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Foreword

I am pleased to be able to release this Discussion Paper for the review of the Tasmanian Alcohol and Drug Dependency Act 1968 (the ADDA) on behalf of the Tasmanian Department of Health and Human Services.

In 2007, a major review of Alcohol Tobacco and Other Drug Services (ATODS) in Tasmania recognised that legislation supporting the Tasmanian Alcohol and Drug Service is out of date and does not reflect current service delivery or practice. The need to reconsider the ADDA was reinforced in the ATODS’ Future Service Directions Plan and was subsequently confirmed as a priority by the Tasmanian Government.

The ADDA was first enacted in 1968 and provided for the treatment and control of persons suffering from alcohol dependency and/or drug dependency. Currently, the ADDA is used to compulsorily detain a relatively small number of persons in Tasmania who have significant alcohol or drug dependency.

Research suggests that in Tasmania alcohol is the second most common principal drug of concern for which treatment is sought and when all drugs of concern are considered 41 per cent of episodes include alcohol. Furthermore, one in five people aged 14 years or older nationally consume alcohol at a level that puts them at risk of harm from alcohol-related disease or injury over their lifetime. The majority if not all recent involuntary applications under the Act relate to severe alcohol dependence.

Major changes in society, since the enactment of the Act, have caused people to raise important questions around the use and need for compulsory treatment. Issues put forward relate to human rights, clinical practice, ethics and public policy.

This Discussion Paper has been developed to help facilitate and guide stakeholders during the consultation phase of the Review. It canvasses a number of options and includes a series of questions to assist stakeholders in considering the key issues. These are intended to promote discussion and stimulate debate. It should be noted that the options are not government policy and are for consultation purposes only and they do not represent the final view of the Department.

Stakeholder consultations will play an important role in determining the recommendations that will be provided to government in a final report. The Department is seeking the views of stakeholders and the community to inform the Review process. Therefore, I encourage anyone who wishes to express their point of view about the future management of compulsory alcohol and drug treatment in Tasmanian to provide feedback or make a written submission during the consultation period.

We welcome your input and hope you will take the time to share your thoughts and ideas on this important matter.

Nick Goddard
Acting Chief Executive Officer
Statewide and Mental Health Services

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1 A Review of Alcohol, Tobacco and Other Drug Services in Tasmania, Final Report.
2 (National Minimum Data Set, 2008-09).
Invitation to comment

The ADDA Review Discussion Paper aims to set out the key issues and potential options for the future regulation of the treatment of persons with a severe alcohol or drug dependency. The Department of Health and Human Services (DHHS) is seeking comments, feedback and submissions on this paper. The Discussion Paper also raises specific questions in order to facilitate discussion and debate and to assist stakeholders in responding (see Appendix A).

If you wish to comment on the issues raised in this paper, you can make a written submission. Your submission can address some or all of the questions posed in the discussion paper and you are also welcome to raise any other relevant issues.

Submissions should be forwarded to the ADDA Review Project Manager via:

Email: addareview@dhhs.tas.gov.au
Post: 13 Mulgrave Street, Launceston 7250
Fax: (03) 6336 5567

Feedback can also be provided online. A form for this purpose can be accessed at www.dhhs.tas.gov.au/mentalhealth

Please note that all submissions made are treated as public documents unless they are specified otherwise.

If you wish to provide verbal feedback or you have any questions or queries, please contact Emma Walkem (03) 6336 5403.

The closing date for the receipt of feedback is 21 December 2012.

Copies of the Legislation

If you wish to obtain a copy of the ADDA and the associated regulations, it is available from:

Print Applied Technology
123 Collins Street, Hobart Tasmania 7000
1800 030 940

The Tasmanian Legislation Online website also contains electronic versions of Tasmanian Acts of Parliament. The ADDA legislation can be downloaded via the website at www.thelaw.tas.gov.au. Alternatively, hard copies can be printed and posted on request.
Introduction

The Alcohol and Drug Dependency Act 1968 (the ADDA) makes provision with respect to the treatment and control of persons suffering from alcohol or drug dependency. When introduced in 1968, it replaced the Inebriates Act 1885 and the Inebriate Hospitals Act 1892 and certain provisions of the Dangerous Drugs Act 1959. Currently, it is used primarily to compulsorily detain persons suffering from alcohol or drug dependency.

The DHHS is currently reviewing the relevance and appropriateness of the ADDA in the context of Tasmania’s current alcohol and drug treatment climate. The objective of the review is to critically evaluate the ongoing suitability of the ADDA and to identify a potential way forward.

This Discussion Paper has been developed as a tool to assist respondents to explore options for the role of legislative regulation with regards to compulsory treatment and to guide stakeholders in providing feedback on the philosophical and practical issues surrounding and underpinning the ADDA. The Paper also highlights a number of potential alternatives, identifies some of the benefits and detriments associated with each and seeks feedback with respect to these matters.

To this end, the Discussion Paper provides a background to the ADDA, a summary of the main legislative provisions, and a comparative overview of equivalent legislation in other Australian jurisdictions and overseas. The Discussion Paper also includes an extensive literature review for compulsory detention and treatment and poses a series of questions for consideration.

Current Tasmanian Legislative Framework

The ADDA was first proclaimed in December 1968 and is supported by the Alcohol and Drug Dependency Regulations 2009. The objective of the ADDA is to “… make provision with respect to the treatment and control of persons suffering from alcohol dependency or drug dependency…” (ADDA, 1968). However, contrary to its objectives, the ADDA no longer expressly confers the power to compulsorily treat an individual.

The main aim of the ADDA was to provide for a separate legislative regime for the treatment of alcoholism partly because of the absence of a serious drug problem in Tasmania in the 1960s. Until the ADDA’s development, alcoholics who were unresponsive to social pressures and who required hospitalisation were sent to mental hospitals under an involuntary order pursuant to the Mental Health Act 1963. At the time, the consensus of opinion appeared to be against alcohol and drug dependency being coupled with mental illness and a suggestion was made that a separate Act should be introduced to cover these cases (DHHS file notes, 1967).

Under the ADDA, a person may be detained in a treatment centre pursuant to an admission application. The ADDA distinguishes between admission applications initiated by a patient (called a ‘personal application’) and applications made by a relative or welfare officer (called, for the purposes of this document an ‘involuntary application’).

An involuntary application must be made with the support or recommendation of a practitioner, and a person may be detained for up to fourteen days after admission on the basis of an application that is made with such support or on recommendation. The detention may be extended for up to six months if the “appropriate medical officer” (the superintendent of the treatment centre or a medical practitioner directed by the superintendent to examine the patient) issues a certificate to that effect. A person’s

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4 See Appendix A for a summary of questions.
5 [section 24(3)].
6 sections 26(3).
detention may also be extended for subsequent six month periods if the medical officer deems this to be necessary and in the interest of the patient's health or safety or the protection of others.\(^7\)

A person who is being detained, or his or her relative, may apply to the Alcohol and Drug Dependency Tribunal (the Tribunal) for the person’s discharge from the treatment centre\(^8\). The Tribunal consists of five members, three of whom are medical practitioners with experience in the treatment and rehabilitation of persons suffering from alcohol or drug dependency and two of whom are persons with suitable qualifications or experience.

For a further examination of the ADDA, including definitions and a description of the major legislative provisions, refer to Appendix B.

The ADDA has been amended a number of times since 1968, as follows:

- Division II of Part IV of the ADDA (provision to make court mandated treatment orders) was repealed in 1997 with the development of the Sentencing Act 1997 which drew together the range of sentencing provisions located in various Acts of the Tasmanian Parliament, including the ADDA, into a single statute.

- The Alcohol and Drug Dependency Tribunal replaced the Alcohol and Drug Dependency Board in 1993. This occurred following the integration of alcohol and drug services into regional health services and individual boards of management. This greatly reduced the ADDA Board’s functions (which had previously included providing advice on alcohol and drug services and other advisory roles). As a result, a smaller and independent Tribunal was established to hear applications for release from ADDA treatment orders as the Tribunal was no longer required to provide advice.

- Part III of the ADDA (restriction on the prescription and supply of certain substances) was transferred to the Poisons Act 1971 in 2008.

Currently, there is no power or capacity to detain and treat Tasmanian ADDA clients who abscond to a different state or jurisdiction whilst they are subject to an ADDA order in Tasmania. ADDA orders are not automatically recognised and enforced in other Australian states. It would be both difficult and time consuming to achieve cooperation from other states and jurisdictions regarding reciprocal compulsory treatment arrangements for two reasons. Firstly, because there is significant variation in the laws for compulsory treatment in Australian states and territories (not all jurisdictions have legislation relating to the compulsory treatment of non-offenders to alcohol and drug treatment) and secondly there are some major differences amongst the jurisdictions that do have compulsory treatment legislation in place in terms of treatment models, policies and practices.

A comparative overview of equivalent legislation in other Australian jurisdictions and New Zealand is contained in the section “What are other jurisdictions doing”.

\(^7\) section 27(2) (3)].

\(^8\) Section 29
Terminology in this paper

There is wide variation in the implied meaning and usage of definitions and terminology for alcohol and drug dependent individuals who are coerced or diverted into detention and treatment. For example, civil commitment, compulsory treatment, involuntary care, mandated diversion and so forth. These key terms are not always equivalent in meaning and are used interchangeably in Australian and overseas literature. This generally makes research findings difficult to interpret and understand (Broadstock, Brinson and Weston, 2008).

For the purposes of this Discussion Paper and the ADDA Review the term compulsory treatment will be used to refer to coerced detention and treatment. The term compulsory treatment relates to interventions over a wide range of coercive situations (Broadstock et al, 2008). Compulsory treatment encompasses legal orders such as court mandated diversion programs and civil commitment orders. It is important to note that the term involuntary care shares the same meaning as compulsory treatment.

Civil commitment is an example of compulsory treatment but targets people who are non-offenders that have not committed an offence but whose substance dependence is considered to be high-risk or life threatening. Although, civil commitment schemes relate to non-offending individuals they are legally sanctioned and allow individuals no choice in the matter (Pritchard, Mugavin and Swan, 2007). Within this context the ADDA could best be described as providing for civil commitment.

In contrast to civil commitment, mandated diversion (legal orders) refer to treatment which is required by police or the criminal justice system. For example, a referral to treatment through a court mandated diversion program.
The need for a review

As noted previously, the social, medical and legal context that informed the development of ADDA has changed substantially over the past forty years, not only in Tasmania and Australia, but worldwide. There are significant concerns about the extent to which the ADDA (and its focus on compulsory detention) is consistent with the shift towards increased recognition of human rights, the need for a consumer-centred focus, and with the overarching goal of harm minimisation contained within the National and Tasmanian Drug Strategies.

The numerous amendments that have been made to the ADDA over its lifetime have rendered it confusing and difficult to apply. Specific issues that have been identified through internal DHHS stakeholder consultation include:

- The disjunction between the approach underpinning the ADDA and current approaches to alcohol and drug service delivery which feature assertive case management, treatment in the community and short term treatment focussed interventions rather than long term detention;
- The lack of clarity around the ADDA’s operation and a general lack of awareness and understanding of the ADDA;
- The failure for the ADDA to adequately protect or provide for appropriate oversight of client rights;
- A perception that the treatment model underpinning the ADDA requires a level of resourcing and type of accommodation and service delivery model that is no longer appropriate nor available;
- The inability for a treatment centre model to adequately provide services to consumers outside of the three major centres and the limitations that exist in those three major centres;
- The lack of appropriate oversight mechanisms and systems (such as requirements to record relevant information); and
- The professional conflict that compulsory treatment creates for clinicians and the impact that it has on client outcomes, efficacy and level of engagement.

Perhaps as a result of these issues the ADDA is rarely utilised. Analysis of the paper-based register of ADDA admissions identifies approximately twelve admissions for the period June 2005 to June 2008 with anecdotal information suggesting an additional four admissions from the period June 2008 to June 2010.

