibid*

¹⁰⁰ Testa M. Civil commitment in the United States. *Psychiatry* 2010; 7: 30-40.

In the US, although legislation allows for involuntary treatment in many states, the practice of committing addicted individuals who have not broken laws is rare. A number of factors have been proposed that explain this. First, among psychiatrists (the main professional group responsible for civilly committing patients in the US) only 20 per cent believed that substance dependence as a diagnosis fulfilled criteria for civil commitment¹⁰¹. Second, clinicians and advocates of drug treatment argue that because of limited access to programs and a widely shared belief that resources should be prioritised for people who truly want to be in recovery of their own accord¹⁰². Third, advocates against involuntary treatment of alcohol and other substance dependence argue that it is a withdrawal of basic human rights and a violation of personal liberty and patient autonomy¹⁰³. Further, it is unclear what criteria should be applied to the State legitimately intervening to treat a person against their will, and conversely, whether a person has the right to 'drink themselves to death'.

People with chronic alcohol and/or drug abuse problems might not be able to look after their own interests as chronic drug misuse can cause problems with decision-making and impulse control. When a patient has impaired decision-making a third party may have a legitimate role in making decisions on behalf of the person with impairment, provided this is supported by legislation. However, it can be difficult for clinicians to determine whether in the absence of alcohol and / or drugs the patient's symptoms will reduce and / or their immediate health will improve, justifying the decision to require involuntary treatment of their patient¹⁰⁴.

Clinical practice guidance and involuntary treatment

According to the World Health Organisation (WHO) treatment carried out without the informed consent of the patient in clearly defined exceptional circumstances needs to follow similar criteria to those used in mental health emergency situations. WHO states this treatment should¹⁰⁵:

- require a clinical judgement by at least two qualified health care professionals that such treatment was necessary;
- impose a time limit of several days on compulsory treatment;
- include a judicial review for any continued necessity, including the right to appeal; and
- involve medically appropriate, individually prescribed plan, subject to regular review, that is consistent with international evidence-based best practice and ethical standards.

The European Commission funded the EUNOMIA study in 12 European countries in order to develop European recommendations for good clinical practice in involuntary hospital admissions¹⁰⁶.

¹⁰¹ Brooks R. Psychiatrists opinions about involuntary civil commitment: results of a national survey. *J Am Acad Psychiatry Law*. 2007; 35:219–228.

¹⁰² Testa M. Civil commitment in the United States. *Psychiatry* 2010; 7: 30-40.

¹⁰³ Nace E.. Socially sanctioned coercion mechanisms for addiction treatment. *American Journal of Addiction* 2007; 16: 15-23.

¹⁰⁴ Freckleton I. Ideological divarication in civil commitment decision-making. *Psychiatry, Psychology and Law* 2011; 10:390-6.

¹⁰⁵ WHO. WHO Resource Book on Mental Health, Human Rights and Legislation. Geneva, WHO.

¹⁰⁶ Fiorillo A. How to improve clinical practice in involuntary hospital admissions of psychiatric patients. *European Psychiatry* 2011; 26: 201–207.

This study pertains to involuntary admission on mental health grounds rather than for substance use disorder per se.

According to the consensus recommendations developed as a result of the study, an involuntary hospital admission should be performed only if the following clinical pre-requisites are simultaneously present:

- the patient is suffering from a serious mental disturbance;
- the patient needs urgent therapeutic hospital-based interventions; and
- the patient does not agree to such care, so that the care cannot be given with his or her consent.

In terms of clinical practice, recommendations from the study stress the need to:

- provide information to patients about the reasons for hospitalisation and its presumed duration;
- protect patients' rights during hospitalisation;
- encourage the involvement of family members;
- improve communication between community and hospital teams; and
- train involved professionals on the legal and administrative aspects of involuntary hospital admissions.

During the involuntary hospital admission procedures and the admission itself, patient's rights should be granted and interventions must be provided according to the principle of the 'least restrictive alternative'.

SUMMARY

Involuntary treatment of substance use disorders refers to commitment of the patient to treatment where the individual has no choice. This includes treatment for substance use disorders with a mandate based in legislation and / or government implemented programs such as court-mandated treatment of offenders and civil commitment of non-offenders.

Involuntary treatment of substance use disorders may be clinically indicated when a person's dependence has seriously impaired their capacity to make choices about ongoing substance use and personal welfare, care and treatment is necessary to protect the person from significant harm, no other less restrictive means are reasonably available for caring for the person, the person is likely to benefit from the treatment and the person has refused treatment.

The majority of countries worldwide have some legislative basis for involuntary treatment of people with substance use disorders. The majority are for the treatment of offenders rather than non-offenders. Available data suggest the number of people mandated to receive care for substance use disorders worldwide has increased over time.

Evidence of effectiveness of civil commitment involuntary treatment is limited. Most research and evidence on the effectiveness of involuntary treatment relates to offenders who are coerced and referred via the criminal justice system. The majority of studies suggest short term involuntary treatment can provide improved patient outcomes for some people at least some of the time. However, evidence regarding the effectiveness of involuntary treatment in rehabilitating or achieving long-term behavioural change is more limited.



Some research suggests internal motivation is required for effective treatment and that people pressured into treatment are less likely to be motivated. In comparison, other studies have either found no difference between motivation in patients receiving involuntary versus voluntary treatment or that involuntary treatment is associated with greater treatment motivation.

