Standing Committee on Social Issues

Report on the *Inebriates Act 1912*

Ordered to be printed according to the Resolution of the House

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Terms of reference

That the Standing Committee on Social Issues inquire into and report on:

(1) The *Inebriates Act 1912* and the provision of compulsory assessment and treatment under that Act;

(2) The appropriateness and effectiveness of the Act in dealing with persons with severe alcohol and/or drug dependence who have not committed an offence and persons with such dependence who have committed offences;

(3) The effectiveness of the Act in linking those persons to suitable treatment facilities and how those linkages might be improved if necessary;

(4) Overseas and interstate models for compulsory treatment of persons with severe alcohol and/or drug dependence including in Sweden and Victoria;

(5) Options for improving or replacing the Act with a focus on saving the lives of persons with severe alcohol and/or drug dependence and those close to them; and

(6) Any other related matter.

These terms of reference were referred to the Committee by the Attorney General, the Hon Bob Debus MP, on 23 September 2003.

Committee membership

- Jan Burnswoods, MLC, Australian Labor Party **(Chair)**
- The Hon Robyn Parker, MLC, Liberal Party **(Deputy Chair)**
- The Hon Dr Arthur Chesterfield-Evans, MLC, Australian Democrats
- The Hon Kayee Griffin, MLC, Australian Labor Party
- The Hon Greg Pearce, MLC, Liberal Party
- The Hon Ian West, MLC, Australian Labor Party

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Chair's foreword

I am very pleased to present this report on the *Inebriates Act 1912*. The inquiry was referred to the Social Issues Committee by the Attorney General in response to a recommendation of the 2003 Alcohol Summit. At the Summit, the Act was highlighted as unworkable by both the Chief Magistrate of the Local Court of New South Wales, and Ms Toni Jackson, who had tried without success to have her husband detained and treated against his will under the Act. The discussion raised the fundamental ethical issue of when the state can legitimately intervene to treat a person against their will, and conversely, whether a person has the right to drink themselves to death.

The *Inebriates Act* was born in another era, when we had different attitudes to addiction and few effective treatments for it. It enables people to be detained for up to a year simply because they use alcohol or drugs to excess. Despite longstanding criticism and numerous formal reviews, the *Inebriates Act* has remained on the statute books, with in recent times about fifteen people subject to it per year.

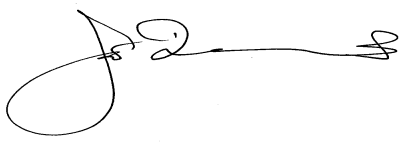
The terms of reference of the inquiry asked the Committee to evaluate the Act, and to identify the most appropriate system of compulsory treatment, if any, to replace the Act. Having found that the Act is an historical relic that must be repealed, the Committee then set out to determine in what circumstances involuntary treatment is ethically justified.

While previous reviews of the *Inebriates Act* failed to deliver a feasible alternative, I am confident that this report provides a clear way forward for the Government. We received overwhelming evidence in support of new legislation that provides a much more targeted, safeguarded and time-limited system of involuntary care for people with severe substance dependence. The proposed system is informed by the values of compassion, dignity, understanding and respect, and is necessarily built around evidence-based medical care. Aimed at protecting people from serious harm, it will safeguard the rights of those subject to involuntary care and maximise the benefits they gain from it. Alongside this system we have made a number of recommendations to strengthen the voluntary service system.

This has been a challenging inquiry that has involved detailed consideration of philosophical issues as well as the development of legislative and service solutions. I am grateful to the diverse range of people who participated in the inquiry, sharing their expertise through submissions, formal hearings or consultations. Thank you for your very important contribution. I also thank my Committee colleagues for their substantial effort in developing the most appropriate solution to this complex policy problem.

On behalf of the Committee I thank Merrin Thompson, Tanya Bosch, Julie Langsworth, Victoria Pymm, Heather Crichton and Christine Lloyd in the Social Issues Secretariat for their dedication, hard work and expertise in contributing to this report.

I commend this report to the Government, and call on it to ensure, once and for all, that the *Inebriates Act* is repealed and replaced with the sound and safeguarded system that the Committee has proposed.



Jan Burnswoods MLC
Chair

Executive summary

Having examined the *Inebriates Act* in detail, the Committee recommends that it be immediately repealed. We have received overwhelming evidence in support of new legislation to replace the Act and provide a much more targeted, safeguarded and time-limited system of involuntary care for people with severe drug or alcohol dependence.

The primary focus of the report is on *non-offenders*. Throughout the inquiry it has been clear that government policy and programs in relation to compulsory treatment of *offenders* are fairly straightforward and broadly supported. By contrast, involuntary treatment of non-offenders raises more complex ethical issues and is correspondingly more complicated to operationalise, both in terms of legislation and service delivery. It is in relation to non-offenders that governments have struggled to determine the most appropriate policy response. In addition, the *Inebriates Act* has for some decades been primarily used in relation to that group. Issues in relation to offenders are considered at the end of the report, in Chapter 9.

In **Part One** of the report the Committee examines the *Inebriates Act* in the light of contemporary social values, the current medical understanding of substance dependence, the present health and legal systems and the evidence base available in the early 21st century. Documenting the litany of criticisms of the Act, we note its archaic premise - that there is a class of people who need to be controlled simply because they use alcohol or drugs to excess - and observe that this premise forms the basis for many of the Act's failings, including its poor regard for human rights, its outdated legal provisions and its requirement for detention in mental health facilities. On the basis of these criticisms we conclude that the Act is an historical relic that chafes against the present day health and justice systems to the point where it cuts people off from the drug and alcohol services that will most benefit them. In Chapter 4 we make use of the case studies put before the Committee to build a picture of the people subject to the Act, determining that it continues to be used primarily for the purpose of control. Having considered the outcomes for those subject to the Act, we find that while it has reduced harm for some people, it has also in many cases achieved very little, or has actually done harm.

On the basis of this analysis we conclude that the *Inebriates Act* is fundamentally flawed and recommend that it be immediately repealed and replaced with an entirely new framework of involuntary care for a small and tightly defined group of people with drug or alcohol dependence.

In **Part Two** the Committee focuses on the system that might replace the *Inebriates Act*, again with a focus on non-offenders. As a first step, we examine the research evidence on drug and alcohol interventions and compulsory treatment for non-offenders, but find that the literature on the latter is so scant that it is difficult to draw conclusions on which a new system might be based. In Chapter 6 we examine the ethical question at the heart of the inquiry: whether, and in what circumstances, some form of involuntary intervention is justified for non-offenders. We conclude that we do not support compulsory treatment aimed at rehabilitation or addressing a person's substance dependence in the longer term; nor do we support coercive treatment in the interests of others. However, we do consider that coercion may be justified in certain circumstances for the purpose of reducing serious harm to self.

Having considered these ethical issues in detail, we recommend that the Government establish a system of short term involuntary care for people with severe substance dependence who have experienced, or are at risk of, serious harm, and whose decision making capacity is considered to be compromised, for

the purpose of protecting their health and safety. At the same time, we identify the need for non-coercive measures to be developed for people with complex needs and/or antisocial behaviour arising from their substance dependence.

In Chapter 7 we set out the elements of a new legislative framework for involuntary care, and in Chapter 8 we develop a service framework to complement the proposed legislation, based partly on the Victorian system of 'compulsory detoxification and assessment'.

Focusing on offenders in Chapter 9, the Committee notes that this group, with some exceptions, is well catered for under other legislation and we firmly state that provisions in relation to compulsory treatment of offenders should not be included in the proposed new legislation. We make a number of recommendations to address areas of identified need in relation to the Drug Court, the MERIT program and the Compulsory Drug Treatment Correctional Centre.

Ethical basis

The Committee considers that there is a firm ethical basis for intervention to detain and treat a person against their will for the purpose of reducing harm, where that person has experienced, or is at risk of, serious harm to self, and where their decision making capacity is considered to be compromised. The aim of such interventions should be to stabilise the person and assess their needs, restore their capacity to make an informed choice about substance use, and where appropriate, provide an entry point for care and support under guardianship.

We consider that involuntary interventions are not justified in circumstances where a person is simply using or dependent on substances, nor, given the absence of evidence to support it, for the purpose of addressing substance dependence in the longer term. Similarly, we consider that compulsory treatment in the interests of others such as family members and the community cannot be justified, but that there is a need for non-coercive strategies to address complex needs and antisocial behaviour associated with substance dependence where this exists.

When intervening against a person's will, the state has a responsibility to maximise the benefits to the person. Involuntary care should thus be seen as an opportunity to do most good. Once a person is provided, through involuntary care, with the opportunity to make an informed choice, that choice is to be honoured. Where decision making capacity cannot be restored, there is a clear duty of care on the part of the state and society to provide care, protection and support under guardianship.

The proposed system of involuntary care is to be informed by the values of compassion, dignity, understanding and respect. In any decision in relation to involuntary care, the person's interests are to be paramount.

The proposed legislation

The proposed legislation, based partly on Victoria's compulsory treatment legislation, would draw on some elements of the *Mental Health Act 1990*, and conform with relevant human rights instruments, thus ensuring that the person's rights are carefully safeguarded. The primary goal of the proposed legislation enabling short term involuntary care for people with severe substance dependence is to protect the health and safety of the person, and its aims are: to reduce harm to the person through the provision of medical treatment including, where necessary, medicalised withdrawal; to stabilise the person and comprehensively assess them; to restore their decision making capacity and provide the

opportunity to engage in voluntary treatment; and to provide an entry point, where appropriate, for care and support for people with significant cognitive impairment under guardianship.

The new legislation would fall within the Health portfolio, but will necessarily be underpinned by interagency agreements setting out the respective roles of agencies including NSW Health, the Attorney General's Department, NSW Police and the Department of Community Services.

The Committee recommends that a person may only be subject to involuntary care when all of the following criteria are satisfied: the person has a severe substance dependence; they have experienced or are at immediate risk of serious harm to self; they lack the capacity to consent to treatment; and there is an initial treatment plan demonstrating that the intervention will benefit them.

We consider that orders enabling involuntary care will necessarily involve detention in an appropriate medical facility in order to ensure protection from serious harm. We recommend that detention may be ordered for an initial period of 7 to 14 days on the basis of a medical examination. In exceptional circumstances, where it is medically determined that the person remains at risk of serious harm, a further period of detention for up to 14 days may be ordered, subject to a further legal decision. Treating clinicians are to be empowered to discharge the person before the period of the order has elapsed, where they consider that the person has recovered sufficiently to be released.

We have stipulated that every person subject to involuntary care must, while in care, receive a comprehensive assessment which then forms the basis for a post-discharge treatment plan. On the basis of the plan they are to be actively linked to appropriate services, including primary care and case management, and to receive assertive follow-up.

The decision making process in relation to involuntary care is to be clinically driven, but with appropriate legal adjudication. Further consultation and consideration are necessary to determine the most appropriate process, but the Committee considers the process should include a number of elements. Detention should commence on the certificate of a medical practitioner, but should only continue subject to further medical examination(s) and review by a magistrate. Where possible, two medical practitioners are to be involved in this process, and as far as possible, at least one of them is to have expertise in addictions medicine. Review by a magistrate is to occur as soon as practicable, preferably within 3 days, and people subject to the proposed legislation are to have both the right to legal representation and the right of appeal. All formal proceedings in relation to decision making are to occur in private. It will be important to ensure that this process is implemented in a culturally sensitive manner.

We have recommended that requests for involuntary care orders in respect of a person at risk of harm may be made by a range of parties including a relative or friend, member of the police service, medical practitioner, drug or alcohol professional or magistrate.

Police are to be empowered to detain people and deliver them to an appropriate facility where they can be examined in respect of their need for involuntary care, and in the event that they abscond, to return them to the facility where they are being detained. However, as far as possible, the person is to be delivered into care through informal means, such as through a drug and alcohol worker or other service provider, or a family member.

We have also recommended that provision for court-ordered outpatient assessment be considered, where a person undergoes an initial assessment and has a treatment plan developed with a minimal level of coercion, and that provision for advanced care directives be included in the legislation.

The Committee considers that given the seriousness of the decision to detain a person against their will, and the experimental nature of the proposed framework, a system of centralised data collection on use of the legislation will be essential. This will enable monitoring by government agencies on use of the legislation, and will feed into a formal evaluation, to occur within five years of commencement of the legislation.

Having recognised the need for a non-coercive mechanism to address the complex needs and antisocial behaviour associated with some people with substance dependence, the Committee has recommended that the Attorney General's Department, the Cabinet Office, NSW Police, NSW Health, the Department of Community Services, the Department of Housing and other relevant agencies collaborate in a cross-agency task force to determine the most appropriate non-coercive policy response to this group. Strategies that help address people's behaviour, and which ensure a 'joined up' response to their multiple needs are required. In particular, this forum should investigate the feasibility of grafting onto the proposed legislation elements of the *Victorian Human Services (Complex Needs) Act 2003* to provide for a localised assessment and decision making body that holistically assesses people and acts as a filter, channelling them towards involuntary care and/or non-coercive services as appropriate to their needs.

The service framework

In keeping with the principle of maximising the benefits to the person subject to involuntary care, the Committee considers that involuntary care will necessarily entail evidence-based medical interventions provided in a medical setting. We believe that additional resources to fund the proposed system will be essential.

While treatment, harm reduction and psycho-social measures are to be tailored to a person's needs, several core interventions are envisaged: containment in a safe place; where necessary, medicalised withdrawal; comprehensive assessment, including neuropsychological assessment where required; the development of a post-discharge treatment plan; referral and support to engage people in the voluntary system and other services, including care and support under guardianship where necessary; and assertive follow-up.

Facilities where involuntary care is provided will necessarily be locked and equipped to provide the medical care required during the period of withdrawal and stabilisation, and to meet other acute care needs. They will also need to be staffed by people with a drug and alcohol skills base in order to assist the person to make the most of the opportunity to gain insight and engage in a process of change.

The Committee considers that a reasonable estimate of demand for involuntary care is required before the most appropriate service arrangements can be determined, as is a scoping study of all detoxification facilities across the State. The Committee favours a localised model making use of existing medical detoxification facilities, perhaps two in every area health service. Given the historically greater demand in rural areas, and issues associated with distance, the number of facilities in rural areas may need to be greater. Involuntary and voluntary patients would be co-located. Services will need to be sensitive to both Indigenous people and culturally and linguistically diverse communities.

Further thought also needs to be given to where people are to be detained while they sober up, are examined, and the decision made as to whether they are to be subject to involuntary care. We envisage that this is best determined through local interagency protocols.

We have identified three key elements essential to the service framework: evidence-based services and treatment guidelines; integrated service delivery; and investment in specific services including neuropsychological testing, supported accommodation and other programs for people with alcohol related brain injury, and support for families and carers. There is a particular need for adequate provision for people with alcohol related brain injury, who at present are explicitly excluded from eligibility for disability services.

The Committee considers that involuntary care should be conceptualised along a continuum of services, with the proposed legislation being seen as one measure within a much broader spectrum of services and provisions in relation to drug and alcohol problems. Prevention, timely access to treatment, and humane and compassionate care are all required. At the same time, a holistic approach that seeks to respond to the totality of people's needs is essential. It is vitally important that government comes to grips with this issue, especially in relation to housing and shelter, one of the most basic of human needs.

Key themes

Several themes underpin the discussion throughout this report. The first is the need to shift from a system that seeks to punish and control to one that provides humane and safeguarded protection. It is a weighty decision to detain and treat someone against their will. Rather than simply locking people up for a time in an inappropriate setting, we must ensure that involuntary care is used as a last resort, that the rights of those subject to it are well protected, and that they derive real benefit from such intrusion on their autonomy. At the same time, we need to build a system that respects and affirms the dignity of people with substance dependence, and which recognises that there are limits to what treatment, whether voluntary or involuntary, can achieve.

A related theme is the profound impact that a person's addiction can have on others. In building the proposed framework for involuntary care, the Committee has sought to balance the rights of the person and those around them, also pointing to the need for better provisions to support family members to cope with their loved one's substance dependence.

A final theme is the need to rebalance investment towards addressing alcohol dependence. It is clear that at present, illicit drugs programs for both offenders and non-offenders are much better resourced than those for people with alcohol dependence. This is despite the greater prevalence of alcohol misuse and addiction in the community, and the greater resulting harm. While many more people, their families and communities are affected by alcohol dependence, we do not prioritise this group, perhaps at least partly because alcohol use is so deeply entrenched in our society. At the same time, value judgements about the 'deservingness' of people with alcohol dependence continue to influence government decisions. While such judgements formed the premise of the *Inebriates Act*, they have no place in policy in the early 21st century.

Summary of recommendations

Recommendation 1 *Page 66*

That the *Inebriates Act 1912* be repealed and replaced at once with legislation reflecting subsequent recommendations of this report.

Recommendation 2 *Page 105*

That the Government establish a system of short term involuntary care for people with substance dependence who have experienced or are at risk of serious harm, and whose decision making capacity is considered to be compromised, for the purpose of protecting the person's health and safety.

Recommendation 3 *Page 108*

That the purpose of the new legislation be to enable involuntary care of people with severe substance dependence, in order to protect the health and safety of the person, and that the aims of the legislation be to:

- reduce harm to the person through the provision of medical treatment including, where necessary, medicalised withdrawal
- stabilise the person and comprehensively assess them
- restore their decision making capacity and provide the opportunity to engage in voluntary treatment and
- provide an entry point, where appropriate, for care and support for people with significant cognitive impairment under guardianship.

Recommendation 4 *Page 108*

That the proposed legislation enabling involuntary care for people with severe substance dependence be inclusive of any substance dependence.

Recommendation 5 *Page 109*

That the proposed legislation fall within the Health portfolio.

Recommendation 6 *Page 109*

That the Government develop an interagency agreement setting out the respective roles and responsibilities of relevant agencies under the proposed legislation.

Recommendation 7 *Page 110*

That the proposed legislation be stand-alone legislation.

Recommendation 8 *Page 111*

That the proposed legislation conform to the United Nations *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*. The legislation should stipulate that in any decision in relation to involuntary care, the person's interests should be paramount.

Recommendation 9 *Page 113*

That the proposed legislation stipulate the following criteria for involuntary care, all of which are essential:

- the person has a severe substance dependence
- the person has experienced or is at immediate risk of serious harm to self
- the person lacks the capacity to consent to treatment
- there is an initial treatment plan demonstrating that the intervention will benefit the person.

Recommendation 10 *Page 113*

That the proposed legislation define 'serious harm' in the second criterion holistically, that is, in terms of a person's health and welfare.

Recommendation 11 *Page 113*

That the proposed legislation explicitly exclude the use of involuntary care for people who are simply using or dependent on substances.

Recommendation 12 *Page 116*

That the proposed legislation provide for the following elements of involuntary care orders:

- detention in an appropriate medical facility
- detention may be ordered for an initial period of 7 to 14 days, on the basis of a medical examination of the person, especially with regard to the nature of their substance dependence, other medical needs and the suspected presence of cognitive damage
- in exceptional circumstances, that is, where it is medically determined during the comprehensive assessment process that the person remains at risk of serious harm, a further period of detention for up to 14 days may be ordered, subject to a further legal decision
- treating clinicians are to be empowered to discharge the person before the period of the order has elapsed, where they consider that the person has recovered sufficiently to be released.

Recommendation 13 *Page 116*

That the Minister for Health ensure that every person subject to involuntary care must, while in care, receive a comprehensive assessment which then forms the basis for a post-discharge treatment plan. On the basis of that plan, the person must then be actively linked to appropriate services and receive assertive follow-up.

Recommendation 14 *Page 118*

The Committee recommends against a longer term mechanism to deal with people who are placed under an involuntary care order on a number of occasions, and also against provision for community treatment orders.

Recommendation 15 *Page 123*

That the decision making process in relation to involuntary care include the following elements:

- detention may commence on the certificate of a medical practitioner, but may only continue subject to further medical examination(s) and review by a magistrate
- where possible, two medical practitioners are to be involved in this process, and as far as possible, at least one of them is to have expertise in addictions medicine
- review by a magistrate is to occur as soon as practicable, preferably within 3 days
- the right to legal representation in magistrates' inquiries
- the right of appeal
- formal proceedings to occur in private.

Recommendation 16 *Page 124*

That the proposed legislation enable requests for involuntary care orders in respect of a person at risk of harm to be made by a range of parties including a relative or friend, member of the police service, medical practitioner, drug or alcohol professional or magistrate.

Recommendation 17 *Page 125*

That NSW Health and the Attorney General's Department consult with Indigenous communities in order to ensure that the decision making process in Recommendation 15 is implemented in a culturally sensitive manner.

Recommendation 18 *Page 126*

That the Government provide for a system of official visitors to monitor service provision and the rights of patients under involuntary care orders. In determining the most appropriate

mechanism, consideration should be given to the potential to augment an existing official visitors system to fulfil the function in relation to this group.

Recommendation 19 *Page 126*

That the Government request that the Judicial Commission develop an education program for magistrates in relation to the proposed legislation.

Recommendation 20 *Page 126*

That as part of an implementation strategy for the proposed legislation, the Government develop an appropriate information and education strategy targeting medical practitioners with addictions expertise, other medical practitioners and drug and alcohol practitioners, in relation to involuntary care orders and the decision making process pertaining to them.

Recommendation 21 *Page 127*

That the proposed legislation make provision for regulations to articulate the responsibilities of treating services and staff.

Recommendation 22 *Page 127*

That the proposed legislation empower police to detain a person and deliver them to an appropriate facility where they are to be medically examined regarding their need for involuntary care, and in the event that they abscond from care, to return the person to the facility where they are being detained.

Recommendation 23 *Page 128*

That provision for court ordered outpatient assessment through which a person may undergo an initial assessment and have a treatment plan developed with a minimal level of coercion be considered, and if appropriate, included in the proposed legislation.

Recommendation 24 *Page 129*

That the Government make provision for advanced care directives to be included in the proposed legislation.

Recommendation 25 *Page 130*

That the Government establish a system of centralised data collection on use of the proposed legislation for the purpose of monitoring and evaluation.

Recommendation 26 *Page 131*

That the Government evaluate the proposed system of involuntary care within five years of commencement of the legislation. The evaluation should consider:

- demographic and social characteristics of people subject to an order
- circumstances precipitating the order
- the parties who sought the order
- length of orders and length of time in care
- outcomes of legal review
- use and outcomes of appeal
- interventions provided while in care
- client outcomes achieved by discharge and upon follow-up
- use of the legislation in respect of Aboriginal people.

Recommendation 27 *Page 134*

That the Attorney General's Department, The Cabinet Office, NSW Police, NSW Health, the Department of Community Services, the Department of Housing and other relevant agencies collaborate in a cross-agency task force to determine the most appropriate non-coercive policy response to address the complex needs and antisocial behaviour associated with some non-offenders who have a serious substance dependence. In particular, this forum should investigate the feasibility of grafting onto the proposed legislation elements of the *Victorian Human Services (Complex Needs) Act*. Consideration should be given to:

- how the elements might be modified to respond to a larger group of people with substance dependence but lower grade needs than those targeted by Victorian legislation
- provision for a regionalised or localised decision making body that holistically assesses people's needs and channels them towards involuntary care and/or other services as appropriate to their needs
- provision to enable sharing of client information
- requirement of agencies to deliver what is in a person's care plan
- cross-agency initiatives already under development in New South Wales
- whether a legislative mechanism is required
- how the mechanism should be operationalised in rural areas.

Recommendation 28 *Page 138*

That the Government review the legal framework and supported accommodation arrangements existing under the *Intoxicated Persons Act* with a view to reducing the use of police cells for detaining intoxicated persons and exploring more community-based options for intoxicated persons. The review should consider the reasons for, and impact of, the repeal of proclaimed places.

Recommendation 29 *Page 138*

That the Government urgently expand the number of intoxicated persons services which will take intoxicated persons, particularly in inner-city, rural and remote communities that do not have these facilities.

Recommendation 30 *Page 143*

That the Government provide additional resources to fund the proposed system of involuntary care for people with severe substance dependence.

Recommendation 31 *Page 148*

That NSW Health immediately undertake:

- a detailed survey of all drug and alcohol services in New South Wales, and facilities where people are currently detained under the *Inebriates Act*, to estimate the likely annual demand for involuntary care
- a scoping study of all detoxification services in New South Wales to determine where people could be detained and treated, and identify the work necessary to provide for locked environments.

This information should then be used to determine the most appropriate service arrangements for the provision of involuntary care.

Recommendation 32 *Page 148*

That involuntary care be provided according to a localised model making use of existing medical detoxification facilities.

Recommendation 33 *Page 148*

That in light of the information gathered through Recommendation 31, NSW Health should consider the potential for a purpose built facility in the inner city.

Recommendation 34 *Page 150*

That in implementing the Committee's proposed model of involuntary care, NSW Health recognise and incorporate the needs of Indigenous people, in consultation with Indigenous communities.

Recommendation 35 *Page 151*

That in implementing the Committee's proposed model of involuntary care, NSW Health recognise and incorporate the needs of culturally and linguistically diverse communities, in consultation with them.

Recommendation 36 *Page 152*

That NSW Health lead a process of developing interagency protocols at the area health service level about the management of persons for whom involuntary care is being determined, during the intoxication phase.

Recommendation 37 *Page 153*

That the interagency agreement on respective roles and responsibilities under the proposed legislation referred to in Recommendation 6 address transport of people under an involuntary care order. In determining this responsibility, consideration should be given to establishing a budget specifically for the purpose of funding such transport.

Recommendation 38 *Page 155*

That in order to ensure quality of care and optimal outcomes for those subject to the proposed legislation, NSW Health develop and publish guidelines for the treatment of people in involuntary care. The guidelines should address:

- the key elements of involuntary care, that is, comprehensive assessment and the development of a treatment plan, referral to appropriate services, and assertive follow-up
- how families and carers are to be engaged in the process of involuntary care
- the rights and responsibilities of staff.

Recommendation 39 *Page 157*

That interagency protocols be developed in each area health service setting out the roles and responsibilities of government and non government agencies in relation to involuntary care.

Recommendation 40 *Page 157*

That the treatment guidelines to be developed by NSW Health in Recommendation 38 also reflect the need for interagency collaboration.

Recommendation 41 *Page 158*

That NSW Health develop a strategy to ensure the availability of neuropsychological testing services for people subject to involuntary care.

Recommendation 42 *Page 159*

That NSW Health re-establish specific treatment and living skills development services for people with significant cognitive impairment arising from their substance use.

Recommendation 43 *Page 160*

That NSW Health and the Department of Ageing, Disability and Home Care establish a consultancy service providing specialist support to mainstream treatment and other service providers to enable them to work more effectively with people with alcohol related brain injury.

Recommendation 44 *Page 163*

That the Department of Ageing, Disability and Home Care acknowledge its responsibility towards people with acquired brain injury, including those with alcohol related brain injury, as part of the target group for the Disability Services Program.

Recommendation 45 *Page 163*

That the Department of Ageing, Disability and Home Care, in collaboration with NSW Health, Treasury and other relevant agencies, develop a funding and policy framework for strategically addressing the needs of people with brain injury, in order to improve their access to the range of disability and mainstream support services, and to brain injury specific services. In particular, this framework should consider:

- Living skills and behaviour/social skills development services
- Accommodation, respite, case management and other services.

Recommendation 46 *Page 164*

That the *Drug and Alcohol Treatment Services Development Plan 2006-2015* provide for greater engagement of families in treatment, and enhance provisions specifically aimed at supporting families and carers.

Recommendation 47 *Page 164*

That the evaluation of the proposed legislation in Recommendation 26 also consider:

- service coordination and integration
- service gaps
- the experience of families and carers.

Recommendation 48 *Page 173*

That no provisions relating to offenders be included in the new legislation that replaces the *Inebriates Act*.

Recommendation 49 *Page 177*

That the Government assess the feasibility of expanding the Drug Court program with a view to making it accessible throughout New South Wales.

Recommendation 50 *Page 184*

That the Committee support the planned trial extension of MERIT to alcohol in the mid-West and Broken Hill, and recommends that the Government ensure that the programs are adequately resourced.

Recommendation 51 *Page 185*

That a pilot project be developed to trial the inclusion in the Drug Court program of alcohol related offenders who meet the other eligibility criteria. This should include the provision of relevant alcohol-focused interventions.

Recommendation 52 *Page 189*

That, given the importance of addressing the link between alcohol and family violence, the Attorney General consider, as a matter of priority, interagency task force reports due in 2005 relating to the Domestic Violence Court Intervention Model and the issue of Apprehended Violence Orders and alcohol treatment.

Recommendation 53 *Page 190*

That the level of need for post-program support for MERIT graduates be assessed and appropriate programs be developed to address the unmet need.

Recommendation 54 *Page 193*

That the Government ensure that the full range of evidence-based interventions are available at the Compulsory Drug Treatment Correctional Centre.

Recommendation 55 *Page 194*

That the Government reconsider the exclusion of offenders with serious alcohol problems from participation in the Compulsory Drug Treatment Correctional Centre.

Glossary

A range of terms are used in this report relating to compulsory treatment, some of which are synonyms, while others denote variations. A short glossary appears below.

civil commitment	legally sanctioned, involuntary commitment of a non-offender into treatment
coerced treatment	treatment of an offender required by a court order, often in situations where the offender is required to choose between attending treatment or submitting to traditional criminal justice sanctions such as prison
compulsory treatment	legally sanctioned, involuntary commitment of a person into treatment for drug or alcohol dependence. This term can cover offenders and non-offenders
court-mandated treatment	treatment of an offender required by a court order, usually seeking to address the substance abuse that contributes to the offending behaviour
involuntary treatment	synonymous with compulsory treatment
mandated treatment	see court-mandated treatment
non-offenders	people who have not been convicted of any offence
offenders	people who have been convicted of an offence, usually relating to their drug or alcohol use
treatment	treatment may include containment, enforced abstinence, supervised withdrawal (detoxification), and/or any range of therapeutic interventions aimed at addressing the person's dependence over the longer term

Chapter 1 Introduction

> The Alcohol Summit highlighted the fact that there is a substantial group of people in the community whose [alcohol and other drug] use is killing them in front of a caring but apparently powerless family. As a community we need to get rid of the stigma associated with these problems … but in the meanwhile what do we do?[1]
>
> The impact of the Act, whether it remains unchanged, is amended, or abolished, should be considered in terms of how each alternative will affect issues such as … limited resources, civil liberties, law, social responsibility and treatment outcomes.[2]

While rarely used at the present time, the *Inebriates Act 1912* remains an active piece of legislation which affords the state significant powers: the power to detain people with drug and alcohol problems against their will, to compel them to undergo medical intervention, and to enforce their abstinence. In spite of its age and vocal and longstanding criticism, the Act has undergone conspicuously little amendment since it was originally passed in 1900. Over one hundred years later, the NSW Summit on Alcohol Abuse in August 2003 provided the catalyst for a thorough reappraisal of the Act's social, legal, medical and ethical implications. The Committee has carefully considered the *Inebriates Act* in the light of contemporary social values, the current medical understanding of substance dependence, the present health and legal systems and the evidence base available in the early 21st century.

This report documents the inquiry's thorough examination of the *Inebriates Act* and proposes a modern legislative and service framework for the involuntary care of a small, well-defined group of people dependent on alcohol or other drugs, the effectiveness of which must be carefully evaluated. We have drawn on the expertise of many inquiry participants to make detailed recommendations on the legislative and service elements to comprise the new framework. Thus the Committee has furnished the Government with a comprehensive and informed basis on which to move forward in response to the inquiry. At the same time, we have identified the need for key government agencies to come together within a cross-agency forum to resolve an outstanding policy issue. This work will necessarily involve the Attorney General's Department, The Cabinet Office, NSW Health, NSW Police and other government agencies.

While this further cross-agency work is vital, we emphasise that it should not mean that once again the *Inebriates Act* fails to be repealed, or that immediate action in those areas that are clear does not occur. The *Act* is an historical relic that has already lasted far longer than it should. We believe it is essential that the momentum accompanying this inquiry, and the opportunity for change which it has helped to create, are brought to completion.

Background to the inquiry

1.1 The Summit on Alcohol Abuse convened by the NSW Parliament brought together a broad range of community, industry and government stakeholders to examine current approaches to alcohol misuse and recommended a future course of action for government across a broad

[1] Submission 53, Mid Western Area Health Service, p4

[2] Submission 22, Alcohol and Drug Information Service, St Vincents Hospital, p2

range of policy areas including alcohol supply, prevention of misuse, treatment and health service delivery, and the justice system.[3]

1.2 On the first day of the Summit, Ms Toni Jackson gave a personal account of the effects of extreme alcohol misuse. She spoke of how her 48 year old husband, Wayne Jackson, had died two months earlier, after eight years of severe alcohol dependence. She told of his struggle to deal with his addiction in the voluntary treatment system, and her own desperate, unsuccessful attempt to have him detained and treated against his will under the *Inebriates Act*:

> I rang a local doctor and was informed there was nothing that I or they could do – that it was up to Wayne and if he wanted to drink himself to death there was no law against it … I spoke to a magistrate and picked up the application papers for an inebriate's order. It took a while to find them because they had not been used for about 50 years. However, a bed must be found before an order can be granted. We needed to find a hospital bed in a lock-down unit, but there are no such beds in New South Wales … Why did the system stop me from helping him? If it is illegal to commit suicide, why is it not illegal to drink oneself to death? If we had been able to enforce the *Inebriates Act 1912* and if some of the taxes collected from this powerful and socially accepted drug had been used to provide a private, lock-down rehabilitation centre, Wayne might have been held for two or three months and not only chemically rebalanced but also helped to regain his health and weight, to sort out what was behind his self-destruction and, with the help of counsellors, to rebuild his self-esteem. If that had occurred, he might have been alive today.[4]

1.3 Clearly resonating with the broader community, Ms Jackson's call was widely reported in the media. The following day, by coincidence, the Chief Magistrate of the Local Court of New South Wales, Judge Derek Price, raised the *Inebriates Act* during his address. He told the Summit that orders for compulsory treatment under the Act are rarely made, but when they are, they create 'unnecessary tension between the justice system and the NSW Health Department' because they are often unenforceable.[5]

1.4 The Chief Magistrate gave an example of a 39 year old man, referred to as 'B', whose parents applied for an inebriates order because his health was seriously in danger:

> The magistrate made a three months order committing B to a gazetted hospital. Having made the order, police were contacted and attended the court to convey B to the hospital. B was refused admission to the hospital. The police, B and his parents returned to the court. The magistrate, acting in the belief that a court order had been made and should be complied with, directed the police to return B to the hospital. The police, B and B's parents returned to the hospital and once again were told to return to the court as the medical superintendent refused to admit him. B's parents were unable to understand how the hospital could refuse to comply with the court's order and were very frustrated.[6]

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3 *www.alcoholsummit.nsw.gov.au/purpose_and_objectives* (accessed 17 September 2004)

4 Ms Toni Jackson, *NSW Summit on Alcohol Abuse: Report of Proceedings*, First Day, Tuesday 26 August 2003, p25

5 Judge Derek Price, Chief Magistrate of the Local Court of New South Wales, *NSW Summit on Alcohol Abuse: Report of Proceedings*, Second Day, Wednesday 27 August 2003, p13

6 Judge Price, *NSW Summit on Alcohol Abuse: Report of Proceedings*, Second Day, Wednesday 27 August 2003, p13

1.5 Judge Price concluded, 'The justice system is an inefficient instrument for dealing with the chronically intoxicated. The Act in my view should be repealed or at the very least significantly amended.'[7]

1.6 As the Summit proceeded, the Act and the broader issue of compulsory treatment of offenders and non-offenders were discussed in detail by the Summit working group focusing on alcohol and the justice system. Alongside the unworkability of the Act emphasised by Ms Jackson and Judge Price, participants highlighted a range of other problems in relation to the Act and called for its review. Recommendations 9.35 and 9.36 of the Summit were, respectively:

> The *Inebriates Act* should be reviewed by the Social Issues (Legislative Council Standing) Committee:
>
> - To consider whether the compulsory treatment of people (not offenders) with severe alcohol dependence should be provided and, if so, under what conditions
>
> - To consider whether legislation is required to provide for the compulsory assessment or treatment of persistent alcohol related offenders.
>
> Persons, who as a result of their alcohol abuse and who are within the jurisdiction of the *Inebriates Act*, should be considered for assessment of the level of impact of their alcohol use. This assessment may be imposed as a condition of the Act, which may serve to assist the person to receive appropriate interventions, which may minimise the harm associated with their alcohol use. [8]

1.7 In response to these recommendations, on 23 September 2003 the Attorney General, the Hon Bob Debus MP, wrote to the Standing Committee on Social Issues formally referring the inquiry. The terms of reference for the inquiry are set out at the commencement of this report.