While precise client demographics are not recorded at the time of admission, anecdotal evidence suggests that the ADDA client group is characterised by a high prevalence of co-occurring factors that can include mental health issues, behavioural and cognitive impairment, poor attention to personal health and safety, lack of family and social support and inability to manage financial and accommodation issues.

9 Any future legislative framework that provides for involuntary care would need to take into account the etiology of substance abuse to inform treatment modalities.
About the Review

Scope of the Review

The ADDA Review is being conducted in two stages.

The first stage involves consultation with key stakeholders about the most suitable framework for the treatment of persons with a severe alcohol and/or drug dependency. Outputs of this stage will include the identification of options and the development of recommendations around these future options. The purpose of this document is to inform the first stage of the Review process.

Consideration of these recommendations and, if relevant, the progression of legislative options will comprise the second stage of the Review.

Governance arrangements

The governance arrangements for the ADDA Review consist of a Steering Committee and a Reference Group.

The Steering Committee includes representatives from DHHS and the peak body representing community sector organisations (CSOs) that provide alcohol and other drug services in Tasmania, the Alcohol, Tobacco and Other Drugs Council (ATDC).

The primary function of the Steering Committee is to take responsibility for and to support the major objectives of the ADDA Review. The Steering Committee will report to the Minister for Health via the CEO for Statewide and Mental Health Services on the outcomes of the Review and recommendations for future regulation in this field.

The Reference Group is comprised of representatives from DHHS, the Department of Police and Emergency Management, the Mental Health Tribunal, the Guardianship and Administration Board, Disability Services, the ATDC, Advocacy Tasmania Inc., the Alcohol and Drug Dependency Tribunal, CSOs and the four major Hospitals.

The primary function of the Reference Group is to assist the Steering Committee to deliver the major objectives of the Review.

The Steering Committee is being assisted by an Internal Project Team comprised of key DHHS staff members. The role of the Internal Project Team is to assist the Steering Committee to deliver outputs necessary for the delivery of the Review’s objectives.
What is the Evidence Base?

Contemporary Trends and Current Clinical Practice for Compulsory Treatment

Harm minimisation includes preventing anticipated harm and reducing actual harm (National Drug Strategy, 2010-2015) and recognises the acceptability of both abstinence oriented approaches and alternative initiatives. Compulsory treatment programs support, and are consistent with a harm minimisation philosophy.

Compulsory treatment is a well-established concept and has a firm place in the Australian treatment context. It is one of a range of programs and initiatives through which individuals may be coerced and compelled by legal mechanisms into alcohol and drug treatment. Other examples include the Tasmanian Illicit Drug Diversion Initiative and the Tasmanian Court Mandated Diversion Program. Compulsory treatment initiatives operate in a number of states at every stage of criminal justice proceedings and through civil commitment legislation in four Australian States10. Despite its prevalence, a comprehensive national policy on how compulsory treatment, in its many forms, should be conducted is not available. Instead, a maze of national, State and local codes and practices are in existence. For the most part, compulsory treatment programs have developed and operate independently of one another, without any overarching or consistent standards or objectives (Pritchard et al, 2007).

Very little research has occurred into the effectiveness of compulsory treatment generally or in relation to different treatment types such as (residential detoxification, opiate substitution, brief education or counselling). Wild, Cunningham and Ryan (2006) state: “...proliferation of social control tactics to facilitate addiction treatment is a world-wide social experiment being implemented without a compelling evidence base on its utility...”.

What is clear is that greater efforts are required to build the knowledge and evidence base regarding compulsory treatment. This includes the collection and analysis of data pertaining to the nature of treatment(s) stemming from compulsory treatment orders and subsequent evaluation research to examine:

- which types of treatment hold the most promise for being effective and cost-effective (and for which groups);
- the interplay between client motivation, perceived coercion, client characteristics, the content and components of treatment programs; and
- which models and treatments are effective (Pritchard et al, 2007).

Effectiveness of Compulsory Treatment

Two recent studies, a 2007 Australian National Council on Drugs (ANCD) Research Paper on Compulsory treatment in Australia (Pritchard et al, 2007) and a 2008 New Zealand (NZ) report (Broadstock et al, 2008) do however provide some limited insight into the effectiveness of compulsory treatment. The 2007 ANCD report (Pritchard et al, 2007) presented a national perspective on compulsory treatment in Australia and made a number of recommendations for both offenders and non-offenders. This paper concluded that while there is some evidence, mainly anecdotal, that civil commitment (legally sanctioned, involuntary commitment of a non-offender) for short periods can be an effective harm reduction mechanism, there is little evidence to support its effectiveness in rehabilitating or achieving long-term behavioural change.

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10 Tasmania, Victoria, New South Wales and the Northern Territory.
The 2008 New Zealand report (Broadstock et al, 2008) systematically reviewed literature on the effectiveness of compulsory drug and/or alcohol treatment to draw conclusions for non-offenders. Among a range of conclusions, the New Zealand report concluded that:

- Most research and evidence on the effectiveness of compulsory residential treatment relates to offenders who are coerced and referred to treatment via the criminal justice system;
- Short term compulsory treatment can provide benefits in harm minimisation for at least some people, some of the time;
- While alcohol and drug abuse is generally viewed as a chronic condition, acute emergency situations do occur, and if compulsory treatment is one mechanism to prevent deaths and minimise harm, then it can be considered to play a useful role. Nevertheless, there may be other mechanisms that are as effective, or more so, as compared with compulsory treatment and this has not been robustly investigated;
- There is no evidence of harm from compulsory treatment; and
- In terms of deciding whether there is any place for compulsory treatment in New Zealand, policy makers need to rely on case studies, anecdotal and expert opinion.

Consistent with the general lack of research in this area the New Zealand report found only four papers eligible for inclusion in a literature review and the results and recommendations for non-offenders were sourced primarily from offender based literature. This is not surprising given that most research and evidence on the effectiveness of compulsory residential treatment relates to offenders who are coerced and referred to treatment via the criminal justice system.

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11 This is debatable, see “Consequences and harms associated with compulsory treatment” section.
What are other Jurisdictions doing?

In Australia, New South Wales (NSW), Victoria (Vic), the Northern Territory (NT) and Tasmania (Tas) all have legislation relating to the compulsory treatment of individuals dependent on alcohol and other drugs. Legislation allowing for the compulsory treatment of non-offenders to alcohol and drug treatment also exists in counties such as Switzerland, Sweden, New Zealand and the United States (Swan and Alberti, 2004). Sweden, in particular, has had a long history of coerced treatment and there is strong support for compulsory treatment programs in Swedish society. Compulsory treatment is an integrated part of the Swedish treatment system but the goal is not just to provide treatment but to motivate the individual to voluntary treatment. Compulsory treatment is favoured, at least in certain cases by the majority of clinicians in the Swedish health-based addiction treatment system (Storbjork, 2006). The United Kingdom (UK), Scotland, Netherlands and Canada have taken a different approach to this and have implemented generic capacity based legislation for the compulsory treatment of individuals, who under relevant circumstances lack capacity to make decisions for themselves. The UK Act in particular covers major decisions about healthcare treatment and lays out a single test for assessing whether a person lacks capacity to make a particular decision at a particular time.

Victoria

The Victorian Alcoholics and Drug-dependent Person’s Act 1968 (ADDPA) provided for the detention of alcoholics and drug-dependent persons on a voluntary and involuntary basis for assessment and treatment. A Review for ADDPA commenced in 2005, with the release of a Discussion Paper and widespread public consultation with stakeholders. The Review resulted in the development of the Severe Substance Dependence Treatment Act 2010 (SSDT) which has repealed and replaced the ADDPA. The SSDT Act came into effect on 1 March 2011.

The main provisions of the SSDT are that it grants adults with the power to lodge an application for a detention and treatment order, which if granted, enables a person to be detained and treated to enable medically assisted withdrawal from severe substance dependence, for up to fourteen days.

All persons subject to a detention or treatment order under the SSDT have access to legal representation and advocacy support through the Public Advocate and Victorian Legal Aid. There are also provisions for a discharge and case management plan (s36). This is to be developed in conjunction with the person on the detention and treatment order.

The SSDT sets out criteria for the detention and treatment of persons with a severe substance dependence. In clause 5 a person is defined as having a ‘severe substance dependence’ if:

| 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. |

Section 8 of the SSDT sets out the criteria for detention and treatment as being where: 'the person has a severe substance dependence’ as previously defined; where 'because of the person’s severe substance dependence, immediate treatment is necessary as a matter of urgency to save the person’s life or prevent serious damage to the person’s health'; where 'the treatment can only be provided to the person through

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12 See the “Capacity Legislation” section under “Other relevant Tasmanian legislation” for further information.
the admission and detention of the person in a treatment centre'; and where 'there is no less restrictive means reasonably available to ensure the person receives the treatment'.

An application for a detention and treatment order must contain a medical recommendation by a prescribed registered medical practitioner and they must consult and seek a second opinion from a senior clinician at a drug and alcohol treatment centre. Once the assessment has been completed a person can lodge an application with the Magistrates Court. The person subject to the detention and treatment order will then be granted the right to obtain legal representation. A hearing must be held within 72 hours of the filing of the application, and the person who is subject to the application has the right to appear.

Once a court order is made, the person is given a priority listing on the waiting list to access a treatment service. The legislation provides that a person can only be placed on a detention and treatment order for a maximum of fourteen days. This differs somewhat from the previous Act, which allowed the court to make a treatment order for a maximum of seven days, with a provision for the treatment centre to apply for an additional seven day extension.

The SSDT Act also differs from the ADDPA in that it introduces a set of guidelines which affect the operation of treatment centres and provides for greater involvement of a person throughout all stages of their treatment. As part of these new provisions, a person entering a treatment facility is given the right to nominate a person to act to protect their interests. This nominated person may act as an advocate and provide support and assistance to the person receiving treatment for their dependence. The Office of the Public Advocate also plays an important role in the administration of this legislation. Acting as an independent voice, the public advocate visits and supports the person subject to the detention and treatment order with the aim of assisting them in exercising their rights (Severe Substance Dependence Treatment Act 2010 and Parliament of Victoria, Severe Substance Dependent Treatment Bill 2009, Second Reading Speech 2010).

New South Wales

In 2004, the NSW Government reviewed the Inebriates Act 1912. Amongst the numerous and detailed review recommendations was the use of a short-term model of involuntary care. Consequently, the New South Wales Drug and Alcohol Treatment Act 2007 was created to provide the legal basis for a trial short-term involuntary care and treatment program. The program was trialled for two years at a hospital in Western Sydney and surrounding Local Government Areas (LGAs) were gazetted for the purpose of the trial to enable participation by a limited catchment area.

The target population for the NSW trial legislation was: "...individuals with a substance dependence who had experienced or were at risk of serious harm and whose decision making capacity was considered compromised…" (NSW Standing Committee on Social Issues, 2004). Under this Act, persons with severe substance dependence were required to undergo detoxification to rebuild their health and were linked in a planned and considered way to longer-term rehabilitation and support.

The involuntary treatment trial occurred in a four-bed unit within the existing Centre for Addiction Medicine at the NSW Nepean Hospital. This unit was equipped to deal with acute withdrawal symptoms and its on-site location at Nepean Hospital meant that intensive medical care was immediately accessible. The Centre was staffed by a medical team consisting of a staff specialist, 24-hour nursing cover, a clinical/neurological psychologist, and a discharge planning team with a part time psychologist and social worker as well as drug and alcohol workers.

Under the trial health workers, family members and other concerned parties were able to refer a person to a medical practitioner for an initial assessment. If the medical practitioner was satisfied that the person met the criteria for the trial they were able to refer the person to a specialist accredited medical practitioner at the Treatment Centre for a comprehensive assessment.
A dependency certificate, which allowed a person to be involuntarily admitted, could only be issued if:

- The person had a ‘severe substance dependence’, meaning they:
  1. Have a tolerance to a substance
  2. Show withdrawal symptoms when they stop or reduce levels of its use
  3. Do not have the capacity to make decisions about their substance use and personal welfare primarily because of their dependence on the substance
  4. The care, treatment or control of the person is necessary to protect the person from serious harm
- The person was likely to benefit from treatment for his or her substance dependence but refused treatment; and
- No other appropriate and less restrictive means for dealing with the person were reasonably available.