Evidence from studies of client perceptions of involuntary treatment is mixed. Some studies show that being legally mandated to enter treatment does not influence treatment engagement or retention. Some patients are satisfied with their receipt of mandatory treatment and agree, in retrospect, that they required hospital admission. However, a percentage of patients believe they did not need hospital admission.

This raises important ethical issues regarding the place of involuntary treatment in the management of substance use disorder. It is a fundamental ethical and legal principle that medical treatment cannot be imposed upon a competent adult without that person's consent. However, severe substance use disorder may seriously impair the patient's capacity to make choices about ongoing substance use and personal welfare. For this reason, clinical practice guidance recommends that involuntary treatment is only carried out in clearly defined exceptional circumstances, in the least restrictive manner possible, for the shortest timeframe possible and only when clinically necessary.

ATTACHMENT 1: ESTABLISHING THE CONTEXT - SUBSTANCE USE DISORDERS

Defining substance use disorder

Numerous definitions and concepts for substance use disorders have been proposed in the literature. These have changed significantly over the past decades as a result of various clinical, social, economic and political influences.

In the late 1950s the World Health Organisation promulgated definitions that distinguished between drug addiction and drug habituation. Addiction-producing drugs were characterised by compulsion, tolerance, psychological and physical dependence whereas habit-forming drugs (including alcohol and tobacco) were characterised by a desire to take the drug for individual wellbeing¹⁰⁷. Later the term ‘dependence’ was used in relation to substance use to describe physiological, behavioural and cognitive phenomena that lead to loss of control over use¹⁰⁸. Dependence to alcohol and tobacco were recognised.

Substance dependence, within the context of the Severe Substance Dependence Treatment Act, may therefore be considered as an adaptive state that develops from repeated drug administration, and which results in withdrawal upon cessation of drug use. However, not all harms associated with substance use occur as a result of the dependence state. For example, a drug addiction, a distinct concept from substance dependence, is defined as compulsive, out-of-control drug use, despite negative consequences¹⁰⁹.

The DSM-IVR criteria for substance dependence are dependence or significant impairment or distress, as manifested by 3 or more of the following during a 12 month period:

1. Tolerance or markedly increased amounts of the substance to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount of substance
2. Withdrawal symptoms or the use of certain substances to avoid withdrawal symptoms
3. Use of a substance in larger amounts or over a longer period than was intended
4. persistent desire or unsuccessful efforts to cut down or control substance use
5. Involvement in chronic behavior to obtain the substance, use the substance, or recover from its effects
6. Reduction or abandonment of social, occupational or recreational activities because of substance use
7. Use of substances even though there is a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance

The International Classification of Diseases (10th edition) describes between ‘harmful use’ and a ‘dependence syndrome’. A dependence syndrome is a cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take psychoactive drugs (which may or may not have been medically prescribed),

¹⁰⁷ http://whqlibdoc.who.int/trs/WHO_TRS_116.pdf

¹⁰⁸ American Psychiatric Association, 2000

¹⁰⁹ Pubmed Health. National Institutes of Health.

alcohol, or tobacco. There may be evidence that return to substance use after a period of abstinence leads to a more rapid reappearance of other features of the syndrome than occurs with nondependent individuals.

Most recently, the new revision of the Diagnostic and Statistical Manual of Disorders (DSM-5), the main system of classification of mental and behavioural disorders used clinically in Australia, moved away from the term 'dependence' and instead it substitutes 'use disorder', defined in terms of eleven criteria including physiological, behavioural and cognitive elements, as well as consequences of criteria, any two of which qualify for a diagnosis¹¹⁰.

Clinical and neuro-biological research demonstrates that substance dependence is a chronic, multi-factorial condition that affects brain functioning in ways that makes abstinence difficult to achieve in the short term¹¹¹. Many factors contribute to the pathogenesis of drug dependence. These include someone's readiness to experiment with drugs and their susceptibility to develop dependence if used. Harmful and dependent substance use is often related to individual and social disadvantage. Prenatal problems, adverse childhood experiences, lower educational attainment, social isolation and psychiatric disorders may also contribute to increased susceptibility to substance use disorders. Moreover, a large proportion of people with substance use disorders use drugs in an attempt to cope with adverse conditions in their life¹¹².

The consequences of substance use on wellbeing

Substance use can have short- and long-term impacts on health and wellbeing. In 2010, it was estimated that 2.7% the burden of disease in Australasia was attributable to alcohol use and a further 2.6% was attributable to the use of illicit drugs¹¹³.

Substance use is a serious and complex problem, which contributes to increased morbidity and mortality, injury, social and family disruption, violence, and crime and community safety problems¹¹⁴.

Excessive alcohol intake is a major risk factor for morbidity and mortality. Short episodes of heavy alcohol consumption are a contributor to accidents and injuries, violence and crime. Long-term heavy drinking is associated with numerous chronic diseases, including cardiovascular diseases, liver disease, mental health problems, and cancer and brain injury¹¹⁵.

Illicit drug use is a major risk factor for illness and death. It is associated with blood borne viruses, infective and cardiovascular disease, mental illness and suicide, injury and overdose¹¹⁶.

¹¹⁰ Ibid

¹¹¹ United Nations Office on Drugs and Crime. From coercion to cohesion. Discussion Paper. Vienna, October 2009.