The purpose of the inquiry

1.8 Appearing before the Committee in December 2003, representatives of The Cabinet Office and the Attorney General's Department explained that in referring the inquiry to the Committee, the Government sought a detailed and systematic examination of the Act's provisions for compulsory treatment for both offenders and non-offenders, informed by extensive consultation.[9]

1.9 A considered view was also sought on the most appropriate legislative and service provisions, if any, for compulsory treatment of people with severe drug and alcohol problems. While criticisms of the Act have been voiced by a range of stakeholders over many years, and numerous formal reviews of the Act have been undertaken, no firm position has ever been

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7 Judge Price, *NSW Summit on Alcohol Abuse: Report of Proceedings*, Second Day, Wednesday 27 August 2003, p13

8 *NSW Summit on Alcohol Abuse: Communique*, 29 August 2003, p40

9 Mr Geoff Barnden, Director, Office of Drug and Alcohol Policy, The Cabinet Office and Mr John Feneley, Assistant Director General, Policy and Crime Prevention, Attorney General's Department, Evidence, 11 December 2003, p2

reached as to the desirability of legislation to enable involuntary treatment for substance dependence, and if this were deemed desirable, what legislation might take the place of a repealed *Inebriates Act*. In the absence of this clarity, the *Inebriates Act* has remained on the statute books. As Mr John Feneley, Assistant Director General, Policy and Crime Prevention in the Attorney General's Department, put it, 'There have been a lot of concerns but not a lot of clarity about the alternatives.'[10]

1.10 While most of the criticisms have focused on the Act's provisions for the target group of non-offenders with severe drug and alcohol problems, its measures for offenders have also been questioned over a long period. The NSW Government's submission to the inquiry notes that in the context of the Government's significant expansion of 'therapeutic jurisprudence' models which link the criminal justice and health systems and provide coercive treatment to certain offenders with drug and alcohol problems, it is timely to review 'the appropriateness and relevance of the Act in relation to offending and sentencing'.[11]

1.11 The primary focus of the inquiry has been on non-offenders. Throughout the inquiry it has been clear that NSW Government policy and activities in relation to compulsory treatment for offenders are fairly straightforward and broadly supported. By contrast, involuntary treatment for non-offenders, whether as a lifesaving, short-term measure or as a longer term strategy aimed at 'rehabilitation' and abstinence, raises more complex ethical issues. Correspondingly, compulsory treatment for non-offenders is more complicated to operationalise, both in terms of legislation and service delivery. Consideration of the ethical issues, and the development of a legislative and service framework for modern, safeguarded involuntary treatment for non-offenders comprises the largest portion of this report.

1.12 While the *Inebriates Act* has primarily been associated with compulsory treatment for people with an alcohol dependence it also explicitly provides for habitual users of 'narcotic drugs'. Correspondingly the terms of reference for the inquiry direct the Committee to consider compulsory treatment for both groups.

Terminology

1.13 In broad terms, compulsory treatment refers to legally sanctioned, involuntary commitment of people into treatment for drug or alcohol dependence. The term may apply to offenders or non-offenders, and a range of other terms are used in relation to these two groups. A glossary of terms used in this report is provided at page xxiv.

The broader context

1.14 Placing the inquiry in a broader context, Emeritus Professor Ian Webster AO, drug and alcohol physician and Chair of the NSW Expert Advisory Committee on Drugs, has identified a number of factors contributing to the imperative to review the Act:

- Community concern about alcohol problems, as reflected in the holding of the Alcohol Summit and the range of issues explored in it

[10] Mr Feneley, Attorney General's Department, Evidence, 11 December 2003, p2

[11] Submission 47, NSW Government, pp5-6

- Pressure on mental health beds, in which people under an inebriates order must be placed
- The decline in access to suitable accommodation for people with substantial support needs, including those with severe alcohol and related disorders
- A recognition that people with complex health and social problems are poorly managed in comparison with those whose needs fit neatly within the boundaries of one service system.[12]

1.15 A further important aspect to the landscape for this inquiry is the maturation of the alcohol and other drug service system in recent years. The 1999 Drug Summit is seen as a watershed for policy and service delivery, helping to bring about a major boost to investment in treatment services by both the State and Commonwealth Governments. In addition, the drug and alcohol workforce is undergoing a process of professionalisation, as exemplified by the establishment of addictions medicine as a clinical specialty within the Royal Australian College of Physicians in 2002. Further, a range of medications have emerged to offer more effective interventions for people with dependencies. The system is moving from a long history of marginalisation to a sophisticated clinical approach.[13]

1.16 In this context, participants from the drug and alcohol sector see the *Inebriates Act* as an archaic piece of legislation that does not reflect their professional, therapeutic ethos, and that indeed prevents vulnerable clients from accessing effective treatments. At the same time, that sector is open to exploring safeguarded, targeted compulsory treatment as a further option in the range of interventions for people with severe substance dependence.

The nature and prevalence of dependence

1.17 Before exploring the key questions for the inquiry and discussing previous reviews of the *Inebriates Act*, it is important to establish an understanding of the nature and prevalence of substance dependence, as explained to the Committee by various inquiry participants.

What is substance dependence?

1.18 Patterns of alcohol and other drug use are broadly conceptualised as falling along a continuum from occasional use to problematic use or abuse, to dependence or addiction. The key elements of substance dependence are 'the loss of control over use, and continued use despite awareness of problems caused or exacerbated by the using behaviour.'[14] The clinically accepted definition, on which diagnoses of dependence are made, is that of the American

12 Supplementary Submission 43, Emeritus Professor Ian Webster AO, Chair, NSW Expert Advisory Committee on Drugs, Chair, Alcohol Education and Rehabilitation Foundation, visiting physician to the Matthew Talbot Hostel and physician in drug and alcohol, Liverpool Hospital, p4

13 Dr Stephen Jurd, Area Medical Director, Drug and Alcohol Services and Addictions Psychiatrist, Northern Sydney Health, Evidence, 4 March 2004, p7; Ms Michelle Noort, Director, Centre for Drug and Alcohol, NSW Health, Evidence, 29 April 2004, p23

14 Australian National Council on Drugs (ANCD), *Evidence Supporting Treatment*: *the Effectiveness of Interventions for Illicit Drug Use*, p6

Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV), which sets out the criteria of dependence as follows:

> A maladaptive pattern of substance use, leading to significant impairment or distress, as manifested by three or more of the following in a period of 12 months:
>
> 1. tolerance – the need for larger amounts of the substance to achieve the same effect, or markedly diminished effect with continued use of the same amount of the substance
>
> 2. withdrawal – characteristic syndrome present upon cessation of the substance, or the substance is taken to relieve withdrawal symptoms
>
> 3. the substance is taken in larger amounts or over a longer period than was intended
>
> 4. persistent desire or unsuccessful efforts to cut down or control substance use
>
> 5. a great deal of time is spent in activities necessary to obtain or use the substance, or recover from its effects
>
> 6. important social, occupational or recreational activities are given up or reduced because of the substance use
>
> 7. continuation of substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.[15]

1.19 The characteristics of alcohol and drug dependence were explained to the Committee during the inquiry. Dr Richard Matthews, Acting Deputy Director General of NSW Health who is also a physician with drug and alcohol expertise, described how dependence is distinct from abuse. Abuse generally refers to use which either causes some physical damage or incapacity, or which causes people to behave in unacceptable ways, for example when a person becomes aggressive or violent as a result of drinking. When a person is dependent on a substance, the cells in their brain are permanently altered, so that when the drug is not taken, there are clear symptoms of withdrawal.[16]

1.20 Mr George Klein, a behavioural scientist and practitioner with the Centre for Drug and Alcohol Medicine at Nepean Hospital, explained how these physical changes to the brain occur through a process of 'neuro-adaptation', whereby cells adapt to the stimulation induced by ingestion of substances. Some of these changes are acute, such that the person becomes intoxicated or stimulated, with feelings of euphoria, relaxation, pleasure, etc depending on the substance that has been taken. However, there are also longer term changes that the brain must make to avoid being destroyed through regular use:

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15 American Psychiatric Association (1994), *Diagnostic and Statistical Manual of Mental Disorders*, *Fourth Edition,* cited in Australian National Council on Drugs (ANCD), *Evidence Supporting Treatment*: *the Effectiveness of Interventions for Illicit Drug Use*, 2001, p6

16 Dr Richard Matthews, Acting Deputy Director General, Strategic Development, NSW Health, Evidence, 11 December 2003, pp16-17.

> I will not attempt to describe those changes except to say that the changes that are made with continued drug use are relatively long lasting and some of the evidence of those changes that are observable behaviourally are things like craving for the drug in its absence, the phenomenon of withdrawal symptoms when the drug is removed, tolerance which is that a person requires more of the drug to obtain the same effects. One of the mechanisms of tolerance is the way that brain cells adapt to constant availability of the drug by decreasing their responsiveness to that availability. If they did not the brain would basically die.[17]

1.21 Professor Richard Mattick, Director of the National Drug and Alcohol Research Centre at the University of New South Wales described the typical behaviours of an alcohol dependent person:

> Along with the two physical criteria of tolerance and the effects of alcohol withdrawal are a set of other criteria that mark alcohol dependence. They are a strong desire to continue drinking, difficulty controlling drinking, neglect of interests, substantial time drinking or recovering from drinking and persistent drinking despite consequences - physical or psychological consequences. The individual can have a few of those or can have all of those - hence the notion of mild through to severe dependence. Severe dependence really is a chronic and relapsing disorder.[18]

1.22 Mr Klein's research and work suggest to him that long term substance abuse also impacts on what is generally referred to as "the will". While an ordinary person makes reasoned decisions, the neuro-adaptation process that had occurred in a dependent person's brain occurs in the areas responsible for volition, so that their capacity to make informed decisions about their substance use or welfare is corrupted.[19] Others participants such as Ms Tonina Harvey, Area Director, Drug and Alcohol Services, Northern Sydney Health, emphasised how alcohol in particular affects the areas of the brain responsible for learning new behaviour, so that people's ability to overcome their substance misuse is compromised:

> It is fairly well documented that alcohol causes frontal lobe dysfunction to varying degrees, depending on the length of time people have been drinking. That is evident in people's lack of insight into their illness, their lack of planning and organisational skills, their inability to learn new tasks, decreased motivation and so on. We expect people with severe dependence to be motivated to change when physiologically that is impossible. That is very important.[20]

How prevalent is substance dependence?

1.23 Statistics collated from the 1998 National Drug Strategy Household Survey reveal that in 1998 89.6% of Australians aged 14 years and over had used alcohol in their lifetime. The corresponding figure for illicit drugs overall was 46%, with use of specific drugs broken down

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17 Mr George Klein, Behavioural Scientist, Centre for Drug and Alcohol Medicine, Nepean Hospital, Evidence, p52

18 Professor Richard Mattick, National Drug and Alcohol Research Centre, University of New South Wales, Evidence, 8 April 2004, p1

19 Mr Klein, Nepean Hospital, Evidence, 7 April 2004, p53

20 Ms Tonina Harvey, Area Director, Drug and Alcohol Services, Northern Sydney Area Health, Evidence, 4 March 2004, p3

as follows: cannabis – 39.3% ; heroin – 2.2%; amphetamines – 8.7%; hallucinogens – 10% and cocaine – 4.3%.[21] Of these 'users' of drugs and alcohol, a minority of people will become dependent, according to the Australian National Council on Drugs:

> The proportion of users who become dependent is estimated to be about 23% of those who ever use heroin, 32% for nicotine, 15% for alcohol, 15% for cocaine and 9% for cannabis.[22]

1.24 Dr Richard Matthews described the scope of the problem in relation to alcohol dependence:

> In terms of how big is the problem, we do have some reasonable data from the national mental health interview which was conducted with about 13,000 people across Australia - that is, 13,000 adults - and we can tell you from that group that with males it is around about 5.2 per cent dependent and about 4.3 per cent are abusers of alcohol. The figures are less in women - about 1.8 per cent for dependent and about the same, 1.8 per cent, for abuse. If you took the back of an envelope and said how many adult males are there in New South Wales, the answer is probably 1.5 to 2 million, then you are looking at about 70,000 adult males and probably about one-third of that number of adult females who are dependent on alcohol, and that is a very large cohort.[23]

1.25 Throughout the inquiry the Committee has heard that alcohol dependence occurs across a broad spectrum of society, with a number of people challenging the stereotype of a homeless person drinking under a railway bridge. As Mr Klein told the Committee:

> Most of the people we see at the Nepean Hospital have a home to go to. The drugs that do the most damage in fact are not illicit drugs at all; they are drugs that are relatively freely accessible, and that is part of the problem. They can buy a five-litre cask of wine for about $9. It is possible to consume five litres of wine a day very comfortably on a pension. You will not have any money to eat, however.[24]

Key questions for the inquiry

1.26 The two critical questions for this inquiry are in what circumstances compulsory treatment is ethically justified, and what the purpose and nature of that treatment should be. We have identified three potential goals for compulsory treatment of non-offenders: to address the person's substance dependence, to reduce harm to the person, and to protect the interests of others. In this report the Committee explores, and makes conclusions on, the appropriateness of compulsory treatment for each of these goals.

1.27 The NSW Government submission to this inquiry lists seven questions quoted from a discussion paper prepared for a review of similar legislation in New Zealand which are seen as

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21 Cited in Australian National Council on Drugs (ANCD), *Evidence Supporting Treatment*: *the Effectiveness of Interventions for Illicit Drug Use*, p10

22 Cited in Australian National Council on Drugs (ANCD), *Evidence Supporting Treatment*: *the Effectiveness of Interventions for Illicit Drug Use*, p6

23 Dr Matthews, NSW Health, Evidence, 11 December 2003, pp16-17

24 Dr Klein, Nepean Hospital, Evidence, 7 April 2004, p55

especially relevant to the work of the Committee. We agree that this list is an excellent summary of many of the issues with which we have grappled throughout the inquiry:

- Is dependence on alcohol and narcotic drugs a significant enough condition for society to intervene to remove people's liberty in order to legally enforce assessment, detoxification and treatment? If so, under what conditions should this happen?
- Should there be a minimum and/or maximum time for committal under any compulsory treatment legislation? If so, how should this time be determined and what controls do there need to be to protect patients?
- Should legislation for the compulsory treatment of people who are addicted to alcohol or other drugs include additional provisions to protect the committed person? If so, what additional protection do these people need?
- Is it appropriate for people to be compulsorily detained in the interests of their relatives? If not, what should the rationale for compulsory treatment be?
- Should compulsory treatment apply to treatment in non-institutional settings such as community programs or day programs?
- Should there continue to be a process of certifying institutions for the purpose of treatment under the Act or should any agency be able to provide compulsory treatment?
- If it is decided that compulsory treatment should be continued should all drug and alcohol treatment organisations be required to accept people referred by the Courts? How would this work in practice?[25]

Previous reviews of the Act

1.28 Over the past four decades there have been several fruitless attempts to repeal the *Inebriates Act*. According to an unpublished discussion paper prepared by NSW Health, in the mid 1960s that Department reviewed the Act and developed draft replacement legislation that was not progressed. In the mid 1970s the NSW Health Commission's Review of the 1958 Mental Health Act strongly criticised the Act on a number of philosophical and practical grounds. In 1983, the legislation enabling the repeal of the Mental Health Act 1958 was also to repeal the *Inebriates Act* but the latter did not occur.[26]

1.29 In 1989, the then Minister for Health, the Hon Peter Collins MP, wrote to the then Attorney General, the Hon John Dowd, seeking the Act's repeal. After Mr Dowd expressed concerns about doing so, a working party comprising representatives of the Health and Attorney General's Departments was proposed to investigate the need for the *Inebriates Act* and to identify alternative arrangements.

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25 Submission 47, NSW Government, pp5-6

26 MacAvoy MG and Flaherty B, 'Compulsory treatment of alcoholism: the case against', *Drug and Alcohol Review*, 1990, Vol 9, pp267-72, p267

1.30 Two years later, following an exchange of letters by the then Minister for Health, the Hon John Hannaford MLC, and Mr Peter Collins MP, who was then Attorney General, a working party chaired by the Director of the Drug and Alcohol Directorate in the Department of Health was established to review the Act in the context of the Mental Health Act 1990, the Guardianship Act 1987 and the Disability Services Act 1987.[27]

1.31 By 1992 the report of the review of the Mental Health Act 1990 chaired by Professor Webster noted that despite the inappropriateness of the *Inebriates Act* being identified during the final drafting of the 1990 Act, no resolution had been reached, nor any real progress made by the working party. Professor Webster recommended that a new Committee be established by the Minister for Health in consultation with the Attorney General and Minister for Community Services, to examine the *Inebriates Act* and other legislation in relation to provision for the care and control of people with alcohol related brain injury.[28]

1.32 By 1996 the Ministerial Advisory Council on Alcohol, Tobacco and Other Drugs established under Andrew Refshauge MP, then Minister for Health, sought to finalise the review, and a discussion paper was prepared for public consultation. The directions of the review were publicly flagged: that the Act 'be repealed and for the specific needs it addresses to be taken up under modern legislation such as the Mental Health and Guardianship Acts.'[29] However, the discussion paper was never released and no formal recommendations were ever made.

1.33 The *Inebriates Act* was also considered during the comprehensive review of sentencing law undertaken by the New South Wales Law Reform Commission in 1995 and 1996. Necessarily focusing primarily on the Act's provisions for offenders, the Commission recommended that 'So much of the *Inebriates Act* 1912 (NSW) as relates to sentencing should be repealed.'[30]

1.34 Representatives of the Attorney General's Department and NSW Health told the Committee that the reasons these endeavours failed to achieve change lay in the complexity of the issues and the absence of clear and trustworthy alternatives. As Dr Richard Matthews, Acting Deputy Director General, Strategic Development, NSW Health told us:

> I could not find any evidence that a review ever went from beginning to end and came up with a set of conclusions and recommendations. Why did that happen? It is a very difficult area and other priorities got in the way. Nobody looking at the problems could see their way to any obvious solution. I think that is probably the answer.[31]

1.35 The Committee understands that while the weight of opinion in the reviews was against the Act and its provisions for compulsory treatment, concerns to maintain some form of protection for people with alcohol related brain injury and for family members anxious about their loved one meant that no viable alternative with government support was ever achieved. As Mr John Feneley explained, 'I understand that there has often been a concern that if you

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27 Draft discussion paper on the *Inebriates Act* prepared by NSW Health, unpublished

28 Mental Health Act Implementation Monitoring Committee, *Report to the Honourable RA Phillips MP, Minister for Health on the Mental Health Act 1990*, August 1992, pp94-95

29 Dr Andrew Penman, then Director, NSW Drug and Alcohol Directorate, NSW Health Department, quoted in McKey, J, 'NSW Inebriates Act: Out of date and out of place?', *Connexions*, Vol 17, No 1, December 1996/January 1997, pp10-12

30 NSW Law Reform Commission, *Sentencing*, Report 79, December 1996, p231

31 Dr Richard Matthews, Acting Deputy Director General, NSW Health, Evidence, 11 December 2003, p27-28

took away the *Inebriates Act* there would be nothing and, therefore, in those extreme cases, what would people do?'[32]

Conduct of the inquiry

1.36 Recognising the diversity of stakeholders with regard to the compulsory treatment of people with severe drug and alcohol problems, the Committee has sought input from a broad range of interest groups, organisations and individuals. We have done this by calling for submissions, taking oral evidence from witnesses, and conducting field visits within metropolitan Sydney and in regional and rural New South Wales.

1.37 In response to its call for submissions the Committee received a total of 53 submissions to the inquiry. Submissions were provided by a range of stakeholder agencies including the NSW Government, the Law Society of New South Wales, the Council of Social Services of New South Wales (NCOSS), the Network of Alcohol and Other Drugs Agencies (NADA), the Guardianship Tribunal, Legal Aid New South Wales, and various area health services. Submissions were also received from a number of individuals. The full list of submissions and authors appears at Appendix 1.

1.38 The Committee has held 11 days of hearings with a total of 51 witnesses, along with a number of groups. A broad range of perspectives was gathered during this process, including those of drug and alcohol professionals, administrators of mental health facilities, peak agencies, Aboriginal groups, and academics in law, ethics and drug and alcohol research. In addition, representatives of a number of government agencies, including the Attorney General's Department, NSW Health, the Cabinet Office, NSW Police, the Office of the Public Guardian and the Local Court have all appeared before the Committee. Appendix 2 sets out all of the witnesses and hearings for the inquiry.

1.39 The Committee travelled to Moree and Orange in order to gather rural and regional perspectives on the issues being considered in the inquiry. Over two days we spoke with two panels of drug and alcohol workers, administrators of Bloomfield Hospital, and a group of 18 Aboriginal service providers and community members. We also took in camera evidence from two people who were detained under an inebriates order at that time.

1.40 We also travelled to Melbourne to take evidence from a number of witnesses and to meet with members of the Reference Group for the review of Victoria's equivalent legislation, the Alcoholics and Drug-dependent Persons Act 1968. The coincidental timing of the two reviews created the opportunity for our respective committees to share information and insights, for mutual benefit.

1.41 Towards the end of the inquiry the Committee took the innovative step of holding a roundtable discussion with 12 key inquiry participants in order to test and refine a potential legislative and service model to replace the *Inebriates Act*. The roundtable was attended by: Acting Chief Magistrate Graeme Henson, Local Court of New South Wales; Emeritus Professor Ian Webster, Medical Practitioner and Chair, NSW Expert Advisory Committee on Drugs; Professor Terry Carney, Director of Research, Faculty of Law, the University of Sydney; Professor Duncan Chappell, President, Mental Health Review Tribunal; Mr Larry

[32] Mr Feneley, Attorney General's Department, Evidence, 11 December 2003, p6

Pierce, Director, Network of Alcohol and Drug Agencies; Dr Stephen Jurd, Medical Director, Drug and Alcohol Services, Northern Sydney Health; Dr Martyn Patfield, Medical Superintendent and Director of Acute Services, Bloomfield Hospital; Dr Joanne Ferguson, Staff Specialist Psychiatrist, Drug Health Services, Rozelle and Concord Hospitals; Ms Val Dahlstrom, Area Manager, Aboriginal Health, New England Area Health Service; Mr John Feneley, Deputy Director General, Policy and Crime Prevention, Attorney General's Department; Dr Richard Matthews, Acting Deputy Director General, Strategic Development, NSW Health; Mr David McGrath, Deputy Director, Centre for Drug and Alcohol, NSW Health.

The structure of this report

1.42 The report is divided into two parts. Part One, comprising Chapters 2 to 4, examines the old Act, while Part Two, comprising Chapters 5 to 9, focuses on the system that we recommend replace it.

1.43 Part One commences with a broad overview of the key features and provisions of the *Inebriates Act* and a discussion of the data available on its use. Chapter 3 documents the broad range of criticisms made of the Act, while Chapter 4 draws together a number of case studies of people placed under the Act in recent years to identify the key groups of people for whom the Act is used, and the outcomes for them. Drawing on the findings of each of these chapters, Part One concludes with a recommendation that the *Inebriates Act* be repealed and replaced at once with legislation reflecting the subsequent recommendations of the report.

1.44 Part Two is primarily focused on non-offenders, and commences in Chapter 5 with an exploration of treatments available for substance dependence and the research evidence in relation to compulsory treatment. Our findings in that chapter inform a detailed consideration of the ethical issues associated with involuntary treatment in Chapter 6, with the conclusion that compulsory treatment may be justified for the purpose of protecting the health and safety of a person with substance dependence, where they are at risk of serious harm and their decision making capacity has been compromised. In Chapter 7, we operationalise the ethical discussion and conclusions to identify the key elements of legislation which we recommend replace the *Inebriates Act*. The service framework to underpin the legislation is set out in Chapter 8. In Chapter 9 we consider compulsory treatment in relation to offenders and how government initiatives in that area might be improved.

Next steps

1.45 Like the review bodies before it, the Committee has grappled with the complexities and conundrums surrounding compulsory treatment for non-offenders with severe drug and alcohol dependence and the most appropriate legislation, if any, to take the place of the *Inebriates Act*. While previous reviews failed to deliver change, we believe that it is vitally important that the Government ensure that the momentum accompanying this inquiry be brought to completion. The Committee has utilised the expert evidence put before us to develop a comprehensive and informed legislative and service framework to replace the Act. We have also identified an area where further investigation and consideration within a cross-agency framework is essential to determine the most appropriate policy response. We consider that our proposed framework provides the Government with a very firm basis on which to

move forward in replacing the Act with a humane, safeguarded and effective system of involuntary care.

1.46 On the basis of the evidence gathered throughout this inquiry, the Committee believes that the *Inebriates Act* must be repealed and replaced with modern, targeted legislation which provides an appropriate and time limited safety net for people at risk of severe harm, and which offers tangible, realistic outcomes to those made subject to it, while ensuring that their human rights are protected. At the same time, this new legislation must be supported by significant investment in a service system that ensures effective treatment is provided within an appropriate environment.

Part One

Chapter 2 The *Inebriates Act 1912* and other legislation

Before the Committee explores the many criticisms of the Act and the substantial ethical issues raised by compulsory treatment, it is important that its features are well understood. This chapter describes the key elements of the *Inebriates Act 1912*, setting out the provisions it makes for both non-offenders and offenders. It explains the genesis and intent of the Act, which reflect the social and medical understanding of substance dependence a century ago, and documents the origins of the problematic 'default' provision for people to be detained in psychiatric hospitals. The chapter then draws together data to build a picture of current and past use of the Act. It concludes by outlining the key provisions of related legislation and describing relevant compulsory treatment legislation in other Australian and key international jurisdictions.

The Act's purpose

2.1 The stated purpose of the *Inebriates Act 1912* is to provide for the care, control and treatment of 'an inebriate', that is, 'a person who habitually uses intoxicating liquor or intoxicating or narcotic drugs to excess'.[33]

Provisions for non-offenders

2.2 Provisions for non-offender inebriates are set out in Part 2 of the Act. It is important to note that these provisions apply to people who have neither been charged with nor convicted of any offence. A person's habitual use of alcohol or other drugs is the sole criterion for the invocation of the Act.

2.3 Section 3 of the Act enables a judge of the Supreme or District Court or a magistrate to order a chronically intoxicated person whom he or she is satisfied is an inebriate to be detained in a licensed institution established under Section 9 for up to one year.[34] This is the most commonly used provision in the Act, as well as the most controversial. Such an order may be extended by a Supreme or District Court Judge for further periods of up to twelve months at a time.[35]

2.4 Alternatively, the person may be placed under the care and control of another person for up to 28 days, either at home or in a public or private hospital or some other place, or put under the charge of an attendant or guardian for up to a year.[36]

2.5 Lastly, the person may be ordered to enter into a recognizance or bond under which he or she must abstain from using alcohol and/or drugs for no less than one year.[37]

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33 *Inebriates Act 1912 (NSW)*, Pt I, s 2

34 The Act, s 3(1), par (f)

35 The Act, s 3(4)

36 The Act, s 3(1) pars (e) and (g)

37 The Act, s 3(1) pars (d)

2.6 The Act stipulates that any such order can only be made if a medical practitioner has certified that the person is an inebriate, with corroborating evidence from some other person. Also, the person must be personally inspected by the Court, judge or magistrate, or their appointee.[38]

2.7 An application for an order can be made by the person him or herself, or his or her authorised representative, by a spouse, parent, sibling, adult child or business partner, or finally, by a member of the police force at or above the rank of sergeant on the request of a medical practitioner, relative or a justice.[39]

2.8 Provision is made for the person to be remanded into custody for up to seven days, if necessary, so that a medical practitioner can examine him or her and determine his or her status as an inebriate.[40] The Act also makes provision for voluntary recognizances.[41]

2.9 The Act stipulates that the judge, magistrate or court may decide whether the person is to appear in open court or in private. While a person for whom an order is sought is to be given the opportunity to object to an application, no provision is made for an order to be reviewed.[42]

2.10 If a person escapes from an institution, from the care of an attendant, or from custody while on remand, he or she may be arrested and returned to custody.[43]

Provisions for offenders

2.11 The Act makes separate provision in Part 3 for inebriates who have been convicted of an offence in which drunkenness was a contributing cause, or of assaulting women, cruelty to children, wilful damage to property or attempted suicide.

2.12 In such cases, the court may either sentence the offender according to law, discharge him or her on condition of entering into a recognizance for a year or more, or again, order him or her into treatment in an institution for one year.[44]

2.13 As with non-offenders, a medical certificate, supporting evidence from another party, and an inspection by the judge or magistrate or their representative, are all required. An order for compulsory treatment may be extended for further periods of up to 12 months,[45] and repeat offenders may be detained in an institution for up to three years.[46]

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38 The Act, s 3(1), (i) and (ii)

39 The Act, s 3(1), pars (a)(b) and (c)

40 The Act, s 3(1A)

41 The Act, s 5

42 The Act, s 3(3)

43 The Act, s 23 and Pt 2, s 3(1B)

44 The Act, s 11

45 The Act, s 11(1), par (c)

46 The Act, s 16

Historical context

2.14 Originally introduced as a bill in 1897 that was passed in 1900, amended in 1909, and then consolidated in 1912, the Act has seen few significant changes.

2.15 The 1897 bill drew on the recommendations of the Intoxicating Drink Inquiry Commission which reported to the Legislative Council in 1887. Parliamentary debates reveal that the legislation reflected the prevailing views of alcohol dependence, enshrining enforced abstinence as the mechanism to achieve the twin objectives of curing the 'diseased' individual and guarding the proper functioning of the community:

> … the bill is intended to provide those who are helpless victims of intemperance with a protection against themselves by making careful safeguarded provision for putting them into homes where they can be guarded from their thirst and restored to a condition in which they will be able to do work and return to the world.[47]

2.16 The architect of the bill, JM Creed, a senior member of the medical profession, stated:

> It has been remarked that a vast amount of poverty is due to drink; and that the largest proportion of crime is committed under its influence. We believe that much of the evil so arising would be preventible if proper means were taken to enable … habitual drunkards … to submit to … proper restraint.[48]

> … the children of habitual inebriates on either side are less able to fight the world than others, are more likely to be lunatics, and are very likely to become criminals. The passing of legislation such as this, therefore, would add to the well-being of our future population.[49]

2.17 The legislation also sought to address the cycle of arrest, release and re-arrest among habitual drunkards by diverting them from the prison system, thereby 'enabling greater economy in the administration of the police and of our gaols'.[50] At that time, arrests for drunkenness comprised a large proportion of all arrests and thus contributed heavily to prison overcrowding.[51]

2.18 According to Dr G Edwards, Chair of the Review of the 1958 Mental Health Act:

> It was a piece of essentially benevolent, protective legislation which was intended to enable care of inebriate persons in special institutional facilities. It was set very much in a paternalistic nineteenth century mould, similar, in more respects, to penal than to treatment legislation.[52]

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47 Hon Mr Wise MP, Attorney General, Legislative Assembly, *Hansard*, Vol 105, 12 September 1900, p2903

48 Report of the Intoxicating Drink Inquiry Commission, 1887, cited by the Hon JM Creed MLC, Legislative Council, *Hansard*, Vol 94, 13 October 1898, p1401

49 Hon JM Creed MLC, Legislative Council, *Hansard*, Vol 94, 13 October 1898, p1402

50 Hon JM Creed MLC, Legislative Council, *Hansard*, Vol 94, 13 October 1898, p1402

51 Lewis M, *A Rum State: Alcohol and State Policy in Australia 1788-1988*, AGPS, Canberra, 1992, p108

52 Edwards GA, Mental illness and civil legislation in New South Wales, MD Thesis, University of Sydney, quoted in MacAvoy MG and Flaherty B, 'Compulsory treatment of alcoholism: the case against', *Drug and Alcohol Review*, 1990, Vol 9, pp267-72, p268

2.19 The historian Dr Milton Lewis has noted that the New South Wales legislation was consistent with that of other States at the turn of the century:

> These embodied the concept of alcoholism as a disease to be cured rather than a crime to be punished. But the conditions under which treatment was carried out were often punitive in character and treatment itself was usually not very successful.[53]

2.20 It is also important to note, given the origins of the Committee's inquiry, that the *Inebriates Act* was originally legislated at least partly in response to pressure from families of alcoholics for the government to provide suitable treatment facilities.[54]

2.21 In his submission to the inquiry, Professor Webster explores the contrast between the medical and social understanding of substance dependence operating then and now:

> The medical knowledge and understanding of mental disorders were primitive then by today's standards. And there were very different notions of free will, individual rights and responsibilities … the Act was intended to remove seriously alcohol dependent people ("inebriates") from access to alcohol; it may have been to protect family members and others from a range of harms; and, since asylum was then a humane movement, it is likely that society was concerned to protect the person themselves from harm, to improve their welfare and possibly to aim for recovery … Today we are inclined, with issues of this kind, to examine the nature and strength of motivation, the degrees of dependence (addiction) and the interplay of these with the external social world and the internal neurobiological systems of the brain and related organ systems.[55]

Institutions where inebriates may be detained

2.22 The list of institutions in which people under an inebriates order may currently be detained is very limited. Section 9 of the Act provides that the Governor may establish institutions for the compulsory treatment of non-offenders who have been placed under an inebriates order. These institutions fall under the control of the Minister for Health and are notified in the Government Gazette.[56] As was highlighted by the NSW Chief Magistrate at the Alcohol Summit, the detention of people under an inebriates order within psychiatric hospitals is highly contentious.

2.23 The second reading speech on the Inebriates Bill makes it clear that the intention was that people be detained and treated in purpose built facilities:

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53 Lewis M, *Managing Madness: Psychiatry and Society in Australia 1788-1980*, AGPS, Canberra, 1988, p168

54 Edwards GA, Mental illness and civil legislation in New South Wales, MD Thesis, University of Sydney, cited in MacAvoy MG and Flaherty B, 'Compulsory treatment of alcoholism: the case against', *Drug and Alcohol Review*, 1990, Vol 9, pp267-72, p268

55 Supplementary Submission No 43, Emeritus Professor Ian Webster AO, Chair, NSW Advisory Committee on Drugs, pp1-2

56 The Act, s 9

> persons convicted of habitual intoxication should be separated from those undergoing sentences for crimes, and they should be sent to asylums or reformatories specially designed for the treatment of inebriates.[57]
>
> Although, undoubtedly, drunkenness is a species of lunacy, I do not think it is well that the two particular classes of patients should be mixed together in the same institution.[58]

2.24 One such institution, the Shaftesbury Institute, was established under the Comptroller of Prisons rather than the Health Department, but by the late 1920s was widely condemned as a failure and closed. As an interim measure, in 1929 the Act was amended to make provision for inebriates to be detained in psychiatric hospitals. This temporary 'default' solution, recognised at the time as undesirable, was never redressed.[59] The list of gazetted psychiatric hospitals – which remains unamended to this day - comprises seven still operational facilities. These are the only public institutions currently authorised to accept people placed under an inebriates order:

- Rozelle Hospital, Sydney
- Cumberland Hospital, North Parramatta
- Macquarie Hospital, North Ryde
- James Fletcher Hospital, Newcastle
- Morisset Hospital, Morisset
- Bloomfield Hospital, Orange
- Kenmore Hospital, Goulburn.60

2.25 As early as 1932 the Inspector General of Mental Hospitals highlighted the undesirability of placing inebriates with psychiatric patients and urged that the Act's provision for a purpose built facility be expedited. These calls continued throughout the last century.[61]

2.26 The continued placement of people under the *Inebriates Act* in psychiatric facilities is a major focus of the criticisms of the Act which are explored in detail in Chapter 4. As Dr Richard Matthews, Acting Deputy Director General, NSW Health explained:

> the model of care provided in psychiatric hospitals has changed over the past 100 years. People being locked in wards is now a relatively rare event, apart from a small group of very, very mentally ill people [and] another subset of forensic patients. Most wards are open wards with relatively free access and egress for patients. The security required is simply not available … So we have essentially reached the point where we

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57 The Hon JM Creed MLC, Legislative Council, *Hansard*, Vol 94, 13 October 1898, p1401

58 The Hon JM Creed MLC, Legislative Council, *Hansard*, Vol 94, 13 October 1898, p1404

59 MacEvoy MG and Flaherty B, 'Compulsory treatment of alcoholism: the case against', *Drug and Alcohol Review*, 1990, Vol 9, pp267-72, p270

60 Submission 47, NSW Government, p11

61 MacEvoy MG and Flaherty B, 'Compulsory treatment of alcoholism: the case against', *Drug and Alcohol Review*, 1990, Vol 9, pp267-72, p270

> have a custodial system imposed upon a non-custodial system and it simply does not work.[62]

2.27 Dr Martyn Patfield, Medical Superintendent and Director of Acute Care at Bloomfield Hospital, spelled out for the Committee how anachronistic the Act is in this regard:

> The *Inebriates Act* was promulgated at a time when large stand-alone psychiatric hospitals were the main form of delivery of services to psychiatric patients but were also called upon to care for many other categories of people who the general community was either unwilling or unable to tolerate – homeless, epileptics, unmarried mothers, "inebriates" and others. The social changes and approaches to treatment over the last 40 years have been broadly discussed and are widely understood. However, the *Inebriates Act* has not been amended. It is still invoked with the implicit expectation that the facilities, role and capacities (for example, the capacity to contain) have not changed since 1912.[63]

The process by which an order is obtained

2.28 An inebriates order can only be sought by one of the parties stipulated in the Act. The applicant must make an affidavit swearing that the alleged inebriate is a person who habitually uses intoxicating liquor to excess. The application, including a certificate from a qualified medical practitioner indicating that in their opinion the person is an inebriate, is filed in court and listed for hearing. A summons is issued on the person for whom the application has been sought. After hearing from all relevant parties in court, the magistrate makes a decision as to whether an order will be made. Generally, the hearing is held in open court, that is, in public, although provision is made in the Act for the proceedings to occur in private should the judge or magistrate require it.