An accredited medical practitioner could issue a dependency certificate for up to three months, in extreme circumstances, where detoxification, stabilisation and discharge planning may take longer than anticipated or required.

While at the Treatment Centre the person was comprehensively assessed on their capacity to make decisions about their substance abuse, personal welfare and future treatment options. They underwent medically assisted detoxification as well as medical treatment for any concurrent physical and/or mental illness. A comprehensive Treatment Plan was also developed, which included thorough discharge planning (NSW Health, 2007).

It is notable that the proposed NSW and Victorian legislation makes reference to decision making and capacity, a construct that is absent from other such civil commitment legislation. This approach is similar to capacity legislation that is currently in place in the United Kingdom.  

The NSW trial for involuntary care ceased on 30 June 2011. NSW has subsequently sought to repeal the Drug and Alcohol Treatment Regulation that gazetted the participating LGAs. This will automatically reinstate the Inebriates Act 1912. Evaluation was undertaken for the duration of the trial. The outcomes of the trial and recommendations in terms of future program implementation (including the rollout of the new legislation) are currently awaiting submission to Cabinet for endorsement.

**Northern Territory**

In the Northern Territory (NT), civil commitment is limited to persons who use alcohol to excess (Liquor Act 2004) and for compulsory treatment orders for those individual’s that abuse volatile substances (Volatile Substance Abuse Prevention Act 2005), (Pritchard et al, 2007). Section 3(1) of the Volatile Substance Abuse Prevention Act 2005 (VSAP) states:

The objects of this Act are to support child, family and social welfare and to improve the health of people in the Territory by providing a legislative framework for:

- the prevention of volatile substance abuse; and
- the protection of persons, particularly children, from harm resulting from volatile substance abuse.

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13 Ibid 12.
In order to achieve these objectives, section 3(2) of the VSAP specifies several actions that are permissible, including ‘the making of orders that persons at risk of severe harm as a result of abuse of volatile substances must participate in treatment programs’ [s3(2)(c)].

Part 3 of the VSAP specifically addresses treatment orders for persons who are at risk of severe harm. ‘Severe harm’ is defined as: “physical harm, neurological harm and/or significant deterioration of or damage to the person’s mental condition” (s31). A police officer, a health practitioner or a family member have the authority to request the NT Minister for Family and Community Services to apply for a treatment order (s33). The Minister may then order the person to be assessed by a health practitioner under s34(1) (Parliament of Victoria, Research Brief, 2010).

The NT Government has also just recently introduced new laws and a number of reforms to address alcohol and drug misuse including mandated treatment. The Alcohol Reform (Prevention of Alcohol-Related Crime and Substance Misuse) Act 2011 aims to reduce access to alcohol for people who have demonstrated problem behaviour as a result of their drinking and to encourage or direct those people to seek treatment. The new legislation establishes police-issued Banning Alcohol and Treatment [BAT] notices to turn problem drinkers “off tap” when they are taken into protective custody three times during a three month period. The BAT notice prohibits a person from purchasing, possessing or consuming alcohol. Breaching the police-issued bans will lead to longer bans and on a third breach the person may be referred to the Alcohol and Other Drug (AOD) Tribunal which can issue appropriate rehabilitation orders. The AOD Tribunal recently commenced operation and has the power to review police-issued bans and to order people who are misusing alcohol or drugs to attend treatment or rehabilitation. The AOD Tribunal’s orders must be followed and non-compliance will lead to a person being “banned” – possibly indefinitely from purchasing, possessing or consuming alcohol. However, the AOD Tribunal does not have powers to detain the person or impose fines or imprisonment in order to enforce its orders.

The Alcohol Reform (Substance Misuse Assessment and Referral for Treatment Court) Act 2011 is also a new NT Act addressing alcohol or drug misuse. This Act came into force on 2 July 2011 and aims to provide increased opportunity for rehabilitation. It is anticipated that a new Substance Misuse Assessment and Referral for Treatment (SMART) Court will be established to make orders for people who have been found guilty of a criminal offence related to alcohol or drug misuse. A Magistrate will preside over the SMART Court and will be able to hand down orders, either before sentence or as part of a sentence that can include mandatory treatment. The SMART Court offers assessment and access to programs for offenders misusing substances to make treatment or rehabilitation a part of the sentencing process, reducing the likelihood of further offending (NT Government, 2011).

**Australian Capital Territory**

There is no legislation for the compulsory treatment of persons with an alcohol or drug dependency in the ACT. The only relevant legislation is the Intoxicated Persons (Care and Protection) Act 1994, which essentially allows the police to apprehend intoxicated persons and hold them briefly for their own protection [Review of the Alcoholics and Drug-Dependent Persons Act 1968, (ADDPA) Victoria, Discussion Paper, 2005].

**Western Australia**

There is also no equivalent legislation for the compulsory treatment of persons with an alcohol or drug dependency in Western Australia (WA). Some provisions are made for certain ‘alcoholic/drug-dependent persons’ via the WA Mental Health Act 1996. The Ministry of Justice also refers people to Court Diversion, and Magistrates can refer to drug treatment as part of a Community Based Treatment order.
Queensland

Queensland’s *Inebriates Institutions Act 1896* was repealed in 1994. There is now no legislation in Queensland that allows for the civil commitment of people with solely alcohol and drug issues. Queensland’s *Mental Health Act 2000* allows for civil commitment of people with alcohol and drug dependency issues but only where a person has a mental illness, and for the purposes of that illness (Parliament of Victoria, Research Brief, 2010).

New Zealand

New Zealand’s *Alcoholism and Drug Addiction Act 1966* (ADA Act) provides for the compulsory treatment of alcohol and drug dependent persons at certified institutions. Any person subject to the ADA Act can be detained for up to a maximum of two years. In practice, most patients are discharged after six months or released on leave (where they can be recalled to the facility within the two year period). Currently, compulsory treatment is provided by two non-government service providers in one of four certified facilities. Detention under the ADA Act is court-ordered through either a voluntary or involuntary application. However, the court’s power to make an order is a discretionary one and an order is not necessarily regarded as appropriate just because an application meets the eligibility criteria (New Zealand Law Commission Issues Paper, 2010).

The New Zealand Ministry of Health is currently reviewing the ADA Act. The ADA Act is universally regarded as reflecting an out-dated treatment philosophy and has not kept pace with international human rights laws as reflected in the New Zealand *Bill of Rights Act 1990* and *The Code of Health and Disability Services Consumers’ Rights*. Since the 1970s the use of the ADA Act has been declining steadily as a consequence of its clinical, legal and practical problems including difficulties with the application process, lack of flexibility in the available treatment programmes and inadequate provision for the review of court decisions.

An Issues Paper by the New Zealand Law Commission, *Compulsory Treatment for Substance Dependence, A Review of the Alcoholism and Drug Addiction Act 1966* was consulted on in 2010. In December 2010, the New Zealand Ministry of Health obtained Cabinet approval for proposed new legislation that will enable short-term compulsory treatment for severe substance addiction where it is unlikely that less restrictive options will enable effective treatment. The period of commitment can be extended where the person appears to have a brain injury to enable proper assessment and facilitate ongoing care and support. The proposed legislation contains explicit criteria that must continually be met and includes a rigorous framework to protect an individual’s rights while they are undergoing compulsory treatment.

The objective of the proposed legislation is to provide an opportunity for the patient to recover mentally and physically, to regain the capacity to make informed decisions and to then engage voluntarily in ongoing treatment. Commitment for treatment will involve a medically managed withdrawal followed by residential treatment (not a dedicated facility) for the patient to receive addiction treatment.

The New Zealand Ministry of Health anticipates having a Bill before Parliament in 2012 and is currently developing an implementation plan to assist with the reforms (New Zealand Ministry of Health, 2011).
Other relevant Tasmanian legislation

The ADDA intersects and operates in conjunction with several other pieces of legislation. The ADDA Review provides the opportunity to consider whether authority to treat and/or detain a person with alcohol or drug dependency could be located within one or more of those pieces of legislation.

Guardianship and Administration Act 1995

The Guardianship and Administration Act 1995 (GAA) establishes a substitute decision making framework for persons with a disability who are incapable of making decisions because of their disability. It is important to note that under this Act alcohol or drug dependency is not, of itself, a disability.

Under the GAA, the Guardianship and Administration Board (GAB) can:

- Appoint an administrator to control the financial affairs of a person with a disability for up to 3 years (Part 7 GAA)
- Appoint a guardian to make accommodation or health care decisions on behalf of a person with a disability for up to 3 years (Part 4 GAA)
- Give direct consent to specific medical treatment on behalf of a person with a disability (Part 6 GAA)
- Appoint an emergency guardian or administrator for up to 28 days in urgent circumstances (Part 8 GAA)

The GAA also provides a legislative regime relating to the provision of consent to medical treatment on behalf of persons with a disability which does not always require an application to the GAB, for instance in medical emergencies or where there is a “person responsible” (usually a spouse, carer, relative or close friend) available to give that consent (Part 6 GAA). Guardians, administrators, persons responsible and the GAB itself are collectively referred to for the purpose of this document, as “substitute decision makers”.

Many people with alcohol and/or drug dependency are the subject of guardianship and administration orders via the GAA where they have a disability such as dementia, psychiatric disabilities, acquired brain injury or an intellectual disability. The Tasmanian GAB estimates that of the 1,000 cases per year, approximately 150 new cases per year result in the appointment of an administrator to control excessive spending on alcohol and/or drugs. The GAB may also appoint a guardian to make decisions that control a person’s access to alcohol in supported accommodation settings. Guardians are rarely, if ever, appointed for the purpose of a guardian specifically consenting to rehabilitation or detoxification.

The GAA is currently not applicable to a person who lacks the capacity to make decisions for him or herself because of an alcohol or drug dependency unless there is also evidence of a disability such as acquired brain injury, dementia or depression. The GAB lacks the powers to make orders for such persons as an addiction does not amount to a diagnosed “disability” even though the addiction may make the person temporarily incapable of making decisions, as demonstrated in the case below, during periods of intoxication.

In 2006, the GAB heard an application under section 50 of the GAA for the appointment of an administrator for “XT”, a 64 year old male with drinking and gambling addictions (XT (Administration) [2006] TASGAB 2). The case of XT related to the management of XT’s money under an administration order. When XT’s family first made an application to the Board in 2005 he had sold the family home for $280,000 and purchased a unit for $160,000. The application failed because the GAB was not satisfied that when XT was sober, he was a person with a disability; that is, the GAB did not receive any conclusive evidence that

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14 Source: President of the Tasmanian Guardianship Administration Board.
XT had experienced any absence, loss or abnormality of mental, psychological, physiological or anatomical structure or function. The GAB held in this case that if sober, XT retained the capacity to make reasonable judgments. Therefore, the Board was not satisfied that XT was a person with a disability. A further application was made in 2006 by which time XT had spent the balance of the funds. That application also did not succeed for lack of evidence of a disability. A further application was made in 2007 by which time the unit was on the market with a view to managing XT’s debts. At that time the Board had evidence that he had dementia with impaired memory and executive functioning. The Board’s decision referred to XT’s inability to control spending on alcohol and the effects of that spending on his personal, physical and financial wellbeing. XT’s estate is now approximately $100,000.\(^\text{15}\)

Following this case the GAB commented that: “It is absolutely tragic that there is no facility under Tasmanian law whereby a person who is firmly in the grip of alcohol and gambling addictions can access the provisions of Part 7 of the Guardianship and Administration Act 1995”.

What this means for a person with an alcohol and/or drug dependency in terms of their capacity and ability to consent to treatment is that effectively there are no powers under the GAA to appoint a substitute decision maker even if the person, by reason of their addiction, has insufficient capacity to make a decision when actively intoxicated. Hence, there may not be any lawful authority to provide the treatment (apart from in emergencies) and the Common Law position around treatment would apply which is that, for an adult, unless there is valid consent, treatment may not be given.