¹¹² Ibid

¹¹³ IHME (Institute for Health Metrics and Evaluation) 2014. Data visualizations. Seattle: IHME. Viewed 16 September 2014.

¹¹⁴ MCDS (Ministerial Council on Drug Strategy) 2011. The National Drug Strategy 2010–2015. Canberra: Commonwealth of Australia.

¹¹⁵ Ibid

¹¹⁶ AIHW 2010. Australia's health 2010. Australia's health series no. 12. Cat. no. AUS 122. Canberra: AIHW.

The use and misuse of licit and illicit drugs imposes a heavy financial burden on the Australian community. The estimated annual economic costs associated with drug use in Australia are \$23.5 billion, comprising \$15.3 billion to alcohol and \$8.2 billion to illicit drugs¹¹⁷.

The epidemiology of substance use disorders

Approximately 224,000 Victorians have a substance abuse disorder¹¹⁸. Only a small proportion of these people seek help from treatment services. The majority of people with an alcohol or drug problem do not seek help from health professionals or treatment services for their addiction.

Between 2010 and 2013 Victoria was the only jurisdiction where a significant decrease in daily drinking was observed (from 6.6% to 5.5% of adults). In some jurisdictions (South Australia, Australian Capital Territory and Northern Territory) there was an increase daily drinking¹¹⁹.

According to 2013 national survey results, population rates of illicit use of any drug were lowest in New South Wales and Victoria (14.2 % and 14.3% respectively)¹²⁰. However, estimates of drug use by states and territories should be interpreted with caution due to the lower prevalence of drug use compared with alcohol use. Between 2001 and 2013 there were no significant changes in population rates of illicit drug use.

The epidemiology of severe substance use disorders

The prevalence of severe substance use disorders is more difficult to determine as criteria of ‘severity’ are not universally agreed. Severe substance dependence is defined in the *Severe Substance Dependence Treatment Act* (2010) as “(a) the person has a tolerance to a substance and (b) the person shows withdrawal symptoms when the person stops using, or reduces the level of use of, the substance; and (c) the person is incapable of making decisions about his or her substance use and personal health, welfare and safety due primarily to the person’s dependence on the substance”.

Severity can also be described according to frequency of use, quantity of use, the presence of symptoms of withdrawal on cessation of use, likelihood and occurrence of relapses after cessation of use and / or the presence of comorbid conditions associated with excess use (e.g. chronic liver disease in people with severe alcohol dependence)^{121 122}. Hence, drawing conclusions about the epidemiology of severe substance use disorders is problematic.

¹¹⁷ Collins D. The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004–05. National Drug Strategy Monograph Series no. 66, 2008. Canberra: Australian Government Department of Health and Ageing.

¹¹⁸ AIHW. National Drug Strategy Household Survey (NDSHS). 2013. Canberra: AIHW.

¹¹⁹ <http://aihw.gov.au/alcohol-and-other-drugs/ndshs-2013/ch7/>

¹²⁰ Ibid

¹²¹ Dawson D. Quantifying the risks associated with exceeding recommended drinking limits. *Alcohol Clin Exp Res.* 2005; 29:902-908.

¹²² Saha T. Toward an alcohol use disorder continuum using item response theory: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Psychol Med.* 2006; 36:931-941.

ATTACHMENT 2 - TREATING SUBSTANCE USE DISORDERS

Substance use treatment produces positive behavioural and psychological changes in people with substance use disorders. Treatment approaches that are most effective incorporate psychosocial approaches matched to patient need and pharmacological agents when clinically indicated¹²³. Substance use treatment has been shown to reduce associated health and social costs by significantly more than the cost of the treatment itself. Conservative estimates suggest every dollar invested in addiction treatment yields a return of between \$4 and \$7¹²⁴.

Alcohol treatment guidelines

In Australia, the National Health and Medical Research Council (NHMRC) produces guidelines about alcohol use. The most recent version of these guidelines, *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* (2009) provide guidance to Australians to assist them in making informed choices in reducing their health risks associated with drinking alcohol. These guidelines do not provide advice to clinicians regarding evidence-based management of patients with severe alcohol dependence.

The University of Sydney developed the 2009 *Guidelines for the Treatment of Alcohol Problems* on behalf of the Australian Government Department of Health and Ageing (DoHA). These guidelines recommend a structured approach to treating alcohol dependence that is based on the following:

- screening, assessment and treatment planning;
- brief interventions;
- alcohol withdrawal management;
- psychosocial interventions;
- pharmacotherapies; and
- self-help programs.

These guidelines also describe aftercare and long-term follow-up requirements for people with alcohol dependence. The guidelines note that brief interventions are not recommended for patients with more severe alcohol-related problems.

The 2009 clinical practice guidelines make reference to involuntary treatment of patients with cognitive impairment. The guidelines state clinicians should 'consider the need for involuntary treatment if the patient continues to drink and refuses to engage in appropriate treatment'¹²⁵.

Guidelines for the treatment of people who use other substances

There are various national and international guidelines to aid medical practitioners in the assessment and management of patients who use licit and illicit drugs. These include¹²⁶:

¹²³ Hussain Q. Alcohol and other drug treatment within the context of the criminal justice system: a review of the literature. February 2005.