2.29 If the application is successful, the magistrate completes and signs the order setting out his or her finding that the person is an inebriate, identifying the institution in which the person is to be detained or the person into whose care he or she is to be placed, and naming the period of the order (generally three, six, nine or 12 months, at the discretion of the magistrate). Often the police will immediately transport the person to the relevant institution. If, instead, the order is for a recognizance, that is duly noted, again with the length of the order specified. [64]

2.30 According to the NSW Chief Magistrate, it is extremely rare for an application to be made to the Supreme or District Court. Rather, applications are conventionally made to a magistrate of the Local Court.[65]

2.31 When an application is sought for a person in a rural area where a magistrate does not preside full time and the matter is urgent, for example if the medical certificate indicated that the situation was a matter of life and death, then the person is transported to a court where a

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62 Dr Richard Matthews, Acting Deputy Director General, Strategic Development, NSW Health, Evidence, 11 December 2003, p17

63 Submission 11, Dr Martyn Patfield, Bloomfield Hospital, p1

64 Tabled Document No 1, *Summons and Supporting Documents*; Judge Price, Chief Magistrate, Evidence, 26 November 2003, p5

65 Judge Price, Chief Magistrate, Evidence, 26 November 2003, p2

magistrate is currently presiding. If the matter is not urgent, it is listed for the next date that a magistrate presides in that location.[66]

How often is the Act used?

2.32 The Committee heard from many inquiry participants that the Act is rarely if ever used. Indeed, until our inquiry, many believed that it no longer existed. The Police Association, for example, reported that many police are unaware of the Act and its purpose; others believe it was repealed some time ago.[67] Certainly, the Committee found that the Act is still in use, albeit rarely. It is also clear that use of the Act has declined in recent decades.

Local Court data

2.33 Comprehensive data on the number of applications made and orders granted is not available. In the absence of a manual court by court audit, it is not possible to accurately determine the extent of the Act's use.

2.34 The Chief Magistrate provided the Committee with what information has been collected on applications made to the Local Court between 1 January 2001 and 24 November 2003. This information is set out in Tables 1, 2 and 3 in Appendix 4.

2.35 There are a number of limitations to this data. Information was only available from the 51 local courts connected to the Court's computer system, out of a total of 151 Local Courts across the State. While it is estimated that the data provided by these 51 Courts represents approximately 85 percent of the total of criminal matters dealt with by Local Courts in New South Wales, as inebriates matters are of a non-criminal nature they may not reflect this distribution. In addition, some courts that were captured were 'coming online' during the early period of data collection and thus any cases prior to that point would not have been captured.[68] Finally, the Courts not connected to the computer system are largely in rural and remote areas, and anecdotal evidence before the Committee was that a substantial portion of those placed under the Act are living in country areas.

2.36 In summary, the data available support the anecdotal assertions to the Committee that use of the *Inebriates Act* has been extremely limited in recent times. In the last three years, a total of 37 applications for an inebriates order have been documented, 27 of which are known to have resulted in the making of an order. Of these, 17 were documented as compelling detention in a gazetted hospital. Over the three years, the length of orders ranged from four weeks to seven months, with one order for between six and 12 months. Most commonly, orders were for between one and three months. The applications were made in respect of 16 females and 21 males. In 15 out of the 37 cases, the application was made by the police.

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66 Judge Price, Chief Magistrate, Evidence, 26 November 2003, p4

67 Submission 40, Police Association of New South Wales, p3

68 Tabled Document No 2.2, 'Information provided regarding orders made by the Local Court under the Inebriates Act, 1912: relevant period 1 Jan 2002 to date'

Hospital admissions

2.37 Data on the number of people actually admitted into a gazetted hospital as a result of an order is not centrally collected by NSW Health. Such information might provide a greater sense of the true number of orders made than is captured by Local Court data.

2.38 A number of hospitals volunteered information regarding their admissions to the Committee. Bloomfield Hospital has admitted 25 patients in the past three years,[69] while Rozelle has had nine presentations in that time,[70] and Macquarie Hospital has had six.[71] Cumberland Hospital cites five admissions since the beginning of 2002.[72] The Committee notes that the total of 45 presentations cited by these hospitals is significantly greater than those captured by the Local Court data. Nevertheless, the numbers are still extremely small.

2.39 It appears that Bloomfield receives a higher proportion of admissions under the Act than other gazetted hospitals, probably reflecting greater demand from country areas, where people with serious substance dependence and resulting behaviours are more visible and have less access to the range of services that may assist them.

2.40 More qualitative information on the people being placed under inebriates orders is provided in Chapter 4.

Past use of the Act

2.41 It appears that resort to the *Inebriates Act* has declined over time, markedly so in recent years, although again no comprehensive data allowing a full comparison is available. Here we have pulled together what patchy and impressionistic information is available.

2.42 The Committee understands that use of the Act was greatest during the 1940s, 50s and 60s. Dr John Hoskin, the former Medical Superintendent of Bloomfield Hospital, told the Committee that in the early 1980s there were as many as 90 to 100 people placed at Bloomfield at any time.[73]

2.43 Dr Martyn Patfield, current Medical Superintendent and Director of Acute Services, supplied the Committee with detailed figures of admissions to Bloomfield Hospital over the past 10 years. Between January 1994 and March 2004, there were 125 inebriate admissions, with 20 sent there in 1994, 13 in 2000, 4 in 2003 and 3 in January to March 2004. While the figures show an overall decline, they do rise and fall over the years. Of the total of 125 admissions, 43 were Aboriginal people. The vast majority were aged between 30 and 59 years, with 47 people

69 Submission 11, Dr Martyn Patfield, Bloomfield Hospital, p2

70 Dr Victor Storm, Clinical Director, Central Sydney Area Mental Health Service, Evidence, 27 November 2003, p34

71 Email from Dr Glenys Dore to Senior Project Officer, 13 August 2004

72 Dr Peter Tucker, Medical Superintendent, Cumberland Hospital and Director, Clinical Services (East), Western Sydney Area Mental Health Service, Evidence, 27 November 2003, p35

73 Dr John Hoskin, Psychiatrist and former Medical Superintendent, Bloomfield Hospital, Evidence, 25 March 2004, p9

in their 30s, 31 in their 40s and 22 in their 50s.[74] This information is presented in Table 4 of Appendix 4.

2.44 A 1990 article by Michael MacAvoy and Bruce Flaherty, then of the Directorate of the Drug Offensive in the Department of Health, cites a 1987 telephone survey of gazetted hospitals, which estimated 'fewer than 100' admissions per year under the Act at that time.[75]

2.45 Interestingly, use of the Act appeared to grow substantially in the 1990s. Figures from one institution, Morisset Hospital, were presented at a Corrections Health symposium in 1995. Dr Allan White, a psychiatrist at that facility, stated that in 1985, four people were sent to Morisset under an inebriates order, and ten in 1989. In 1993 that number was 66, and in 1994, 61 were admitted. In the period January to May 1995, 28 people were admitted to Morisset under the Act.[76]

2.46 The draft discussion paper prepared by the then Drug and Alcohol Directorate of NSW Health during its mid 1990s review of the *Inebriates Act* states that in the 1989-1990 financial year there were 95 people admitted to psychiatric hospitals under the Act, and in 1990-1991 there were 105. The same paper states that despite claims to the contrary, use of the Act remained relatively stable over that period. Rather, the demand on some hospitals grew as others closed or contracted available beds for other uses.[77]

2.47 Associate Professor Paul Fanning, Director of Medical Services for the Mid West Area Health Service, told the Committee that after coming to Bloomfield 30 years ago, he witnessed a slow decline during the 1970s in the numbers of people sent as inebriates. That decline became more rapid during the 1980s as a result of the policy decision to separate alcohol and other drug services from mental health services, as well as the de-institutionalisation of mental health services towards community based care. A further reduction in numbers followed the advent of the 1990 *Mental Health Act*. Over time, the diminishing capacity of the mental health system to absorb these clients became clearer to magistrates, and in turn, reduced but did not stop the number of orders:

> Consequently you now have a situation today where magistrates have learnt that there are not many places in New South Wales that will happily take people on inebriates orders, although the magistrates that I have met with over the years … do like to see this as a medical problem, so they are sending people here for treatment. They do not always recognise our incapacity to provide that treatment.[78]

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74 Tabled Document No 25, Dr Martyn Patfield, *Inebriates breakdown of statistics,* p1; Dr Martyn Patfield, Consultant Psychiatrist, Medical Superintendent and Director of Acute Services, Bloomfield Hospital, Evidence, 25 April 2004, p1

75 MacEvoy MG and Flaherty B, 'Compulsory treatment of alcoholism: the case against', *Drug and Alcohol Review*, 1990, Vol 9, pp267-72, p267

76 White A, 'The use and abuse of the Inebriates Act 1912' in *Drug Related Crime: Achieving Better Outcomes in and out of Gaol*, Second Annual Symposium of the Corrections Health Service, Sydney Hilton Hotel, September 21-22 1995, pp1-5, p4

77 Drug and Alcohol Directorate, NSW Health, *Discussion Paper on the Inebriates Act*, unpublished draft prepared 1997

78 Associate Professor Paul Fanning, Area Director, Mid Western Area Mental Health Service, Evidence, 25 March 2004, p8

2.48 In addition, it is very likely that the broad ranging and serious criticisms of the Act detailed in Chapter 4 have undermined the credibility of the Act with both magistrates and a range of stakeholders. Not least among these is the view that the Act is not particularly effective in assisting those made subject to it.

Is the Act primarily used for people with alcohol dependence?

2.49 While the Act explicitly covers habitual users of both alcohol and narcotic drugs, anecdotal evidence is that inebriates orders are primarily sought and made in relation to alcohol. The Chief Magistrate told the Committee that in his experience, and that of the judicial officers of the Local Court he consulted, applications are generally not made in respect of persons using illicit drugs to excess.[79]

2.50 Nevertheless, a number of gazetted hospitals have indicated that in their experience, people using illicit drugs are admitted under the Act; indeed this group is the source of significant problems documented in Chapter 4. In addition, in his 1995 paper, Dr Allan White reported that at that time, the tendency for magistrates to make inebriates orders for people using illicit drugs had increased with the growing prevalence of illegal substance use, along with greater use of plea bargaining for offenders, and the preference for clinical rather than penal placements for Aboriginal people coming before the courts.[80] It is also possible that since the development of diversion programs targeting offenders with substance dependencies such as the Magistrates Early Referral Into Treatment (MERIT) program, the numbers of these clients placed under the *Inebriates Act* has declined. Dr Joanne Ferguson, a psychiatrist specialising in addictions at Rozelle and Concord Hospitals told the Committee:

> I think that in magistrates' minds inebriates orders are associated with alcohol, and there are diversion programs that have been developed that are more appropriate for people who are heroin dependent, and they are more likely to be referred into those systems.[81]

2.51 The circumstances bringing people under the Act are explored in detail in the next chapter.

Outcomes

2.52 As with other information on people placed under the *Inebriates Act*, no data is collected on the immediate or longer-term outcomes for people placed under an order, most notably in relation to their use of substances upon completion of their order. Furthermore, according to Dr Matthews, Acting Deputy Director General, Strategic Development, NSW Health, 'There is no evidence or evaluation that I am aware of or which has ever been conducted into its effectiveness.'[82] In speaking with a range of inquiry participants, the Committee has sought

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79 Judge Price, Chief Magistrate, Evidence, 26 November 2003, p2

80 White AP, 'The use and abuse of the Inebriates Act 1912' in *Drug Related Crime: Achieving Better Outcomes in and out of Gaol*, Second Annual Symposium of the Corrections Health Service, Sydney Hilton Hotel, September 21-22 1995, pp1-5, p3

81 Dr Joanne Ferguson, Staff Specialist Psychiatrist, Drug Health Services, Rozelle and Concord Hospitals, Evidence, 27 November 2003, p39

82 Dr Matthews, NSW Health, Evidence, 11 December 2003, p17

anecdotal information on outcomes for people made subject to the Act. These are documented in Chapter 4.

Related legislation

2.53 Several other New South Wales statutes are relevant to this inquiry as they provide for the involuntary treatment, care or protection of citizens in certain circumstances. The Mental Health Act 1990, Intoxicated Persons Act 1979 and the Guardianship Act 1987 are outlined briefly here and referred to extensively throughout this report.

Mental Health Act 1990

2.54 Under the Mental Health Act, involuntary admission, detention and treatment may occur in respect of persons who are either 'mentally ill' or 'mentally disordered', subject to a highly safeguarded process of examination, decision making and review. The processes and timeframes for decision making about admission and detainment are clearly codified in this Act, as are the rights of patients.

2.55 A mentally ill person is someone who is suffering from a mental illness (that is, a condition that seriously impairs, either temporarily or permanently, their mental functioning, and is characterised by the presence of one or more of a number of specific symptoms) and as a result, there are reasonable grounds for believing that care, treatment or control of the person is necessary to protect them or others from serious harm. Those meeting this definition may initially be detained for five days. Once in hospital, and examined by a requisite two medical practitioners (one of whom must be a psychiatrist) who find that the person is still mentally ill, the person must be seen by a magistrate as soon as practicable, who decides whether detention may continue.

2.56 A mentally disordered person is someone whose behaviour is so irrational that there are reasonable grounds for deciding that temporary care, treatment and control of the person is necessary to protect them or others from serious harm. People meeting this definition may be initially detained for one day; once in hospital they can only be detained for three working days at a time for a maximum of three consecutive three day periods.[83]

2.57 Having used alcohol or other drugs is one of a number of exclusion criteria listed in the Act in order to prevent inappropriate use of the Act's detention powers. Thus people with drug or alcohol dependence alone cannot be compelled into treatment under that Act. However, a person may be made subject to this Act when their substance use worsens an existing mental illness, or as is very often the case in the use of 'mentally disordered' provisions, it induces irrational behaviour. A very substantial proportion of involuntary admissions fall into this latter category, with a person detained for a short period.

2.58 All patients whose detention continues are reviewed by the Mental Health Review Tribunal. The Mental Health Act also makes provision for 'involuntary' care in the community through community treatment orders.

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83 *Mental Health Act 1990*, ss 9 and 10; Centre for Mental Health, *The Mental Health Act Guide Book (Amended May 2003),* NSW Health Department, 2003, p3-6, p25

Intoxicated Persons Act 1979

2.59 While public drunkenness is no longer an offence in itself, under the Intoxicated Persons Act a person who appears to be seriously affected by alcohol or other drugs in a public place may be detained by police if he or she is behaving in a disorderly manner, is likely to cause injury to themselves or someone else, or is in need of physical protection.

2.60 As a first option, the intoxicated person is to be taken to and placed in the care of a 'responsible person' such as an employee of a shelter or accommodation service, or may be taken home. Where this is not possible or practical, for example where there is no appropriate service in the area, or if the person is violent, he or she may be detained at a police station, or in the case of a young person, at a detention centre. The Act stipulates that the person must not be detained in a cell unless it is necessary or it is impractical to do otherwise, and that the person must be released as soon as they are no longer intoxicated.[84]

2.61 An amendment to this Act in 2000 abolished the system of proclaimed places, whereby certain shelters and services generally run by non government agencies also had the power to temporarily detain intoxicated people.

Guardianship Act 1987

2.62 The Guardianship Act provides for temporary or permanent orders enabling substitute decision making for people who, because of a disability (which by definition is enduring) cannot make decisions for themselves. The intent of this Act is that it be used for the purpose of advocacy and maximising freedom, rather than coercion.

2.63 Guardianship orders provide for substitute decision making in relation to medical treatment, care and accommodation, while financial management orders concern the person's finances. In order for a guardian to be appointed, the Guardianship Tribunal must be satisfied first, that the person has a disability by virtue of which he or she is restricted in one or more life activities to the extent that he or she requires supervision or social rehabilitation, and second, that the person is totally or substantially incapable of managing themselves as a result of that disability. Consideration must also be given to a number of rights-based principles. When making a financial management order, the Tribunal must consider the person's capacity to manage their financial affairs and be satisfied that he or she is not capable of managing their affairs, that there is a need for someone else to manage them on their behalf, and that it is in the best interests of the person that the order be made.[85]

2.64 In his submission to the inquiry, the President of the Guardianship Tribunal, Mr Nick O'Neill, has explained that habitual alcohol use and intoxication are not considered a disability. Rather,

> [T]he Guardianship Tribunal's jurisdiction extends only to those people whose alcohol or drug related intoxication has left them with disabilities caused by the damage done to the physical structure of their brain, and often, to other parts of their body.[86]

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84 s 5, *Intoxicated Persons Act 1979*

85 Submission 44, Mr Nick O'Neill, President, Guardianship Tribunal, pp1-4

86 Submission 44, Mr Nick O'Neill, President, Guardianship Tribunal, p6

Compulsory treatment legislation in other jurisdictions

2.65 In keeping with the major focus on non-offenders with substance dependence in this inquiry, a summary of legislative provision for involuntary treatment of that group is set out below.

Australian legislation

2.66 Only Victoria, Tasmania and the Northern Territory have statutes explicitly enabling involuntary treatment for people with substance dependence.

Victoria

2.67 Under Section 11 of Victoria's Alcoholics and Drug-dependent Persons Act 1968 (ADDPA) a court may order a person to be involuntarily admitted to an 'assessment centre' (essentially a detoxification facility) for up to seven days for the purpose of 'assessment and treatment'. Evidence of a registered medical practitioner that the person is 'an alcoholic or drug-dependent person' is required. The person may be detained for a further seven days, either by order of the court or at the discretion of the medical officer in charge of the facility. Section 12 makes further provision for commitment to a 'treatment centre' (for example a residential rehabilitation facility) for an indefinite period. In practice the Act is used to provide emergency detoxification and assessment, after which the person is discharged to the community.[87] Over the five years of 1998-2003, this Act was used in respect of 32 people, in a total of 39 episodes of care.[88]

2.68 Coincidentally, the Victorian Department of Human Services is currently reviewing the ADDPA. As in our inquiry, a primary focus of the review is the appropriateness of coercive treatment for people with severe drug or alcohol dependence.

Tasmania

2.69 Tasmania's Alcohol and Drug Dependency Act 1968 provides for the 'treatment and control of persons suffering from alcohol dependency or drug dependency' in a treatment centre for 6 months, subject to a decision by a tribunal that the person satisfies the definition of drug or alcohol dependence to the degree that detention is warranted and that it is necessary for the person's health or safety, or for the protection of others. Applications must be supported by the recommendation of a medical practitioner. Detention may be renewed for a further period of 6 months. The Act also makes specific provision for application by the person themselves.[89]

Northern Territory

2.70 Section 122 of the Northern Territory's *Liquor Act 1980* enables court-ordered assessment and treatment for a person named in a 'prohibition order'. Such an order may be made in respect of a person who, due to 'habitual or excessive use of liquor, wastes his means, injures or is

87 *Alcoholics and Drug-dependent Persons Act 1968* (Vic)

88 Turning Point Drug and Alcohol Centre, *The Alcoholics and Drug-Dependent Persons Act (ADDPA) 1968: A Review*, prepared for the Victorian Department of Human Services, March 2004, p20

89 *Alcohol and Drug Dependency Act 1968* (Tas)

likely to injure his health, causes or is likely to cause physical injury to himself or to others or endangers or interrupts the peace, welfare or happiness of his or another's family' or who has been taken into custody on three or more occasions in six months. As part of the order the person may be referred to an appropriate body for a physical or mental health assessment, with a report back to the court, or may be compelled to undergo treatment (at their own expense if so ordered). An initial recommendation by a medical practitioner is not required and no time limit on treatment is specified, although the prohibition order remains in force for 12 months or as otherwise specified.[90]

Other States and Territories

2.71 The Australian Capital Territory and South Australia do not legislate for compulsory treatment for substance dependence but do make legislative provision for the short term care and protection of intoxicated persons. Queensland has no equivalent legislation to the *Inebriates Act*; nor does Western Australia, although that State does make some provision for apprehension, involuntary assessment and treatment in certain circumstances under its *Mental Health Act* and *Child Welfare Act*.

International provisions

New Zealand

2.72 New Zealand's equivalent to the *Inebriates Act*, the *Alcoholism and Drug Addiction Act 1966* (ADA Act) is also under review. The ADA Act provides for people with substance dependence to be compulsorily detained for assessment, detoxification and treatment in certified institutions. It allows for both voluntary and involuntary applications, with a significant proportion of orders being voluntarily sought. The maximum period of detention is two years: while an institution is able to discharge a person at any time, the person only has the right to apply for discharge after six months. People are generally detained for up to four months. People may also be released on leave while under an order. This Act is used in respect of around 200 people a year.[91]

Sweden

2.73 The *Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents (Special Provisions) Act 1988* enables people with drug and alcohol dependence to undergo compulsory treatment for up to six months. Under that Act, authorities coming into contact with people misusing substances and placing themselves or others at risk are obliged to intervene. 'Compulsory care' orders are made by a court as a last resort for those in urgent need of assistance who have refused voluntary treatment. Compulsory care is provided in one of 25 state-run special purpose institutions, with an annual throughput of around 1000 people per year. The legislation enables immediate orders to be made by police in urgent circumstances, and these make up around two thirds of applications.[92]

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90 *Liquor Act 1980* (NT)

91 New Zealand Ministry for Health, *Review of the Alcoholism and Drug Addiction Act 1966: A discussion paper for consultation*, March 1999, pp6-7

92 *www.eurocare.org/profiles/Sweden/services.htm* (accessed 23 September 2003); Submission 47, NSW Government, pp20-21

2.74 Young people aged up to 21 are catered for under the *Care of Young Persons (Special Provisions) Act 1990*, whereby compulsory care orders can be made for those who 'expose their health or development to palpable risk of injury through the abuse of addictive substances.'[93] The duration of orders may last as long as it is considered that care is required, or until the person turns 21.[94]

2.75 Use of compulsory treatment in Sweden has reportedly decreased in recent years.[95] This legislation is also being reviewed.[96]

The United States

2.76 Thirty one US states, along with the District of Columbia, have statutory provision for the compulsory treatment of people with substance dependence. In some of these states this is provided for under mental health legislation; in others, statutes exist specifically for drug or alcohol dependent people.

2.77 The criteria for involuntary treatment generally require a court to find that the person is drug or alcohol dependent and that he or she is dangerous to themselves or to others. Various states also allow for immediate detention in emergencies, on the order of a police officer or health official. Others require any detention to be considered by a court. Several make an order conditional on treatment being available and likely to benefit the person. Applications must generally be supported by medical, police and family advice.

2.78 There is also variation with respect to the length of detention. Most states set a limit on the initial period, with 30 or 90 day 'initial limits' common, but some provide for much longer periods, such as Rhode Island which allows for up to three years, West Virginia up to two, and the District of Columbia specifying no limit.

2.79 Commitment is generally made to a drug or alcohol treatment facility, but where no such facility is available, some states allow for the person to be detained in a correctional facility.[97]

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93 *Care of Young Persons (Special Provisions) Act 1990* quoted in Submission 47, NSW Government, p21

94 *Care of Young Persons (Special Provisions) Act 1990* cited in Submission 47, NSW Government, p21

95 Centre for Social Research on Alcohol and Drugs, Stockholm University, *www.sorad.su.se/projverk.html* (accessed 23 September 2003)

96 Submission 47, NSW Government, p21

97 Kitzmann, JH, 'Developments in Mental Health Law: A Survey of Statutes Allowing Involuntary Commitment for Drug and Alcohol Dependent Persons', Institute of Law, Psychiatry and Public Policy, University of West Virginia, Attachment 7 to Submission 47, NSW Government; Submission 47, NSW Government, pp19-20

Chapter 3 Criticisms of the *Inebriates Act 1912*

> The *Inebriates Act* is draconian legislation, with a stigmatising impact.[98]
>
> The *Inebriates Act* in its current state acts as an empty shell, not making available to either Police or family members of inebriates any suitable means of providing treatment to those who desperately require it.[99]

In the previous chapter the Committee outlined the Act's provisions and the social context in which it was introduced over a century ago. The outdated premise of the Act forms the basis for many of the criticisms documented in this chapter, with those criticisms falling into three main areas: the Act's implications for human rights, its legal provisions, and its requirement for detention in mental health facilities. Each of these is explored in the following pages, drawing on the perspectives of a range of inquiry participants. Despite the diversity of interests represented, there is remarkable agreement on the Act's failings. The weight of evidence is that the Act is now an historical relic, sitting most uncomfortably in the present day health and justice systems, to the point where it undermines the capacity for people subject to it to access the assistance that will most benefit them.

The Act's premise

3.1 Many inquiry participants highlighted the anachronistic premise of the *Inebriates Act*, that there is a class of people who need to be controlled simply because they use alcohol or drugs to excess. As the NSW Government submission pointed out, the Act is simply aimed at containing people and limiting their access to drugs, and does not reflect the modern understanding of substance dependence, nor current day approaches to it, which emphasise harm reduction, management of misuse and access to appropriate treatment.[100] Indeed, the Act makes no mention of the treatment that those placed under it are to receive. As Mr Nick O'Neill, President of the Guardianship Tribunal put it:

> [T]he *Inebriates Act* is based on the false premise that confinement in a place where alcohol or drugs are not available, of itself, will help those seriously affected.[101]

3.2 Despite its benevolent intentions, the Act is essentially punitive rather than therapeutic, treating dependence on a legal and widely available drug – alcohol – as if it were a criminal offence, and using 'treatment' as a means of social control rather than for the benefit of the person.[102] Participants such as the Haymarket Foundation and the Network of Alcohol and Other Drugs Agencies (NADA) emphasised that this runs counter to our current understanding of substance dependence as a health issue, not a criminal justice issue.[103]

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98 Submission 36, Law Society of New South Wales, p3

99 Submission 40, Police Association of New South Wales, p12

100 Submission 47, NSW Government, p7

101 Submission 44, Mr Nick O'Neill, President, Guardianship Tribunal, p7

102 Submission 9, The Shopfront Youth Legal Centre, p2; Submission 37, Centacare Sydney, Catholic Community Services, p3

103 Submission 45, The Haymarket Foundation, p2; Submission 29, Network of Alcohol and Other Drugs Agencies, p7

3.3 Participants emphasised that our responses to addiction have improved greatly in recent years, and any legislation in this area needs to reflect that greater sophistication. Best practice in alcohol and other drug services takes an individualised approach, with treatments tailored to particular needs, depending on where the person's substance use falls along the continuum of dependence. According to NADA, the lack of flexibility available under the current Act serves to mitigate against best care for those subject to it. [104]

Human rights

3.4 Implicit in many of the comments on the premise of the Act is a concern for human rights and civil liberties, most especially the rights to liberty, self determination and fair legal process. In turn, these concerns inform many of the criticisms of the specific provisions of the Act that are documented throughout this chapter. A significant proportion of inquiry participants also highlighted the human rights implications of compulsory treatment more broadly. That issue is fundamental to the Committee's inquiry and is explored in detail in Chapter 6.

3.5 The North Coast Regional Coordination Management Group questioned the legitimacy of the Act on the most basic of human rights principles:

> One of the basic tenets of human rights is the freedom from arbitrary detention. The *Inebriates Act 1912* would appear to contravene basic principles of human rights in its arbitrary criteria for involuntary detention and treatment.[105]

3.6 It also noted, as did Professor Terry Carney when he appeared before the Committee, that unlike the *Guardianship* and *Mental Health Acts*, the *Inebriates Act* does not conform to the United Nations *Principles for the Protection and Care of People with Mental Illness* to which Australia is a signatory.[106] These principles ensure that involuntary treatment occurs only in cases that satisfy strict criteria. While drug or alcohol dependence is not a mental illness, the two conditions are broadly comparable, and in Professor Carney's view, that instrument is broad enough to encompass both.[107] Relevant aspects of these principles which the Act appears to contravene include:

- Involuntary treatment may be given only on the condition that an independent authority is satisfied that the person lacks the capacity to consent or unreasonably withholds their consent, and that the proposed treatment is in the person's best interests. Alternatively, it may be given where a medical practitioner determines that it is urgently necessary to prevent imminent harm to the person or others. Such treatment shall not be prolonged beyond that which strictly necessary (Principle 11, paragraphs 6 and 8)
- Involuntary admission may only occur when a person is considered by a medical practitioner to be mentally ill, and as a result, that there is a serious likelihood of immediate or imminent harm to that person or to others, or that failure to admit the

104 Submission 29, Network of Alcohol and Other Drugs Agencies, p5

105 Submission 16, North Coast Regional Coordination Management Group, p2

106 Submission 16, North Coast Regional Coordination Management Group, p2; Professor Terry Carney, Professor of Law, University of Sydney, Evidence, 8 April 2004, p17

107 Professor Carney, University of Sydney, Evidence, 8 April 2004, p17

person is likely to lead to a serious deterioration in their condition or will prevent the giving of appropriate treatment (Principle 16, paragraph 1)

- The right to best available care (Principle 1, paragraph 1)
- Determination of mental illness is to be made in accordance with internationally accepted medical standards (Principle 4, paragraph 1)
- The right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment (Principle 9, paragraph 1)
- Treatment be based on an individually prescribed plan (Principle 9, paragraph 2)
- Treatment be directed towards preserving and enhancing personal autonomy (Principle 9, paragraph 4)
- Involuntary admission or retention shall initially be for a short period a specified by domestic law for observation and preliminary treatment pending review (Principle 16, paragraph 2)
- Various other provisions for review, procedural safeguards, access to information and complaints (Principles 17, 18, 19 and 21).[108]

3.7 Those working in the mental health system, familiar with safeguards and provisions under the *Mental Health Act 1990*, readily noted the contrast between the two Acts. Reverend Rennie Smith, Uniting Care Chaplain at a gazetted hospital, stated in his submission:

> The lack of clarity about legal responsibilities and human rights should be reason enough to overhaul the *Inebriates Act* to bring it in line with ground breaking reforms represented within the current Mental Health Act that was introduced in the 1990s.[109]

3.8 Many of these human rights concerns are focused on the processes required by the Act, and are detailed in following sections. These concerns are, moreover, long held. When reviewing the 1958 *Mental Health Act*, Dr G Edwards noted that the *Inebriates Act*:

> contained very broad commitment criteria … There was no onus on the judge or magistrate to satisfy himself that the person was unable to manage his affairs as was required when determining unsoundness of mind under the Lunacy Act. As well, there was certainly no requirement for the judge or magistrate to consider issues of dangerousness to self or others when making an order.[110]

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108 United Nations, *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, Adopted by General Assembly Resolution 46/119 of 17 December 1991

109 Submission 41, Uniting Care NSW ACT, p2

110 Edwards GA, Mental illness and civil legislation in New South Wales, MD Thesis, University of Sydney, quoted in MacAvoy MG and Flaherty B, 'Compulsory treatment of alcoholism: the case against', *Drug and Alcohol Review*, 1990, Vol 9, pp267-72, p268

Disproportionate use in relation to Aboriginal people

3.9 A further aspect to the human rights concerns is one expressed by many stakeholders over the years, that the Act is used disproportionately against Aboriginal people.[111] It is also seen to be used excessively in relation to people of marginalised socio-economic status and people in rural areas.

3.10 Anxieties that the Act is a vehicle for discrimination against Aboriginal people were particularly strong, and are apparently justified in light of the figures from Bloomfield cited at the end of the previous chapter, which showed that over one third of inebriates admissions in the last ten years were Aboriginal people. Participants were also very concerned that the Act enables prolonged detention in contradiction of recommendations of the Royal Commission into Aboriginal Deaths in Custody, and in spite of the broad understanding that incarceration is personally and culturally traumatic for Indigenous people. Similarly, stakeholders noted that there is inadequate provision for culturally appropriate service provision under the Act.[112]

3.11 Representatives of gazetted hospitals shared these concerns. Associate Professor Paul Fanning of the Mid Western Area Health Service told the Committee that Aboriginal people sent to gazetted hospitals tend to isolate themselves and experience their order as incarceration:

> So for Aboriginal people, coming to Bloomfield is as big a problem now as it was 30 or 40 years ago. The stigma is still greater. They see it in a way that they are coming in to do time and they are being locked up. They do not see themselves necessarily as coming here for treatment.[113]

Legal provisions

3.12 Many aspects of the specific provisions of the Act have been criticised. These include the absence of meaningful criteria, its overly judicial decision making process, its inadequate safeguards, practical unworkability, the inability to enforce orders, and a range of obsolete or outdated provisions. These are dealt with in turn below.

Definition and criteria

3.13 The term 'inebriate' is itself anachronistic and value laden. A number of participants pointed to the Act's broad definition of 'an inebriate' based simply on using substances 'to excess'. The NSW Government's submission notes that this definition could potentially apply to a substantial number of people.[114] As Dr Stephen Jurd, Addictions Psychiatrist and Area Medical Director, Drug and Alcohol Services, Northern Sydney Health told the Committee, 'theoretically I could get drunk for the next three weekends and I could go in under the *Inebriates Act*.' An appropriate definition would be highly targeted, clinically based and include

111 Supplementary Submission 43, Emeritus Professor Ian Webster AO, Chair, NSW Expert Advisory Committee on Drugs, p3

112 Tabled document No 7, *Responses to proposed questions*, p4

113 Associate Professor Fanning, Area Director, Mid Western Area Mental Health Service, Evidence, 24 March 2004, p8

114 Submission 47, NSW Government, p8

a time dimension, he suggested.[115] Mr John Feneley, Assistant Director General of the Attorney General's Department, also observed the potential for inappropriate orders, noting that the definition does not assist magistrates to distinguish between someone who is temporarily intoxicated and a person who has a severe and chronic condition.[116] Participants such as the North Coast Regional Coordination Management Group were concerned that this broad definition means that the Act is open to abuse, whether 'maliciously or by well-meaning misinformed people'.[117] Clear criteria focusing on those at serious risk would both assist decision makers and help obviate misuse of such legislation.

Decision making process

3.14 Clearly, the decision to detain someone for treatment against their will is a serious one and the decision making process needs to be fair, transparent and effective in furnishing desirable outcomes for those subject to it. Many criticisms were levelled at this aspect of the Act.