Another restriction or issue regarding the GAA is that it does not empower the GAB to compel an assessment or to compel a period of sobriety to have an assessment to see whether the person has an underlying disability. One proposal to address this issue is the creation of a short term order to allow for or enable reliable or accurate assessment by a suitably skilled professional under the GAA. These issues along with many others will be considered during a review of the Tasmanian GAA anticipated in 2012.\(^\text{16}\)

Where a person’s drug or alcohol use has resulted in cognitive impairment or mental illness and they are incapable of making decisions about medical treatment, consent to treatment can be given on their behalf by a guardian, a ‘person responsible’ or the GAB under the GAA. In these circumstances, practitioners might rely upon the ADDA to detain and the GAA for authority to treat the person. The GAA would usually be a less restrictive alternative than the ADDA. However, the lack of clear guidelines often makes it difficult to delineate the circumstances or level of risk that would warrant the application of the ADDA.

In an emergency, there are three possible responses available under the GAA. Firstly, section 40 enables a person to whom Part 6 applies to be medically treated to prevent serious damage to their health, save their life or prevent the person from suffering significant pain or distress without consent. Secondly, the GAB can issue an emergency guardianship and/or administration order for up to 28 days and that order can be renewed for a further 28 days where there are urgent circumstances (such as a need to keep a person, who wants to leave, in hospital for treatment). Thirdly, the GAB can hear an application for consent to medical treatment without (10 days) notice in an emergency. Each of these responses can be obtained usually within hours of an application or enquiry by a concerned party. However, each of these responses is only available where the person is incapable by reason of a disability (although it should be noted that there is authority at Common Law to provide any person regardless of their consent, with treatment in an emergency provided that certain conditions are met).

\(^\text{15}\) Decision available on www.austlii.edu.au

\(^\text{16}\) Note: Victoria has similar Guardianship legislation to Tasmania and Victoria’s Act has been the foundation for Tasmania’s legislation. Victoria’s Guardianship and Administration Act 1986 (Vic) has recently been subject to comprehensive review and the Victorian Law Reform Commission (VLRC) will deliver its final report in December 2011. Recommendations from the review will have a potential flow on effect with Tasmanian possibly adopting some of the VLRC’s reforms.
Whilst it is plausible that the GAA may have the capacity to address issues in relation to risk to the individual (in serving their best interests), the GAA does not provide a framework to consider the public element (i.e. risk to other persons). This means that risk to others or to the broader community as a result of alcohol or drug use would not be adequately met without substantial amendment to the existing ADDA Act, involving a shift in its focus. The focus of the GAA is upon the appointment and regulation of substitute decision makers. This is consistent with a focus on the person’s best interests, rather than on broader considerations of what may be the best decision for the safety of community members.

Currently, individuals with a mental illness may be treated with informed consent or if the treatment is authorised by or under the GAA.

There is a suggestion that perhaps the GAA could be broadened to provide a source of authority for the treatment of clients who lack capacity to make their own decisions as a result of alcohol or drug addiction. Some argue that there is merit in this rationale and that the GAA is able to address the holistic issues related to an individual’s care that can be extended beyond a hospital/treatment centre, which is the current limitation of the ADDA. It is this aspect of an individual’s circumstances that may have led to a crisis in the individual’s life that required involuntary treatment. The GAA would facilitate the application of such orders beyond the treatment centre in order to address the broader psychosocial issues. For instance, the appointment of an administrator to control spending on alcohol or drugs may enable a person to maintain rental payments and avoid homelessness, or the appointment of a guardian may compel the delivery of essential support services where a person with an addiction may decline necessary self-care such as ‘meals on wheels’ or regular wound dressings by a community nurse. Expanding the provisions in Parts 4, 6 and 7 and the definition of disability may also allow a person with an alcohol and/or drug dependence to access the GAA. This would allow people who lack capacity to make their own decisions to do so by virtue of a decision made by a substitute decision maker.

However, a counter argument is that the GAA may not be well suited to dealing with a client group with fluctuating capacity.

**Mental Health Act 1996**

Clients with an alcohol and drug dependency may fall within the scope of the Tasmanian Mental Health Act 1996 (MHA) but only if they also have a mental illness as defined by the MHA and are a significant risk of harm to themselves or others as a result of the mental illness. The risk arising purely from their alcohol or drug addiction alone would not be sufficient to meet the criteria. A person can be detained under the Act but not treated unless the person gives informed consent or there is authority under the GAA. A person can also be the subject of a community treatment order and treated in the community. The Act’s application in its current form to the alcohol and drug dependency client group is therefore limited.

As the prevalence of individuals with co-morbid health issues increases the nature of risk to self or others often becomes an issue for the alcohol and other drug sector as well as for the community and the consumer. If an individual has a severe dependency coupled with a mental illness often their clinical risk increases due to lowered resilience and limited protective factors. Where an individual may be at risk to themselves or others the MHA and the facilities that support this legislation are best placed to manage and monitor the identified risk.

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17 People with mental health disorders particularly anxiety and borderline personality disorder (BPD) commonly have a comorbid drug use disorder and it remains a significant challenge for the delivery of effective health-care services and treatment [Teesson, M., Hall, W., Slade, T., Mills, K., Grove, R., Mewton, L., Baillie, A., and Haber, P. (2010)].

Alcohol and drug use is common among this population, with between 21-81 per cent reporting a co-occurring substance use disorder (SUD), and up to 65 per cent of substance users in treatment meeting the criteria for BPD [Trull, T.J., Sher, K.J., Minks-Brown, C., Durbin, J., and Burr, R (2000)].
A new Tasmanian Mental Health Act is in the process of being developed and there may be an opportunity to consider amending this new legislation at a future point in time, to include persons with alcohol or drug dependency within its scope. Effectively, what this would mean is that the mechanisms anticipated to be available under the Act, including the imposition of a short term Assessment Order, may also be applied to such persons. This could only be achieved if alcohol and other drug addiction was defined as a mental illness. Consideration would however need to be given to the extent to which the new Mental Health Act’s focus – namely on providing a mechanism for the authorisation of treatment of persons with a mental illness who lack decision making capacity – is compatible with the recommended outcomes of the ADDA Review and is supported by Government.

**Police Offences Act 1935**

The Tasmanian Police Offences Act (POA) 1935, amongst other matters, provides guidance for police who take an intoxicated person in a public place into police custody. The POA gives specific direction on who a police officer may release an intoxicated person to and in what circumstances. The POA makes it clear that police may only hold an intoxicated person in custody if they are unable to find an alternative Place of Safety (PoS) after making reasonable inquiries. Alternatives to police custody include the release of the intoxicated person into the care of a responsible person willing to take that person into care or to a PoS (Police Offences Act 1935 s4A, 4 and Hunter, Kenny, Berends, Eleftheriadis and Mugavin, 2009).

The Tasmanian PoS model involves police, major public hospitals, alcohol and drug services, ambulance and community based facilities working collaboratively to deliver support and related services to intoxicated persons found in a public place and who are considered to pose a risk to themselves or others (Hunter et al, 2009).

Currently, there are a small number of repeat presentations to Tasmanian PoS services. As a last resort, stakeholders can discuss the appropriateness of applying the ADDA and making on behalf of, or encouraging the client to make, an application for admission to a treatment centre. However, this generally only occurs where a person is suffering from alcohol or drug dependency to a degree that warrants detention in a treatment centre, and when their detention in a treatment centre is necessary for their health and safety or for the protection of others (Hunter et al, 2009).

Whilst the PoS model allows for potential application of the ADDA via the POA, a weakness is that the model only captures individuals that are visible through public intoxication. Carney (2006) suggests that this is a disadvantage because police administer such laws through the prism of ‘peace and good order’ rather than that of public health and community services. Carney also suggests that the unobtrusive and socially isolated complex needs clients including those with severe substance misuse or dependence issues are at the greatest risk of not receiving public and community health services. People who are visible enough, or disruptive enough to come to attention would not be at the same risk of being overlooked (Carney, 2006). On this basis, it could be argued that there may be more individuals regarded as suitable for compulsory treatment.

Some suggestion has been made of providing police with the power or ability to use the POA provisions to remove a severely dependent person from a private dwelling to a place where clinical observation can be conducted and clinical reports made available, on the basis that this could assist with the evidence required for the making of a GAA order. Careful consideration needs to be given to this suggestion as this may present civil liberties issues. Also, police officers are not trained or equipped to determine whether a person is ‘severely dependent’ and such a determination would have to be made by a suitably qualified and independent medically trained person in the first instance. The GAB can technically make an emergency order but there still needs to be evidence to support the application. Consideration also needs to be given to whether a determination of ‘severely dependent’ would be sufficient evidence without also providing police with the power to forcibly remove someone from a private dwelling.
Question 1: Is there potential for existing legislation (other than the ADDA) to support the delivery of alcohol and drug services to persons with a severe alcohol and/or drug dependency (i.e., The Guardianship and Administration Act 1995, the new Mental Health Act)?

Capacity legislation

As mentioned previously, a new Tasmanian Mental Health Act is in the process of being drafted, to replace the current Mental Health Act 1996. One approach canvassed during the development of the new Mental Health Act was the comprehensive review of relevant legislation (including the ADDA) and the development of a single generic, capacity based legislative framework. While this approach did not proceed it is still a potential approach that could be considered.

Capacity legislation could establish a standard capacity test, promote and facilitate decision-making by persons with reduced capacity and establish a substitute decision making framework for persons assessed as lacking capacity to make their own decisions. The legislation would apply regardless of the source of the person’s lack of capacity (i.e. mental illness, addiction, disability or other reason).

There are several international jurisdictions, including the United Kingdom (UK), Scotland, Netherlands and Canada that have implemented generic capacity legislation. The UK Mental Capacity Act 2005 provides a statutory framework to protect individuals who may lack capacity to make certain decisions for themselves, for example an individual who lacks capacity due to alcohol and/or drug dependency.

The capacity test under the UK Mental Capacity Act is a decision-specific and time-specific test. The person should be able to understand, retain and weigh the information provided and communicate their decision. A person cannot be labelled ‘incapable’ simply as a result of a particular medical condition or diagnosis. The approach to establishing whether someone has capacity under the Act is underpinned by the belief that whenever possible individuals should continue to make as many of their own decisions as possible. From a legal perspective the legislation reflects the view that, for medical treatment, a person’s capacity is their ability to understand the nature and effect of the treatment being proposed at the time that consent is required; and that every adult must be presumed to have capacity. ‘All practicable steps’ must be made to help the person make the decision before they can be regarded as lacking the capacity to make that decision (United Kingdom: Department for Constitutional Affairs, Department of Health, Public Guardianship Office).

Scotland also has one comprehensive involuntary treatment regime based on incapacity to consent legislation. The Scottish Adults with Incapacity Act (AWIA) 2000, provides guidelines on obtaining consent for adults who are incapable of providing informed consent. Under the AWIA, ‘incapable’ means incapable of: acting; or making decisions; or communicating decisions; or understanding decisions; or retaining the memory of decisions.

The AWIA applies to adults (people aged 16 or over) that cannot make some or all decisions for themselves due to a mental disorder or an inability to communicate. Any action taken under the AWIA must only be one that benefits the adult with incapacity, and the benefit cannot be achieved any other way. The AWIA allows medical treatment to be given to protect or promote the physical and mental health of an adult who is unable to consent. This can include one-off medical treatment or ongoing treatment i.e., alcohol and drug rehabilitation.

18 The UK also has separate mental health legislation, The Mental Health Act 2007. It primarily deals with the detention in hospital of people with mental disorders, as well as other compulsory measures including guardianship and supervised community treatment. It sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for patients [The United Kingdom, Government Department of Health website (www.dh.gov.uk)].
The question is whether alcohol and/or drug dependency in Tasmania should be treated as per any disability or mental illness under a capacity based framework such as the models operating in the UK and Scotland. However, the issue with this option is that it would take a significant amount of time to develop a single legislative framework for Tasmania. Existing legislative frameworks would need to be reviewed such as the new MHA, the GAA and the Disability Services Act 2011 to determine whether they would remain and if so to ensure that they are consistent and complementary with any new generic capacity based legislation.