¹²⁴ National Institute on Drug Abuse. The Science of Drug Abuse and Addiction. December 2012.

¹²⁵ DoHA. Guidelines for the Treatment of Alcohol Problems. 2009. Available at: http://www.drugsandalcohol.ie/20201/1/Gudelines_for_treatment_of_alcohol_problems.pdf. Accessed December 2014.

- the British Association for Psychopharmacology guidelines;
- National Guidelines for Medication-Assisted Treatment of Opioid Dependence;
- Brief Guide to Prescribing Buprenorphine / Naloxone;
- psychostimulant use guidelines; and
- clinical guidelines for the management of patients with comorbid mental disorders and substance use disorders.

In Victoria the Turning Point Alcohol and Drug Centre, Eastern Health, produce treatment guidelines for alcohol and drug clinicians, including *Alcohol and Other Drug Withdrawal Practice Guidelines (2012)*, that describes approaches to withdrawal from alcohol, benzodiazepines, opioids, cannabis, psychostimulants and tobacco. The principles of withdrawal are that patients require a comprehensive assessment, treatment planning for withdrawal care and planning for post-withdrawal including a maintenance phase¹²⁷.

Goals of substance use treatment^{128 129}

Goals of substance use treatment are negotiated between patient and service providers, together with people of significance in the patient's life if the patient wishes. Both medication management and psychological interventions may be used to support patients. There is limited evidence regarding whether there is an optimal pharmacological–psychosocial combination¹³⁰.

Pharmacological interventions for the substance use disorder itself are of most value in dependence, and are targeted at the following areas of patient management¹³¹:

- withdrawal syndromes;
- relapse prevention and maintenance of abstinence;
- reduction of harms associated with illicit drug use by prescribing a substitute drug or drugs (e.g. methadone / buprenorphine maintenance treatment in which aims may include cessation of injecting, reduction or cessation of illicit heroin use, and reduction or cessation of other high-risk behaviours); and

¹²⁶ <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-publth-strateg-drugs-illicit-index.htm>

¹²⁷ Turning Point. Alcohol and Other Drug Withdrawal Practice Guidelines, 2012.

¹²⁸ British Association for Psychopharmacology. BAP updated guidelines: evidence-based guidelines for the pharmacological management of substance abuse, harmful use, addiction and comorbidity: recommendations from BAP. *Journal of Psychopharmacology*, 2012. 0: p. 1-54.

¹²⁹ DoHA. Guidelines for the Treatment of Alcohol Problems. 2009. Available at: http://www.drugsandalcohol.ie/20201/1/Gudelines_for_treatment_of_alcohol_problems.pdf. Accessed December 2014.

¹³⁰ British Association for Psychopharmacology. BAP updated guidelines: evidence-based guidelines for the pharmacological management of substance abuse, harmful use, addiction and comorbidity: recommendations from BAP. *Journal of Psychopharmacology*, 2012. 0: p. 1-54.

¹³¹ British Association for Psychopharmacology. BAP updated guidelines: evidence-based guidelines for the pharmacological management of substance abuse, harmful use, addiction and comorbidity: recommendations from BAP. *Journal of Psychopharmacology*, 2012. 0: p. 1-54.

- prevention of complications of substance use (e.g. use of thiamine to prevent Wernicke's encephalopathy and Korsakoff's syndrome in patients with alcohol dependence).

The acute detoxification and treatment phase

The acute detoxification and treatment phase is of most relevance to our understanding of the application of the Severe Substance Dependence Treatment Act in Victoria as the Act allows for involuntary treatment of patients for a maximum of 14 days without a further recommendation being provided to the courts.

Australian clinical practice guidelines for alcohol withdrawal recommend inpatient hospital treatment as appropriate for patients with severe withdrawal complications and / or severe medical or psychiatric comorbidity¹³².

The acute detoxification and treatment phase for substance use other than alcohol depends on the substances which the patient is receiving treatment for¹³³. It is outside the scope of this review to describe these in detail.

The selection of psychosocial interventions for treatment require comprehensive patient assessment, implementation of a treatment plan, regular review of progress in increasing intervention intensity in the absence of a response to treatment. Australian guidelines recommend residential rehabilitation programs for patients with moderate to severe dependence that needs a structured residential setting¹³⁴.

Although many alcohol-withdrawal episodes take place without any pharmacological support, patients with severe alcohol dependence require medication management¹³⁵. Benzodiazepines and thiamine are the mainstay of treatment. Benzodiazepines are efficacious in reducing signs and symptoms of withdrawal. There is evidence supporting the use of anticonvulsants, including irreversible gamma-aminobutyrate transaminase inhibitors in the treatment of alcohol withdrawal¹³⁶¹³⁷. Medication management is also indicated for the prevention and management of complications in the withdrawal phase, including for seizures, delirium and alcohol-related brain disorder¹³⁸.

¹³² DoHA. Guidelines for the Treatment of Alcohol Problems. 2009. Available at: http://www.drugsandalcohol.ie/20201/1/Gudelines_for_treatment_of_alcohol_problems.pdf. Accessed December 2014.

¹³³ Turning Point. Alcohol and Other Drug Withdrawal Practice Guidelines, 2012.

¹³⁴ Ibid

¹³⁵ British Association for Psychopharmacology. BAP updated guidelines: evidence-based guidelines for the pharmacological management of substance abuse, harmful use, addiction and comorbidity: recommendations from BAP. *Journal of Psychopharmacology*, 2012. 0: p. 1-54.