3.15 There was broad agreement among legal and health stakeholders that the Act's provision for decision by a magistrate with minimal medical input was most undesirable. Dr Peter Tucker, Clinical Director of Mental Health Services for Western Sydney Area Health Service, highlighted the 'fundamental incongruity' in a court of law prescribing medical treatment.[118]As Legal Aid NSW put it:

> All that is required is a certificate of a medical practitioner that the person is an inebriate, together with the corroborative evidence of one other person, and personal inspection of the inebriate by the Magistrate. There is no requirement that the medical practitioner have any specialist qualifications, and very little guidance is provided to the medical practitioner by the definition of inebriate in the Act. There is no requirement for the medical practitioner to certify that the inebriate will benefit from an order being made.[119]

3.16 Both the Attorney General's Department and NSW Health echoed this concern,[120] with the former pointing to the need to carefully assess the person's health and other circumstances and ensure that they satisfy appropriate benchmarks:

> It does not address the broader issues such as whether people are incapable of taking care of their own affairs, whether their health problems in the short and long-term may be danger to themselves and bring about their likely death, and whether they are a danger to themselves in some other way or to family members. It does not address in any holistic way the [individual's needs].[121]

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115 Dr Stephen Jurd, Medical Director and Addictions Psychiatrist, Drug and Alcohol Services, Northern Sydney Health, Evidence, 4 March 2004, p2

116 Mr John Feneley, Assistant Director General, Policy and Crime Prevention, Attorney General's Department, 11 December 2003, p3

117 Submission 16, North Coast Regional Coordination Management Group, p1

118 Submission 33, Western Sydney Area Health Service, p33

119 Submission 46, Legal Aid NSW, p5

120 Submission 47, NSW Government, p8

121 Mr Feneley, Attorney General's Department, Evidence, 11 December 2003, p 3

3.17 The Chief Magistrate indicated that the current provisions are undesirable for magistrates as well. For example, while the length of an order is determined on the evidence, there are no guidelines for how this is to be done, so it is a matter of the magistrate's discretion.[122] As such decisions are weighty and have significant consequences for the individual concerned, it is critical that they be transparent and consistent.

3.18 Like psychiatrist Dr Joanne Ferguson,[123] the Chief Magistrate also questioned the desirability of a court-based process which can be disempowering and embarrassing for the person and their family:

> One of my criticisms of the *Inebriates Act* is that it is a court-based application … In my view it is a very difficult process for both the inebriate and those who care for and are concerned for 'the inebriate' … there is a better and more sympathetic way for the justice system to deal with people who have essentially what is a medical problem.[124]

3.19 The Act's establishment of magistrates as all-powerful in this decision making process is the source of great frustration for the administrators and clinicians of psychiatric hospitals where people under an inebriates order are placed. Magistrates are not required to consult with a hospital before committing a person to be detained there for a lengthy period. Already facing high demand for beds, facilities are then forced to immediately make one available for someone outside their client group. For these administrators, this seems highly unreasonable and impacts on their duty of care to other patients. [125]

3.20 Just as the treating doctors have no role in the decision to detain a person, they also have no ability to discharge them:

> Clinicians have no control over the *Inebriates Act*. The only way the Act can be revoked is by taking the matter before the Magistrate at the local court and having him or her revoke the Order. This means that if there are problems with someone under the *Inebriates Act*, clinicians are unable to exercise any clinical judgement about the person's placement or discharge from the hospital. For example, if someone … is clearly unable to respond to a treatment plan, and is threatening other mentally ill patients on the unit because of antisocial behaviour, it is not possible to discharge that patient from the hospital without going to the local court to ask for the Order to be revoked. There is also no guarantee the Magistrate will agree … [126]

3.21 Several mental health administrators agreed it can be very difficult to have the magistrate reverse the decision, as well as very time consuming. Associate Professor Paul Fanning of Bloomfield Hospital told the Committee:

> The magistrates do not want to rescind the order. If they have sent someone here for six months they do not want that person necessarily to be out of here before six

122 Judge Price, Chief Magistrate, Local Court of New South Wales, Evidence, 26 November 2003, p5

123 Dr Joanne Ferguson, Staff Specialist Psychiatrist, Drug Health Services, Rozelle and Concord Hospitals, Evidence, 27 November 2003, p41

124 Judge Price, Chief Magistrate, Evidence, 26 November 2003, p3

125 Submission 50, NSW Chapter on Addiction Psychiatry, p1; Submission 33, Western Sydney Area Health Service, p2; Dr Victor Storm, Clinical Director, Central Sydney Area Mental Health Services, Evidence, 27 November 2003, p35

126 Submission 35, Dr Glenys Dore, Northern Sydney Health, p3

> months because of [the difficulty the person's behaviour is causing for their home community.] They believe this is the best place for treatment. We therefore end up chasing magistrates across the State trying to find the one who gave the order. We try to convince them into giving a rescission. When push comes to shove sometimes they co-operate but sometimes they say, "No way. That patient is in the right place."[127]

3.22 Receiving hospitals also reported that referrals from magistrates are generally marked by poor communication, with supporting documentation that might assist treatment being extremely rare. Dr Patfield of Bloomfield Hospital told the Committee, 'Of the 20 [most recent admissions] I have been through there was only one where the supporting affidavits came with the order'; sometimes not even the order is supplied.[128] This creates a sense for the hospitals that the motivation for orders is not so much the person's health and welfare as containment.

3.23 Other problems associated with the placement of people under inebriates orders in psychiatric hospitals are documented in a later section of this chapter.

Poor safeguards

3.24 Underpinning the range of criticisms about criteria and decision making is the widespread concern that there should be strict safeguards to protect the rights of people subject to compulsory treatment. The absence of procedural protections in the *Inebriates Act* was a prominent concern for representatives of the Attorney General's Department:

> … if someone is not an offender today and there is otherwise no reason for them to be brought to the attention of authorities, then anything that looks like denying them their liberty, even for a short period of time, needs to have some strict safeguards put around it.[129]

3.25 Unlike in the *Mental Health Act*, the people's rights are very limited and do not form the basis for the *Inebriates Act*'s provisions. Some participants emphasised the vulnerability of substance dependent people to abuse of the Act, especially in the light of the stigma of dependence and the impact the person's behaviour may be having on their family or community.

3.26 The Committee was told of several instances where people's rights were compromised under the Act. Hospital Chaplain, the Reverend Rennie Schmid told us that one of the people he had supported was placed under an order for 12 months by his brother and sister (see case study of Barry later in this chapter). Rather than being concerned for Barry's best interests, he believed they were motivated by embarrassment and a desire to have him out of their lives for a time. Also, while the Act stipulates that 'The inebriate shall be afforded an opportunity of being heard in objection',[130] Reverend Schmid reported that this man was given no such opportunity. The Committee was concerned when an Aboriginal man we spoke with who was under an order at that time told us he had no idea how he came to be at the hospital or why

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127 Submission 11, Dr Martyn Patfield, Bloomfield Hospital, p2

128 Dr Martyn Patfield, Consultant Psychiatrist, Medical Superintendent and Director of Acute Services, Bloomfield Hospital, Evidence, 25 April 2004, p3

129 Mr Feneley, Attorney General's Department, Evidence, 11 December 2003, p7

130 The Act, s3(3)

he was sent. After he appeared in court the police came and picked him up, and out of curiosity he went with them, only to find himself in a paddy wagon and on his way.[131]

3.27 A number of participants such as Dr Glenys Dore of Macquarie Hospital highlighted the absence of a review mechanism under the Act:

> There is no review process. The only review process is if the patient asks for the order to be appealed and it is placed back before the magistrate. But nobody else has any control over that order. There is no tribunal. For example, with the *Mental Health Act* we would have the Mental Health Review Tribunal that would come in at specified periods and there would be a hearing, the case would be put by both the patient, their legal representative, their family and the treating clinicians about whether it was appropriate for that person to stay in hospital or not stay in hospital. There is no forum to do that under the *Inebriates Act* unless you specifically request to go back to court.[132]

3.28 In addition, Dr Ferguson told us that unlike the *Mental Health Act*, which is clear that staff are required to contain patients and that this may, where necessary, involve use of physical restraints, the responsibilities of staff are not articulated in the *Inebriates Act*. As a consequence, some are concerned that they may be considered to have acted inappropriately if they do restrain someone.[133]

Cumbersome to use

3.29 As well as the widespread concerns about the decision making process required under the Act and the absence of safeguards, many participants reported that the process of seeking an inebriates order is cumbersome, extremely inefficient and frustrating. The Police Association and various drug and alcohol and mental health service providers all testified to this protracted and complicated process, which involves ensuring that the necessary paperwork is completed by the individuals stipulated and then having the matter listed for court. While these requirements are being met, the person often remains in the community, not getting the help they need and potentially continuing to place themselves or others at risk. When the matter comes before the magistrate, the person may be unable to be located, with the hearing continuing in their absence. It then becomes the responsibility of the police to act on the order when the person is found.[134] Clearly, the process works against the timely response required in situations of crisis. Several participants told us, moreover, that because the process is so unworkable it means that the Act is invoked less than it might be.[135] As one rural drug and alcohol worker told us about a case that she had observed:

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131 Confidential evidence

132 Dr Glenys Dore, Addictions Psychiatrist and Deputy Medical Superintendent, Macquarie Hospital, 4 March 2004, p4

133 Dr Ferguson, Rozelle and Concord Hospitals, Evidence, 27 November 2003, p41

134 Submission 40, Police Association of New South Wales, p4; Submission 35, Northern Sydney Health, p4; Submission 22, Alcohol and Drug Information Service, p5

135 Submission 40, Police Association of New South Wales, p4; Mr John Williams, Senior Project Officer, Aboriginal Health and Medical Research Council, Evidence, 27 November 2003, p8

> The feedback that I got showed it was just not worth all the rigmarole - the doctor, the family and the magistrate's hearing. It just was not worth it in the end.[136]

3.30 The following case study provided by Ms Leonie Jefferson, Senior Aboriginal Drug and Alcohol Counsellor with the Northern Rivers Area Health Service, highlights the potential consequences when the necessary cooperation of all parties is unable to be secured.

Tom

Tom was a 45 year old Aboriginal man, whose first contact with me was at a previous service in Sydney. This man had a long history (over 10 years) of heroin dependence, with occasional periods on low dose methadone. When I encountered Tom in the Northern Rivers, he was drug free and stable, living with his long-term partner, who had no history of dependent drug use. About 12 months after this encounter, I spoke to Tom in Nimbin, still drug free, from my observation and his statement. Soon after this meeting, Tom began to drink heavily, and was eventually homeless and living on the streets in Nimbin. He rapidly lost any control over his substance use, and was consuming anything he could buy legally (including methylated spirits) or illegally (heroin and methadone). Attempts were made to get him into treatment, and away from the environment, by invoking the *Inebriates Act*, initiated by Nimbin needle and syringe program workers. This met with some difficulty, as the local police had (I'm told) used their transport budget, and this was the only way to transport Tom to Morisset, near Newcastle, which was the only clinic that functioned within the *Inebriates Act*. Two weeks after the moves to invoke the Act were initiated, Tom was found dead by opioid overdose beside the local river.

Inability to enforce orders

3.31 The inability to obtain a timely order was linked to a further issue of the inability to enforce orders that are made. The Chief Magistrate highlighted this problem at the Alcohol Summit and when he appeared before the Committee. As the Act makes no provision for the Court to enforce an order, if a hospital refuses to admit a person under an inebriates order, the Court's hands are tied; it has no sanctions to force the hospital to comply. Similarly, the Act contains no penalties for non-offenders who break a recognizance made under the Act. The Chief Magistrate's strong concern is that when an order of the local court is rendered ineffectual in this way, which the Act is powerless to prevent, the justice system is undermined.[137]

3.32 From the perspective of a number of inquiry participants, this situation prevents people from obtaining necessary interventions. In his submission, Mr Tim O'Neill of the Wagga Wagga Command of the Police Service, cited a recent example of having sought an order for a woman with alcohol related brain damage. While the magistrate made the order, police were advised that none of the gazetted hospitals would detain her - he was told the woman would 'come in through the front door and be let out the back door' - and she was also refused admission to the local hospital. The Police were very dissatisfied that, having sought and gained a remedy to assist a very vulnerable person, it could not be carried out.[138] Similarly, alcohol and other drug workers such as Mr Owen Atkins reported that it was not uncommon

136 Ms Beth Burton, Clinical Nurse Consultant, Alcohol and Other Drug Services, New England Area Health Service, Evidence, 24 March 2004, p11

137 Judge Price, Chief Magistrate, Local Court of New South Wales, address to the NSW Summit on Alcohol Abuse, Report of Proceedings, Second Day, 27 August 2003, p13; Judge Price, Chief Magistrate, Evidence, 26 November 2003, p5

138 Submission 19, NSW Police Service, Wagga Wagga Command, p2

for the person to return home quickly as they were not in any real sense detained. Again this frustrates workers, especially after the taxing process of actually obtaining an order.[139] Ms Vi Hunt, Area Coordinator, Alcohol and Other Drug Services, New England Area Health Service, told the Committee of how she was involved in obtaining an order on two occasions for a woman who was seriously ill and at risk as a result of substance dependence and mental illness:

> On both occasions [the hospital] had the Act revoked and they sent her on the next train home. So from my experience it was difficult. We could go through the process, get somebody under the *Inebriates Act* and into treatment, but when we got that person there, there was just not a capacity or a willingness to keep that person there.[140]

3.33 For some inquiry participants such as the Police Association there is a strong belief that the Act is ineffective in providing an important safety net for people at significant risk of harm.[141]

Inflexibility

3.34 As well as being cumbersome, from the perspective of the magistracy the Act is also inflexible. The Chief Magistrate pointed to the 'legal gymnastics' sometimes required for magistrates to effect an order for a particular person. If, for example, a suitable service or facility which is not a gazetted hospital is found for a person, but they are to be treated for more than 28 days, this is not technically permissible under the Act. Similarly, a private hospital, which is not classed as a 'prescribed residence' under the Act, is not able to prevent an inebriate from leaving the facility. As well as working against arrangements in the best interest of the person, according to the Chief Magistrate, this can also lead to legal arguments and does not make for an efficient and effective court system.[142]

Offender provisions

3.35 Perhaps reflecting the practical irrelevance of the Act for the current criminal justice system, few participants made specific criticism of the Act in relation to offenders.

3.36 In its 1996 review of sentencing provisions in New South Wales, the Law Reform Commission recommended the repeal of all aspects of the *Inebriates Act* that have a bearing on sentencing. In the Commission's view, the Act enables punishment disproportionate to the criminality of an offence, and when this does not occur, the Act provides no more than is available to a sentencing court anyway.[143] In its submission to this inquiry the Law Society noted its support for the Commission's recommendation.[144]

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139 Submission 2, Mr Owen Atkins, p2

140 Ms Vi Hunt, Area Coordinator, Alcohol and Other Drug Services, New England Area Health Service, Evidence, 24 March 2004, p11

141 Submission 40, Police Association of New South Wales, p12

142 Judge Price, Chief Magistrate, 26 November 2003, p10-11

143 NSW Law Reform Commission, *Sentencing*, Report 79, December 1996, pp233-235

144 Submission 44, Law Society of New South Wales, p3

3.37 The Attorney General's Department advised the Committee that the offender provisions 'may at some stage have been used as an option for sentencing people to treatment rather than imprisonment, but have not been used for many years'.[145] The Department of Corrective Services has no record of any offender, among all those received into custody in NSW, incarcerated under the Act since the mid 1980s; Corrections Health is also unaware of any use of the Act's offender provisions in recent years.[146]

3.38 There was broad agreement among the Attorney General's Department, Department of Corrective Services and Chief Magistrate that these aspects of the Act are obsolete and better dealt with under other legislation.[147] The Chief Magistrate noted that section 11 of the Act, which forms the basis for the offender provisions, goes back to the time when public drunkenness was an offence, which it ceased to be in 1979. As he succinctly put it to the Committee, 'The law has moved on.'[148]

Other provisions

3.39 Various inquiry participants noted a number of further obsolete, rarely used or undesirable provisions in the *Inebriates Act*:

- Recognizances have little credibility as an effective tool for addressing serious substance misuse[149]
- There is no supervising board, as required under section 29, currently in operation
- Section 18 enables a court to order that the expenses associated with the care, charge and maintenance of an inebriate be paid out of his or her property
- The financial penalties provided in sections 21, 25 and 26 are out of date and probably unnecessary[150]
- The state institutions for 'inebriates convicted of certain offences' provided for in section 13 were never established
- There are outdated references to the *Vagrancy Act 1902*, the *Lunacy Act 1898* and to 'release on license'.[151]

145 Submission 47, NSW Government, p12

146 Submission 47, NSW Government, p12

147 Submission 47, NSW Government, p15-16; Judge Price, Chief Magistrate, Evidence, 26 November 2003, pp7-8

148 Judge Price, Chief Magistrate, Evidence, 26 November 2003, pp7-8

149 Judge Price, Chief Magistrate, *NSW Summit on Alcohol Abuse: Report of Proceedings*, Second Day, Wednesday 27 August 2003, p13; Submission 9, Shopfront Youth Legal Centre, p2

150 Submission 47, NSW Government, p9

151 Submission 36, Law Society of New South Wales, p2

Detention in mental health facilities

3.40 Much has been said throughout this inquiry about the inappropriateness of the Act's provision for compulsory treatment for alcohol or other drug dependence to occur within psychiatric hospitals. Clearly, this longstanding fundamental problem must be addressed.

3.41 The Committee has found that there is universal agreement that psychiatric hospitals are an inappropriate setting for the detention and treatment of this group. In its submission to the inquiry the Government formally acknowledged the need to address this issue:

> NSW Health considers that the psychiatric institutions which are in the schedule of gazetted institutions for compulsory treatment of non-offenders under section 9 of the Act are not suitable repositories for such persons.[152]

3.42 For the Chief Magistrate these placements are no less problematic, but as he told the Committee, 'the courts have no alternative under this legislation'.[153] As noted in Chapter 2, the model of care now operating in mental health facilities is vastly different to that when the Act was passed, and indeed mental health facilities were never seen as an appropriate environment for the Act's purpose.

3.43 Inquiry participants told us that there are several aspects to this problem in the present day. First, the Act places psychiatric hospitals in the invidious position of having to contain people for long periods for whom they do not offer appropriate services and requires them to fulfil a custodial role that they are not necessarily equipped for. In addition, mental health facilities have become highly specialised environments that cater to people with severe mental illness, particularly chronic schizophrenia, and generally do not provide the specialised services required by people with severe substance dependence:[154]

> Because the numbers of Inebriates are small (usually one or two patients at any one time), it is not possible to channel limited psychiatric resources into developing specialised programs for them. They cannot be sent elsewhere for programs because no other treatment services are able to accept them under the *Inebriates Act* … The treatment environment of a large psychiatric hospital does not meet the standards of best practice for someone who is detoxifying and in recovery from an addiction disorder. Ideally, those under the Act should be placed with other patients with addictive disorders in a low stimulation environment, not with patients who are psychotic and severely mentally unwell.[155]

3.44 Thus these hospitals are unable to fulfil the right to quality treatment that is implicit in ethically sound involuntary care, and the Act itself prevents the making of more suitable arrangements. The case study of Barry on the following page powerfully illustrates how inappropriate and ineffective such placements can be, and indeed how they may actually undermine recovery.

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152 Submission 47, NSW Government, p17

153 Judge Price, Chief Magistrate, Evidence, 26 November 2003, p10

154 Dr Dore, Macquarie Hospital, Evidence, 4 March 2004, p3; Submission 47, NSW Government, p18

155 Submission 35, Northern Sydney Health, p2

Barry

Barry was placed in a psychiatric facility for 12 months under the *Inebriates Act 1912*. He was presented to a magistrate by his sister and brother and a member of the police force. Barry had been taken from a general hospital to the court after receiving intensive care for a coma that had resulted from his abuse of alcohol. Medical authorities had not expected him to recover. His alcoholism was well documented and he admitted he was an alcoholic and would drink anything when he was on a binge. He had no history of violence and no charges against him; nor was he mentally ill. Barry felt he had been disadvantaged by his family bringing him before the magistrate while he was physically and emotionally weak and disoriented from his near-death experience.

After some time at the hospital, Barry was given leave and allowed to make day trips as his condition improved and as is normal practice within the mental health system. During one of these excursions he was devastated to learn of the death of a good friend. He again turned to alcohol. Under pressure from Barry's sister and brother and the threat of legal action the hospital placed him in a locked ward for severely mentally ill people. He stayed there for the remainder of his sentence, over 250 days. During this time he was unable to find a way for his circumstances to be reviewed within the legal system.

The hospital felt constrained by the law to keep him in the locked ward. Barry often expressed his concern at the level of violence he witnessed in other patients and felt he always had to be on guard. He also found it difficult to communicate with those who were constantly disordered, delusional or hallucinating. Barry became lonely and had to develop ways of protecting himself and his belongings.

As a high functioning person, Barry found the rehabilitation programs on the ward inappropriate and not useful. He retreated into reading books. As time went on he became frustrated as he saw fellow patients move into open wards despite behaviours that were well below his level of functioning. He felt trapped by the ward and the lack of rehabilitation opportunities he had there. The ward had become his prison. His situation added anxiety and depression to an otherwise model patient.

With support from the social worker and other staff, Barry tried to initiate his own rehabilitation program. However, drug and alcohol services would not visit him in hospital, as they required clients to attend their offices. The hospital administration were reluctant to allow Barry to attend Alcoholics Anonymous (AA) because they were unsure whether they had a legal obligation to keep him within the hospital. They were also concerned that they did not have sufficient staff to escort Barry to AA. At the same time, Barry was concerned about the anonymity of AA meetings and that it may not be acceptable for staff to sit in on them. Attempts were made to try and get him into a training program, but again this was frustrated by the legal ambiguity of letting him attend classes in the community. The Housing Department had concerns about providing accommodation because Barry would not be under a mental health community treatment order or rehabilitation plan after his twelve month order was completed.

As the time approached for Barry's release, it became clear that the hospital would not be able to offer any support after he left the facility's care. The Department of Housing did provide resources for some trial accommodation. Various staff gathered furniture and other equipment to help support Barry. Once free of hospital, he could attend counselling with drug and alcohol services and pursue educational opportunities through the Commonwealth Rehabilitation Service. The hospital chaplain was the only staff member who could appropriately continue support in the community.

In the end, Barry was imprisoned in the hospital without a formal rehabilitation plan that could be sustained into the community. After being sober for the best part of a year, he re-entered the community with some human support, shelter and food, but with the same vulnerabilities that he had when he was first placed in the hospital.

Barry struggled for about three months to establish himself in the community. He slipped once, but recovered quickly with support. He seemed to cope through AA, drug and alcohol counselling and regular pastoral support. One weekend his addiction again took hold. He consumed four bottles of methylated spirits and died in the loneliness of his flat.

3.45 The two people under inebriates orders with whom the Committee spoke appeared to be simply being housed and were not able to access programs that they themselves thought would assist them to deal with their dependence. They were also extremely bored, with no meaningful activities to occupy their time.[156]

3.46 In addition, the Act is fundamentally at odds with the philosophy underpinning the mental health system:

> The whole ethos of mental health institutions is towards wellness and to identify and offer support to patients as they take charge of their lives. Staff use containment only when the patient is at risk of self harm, harming other people, or that a person's reputation is at risk as a result of their illness. Consequently, mental health institutions are NOT run like prisons. The emphasis is on promoting freedom and self responsibility as soon as a person recovers from their illness or is appropriately managed through a rehabilitation plan. Community support is defined and enacted as a duty of care and as a natural outcome of the rehabilitation process … Hospitals are not gaols. The staff is not trained and the facilities are not designed to respond to criminal containment. Patients are vulnerable.[157]

3.47 Further, the placement of people under inebriates orders exacerbates the shortage of mental health beds. Dr Peter Tucker of Cumberland Hospital has estimated that a single referral under the Act for 3 months prevents up to 25 acutely ill psychiatric patients from accessing inpatient treatment.[158]

3.48 Each of the representatives of gazetted hospitals we spoke to questioned the appropriateness of many orders and the capacity of the system to benefit those subject to them. The perceived effectiveness of the Act is explored in detail in Chapter 4. Dr Tucker gave an example, pointing also to the negative effects that such a heavy handed Act can have on motivation:

> A man in his sixties was given a three-month order … This person was plausible and denied a serious drinking problem. He was reluctant to take anti-craving medication and felt that he could control his drinking. He normally lived with a close family member, to whom he paid rent. He is an example of somebody who just sat there for three months. He had no insight or motivation to go anywhere with his treatment.[159]

3.49 Various administrators also emphasised the 'poor fit' between those sent under inebriates orders and the models of care operating in psychiatric hospitals, such that they are mixed with other patients in ways that are not ideal for anyone.[160] Of particular concern to the Committee are reports that some people under an order have placed the wellbeing and safety of other patients at risk. Representatives of two hospitals reported that people under an inebriates order had supplied illicit drugs to other patients (whose illness might be adversely affected by

156 Confidential evidence

157 Submission 41, Rev Rennie Schmid, Uniting Care NSW ACT, pp2-3

158 Submission 33, Western Sydney Area Health Service, p2

159 Dr Peter Tucker, Medical Superintendent, Cumberland Hospital and Director, Clinical Services (East), Western Sydney Area Mental Health Service, Evidence, 27 November 2003, p35

160 Associate Professor Fanning, Mid Western Area Mental Health Service, Evidence, 24 March 2004, p8

these substances) and one reported allegations of a sexual assault.[161] In his submission, Dr Patfield stated:

> A more serious issue, however, is the detrimental effect that such patients can have on the care of other patients. A number of these patients have brought drugs into the hospital and many are disdainful of the hospital and its staff and choose not to behave in a considerate and reasonable manner. This has a dreadful effect on staff morale and produces a disheartening environment for mentally ill patients who are in hospital for treatment rather than containment. They have been sent because their behaviour has not been tolerated in their home communities but they are sent to a place where they reside with some of the most vulnerable members of our society.[162]

3.50 Dr Patfield gave the committee an example:

> One of them is an example of someone who was a particular danger to the hospital. He was a young fellow of about 25 who had had five recent admissions to the hospital under the *Mental Health Act* … as being mentally disordered. That was usually after violence and agitation, probably as a result of speed or overdoses. He was sent down from a major town in our catchment area always after he had been threatening and aggressive towards people - usually hospital staff. He was sent down as [mentally disordered] and he quickly became quite rational again. As per the requirements of the Act he was discharged very quickly. He had been repeatedly very threatening to hospital staff in the town from which he came. Eventually an inebriates order was secured. This man's drugs were heroin and cocaine … He arrived here, absconded the next day from the ward and was returned by police. During his stay there were considerable fears for the safety of one patient, because this fellow was constantly threatening and intimidating him. He made numerous threats to kill staff. During his stay there was an allegation of sexual assault by a woman who had been admitted six weeks after delivery with post-partum depression. We do not know whether or not he did sexually assault her; we think he probably did. He was dealing with his associates over the back fence of our special care unit. Eventually, because he was well connected in the town where he had come from, he secured a stay of his inebriates order. Luckily, he went after one week, because we were starting to have industrial problems as he was so dangerous to staff here. After he was discharged the hospital was very heavily criticised by health staff at the referring hospital because they felt that we had not kept him secure enough; therefore, their staff were at risk. But they did not seem to pay much attention to the safety of our staff and patients. It was a very frightening time for us.[163]

3.51 The case study of Michael on the following page illustrates the contorted process one hospital had to use to have a patient removed because of the risks he posed to other patients.

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161 Dr Dore, Macquarie Hospital, Evidence, 4 March 2004, p1; Dr Patfield, Bloomfield Hospital, Evidence, 24 March 2004, p2

162 Submission 11, Dr Martyn Patfield, Bloomfield Hospital, p2

163 Dr Patfield, Bloomfield Hospital, Evidence, 24 March 2004, p2

Michael

Michael was sent to a psychiatric hospital under the *Inebriates Act* for three months because he was drinking very heavily, committing petty crimes and being a public nuisance. He started out in the acute care unit, and was assessed to see if he could be placed in an open ward for people with schizophrenia. The only other option was for him to be placed in a locked ward for people with long term, serious mental illness, but the hospital was at pains to avoid that, as they saw it as an extremely inappropriate place for Michael, who did not have alcohol related brain damage and did not have another major mental illness.

After the initial detoxification period, he went to the open ward. According to the hospital, the difficulties that quickly arose were based on the fact that he had no mental illness but had to live with almost twenty young people who were experiencing psychosis, and thus were often hallucinating, thought disordered, difficult to talk to, and were generally mentally unwell. Michael did not feel that he had anything in common with them, and was very derogatory towards them, calling them morons and so on. All the hospitals programs were geared towards that patient group, and he understandably did not feel that the programs were helpful for him. The hospital tried to accommodate his needs by arranging for him to attend Alcoholics Anonymous, which was helpful.

According to the hospital, Michael did pretty well in the ward in terms of his drinking. While he could come and go from the ward, and there was a bottle shop nearby, breathalyser tests showed that he wasn't drinking. But soon reports came in from a number of the young patients independently, saying that Michael was dealing drugs on the unit. He was bringing marijuana into the unit and selling it to the patients with schizophrenia. The hospital was very distressed to hear of this, in light of the well known effects that cannabis can have in triggering psychosis. Despite a number of the patients having complained about this, none wanted to lay a complaint or to be named, so the hospital could not ask the police to become involved. Nor could they remove him from the hospital because he was under a three-month order. As a last resort he was transferred to the locked ward for seriously mentally ill patients to at least remove him from the vulnerable young patients. He was very angry and he denied that he was dealing in drugs.

The hospital took Michael's case back to the magistrate. The hospital did not believe it could successfully argue for him to be removed because he was dealing to other patients, but was able to argue that he had been in the hospital under the *Inebriates Act* for about 2½ months, that he had made progress in terms of his alcohol dependency, that he had not been drinking, had had leave, was on anti-craving medication, was attending Alcoholics Anonymous, was attending drug and alcohol relapse prevention programs. They argued that it was appropriate for him to be discharged because he was doing well and because we had a treatment plan set up in the community. The magistrate agreed to rescind the order, two weeks early.

The poor spread of facilities across the State

3.52 There was broad criticism of the poor spread of treatment facilities across the State, which means that those under an order are often forced to travel great distances. NSW Health identified this as problematic,[164] as did the Chief Magistrate:

> [The poor coverage across the State] is a major difficulty with orders for applicants who are outside the metropolitan area, and that is one of the matters that troubles magistrates. There are not available beds, to put it that way, within a reasonable geographic location. Consider the situation, for example, at Wilcannia or Broken Hill, or somebody going down south to Tumut or Cooma. One does not need a lot of imagination to understand, amongst other things, the difficulties for relatives and the difficulties of access for seeing the person …[165]

[164] Submission 47, NSW Government, p18

[165] Judge Price, Chief Magistrate, Evidence, 26 November 2003, p6

3.53 Similarly, Dr Victor Storm, Clinical Director of Central Sydney Area Mental Health Service, commented that when people are cut off from their normal environment and support networks it is very hard to integrate any ongoing treatment once their order is completed.[166]

3.54 The issue of distance also creates the substantial practical problem of transporting those under orders to hospital. This is a significant issue, consuming substantial resources both for police and health staff.[167]

Conclusion

3.55 This chapter has outlined the many criticisms of the *Inebriates Act* and the interventions it compels for those made subject to it. Key among these are the Act's poor regard for human rights, its disproportionate use in relation to Aboriginal people, its inadequate safeguards, its unworkability and inflexibility, and its provision for people to be detained in mental heath facilities where they have limited access to appropriate alcohol and other drug services and can impact on the wellbeing of other patients. The evidence put forward by inquiry participants is that the *Inebriates Act* not only has a draconian premise; it can prevent an humane and helpful response when this is required. This claim is further investigated in the following chapter, which looks in detail at those made subject to the Act, and the outcomes it achieves for them.

166 Dr Victor Storm, Clinical Director of Central Sydney Area Mental Health Service, Evidence, 27 November 2003, p35

167 Submission 2, Mr Owen Atkins, p2

Chapter 4 Time to repeal the Act

> The [Act] as it exists is difficult to implement and does not necessarily have any outcomes other than keeping people alive and sober for the time that they are in the clinic. The problems the [Act] is attempting to address are long-term, severe, and multifactorial. They are also extremely resistant to intervention.[168]

In the previous chapter the Committee documented the vast range of criticisms that inquiry participants levelled at the *Inebriates Act*, establishing that its archaic, punitive premise is matched by inflexible, poorly safeguarded provisions and a highly inappropriate requirement that people be detained in mental health facilities. This chapter makes use of some of the more qualitative information gathered through the inquiry to build a picture of the people being placed under inebriates orders, identifying that common to almost everyone is the presence of chaos, problematic behaviour and multiple needs. On the basis of the evidence, the Committee finds that the Act continues to be used primarily for the purpose of control. In the second half of the chapter we explore the outcomes of inebriates orders, and conclude that while the Act has resulted in harm reduction for some people, it has also in many cases achieved very little or has actually caused harm. On the basis of this analysis and the raft of criticisms documented in Chapter 3, the Committee concludes that the *Inebriates Act* is irredeemable and recommends that it be repealed and replaced at once with modern, safeguarded legislation reflecting the recommendations set out in subsequent chapters of the report.

Who are the people for whom inebriates orders have been sought?

4.1 In the absence of centrally collected data, the Committee has utilised the inquiry process to gather information on those made subject to the *Inebriates Act* from participants, primarily drug and alcohol professionals and members of the police service who have sought an order, along with psychiatrists and mental health administrators who have received people into gazetted hospitals. We note that the information gathered is impressionistic and anecdotal, and because admissions under the Act are so rare, it is difficult to draw strong, generalised conclusions about them. In some cases the examples are several years old and there is potential for some double-up in those cited. Moreover, the information is quite subjective such that, for example, those who seek orders may have a different perspective than those receiving them. Nevertheless, the examples we were given provide very useful insights into the use of the Act, and into the potential demand that might arise around any new legislation enabling involuntary treatment for people with substance dependence.

4.2 While there are several discernable categories of people made subject to the Act, common to almost all of the cases reported to the Committee was the theme of chaos and difficult behaviour. Rather than conforming to the stereotype of someone who is homeless and quietly destitute, those subject to the Act appear in the majority of cases to be visible and creating difficulties for their family or community. As Dr Joanne Ferguson, psychiatrist at Rozelle and Concord Hospitals put it, 'People coming to me under the *Inebriates Act* are those who are creating a problem for someone else.'[169] Correspondingly, the issue of difficult behaviour looms large in the various categories we have identified.

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168 Submission 16, North Coast Regional Coordination Management Group, p1

169 Dr Joanne Ferguson, Staff Specialist Psychiatrist, Drug Health Services, Rozelle and Concord Hospitals, Evidence, 27 November 2003, p39

4.3 A second related theme was of people having multiple needs on top of their alcohol or drug dependence: those subject to the Act often also have mental health problems, significant cognitive damage, are socially isolated, homeless, and/or are coming into contact with the criminal justice system.

4.4 While there is a great deal of commonality between the four groups identified, the Committee believes it is valuable to identify and explore each one, as each raises distinct ethical issues in relation to compulsory treatment.

People at risk of serious harm, including those with alcohol related brain injury

4.5 In a modern context, the provision of humane protection for those at risk of serious harm might reasonably be seen as legitimating involuntary intervention. A number of participants told the Committee that they had sought or observed inebriates orders being made for people who had experienced or were at risk of significant harm as a result of their substance misuse. The person's health was in crisis, or he or she was perceived to be extremely vulnerable and at risk. Various cases were outlined of people whose drinking had resulted in coma, internal bleeding, physical collapse or other acute or life threatening conditions. Others cited examples of the non-acute but no less serious harm associated with brain damage arising from long term alcohol misuse.