**Question 2:** Is there potential for future legislation such as a generic capacity act to effectively replace the need for the ADDA?
Key Issues for Consideration

Meaning of alcohol and drug dependency in the ADDA

The meanings contained within the ADDA for alcohol and drug dependency establish the criteria a person must meet before they are brought within its scope (see Appendix B). There are issues with the way in which the current ADDA defines alcohol and drug dependency. In particular, the requirement for a person to meet the ADDA definition of alcohol and drug dependency before the provisions of the ADDA may be applied is problematic.

The ADDA’s requirement in section 3 (a) for a person to be dangerous, or to show signs of becoming dangerous to him or herself or to others or to be incapable of managing himself or herself or his or her affairs because of excessive consumption of alcohol, is inconsistent with contemporary practice. This involves the use of well-established subjective and objective measures to determine an individual’s level of substance dependence.

Section 3(b) of the ADDA also states that “…a person shall be regarded as suffering from alcohol dependency if he consumes alcohol to excess and shows prodromal signs of becoming so dangerous or so incapable”. The term ‘prodromal’ means premonitory, indicating the approach of a disease and is consistent with the disease model of addiction.

The disease model suggests that the only effective treatment is total life-long abstinence. At the time of the enactment of the ADDA in 1968, this was probably the most widely accepted theory of substance dependence in Australia (Pritchard et al., 2007). ‘Prodromal’ is a term that is not established or commonly used in contemporary alcohol and drug literature and it does not have evidenced application to the alcohol and other drugs sector.

The Biopsychosocial approach is now the current theory that informs a range of treatment programs within Tasmania. The Biopsychosocial model is a holistic approach that focuses on three categories that play a role in an individual’s overall functioning and health outcomes. The three factors are Biological, Psychological and Social factors that contribute to the development of substance use, abuse and dependence (Engel, 1977, 1980).

Current alcohol and drug treatment is also centred around Evidence Based Practice (EBP). EBP is a decision making model designed to assist clinicians in making the most appropriate recommendations for their clients. It is an approach to decision-making in which the clinician uses the best evidence available, in consultation with the patient, to decide upon the option which suits that patient best (Gray, 1997). EBP involves three components: best available evidence, clinical expertise, and patient values and preferences (Sackett, Straus, Richardson, Rosenberg and Haynes, 2000). According to this model, clinicians need to be up to date with the best available, most current and relevant research evidence and apply that evidence in the context of the patient’s circumstances.19

One of the most commonly used classification systems for determining dependence is the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR) (Mills, Deady, Proudfoot, Sannibale, Teesson, Mattick and Burns, 2010). The internationally recognised DSM-IV-TR describes severe substance dependence as a maladaptive pattern of substance use, leading to clinically significant impairment or distress.

19 Harm Minimisation is also a fundamental concept underpinning the management of people with alcohol, tobacco and other drug problems in Australia (this concept has been discussed previously).
This is demonstrated by three (or more) of the following criteria, occurring at any time in the same 12-month period:

1. Tolerance (i.e. a need for markedly increased amounts of the substance to achieve intoxication or desired effect, markedly diminished effect with continued use of the same amount of the substance)
2. Withdrawal (i.e. the characteristic withdrawal syndrome for the substance, the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than was intended.
4. There is persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance, use the substance or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

To provide another example, the World Health Organisation (WHO) views dependence as a group of phenomena (cognitive, behavioural, and physiological) and also implies that multiple criteria are necessary for its assessment (Edwards and Gross, 1976). Under this model the phenomena or dimensions that together identify dependence include some of the following:

1. a subjective awareness of compulsion to use a drug or drugs, usually during attempts to stop or moderate drug use;
2. a desire to stop drug use in the face of continued use;
3. a relatively stereotyped drug-taking habit, i.e., a narrowing in the repertoire of drug-taking behaviour;
4. evidence of neuroadaptation (tolerance and withdrawal symptoms);
5. use of the drug to relieve or avoid withdrawal symptoms;
6. the salience of drug-seeking behaviour relative to other important priorities;
7. rapid reinstatement of the syndrome after a period of abstinence.

The inconsistencies around the ADDA definitions for dependency make the ADDA difficult to work with and can result in a disparity between the person’s medical diagnosis and whether or not they fall within the scope of the ADDA. However, contemporary criteria and classification systems from the WHO and the DSM-IV-TR could potentially provide some clearer direction if existing compulsory treatment legislation is amended or if new legislation were to be developed.

**Question 3:** How should we define alcohol and drug dependency?
Defining the Client Group

Any new legislation allowing for the compulsory treatment of individuals with severe substance dependence would also need to clearly define the intended client group. The definition of alcohol and drug dependency in the current Act is important not only because it provides the eligibility criteria for an ADDA order but because it also identifies the intended client group. However, as discussed previously the definition of alcohol or drug dependency currently contained in the ADDA is not helpful because it doesn’t clearly articulate the level or extent of dependency.

Any new legislation for compulsory treatment may require a test or assessment framework to help identify those individuals with severe substance dependence so that not every single client with a dependency is captured within the scope of any future legislation. Definitions of dependency in any new legislation might also focus on impaired capacity to make decisions and the level of reduced capacity in addition to set criteria such as the DSM-IV-TR or the International Classification of Diseases (ICD-10).

Question 4: How should we define the client group?

Involuntary Clients and Self-Determination Theory

A review of the Victorian Alcoholics and Drug-Dependent Persons Act 1968 (ADDPA) by the Turning Point Alcohol and Drug Centre in 2004 focused on the effectiveness of compulsory alcohol and drug interventions. This paper suggested that problems can arise from placing involuntary clients with voluntary clients in a rehabilitation service. Issues were raised about the dilemma of ‘prioritising’ involuntary patients’ access to residential care given the significant delays experienced by some voluntary patients in accessing treatment (this is the case for Tasmania).

Involuntary clients can also potentially undermine the care and motivation of those who choose to be there and can sometimes have disruptive behaviours, challenging the motivation of voluntary clients, and sometimes leading them astray. A possible solution to this issue could be to isolate voluntary clients from involuntary clients. However, in reality this would be impracticable in Tasmania due to a diseconomy of scale. Tasmania, unlike other jurisdictions has few clients who fall under the ADDA and limited resources available for alcohol and drug services for this approach to be cost effective.

Researchers and health professionals maintain that it is a client’s own internal motivation that is an essential determinant in terms of whether they succeed or stay with treatment, regardless of how much external coercion there is. Furthermore, how events are perceived can dictate motivational processes. Self-Determination Theory (Deci and Ryan, 1985) which is supported by a large body of research states that when events promote perceptions of being controlled or coerced, intrinsic motivation (i.e. interest and engagement in activities) is undermined. On the contrary, intrinsic motivation towards activities is enhanced when events promote perceptions of autonomy (Wild et al).

Duration for service assessment and compulsory treatment order

Another issue which needs to be considered and which is central to the effectiveness of compulsory treatment, is the appropriate duration of a compulsory drug treatment order and whether potential legislation should specify a maximum period for detention and treatment.

On an international level, laws governing the length of time an individual can be detained for compulsory treatment vary dramatically. Some countries provide long term residential treatment for drug dependence for up to six months and in other places drug users can be consigned for extended periods of time to
locked treatment facilities and labour institutions for years (International Harm Reduction Association, 2010).

Ideally, a compulsory treatment order should remain in place long enough to ensure that a committed person is properly assessed and fully detoxified from his or her drug(s) of dependence, has improved their capacity and is better able to make an informed and well considered decision on whether to continue with treatment on a voluntary basis or not (Reynolds, 1988). However, an appropriate length of time for any proposed compulsory treatment model in Tasmania will also depend on factors such as the type of compulsory treatment regime that is adopted, the drug type, whether there is poly drug use and if there is evidence of cognitive damage or a significant physical health disorder that may place an individual at risk.

If the purpose of compulsory treatment is for time out and reducing the risks associated with severe substance use then a short-term stay may be adequate. Short-term compulsory treatment aims to restore decision-making capacity and provide an opportunity to motivate the user to continue treatment on a voluntary basis. Recently, in Australia there has been a shift towards short-term care but with an aftercare framework, for example, discharge and aftercare planning, ongoing case management/follow-up and links to suitable aftercare services. During a review of the New South Wales Inebriates Act 1912 in 2004, the New South Wales Standing Committee on Social Issues recommended a short-term model of involuntary care and a key feature being involuntary care for the duration of 7-14 days (Pritchard et al 2007).

Critics of shorter treatment periods argue that:

- Longer treatment periods are more likely to produce post-treatment success and are a consistent predictor of positive therapeutic outcomes in offender based literature (Broadstock et al 2008);
- An individual may respond more slowly to treatment and take longer to recover where there is a significant physical health disorder or cognitive damage/impairment as a result of chronic alcohol or drug use;
- The period of intervention should be lengthy because drug dependence is a chronic, recurring condition (Anglin, Prendergast and Farabee, 1998);
- Short-term stays (i.e., a 7 or 14 day order) only offer a short-term fix and nothing can be achieved in such a short timeframe; and
- Longer withdrawal periods are required for poly drug use and certain drug types. For example, benzodiazepines require a minimum of 2-3 weeks for proper assessment and withdrawal.

Evidence that there may be a significant physical health disorder that could place an individual at risk or evidence that the individual may have a short-term/partially reversible or enduring cognitive impairment may warrant an extended treatment period as it may impact on their capacity to give consent or make informed decisions about involuntary care. In which case, a four week extension of time (following a short period of withdrawal) may be required to investigate and complete tasks such as initial psychometric testing and initial physical investigations/testing.

If there is evidence of an enduring physical health disorder/chronic illness or an enduring cognitive impairment that impacts on an individual’s capacity to give consent or make informed decisions, then a further four week extension may again be necessary. In this case, a more specialist assessment/investigation would be required (such as neuropsychological testing) to inform functional capacity, cognitive capacity and treatment. Specific medical/physical assessment and treatment intervention for a chronic or life threatening illness may also be necessary. In these circumstances, the GAA would apply.

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20 See “What are other Jurisdictions doing?” for further information on the NSW proposed short-term involuntary care model.

21 Note: there is no guarantee that psychometric testing will be available and can be arranged within these timeframes.
These timeframes would certainly assist in cases where an individual doesn’t meet the threshold or requirements for an Emergency Guardianship Application under the GAA (section 40) or where there may be cognitive impairment creating vulnerability for the individual or risk to the community but there is insufficient time to investigate and provide further assessment and treatment.

Question 5: What are the key factors that need to be taken into account with regards to timeframes for a person detained for the purposes of compulsory treatment?

Consequences and harms associated with compulsory treatment

There is very little research that focuses on a client’s experience of compulsory treatment. Kronberg, Ojehagen and Berglund (2005) have identified a need to study the entire coercive process from assessment to treatment and aftercare from a client’s perspective.

Coerced clients have not opted to receive treatment or the intervention they are given as a result of compulsory drug treatment programs. In some cases, the client may be strongly and actively opposed to receiving treatment. They might believe that it is unnecessary and intrusive.

Anecdotally, in Tasmania compulsory treatment can in some cases from a client’s perspective result in harm to the individual and can have an impact on an individual’s employment, interpersonal/familial relationships as well as their community/social connectedness. Equally, many of these adverse outcomes from compulsory treatment can arise without any intervention.

However, the effect that compulsory treatment can have on an individual and how they cope and respond to coerced treatment may depend on their level of resilience as well as other risk and protective factors. Research has demonstrated that these factors are also related to the success of drug treatment programs (United Nations Office on Drugs and Crime, 2003). Resilience is measured by how individuals avoid serious adverse outcomes despite exposure to multiple risk factors which are critical to an individual’s health and wellbeing. Risk factors can include: life experiences, genetic and biological factors, physiological factors, family history, personality, individual capacity and coping skills. Protective factors can also play a part and can reduce the impact of a risk factor. Protective factors promote an alternative pathway and help individuals not to engage in potentially harmful behaviour (Spooner, Hall and Lynskey, 2001). Protective factors can include but are not limited to the following: positive relationships with family; a positive home environment, access to support services and so on.