¹³⁶ Stuppaeck C. The irreversible gama-aminobutyrate transaminase inhibitor Vigabatrin in the treatment of the alcohol withdrawal syndrome. *Alcohol and Alcoholism* 1996; 31: 109-11.

¹³⁷ Ait-Daoud N. An overview of medications for the treatment of alcohol withdrawal and alcohol dependence with an emphasis on the use of older and newer anticonvulsants. *Addictive Behaviour* 2006; 31: 1628-49.

¹³⁸ Ibid

Maintenance phase for treatment

Although outside the scope of the Act, an understanding of the maintenance phase for treatment is relevant to the discussion of the likely efficacy of involuntary treatment in contributing to long-term positive outcomes for patients.

For patients with substance use disorders there is ongoing debate about what is a reasonable or appropriate outcome regarding substance use behaviour. Abstinence as a treatment goal can imply continuous complete abstinence or time limited abstinence. The level of substance use that confers an acceptable low risk depends on the individual's circumstances^{139 140}.

The majority of people treated under the Act receive treatment for severe alcohol dependence. For patients with cirrhosis and liver failure any drinking is likely to be harmful and complete abstinence is the best treatment goal. However, reduced drinking may be acceptable as an intermediate treatment goal where patients are unlikely to achieve complete abstinence or have lost control of their drinking as this may confer some health benefit. Ideally clinical benefit should be evident if this goal is pursued.

Patients should engage with whichever approach is most clinically appropriate and that they find beneficial. The use of medication alone in the maintenance phase of treatment is not advocated as pharmacotherapies have been studied in clinical trials as an adjunct to psychosocial interventions^{141 142}.

¹³⁹ DoHA. Guidelines for the Treatment of Alcohol Problems. 2009. Available at: http://www.drugsandalcohol.ie/20201/1/Gudelines_for_treatment_of_alcohol_problems.pdf. Accessed December 2014.

¹⁴⁰ Turning Point. Alcohol and Other Drug Withdrawal Practice Guidelines, 2012.

¹⁴¹ DoHA. Guidelines for the Treatment of Alcohol Problems. 2009. Available at: http://www.drugsandalcohol.ie/20201/1/Gudelines_for_treatment_of_alcohol_problems.pdf. Accessed December 2014.

¹⁴² Turning Point. Alcohol and Other Drug Withdrawal Practice Guidelines, 2012.

ATTACHMENT 3 - DRUG AND ALCOHOL POLICY

The Australian National Drug Strategy (2010 to 2015) aims to build safe and healthy communities by minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities.

The national strategy is built on the three pillars of demand reduction, supply reduction and harm reduction. Since the National Drug Strategy began in 1985, harm minimisation has been its overarching approach. This encompasses the three equally important pillars of demand reduction, supply reduction and harm reduction being applied together in a balanced way.

Demand reduction means strategies and actions which prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community.

Supply reduction means strategies and actions which prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs.

Harm reduction means strategies and actions that primarily reduce the adverse health, social and economic consequences of the use of drugs.

A number of sub-strategies sit under the umbrella of the *National Drug Strategy 2010–2015*. These sub-strategies provide direction and context for specific issues, while maintaining the consistent and coordinated approach to addressing drug use, as set out in this strategy.

To complement the national policy framework, all states and territories have developed strategies and plans to address alcohol issues in their own jurisdictions. Victoria does not have a current strategy since the recent change in government.

National drug and alcohol policy is relatively silent on the matter of involuntary treatment.

National policy on substance use treatment

According to the strategy, treatment of alcohol, and the use of tobacco and other drugs requires a range of approaches across the continuum of use, from experimental to dependent use. The strategy emphasises the importance of ensuring appropriate treatment is available and accessible and affirms that engaging the support of family and friends for those seeking treatment is an important part of helping people reduce their drug use.

Actions proposed in the strategy that relate to treatment are to:

- develop new evidence-based national planning tools to help jurisdictions better estimate the need and demand for alcohol and other drug health services across Australia. This should include the full spectrum of services from prevention and early intervention to the most intensive forms of care, and a range of services across the life span;
- develop a set of national clinical standards for alcohol and other drug treatment services;
- improve the links and coordination between primary health care and specialist alcohol and other drug treatment services to enhance the capacity to deal with all health needs and to facilitate the earlier identification of health problems and access to treatment;

- improve the communication and flow of information between primary care and specialist providers, and between clinical and community support services to promote continuity of care and the development of cooperative service models;
- investigate appropriate structures that could be developed to help engage families and other carers in treatment pathways and ensure that information about the pathways is readily accessible and culturally relevant;
- identify and link the necessary services to provide those affected by drug use and dependence, such as family members, children and friends, with ongoing support including links to child welfare and protection services;
- move towards a nationally consistent approach for non-government treatment services including quality frameworks and reporting requirements;
- develop a sustained and comprehensive stigma reduction strategy to improve community and service understanding and attitudes towards drug dependence, help seeking and the related problems of individuals; and
- improve links and coordination between health, education, employment, housing and other sectors to expand the capacity to effectively link individuals from treatment to the support required for them to reconnect with the community.

The strategy itself does not make special treatment recommendations regarding severe substance use disorders.