4.6 Ms Kim Lewis, Drug and Alcohol Worker from Mid Western Area Health Service, told the Committee of four people she was aware of who had been placed under inebriates orders in the past ten years. All were sent to Bloomfield Hospital. The first was a woman in her early thirties who had been placed under an inebriates order three times over a three year period due to alcohol abuse. Because she was emaciated, had liver damage and suspected alcohol related brain injury, her health and safety were considered to be at significant risk. The second was a man in his mid thirties with bleeding oesophageal varices and liver damage arising from severe, long term alcohol dependence. Potentially complicating his health crisis was his dependence on methadone, with his clinic unable to establish maintenance because of his alcohol intoxication. In both these cases, the person's family was reportedly exhausted and had sought the order. The third person, also a man in his mid thirties, had alcohol related brain injury and liver damage and had been placed under an order three times in two years. He was also charged with public mischief due to multiple calls to Triple 0 and had been admitted to accident and emergency around 20 times in three months. A subsequent attempt to obtain a further inebriates order, while he was in hospital with internal bleeding, was not granted by the magistrate. The fourth person was a man in his late fifties also with alcohol related brain injury, whose health and safety were considered to be at risk. In this case, the doctor of the man's elderly mother approached the alcohol and other drug service to encourage her to seek the order, and he was detained for six months.[170]

4.7 Ms Lewis noted the multidimensional needs of this group and observed that common to each person was that their 'social world was out of control', that they were generally involved in public mischief or nuisance behaviour, and particularly, that their family relationships were breaking down or had already done so:

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[170] Ms Kim Lewis, Alcohol and Other Drugs Project Worker, Mid Western Area Health Service, Evidence, 25 March 2004, p30

> The interesting thing that we found is that if these people have good family support – a wife, a husband, a father, a brother or a sister they seem to be absent; we do not know of them. They are still as harmful within their homes, their families and their bodies, but we do not see them until they spill out to the community.[171]

4.8 Ms Andrea Taylor gave the Committee an example of someone she had placed under the Act in her previous role as a community mental health professional:

> One was a woman who dressed as a man, lived on the streets, was regularly brought into a proclaimed place, was being raped daily and was coming in with clothes ripped off and obvious trauma associated with rape and would do absolutely nothing about it. She had shocking peripheral neuropathy and was in her late thirties or early forties. It took me seven days to put her under the *Inebriates Act*. As a worker I could not stand by and watch that.[172]

4.9 Mr Faulkner Munroe told us that when he was manager of the proclaimed place in Moree he was instrumental in placing a number of people from the Aboriginal community under the Act. He generally did this in response to self neglect and social and financial vulnerability arising from cognitive damage:

> The experience we have had is with people who have drunk themselves to the point where they cannot manage themselves, their affairs or their money. We have placed people under the Act because we saw them being robbed without their knowledge - people would go to the bank and take their money - and they had to be picked up every night in an inebriated state in a park and brought to a refuge.[173]

4.10 The Committee understands that alcohol related brain injury encompasses a range of conditions that may affect thinking patterns, memory, behaviour and personality, along with coordination, balance and peripheral nerve functioning. It may also be marked by challenging behaviour, poor impulse control, confusion, delirium and hallucinations. A major causal factor is the toxic effect that alcohol has on the central nervous system, but brain damage may also result from other problems associated with significant alcohol consumption such as thiamine (Vitamin B1) deficiency, poor nutrition, dehydration, poor circulation, metabolic problems and falls. Significantly, the ability to have insight into one's behaviour, to process new information and to develop new skills are often affected. In some cases, especially for younger people, cognitive damage is reversible with abstinence; in others the effect is permanent and may have a profound impact on daily functioning.[174] The Committee was advised that in the past, a significant portion of those placed under the Act who had a brain injury were assisted through formal programs at Rozelle Hospital specifically designed for this group, but that these programs no longer operate.[175]

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171 Ms Lewis, Mid Western Area Health Service, Evidence, 25 March 2004, p30

172 Ms Andrea Taylor, Manager, Quality and Risk Management Royal North Shore and Ryde Health Services, Evidence, 7 April 2004, p18

173 Mr Faulkner Munroe, Manager, Byamee Homeless Persons Service, Moree, Evidence, 24 March 2004, p29

174 'What is ARBI?' *http:www.arbias.org.au/arbi.htm* downloaded 20 May 2004; Dr Stephen Jurd, Area Medical Director and Addictions Psychiatrist, Drug and Alcohol Services, Northern Sydney Health, Evidence, 4 March 2004, pp3 and 13-14; Ms Tonina Harvey, Area Director, Drug and Alcohol Services, Northern Sydney Health, Evidence, 4 March 2004, p3

175 Ms Harvey, Northern Sydney Health, Evidence, 4 March 2004, p12

4.11 Ms Vi Hunt, Area Coordinator, Alcohol and Other Drug Services for New England gave a further example of a woman perceived to be at serious risk as a result of substance dependence and mental illness, for whom an order was obtained, but who was refused admission by the hospital:

> In the 12 years that I have been in the Alcohol and Other Drugs Service I have tried one person twice, so I can talk about that person. Obviously it is not something that we use frequently at all. The person who presented was a female in her early thirties. She had presented to the drug and alcohol service on numerous occasions. She also had a diagnosis of bipolar disorder. She had had a very high alcohol intake since the age of 18. When I say "high" I am talking about a cask of wine a day. She would go on a binge which would last four to six weeks. During that time there would be constant calls to drug and alcohol and mental health services. You would get her off the grog and you might get her into hospital for detoxification. She would go out and then we would start all over again. She lived alone. She had two parents and a brother. She had contact with her father, but her mother and her brother would have absolutely nothing to do with her. So she was really quite isolated. As I said, she had numerous admissions for detoxification, but she never stayed very long. She had a number of stays in the mental health unit because sometimes when she was drinking she would become quite suicidal and depressed - another reason for her to be in there. I know that on two occasions we put her under the *Inebriates Act*. Her father actually initiated that process.[176]

4.12 Most of the cases in this category related to alcohol dependence, but dependence on other drugs was identified in some. Ms Leonie Jefferson, Senior Aboriginal Drug and Alcohol Counsellor, Northern Rivers Area Health Service, cited an example of a 25 year old woman with a history of chaotic behaviour and polydrug use (including benzodiazepines and opioids), who had been diagnosed with a severe borderline personality disorder. She was admitted to Morisset Hospital under the Act because she was judged to be at risk.

4.13 In the experience of the practitioners we spoke with, the Act is resorted to only in extreme cases, where damage is manifest and risk palpable. As Ms Beth Burton from the New England Area Health Service told the Committee 'We are talking about damaged people. We would not use the Act until they are quite damaged. You are in fear of their health, or their life in some cases.'[177]

People with antisocial behaviour arising from substance dependence

4.14 A qualitatively different group are those who are reported to be placed under an inebriates order primarily because of the problems their behaviour is causing for their community. This group was emphasised by representatives from the gazetted hospitals, partly because of the major impact they have on other patients and the hospital environment. Dr Glenys Dore of Macquarie Hospital gave a number of examples:

> The gentleman was placed under the Act because he was being a repeated public menace. He was drinking heavily, all day every day; he was essentially drunk all day

[176] Ms Vi Hunt, Area Coordinator, Alcohol and Other Drug Services, New England Area Health Service, Evidence, 25 March 2004, p11

[177] Ms Beth Burton, Clinical Nurse Consultant, Alcohol and Other Drug Services, New England Area Health Service, Evidence, 25 March 2004, p10

> every day. In that context, he was committing petty crimes and making a public nuisance of himself. The police were involved, his family was involved, and he was placed under the Act and sent here for three months.[178]
>
> This was a young woman in probably her mid-twenties who was placed under the *Inebriates Act* because she was out of control in the community, she was using a lot of drugs, a lot of alcohol, she was prostituting herself, she was becoming angry, violent, threatening, there was a concern that in an intoxicated state she might attack and harm someone. She came to the hospital—and it was very clear very early on that she had a severe personality disorder underlying all her problems, as well as a severe drug and alcohol dependence—and she was placed in [a long-stay ward]. I think she was on a nine-month order. It became clear very quickly that there was a risk that she might harm the other patients because she would become very angry, very explosive, very threatening and very intimidating.[179]

4.15 Dr Martyn Patfield, Medical Superintendent at Bloomfield Hospital, told the Committee that in his experience it is rarely a person's dependence per se that sees them sent to that facility. Rather, it is usually the result of *behaviour* associated with their substance misuse. Having reviewed the last 20 admissions to Bloomfield (representing around 10 individuals due to a number having multiple admissions under the Act), Dr Patfield estimated that in only three cases was it simply the person's severe dependence, and their family's desperate endeavours to help them, that saw them placed under the Act. By contrast, he thought that 12 admissions were a result of what he termed 'community burnout', where the individual might have had multiple hospital admissions, made many ambulance calls and had repeated contact with the police and the courts for public nuisance offences, domestic violence, being drunk and disorderly, and so on. Their criminality, where it exists, does not lead to a gaol sentence, but their community cannot cope with them any more, and the magistrate makes an inebriates order as a last resort. It appears that at least one of the people cited by Ms Lewis also fell into this category.

4.16 Dr Patfield estimated that another five of the 20 admissions were instances where, in his view, the *Inebriates Act* had been used, sometimes cynically, to avoid the legal consequences of offensive behaviour. In some cases a solicitor had suggested that the magistrate give an inebriates order instead of a custodial sentence; in other cases the patient had asked for it. He offered an example of a person who he believed had done this. The man, who was on methadone, initially came to the hospital under section 33 of the *Mental Health (Criminal Procedure) Act* following a charge of break and enter. While he was diagnosed with an antisocial personality disorder he was not believed to be mentally ill, and was refused admission. Four days later he was sent back to the hospital, this time under a one month inebriates order. He was angry that he had not been admitted the first time and seemed to feel 'entitled' to a diagnosis of mental illness, which he thought would lead to financial assistance and possibly assist him in relation to two pending court cases. After his order expired he was discharged and then returned a couple of months later with a shorter term inebriates order. Again it seemed to Dr Patfield he was manipulating the system.[180]

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178 Dr Glenys Dore, Addictions Psychiatrist and Deputy Medical Superintendent, Macquarie Hospital, Evidence, 4 March 2004, p1

179 Dr Dore, Macquarie Hospital, Evidence, 4 March 2004, p6

180 Dr Martyn Patfield, Consultant Psychiatrist, Medical Superintendent and Director of Acute Services, Bloomfield Hospital, Evidence, 25 March 2004, p2

4.17 This analysis led Dr Patfield to conclude:

> [I]n most cases, the person really has been sent to be held in custody for behaviour which their home community will not tolerate and where criminal charges and custody in gaol is an option but not one that is preferred … In any event the hospital is being used as a defacto gaol after a sentencing process which has few legal safeguards … My chief contention is that the Act is currently being used by the courts to contain behaviour … It should be acknowledged that if an *Inebriates Act* exists, it is to provide a sanction against unacceptable behaviour and to provide respite and protection for the communities in which these people live.[181]

4.18 Representatives of the Police Service verified that low-grade offending behaviour, as reflected in the largest group seen by Dr Patfield, is a primary catalyst for inebriates orders. From their perspective, this remedy is used with benign intentions, in the absence of more appropriate and effective measures, to help address the person's problems and protect the community to some degree. As Assistant Commissioner Bob Waites told the Committee:

> Some officers in the country in recent times have given me examples of trying to use the *Inebriates Act* to assist homeless people who are living on the proceeds of crime simply because they need to support themselves. They have utilised the Act by coercing these people - or convincing them - to go to court and then getting a doctor's certificate so that they can be placed in care.[182]

4.19 Both the Assistant Commissioner and the Police Association associated this behaviour with people who are continually intoxicated with alcohol. Typically they are committing 'crimes of subsistence' associated with their substance misuse such as shoplifting, trespass, offensive behaviour, being drunk and disorderly and so on. As such, they are more 'everyday nuisances' than serious offenders.[183] It is likely that such behaviour is a greater problem in small communities because it is more visible.

4.20 Providing some insight into the absence of effective options for this group, the Police Association reported that the police find conventional law enforcement measures powerless against nuisance behaviour, with 'move along' provisions providing only a short term solution, imposition of fines impractical, and gaol neither effective in addressing the problem, nor an option that is preferred by the courts.[184] Assistant Commissioner Waites stressed the absence of treatment and support options for this group, especially in rural areas.[185] Both bodies saw use of the Act for this purpose as appropriate and gave the Committee the impression that if the Act were more workable, and was more widely understood to have retained its powers, it would be utilised by Police for this purpose more often.

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181 Submission 11, Dr Patfield, Bloomfield Hospital, p4

182 Assistant Commissioner Bob Waites, Commander, Greater Metropolitan Region and Corporate Spokesperson on Alcohol related Crime, NSW Police, Evidence, 27 November 2003, p19

183 Assistant Commissioner Waites, Evidence, 27 November 2003, p20; Submission 40, Police Association of New South Wales, p2

184 Submission 40, Police Association of New South Wales, p9

185 Assistant Commissioner Waites, NSW Police, Evidence, 27 November 2003, p21

People whose behaviour is impacting on their family

4.21 A very similar group to the previous one is those people whose behaviour is impacting on their family in some way. In fact, many people may be grouped in both this and the previous category. While the previous one focused on 'public' nuisance, this group is noted for its impact in the private sphere. The orders may be sought by family members desperate to help their loved one, or the person's substance use may be impacting seriously on the wellbeing or safety of family members. Sometimes the motivation for invoking the Act may be less altruistic. People in this category fall along a continuum in terms of the impact they have on others.

4.22 Dr Stephen Jurd, Area Medical Director and Addictions Psychiatrist, Drug and Alcohol Services, Northern Sydney Health, cited a case from several years ago, memorable for belying the 'inebriate' stereotype:

> The Phoenix Unit's previous incarnation was Bridgeview House, which was a ward of Macquarie Hospital. It was closed and the Phoenix Unit opened at Manly. I was the director at Bridgeview House … I remember it was a little unsettling that one of the patients was a middle-aged Turramurra mother of three teenage children who had terrible trouble and had been to a few private hospitals. She kept relapsing and in his desperation her husband got an inebriates order. She stayed for two or three months in Bridgeview House and apparently did quite well in the program. It was an open facility at the time. She actively participated in the program and I had some hope that she would be okay on discharge.[186]

4.23 Dr Joanne Ferguson told the Committee that impact on families was common among the cases she has seen, implying that sometimes such orders are inappropriate:

> I would like to talk about some of the cases that came to Rozelle. They have some common themes. The common theme I have found is that the patients create difficulties for their families. A 38-year-old mother of two who ran her own business and used to get drunk a couple of times a week would continually fight with her relatives and her ex-husband. They were embarrassed by her performance. She stopped drinking about eight months prior to her presentation. They had been taking her to see a psychiatrist, and the psychiatrist suggested an inebriates order, then the family worked on statements. When she came to the hospital she did not have an alcohol problem and I could not make a diagnosis of alcohol dependence. She was comfortable and happy to stay. It was useful for her but it was not an effective treatment.[187]

4.24 A more profound impact on family was evident in an example from Cumberland Hospital provided by Dr Peter Tucker of Western Sydney Area Mental Health Service:

> For example, a woman in her thirties came to us who was noted to have abused alcohol in the preceding 12 months in the context of a marital breakdown. There had been aggression, apprehended violence orders, damage to property, rage and violence towards family members. The local community mental health team had also been involved. There was a history of treatment for anxiety and depression over the preceding 10 years but close questioning shortly before admission revealed that she

186 Dr Jurd, Northern Sydney Health, Evidence, 4 March 2004, p11

187 Dr Ferguson, Rozelle and Concord Hospitals, Evidence, 27 November 2003, p39

> had been drinking since her mid teens, drinking heavily by the age of 20 and drinking very heavily in the preceding year. Her life was clearly very disturbed. There was no doubt about that.[188]

4.25 In an example presented by the Police Association, the application did not result in an inebriates order as no bed was available, but the case is noteworthy as it illustrates the vulnerability of some family members and the resort to formal intervention that they may require:

> This situation involved an 85-year-old lady at Castle Hill. The woman had an alcoholic son in his fifties who couldn't or wouldn't work, was constantly drinking and who would defecate throughout the house. The mother had tried everything to have him removed from the house. Her efforts included asking him to leave; directing him to leave and eventually in desperation, seeking help from her doctor. It was the doctor who then contacted the police, asking for their assistance with eventual action taken under the *Inebriates Act*.[189]

People who place themselves under the Act

4.26 The final category of people placed under the *Inebriates Act* are those who have in fact initiated the order themselves. While self-imposed civil commitment seems a contradiction in terms, it is not uncommon under the *Inebriates Act*. When we visited Bloomfield Hospital, the Committee spoke with a man who had done this with the help of a friend who was a policeman. He had previously been placed under an order involuntarily, but sought one himself this time as his living circumstances and health were rapidly deteriorating.[190]

4.27 A number of other examples of self-committal were conveyed to the Committee, including by Ms Manda Bishop of the Alcohol and Drug Information Service, from her experiences working at what was then an inner-Sydney proclaimed place, the Albion Street Lodge (ASL).

> XX was a long-term alcohol and drug user in his late thirties. He had been using since he was ten years old and had over 1000 admissions at ASL. He was an intelligent man with mild brain damage. He felt frustrated with his current lifestyle and saw the *Inebriates Act* as a last option. He asked me to facilitate it for him … YY was watching with interest as XX had been going through this process and had decided he too wanted to be committed under the *Inebriates Act*. A man in his early forties, he was more a seasonal user of ASL rather than a regular one. He used alcohol rarely, but was a regular heroin user. With YY, we went through the same actions as XX, but he was court ordered to a different facility.[191]

4.28 It seems that some people initiate the Act as a means of imposing an external source of control upon themselves. Presumably many have tried voluntary services with limited success; presumably they also have a reasonable degree of insight and motivation. The potential for

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188 Dr Peter Tucker, Medical Superintendent, Cumberland Hospital and Director, Clinical Services (East), Western Sydney Area Mental Health Service, Evidence, 27 November 2003, p35

189 Submission 40, Police Association of New South Wales, p13

190 Confidential evidence

191 Submission 22, Alcohol and Drug Information Service, pp7-8.

some provision for voluntary orders to be retained was raised by a number of inquiry participants, and is explored in detail in Chapter 8.

Discussion

4.29 The Committee has identified four overlapping groups of people made subject to inebriates orders: those who have experienced or are at risk of serious harm, including those with alcohol related brain injury; those whose antisocial behaviour impacts on their community; those whose behaviour impacts on their family; and lastly, those who have initiated the order themselves. Each of these groups raises separate ethical issues which need to be considered and resolved in determining whether involuntary intervention is ethically justified, in what circumstances, and what that treatment might involve. Only when that ethical position is resolved can an appropriate legislative and service framework be developed, with consideration of the implications for resources and service delivery. These issues are examined in Chapters 6, 7 and 8.

4.30 Some important issues emerge from the analysis of those subject to the Act at the present time. The first arises from the observation that in many cases, use of the Act is consistent with its anachronistic and punitive premise: to put people away for a time when they are causing trouble. The evidence before the Committee is that in a minority of cases the *Inebriates Act* is used solely for the humane purpose of protection from serious harm. In the majority of cases it is used for the purpose of managing difficult behaviour, that is, for social control.

4.31 It may be that the Act is resorted to in such cases for benevolent reasons, under the assumption that appropriate drug and alcohol treatment is available in mental health facilities. However, the previous chapter showed that this assumption is ill-founded, and that detainment of people under inebriates orders alongside those with serious mental illness may seriously affect the wellbeing of both groups. Alternatively, it may be that the Act is invoked for less benign reasons, to simply remove a difficult person to another place for a time. In either case, given the inherent faults of the Act, the effect is control.

4.32 In this context we note our strong concern, reflected in the evidence presented in previous chapters, that the Act is used disproportionately in relation to Aboriginal people. Incarceration has long been used as a tool to control Indigenous people. While significant work is being done in the criminal justice and health arenas in relation to Aboriginal communities, every effort must be made to ensure that any legislation enabling detention does not result in discriminatory outcomes.

4.33 There is evidence that the Act is being used as an alternative to criminal detention. Over the past few decades there has been an important shift away from criminalisation and incarceration of low grade offenders. That shift has accelerated in recent years with the development of diversion programs, primarily for illicit drug users, that offer community based coercive treatment for certain offenders. Evidence before the Committee suggests that there is a group whose behaviour, in the absence of appropriate community based supports, is a problem for people's family or community. The 'public nuisance' behaviour associated with severe alcohol dependence is experienced as particularly troublesome in rural areas where people are more visible and there are fewer services to assist them. The most appropriate response to this 'antisocial behaviour' group - coercive or non-coercive - has not yet been determined at a policy level.

4.34 In the meantime, the Committee is very concerned that people for whom gaol is deemed inappropriate because their offences do not justify such punishment are in effect being incarcerated under the *Inebriates Act*. Where the Act is being used as an alternative to punishment for more serious crimes, the Committee believes this is highly inappropriate.

4.35 The Committee also found some evidence of unwarranted use of the Act by family members, again in response to difficult behaviour. There were, however, instances where a person's behaviour was profoundly impacting upon others, where the Act appeared to be invoked to protect them from harm.

4.36 This analysis points to a number of ethical issues in relation to compulsory treatment, including to what extent the problems arising from severe substance dependence are best managed within a voluntary framework, and how the potentially competing rights of the person versus their family or community are to be weighed. At what point is involuntary intervention justified, and when do we accept that we are ethically bound to tolerate a person's substance use and resulting behaviour and simply provide the opportunity for them to choose to change?

4.37 The Committee also notes that it is very easy to judge people for their antisocial behaviour and consider them fully responsible for the sometimes significant trouble they cause. Yet we know, and many of the examples in this chapter attest, that in many cases the person's behaviour is beyond their immediate control, being the result of physical addiction, brain damage or mental illness. Our ethical, legislative and service frameworks must necessarily be informed by understanding and compassion.

4.38 A related theme is that of complex needs. The multidimensional aspects to people's difficulties was readily apparent in the cases outlined, and was noted by several inquiry participants. Both Professor Ian Webster, Chair of the NSW Expert Advisory Committee on Drugs and Terry Carney, Professor of Law, University of Sydney, observed that by the time a person comes to be considered for compulsory treatment, their needs are high and complex.[192] This means that by their very nature, the problems of those subject to inebriates orders are not easily addressed. These people, by and large, sit at the extreme end of the substance misuse spectrum: their dependence is severe and long term; it is seriously impacting on their health, relationships and functioning, and indeed their ability to address their addiction and change their lives. This raises the important question of how much can legitimately be expected of this group, especially when severe alcohol dependence is regarded as a chronic relapsing condition, and where many lack the personal, social and indeed cognitive resources to change.

4.39 Our analysis also points to the difficulty that the service system has in responding to people whose needs traverse the boundaries of several systems, such as the alcohol and other drugs system, the disability service system, and the mental health system. As Professor Webster observed:

> These are people who have not fitted with any of the services. [Government has] altered barriers or put up barriers or we have not been prepared to engage with them

[192] Emeritus Professor Ian Webster AO, Chair, NSW Expert Advisory Committee on Drugs, Evidence, 18 April 2004, p13; Professor Terry Carney, Professor of Law, University of Sydney, Evidence, 8 April 2004, p22

> … They are mixed up, they are complicated, they have got several things happening at one time.[193]

4.40 The following case study of Esther illustrates this difficulty well.

Esther

Esther was a 54 year old homeless woman living in a rural centre. She was known to have Korsakoff's syndrome, and as a result, had extremely volatile behaviour with huge changes in personality: one day she would be irrational, emotional and aggressive, and the next, according to Sister Anne of the Society of St Vincent de Paul, 'this beautiful, intelligent person would appear'. While Esther was an alcoholic, she would often go weeks without drinking.

She had a son, Michael, who was in his late twenties and had a mild intellectual disability, as well as his own substance dependence. He was in and out of prison. Esther and Michael spent a lot of time together, but had a very mercurial, tumultuous relationship.

Over a period of about a year, Esther sought assistance from the St Vincent de Paul welfare service run by Sister Anne, sometimes every day. Esther's behaviour when she came into centre was very difficult: she was highly emotional, very demanding, abusive to staff and other clients, often paranoid, and at other times, quite depressed. She often needed calming down as well as practical assistance with things that were upsetting her, but attempts to help her to access health and other services had little success.

Sister Anne tried to help her to get stable accommodation as she was continually in crisis, moving between refuges, caravan parks, in and out of town and so on. The staff at the women's refuge said that they would go on stress leave if she returned because the havoc she had already caused there. On many occasions Sister Barbara believed Esther required hospitalisation, but despite her paranoia, confusion and threats of suicide, the mental health service determined that she did not. Her diagnosis of Korsakoff's meant that technically, she did not have a mental illness. The Police were reluctant to get involved. The Salvation Army found her some short term accommodation, but again this did not last.

Over a period of months, as Esther's erratic and aggressive behaviour continued, further attempts to engage health or other services, in Sister Anne's words, 'got nowhere'. The Aged Care Assessment Team (ACAT) got involved, but could find no suitable place for her. At a meeting Sister Anne and a priest organised with the local member of parliament, police, health services and the Salvation Army, the police raised the possibility of seeking an inebriates order but did not pursue it as it was felt she did not fit its criteria.

One day, Sister Anne received a call from a psychiatrist at Rozelle Hospital who had admitted Esther after she was removed from a train in Sydney. Sister Anne detailed Esther's story and was greatly relieved when the psychiatrist agreed Esther really needed help. 'Finally', she thought, 'We might be able to get her the help she needs.' A few days later, Sister Anne received a call from the priest to say Esther was on her way home on the train. When Sister Anne spoke to the psychiatrist he told her that when he had tested Esther for dementia she had scored 29 out of 30, so he was not able to keep her in the hospital. Once again she did not meet the right criteria.

At some stage, Esther was also diagnosed with lung cancer. Sister Anne and the ACAT arranged for her case to be considered by the Guardianship Tribunal and her finances were placed under the management the Office of the Protective Commissioner. She was also given a Housing Department placement, but within weeks was moved because her behaviour was so disruptive for others. She was very unhappy in this second public housing facility, where she and other residents, who had similarly difficult behaviours, were continually in conflict.

Her story continued in much the same way for several months, with Sister Anne and others struggling to support her as much as they could. Sadly, she died a few months ago.

[193] Professor Webster, NSW Expert Advisory Committee on Drugs, Evidence, 4 June 2004, p8

4.41 The importance of overcoming service boundaries and providing a 'joined up' response is increasingly recognised by government, but achieving it is no easy task. At the same time, there are groups such as those with significant alcohol related brain injury who have been defined out of any service system, despite their profound level of need and vulnerability. The case study of Esther highlights just how difficult it can be for a person to access the supports they require, and indeed how their difficult behaviour contributes to this situation. In this context, a critical question emerges concerning the extent to which the problems the *Inebriates Act* is being used to address are really problems arising from poor policy and service delivery.

4.42 A final, related question concerns the effectiveness of compulsory treatment as an intervention. What does research tell us it achieves? This knowledge base must feed into the ethical discussion, and is the focus of Chapter 6. In the meantime, the second half of this chapter explores the effectiveness of the *Inebriates Act*. What does the evidence before the Committee tell us about the outcomes for people placed under the Act?

What does the Act achieve for those placed under an order?

4.43 Having considered the range of circumstances precipitating the placement of people under an order, the Committee now turns to an analysis of the outcomes for those people, again based on the cases reported to us. Participants varied in their observations on the effectiveness of the Act: some believed that it had been beneficial, others harmful; still others saw both costs and gains. As with the observations documented in the first half of this chapter, the information given to the Committee was anecdotal and somewhat subjective, with different perspectives evident between those who had initiated an inebriates order and those who had admitted someone under one.

Beneficial outcomes

4.44 There were a few examples put before the Committee where the Act was seen to have resulted in substantial benefit to the person.

4.45 Reflecting on the outcomes for the four people at risk of serious harm cited at the beginning of this chapter, Ms Kim Lewis reported broadly positive outcomes for three out of the four people, despite the absence of appropriate programs for them while detained. The young woman in her thirties who was sent to Bloomfield three times, according to Ms Lewis, 'ended up eventually grateful that someone had made the choice for her when she was unable to do so herself … she started making some different choices for her life'.[194] Similarly, the man who was using both methadone and alcohol continued to use substances but, realising how he had placed himself at risk, sought to reduce the harm associated with his substance use. Ms Lewis also reported that the man in his late fifties who had alcohol related brain injury had been placed in a nursing home soon after completing his order. She told the Committee that he is not drinking, is reported to be happy, and his relationships with family have improved, although he did have some setbacks along the way:

194 Ms Lewis, Mid Western Area Health Service, Evidence, 25 March 2004, p31

> The last case involved an older person who had one long stay here for five and a half months. His family were burnt out and his GP approached us because his mother had … Alzheimer's. He was 58 when the GP came to us. His family were furious with him because he continued to drink and his elderly mother was caring for him. The family was busted up because of it. When she became unwell the GP said we had to do something. We encouraged the family to go through with the order. After he was here for five and a half months they were reunited and got to know him again. When he came out he did not make it back to [to his home town] on the train or bus. He drank all the way home and [his family] refused to deal with him. They moved him to an aged care facility and they visit him twice a week. The family is not fragmented now … I have phoned [the nursing home] and he is doing well and does not want to leave. He is involved in activities … They have an outing once a fortnight to a hotel where they have dancing, pool and light beer. I do not know whether he goes, but he knew the option was there when he went in. They told me he never misses a cigarette break.[195]

4.46 The fourth person, notorious for his multiple hospital admissions and ambulance calls, chose to enter a residential rehabilitation program after the magistrate refused to have him admitted under the Act a fourth time. He remained in that program for five and a half months, but then left and is now presumed to be drinking. Summing up the outcomes for all four clients, Ms Lewis concluded:

> I have noted that they all commented that they did not really want to die. The language is different, but they have all given me the message that they did not want to die. They knew they were drinking themselves to death, but it was not their ultimate goal. They were grateful to be alive.[196]

4.47 Commenting on these same cases, the Mid Western Area Health Service stated:

> From our limited experience, we have found that the Act does have a place with a focus on saving the lives of people with severe alcohol dependence and those close to them. (i.e. it is a short-term life saving intervention).[197]

4.48 Reporting a positive story among many negative ones, Dr Patfield cited the case of a 68 year old man with frontal lobe damage and gait disturbance typical of long term alcohol misuse, who was also socially isolated. His son had sought the order out of concern for his father's wellbeing and liaised with the hospital throughout his father's stay. Not long after his admission the man himself said that he was glad he had been admitted. According to Dr Patfield, 'Plans were made for appropriate discharge, and the file notes suggest that things have worked out pretty well.'[198]

4.49 Many of those who commented on the outcomes of placement under the Act were perhaps best described as pragmatic. They were realistic about what the Act could achieve, especially for people whose needs were so complex and entrenched. Participants stressed the benefits of giving people a break from harmful substance use, and perhaps also some respite for their

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195 Ms Lewis, Mid Western Area Health Service, Evidence, 25 March 2004, pp31-32

196 Ms Lewis, Mid Western Area Health Service, Evidence, 25 March 2004, p32

197 Submission 53, Mid Western Area Health Service, p5

198 Dr Patfield, Bloomfield Hospital, Evidence, 25 March 2004, p4

families or communities. As Mr Owen Atkins and the Mid Western Area Health Service stated, respectively:

> [Alcohol and other drugs] staff in the wider team saw the value of Inebriates Orders as an effective means of giving the person "time out" from their destructive lifestyles, but not necessarily as a useful treatment. Our experience with Inebriates Orders was that most clients returned to their previous lifestyles within a very short time after their return home.[199]

> Clients accommodated under the Act generally relapse when returned to the community (better outcomes could be achieved if a structured plan were to be used, including neuropsych assessment, appropriate medication and perhaps even assertive case management after discharge). However, in the short term, respite from abusive alcohol use benefits clients' health, families, carers and communities.[200]

4.50 A number of participants commented on how readily people regained their physical health when forced to abstain as a result of an order: depending on their symptoms prior to detention, within a short period they return to a healthy weight, and can walk and even talk more easily. For some, involuntary treatment has also provided the opportunity to have more incidental but still serious physical problems addressed. Dr Richard Matthews, Acting Deputy Director General, Strategic Development, NSW Health indicated to the Committee that he recognised the value in such outcomes:

> This is where the *Inebriates Act* probably functioned as a harm reduction measure in the past because individuals went into the Schedule 5 hospitals for a period where they had no alcohol and they got an adequate diet and some care. Over the period they were in there that actually improved their health. Providing those sorts of beds for that sort of thing to happen is something that we should importantly be doing.[201]

Harmful outcomes

4.51 There were a number of cases where participants cited harmful outcomes following detention under an inebriates order. Several case studies, including that of Barry in Chapter 3, testified to the extremely unpleasant, even traumatic, experience that placement in a psychiatric facility can be for those who do not have a serious mental illness, even more so when detention extends over a long period. According to Reverend Rennie Schmid, who documented Barry's story in his submission, Barry felt very disempowered and experienced anxiety and depression as a result of the environment he was placed in; he was fearful of other patients and frustrated at his inability to access treatment. He isolated himself with little choice but to simply sit through the 12 months of his order. Barry's experience accorded with the views of some other participants. For example, in his submission Mr Jim Sheedy stated:

> Only on one occasion have I supported a recommendation to use the *Inebriates Act*, which was on a mental health patient in a rural setting. I will never do so again under the current conditions. The person in question suffers from a severe mental illness

199 Submission 2, Mr Owen Atkins, p1

200 Submission 53, Mid Western Area Health Service, p1

201 Dr Richard Matthews, Acting Deputy Director General, Strategic Development, NSW Health, Evidence, 11 December 2003, p21

> and multiple addictions. The addictions are more life threatening and cause greater social harm than the mental illness. Community Treatment Orders proved ineffectual. While under 6 months containment under the *Inebriates Act* there were systems failures. For example, it was made overtly clear that this type of patient was not wanted at the designated hospital and according to urine screens there was no difficulty in obtaining drugs while supposedly in care. We deprived a citizen of his liberty for 6 months, taking him against his will to an institution he finds extremely stressful to cope in, only to provide poor clinical and social outcomes. Even though we had good intentions we failed this individual.[202]

4.52 Other harms reported to the Committee included a patient who had severely lacerated his arm while attempting to escape from the hospital where he was detained by digging and climbing under a fence.[203] We were also told of two different people who had 'gone underground' after absconding from their facility, thus cutting themselves off from potential supports out of fear of being returned, and in effect, becoming fugitives.[204] Such drastic actions, as described in the case study of Susan below, speak of just how negative and counterproductive the experience of being placed under the Act can be. Such a stressful experience cannot assist the person's recovery; at worst, it may badly undermine it. It is sadly ironic that in Susan's case the order was voluntarily sought.

Susan

Susan was a young woman in her early twenties who was involved in placing herself under the *Inebriates Act* and was given a three month order. Both she and her family felt that this was the best thing to do. She was initially placed in the acute ward, and needed a brief period of detoxification. Hospital staff also felt that it was not going to be appropriate to place her in a locked long-stay ward so they arranged for her to be placed in an open ward. She was the only female there. There were 19 others who were all young men with schizophrenia, and she found it very frightening. She felt the patients were bizarre and that she had nothing in common with them. She had a number of underlying psychological problems which psychiatric staff started to piece together with input from her case managers in the community and from the drug and alcohol services. It seemed that she had serious problems with depression and anxiety and probably a history of sexual abuse.

Susan hated participating in any of the programs at the hospital. She did not feel that they were relevant for her and she did not want to mix with the other patients. She was also quite phobic about groups and she started indicating that she might be thinking about running away. She asked one of the psychiatrists what would happen if she went underground, and whether the hospital could lock her up again after the period of her order had passed.

She sought the support of the hospital to return to the magistrate to vary the order, but on the basis of the hospital's past experience with the *Inebriates Act*, she was advised that she needed to make enough progress to persuade the court that she was doing well, but that her needs would be better met in another environment. Up until that time she had not made good progress in her treatment.

Before the hospital could place Susan back on a locked ward, or make other arrangements for her, she ran away, going underground for the rest of her order. She would ring her family from time to time but was not seen or heard from again until the order expired.

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202 Submission 3, Mr Jim Sheedy, p1

203 Submission 46, Legal Aid NSW, p7

204 Dr Glenys Dore, Addictions Psychiatrist and Deputy Medical Superintendent, Macquarie Hospital, Evidence, 4 March 2004, p3; Submission 22, Alcohol and Drug Information Service, p7

4.53 A number of participants suggested less tangible harms arising from placement under the Act, questioning the capacity of inebriates orders to substantially assist people, especially in the light of the Act's emphasis on containment, the absence of appropriate treatment, and the costs for individuals in terms of their loss of liberty and autonomy. Dr Ferguson cited two examples, highlighting the counterproductive effects of detention under the Act on people's motivation:

> Another patient this year had conflict within her family related to issues in addition to alcohol use. She did not want to be there but agreed to the order. As a result she would not engage with me in a conversation about it. She went into rehabilitation and we went back to the magistrate to get the order changed and there was recognizance to the court, but that was not effective. Because she felt forced into treatment she took a long time to get over her feelings of resentment. That is an important component. People will come to treatment - they reach the point at which the consequences force them into treatment - but when it is imposed they take a long time to get over the resentment and they feel a loss of autonomy.[205]

> Another case involved someone bothering a magistrate by repeatedly presenting as drunk and disorderly in a park and so on. That person came without a doctor's note from the magistrate. She was Aboriginal and homeless and had multiple other problems. She had some cognitive impairment, but I think that was due to alcohol abuse. She had a nice stay in hospital for three months but would not discuss her alcohol problems and did not want to go into rehabilitation. It was a good intervention in that she looked a lot better at the end of three months, but it did not address her real problems - homelessness, isolation from her family and so on. We could not touch the real problems because she did not want to be there.[206]

4.54 In this context the Committee again notes our concern for the profoundly disturbing effect that detention can have for Indigenous people.