Costs versus benefits of compulsory treatment

When considering the effectiveness of compulsory treatment the cost of compulsory treatment programs must also be taken into account relative to client outcomes. Public funding and resources for the Alcohol and Drug (AOD) sector are scarce so cost-benefit studies are an important tool for decision making and for the efficient and equitable allocation of resources (Cartwright, 2000). That being said, a socially just society recognises the need to sometimes invest in areas where there might not be the optimum net population level gains but there is a moral or social obligation to act (Reynolds, 2011).

Compulsory treatment programs may produce huge economic benefits such as a reduction in: the utilisation of general health care services; costs to other government agencies; social security payments to drug users and costs associated with drug related crime, such as policing, law enforcement and incarceration (Pritchard et al, 2007).

According to Pritchard et al (2007) cost-benefit analysis of civil commitment is a particularly complex task for several reasons:
• Civil commitment only applies to a small number of individuals, so reductions in public health and justice costs (e.g. hospital admissions and police detainment) may be impossible to detect.

• It is difficult to measure the reduced dependence on charitable organisations, which many of those to whom this legislation applies are dependent on for support and survival.

A review of existing literature indicated that there were no published economic evaluations or cost-benefit analysis that relate specifically to compulsory treatment. However, in Tasmania providing a one-off compulsory treatment service with application to only a small number of individuals would be an inefficient and costly exercise. If funding were to be invested in this area the net impact on the Tasmanian AOD sector overall would need to be measured and taken into account.

Autoynomy, capacity to consent and the ability to detain without treating

It is a well established Common Law principle that an individual has the right to determine what should be done to his or her own body, including refusing treatment regardless of how medically necessary that treatment may be. Australian courts have upheld the right of a competent adult patient to refuse medical treatment, even where that refusal will lead to the patient’s death and this prevails over other considerations such as a duty of care.

As discussed previously, the provisions of the Guardianship Administration Act 1995 do not apply to a person suffering from an alcohol or drug dependency who lacks the capacity to make decisions for him or herself in the absence of a diagnosed disability22. This means that in the absence of a diagnosed disability, the Guardianship and Administration Board is unable to, for example, appoint a guardian for such a person or make a decision about the person’s medical treatment.

Without any legislative authority regarding the provision of treatment to a person with an alcohol or drug dependency with capacity who refuses treatment, the provision of treatment to this client group is covered by the Common Law. The Common Law recognises the right of a competent adult to refuse treatment, such that treatment of that person against their will, without appropriate legislative or other legal authority, is potentially illegal.

However, the ADDA detention criteria are silent on a person’s capacity or willingness to consent to detention such that it is feasible both for a person with capacity who refuses treatment and for a person with capacity who accepts treatment but who refuses to do so in a treatment centre to be detained pursuant to the ADDA.

The Common Law provides that a person’s capacity to consent to treatment should be assessed on the basis of whether they can understand the nature and effect of the actual treatment being proposed at the time that the consent is required. This can be particularly difficult to determine with respect to persons who are alcohol and/or drug dependent. Fluctuating capacity is a common scenario for such persons and their capacity to make reasonable judgements can depend on when they consume alcohol or drugs.

Another typical scenario is when a dependent person may be informed by their medical practitioner that if they continue with their substance abuse they will incur a severe and potentially life threatening medical condition. Despite medical advice the person may still refuse to accept that they are dependent. Often a person has the capacity to make decisions however their dependence influences their ability to fully consider the adverse effects of the condition and the benefits that treatment may afford (Tasmanian Legislative Council Select Committee, 2009).

**Question 6:** Should it be possible to detain a person who is alcohol or drug dependent if the person has capacity but is unwilling to consent to treatment? If so, under what circumstances?

22 (XT (Administration) [2006] TSGAB 2).
Human Rights considerations

As noted above the legal context has changed significantly since the ADDA was drafted. In particular, there has been a shift towards increased recognition of human rights.

Alcohol and drug clinical practice and policy is guided and informed by the National Drug Strategy and Tasmanian Drug Strategy. The Australian Alcohol and Other Drugs Charter also outlines rights and responsibilities with regard to drug use and the development and implementation of policies and programs. The charter recognises that ‘public health, clinical and law enforcement approaches to drug use need to be ethical, informed by evidence, cost-effective and formulated without undue influence from commercial and political interests or other pressure groups’ and that ‘policy makers and their advisors should develop and implement non-discriminatory policies on drugs that are ethical, informed by evidence and which accurately reflect the harm and nature of the drugs being addressed’. Currently, there is limited evidence to support the use of compulsory treatment and it can present an ethical dilemma.

Compulsory treatment may also contravene the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights which advocate respect for and promotion of the right to liberty, freedom from arbitrary detention, access to transparent, independent and accountable appeal and review processes and the principle of treatment in the least restrictive manner and environment. Similarly the WHO recommends that national legislation that provides for treatment under coercion should be compatible with international human rights conventions (Pritchard et al, 2007).

The ADDA is deficient in its adherence to international human rights principles in a range of respects. In particular the ADDA does not require a person’s detention to be provided in the least restrictive manner; it does not clearly establish what a detained person’s rights are and there is a lack of oversight around detention decisions.

Question 7: What provisions or safeguards would be required to protect an individual who is compulsorily detained for the purpose of alcohol and drug treatment?

\[23\] The Universal Declaration of Human Rights is technically not legally binding but it sets a standard of achievement for all nations and signatories to strive for.
Consistency with existing service delivery frameworks

If a person is to be compulsorily detained for the purposes of alcohol or drug treatment the benefits to that person should be maximised. However, without the right infrastructure or necessary resources this cannot be achieved. During a review of the NSW Inebriates Act 1912, the NSW Standing Committee on Social Issues commented that: “There is not much point in making a decision to retain an involuntary care model if we have not got places or environments where people can be cared for”.

Therefore, any reforms to the ADDA must be realistic and any new system or framework must be adequately resourced so that current alcohol and drug treatment services in Tasmania can meet the needs of involuntary clients. The key elements of a new service framework underpinning compulsory treatment legislation as with existing programs would need to include evidence-based services and treatment guidelines, integrated service delivery, a secure and equipped physical environment, follow-up/after care services and investment in specific services.

The ADDA currently provides for detention in four designated treatment centres (Royal Hobart Hospital, Launceston General Hospital, North West Regional Hospital and the ADS Inpatient Withdrawal Unit) and doesn’t make reference to treatment in any other setting. A key issue with any proposal to expand the treatment or detention criteria or implement new treatment models via the ADDA is the capacity of the existing Tasmanian AOD sector to absorb and cope with any resulting increase in demand. Matching the theoretical with the practical could become problematic. This is particularly so if the provision of service shifts from capacity to provide (as currently occurs with voluntary patients) to a requirement to provide (as would occur with involuntary patients).

**Question 8:** What resources and complementary services need to be made available if any to support an individual who has undergone compulsory treatment?

**Question 9:** Are there any other general issues that need to be considered as part of the ADDA review in addition to those key issues that have already been discussed?
The Way Forward

Do we need to provide compulsory treatment and do we need to legislate?

As noted previously, the ADDA is infrequently used and is poorly understood. It provides only for involuntary detention and does not regulate treatment. This raises the question of whether there is a need for it to continue and whether we actually need specific legislation.

Generally, in any treatment field, legislation would only be necessary to do something that would otherwise be illegal (i.e. compelling a person to receive treatment). It may also be necessary if something is not sufficiently regulated at Common Law (i.e. determining who may be a substitute decision maker for a person with an alcohol or drug dependency who lacks capacity to make their own treatment decisions; enunciating a rights statement and requirements around how a person should be provided with treatment and care, etc). Currently, there is no general legislation around the treatment and care of persons with mainstream illnesses and conditions (i.e. heart disease, diabetes etc.) and who may need surgical procedures in a major hospital but who refuse treatment and so legislation to authorise, regulate and support compulsory drug and alcohol treatment needs to be strongly justified.

If Tasmania continues to regulate in this area decisions would have to be made about the level of treatment intervention and the baseline requirements for compulsory treatment. A set or suite of interventions may be required. However, legislation that is too prescriptive and imposes specific pre and post treatment obligations and timeframes may infringe on individual human rights.

Although the research and evidence is scant and quite mixed on its effectiveness, compulsory treatment for a brief period can be a beneficial and life-saving intervention. It captures people at the highest risk and provides some time for “time out” while also giving families an opportunity for respite from what can be very difficult situations (Reynolds, 1988). Compulsory treatment may also act as a circuit breaker interrupting an alcohol and drug ‘binge’ long enough for a person to clarify their actual physical and mental health status. Some may then be able to go on to make informed decisions about moving on to longer term treatment (Broadstock et al, 2008).

Question 10: Is it really necessary and should it be possible to provide for the involuntary treatment of people with alcohol and drug dependencies?

Question 11: At what point is it reasonable to intervene and under what conditions should this occur?

Question 12: Is there a need for specific drug and alcohol dependency legislation?

What are the potential options?

1. Retain the ADDA and no further action

This first option would involve no further action or change in terms of the current ADDA.

There are several potential advantages and disadvantages that relate to this option and these are briefly addressed below.

Advantages:

- Resources could be diverted to other competing priorities if there was no further action.
Disadvantages:

- This option could result in ethical concerns and tensions regarding the application of compulsory treatment principles now and into the future. The ADDA is in need of review and there are significant concerns about the extent to which the ADDA is consistent with human rights principles and requirements.
- ADDA clients are provided with contemporary treatment and care. However, the archaic nature of the existing ADDA and the large number of amendments has created inconsistencies and inefficiencies which have impacted on clinical and administrative processes.
- There are difficulties for clinical staff in interpreting the intent of the existing ADDA and easily applying its provisions.

2. Retain and amend the ADDA

If there is strong support for a compulsory treatment model within the stakeholder group and at a political level another option would be to retain and amend the ADDA.

There are some potential significant advantages and disadvantages associated with this option and these are briefly discussed below.

Advantages:

- It is a familiar framework for the Alcohol and Other Drug (AOD) sector and amending existing legislation may provide time and cost savings as opposed to the full drafting process that stand-alone legislation requires.

Disadvantages:

- It may be difficult to amend the existing ADDA without it remaining unclear and ambiguous.
- Given the current disjointed nature of the legislation, the extent to which the ADDA could be amended without those amendments constituting the development of new legislation is questionable.

3. Retain the ADDA and utilise existing legislation

Again, if there is a significant level of support for compulsory treatment then the ADDA might be retained with a view to the amendment of existing legislation (i.e. the MHA and GAA) to bridge any gaps that currently exist. The advantages and disadvantages for this option are:

Advantages:

- By using existing legislative frameworks there would be immediate access to existing resources and well established review mechanisms. This would increase efficiency and effectiveness of these processes and result in increased accountability and transparency.

Disadvantages:

- The ADDA doesn’t reflect current practice and retaining it is unlikely to effectively solve any of the issues surrounding compulsory treatment and the application of the ADDA nor will it provide clinicians with clarity.
- The use of multiple pieces of legislation might create an overly complicated client pathway.
- This option may also be resource intensive particularly for clinicians who have little or no experience with alternate/existing pieces of legislation. Understanding multiple pieces of legislation...
and how they intersect adds an extra level of complexity. Staff training and close monitoring is likely to be required.

4. **Repeal the ADDA and utilise existing legislation**

This option would involve repealing the ADDA with a view to amending existing legislation other than the ADDA to provide the necessary legal authority for compulsory detention and alcohol/drug treatment. Queensland repealed their legislation in 1994 and now involuntary care can only be provided under Mental Health legislation where people with alcohol and drug dependency issues may be committed for treatment but only where a person has a mental illness.

The ADDA intersects and operates in conjunction with several other pieces of legislation. The ADDA review process provides the opportunity to consider whether authority to treat and/or detain a person with alcohol or drug dependency could be located within one or more of those pieces of legislation.