Victorian drug and alcohol policy

Victoria's most current plan for alcohol and drugs is outlined in *Reducing the alcohol and drug toll: Victoria's plan 2013-2017*. The Plan was released in January 2013. The plan sets out a whole of government strategy to reduce the use of illegal drugs, make alcohol and drug treatment services more accessible, tackle the misuse of pharmaceutical drugs and promote a healthy culture around alcohol. The Plan makes no reference to involuntary treatment.

Victoria has had a change of government since this plan was released. However, the following is still relevant to establishing the policy context within which the St Vincent's Program for involuntary treatment has operated.

The Plan takes an evidence-based approach to reducing harm from alcohol and drugs and has targeted strategies in a number of areas to improve prevention and education, regulation and policing, and treatment and care.

ATTACHMENT 4 - THE *MENTAL HEALTH ACT 2014* (VIC)

Victoria's mental health legislation has been updated since the Severe Substance Dependence Treatment Act was declared. This is relevant to patient with severe substance dependence, both because severe substance dependence can be considered a mental health problem, and psychiatric comorbidity among people with severe substance use disorders is common.

The *Mental Health Act 2014* (Vic) (the Mental Health Act) passed through parliament on 26 March 2014. The definition of *mental illness* in the Act specifically states that the use of drugs or consumption of alcohol in and of itself does not comprise a mental illness. However, drug or alcohol use does not exclude the presence of a mental illness either.

The Mental Health Act defines mental illness as follows (Section 4):

1. Subject to subsection (2), *mental illness* is a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.
2. A person is not to be considered to have mental illness by reason only of any one or more of the following:
 - that the person expresses or refuses or fails to express a particular political opinion or belief;
 - that the person expresses or refuses or fails to express a particular religious opinion or belief;
 - that the person expresses or refuses or fails to express a particular philosophy;
 - that the person expresses or refuses or fails to express a particular sexual preference, gender identity or sexual orientation;
 - that the person engages in or refuses or fails to engage in a particular political activity;
 - that the person engages in or refuses or fails to engage in a particular religious activity;
 - that the person engages in sexual promiscuity;
 - that the person engages in immoral conduct;
 - that the person engages in illegal conduct;
 - that the person engages in antisocial behaviour;
 - that the person is intellectually disabled;
 - that the person uses drugs or consumes alcohol;
 - that the person has a particular economic or social status or is a member of a particular cultural or racial group;
 - that the person is or has previously been involved in family conflict;
 - that the person has previously been treated for mental illness.
3. Subsection (2)(1) does not prevent the serious temporary or permanent physiological, biochemical or psychological effects of using drugs or consuming alcohol from being regarded as an indication that a person has mental illness.

Similar to the *Severe Substance Dependence Treatment Act 2010* (Vic), the Mental Health Act allows for the involuntary treatment of people. The *treatment criteria* for a person to be made subject to a Temporary Treatment Order or Treatment Order are:

- the person has mental illness; and
- because the person has mental illness, the person needs immediate treatment to prevent:
 - serious deterioration in the person's mental or physical health; or
 - serious harm to the person or to another person; and

- the immediate treatment will be provided to the person if the person is subject to a Temporary Treatment Order or Treatment Order; and
- there is no less restrictive means reasonably available to enable the person to receive the immediate treatment.

According to *The Mental Health Bill 2014 - An Explanatory Guide*, the legislative framework in the Mental Health Act has been developed to promote recovery-oriented practice, to minimise the use and duration of compulsory treatment, to safeguard the rights and dignity of people with mental illness and to enhance oversight while encouraging innovation and service improvement.

Although the Mental Health Act does provide for the assessment, detention and compulsory treatment of people with severe mental illness, it includes checks and balances to ensure that compulsory treatment is only used where necessary to prevent serious harm to the person or another person.

A presumption of capacity is the foundation of the supported decision-making model in the Mental Health Act. The Act provides that all people are presumed to be able to make treatment decisions. However, it recognises that people with serious mental illness may have fluctuating capacity to make decisions about treatment, that a person with mental illness may not be able to make a treatment decision at a particular point in time and that the person may regain capacity to make that decision at another point in time.

Patients are provided with information and support to make decisions about their treatment. This support may include the support of a carer, a nominated person or a parent of a young person. Where a patient is unable to consent, they will be supported to be involved in the decision-making process to the greatest extent possible.

The Mental Health Act promotes voluntary treatment in preference to compulsory treatment wherever possible and seeks to minimise the use and duration of compulsory treatment to ensure that the treatment is provided in the least restrictive and least intrusive manner possible. It achieves this by introducing specific criteria for compulsory treatment, creating Treatment Orders that operate for a fixed duration and requiring timely oversight by an independent Mental Health Tribunal.

A background to the *Mental Health Act 2014* (Vic)

Reform of Victoria's mental health legislation began in 2008, when the then former Labor Government announced a review of the existing Act. The then Minister for Mental Health stated that the review would, 'examine whether [the Act] provides an effective and contemporary legislative framework for the treatment and care of Victorians with a serious mental illness'.

The consultation paper for the review was released in December, 2008. The paper began with a brief history of mental health legislation in Victoria.