Ambivalence

4.55 Finally, a number of participants were clearly ambivalent about the outcomes they had observed. Mr Lloyd Duncan from the Aboriginal community in Moree said that he feels now that while it was wrong to send people away from their community, and it did not address their addiction, it did do some good:

> We used to take them to Newcastle, but they stopped that. When they came back they would be fat. We must have put six or seven years on their lives. They came back fat and healthy.[207]

4.56 Ms Manda Bishop reported on the two people she had helped place under an inebriates order, both of whom were voluntary committals outlined in the relevant section earlier in this chapter. She described how the first person, a man in his late thirties with a serious alcohol dependence who had been a long term client of Albion Street Lodge, had passed through his order uneventfully and was given the opportunity for a fresh start:

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205 Dr Ferguson, Rozelle and Concord Hospitals, Evidence, 27 November 2003, p35

206 Dr Ferguson, Rozelle and Concord Hospitals, Evidence, 27 November 2003, p39

207 Mr Lloyd Duncan, Byamee Homeless Persons Service, Evidence, 24 March 2004, p40

> Upon discharge after three months, XX was taken to his newly acquired flat that had been set up with food, furniture etc. Within 24 hours, XX was intoxicated and knocking on [Albion Street Lodge's] door.[208]

Robert

Robert was a man in his 40s with a long history of excessive alcohol and other drug use. On a number of occasions Robert had entered his mother's house and collapsed. On each of these occasions she had him admitted to the local hospital. Robert was also found collapsed at a boarding house. There was significant concern that during one of these episodes Robert would die by drowning in his own vomit.

Robert was, at this time, also on a high dose of methadone. He had broken his wrist in a bad fall while intoxicated and required further surgery. The doctors were unwilling to perform this surgery due to his constant intoxication.

In 1995 a 12 month inebriates order was made at the request of his mother. Initially Robert was detained in an acute ward in a psychiatric hospital. The hospital felt that this was clearly inappropriate as he had no mental illness and they had no treatment for him.

Arrangements were made for Robert to be accepted into a residential therapeutic community. An application was made to the Magistrate who had made the initial order for discharge to allow this to take place. The Magistrate did not revoke the order but amended it to allow Robert to conditionally reside in the community. Any breaches of the community's rules or use of alcohol was to be reported to him and the release would be revoked. It is doubtful whether the Magistrate in fact had the power to amend the order in this way. Robert broke a condition of his release almost immediately and was quickly returned to hospital for the balance of the order.

Robert made an application to the Supreme Court for the order to be revoked. The Court declined to do this, but amended the order to allow Robert to be detained in hospital or a suitable residential rehabilitation service approved by the medical superintendent. As no suitable alternative was found, Robert spent the balance of the 12 months in locked wards of the psychiatric hospital. There was no suitable program for Robert, and he was discharged to private accommodation at the end of the period.

Robert has also been the subject of a guardianship order (later revoked) and an ongoing financial management order. On at least one occasion since his release from hospital Robert was unable to attend the Guardianship Tribunal hearings because he was so intoxicated he could not get out of his mother's car. He has also been extremely intoxicated on occasions when he has telephoned the Mental Health Advocacy Service solicitor. As against that, he has also had periods when he claimed to be alcohol free for six months or more.

The Commission is unaware of Robert's long term progress.

It is probable that Robert's life was saved by the initial inebriates order.

However, once the crisis had passed Robert received no appropriate treatment and was detained in a locked ward with severely psychotic people. This provided no benefit to Robert, but he did occupy a badly needed hospital bed.

4.57 The second person, a heroin user, absconded one month into his order and went underground. A third person, a man in his late 60s with significant cognitive damage, initially sought an inebriates order but a guardian was appointed for him instead, and he was found permanent accommodation in a secure aged care facility. However, after a few months, during which he regained much of his health and mobility, he decided to leave and took action to enable this to occur. Like the other two men, he returned to the streets. Ms Bishop reflected

[208] Submission 22, Alcohol and Drug Information Service, p7

on these outcomes, juxtaposing the men's complex needs with their right to self determination:

> These men were, by all counts, people who should have benefited most from being forced to stay in a treatment facility. But despite mandatory confinement, treatment and constant support, at best, it could be seen that their bodies had a rest from substance use and a chance to recover somewhat.[209]

4.58 Similarly, Legal Aid NSW reported the case of Robert, reproduced on the previous page, that illustrates how complex and entrenched some people's needs may be, and how blunt the *Inebriates Act* is as a mechanism to address them.

4.59 A more unusual comment on outcomes – in this case for the community - was made in the Mid Western Area Health Service submission. This comment is particularly interesting in the light of the previous discussion about behaviour and the use of the Act in rural areas to contain people whose behaviour cannot be tolerated:

> The use of the *Inebriates Act* may impair the development of local resources and responses, and there is the likelihood that the process may confirm a sense of hopelessness, especially in small communities, when the only "treatment" is the Act, and that 'it' does not seem to do much in the long term … as the Act stands it is of limited help, used only as a last resort, but at the same time it may hinder the development of more appropriate local resources.[210]

Discussion

4.60 In summary, the outcomes for people placed under inebriates orders, as reflected in the evidence before the Committee, are mixed. Some participants stressed positive outcomes, others negative, while some identified both. In the Committee's view it is noteworthy that we were given few, if any, examples of people who successfully overcame their substance dependence as a result of an order. At best, the Act was a circuit breaker, giving people time out from harmful substance use, restoring their health and providing an opportunity to reflect on and perhaps reduce the harm associated with their substance use. For a few the Act was a stepping stone towards long term care. It is also significant that several people were noted to have expressed appreciation that someone intervened to protect them from serious harm.

4.61 At the same time, the Committee has found that placement under the Act was not beneficial to numerous people. In some cases, not only did it not achieve anything positive, it actually caused psychological harm, and/or drove some to the extreme of escaping and going underground. Some simply sat out the time of their order, deprived of their freedom for a long time, with the very fact that they were detained undermining their preparedness to address the real problems behind their order. Thus the evidence before the Committee indicated that inebriates orders have been counterproductive in some cases.

4.62 In the Committee's view all of the positive outcomes reported to us are important and legitimate. They do, however, need to be weighed against the potential costs to the person in terms of their loss of liberty, the environment in which they are placed, and their access to

[209] Submission 22, Alcohol and Drug Information Service, p8

[210] Submission 53, Mid Western Area Health Service, pp2-3

appropriate treatments. The placement of people in mental health facilities, in particular, has emerged as a critical issue. In many of the cases where both tangible or more subtle harms were reported, this was identified as the cause.

4.63 A further important issue, we believe, is the length of time that people are detained under the Act. Many of the positive outcomes reported could surely be achieved within a much shorter period.

4.64 Interestingly, given the extent to which the Act is used to manage difficult behaviour, few people commented on whether it was effective in addressing that in the longer term. In Dr Patfield's view it is not, but it is effective in providing a break for the person's community or family for a time. Again this raises the question of how the competing rights of the person and their family or community are to be balanced.

4.65 In the Committee's view, the modest harm reduction benefits that the Act confers stand in contrast to the level and complexity of people's need. In considering the ethics of compulsory treatment we need to be clear about the purpose of involuntary interventions, and realistic about what they can achieve. Similarly, we need to be very mindful of people's right to self determination. Thus our analysis of the outcomes reported to the Committee raises the fundamental question of what the legitimate goals of compulsory treatment should be. Can we expect compulsory treatment to result in long term abstinence and/or changed behaviour, or should we limit our goals to saving lives in the short term and minimising harm? These issues form the basis for the ethical discussion that takes place in Chapter 6.

Repeal the *Inebriates Act*

4.66 The Committee reiterates our finding in the previous chapter that on the basis of the raft of criticisms documented there, the Act is an historical relic that grates against the current health and justice systems and actually cuts people off from the specialised drug and alcohol interventions that can assist them. The evidence in this chapter also indicates that some are placed under the Act in the absence of more appropriate services. It also reveals both positive and harmful outcomes for those placed under inebriates orders. We have concluded that despite a widespread understanding to the contrary, the *Inebriates Act* is used less for humane purposes than for the purpose of detention and control. Where harm reduction aims have been achieved this has been in spite of the Act's archaic and punitive premise.

4.67 Quoting from the findings of a draft discussion paper prepared by NSW Health in 1997, the Network of Alcohol and Other Drugs Agencies and the Council of Social Services of New South Wales summarised the faults of the *Inebriates Act* and called for it to be repealed:

- The Act offers little benefit to the community or to those individuals who are chronically substance dependent;
- The Act treats [intoxication] as a criminal rather than a health issue;
- Most of the provisions of the Act are rarely used;
- There are no appropriate facilities which can provide a secure environment as called for by the Act;

- The Act is used in a discriminatory manner – primarily against unemployed Aboriginal males;
- The Act infringes the civil rights of individuals without providing appropriate checks and balances;
- The Act cannot be amended in a way which would allow it to be consistent with current legislation and practice.[211]

4.68 While the vast majority of inquiry participants supported some sort of involuntary regime to enable carefully safeguarded involuntary intervention for people with serious substance dependence in certain circumstances, the vast majority also called for the Act's repeal. Like the Committee, they recognised the Act as draconian and ultimately unhelpful, and saw the value in starting afresh. This call came from a broad range of stakeholders, from legal bodies to the fill range of health professionals. As the NSW Chief Magistrate put it, 'It is my view that the Act ought to be repealed, and we should start again'.

4.69 As noted at the start of this report, despite much criticism and numerous formal reviews, the *Inebriates Act* has remained in effect, partly out of a concern as to what would happen without it in situations of extreme risk of harm. The Committee is very concerned to ensure that this situation not be allowed to continue. We consider that the *Inebriates Act* is irredeemable and must be repealed. We call for the development of new legislation, matched with an appropriate service framework, based on our consideration of the ethical issues in relation to compulsory treatment. At the same time, we are mindful of the need to ensure that there is an adequate safety net to capture those who might be at immediate risk before new legislation comes into effect. Thus we strongly encourage the Government to develop the new legislative and service framework as a matter of priority. Our recommendations for this new regime are set out in Chapters 6, 7 and 8.

Recommendation 1

That the *Inebriates Act 1912* be repealed and replaced at once with legislation reflecting subsequent recommendations of this report.

[211] Submission 29, NCOSS, pp13-14; Submission 29, NADA, pp13-14

Part Two

Chapter 5 The evidence on compulsory treatment

> … the absence of good literature makes it really hard to make confident statements about where we should go.[212]

> The most important thing I want to say is that there are no different treatments. There are no things to pull out of the hat and say "We can treat drug or alcohol dependence in this way if it were coerced". We are going to use the existing treatments and the risk is that they will be less effective in coerced individuals than in those who are not coerced.[213]

In the previous chapter the Committee concluded that the *Inebriates Act* is so archaic, and so open to misuse, that it should immediately be repealed and replaced with an entirely new framework for the involuntary treatment of people with drug and alcohol dependence. In this chapter, the Committee assesses the evidence about the efficacy of compulsory treatment of people with substance dependence, which we see as essential to any consideration of a new system for compulsory treatment. Before examining the available literature and anecdotal information we briefly examine the available treatments for substance dependence and their effectiveness. As the above quote from Professor Mattick of the National Drug and Alcohol Research Centre attests, these same treatments will necessarily be the ones provided in a compulsory setting. Our finding is that the available literature on compulsory treatment does not provide an adequate basis for strong conclusions about the effectiveness of compulsory treatment for non-offenders.

What treatment is available for drug and alcohol dependence?

5.1 In the following section we draw on the evidence of witnesses and the research literature to provide a brief overview of the available treatments for drug and alcohol dependence.

Detoxification

5.2 Ms Tonia Harvey, Area Director of Drug and Alcohol Services, Northern Sydney Health, told the Committee about the typical treatment pathway for people with severe drug or alcohol dependence, which commences with detoxification:

> Detoxification, followed by either residential rehabilitation or long-term follow-up on an outpatient basis. Some people, especially those with significant brain injury, may require supervised care in a structured environment and that is because it gives them boundaries by which to build their recovery.[214]

5.3 According to Ms Diane Paul, the manager of the detoxification unit of the Herbert Street Clinic, the detoxification process is crucial for:

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212 Ms Amy Swan, Research Fellow, Turning Point Drug and Alcohol Centre, Evidence, 28 April 2004, p35

213 Professor Richard Mattick, Director, National Drug and Alcohol Research Service, University of New South Wales, Evidence, 8 April 2004, p9

214 Ms Tonina Harvey, Area Director, Drug and Alcohol Services, Northern Sydney Health, Evidence, 4 March 2004, p5

> … getting clients to a stage where they can actually make some decisions based on the choices they have in managing their addiction and providing education links to support networks so that they will have the resources to access support in the event of a relapse.[215]

5.4 When an individual has become dependent on a substance, the detoxification process will involve physical withdrawal symptoms. This occurs when 'the drug of dependence is eliminated from the body, and any physical adaptation that has occurred as a consequence of dependent drug use is reversed.'[216] The severity and nature of the withdrawal symptoms vary according to the type and amount of drugs used. Alcohol withdrawal can entail delirium, seizures and convulsions, while for opioids, symptoms of withdrawal include irritability, anxiety, muscular and abdominal pains, chills, nausea, sweating and insomnia.[217] Cocaine withdrawal can involve dysphoric mood, fatigue, craving, insomnia or hypersomnia.[218] Professor Mattick noted the particular seriousness of alcohol withdrawal:

> Alcohol dependence is a bit different because it invokes the notion of tolerance to the effects of alcohol, and withdrawal can be quite severe. You can suffer an organic brain syndrome called delirium tremens. Of all the drug dependencies, alcohol withdrawal is the only one that has the potential to cause death. A lot of people do not appreciate that either. The potential of opiate dependence or other dependencies to cause serious harm is minimal. They are very uncomfortable withdrawal states but they do not cause death.[219]

5.5 Detoxification, or 'medicalised withdrawal', can take place in a variety of settings according to patients' needs and circumstances. It can be provided on an outpatient or inpatient basis, depending on the severity of dependence, the availability of family support, and the likelihood of complications and health risks. Medications are available to alleviate the symptoms of withdrawal or to prevent complications. For alcohol dependence, benzodiazepines such as diazepam are used to treat or prevent delirium and seizures, and anti-psychotic drugs can be used for treating hallucinations.[220] For opioid withdrawal, patients may be given reducing doses of methadone to minimise withdrawal symptoms. Drugs such as clonidine and lofexident have been found to have less success due to their adverse effects, while buprenorphine has fewer adverse effects.[221]

5.6 While detoxification is an important prelude to treatment, Professor Mattick noted that it does not of itself constitute treatment, it merely addresses the physical adaptation to the drug:

> Withdrawal management, or detoxification, is not a treatment for alcohol dependence; it is a way of managing people when they need to detoxify … It really is not a treatment that will stop heavy drinking, it is a way of managing, particularly for the

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215 Ms Diane Paul, Manager, Detoxification Unit, Herbert Street Clinic, Evidence, 4 March 2004, p8

216 Australian National Council on Drugs, *Evidence Supporting Treatment: the Effectiveness of Interventions for Illicit Drug Use*, Research Paper 3, (hereafter referred to as ANCD Research Paper), p16

217 ANCD Research Paper, p22

218 ANCD Research Paper, p28

219 Professor Mattick, National Drug and Alcohol Research Centre, Evidence, 8 April 2004, p1

220 National Alcohol Strategy, *The Treatment of Alcohol Problems: A Review of the Evidence*, June 2003, pp 31-33

221 ANCD Research Paper, pp23-24

> severe end of alcohol withdrawal, for epileptic seizures or delirium tremens, an organic brain syndrome that can eventually cause death. The thing that New South Wales and Australia lost over the last 15 years is that detoxification used to provide very good shelter and humane care. It gave people a place to have a shower, to get away from wet boarding houses or other environments for some time.
>
> Systematically over the 1990s those detoxification facilities were not supported and some closed. Some have reopened. They play an important role in terms of shelter and humanitarian care. It can be provided on an outpatient and inpatient basis, medicated and non-medicated. The most important point that the Committee needs to understand is that the international literature is quite clear; providing detoxification does not change people's drug use or alcohol use. It provides some health gains, potentially, and may be an entree into further treatment. The episode of detoxification, per se, is not a treatment for altering drinking or drug use. It is the way of simply managing the individual for a brief time …
>
> I think proclaimed places and detoxification are very important. That should be supported, but we have to recognise that it is not a treatment and then provide other treatments. That is my first point.[222]

5.7 Following detoxification, psycho-social therapies and/or pharmacotherapies such as naltrexone and acamprosate are typically used. Research into treatment of substance dependence reveals that a number of different interventions can be effective, to a greater or lesser degree. Common treatments are briefly described below.

Psycho-social therapies

5.8 **Cognitive-behavioural therapy** is based on a view of addiction as being:

> learned, maladaptive habit patterns acquired through the interactive processes of classical conditioning, instrumental learning and cognitive mediation … From this point of view, addictive behaviours are maladaptive coping responses when they become the central means individuals use to cope with the stress of life's demands.[223]

5.9 Addiction is considered to be the result of multiple factors, including biological (such as genetic vulnerability and substance-induced physiological changes), psychological and sociocultural factors.[224] Cognitive-behavioural therapy therefore seeks to 'replace addictive behaviours with new and more adaptive coping skills', and to help clients 'meet life's demands without resorting to the excessive use of alcohol and its associated problems.'[225]

5.10 Professor Mattick provided a broad outline of cognitive-behavioural therapy:

> We have a range of cognitive behavioural therapies for alcohol dependence. They are essentially skills training and development of better communication methods and

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222 Professor Mattick, National Drug and Alcohol Research Centre, Evidence, 8 April 2004, pp 3-4

223 Parks GA, Marlatt GA and Anderson BK, 'Cognitive-behavioural Alcohol Treatment', in N Heather and T Stockwell (eds), *Treatment and Prevention of Alcohol Problems*, John Wiley and Sons, Chichester, 2004, pp69-86, pp70-71

224 Parks et al, 'Cognitive-behavioural Alcohol Treatment', pp70-71

225 Parks et al, 'Cognitive-behavioural Alcohol Treatment', p72

> better relationships within the family. The social skills training involves behavioural self-management to set limits for alcohol consumption, cognitive restructuring, cue exposure - which helps people to cope with cravings for alcohol - and interventions for families and couples. There are also self-help guides and self-help materials. The international literature is clear that these interventions reduce drinking. It is quite convincing. They are not unavailable in Australia, but they could be more available.[226]

5.11 Therapists use a variety of interventions differing in intensity and duration, depending on the severity of dependence or abuse, cognitive or neurological impairment, and whether there are other psychiatric conditions present.[227] Interventions include social skills training, community reinforcement, behavioural contracting, aversion therapy, relapse prevention and cognitive therapy, as briefly outlined below.

5.12 Social skills training aims to address deficits in people's coping and life skills that are believed to be behind their substance abuse. It focuses on an individual's particular vulnerabilities and seeks to improve communication skills that will enhance social relationships. Skills training can concentrate on areas such as interpersonal relationships, dealing with stressors and coping with substance cues.[228] One treatment handbook notes that the evidence for the efficacy of this intervention as part of a treatment package is strong.[229] This type of intervention is considered particularly appropriate for severely dependent persons.

5.13 Studies have shown the community reinforcement approach to assist in maintaining abstinence and employment in alcohol dependent people in inpatient or outpatient situations. This approach seeks to enhance patients' access to 'positive activities and makes involvement in these activities contingent on abstinence'.[230] The success of community reinforcement lies, apparently, in its combination of different behavioural approaches and in involving patients in rewarding activities that do not involve drinking.[231]

5.14 In behaviour contracting, the client and therapist identify and make a 'contract' about particular drinking goals. This intervention is useful for providing alternatives to drinking, and has been evaluated as providing consistently positive results.[232]

5.15 Aversion therapies seek to generate an aversion to alcohol by 'establishing a conditioned response to cues associated with drinking'.[233] While conditioning through electric shocks has not been shown to be very effective, nausea aversion therapy, in which medications are used to induce nausea when alcohol is consumed, and covert sensitisation though 'imaginal techniques' have shown short-term success.[234]

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226 Professor Mattick, National Drug and Alcohol Research Centre, Evidence, 8 April 2004, pp4-5

227 Parks et al, 'Cognitive-behavioural Alcohol Treatment', p75

228 Brown JM, 'The Effectiveness of Treatment', in N Heather and T Stockwell (eds), *Treatment and Prevention of Alcohol Problems*, John Wiley and Sons, Chichester, 2004, pp9-20, p11

229 Brown, 'The Effectiveness of Treatment', p11

230 Brown, 'The Effectiveness of Treatment', p11

231 Brown, 'The Effectiveness of Treatment', p12

232 Brown, 'The Effectiveness of Treatment', p12

233 Brown, 'The Effectiveness of Treatment', p12

234 Brown, 'The Effectiveness of Treatment', p12

5.16 Relapse prevention is a behavioural approach that seeks to reduce the cues that can cause relapses, including stress, specific emotions and cravings. The treatment teaches patients to cope with these cues, and has had success in preventing relapses and assisting individuals to recover from relapses.[235]

> Psychological interventions also deal with situations where a risk of relapse is high. This is an important area that also has a good evidence base in the international literature. It is called relapse prevention. It recognises that alcohol and other drug-use disorders are chronic relapsing disorders and that these interventions identify factors likely to cause relapse and help people to develop strategies to overcome those situations. They can be used in a number of settings.[236]

5.17 The Committee heard that relapse is common, and should not be considered as evidence of failure of the treatment. As Ms Harvey told us when we visited the Herbert Street Clinic at Royal North Shore Hospital:

> It is important to recognise that relapse is part of the journey for a percentage of clients. What is important are the gains made in between those relapses and, hopefully, a realistic expectation is that the length of sobriety will extend over time. As clients build new skills in dealing with how they feel - other than using substances - there is an opportunity there for them to make significant life changes. We accept that it is part of the process.[237]

Brief interventions and motivational interviewing

5.18 Brief interventions – which can be as short as a few minutes or a few sessions – aim to assist the patient to recognise their substance abuse problem, to become committed to change and seek to provide skills training. They have some success in reducing alcohol consumption. Motivational interviewing is often used during such interventions, and aims to initiate a person's motivation to change, by providing information about risk and harm, and using 'encouragement and empathy' to help overcome the client's hesitation to change.[238]

5.19 Professor Mattick briefly explained motivational interviewing to the Committee:

> Motivational interviewing is a more recent intervention. It introduces the notion of stages of change; that is, drinkers are at different stages in their desire to change their drinking. Some people are not really thinking about it and some people think they should but have not thought it through. Others are ready to change and some are trying to. The motivational interviewing process, which feeds back the health effects to the drinker, allows for the individual to engage in changing his or her motivation to stop drinking or using drugs.[239]

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235 Brown, 'The Effectiveness of Treatment', p12

236 Professor Mattick, National Drug and Alcohol Centre, Evidence, 8 April 2004, pp4-5

237 Ms Harvey, Northern Sydney Health, Evidence, 4 March 2004, p8

238 Brown, 'The Effectiveness of Treatment', pp10-11

239 Professor Mattick, National Drug and Alcohol Research Centre, Evidence, 8 April 2004, pp4-5

5.20 Brief interventions and motivational interviewing are appropriate for people who are abusing alcohol rather than those who are dependent on it.[240]

Self-help groups

5.21 Studies suggest that evidence of the effectiveness of self help groups such as Alcoholics Anonymous and Narcotics Anonymous in preventing relapse is limited and mixed.[241] Nevertheless, a number of practitioners including Mr Owen Brannigan, Manager of the Phoenix Unit residential rehabilitation program with Northern Sydney Health explained to the Committee that self-help group therapy is useful for some patients:

> Alcoholics Anonymous and Narcotics Anonymous, any of the self-help groups, can be a useful adjunct to our services because people who are severely dependent would rarely still be living in the world they used to live in, so they would have lost a great deal of things. They would have caused sometimes irreparable damage to their social and family relationships. They can experience a tremendous sense of isolation. So linking them into self-help groups to let them know that they are not the only person who has suffered from this problem, to let them know that there are people who have had to fight similar battles, that can be useful for those people and can benefit them greatly. At the Phoenix Unit, of which I am the manager, we have a consumer group.[242]

Medications

5.22 Pharmacotherapy – the treatment of a disease through medication – is available for drug and alcohol dependence. The Committee heard from Dr Stephen Jurd, an addictions psychiatrist and Area Medical Director of Drug and Alcohol Services with Northern Sydney Health that a number of new medications have become available in recent years:

> Addiction medicine in general is a new specialty. The College of Physicians has only recently organised a chapter of addiction medicine that is only 18 months or two years old. Drug and alcohol dependent people in the past have largely being treated as social, not really clinical. There were not many specific medications. When I started in drug and alcohol back in 1983, basically there were only two medications that were used and that was valium for withdrawal and methadone for people with opiate dependence, provided that you do not call vitamin B1 a medication. But now there is an increasing number of medications … There is more on the market, and so now we are beginning to have a field that is more consistent with other fields, and so we are in a better position.[243]

5.23 Early medications for alcohol dependence were **aversion therapies**, and included drugs such as disulfiram that sought to provide a deterrent by inducing disagreeable physical reactions

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240 Brown, 'The Effectiveness of Treatment', pp10-11

241 ANCD Research Paper, p73

242 Mr Owen Brannigan, Manager, Phoenix Unit Residential Rehabilitation Program, Evidence, 4 March 2004, p7

243 Dr Stephen Jurd, Area Medical Director and Addictions Psychiatrist, Drug and Alcohol Services, Northern Sydney Health, Evidence, 4 March 2004, p7

after alcohol had been consumed. The reactions include flushing, headache, nausea, and tightness in the chest.[244] Studies revealed that disulfiram had only limited success in improving abstinence, though this increased if compliance with taking the medication was supervised. There is limited evidence that disulfiram, when combined with buprenorphine or methadone maintenance, may reduce cocaine use in people who are also opioid dependent.[245]

5.24 The Committee was told that **anti-craving medications** can be useful in reducing 'the dysphoria associated with people's ruminations about the substance they have been using'.[246] Acamprosate is one such medication that has been seen to have success in treating alcohol dependent persons. The literature reveals that acamprosate treatment:

> typically [enhances] completed abstinence by some 20% above the rate achieved in the placebo group (ie approximately doubling the proportion of complete abstainers) for up to 1 year … These studies also found that the cumulative total of days of abstinence was significantly greater in the acamprosate-treated patients.[247]

5.25 The Committee heard that acamprosate is available in Australia under the Pharmaceutical Benefits Scheme (PBS):

> Acamprosate has been the subject of 12 randomised clinical trials involving 3,800 patients in eight countries. The trials began in the 1980s and it was approved in 1999 and listed on the PBS in the same year.[248]

5.26 Opioid antagonists such as naltrexone are considered '**blocking agents**' and work by displacing opioids from receptor sites, thus blocking the effects of the opioid. Naltrexone is also believed to reduce cravings for opioids. Although naltrexone is more commonly known as a treatment for opioid addictions, it also can be an effective treatment for alcohol dependence (in combination with psychological therapy). Opioid antagonists are believed to interfere with the endorphin transmission in the brain, which in turn reduces the 'rewarding' effects of alcohol consumption. The effects of naltrexone make it useful in reducing 'catch-up' drinking or drug use that can occur during relapses after periods of abstinence.[249] The Australian Therapeutic Goods Authority [TGA] approved naltrexone in January 1999, and it was PBS listed in February 2000.[250]

5.27 The literature suggests some success for treatment with naltrexone. Three double-blind randomised controlled studies have shown that detoxified alcohol dependent patients in an outpatient program taking naltexone have a reduced risk of relapse over a three month period.

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244 Chick, 'Pharmacological Treatments', in N Heather and T Stockwell (eds), *Treatment and Prevention of Alcohol Problems*, John Wiley and Sons, Chichester, 2004, pp 53-68, p54

245 cited in ANCD Research Paper, p55

246 Mr George Klein, Behavioural Scientist, Centre for Drug and Alcohol Medicine, Nepean Hospital, Evidence, 7 April 2004, pp54-55

247 Chick, 'Pharmacological Treatments', p61

248 Professor Mattick, National Drug and Alcohol Research Centre, Evidence, 8 April 2004, pp4-5

249 Chick, 'Pharmacological Treatments', p57

250 Professor Mattick, National Drug and Alcohol Research Centre, Evidence, 8 April 2004, pp4-5

For example, in one study cited by Chick, the relapse rate for patients completing naltrexone treatment was 25%, compared to 53% for the placebo group.[251]

5.28 One disadvantage with naltrexone appears to be a high level of patient drop-out, with various studies showing between 22.5% and 58% of participants leaving treatment within the first week, and between 39% and 74% leaving by the end of the second week.[252] One study indicated that less than 20% of patients remain in treatment for more than six months, which compares unfavourably with a 60-80% retention over 12 months for methadone maintenance treatment.[253]

5.29 **Substitution treatment** for opioid dependence has been available for some years. This type of treatment 'entails the prescription of a drug with a similar action to the drug of dependence, but with a lower degree of risk'.[254] The main aim of substitution is to stabilise the health and social situation of users as a stepping-stone to further treatment.

5.30 Methadone maintenance is the most commonly used opioid substitute and works by preventing withdrawal symptoms, thus decreasing the frequency of use of opioids.[255] Research cited in the Australian National Council on Drugs literature review suggests that methadone maintenance 'substantially reduces but does not eliminate heroin use' amongst clients, and is 'more effective than no treatment or placebo in reducing rates of imprisonment, reducing heroin use, retaining clients in treatment, and supporting employment or return to further education'.[256] Alternative opioid substitution treatments include buprenorphine and Levo alpha acetyl methadol (LAAM).[257]

5.31 When combined with psychosocial therapies such as regular counselling, social work, family and employment counselling and contingency management interventions, the effectiveness of methadone maintenance increases.[258]

How successful is treatment for substance dependence?

5.32 Mr Klein of the Centre for Drug and Alcohol Medicine at Nepean Hospital told the Committee that treatment for drug and alcohol dependence generally (that is, for both voluntarily-accessed and compulsory treatment) has success over time:

> As a working clinician I see that the impact of treatment - you could say that this is a kind of convenient clinical fiction that I am creating to justify my own position. But after a quarter of a century what I see is that the impact of treatment is cumulative: people get better at recovery, and sometimes it takes them a long time. The reason it

251 Chick, 'Pharmacological Treatments', pp58-59

252 cited in ANCD Research Paper, p42

253 cited in ANCD Research Paper, p30

254 ANCD Research Paper, p30

255 ANCD Research Paper, p30

256 ANCD Research Paper, p35

257 ANCD Research Paper, pp36-39

258 cited in ANCD Research Paper, p59

> takes them such a long time is the way that psychoactive substance use impacts on decision making.
>
> … My view is that people become better at recovery and that treatment provides people with a gradually increasing repertoire of internal defences against the compulsion to take their substance … After a quarter of a century, it is my understanding that people do not decide to give up taking drugs or taking alcohol. Rather, they get better at accepting opportunities not to take these substances. They get better at saying yes to alternatives.[259]

5.33 An important point made by inquiry participants is that any evaluation of treatment success is dependent on the definition of success. While abstinence is the goal of treatment for people with severe dependencies,[260] participants such as Dr Richard Matthews of NSW Health suggested that total abstinence is not a realistic measure of success:

> … we need to define "success". If success is abstinence, then there are fairly poor results for most types of dependence … There is good evidence, for instance, about the effectiveness of methadone maintenance in reducing crime, reducing seroconversion and reducing death, if they are your outcome measures. But if abstinence is your outcome measure, there is not terribly good evidence around about anything much. It is a question of the definition of success.[261]

5.34 Professor Mattick cautioned against unrealistic expectations about treatment outcomes:

> We have another problem when we think about drug dependence as a community. That is, that we would like to cure it. We do not think of curing necessarily other diseases such as diabetes, schizophrenia, depression or hypertension. Unless the community can get out of the notion that we will cure this disorder and only manage the other ones we will be left in a situation where we are always looking for a therapeutic ideal. It is a real problem in this area. We want cure and we are not going to get it. We have good methods of management as we do for other disorders. This has been said before, and you have probably heard it here before, but it is an important point. It is a subtle point that people miss - they slip back into it, but if we can only get them to stop.
>
> If you move away from substance disorders to something like panic disorder, which is an anxiety disorder. We do not feel that we have failed if the panic attacks reduce but someone has one or two every month instead of one or two a day. We feel we have succeeded. With alcohol or other drug disorders if they return to drug use we feel we have failed. It is an issue of management more than cure. There is a need for repeated treatment episodes as there is for blood pressure problems and diabetes when people are not compliant with their medication. There is a need for the avoidance of unrealistic expectations of a therapeutic ideal of cure. That is not an ideal that is applied to other disorders. We are on an uneven playing field here. It actually has quite negative consequences in the drug and alcohol field because the area is criticised if we do not achieve the therapeutic ideal. [262]

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259 Mr Klein, Nepean Hospital, Evidence, 7 April 2004, pp54-55

260 Professor Mattick, National Drug and Alcohol Research Centre, Evidence, 8 April 2004, pp6-7

261 Dr Richard Matthews, Acting Deputy Director General, Strategic Development, NSW Health, Evidence, 11 December 2003, p20

262 Professor Mattick, National Drug and Alcohol Research Centre, Evidence, 8 April 2004, p2

5.35 Similarly, Dr Wilce from the Kirketon Road Centre noted:

> I want to comment on what we consider success is. For me with the case studies that I have talked about, success in a way is keeping them alive and trying to give them a safe breathing space for a short period of time.[263]

5.36 According to a literature review by Ms Amy Swan and Ms Sylvia Alberti of the Turning Point Alcohol and Drug Centre, prepared for the review of the Victorian compulsory treatment legislation, there are six key goals of drug treatment:

- reduced drug use
- reduced blood borne virus transmission
- reduced drug-related mortality
- reduced drug-related crime
- enhanced social functioning
- improved general health and wellbeing.[264]

5.37 The authors reported that a range of studies had demonstrated that treatment for drug dependence is effective across various treatment modalities, with reductions in drug use and improvements in health and wellbeing evident.[265]

The effectiveness of compulsory treatment

5.38 Unfortunately, the Committee was unable to find significant evidence of the efficacy or otherwise of compulsory treatment of individuals with drug or alcohol dependence. That there is a dearth of available evidence is confirmed by the findings of the literature review by Turning Point Alcohol and Drug Centre conducted for the review of Victoria's *Alcoholics and Drug Dependent Persons Act 1968*. Ms Amy Swan, Research Fellow at Turning Point told the Committee:

> … there is very little good research about the effectiveness of compulsory treatment and outcomes. I suggest there is some in relation to drugs and crime issues, but in relation to civil commitment we can't make any conclusions about the effect of interventions because there is very little research. And what does exist warrants further research. [266]

5.39 Ms Swan noted that much of the literature dealing with compulsory treatment of non-offenders fails to provide insight about the effectiveness of this treatment mode:

> One of the problems with all of this literature is the lack of good research. In terms of the broader area of compulsory treatment, there was a review of all research done by Wyle et al. (2002). They reviewed 170 publications in relation to compulsory

263 Dr Hester Wilce, Medical Practitioner, Kirketon Road Centre, 7 April 2004, p6

264 Amy Swan and Silvia Alberti, *The Alcoholics and Drug-dependent Persons Act 1968: A Review*, March 2004, p12

265 Amy Swan and Silvia Alberti, *The Alcoholics and Drug-dependent Persons Act 1968: A Review*, March 2004, p12

266 Ms Amy Swan, Research Fellow, Turning Point Alcohol and Drug Centre, Evidence, 28 April 2004, p26

> treatment. Only 18 of those pertained to effectiveness, and 83% of those were methodologically unsound. That tells you very little about the effectiveness of compulsory treatment – and that is an area about which plenty has been written.[267]

5.40 Only a handful of useful studies were found during the literature review, and these revealed mixed outcomes:

> In terms of civil commitment, we came up with four studies. Two of these were Swedish PhDs that we were not able to access, but had some cited material about. One of the key studies was a Swiss outcome study by Bourquin-Tieche et al in 2001. Seventeen consecutive cases were admitted to an alcohol unit. These people had complex medical, social and psychological alcohol related problems, and there was a risk of death in 15 of 17 of those cases. They stayed in treatment on average 29 weeks and they were followed up after 18 months - and 10 of them could be followed up. So we are talking about really small case numbers here.
>
> Bourquin-Tieche et al found that civil commitments of this group were a lifesaving measure, and they found increased health and wellbeing. Eight of the 10 reported abstinence at eight months, and a leap was made that abstinence equals increased life expectancy, thus the positive outcomes.
>
> The two Swedish dissertations by Solomon in 1999 and Gerdner in 1998 reported significant decreases in alcohol intake, but they still had high mortality rates - much higher-than-expected mortality rates.
>
> In Colorado there was a study by Steiner et al in 1995, which was an acute alcohol treatment at a general hospital, and they had a sample of 99 - a decent-sized patient quota - and these again were consecutive patients. This study found poor treatment outcomes regarding alcohol use, with 60 per cent of the group drinking again six months post intervention.[268]