This option would involve the repeal of the ADDA and amendment of existing legislation so that it would have application to the ADDA client group. An example would be modifying the provisions of new Mental Health Act to include alcohol and drug dependency as a type of condition to which some or all of the provisions of that Act apply.

In summary, the potential advantages and disadvantages for this option are as follows:

**Advantages:**

- Drawing upon various other existing pieces of legislation could result in a more streamlined approach and provide greater consistency and efficiency in the application of compulsory care and treatment.
- By using existing legislative frameworks there would be immediate access to existing resources and well established review mechanisms.

**Disadvantages:**

- This option would require extensive negotiation, collaboration and consultation. How individual State Government Departments would work together and cooperate to achieve this option would need to be discussed at length and key issues would need to be considered (e.g. allocation of resources, cost implications, feasibility, responsibility and oversight for change management, implementation, evaluation etc.).
- This option is likely to take some time to progress as there are differing interests held by departments that currently have responsibility for existing legislation. These interests would need to be worked through and resolved in order to reach common ground.
- The suitability of this option would also depend on whether or not any existing legislation (i.e., the Guardianship Act 1995, the new Mental Health Act, Police Offences Act 1935) could reasonably accommodate the provision of involuntary alcohol and drug treatment and the extent of modifications that may be required and whether existing and future legislative structures are suitable in terms of general approach and language, for this purpose.

5. **Repeal and move parts of the ADDA to existing legislation**

This next option is similar to the previous option canvassed but certain sections of the ADDA would be moved to existing legislation rather than existing legislation being applied as an alternative. There are a

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24 Repeal means the formal or official deletion or withdrawal of legislation (Macquarie Dictionary, 1991).
25 See the “Other relevant Tasmanian legislation” section for further information
number of potential advantages and disadvantages if this option were to be pursued and these are discussed below.

Advantages:

- Consolidating could be a more cost-effective option than drafting new legislation and less time consuming. However, the ADDA is so out of date that any provisions requiring relocation would effectively need to be rewritten in any event.
- Repealing the ADDA and moving parts of the Act to existing legislation may provide greater clarity to users of the legislation about its terms and requirements.
- Moving parts of the ADDA to existing legislation that doesn’t categorically relate to alcohol and drug dependency (such as the GAA) might help reduce the stigma for compulsory treatment clients.

Disadvantages:

- Extensive research and investigation would be required to determine which legislation is an appropriate fit and this may take some time. Compulsory treatment may not be appropriately regulated or managed by other Acts and may cause inconsistencies.
- This option could increase stigma both for persons who are dependent but do not have a mental illness and for people with a mental illness but without a dependence if for example the MHA is utilised as the alternative legislation.

6. New stand alone legislation

The final option is the development of a new Act to replace the ADDA and to provide a regulatory framework for the treatment and care of persons suffering from alcohol or drug dependency. The development of new compulsory treatment legislation would allow for improved and more appropriate oversight mechanisms. Depending on the level of variation between the ADDA and any new legislation that were developed, consideration could be given to enacting the new legislation on a trial basis as has occurred in NSW.26

If there is broad community and political support to develop new legislation enabling the compulsory detention and treatment of persons experiencing alcohol and/or drug dependency DHHS may want to consider whether existing legislative frameworks could be utilised to achieve this aim. This may involve effectively ‘piggy backing’ in part on existing legislation for the purposes of its operation. A similar approach has been adopted in the Criminal Justice (Mental Impairment) Act 1999 which requires certain reviews to be conducted by the Forensic Tribunal established under the Mental Health Act 1996. On this approach appeal and review processes could fall under the one legislative umbrella. In practice, reviews would be conducted by existing bodies utilising existing facilities and infrastructure and drawing upon ADDA-type legislation which would set out matters such as admission and treatment applying to the client group.

Trial legislation would provide the State with sufficient time to determine what would be required from a resource and service delivery perspective. Although, these issues should have already been considered or addressed before Parliamentary approval of any new legislation.

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26 See “What are other Jurisdictions doing?” section for further information.
Potential advantages and disadvantages for this option are summarised below.

Advantages:

- The ability to develop new legislation would enable consideration of whether or not the legislation should be capacity based and intervene only with respect to persons who are lacking in decision making capacity because of their alcohol and drug dependency.
- New stand-alone compulsory treatment legislation that segues into existing legislation could allow for similar functions and activities that are already in place to be consolidated. Consideration might be given to the utilisation of existing mechanisms to perform some functions that would be required under new legislation.
- If trial legislation is adopted then this would allow for reconsideration or amendment at the end of an evaluation/review.
- This option would provide for compulsory treatment which is something that the existing ADDA does not allow (ADDA currently provides for compulsory detention only).

Disadvantages:

- New legislation would require additional funding and resources for implementation. The full drafting and implementation of new legislation may take some time and timeframes will depend on government priorities. For example, it could involve the development of new policies, business processes, models of care, service delivery procedures and training/implementation packages.
- Clinical expertise to support this option is limited and its implementation would require staff training and professional development.
- In reality any compulsory treatment model in Tasmanian would operate only for the benefit of a very small client group.

7. **New generic capacity based legislation**

This option has been discussed previously in the “Other Relevant Tasmanian Legislation” section of this paper.

In summary, the potential advantages and disadvantages of a generic capacity based approach are as follows:

Advantages:

- Development of capacity legislation could enable consideration to be given to establishing a single tribunal or other body with responsibility for making and reviewing decisions.
- One piece of legislation or a single compulsory treatment regime could also simplify things in terms of AOD sector training and education.
- This approach could provide an opportunity to develop legislation which emphasises autonomy, decision making and capacity. These concepts are not adequately addressed in the current ADDA.

Disadvantages:

- The development of a generic capacity based test would be required to facilitate this type of legislative framework. However, there is debate about whether a single standardised test would be an appropriate tool for measuring capacity when the human brain can malfunction and be affected in a multitude of ways, including by alcohol and drugs.
A generic legislative framework would apply to a full range of individuals and situations in which a person’s capacity to consent and to make decisions for themselves is likely to be an issue (i.e. mental illness, addiction, disability etc.). Therefore, it would need to be a very comprehensive framework and this would require a significant amount of resources to identify how a person’s capacity could be appropriately assessed.

Clinical expertise to support this option is limited and again Tasmania would need to invest in additional staff training and professional development in order to successfully implement.

8. **Repeal the ADDA**

Finally, another alternative may be to simply repeal the existing ADDA. If this option were to be pursued treatment could still be provided on a voluntary basis but it would have to be outside any specific legislative framework.

There are several advantages and disadvantages that have been identified for this option.

Advantages:

- The ADDA is considered to be out dated and repealing it would provide greater opportunity to comply with human rights principles.

Disadvantages:

- There wouldn’t be any specific legislation to deal with this client group and this may compromise client safety and increase clinical risk. It currently acts as a potential “circuit breaker” and avenue for avoiding immediate harm.

**Question 13:** Which option(s) do you support and why?
Glossary of Terms and Acronyms

Abstinence
Refraining from drug use.

ADDA
Alcohol and Drug Dependency Act 1968

ADS
Alcohol and Drug Service

ANCD
Australian National Council on Drugs

AOD
Alcohol and Other Drug

ATDC
Alcohol, Tobacco and Other Drugs Council (Tasmania)

ATODS
Alcohol, Tobacco and Other Drug Services (Tasmania)

Case Management
A system of managing and coordinating the delivery of health care in order to improve the continuity and quality of care as well as reducing costs.

Civil Commitment
Legally sanctioned, involuntary commitment of a non-offender into treatment for alcohol or drug dependence.

Client-centred
A form of humanistic therapy and existential counselling in which the counsellor views the client with ‘unconditional positive regard’, refrains from interpreting, and reflects, reframes and empathises with the emotional world of the client in a non-judgmental manner.

Cognitive Impairment
Any diminution in the quality or strength of cognitive functioning. Cognition meaning all forms of knowing and awareness, such as perceiving, conceiving, remembering, reasoning, judging, imagining and problem solving.

Compulsory Treatment and Involuntary Care
Forced treatment interventions over a wide range of both offender and non-offender populations. Compulsory treatment encompasses legal orders such as civil commitment orders.

CSO
Community Sector Organisation
Discharge and aftercare plan

A continuing program of outpatient treatment and rehabilitation services provided for clients who have been discharged. An aftercare plan is directed to maintenance of improvement, prevention of relapse and adjustment of the individual to the community.

Drug

In medical terms, any substance with the potential to prevent or cure disease or enhance physical or mental welfare. In a pharmacological sense, the term refers to any chemical agent that has the capacity to alter biochemical or physiological processes, tissues, or organisms and, in this sense, usually means psychoactive drug.

Drug Dependence

Drug dependence is characterised by a strong desire to take a drug. Among the indicators of dependence are impaired control over drug use, a higher priority given to drug use than to other activities and obligations, increased tolerance, physical withdrawal symptoms, and repeated drug use to suppress withdrawal.

DSM-IV-TR

Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision.

EBP

Evidence Based Practice

GAA

Guardianship and Administration Act 1995 (Tasmania)

GAB

Guardianship and Administration Board (Tasmania)

Harm Minimisation

The underlying philosophy for Australian drug policy. Harm Minimisation refers to policies and programs to reduce harm that include three potential foci: supply reduction (law enforcement); demand reduction (prevention and treatment); and environmental modification. Harm Minimisation as a policy platform covers both licit and illicit drugs, as well as the spectrum of safer use to complete abstinence as possible program goals.

International Classification of Diseases (ICD-10)

The ICD is the international standard diagnostic classification for all general epidemiological, many health management purposes and clinical use. These include the analysis of the general health situation of population groups and monitoring of the incidence and prevalence of diseases and other health problems in relation to other variables such as the characteristics and circumstances of the individuals affected, reimbursement, resource allocation, quality and guidelines.

Mandatory treatment

Alcohol or drug treatment which is required by police or the criminal justice system; for example, a referral to treatment through a court mandated diversion program.
Neuropsychological testing

Neuropsychological tests are specifically designed tasks used to measure a psychological function known to be linked to a particular brain structure or pathway. They usually involve the systematic administration of clearly defined procedures in a formal environment.

Opiate

One of a group of alkaloids derived from the opium poppy (*Papaver somniferum*) with the ability to induce analgesia, euphoria, and, in higher doses, stupor, coma, and respiratory depression. The term opiate excludes synthetic opioids such as heroin and methadone.

Pharmacotherapy

The provision of prescribed drugs to individuals dependent on other, usually more hazardous drugs. Often referred to as substitution therapies or maintenance therapies, these interventions use drugs that act as agonists or, in the case of abstinence-based programs, antagonists, of the problem drug in question.

Poly drug use

Abuse of more than one licit or illicit drug.

PoS

Place of Safety

Protective Factors

Factors that moderate or mediate risk factors and help to protect certain individuals from problems; that is, the things that make a person more resilient or provide some protection against problems.

Psychometric testing

A series of psychological tests administered to determine intelligence, manual skills, personality characteristics, interests, or other mental factors.

Resilience

How individuals avoid serious adverse outcomes despite exposure to multiple risk factors which are critical to an individual’s health and wellbeing.

Risk Factors

Attributes, characteristics, or conditions that increase the chance of someone developing problems (in this instance with drugs). These can include personal, social or community factors.

Severe Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress. Multiple criteria are necessary for its assessment such as tolerance, withdrawal etc.

Social connectedness

Social connectedness refers to the relationships people have with others and the benefits these relationships can bring to the individual as well as to society. It includes relationships with family, friends, colleagues and neighbours, as well as connections people make through paid work, sport and other leisure
activities, or through voluntary work or community service. These relationships and connections can be a source of enjoyment and support. They help people to feel they belong and have a part to play in society.