The *Mental Health Act 1986* (Vic) commenced in 1987 after five years of consultation and policy development. At that time, the Act aimed to define and protect the rights of people with serious mental illness in alignment with international trends. The Act:

- established criteria for involuntary treatment orders;
- established the Mental Health Review Board (the Board), which was formed to provide external reviews of involuntary treatment orders and to hear appeals;

- included oversight of particular interventions including electroconvulsive treatment (ECT); and
- established the role of the Chief Psychiatrist to oversee patients' care.

In the 1990s, a national approach to mental health commenced in response to deficiencies in the quality of mental health care and policies across Australia. This resulted in the introduction of the National Mental Health Statement of Rights and Responsibilities (1991) and the first National Mental Health Policy and National Mental Health Plan (1992). Subsequent plans have since been endorsed by the Commonwealth, State and Territory governments.

In response to changes at the national level, the 1990s resulted in major reforms to mental health services and policies in Victoria. Previously standalone mental health services were integrated into the general hospital system and responsibility for the management of mental health services was transferred from the Department to general hospitals.

The changes resulted in the highest and most restrictive level of care being offered in acute inpatient beds. Specialised community-based services were created to improve the management of people with mental illness in the community. These services included psychiatric crisis intervention, continuing care, community residential support services and community bed-based alternatives to hospital admission.

The consultation paper noted that since the *Mental Health Act 1986* was first introduced, there had also been significant developments in the field of international and Australian human rights law. These developments included the introduction of the Victorian Charter of Human Rights and Responsibilities and the United Nations' Convention on the Rights of Persons with Disabilities.

The review considered whether or not involuntary treatment for people with mental illness was appropriate. The Review Panel reported that views on this issue were mixed, however, **'the majority of submissions identify the need for involuntary treatment, accompanied by robust safeguards to protect human rights'**.

The Victorian Mental Illness Awareness Council, the peak body for people who have experience with a mental illness or emotional distress, stated in their submission:

"Innumerable consumers have stated to the Victorian Mental Illness Awareness Council that if it were not for involuntary detention they would simply not be alive today and on that basis they support the provision in the Act. Others (far less in number) on the other hand believe involuntary detention should not be allowed to occur."

The community consultation considered whether involuntary treatment is consistent with the Victorian Charter of Human Rights and Responsibilities ('the Charter'). The report referenced a judgement by the Honourable Justice Bell, then President of the Victorian Civil and Administrative Tribunal, who delivered the first judicial decision relating to the Charter and the review of involuntary orders. The judgement (in the matter of *Kracke v Mental Health Review Board & Ors*) stated:

"The purposes of the Mental Health Act are to ensure mentally ill people who cannot or do not consent get medically necessary care, treatment and protection. Since the treatment will be involuntary, achieving that purpose will seriously interfere with the human rights of patients."

Consistently with its purposes, the legislation attempts to protect those rights as far as possible. The purposes of the legislation are therefore to ensure such treatment is given only, first, when medically necessary according to definite criteria and, second, subject to strict safeguards that protect the human rights of patients as far as possible.

The Panel stated that, given developments in human rights and mental health legislation both in Australia and overseas, there was an ‘overwhelming community view’ that rights protections in the Act were not sufficient and that ‘The Victorian Equal Opportunity & Human Rights Commission notes a failure to ensure that proper safeguards are put in place when a person receives involuntary treatment for mental illness engages rights under the Charter and under the Disabilities Convention’.

The Panel concluded that limitations on human rights ‘should be proportionate and include effective safeguards’ and that the Charter and the Disabilities Convention provided ‘a clear impetus and framework to improve the rights safeguards in the new Act’.

1. Compulsory treatment

The Minister viewed the compulsory treatment safeguards in the *Mental Health Act 1986* as inadequate to ensure that treatment is provided in the least restrictive and least intrusive manner. In particular, the then involuntary treatment orders had an indefinite duration and the substitute decision-making model for providing compulsory treatment was stated to be inconsistent with contemporary views about patient participation and recovery. A focus in the revised Act on promoting and enabling voluntary assessment and treatment in preference to compulsory assessment and treatment wherever possible was an explicit goal of the revised Act.

The Minister stated that where compulsory treatment is required, the Mental Health Act seeks to minimise its duration and ensure that it is provided in the least restrictive and least intrusive manner possible. The Act does this by introducing specific criteria for compulsory treatment, treatment orders that operate for a fixed duration, and timely independent oversight by a new Mental Health Tribunal.

The Mental Health Act specifies the criteria for providing compulsory assessment and treatment. The criteria provide clear guidance to decision-makers, consumers and other stakeholders about when compulsory assessment and treatment are appropriate. The criteria reflect the objectives of the Mental Health Act and have been designed to ensure that compulsory assessment and treatment are only used when there is no less restrictive means reasonably available to ensure a person receives necessary assessment and treatment.

2. Presumption of capacity

The Mental Health Act establishes a presumption that all people have capacity to give or refuse to give informed consent in relation to their assessment and treatment. This presumption may be displaced where it is demonstrated that the person does not have capacity to make that decision at the time that the decision needs to be made.

The Mental Health Act therefore sets out principles for clinicians and others to consider when determining whether a person can make a treatment decision.

A person may only be made subject to an assessment order or temporary treatment order if there is no less restrictive means reasonably available to enable the person to be assessed or treated. This includes whether the person can receive mental health treatment voluntarily. An assessment order



can only be made following an examination by a registered medical practitioner or a mental health practitioner who considers that all the criteria for an assessment order apply to the person. A mental health practitioner is a prescribed class of persons employed by a designated mental health service.