5.41 The Kirketon Road Centre's search for literature on compulsory treatment of non-offenders identified two research papers. The Centre's submission cited a 2002 Canadian paper focusing on compulsory drug treatment that concluded that 'the main issue, arguably, is that their true effectiveness and cost-effectiveness remains to be proven'.[269] The other paper cited in the submission is an American study which looked at 850 articles on mandatory alcohol and drug treatment and concluded that 81% of them were opinion pieces, legal interpretations, or ethical treatises rather than methodologically sound, original research pieces.[270]

5.42 Asked by the Committee whether there is a sound enough evidence base to indicate that compulsory treatment can actually be of benefit, Professor Wayne Hall of the University of Queensland, and one of the few Australian academics to have published on compulsory treatment responded:

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267 Ms Swan, Turning Point Alcohol and Drug Centre, Evidence, 28 April 2004, pp30, 32

268 Ms Swan, Turning Point Alcohol and Drug Centre, Evidence, 28 April 2004, pp30, 32

269 Fischer B, Roberts JL, Kirst M, 'Compulsory treatment in Canada: historical origins and recent developments', *European Addiction Research*, 2002, 8, p61-68, cited by Dr Hester Wilce, Submission 30, Kirketon Road Centre, p4

270 Wild TC, 'Compulsory substance user treatment and harm reduction: a critical analysis', *Substance Use and Misuse*, 1999, 34(1), pp83-102, cited in Submission 30, Dr Hester Wilce, Kirketon Road Centre, p4

> I think the short answer would have to be "no". I think there is somewhat better evidence for coerced treatment than there is for civil commitment, if we use that in the sense of drug dependent people being committed for their own good rather than because they have committed an offence.
>
> I do not know of any controlled studies of civil commitment, certainly with alcohol. There was some work done in California in the 1960s, the civil commitment addict program there, although a lot of those people in fact were committed because they had committed offences rather than because they were simply using opiates and were dependent on them.
>
> There was a recent update of the review which I did in 1997, which is now seven years old. There was a recent paper in the European *Addiction Research Journal* reviewing the literature since then, which comes to broadly the same conclusion: that there is not a lot of strong evidence for efficacy and it is almost all in the area of coerced treatment … With regard to the civil commitment addict program, I do not know of any evidence that would support that.[271]

5.43 Given that Sweden has made significant use of compulsory treatment for over 90 years, the Committee had hoped that that country would be a source of useful evaluative material. However, as Dr Matthews, who visited Sweden to collect information to inform New South Wales policy in relation to treatment of offenders, pointed out, this is not the case:

> In other jurisdictions where similar legislation applies - and the most notable example would be Sweden - we have been unable to find through a literature search any scientific evaluation or research in relation to their legislation which I think has been in force since 1913 in a country where there are something like 4,000 secure beds for a population of 6 million. There is a very strong belief that it works, but no evidence.[272]
>
> I have to comment that Swedish society is somewhat different to ours. They, as a community, have accepted that the State has a degree of responsibility for the individuals that we, as a nation of somewhat rugged individualists, possibly would not accept. So there is a difference in philosophy within the community in Sweden. In answer to your question, no, I do not really have any basis on which I can make an assessment. Until fairly recent times they have also been one of the most homogenous communities on the planet and that is another factor. Within our society as well, we have a great number and growing difference in cultural views about alcohol that would also need to be taken into account in relation to treatment programs and that, in itself, is a tricky issue.[273]

5.44 The literature about compulsory treatment of non-offenders leaves us with many unanswered questions, and the Committee considers that it is an inadequate basis on which to draw any safe conclusions in relation to effectiveness. As Ms Swan, one of the authors of the literature review noted:

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271 Professor Wayne Hall, Professorial Fellow and Director, Office of Public Policy and Ethics, Institute for Molecular Bioscience, University of Queensland, Evidence, 29 April 2004, pp2-3

272 Dr Matthews, NSW Health, Evidence, 11 December 2003, p17

273 Dr Matthews, NSW Health, Evidence, 11 December 2003, p19

> … the literature is really bare. Lots of it is discursive and descriptive. That was one of the things that we were really clear about when we did the review; that there is not a lot to draw on that's hard and good data, so we should be cautious about it.[274]

Anecdotal evidence on effectiveness

5.45 In the absence of rigorous research on the outcomes of compulsory treatment, the Committee obtained the views of a number of practitioners. The submission from Kirketon Road Centre, while noting the absence of research on the outcomes of compulsory treatment, commented:

> While it is clear from a large body of research that an individual's motivation for change is critical to the success of treatment, it is not clear how effective compulsory assessment and treatment is. An individual who recognises that he/she has a problem and actively seeks help or displays readiness for treatment is far more likely to succeed in treatment than someone who feels coerced into treatment.[275]

5.46 Professor Mattick also observed that motivation is important in successful treatment outcomes:

> I think the answer is that [if] people are disinterested in altering their drug use behaviour - they won't. What you can do, however, is deal with their physical problems and then, through that process, I think it is very important to capture that you can actually get those individuals to become more motivated … So I think engaging people that way is likely to be helpful. Diverting resources from the health care sector to deal with people who do not want to be in treatment and trying to make them change is likely to get less good outcomes than leaving the money where it is.[276]

5.47 Dr Glenys Dore, an addictions psychiatrist and Deputy Medical Superintendent at Macquarie Hospital, noted that there are some people who do not wish to access treatment, as well as others for whom there are no successful treatment:

> The difficulty is that this patient group do not want those services. They do not want to go to detox, or they do not want to go to rehabilitation, or they do not want to go on methadone programs, or they do not want to go on [acamprosate]. They would prefer to be using drugs and alcohol. The services are there, but they either do not want to use them or in some cases they have gone to all those programs and they are still not succeeding.
>
> There are some patients for whom we simply do not have treatments that will be successful. There are cases of individuals that we just do not have adequate treatment services for or they do not exist. We do not know when we will have them. We do not have medication that controls everyone's addiction. So there are individuals who will not survive their problems with addiction and who we will not be able to help, unfortunately, with the best treatment services in the world. [277]

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274 Ms Sylvia Alberti, Manager, Forensic and Clinical Services and Senior Research Fellow, Turning Point Alcohol and Drug Centre, Evidence, 28 April 2004, p32

275 Submission 30, Kirketon Road Centre, p3

276 Professor Mattick, National Drug and Alcohol Research Centre, Evidence, 8 April 2004, p14

277 Dr Glenys Dore, Addictions Psychiatrist and Deputy Medical Superintendent, Macquarie Hosptial, Evidence, 4 March 2004, p11

5.48 While supportive of compulsory treatment, Ms Diane Paul of the Herbert Street Clinic noted a number of challenges associated with imposing treatment on unwilling patients:

> While staff are skilled in using strategies such as motivational interviewing and working with clients to assist them in making changes to their lifestyle this is not always successful. In fact, I found the most challenging group of clients to manage are those who feel that they have been pressured into the treatment facility by others, such as family members, case managers or probation officers.
>
> On the other hand, many clients who are initially lacking motivation for treatment do manage to complete the program and choose to go into rehabilitation post-detoxification. Our main challenge is to get clients through the first three days, get them through the withdrawal process so that we can actually have a chance to work with them.[278]

5.49 Ms Alberti advised the Committee that compulsory treatment can be valuable for some individuals:

> the people who actually participate in it report back - or a large number of them have reported back - that they found it useful or lifesaving. And the field, regardless of where they come from, whether they be police or magistrates or health practitioners, are saying that for a very, very small number of people this can be a very beneficial intervention.[279]

5.50 Similarly, Professor Hall noted some benefits:

> If one were to look at the more positive side of the *Inebriates Act*, there is certainly an important harm reduction function that was served in the wards that I worked in. We did clean people up and got them into much better shape, and by the end of the week they were looking a lot better, before they were shipped off to Bloomfield Hospital in Orange, often for six months at a time.[280]

5.51 This was reflected in the Swiss study referred to earlier, in which:

> The usefulness of residential civil commitment of certain severely impaired alcohol dependent patients is underscored. This study suggests that civil commitment not only may save the lives of endangered patients but could also be a health-promoting measure that may sometimes allow for recovery from dependence. Unexpectedly, this measure was retrospectively well accepted by many patients, who considered the commitment decision as having been justified and useful.[281]

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278 Ms Paul, Herbert Street Clinic, Evidence, 4 March 2004, pp8-9

279 Ms Alberti, Turning Point Alcohol and Drug Centre, Evidence, 28 April 2004, p31

280 Professor Hall, University of Queensland, Evidence, 29 April 2004, p5

281 Bourquin-Tieche, D, Besson J, Lambert H, Yersin, B, 'Involuntary treatment of alcohol dependent patients: a study of 17 consecutive cases of civil commitment', *European Addiction Research*, Vol 7 No 2, 2001, pp48-55, p48

Conclusion

5.52 In this chapter the Committee has briefly overviewed the broad range of treatments available for drug and alcohol dependence, and noted the varying success rates for them. We have also documented the available literature, along with anecdotal information, on the effectiveness of compulsory treatment. What is clear from the information before the Committee is that the evidence relating to the efficacy of compulsory treatment of non-offenders is scant. The few methodologically sound studies that have been published had equivocal findings, with mixed outcomes for those subject to coercion. Anecdotal evidence relayed to the Committee was similarly variable. In the Committee's opinion, the absence of any substantial evidence base for benefits of compulsory treatment raises serious questions about the ethics and cost-effectiveness of instituting a compulsory treatment regime.

Chapter 6 When is compulsory treatment ethically justified?

> The question has to be asked where and how do we draw the line, if at all, in these cases?[282]

> When working with "inebriates" there is a fundamental ethical question: Do people have the right to drink themselves to death?[283]

At the heart of this inquiry lies the question of whether compulsory treatment of people with substance dependence is ethically justified. In what circumstances is the state permitted to override the fundamental right of an individual to choose their own actions? In Chapter 4 the Committee also posed the critical question of what the legitimate goals of compulsory treatment might be, not only in light of people's rights and freedoms, but also in light of what such interventions can realistically achieve. This chapter explores the ethical issues surrounding compulsory treatment and identifies the circumstances where the Committee believes some form of involuntary intervention is justified, and what the purpose of such interventions should be. The discussion is structured around three distinct potential goals for coercive interventions: addressing substance dependence, harm reduction, and protecting the interests of others. We conclude that involuntary interventions may be justified for the purpose of reducing harm to self. At the same time, a new approach using non-coercive measures to assist people with complex needs and antisocial behaviour is required.

Complex ethical issues

6.1 The vast majority of inquiry participants sought some form of legislative mechanism enabling compulsory treatment to replace the *Inebriates Act*, arguing that a safety net was important to protect people in extreme situations of substance dependence. However, the previous chapter showed clearly that research in support of compulsory treatment is extremely limited. This finding has important implications for the inquiry: not only is it unfeasible to recommend policy with a poor evidence base, it is also unethical to intervene against someone's will when it is unknown whether the intervention is likely to benefit them.

6.2 Inquiry participants readily noted the ethical dimension to the debate on compulsory treatment, most notably in relation to whether involuntary intervention is ever justified, in what circumstances, and what that intervention might reasonably involve. At the centre of the ethical debate is the most fundamental principle of liberal democracy, the liberty of the individual, and the critical question of when the state may legitimately encroach on the autonomy of its citizens. In relation to compulsory treatment, that encroachment on autonomy may take various forms at once: detention of the individual, enforced abstinence and the imposition of medical intervention without consent. In the case of alcohol dependence, such intervention has greater implications in that coercion is being exercised in relation to use of a legal drug.

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[282] Submission 16, North Coast Regional Coordination Management Group, p3

[283] Submission 53, Mid Western Area Health Service, p1

6.3 It is a weighty decision to detain and treat someone against their will, and it is critical that the conditions under which this may occur are carefully considered so that any deprivation of liberty, even for a short period, is properly justified.

6.4 Moreover, the Committee acknowledges that the moral judgements that are often made in relation to substance dependence, in addition to the impact that substance dependence and accompanying behaviours can have on others, means that there are significant dangers that such a mechanism may be misused, intentionally or unintentionally. Our finding in Chapter 4 that the *Inebriates Act* is primarily used for detainment and control of people with difficult behaviour is testimony to this risk. As Dr Hester Wilce stated in the Kirketon Road Centre submission:

> Mandatory treatment has civil liberty implications. There should be clear reasons for compelling individuals to treatment to ensure that we as a community are not merely mandating treatment to punish 'bad behaviour' or as a tool for social control. It could be argued that providing individuals are of sound mind and do not harm others they should retain the right to engage in potentially self destructive behaviour.[284]

6.5 Similarly, Dr Glenys Dore of Macquarie Hospital argued that we need to be very careful about who might be subject to involuntary treatment:

> We do not want those kinds of situations arising under the Act whereby anyone, as a heroin user, a stimulant user or an ecstasy user, finds themselves incarcerated in hospital because they have chosen to use a drug and their family are not happy about it. I think we really have to confine the definitions of who we would want to have placed under a compulsory treatment order.[285]

6.6 In Chapter 4, in which we considered the current use and outcomes of the *Inebriates Act*, the Committee identified a number of philosophical questions arising from the evidence before us:

- To what extent are the problems arising from severe substance dependence best met within a voluntary framework?
- When is involuntary intervention justified, and conversely, when does society have a duty to intervene?
- How are the potentially competing rights of the person and their family or the community to be weighed?
- When are we ethically bound to accept a person's substance use and resulting behaviour?
- What is the legitimate purpose of involuntary intervention?
- How much can compulsory treatment reasonably be expected to achieve?

6.7 In seeking the views of a range of inquiry participants about these issues, several other philosophical questions emerged. Significantly, many of these questions related to substance

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284 Submission 30, Kirketon Road Centre, p4

285 Dr Glenys Dore, Addictions Psychiatrist and Deputy Medical Superintendent, Macquarie Hospital, Evidence, 4 March 2004, p9

dependence and its effects, which seems to add a further level of complexity to the ethical issues at hand:

- What does the fundamental principle of the autonomy of the individual mean when a person's decision making capacity may be temporarily or permanently affected by their substance use?
- Can people overcome serious substance dependence as a result of compulsion or do they have to be motivated to change?

Human rights

6.8 The starting point for a discussion on ethics and compulsory treatment is human rights. The Committee believes it imperative that any new legislation enabling involuntary intervention for people with substance dependence has a strong foundation on human rights.

6.9 In Chapter 3, on the evidence of Terry Carney, Professor of Law at the University of Sydney, the Committee noted that the *Inebriates Act* fails to comply with the United Nations *Principles for the Protection and Care of People with Mental Illness*, which sets out the rights and freedoms of voluntary and involuntary patients, including in relation to treatment without the person's consent. The *Principles* stipulate that involuntary treatment may be given only on the condition that an independent authority is satisfied that the person lacks the capacity to consent or unreasonably withholds their consent, and that the proposed treatment is in the person's best interests. Alternatively, it may be given where a medical practitioner determines that it is urgently necessary to prevent imminent harm to the person or others. It should not be provided for longer than strictly necessary.[286] Involuntary admission may only occur when a person is considered by a medical practitioner to be mentally ill, and as a result, that there is a serious likelihood of imminent harm to the person or to others, or that failure to admit the person is likely to lead to a serious deterioration in their condition or will prevent the giving of appropriate treatment.[287]

6.10 Human rights frameworks are drawn from liberal theories of the state dealing with the rights of individuals and the corresponding duties of the state and civil society. Explaining John Stuart Mill's theory of utilitarian liberalism to the Committee, Professor Carney noted that the state's interference in the lives of citizens is justified on the basis of harm to others or harm to self. Harm to others is the rationale for intervention under criminal law: an offender's autonomy may be overridden because he or she has violated the autonomy of others by causing them harm. Interference on the basis of harm to self may be justified on the grounds of 'paternalism' or 'beneficence', that is to protect the wellbeing of the person. However, such interference is subject to certain conditions. Drawing on liberal theory and the UN *Principles*, Professor Carney identified three necessary conditions for interference on the basis of harm to self:

- The presence of real or substantial harm (or the threat of imminent serious harm)

286 United Nations, *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, Adopted by General Assembly Resolution 46/119 of 17 December 1991, Principle 11, paragraphs 6 and 8

287 United Nations *Principles,* Principle 16

- A lack of capacity on the part of the person to consent to treatment to alleviate the harm and
- A demonstrable benefit expected from the proposed intervention, as reflected in a treatment plan.[288]

6.11 Other inquiry participants readily recognised the high threshold and strong principles that must necessarily accompany involuntary treatment. Professor Wayne Hall, Professorial Fellow and Director of the Office of Public Policy and Ethics, Institute for Molecular Bioscience at the University of Queensland, told the Committee:

> I do accept that paternalism can be justified under certain circumstances. When we are doing something for a person's own good, I think the bar has to be higher than it is in the case when we are doing something because people have committed an offence against third parties, as in the case of offenders. Clearly, there has to be evidence that a person's autonomy and capacity to make informed decisions is impaired by reason of their addiction. They have to be at some immediate risk of serious harm. The interference with their autonomy ought to be temporary, for the minimum required to intervene to prevent that harm from occurring and to provide them with an opportunity for treatment. Again, I would be in favour of there being judicial oversight, preferably with the same kind of representation as occurs under the *Mental Health Act*. Humane and effective treatment should be provided to people who are treated in that particular way.[289]

6.12 In previous chapters the Committee highlighted the draconian premise and outcomes of the *Inebriates Act*: control rather than effective treatment. Under a modern framework, involuntary treatment of non-offenders is necessarily in the person's interests, and must have the capacity to assist them. Correspondingly, Mr John Feneley, Assistant Director General of the Attorney General's Department, emphasised the need for a sound evidence base showing that intervention against a person's will has the capacity to benefit them:

> I think the guiding principle, as in so many of these things, is that if we are going to act first we should do no harm. So we need to know that what we do is going to be beneficial … If we are going to put a person into some sort of custody, and it is going to be for any lengthy period of time, then we need to be offering them something; we need to be making the most of that opportunity. Therefore, we talk about the fact that there needs to be real treatment available and some sort of quality treatment which has a solid evidence base.[290]

The goals of compulsory treatment

6.13 Drawing on these important principles and preconditions for involuntary intervention in the lives of citizens, in the following sections the Committee analyses the evidence gathered throughout the inquiry to identify whether the *Inebriates Act* should be replaced with modern

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288 Professor Terry Carney, Professor of Law, University of Sydney, Evidence, 8 April 2004, pp17-18

289 Professor Hall, Professorial Fellow and Director, Office of Public Policy and Ethics, Institute for Molecular Bioscience, University of Queensland, Evidence, 29 April 2004, p2

290 Mr John Feneley, Assistant Director General, Policy and Crime Prevention, Attorney General's Department, Evidence, 11 December 2003, p7

compulsory treatment legislation. This discussion is structured around the potential purposes of such a system:

- Compulsory treatment aimed at address substance dependence
- Compulsory treatment aimed at reducing harm
- Compulsory treatment in the interests of others.

Compulsory treatment aimed at addressing substance dependence

6.14 The key principle that interventions must have a sound evidence base, or in Professor Carney's terms, have demonstrable benefit, is of fundamental importance to the recommendations of the inquiry. In the previous chapter the Committee concluded that the available literature on coercive treatment does not provide an adequate basis for any safe conclusions about the effectiveness of involuntary treatment for non-offenders.

6.15 A significant number of inquiry participants envisaged a system of involuntary treatment with the ultimate goal of 'rehabilitation', or in other words, addressing excessive substance use or changing behaviour over the longer term. Generally these participants advocated involuntary treatment for a period of months, with detention perhaps followed by community-based coercion under a community treatment order. The premise of all these models was that compulsory treatment, used as a last resort, provided something extra which might offer a solution to intractable, serious problems where the voluntary system had failed.

6.16 The NSW Chapter of Addiction Psychiatry, for example, envisaged a system with people placed in appropriately resourced treatment units, where they would receive 'assessment, detoxification, ongoing treatment, and rehabilitation', perhaps in two or three special purpose centres around the state. At an appropriate time, the person would be discharged under a community treatment order.[291] Similarly, Mr George Klein, Behavioural Scientist with the Centre for Drug and Alcohol Medicine at Nepean Hospital, proposed a model with at least six weeks residential period in a locked facility followed by a community treatment order for at least six months.[292] Ms Andrea Taylor, a former community mental health professional with Northern Sydney Health, anticipated that depending on their needs, some people would require detention for up to 12 months, with assertive community follow-up after discharge.[293] Other participants who proposed a comprehensive compulsory treatment model included the Police Association of NSW and the Mid Western Area Health Service.[294] Implicit or explicit in all these models was that the person needs time and comprehensive intervention to address their substantial and long-term needs. As Ms Taylor put it:

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291 Submission 50, NSW Chapter of Addiction Psychiatry, p2

292 Mr George Klein, Behavioural Scientist, Centre for Drug and Alcohol Medicine, Nepean Hospital, Evidence, 7 April 2004, pp52-54

293 Ms Andrea Taylor, past Deputy Director, Ryde Community Mental Health Service and present Manager, Quality and Risk Management, Royal North Shore and Ryde Health Services, Evidence, 7 April 2004, pp21-22

294 Submission 40, Police Association of NSW, p8; Ms Didi Killen, Coordinator, Alcohol and Other Drugs Program, Mid Western Area Health Service, Evidence, 25 March 2004, p34

> It has taken people a lot of learned behaviour and a lot of practice to come within the scope of the *Inebriates Act*. We are not going to undo that learning and those practices and skills - however maladaptive they are - that they have acquired to get where they are. I think … as a long-term approach we need another model.[295]

6.17 However, as detailed in Chapter 6, other participants highlighted the absence of robust evidence to support compulsory interventions of this kind. Dr Richard Matthews, Acting Deputy Director General of NSW Health, stated:

> We do not have any evidence that putting people on a locked ward for 30 days, six months or 12 months will make any difference to the behaviour of people when they are ultimately released.[296]

6.18 Citing international studies, Professor Carney noted that compulsory treatment is no more likely to address substance dependence than non intervention, or the current voluntary system.[297] Pointing to the ethical dubiousness of treatment against a person's will in the absence of effective interventions, he concluded, 'Let us make this absolutely crystal clear: using the law to compel a person to enter treatment does not work.'[298]

The Committee's view

6.19 The Committee considers that the absence of evidence to support the efficacy of compulsory treatment in addressing substance dependence in the longer term is a fundamental problem. This raises important questions about the cost effectiveness of the system that would be required to deliver compulsory treatment, and runs counter to the principle that encroachment on a person's autonomy, even in the community, cannot be justified unless there are substantial grounds for believing that the intervention will benefit the person.

6.20 While we recognise that the models aimed at rehabilitation proposed to us were developed out of a genuine desire to assist a very vulnerable group, the Committee is concerned that such interventions may not in fact be of assistance. We have been advised that compulsory treatment does not offer anything over and above voluntary mechanisms, but necessarily uses the same imperfect tools. In addition, coercion may actually undermine the motivation that is necessary to achieve change, as was borne out in the counterproductive outcomes that we observed among those subject to the *Inebriates Act*. Where people refuse to engage in the voluntary treatment system, and that is an informed choice, we need to honour their right.

6.21 On the basis of the evidence before us, the Committee is satisfied that coercive treatment with the goal of rehabilitation or long term behavioural change cannot be ethically justified.

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295 Ms Taylor, Royal North Shore and Ryde Health Services, Evidence, 7 April 2004, p23

296 Dr Richard Matthews, Acting Deputy Director General, Strategic Development, NSW Health, Evidence, 11 December 2003, p19

297 Professor Carney, University of Sydney, Evidence, 8 April 2004, p21

298 Professor Carney, University of Sydney, Evidence, 8 April 2004, p23

Compulsory treatment aimed at harm reduction

6.22 In the absence of adequate grounds for compulsory treatment for the purpose of rehabilitation and addressing substance dependence, an important question emerges as to whether there are other goals that might be ethically legitimate.

Acute health needs

6.23 The Committee found a clear consensus among participants about involuntary intervention for the purpose of saving a person's life or protecting them from serious harm. Even those who had argued strongly against compulsory treatment saw this kind of intervention as legitimate and ethically sound.

6.24 A number of inquiry participants argued that protecting life and reducing serious harm was in itself an important goal, and indeed constituted a duty of care. Professor Webster told the Committee that from a medical perspective, preventing death and keeping a person safe is a fundamental aim.[299]

6.25 Representatives of NSW Health[300] and the Attorney General's Department[301] saw risk of serious harm to the person as a legitimate threshold for intervention without consent, as did the Chief Magistrate, who put it in terms of 'life and death' and stated that in his view it was 'essential' to intervene in such cases.[302]

6.26 Mr Graeme Smith of the Office of the Public Guardian explained his agency's benchmark for coercion and restrictive practices as 'circumstances where we felt the person's health or wellbeing was compromised to such an extent that a failure to do so would be in a sense tantamount to neglect.'[303]

6.27 Dr Hester Wilce and Dr Ingrid van Beek of the Kirketon Road Centre made a persuasive case that in very rare situations, the ability to contain someone for a brief period is necessary to address immediate risk of harm.[304] They presented the Committee with three case studies, including that of 'Michelle' on the following page, to illustrate the need for involuntary measures with the goal of humane protection. For them, while coercion cannot cure substance dependence, it can remove a person from immediate danger and 'provide a safe breathing place for a short period of time'. [305]

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299 Emeritus Professor Ian Webster AO, NSW Expert Advisory Committee on Drugs, Evidence, 18 February 2004, p10

300 Ms Michelle Noort, Director, and Mr David McGrath, Acting Deputy Director, Centre for Drug and Alcohol, NSW Health, Evidence, 29 April 2004, p15

301 Mr Feneley, Attorney General's Department, Evidence, 11 December 2003, p7

302 Judge Derek Price, Chief Magistrate, Local Court of New South Wales, Evidence, 26 November 2003, p10

303 Mr Graeme Smith, Director, Office of the Public Guardian, Evidence, 7 April 2004, p41

304 Dr Hester Wilce, Medical Practitioner, and Dr Ingrid van Beek, Director, Kirketon Road Centre, Evidence, 7 April 2004, pp1-3

305 Dr Wilce, Kirketon Road Centre, Evidence, 7 April 2004, p6

Michelle

Michelle is a 27 year old woman who has a long term dependence on opioids and cocaine. She uses heroin daily and has heavy cocaine binges. She has been a street-based sex worker in the Kings Cross area since the age of 13, and has been a client of the Kirketon Road Centre (KRC) since she was 16.

Michelle has poor mental and physical health, with a history of sexual and physical abuse as a child. She is Hepatitis C positive and engages in unsafe sex and needle sharing. She has undergone repeated unsuccessful attempts to detoxify from drugs, but has used methadone maintenance with some success for short periods. She has a pattern of chronic homelessness, and a lengthy criminal history with short prison sentences. She is a perpetrator of domestic violence, and has also been violent towards friends as well as animals.

According to Dr Wilce, in 2001 Michelle presented to KRC, hospital emergency departments and other health agencies in the area a total of 21 times in a three week period. After being released from Mulawa prison, she was injecting cocaine and heroin. She was acutely delirious as a result of binging on cocaine, with psychotic and suicidal thoughts, visual hallucinations and paranoid delusions. At the same time, as a result of self-mutilation, she had a severe laceration on her arm which became infected. While the wound had initially been treated, Michelle had pulled the stitches out the next day during a psychotic episode. Dr Wilce told the Committee, 'So throughout the three week period she has this awful, open, gaping, infected wound that throughout that time could not be adequately treated.'

On a number of occasions during the period she presented to hospital seeking treatment, but was asked to leave by security staff as she became agitated while waiting, or left after waiting some hours to be assessed. At one stage, because she had psychotic symptoms, KRC staff took her to a hospital emergency department, had her scheduled under the *Mental Health Act* and she was admitted overnight. A surgical registrar observed her through the door and noting her disruptive and difficult behaviour refused to treat her beyond prescribing antibiotics. She was assessed by a psychiatric registrar in the morning, but by that time was no longer delirious, so did not meet the requirements of the *Mental Health Act*, and was discharged.

Dr van Beek explained that while Michelle rightly could not be detained at that time, her psychosis quickly returned because of her compulsion to use cocaine. This cycle continued over many days, to the distress of both Michelle and KRC staff. According to Dr Wilce, 'It was our frustration and her frustration as well that nothing could be done. This was an individual who came to us seeking help and because of the way she presented … she was not able to be effectively helped during that period.'

The KRC submission concludes, 'A revised *Inebriates Act* may have been useful, containing [Michelle] for some days to weeks to allow her to stabilise and control her cocaine use and allow adequate treatment for her concurrent medical problems. This case may have had a better outcome given that she repeatedly attended for help and wanted to change her behaviour but was unable to do that without containment.'

6.28 While Drs Wilce and van Beek focused on illicit substance users because of their client base, many other inquiry participants emphasised the goal of harm reduction in relation to people at extreme risk due to severe alcohol dependence. As Ms Val Dahlstrom, Area Manager for Aboriginal Health in the New England Area told the Committee:

> If putting them in there meant they got off the grog, even in the short term, and they sobered up and got well, that would be success. I am not talking about living another 12 years. I have seen people who were put away for a week or so and it was the difference between life and death.[306]

[306] Ms Val Dahlstrom, Area Manager, Aboriginal Health, New England Area Health Service, Evidence, 24 March 2004, p40

6.29 Representatives of NSW Health saw the need for intervention for these purposes across the full range of substances, but anticipated greatest demand arising from alcohol dependence because of the cognitive deficits that arise from long term alcohol use.[307]

Reduced capacity

6.30 Like Drs Wilce and van Beek, a number of other drug and alcohol practitioners stressed the needs of those who reach a point where their decision making capacity is compromised. Dr Stephen Jurd, Medical Director, and Ms Tonina Harvey, Area Director, Drug and Alcohol Services with Northern Sydney Health, were particularly concerned about people with cognitive impairment who were also at risk of harm.[308] Professor Webster saw coercion as justified for the purpose of preventing harm and averting death when people reached the point where as a result of their severe dependence they had lost the capacity to make rational decisions about their welfare or substance use.[309]

6.31 Mr George Klein gave a well-developed definition, explaining that it could apply across all substances, but in his experience was likely to be particularly relevant for people dependent on alcohol, opioids, benzodiazepines and amphetamines:

> People should be compelled into treatment in circumstances in which, due to the severity of their substance dependence, they are deemed not to be competent to make informed choices regarding their self-care or substance use, and in which their substance use is causing severe self-neglect, severe harm avoidance failure, escalating injury or misadventure, or escalating risk to others. In effect, I am saying that there should be legislation to compel people into treatment when they are deemed not to be competent to make an informed choice about matters central to their survival and substance use.[310]

6.32 Dr Glenys Dore, Addictions Psychiatrist and Deputy Medical Superintendent of Macquarie Hospital explained how loss of capacity might manifest itself:

> I think that when we are looking at this Act we need to look at a very narrow spectrum of individuals who have lost that capacity to choose or not choose whether they use drugs or alcohol. I am thinking about those who are at a point where they can no longer make an informed decision about using or not using. That may be because they have brain damage, for example from their alcohol abuse. Or it may be a female alcoholic who is so chronically intoxicated she is just lying in a gutter, urinating, incontinent, unable to look after herself. She is so chronically intoxicated that she cannot make a decision. You could not engage in a discussion about the pros and cons of drinking or the benefits of this treatment program over that treatment program.

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307 Mr McGrath, NSW Health, Evidence, 29 April 2004, p15

308 Dr Stephen Jurd, Area Medical Director, Drug and Alcohol Services and Addictions Psychiatrist, Northern Sydney Health, Evidence, 4 March 2004, p11; Ms Tonina Harvey, Area Director, Drug and Alcohol Services, Northern Sydney Health, Evidence, 4 March 2004, p12

309 Supplementary Submission 43, Emeritus Professor Ian Webster AO, NSW Expert Advisory Committee on Drugs, p6

310 Mr Klein, Nepean Hospital, Evidence, 7 April 2004, p52

> It may be a person who is mentally ill as well as drinking and using drugs, and is not capable of having an informed discussion about the drug use and treatment options. I feel that that is where we as a society could legitimately intervene. I do not think we should be intervening outside that, because I think it leaves us open. For example, dad is unhappy because Billy is smoking marijuana all day, every day, and not going to school. So dad wants him locked up so he can be under a treatment program under this order. Billy knows there are problems with his marijuana use. He is able to engage in a discussion about the risks and benefits, he is able to engage in a discussion about how to cut down, and he is able to make a choice about the treatment options that are available.[311]

6.33 A number of participants, like Dr Dore, were explicit in their exclusion of mere substance dependence or substance use as justifying intervention on the basis of harm to self. Professor Duncan Chappell, President of the Mental Health Review Tribunal, stated that in his view, humane involuntary intervention should be restricted to life-threatening situations:

> I am thinking much more of imminent threat. The sort of examples that were given by the Kirketon Road Centre, I feel, are very good ones and very illustrative of the sorts of problems I would be addressing if there were to be compulsive treatment. I am not talking about people who, regrettably, have a severe dependency on drugs. They are obviously doing themselves significant harm, but I do not think that the compulsion can be justified in those circumstances.[312]

6.34 Mr John Feneley of the Attorney General's Department expressed a concern that coercion might be used in cases without the presence of severe harm:

> It is much easier to deal with those extreme cases where there is evidence to suggest a person is a risk to themselves or to those around them. It is harder to justify from an ethical standpoint if all you are saying is that they are continuously intoxicated. Of course, that would not be good for them in the long run, but they are not in immediate risk of harm to themselves. That is a very difficult area to deal with.[313]

Assessment, restoring capacity and referral

6.35 The opportunity that short-term involuntary intervention can provide for restoring the person's capacity and enabling them to make an informed choice about their drug or alcohol use was stressed by Dr Jurd:

> Particularly for those who are shown to have cognitive deficits which impair their capacity to completely comprehend the consequences of their continued drinking, that is the particular niche. Some people may truly not be able to understand the consequences of what they are doing. Across a relatively brief period of time, days or weeks, as their acute intoxification goes out of their brain, they will be in a much better position to be able to make that decision. That is the particular thing that I am concerned there might be a need for.[314]

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311 Dr Dore, Macquarie Hospital, Evidence, 4 March 2004, p9

312 Professor Duncan Chappell, President, Mental Health Review Tribunal, Evidence, 29 April 2004, p41

313 Mr Feneley, Attorney General's Department, Evidence, 11 December 2003, p4

314 Dr Jurd, Northern Sydney Health, Evidence, 4 March 2004, p19

6.36 A number of participants saw short term compulsory treatment as providing an important mechanism for assessment of cognitive functioning, and where appropriate, as an entry point for longer term care and support arrangements under guardianship. They emphasised that appropriate cognitive assessment and diagnosis cannot take place until a person has detoxified and stabilised. Addictions psychiatrists Dr Stephen Jurd, Dr Joanne Ferguson and Dr Glenys Dore[315] all stressed this as an important intervention, as did drug and alcohol workers such as Ms Beth Burton from the New England Area Health Service.[316] Representatives of the Office of the Public Guardian emphasised the need not so much for compulsory treatment as long term care and support for people with significant cognitive damage,[317] while Ms Harvey called for the restoration of medium term programs focused on building the living skills of those with significant alcohol related brain damage.[318] The need for these services is explored in detail in Chapter 9. The case study provided by Ms Burton on the following page illustrates the benefit that short term intervention can provide as a stepping stone towards guardianship and long term care.

6.37 Detainment for a short period to provide detoxification and address harm was readily accepted by a significant number of participants. Ms Vi Hunt, Area Director of Drug and Alcohol with the new England Area Health Service told the Committee that while she and her colleagues would hope to make a real difference in addressing the person's addiction, even detoxification is 'better than nothing'.[319] Other participants such as Professor Hall, the Council of Social Services of New South Wales (NCOSS) and Mr Pierce of the Network of Alcohol and Other Drugs Agencies (NADA) all saw short term intervention, for the purpose of reducing harm as ethically sound. Mr Pierce told the Committee that this should be referred to not as coercive treatment but as harm reduction:

> Basically, I am saying that the compulsory treatment order ought to be conceptualised more as a harm management or harm reduction intervention.[320]

6.38 Similarly, service providers such as Mission Australia's Regional and Rural Services saw need for some intervention 'in extreme circumstances where the life of the person is at severe risk', to ensure client safety. They explicitly noted, however, that unless the client voluntarily becomes engaged in the treatment process, longer term gains are unlikely.