**WHO**

World Health Organisation

**Withdrawal**

Stopping or reducing heavy or prolonged drug use. Usually accompanied by a set of symptoms ranging from mild to severe, which depend on the person and the drug they are withdrawing from.
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Appendix A

Summary of Questions

**Question 1:** Is there potential for existing legislation (other than the ADDA) to support the delivery of alcohol and drug services to persons with a severe alcohol and/or drug dependency (i.e., The Guardianship and Administration Act 1995, the new Mental Health Act)?

**Question 2:** Is there potential for future legislation such as a generic capacity act to effectively replace the need for the ADDA?

**Question 3:** How should we define alcohol and drug dependency?

**Question 4:** How should we define the client group?

**Question 5:** What are the key factors that need to be taken into account with regards to timeframes for a person detained for the purposes of compulsory treatment?

**Question 6:** Should it be possible to detain a person who is alcohol or drug dependent if the person has capacity but is unwilling to consent to treatment? If so, under what circumstances?

**Question 7:** What provisions or safeguards would be required to protect an individual who is compulsorily detained for the purpose of alcohol and drug treatment?

**Question 8:** What resources and complimentary services need to be made available if any to support an individual who has undergone compulsory treatment?

**Question 9:** Are there any other general issues that need to be considered as part of the ADDA review in addition to those key issues that have already been discussed?

**Question 10:** Is it really necessary and should it be possible to provide for the involuntary treatment of people with alcohol and drug dependencies?

**Question 11:** At what point is it reasonable to intervene and under what conditions should this occur?

**Question 12:** Is there a need for specific drug and alcohol dependency legislation?

**Question 13:** Which option(s) do you support and why?
Appendix B

Overview of the main ADDA Provisions

This section of the Discussion Paper provides an overview of the main legislative provisions of the ADDA and considers some of the issues and problems that have arisen in relation to each specific clause.

Interpretation of the ADDA

Section 2 of the ADDA defines and gives special meaning to key terms and concepts that relate to the legislation. If a word is not defined in the interpretation section of the ADDA then the definition may be contained in the Acts Interpretation Act 1931. If both of these options have been exhausted the ordinary and natural meaning of the word should be applied. This can be done simply by using an English dictionary (the High Court of Australia tends to use the Macquarie dictionary).

Definitions for Alcohol and Drug Dependency

Under section 3 of the Act ‘alcohol dependency’ is defined in the following way:

“…a person shall be regarded as suffering from alcohol dependency if he consumes alcohol to excess and;

a) is thereby dangerous at times to himself to others or incapable at times of managing himself or his affairs; or

b) shows prodromal signs of becoming so dangerous or so incapable.”

Section 4 of the Act contains the meaning of drugs and drug dependency. Dependency [s4(1)] is defined as:

“...a condition of a person arising from the taking of a substance that is manifested by:-

a) an interference with his bodily or mental health; or

b) an interference with his capacity to engage in ordinary relations with other persons or to earn his own livelihood or to undertake any duties or perform any functions that he might reasonably be expected to undertake or perform”

Section 4(4) of the ADDA states that:

“...a person shall be regarded as suffering from drug dependency if he takes drugs to the extent that-

a) he is thereby dangerous at times to himself or others or incapable at times of managing himself or his affairs; or

b) he shows prodromal signs of becoming so dangerous or so incapable...”
Alcohol and Drug Dependency Tribunal

The Alcohol and Drug Dependency Tribunal has no formal decision-making role in relation to the original decision to detain a patient in a treatment centre. The ADDA Tribunal can, following a hearing of an application under section 29, either confirm the detention or recommend the patient’s discharge from detention. Part 3 of the Alcohol and Drug Dependency Regulations 2009 outlines the process and procedures for ADDA Tribunal applications and hearings.

A section 29 application may at any time be made to the ADDA Tribunal by a patient liable to be detained or by some relative of his on his behalf. On an application under this section the Tribunal, if in all the circumstances it considers it proper, may order the discharge of the patient if it is satisfied:

a) that the patient was admitted to a treatment centre in pursuance of an application made as a result of a mistake or any false representation; or

b) that there is no sufficient cause for his remaining liable to be detained in a treatment centre.

The ADDA Tribunal has the power to do all things necessary or convenient to be done in connection with the performance of its function. That includes requiring the patient, in respect of whom the application is made, to be brought before the Tribunal, authorising a person appointed by the Tribunal to examine or interview the patient and requiring the production of medical records relating to the patient (s9).

The Alcohol and Drug Dependency Tribunal received one application in 2009 but prior to that it had not received an application for discharge, and had consequently not convened, since 2003.

Treatment Centres

Section 15 of the ADDA enables the Governor, on the recommendation of the Secretary, to declare any premises or part of any premises (being premises or any part of any premises at which mental health services are provided) to be a treatment centre for the purposes of the Act.

Under the Alcohol and Drug Dependency (Treatment Centres) Order 2007 there are four designated ‘Treatment Centres’: The Royal Hobart Hospital; Launceston General Hospital; Northwest Regional Hospital (Burnie Campus) and “that part of the Carruthers Building, St Johns Park, New Town that is used by the Alcohol and Drug Service” (namely, the ADS Inpatient Withdrawal Unit based in Hobart).

Clients who have in recent years been subject to an ADDA order have been or are currently detained in the ADS Inpatient Withdrawal Unit. The ADS Inpatient Withdrawal Unit is currently the only Treatment Centre with an appointed Superintendent therefore it is the only facility considered suitable for detention.

Welfare Officers

When an alcohol or drug dependent person is unwilling to enter a treatment centre, the first point of contact for relatives or a patient’s medical practitioner will be a gazetted Welfare Officer. Section 16 of the ADDA enables the Secretary to appoint various persons as welfare officers for the purposes of the Act and sets out the circumstances in which this may occur.

Patients Admitted to Treatment Centres - Admissions and Applications

A patient may be admitted to a Treatment centre and detained in accordance with the ADDA [s23(1)]. There are two different routes by which a person can be admitted either through a personal (voluntary) application or an involuntary application. The process for each type of admission is detailed below.
Personal (Voluntary) Application

An admission application initiated by the patient himself is referred to in the ADDA as a personal application [s23(2)]. If a patient is admitted within fourteen days of a personal application, then the Superintendent is authorised to detain the person for up to 6 months. Before the end of the period, the treating medical practitioner must examine the patient and report to the Superintendent (or obtain a report from another medical practitioner).

If the medical practitioner reports that it is necessary for health/safety/protection reasons that the patient should continue to be detained and the patient consents then the person may be detained for a further six months. If the patient refuses to consent then the patient is no longer liable to be detained at the expiry of the six months.

Most, if not all applications under the ADDA, are involuntary so whether the process for voluntary applications still has some value is debatable. If a person entering treatment would be willing to attend a treatment facility and remain there for the course of the treatment on a voluntary basis then self-initiated applications under the ADDA may be unnecessary.

Involuntary Application (Relative or Welfare Officer)

The majority of applications for admission to a treatment centre are involuntary applications made by a relative of a patient or a welfare officer. If the admission application is made by a relative of the patient it must state the relationship of the applicant to the patient. An involuntary admission application must not be made by any person unless that person has personally seen the patient within fourteen days [s23(5)].

Section 24(2) of the ADDA states that an involuntary admission application may be made in respect of a patient on the grounds:

1. that he is suffering from alcohol dependency or drug dependency to a degree that warrants his detention in a treatment centre for medical treatment; and
2. that it is necessary in the interests of his health or safety or for the protection of other persons that he be so detained

Unlike a personal application an involuntary admission application must be founded on the recommendation of a medical practitioner [s24(3)] and must specify whether it is made on the grounds that the patient is suffering from alcohol dependency or drug dependency or from both of those conditions [s24(5)]. The medical recommendation necessary to found an involuntary admission application shall not be given by a medical practitioner unless he has personally examined the patient [s24(6)].

The admission application is then sufficient authority for the applicant to convey the patient to the treatment centre at any time during the period of fourteen days (beginning on the day on which the patient was examined by a medical practitioner) [s26(1)]. The Superintendent may then detain the patient in the treatment centre for fourteen days [s26(2)(b)]. The admission application then ceases to have effect at the expiration of fourteen days unless, during that period, the appropriate medical officer issues a certificate confirming the need for admission, in which case the patient may be detained for a total of 6 months (from the date of admission) [s26(3)].

If the patient is detained for six months, one month before the end of the period the treating medical practitioner must examine the patient (or obtain a report from another medical practitioner) and make a report to the superintendent. If the responsible medical officer reports that it is necessary for health/safety/protection reasons that the patient should continue to be detained and the patient or applicant’s relative consents then the patient may be detained for a further six months [sections 27(2), (3) and 27(4)(b)]. If the patient refuses to consent in writing (in the case of an admission application made by a
relative), then the patient is no longer liable to be detained at the expiry of the six months unless another application is put in place [s27(4)(a)].

**Standards for medical officers, superintendents**

Admission under the Act to a treatment centre involuntarily may be facilitated by a relative or a welfare officer with a supporting recommendation by a medical officer. The Act does not specify that the welfare officer or the medical officer is required to have experience or skills in the assessment and management of alcohol and other drug issues. However, a medical practitioner must be a legally-qualified medical practitioner who is registered to practice.

Those individuals charged with the execution of Part IV of the ADDA Act are not required to have significant experience or knowledge and skills of the Alcohol and Other Drugs (AOD) area. Despite the development of the regulations there is still no statutory requirement for training or experience in the AOD area for the medical officer, responsible medical officer, welfare officer and even the superintendent of the treatment centre. Nor is there a requirement for regular training and assessment of the individual’s knowledge of the ADDA in order to attain and ensure a comprehensive working knowledge of the Act and its application.

These standards are in place in relation to the application of Mental Health Acts in other states (such as Queensland). In Victoria, an application under the Severe Substance Dependence Treatment Bill 2009 for a detention and treatment order must contain a medical recommendation by a prescribed registered medical practitioner and they must consult and seek a second opinion from a senior clinician at a drug and alcohol treatment centre before making an application.

**Discharge of patients by a Treatment Centre**

The Superintendent of a Treatment Centre may, by order, discharge a patient who is liable to be detained in a Treatment Centre in pursuance of an Admission Application. However, an order shall not be made except after consultation with the medical practitioner whose medical recommendation resulted in the original admission application [sections 28(1) and (2)].

**Transfer of Patients from one treatment centre to another**

Where a patient is liable to be detained in a Treatment Centre the Superintendent of that Treatment Centre may, by a direction in writing, direct that he be transferred to another Treatment Centre [s44(1)].

A direction under section 44 is sufficient authority for a person to be transferred within a period of 28 days beginning with the date of the direction.
Leave of Absence

A responsible Medical Officer may in the prescribed form grant to a patient who is for the time being liable to be detained in a Treatment Centre leave to be absent from the Centre subject to such conditions (if any) as he considers necessary in the interest of the patient or for the protection of other persons [s45(1)]. Leave of absence may be granted to a patient either indefinitely or on specified occasions or for any specified period.

Where a patient is absent from a Treatment Centre and if it appears to the responsible Medical Officer that it is necessary to do so in the interests of the patient’s health or safety or for the protection of other persons, the responsible Medical Officer may, by notice in writing, revoke the leave of absence and recall the patient to the Treatment Centre [s45(4)].

Patients Absent without Leave

Where a patient who is for the time being liable to be detained in a Treatment Centre absents himself without leave granted, fails to return on any occasion (or at the expiration of any period or absents himself without permission from any place at which he is required to reside) may be taken into custody and returned to the Treatment Centre or that place, by any Officer on the staff of the centre, by a police officer, or by any person authorised in writing by the Superintendent of the Treatment Centre [s46(1)].

Patients found in public places

If a Police Officer finds in a public place a person who appears to him to be suffering from alcohol dependency or drug dependency and to be in immediate need of care or control, the Police Officer may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety for the purpose of enabling him to be examined by a medical practitioner and to be interviewed by a welfare officer under the ADDA (s 58). Where a person has been conveyed to a place of safety under the ADDA the person can be detained for up to 72 hours (s 60). A ‘place of safety’ is defined as being a treatment centre (where the superintendent is willing to receive the patient), a hospital, a police station or any other place (where the occupier is willing to receive the patient).