A person subject to an assessment order may be taken to a designated mental health service for the purposes of being examined and assessed by an authorised psychiatrist to determine whether the criteria for a temporary treatment order apply to that person. An authorised psychiatrist may not make the person subject to a temporary treatment order unless the authorised psychiatrist is satisfied that the person has mental illness and all the other treatment criteria apply. A temporary treatment order may only be made for a person who requires immediate treatment to prevent serious harm to himself or herself or another person or to prevent serious deterioration to the person's health. A temporary treatment order has a duration of 28 days unless revoked earlier.

ATTACHMENT 5 - THE VICTORIAN INQUIRY INTO THE SUPPLY AND USE OF METHAMPHETAMINES, PARTICULARLY 'ICE' IN VICTORIA

This Inquiry makes some reference to mandated treatment for methamphetamine use in the Final Report (Volume 2 of 2) published in September 2014.

According to the findings handed down from the Inquiry, a challenge raised during the Inquiry was whether there are circumstances that warrant compulsory treatment for methamphetamine users.

The Inquiry report states mandated or compulsory drug treatment refers to treatment that is directed by legislation, usually in lieu of justice-focused sanctions, such as prison. There are a variety of types of compulsory treatment, including pre-arrest police diversion, post-conviction diversion through the general or specialist drug courts, prison pre-release programs, as well as various acts that authorise police to detain drug-dependent people for assessment and treatment. The Inquiry report cites the Severe Substance Dependence Treatment Act 2010 (Vic) (the SSDTA) an example of the latter.

The Inquiry report makes reference to cases where the person's drug dependence, although serious, may not be of sufficient severity to give rise to action under the SSDTA. In particular, the user's life or health may not be in immediate danger but the person may be manifesting chaotic and disturbing behaviour.

The Inquiry report states that for some family members who gave evidence, 'forced' treatment is viewed as the only way in which the user can get much needed assistance.

Kerryn Johnston the mother of a young woman with a serious methamphetamine dependency, told the Committee:

"My biggest problem is that [my daughter] she does not think she needs help but if he [an arresting police officer] had been able to put her in a van, take her to the rehabilitation place and say, 'This is what you have to do,' it might have been an opening for her but she was let go, and I had to let her go and there is nothing you can do.

Darlene Sanders from Mildura "told the Committee that she wished her son had been forcibly put into treatment by the magistrate who sentenced him for crimes associated with his ice use".

"I would like to see the law changed that makes it up to them if they go to rehab. I have said to a magistrate, 'That should not be their choice', because it is not our choice to put up with their drug addict behaviour. For me, that law needs to be changed. If they have said, 'You're going to rehab', you need to go to rehab and that is it. You do not get a say in it.

Rob McGlashan from Project Ice in Mildura told the Committee:

"A lot of family members are ringing us and saying, 'We need them [family members who use ice] to be picked up and taken to treatment against their will — yet there is no mechanism to do this at the moment"

The Inquiry report states "other family members who gave evidence in camera made similar observations".

The Inquiry report concludes that while treatment status (either voluntary or mandatory) has been associated with treatment outcomes, particularly as a mediator of client motivation, **"a review of compulsory treatment showed that both custodial and non-custodial participants who have**

been mandated to treatment show good clinical and forensic outcomes" and that an estimated 65% of both mandated and voluntary clients reduce their drug use or harms, suggesting **mandated treatment is not a significant barrier to experiencing good outcomes.**

Several witnesses to the Inquiry noted that while engaging people in treatment voluntarily is philosophically preferable, good outcomes are still possible with the right approach:

Ms Macdougall from Primary Care Connect noted in her testimony to the Inquiry:

"No matter how they walk through the door, whether it is pushed or whether they step in themselves, that gives us an opportunity, and all drug treatment service is an opportunity to start doing that connection. They might come in belligerent and angry, but it is certainly our job to make them feel that we are there to work for them, and that is what we do. I think we do it quite well, and I think most of the drug treatment communities over Victoria use that opportunity; they do not let that chance go by just because they are mandated.

The Inquiry report states Ms Melinda Grady, Youth Worker at Barwon Youth, suggests that although motivation can be lower among mandated clients when they come into treatment, AOD workers have specific strategies they can engage to increase motivation and keep this group in treatment:

"Remembering these are mandated clients, not necessarily voluntary at this point. Our aim is to engage and continue treatment... Young people find it quite interesting themselves to discover where they are at emotionally, how the drug is impacting on their health, lifestyle and their mental health... We use strategies, such as motivational interviewing which is about working out where a person is at in regard to treatment, do they want to make change or not, and if not what we can provide for them.

Whatever the merits or otherwise of a system of mandated treatment for drug dependence, including crystal methamphetamine, some witnesses pointed out to the Inquiry Committee that there are substantial obstacles involved in initiating the process.

Kaz Gurney, from Goulburn Valley Community Legal Centre told the Committee:

"not only are the grounds under the SSDTA limited and the procedure for invoking it difficult and time consuming, there are also few facilities or resources available for working with mandated clients".

Ms Gurney told the Inquiry De Paul House at St Vincent's Hospital in Melbourne is at this stage the only secure facility to cater for the treatment of involuntarily committed drug dependent patients.