6.39 Some participants actually saw involuntary intervention for a short period as creating a window of opportunity to engage the person in the voluntary treatment system. Having

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315 Dr Jurd, Northern Sydney Health, Evidence, 4 March 2004, p14; Dr Joanne Ferguson, Staff Specialist Psychiatrist, Drug Health Services, Rozelle and Concord Hospitals, Evidence, 27 November 2003, p41; Dr Dore, Macquarie Hospital, Evidence, 4 March 2004, p9

316 Ms Beth Burton, Clinical Nurse Consultant, Alcohol and Other Drug Services, New England Area Health Service, Evidence, 24 March 2004, p14

317 Mr Graeme Smith, Director and Ms Frances Rush, Regional Manager, Office of the Public Guardian, Evidence, 7 April 2004, p38

318 Ms Harvey, Northern Sydney Health, Evidence, 4 March 2004, pp5-6

319 Ms Vi Hunt, Area Director, Drug and Alcohol Services, New England Area Health Service, Evidence, 24 March 2004, p10

320 Mr Larry Pierce, Director, Network of Alcohol and Other Drugs Agencies, Evidence, 27 November 2003, p52

brought the person into the system for a brief period, and enabled them to develop insight into their situation, the person is 'introduced' to the treatment options available to them.

Margaret

A few years ago I was asked to consult with community nurses [in a small town]. The girls asked me to see somebody. This lady was in her late fifties, perhaps early sixties. They were concerned about her because she was drinking. They were popping in and trying to do the bathing for her, looking after her and those community nurse type of activities.

They also had a key to this lady's house so they asked me if I would have a look at her and see what I could do, if anything. So I started visiting her at her home. You would have to stand nearly out on the street because of the smell that was coming out of the door. I never actually went into her home. I tried to build up a bit of a relationship over many weeks, just popping in whenever I could, trying to elicit what was going on with her, listening to her stories, and things like that. The longer I had contact with her - and the contact was at different times of the day - sometimes there was obviously the smell of alcohol on her breath and at other times there was no smell. At times she seemed to be a bit more together in relation to her dress and her behaviour. Then she would be talking about her husband who was due to come home when the information that we had received was that he had died many years before.

At other times she would talk about her husband and the domestic violence that she had lived through in that relationship. At times she would not talk to me at all; she would be too agitated or paranoid. Neighbours would complain that she was screaming at somebody at night-time, but when we conducted investigations there was nobody in the house. So there were all these types of behaviours. She was a smoker, so the community nurses were obviously very worried about her setting herself on fire. The bills were not being paid and there was nobody who seemed to be responsible. She had no family, so she was rather isolated. This was a very difficult case and we did not know what we were going to do.

I was concerned that the community nurses also had a key to this woman's house, and how would they stand legally in relation to that. That was one of my concerns. The community nurses actually approached the Guardianship Board. We put it before the Guardianship Board. Of course, the Guardianship Board did not want to touch this case because it said that only alcohol was involved. We tried to put a case together. I suspected that she was no longer able to look after herself and there was dysfunction and alcohol related brain damage. The Guardianship Board came to the party and actually made an order that we could put her into hospital and into detoxification. Then she was put into the confused and disturbed elderly [CADE] unit at Tamworth. She was put in there for a while after the detoxification.

While she was there we were able to achieve a comprehensive assessment. So she was able to be seen by our consultant … [and] an occupational therapist who determined her functioning ability. I think she was seen by a psychologist … Consequently, we were able to obtain a diagnosis of dementia based on alcohol. They took her back before the Guardianship Board and the board was then able to act on that, once that diagnosis was there. They put her into a nursing home. I understand that she started improving quite well once she started to eat. Her house, which was a shack, was sold, so a little bit of money came back. Her bills were all fixed up and her quality of life was improved. That was a case of scratching our heads and working around it. When the *Inebriates Act* was raised as a possibility nobody really wanted to touch it. No doctor was involved. She had no doctor. Even back then, which is a few years ago, it was very hard to get someone like this client in to see a doctor. So this was another approach which worked on that occasion.

6.40 Observing the importance of motivation and active participation in bringing about change, Dr Joanne Ferguson, an addictions psychiatrist at Rozelle and Concorde Hospitals, advocated a system of 'mandatory assessment', where the person is assessed and has a plan developed, has their options explained to them, and is then given the choice as to whether or not they will pursue treatment:

> Most people engage voluntarily in treatment and that is when most people change—when they want to be engaged in the treatment process. This is obviously for people who are not prepared to engage at the moment and it is really about assessing and trying to engage them in that process of change. If that is not going to work at the moment, there should also be a mechanism where they come back later when they are ready to consider working with somebody about their behaviour.[321]

6.41 Similarly, Professor Hall called for a short period of detention involving detoxification, assessment and doing 'everything you could to persuade, encourage, cajole, exhort people to consider the options.'[322]

6.42 Having undertaken a review of the literature on compulsory treatment and consulted with a range of stakeholders about the Victorian system of 'compulsory detoxification and assessment' under the *Alcoholics and Drug Dependent Persons Act 1968*, Ms Sylvia Alberti of Turning Point Drug and Alcohol Centre told the Committee that the opportunity to engage a person who is by nature marginalised from services was very valuable:

> I guess when we think about the literature and about the people who we have spoken with, and about the clients and families, primarily what they are talking about is … people who are not voluntarily engaging in anything, including seeing GPs, for example. So they won't even engage in the generalist health system let alone a specialist health system. What they are trying to do is find a mechanism by which they can put somebody into a health system for a point in time to provide them with a true opportunity to make a choice. It is about balancing their real capacity to choose. It is not about actually making somebody get treated, but creating a space within which they can make a real choice about their life … What we have heard about from some of the clients is that they actually have used that time – not all of them – but some of them have used this mechanism as a way of them engaging back into treatment in some form or other, even if it's community treatment.[323]

6.43 Like others, Dr Wilce saw the opportunity to choose as a positive outcome in itself, and emphasised that once the person has been given the opportunity to make an informed decision, that choice should be honoured:

> I think it is important that the individual is involved in that decision making and that they decide where they want to continue on from there. It may be that at that point they make a rational decision to move back to Kings Cross and back to using, and that is their choice.[324]

The Committee's view

6.44 While there was some disagreement among participants as to whether the Committee should recommend a comprehensive system of compulsory treatment with the goal of rehabilitation,

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321 Dr Ferguson, Rozelle and Concord Hospitals, Evidence, 27 November 2003, p45

322 Professor Wayne Hall, Professorial Fellow and Director, Office of Public Policy and Ethics, Institute for Molecular Bioscience, University of Queensland, Evidence, 29 April 2004, p10

323 Ms Sylvia Alberti, Manager, Forensic and Clinical Services and Senior Research Fellow, Turning Point Alcohol and Drug Centre, Evidence, 28 April 2004, p29

324 Dr Wilce, Kirketon Road Centre, Evidence, 7 April 2004, p9

there was marked agreement that intervention for the purpose of reducing harm was ethically sound, but that it should be limited to circumstances where people have experienced or are at risk of serious harm *and* where their substance dependence is considered to have diminished their decision making capacity.

6.45 Evidence provided by medical practitioners suggests that in some circumstances, a person's ability to make rational choices is profoundly compromised by their substance dependence. In other cases, the presence of cognitive damage corrupts that decision making capacity. In this context, we believe that the goal of involuntary intervention becomes not only to reduce harm, but also, as far as possible, to restore the capacity to decide. Where capacity cannot be restored, for example where a person is found to have a substantive cognitive disability arising from their substance use, longer-term substitute decision making arrangements should be sought via guardianship, as appropriate, and care and support put in place. In such cases there is a clear duty on the part of the state and society to provide care, protection and support.

6.46 The Committee considers that involuntary treatment is not appropriate in circumstances where people are simply using or dependent on substances. There must be clear evidence that the person has experienced, or is at risk of imminent and serious harm. The person must also be considered to lack the capacity to make decisions because of their substance misuse.

6.47 The Committee notes that the value of short term, focused involuntary intervention is borne out in Victoria under the coercive treatment regime provided by the *Alcoholics and Drug Dependent Persons Act (ADDPA*). While the ADDPA is currently under review, having met with the reference group overseeing the review the Committee understands that it is seen to achieve valuable, if limited, outcomes.[325] The ADDPA's provision for 'involuntary detoxification and assessment' for a period of 7 to 14 days is regarded by various stakeholders as providing an important safety net for people at significant risk, which provides 'time out' from substance use and the opportunity for choice about substance use and the option to take up voluntary treatment.[326]

6.48 The Committee considers that there is a firm ethical basis for a model of short term involuntary care aimed at protecting the person's health and safety. Such care should also be aimed at stabilising the person and assessing their needs, restoring their capacity to make an informed choice about substance use, and where appropriate, providing an entry point for long term care and support under guardianship. It should be focused on people with substance dependence who have experienced or are at risk of serious harm, whose decision making capacity is considered to be compromised.

Compulsory treatment in the interests of others

6.49 When the Committee explored the circumstances in which people were placed under inebriates orders, we noted that the greatest number are those with antisocial behaviour arising from substance dependence. A further significant (and overlapping) group was those whose behaviour was impacting on their family. Thus we observed that the Act is not so much used for the purpose of addressing harm to the person, as for the purpose of control. At the very

325 Confidential evidence

326 Ms Amy Swan, Research Fellow, Turning Point Alcohol and Drug Centre, Evidence, 28 April 2004, p29

least, the Act is being used in many cases not in the primary interests of the person, but in the interests of others.

6.50 A number of participants were very clear that a new system of involuntary treatment for people with severe substance dependence should be limited to those at risk of significant harm. Professor Hall, for example, said that involuntary treatment should be restricted to instances where it was necessary to avoid serious harm to self, or else risk large scale use simply for the purpose of control:

> Otherwise you will end up with what happened under the *Inebriates Act*; a chronic alcohol abuser would end up "doing time". It would end up sweeping large numbers of people into the system for that purpose. It might be more humane than imprisoning them and maybe marginally less costly but we should not kid ourselves that it would be therapeutic.[327]

6.51 Similarly, Professor Carney warned against the potential for net-widening and social control were the legislation not tightly targeted towards those at risk of serious harm.[328] In addition, Professor Duncan Chappell, President of the Mental Health Review Tribunal, spoke strongly against any other purpose than harm to self, on the basis of the absence of evidence to show that compulsory treatment can do anything more than reduce harm. He was also concerned about any move away from the philosophy of harm minimisation that might be implied in a compulsory treatment regime:

> I have a further concern about the effect that any compulsory treatment programme in this area might have upon Australia's well established and highly regarded harm minimisation approach to drug and alcohol related issues. I believe strongly in this harm minimisation approach and can only urge extreme caution in moving in any direction which would detract from this core philosophy.[329]

6.52 Mr Graeme Smith, Director of the Office of the Public Guardian, drew on the principles of the *Guardianship Act 1987* to distinguish between involuntary interventions on the basis of the person's interest, and those where consideration is also given to the public's interest. He argued that people's rights would be much better protected were decisions to be made solely on the basis of the person's best interest, as occurs under the guardianship model.[330]

Intervention in the interests of family members

6.53 As noted in the first chapter of this report, a key catalyst for this inquiry was Ms Toni Jackson's heartfelt plea at the Alcohol Summit for a more effective mechanism to protect people such as her husband from drinking themselves to death. Many inquiry participants were very mindful of the impact that a person's substance dependence can have on their family, and very concerned to ensure that families are better supported in coping with

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327 Professor Hall, University of Queensland, Evidence, 29 April 2004, p5

328 Professor Carney, University of Sydney, Evidence, 4 June 2004, p5

329 Tabled Document No 35, *Statement and Response to questions*, p4

330 Mr Smith, Office of the Public Guardian, Evidence, 7 April 2004, p17

substance dependence. Mr George Klein, for example, observed that, 'the cumulative burden on carers, in addition to the patient, is enormous when people are self-destructive.'[331]

6.54 Our analysis of the circumstances in which people are placed under the Act showed that families are often the initiators of inebriates orders, but that there is some variation in their reasons for doing so. Earlier in the report the Committee raised the ethical issue of how the competing rights of families are to be weighed against those of the person with drug or alcohol dependence.

Family concern

6.55 Often family members are those best placed to see that a person is reaching the stage of serious harm, and like Ms Jackson, seek statutory protection as a last resort to save their loved one's life. In such cases, the purpose is still protection from serious harm.

6.56 In the previous section we explicitly argued against the use of coercive intervention for those who are merely using or dependent on substances without any evidence of serious harm. Several participants voiced a concern about the potential demand for intervention from family members who were genuinely concerned for the welfare of their loved one in circumstances where, by community standards, treatment against their will could not be ethically justified.

6.57 While not advocating coercive treatment, Dr Ferguson forecast that any new legislation will attract demand from genuinely anxious relatives, and was concerned that there be some mechanism to respond:

> I think a lot of the social pressure to have people treated will still come from families who are very distressed about their relatives. I think there will continue to be that pressure. And it is not unreasonable to have some response at the community and health level to that degree of concern. I think where there is a degree of concern from relatives, that should be taken seriously.[332]

Respite

6.58 The Committee asked many participants whether they thought that providing family members with respite was a valid reason for coercive action. Perhaps indicating some equivocation, the NSW Chief Magistrate told the Committee that in his view, compulsory treatment is appropriate, 'In life and death situations, and where the relatives, for example, are no longer able to cope with a chronically intoxicated person, but particularly in life and death situations.'[333] Other participants felt that notwithstanding the enormous impact that substance dependence can have on family members, intervention for the purpose of respite alone was insufficient grounds to justify coercion.

6.59 Representatives of NSW Health were very concerned to assist family members to cope with their loved one's substance misuse. While they indicated that respite should not be a criterion for involuntary treatment, they saw that in many cases family stress would be a consideration,

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331 Mr Klein, Nepean Hospital, Evidence, 7 April 2004, p55

332 Dr Ferguson, Rozelle and Concord Hospitals, Evidence, 27 November 2003, pp41-2

333 Judge Price, Chief Magistrate, Evidence, 26 November 2003, p10

and that providing some relief would perhaps be an opportune by-product.[334] Ms Michelle Noort, Director of the Centre for Drug and Alcohol, argued that any intervention should be supplemented by measures that effectively support families and carers to cope with the stresses of their loved one's substance dependence.[335]

> Parallel to that I think we would need to be offering a level of support to the family environment so that they are better able to cope with an individual's decision not to continue with rehabilitation. That is what will stop some of the revolving door.[336]

6.60 Like his colleagues, when asked about respite, Dr Matthews of NSW Health saw that helping families and the person are not mutually exclusive goals:

> That brings us back to harm reduction: we reduce the harm to the family and to the individual, both of which are desirable outcomes, but we do not necessarily cure the dependency. A system that does that would be a good system.[337]

Harm to family members

6.61 Some inquiry participants saw that coercion may be justified in cases where a person's drug or alcohol misuse caused harm to others. Dr Jurd told the Committee that there does come a point where the rights of the family or community should take precedence:

> If a dad has decided that he is going to drink himself to death and he has decided that he is going to do that in his room alone, and somebody else can just keep looking after the kids who are 12, 14 and 16 and the house, and his position is that that would not have an effect on everybody else - I do not think so … I think that, yes, people do have a right to drink to the point where it is destructive to them, but if it is causing lots of harm to the people around them, then that is something that may need to be evaluated in a legal setting - which has nothing to do with us - where a judgment is made to say, okay, in this case with this evidence that is put before me, despite the fact that this man is a highly functioning executive, he is making such trauma in the lives of everybody in his family that I do decide that he has a period of compulsory care.[338]

6.62 In reply to the question of whether coercive treatment in the interests of others was ethically justified, Ms Andrea Taylor stated when she appeared before the Committee:

> To answer that, one must first ask oneself whether it is ethical to permit continued abuse and neglect on the individual or others. Basically, my response to your question is yes. For what purposes? Again, to reiterate that, to protect the individual, to protect the community and to protect others. I can quickly give you a thumbnail sketch of two people I have put under the *Inebriates Act*. [The first is cited in Chapter 4 after paragraph 4.8] … Another was a woman in her early thirties with two young children at home. She was the principal carer for them while dad went to work. She was sitting at home drinking methylated spirits, unable to care for her very, very young children.

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334 Ms Noort and Mr McGrath, NSW Health, Evidence, 29 April 2004, p17

335 Ms Noort, NSW Health, Evidence, 29 April 2004, p17

336 Ms Noort, NSW Health, Evidence, 29 April 2004, p17

337 Dr Matthews, NSW Health, Evidence, 11 December 2003, p28

338 Dr Jurd, Northern Sydney Health, Evidence, 4 March 2004, p14

> It progressed over a period of about three months before we got her in under the *Inebriates Act*. There were quite clear care issues there.

6.63 Asked whether she would limit compulsion to very extreme, perhaps life and death situations, Ms Taylor responded that she would not:

> Life and death, I think, is a bit dramatic. Neglect, I think. If we do not look after the young people and put a lot of work into them - remove probably initially and assist in changing the individual's behaviour pattern - we are then breeding the next generation of people presenting at either mental health services or drug and alcohol facilities. So, not life and death - I think neglect is one of the answers in that equation.[339]

6.64 A number of participants also raised the issue of domestic and family violence, which is widely understood often to have a drug or alcohol component. The Committee considers that significant harm to other family members arising from a person's substance use is a very important issue, and one that is most appropriately dealt with under legislative mechanisms such as those that deal with child protection and domestic violence. The latter is also considered in Chapter 9 on offenders, and in particular, how compulsory treatment might be integrated into current statutory provisions for domestic violence.

Intervention to address antisocial behaviour and complex needs

6.65 A group that raises particular ethical and practical challenges are those people whose substance-related behaviour can no longer be tolerated by their family or community. There is clearly some overlap between this group and the previous category, that focused on family. As we noted in Chapter 4, the greatest demand for inebriates orders at present is in relation to this group. It is not so much the person's substance dependence as their *behaviour* that sees them placed under the Act. Typically, a person might have had multiple hospital admissions, made many ambulance calls, and had repeated contact with the police and the courts for public nuisance offences, being drunk and disorderly and so on. The ethical difficulty arises in that their criminality is of low grade, so they fall into a grey area between harm to others, in which case they would be dealt with under criminal law, and harm to themselves. As we noted in Chapter 4, the most appropriate response to this group has not yet been determined at a policy level.

6.66 Police representatives highlighted that in their experience, this is the group that is most in need of effective strategies, especially in rural communities. As documented in Chapter 4, police report that traditional law enforcement measures are inappropriate and ineffective for this group. At the same time, there is a lack of appropriate voluntary treatment and support to address antisocial behaviour, so police are powerless to assist those individuals and protect community members who in many cases have sought the help of police. It may also be the case that some people reject voluntary treatment. Assistant Commissioner Bob Waites called for a new and localised approach to 'managing' antisocial behaviour:

> … all of us as a society need to provide something at a local level to support these people and manage their behaviour for their sake, firstly, and then for the sake of their families and the greater community. To simply say if they do not want to be treated we cannot treat them does not solve the problem. The problem continues to exist and

[339] Ms Taylor, Royal North Shore and Ryde Health Services, Evidence, 7 April 2004, p18

> in some communities continues to grow … There is a real, genuine need in many of those communities for some [local] facility where those people, even if they flatly refuse any treatment, can go and be managed. I am not talking about locking them up and throwing away the key type of thing here, I am talking about somewhere that becomes part of their practice to attend regularly to undergo counselling, to have some sort of level of supervision, even if it is … in their own environment, someone who actually continually works with them to try to manage the issue.[340]

6.67 For Dr Patfield, involuntary interventions for this group can be ethically justified on the basis of the tangible harms they inflict on others through domestic violence, dissipation of family resources, work place disruption, and significant consumption of police, court and hospital resources.[341] On the basis of his experience, Dr Patfield argued strongly against a model that focuses on short term inpatient treatment to address significant harm to self. Instead, he proposed a system of community-based 'compulsory management', combining treatment and escalating sanctions, aimed at addressing their long term, entrenched behaviour.[342]

6.68 At the roundtable discussion with key stakeholders, participants spoke of the need for measures to help address antisocial behaviour, primarily out of a concern for the impact it has on others, and the importance of supporting families and communities. Mr Feneley of the Attorney General's Department expressed some sympathy for this view:

> If we say to communities, as I must say from a civil liberty point of view I am inclined to say, that look, these people have not committed any crime and they are capable of making day to day decisions, we should not be intervening, then I think what we are saying to communities is it is your problem, and we are saying, families, it is your problem, and that is a bit of a concern because I think this is the very group who run the highest risk of our decisions criminalising their behaviour.[343]

6.69 Participants suggested that the problems associated with such behaviour may partly have emerged out of measures to divert people with drug and alcohol problems and mental illness from the criminal justice system. They envisaged some practical difficulties in developing a workable preventative model in rural areas, given the finite resources and limited services that exist there. Nevertheless, they argued that any new model must necessarily address the needs of small communities.

6.70 Professors Carney and Webster argued strongly against any coercion for this group, pointing to its entrenched social disadvantage and emphasising that the real problem lies in poor policy and service delivery, and inadequate investment in a range of human services. In Chapter 4 the Committee drew on the evidence of these participants to note the multidimensional need that characterises this group. These people's health, behavioural and social needs are by their very nature complex, entrenched and not easily addressed. At the same time, the service system struggles to respond to those needs because they traverse the boundaries of various government agencies. For Professor Webster, there is a moral imperative for this group to be

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340 Assistant Commissioner Bob Waites, Commander, Greater Metropolitan Region and Corporate Spokesperson, Alcohol related Crime, NSW Police, Evidence, 27 November 2003, pp30-31

341 Dr Martyn Patfield, Consultant Psychiatrist, Medical Superintendent and Director of Acute Services, Bloomfield Hospital, Evidence, 24 March 2004, p13

342 Dr Patfield, Bloomfield Hospital, Evidence, 4 June 2004, p3

343 Mr Feneley, Attorney General's Department, Evidence, 4 June 2004, p11

supported and where necessary protected. Both he and Professor Carney emphasised that this will be achieved through mechanisms to ensure that human service systems work together more cooperatively.[344]

The Committee's view

6.71 The Committee considers it a fundamental principle in respect of involuntary intervention in the life of a non-offender with substance dependence, that the person's interest must be paramount. In some cases, the interests of their family or community justify consideration, but until a person commits a more serious offence (that is, he or she confers substantial harm on others), the interests of others cannot take precedence.

6.72 On the balance of the evidence before us, the Committee recognises a need to develop a mechanism to address the complex needs and antisocial behaviour associated with some people who have a severe substance dependence. The fact that this group constitutes the greatest demand for inebriates orders, along with the testimony of police as to the extent of this problem and its impact on communities, indicates that effective strategies are needed for this group.

6.73 The Committee is not convinced, however, that coercion and involuntary mechanisms are the most appropriate or effective solution for this group. We are concerned at how easy it is to make moral judgements about people whose behaviour is extremely difficult, both because of the often repetitive nature of that behaviour and because it results from substance misuse. It needs to be remembered that in many cases these people have not committed offences that justify significant intrusion on their autonomy, and measures simply aimed at detaining them and managing their behaviour would amount to social control. We cannot treat people as criminals if they are not. It is also important to remember that in many cases, such behaviour is beyond the person's control. What is required is a system that protects the community where this is appropriate, but does so in a non-punitive way. Such a system will be informed by understanding and compassion for all relevant parties.

6.74 The Committee acknowledges the profound and distressing impact that antisocial behaviour can have for families and communities, and that this impact may be compounded by the absence of effective approaches to address it. At the same time, the person themselves arguably has a right to the full range of services that will address their complex needs and enable them to live with greater dignity.

6.75 Where crimes have occurred, the Committee believes as a matter of principle that the person should be dealt with according to law. For example there are statutory measures in relation to domestic violence and child protection. However, in many cases it is clear that the person and their family will benefit from treatment as opposed to punishment. In Chapter 9 when we consider compulsory treatment for offenders, we explore the need for greater investment in diversion programs such as the Magistrates Early Referral Into Treatment (MERIT) alcohol pilot that aim to address both an offender's substance use and the behaviour associated with it. Evidence before the Committee is that such programs are particularly called for in relation to domestic violence.

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344 Professor Carney, University of Sydney, Evidence, 4 June 2004, p22; Professor Webster, NSW Expert Advisory Committee on Drugs, Evidence, 4 June 2004, p8

6.76 Finally, like the participants who stressed a civil libertarian perspective, the Committee is concerned about the potential for net-widening that might occur where difficult behaviour is seen as appropriate reason for involuntary intervention. It would be very tempting for communities to put someone away for a time because they are causing trouble, as has occurred extensively under the *Inebriates Act*.

6.77 The need to develop an effective response to those with antisocial behaviour does not detract from the need for short term involuntary measures aimed at protecting the safety and wellbeing of those at risk of serious harm, which is well substantiated in the first half of this chapter.

6.78 We are aware of a number of initiatives that might shed light on the needs of and appropriate measures for this group, including the proposed rural substance abuse prevention trial being coordinated by the Office of Drug and Alcohol Policy in The Cabinet Office and the Alcohol Education and Research Foundation's Reducing Alcohol Related Harm in Rural Communities project.[345]

6.79 The Committee considers that there is a need for a strategy that addresses the group of people with complex needs or antisocial behaviour, but favours a voluntary approach. It is essential that this work be developed as a cross-agency response. In relation to interventions in the interest of family members, we consider that coercive interventions should not occur simply on the basis of a family member's concern, but that there may be potential for some mechanism to respond to requests from families while minimising intrusion on the rights of the person. We also consider that intervention should not occur for the purpose of respite, but that this may be a valid outcome of interventions to address risk of serious harm. The various options for legislative mechanisms are explored in the following chapter.

What treatments should be provided?

6.80 In the first half of this chapter the Committee established the ethical basis for a model of short term involuntary treatment for people with substance dependence who have experienced or are at risk of serious harm, for the purpose of protecting their health and safety, providing assessment, and restoring their capacity to make an informed decision about their substance use. Legal Aid NSW provided a good summary of the model which the Committee and many participants considered was ethically sound. The Committee notes the strong parallel between this and the model of 'compulsory detoxification and assessment' currently operating in Victoria:

> There is a justification for some form of short term detention in an appropriate facility to deal with situations where a person is at imminent risk of dying from alcohol abuse. This detention should be for a short time only. Two weeks would be sufficient to stabilise the person. The detention should be in an appropriate medical detoxification unit. Proper longer term follow-up, including residential rehabilitation, would need to be available to make the process meaningful.[346]

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345 NSW Government, *Outcomes of the NSW Summit on Alcohol Abuse 2003: Changing the Culture of Alcohol Use in New South Wales*, May 2004, p189

346 Submission 46, Legal Aid NSW, pp7-8

6.81 Participants felt strongly, as a matter of principle, that anyone subject to coercive treatment has the right to high quality, evidence-based services tailored to their individual needs, with the period of compulsory care used as an opportunity to do the most good for the person.

6.82 Containment in a safe place and medicalised withdrawal were seen as core aspects to the intervention. Similarly, comprehensive assessment considering the full range of the person's needs (including neuropsychological assessment of cognitive functioning if appropriate) and the development of a post-discharge treatment plan were regarded as essential. Medical care, other harm reduction strategies, and psychological interventions would be given according to the person's needs. If appropriate, their family would also be invited to access support.

6.83 In keeping with the discussion earlier in this chapter on the opportunity to engage the person in the voluntary treatment system, every effort would be made to inform the person of their treatment options, to get their input into their treatment plan, and to actively link them to the voluntary system and any other services set out in their treatment plan, including their general practitioner and case management services. Anyone assessed as requiring guardianship and/or longer term care and support because of substantial disability would likewise be actively linked into that system. Following discharge, people would be subject to assertive follow-up.

6.84 Participants stressed that detainment should occur in an appropriate drug and alcohol treatment facility, but that that facility should work cooperatively with other appropriate services, for example mental health services, to ensure that the needs of clients are addressed. The treatment framework to support the Committee's recommended system of involuntary care is discussed in detail in Chapter 9.

The limits to treatment

6.85 While the Committee has emphasised the potential benefits that involuntary treatment offers a small group of people in terms of reducing harm and restoring their decision making capacity, on the basis of the evidence of a number of participants we emphasise that there are limits to what any treatment can achieve for some people. Reflecting on the genesis of the inquiry we note the fundamental ethical question raised at the Alcohol Summit as to whether people have the right to drink themselves to death.

6.86 As noted in the previous chapter, the research evidence is clear that the available treatments for drug and alcohol dependence are limited and imperfect, and there are some people for whom any treatment is ineffective. While the Committee believes that there are circumstances where we are ethically bound to intervene and 'be our brother's keeper', there is also a limit to what we can expect of such protection.

6.87 Dr Richard Mathews of NSW Health drew the analogy with cancer, where we all accept that it occurs, and when it does occur in us or someone we love, we hope that available treatments will provide a cure. But we also accept that there will be some for whom treatment is not effective, and that they will die. In his view, 'Drug and alcohol dependence are no different'.[347]

6.88 Similarly, Mr Larry Pierce of the Network of Alcohol and other Drugs Agencies told the Committee:

[347] Dr Matthews, NSW Health, Evidence, 11 December 2003, p17

> I will relate to the experience of the woman who described at the Alcohol Summit how she had lost her husband to alcohol poisoning and overdose. It was a very moving and poignant story. Essentially, her point was that the *Inebriates Act* did not work because there were no facilities or arrangements and the system had let her and her husband down. If only some treatment service, a hospital or someone had taken her husband and made him stay there, he would not have drunk himself to death. If we look at that example dispassionately, we can see that the probability is that, even if he had been stuck in a hospital bed for one or two weeks and made to stay there in detox, he may not have changed his behaviour. The pattern was such that the inevitability of his quest to drink himself to death would have been only put off. In the drug and alcohol field we see such cases fairly regularly. Despite numerous best efforts and in some cases hundreds of attempts - literally hundreds of different individual treatment episodes - people succeed in their quest for oblivion. I do not think anything - any system, any policy or any piece of legislation - will ever stop that happening. Having said that, there is a big need to support families.[348]

Conclusion

6.89 The Committee has explored the potential purposes of compulsory treatment to determine whether and in what circumstances compulsory treatment may be ethically justified. Having considered the views of inquiry participants and the available research, the Committee does not support compulsory treatment aimed at rehabilitation or addressing the person's substance dependence in the longer term. Similarly, we do not support coercive treatment for non-offenders in the interests of others.

6.90 The Committee does support a model of short term involuntary care for people with substance dependence who have experienced or are at risk of serious harm, for the purpose of protecting the person's health and safety. We also consider it important that non-coercive measures be developed to address the needs of people with complex needs and/or antisocial behaviour arising from their substance dependence. The following chapter sets out the various elements of the legislative framework that would operationalise the Committee's recommended model of involuntary treatment.

Recommendation 2

That the Government establish a system of short term involuntary care for people with substance dependence who have experienced or are at risk of serious harm, and whose decision making capacity is considered to be compromised, for the purpose of protecting the person's health and safety.

[348] Mr Pierce, Network of Alcohol and Other Drugs Agencies, Evidence, 27 November 2003, p53

Chapter 7 A new legislative framework for involuntary care

> The development of an alternative legislative approach to the *Inebriates Act* needs … to protect individual rights as far as possible; it needs to have clear criteria for its application; it needs to have clearly defined objects; it cannot force judicial officers into making medical decisions; it needs to complement other legislation; it needs to demonstrate that it has a purpose ... it should not remove individuals from the public gaze merely because they are unpleasant or upsetting family members.[349]

In Chapter 4, on the basis of the litany of criticisms of the *Inebriates Act*, the Committee recommended the Act's immediate repeal. In the previous chapter we explored the ethics of compulsory treatment and concluded that involuntary care may be justified for the purpose of reducing serious harm to the person with substance dependence. While we did not support coercion of non-offenders in the interests of others, we did identify the need for a mechanism to address the complex needs and antisocial behaviour associated with some people who have a severe substance dependence. In this chapter the Committee draws on the evidence of a range of participants to build the elements of the legislative framework that we believe should replace the Act. The chapter commences by establishing the scope and objects of the legislation, and the principles to underpin it. We then set out the criteria to be used, the length and features of involuntary care orders, and the various elements of the decision making process to be followed when an individual is considered for involuntary care, and a number of other safeguards to protect the rights of those subject to an order. Provision for a non-coercive mechanism targeting people with antisocial behaviour and complex needs arising from substance use is also discussed. The chapter concludes with recommendations in relation to the *Intoxicated Persons Act.*

Scope and objects of the proposed legislation

7.1 In the previous chapter the Committee established that involuntary care is justified for the purpose of protecting a person with substance dependence from serious harm. Such care is to be short term and limited to those who have experienced or are at risk of serious harm, and whose decision making capacity is considered to be compromised. Other aims of the intervention are assessing the person's needs, restoring their capacity to make an informed decision about their substance misuse, and where appropriate, providing an entry point for care and support under guardianship. The interventions provided should incorporate medical treatment including detoxification as appropriate to the person's needs, along with comprehensive assessment and the development of a treatment plan, and actively linking the person to voluntary services, with assertive follow-up on discharge.

7.2 In the absence of evidence to support the efficacy of compulsory treatment aimed at addressing substance dependence in the longer term, the Committee found against a system for that purpose.

7.3 After considering the ethics of involuntary interventions in the interests of others, we also found against the use of coercion in the interests of anyone other than the person with substance dependence, except as is already provided under law (for example child protection

[349] Submission 23, Council of Social Service of NSW, p14

or criminal law). This was informed by a fundamental ethical principle in respect of any intrusion on the autonomy of a non-offender: that the person's interests must be paramount.

7.4 Nevertheless, the Committee did recognise the need for a non-coercive mechanism to address the complex needs and antisocial behaviour associated with some people who have a serious substance dependence. This was advocated by a range of participants including representatives of the Police Service, the Attorney General's Department, clinicians and academics. The roundtable discussion that we held with key stakeholders towards the end of the inquiry provided valuable information on a potential way forward in this area, and this is explored in detail later in this chapter.

Purpose and aims of the proposed legislation

7.5 Participants at the roundtable indicated broad support for a legislative model providing short term involuntary care to protect people at risk of serious harm, as recommended in the previous chapter.

7.6 In the discussion in Chapter 6 on involuntary interventions with the goal of harm reduction, the Committee concluded that the primary goal of involuntary care should be protection of the health and safety of the person with substance dependence. We also identified several secondary aims:

- to reduce harm to the person through the provision of medical treatment including, where necessary, medicalised withdrawal
- to stabilise the person and comprehensively assess them
- to restore their decision making capacity and provide the opportunity to engage in voluntary treatment and
- to provide an entry point, where appropriate, for long term care and support under guardianship.

7.7 The Committee considers that the purpose and aims described above should be codified in the proposed legislation.

Recommendation 3

That the purpose of the new legislation be to enable involuntary care of people with severe substance dependence, in order to protect the health and safety of the person, and that the aims of the legislation be to:

- reduce harm to the person through the provision of medical treatment including, where necessary, medicalised withdrawal
- stabilise the person and comprehensively assess them
- restore their decision making capacity and provide the opportunity to engage in voluntary treatment and
- provide an entry point, where appropriate, for care and support for people with significant cognitive impairment under guardianship.

Alcohol and other drug dependence

7.8 There was broad agreement among inquiry participants that any new legislation enabling involuntary care be inclusive of any substance, in recognition that serious harm may arise from alcohol or other drugs, and that a distinction between the two is somewhat meaningless. As Dr Victor Storm, Psychiatrist and Clinical Director of Central Sydney Area Mental Health Services stated:

> To do it by substance is probably not particularly helpful. The experience is that most people, even if they start off with one agent, will often use or abuse another agent if that agent is not available. It needs to be broad-based rather than agent-based legislation.[350]

7.9 The Committee considers that it is the harm, rather than the substance, that is the key issue, and that the legislation should be inclusive of any substance dependence.

Recommendation 4

That the proposed legislation enabling involuntary care for people with severe substance dependence be inclusive of any substance dependence.

Responsibility for the legislation

7.10 Given the therapeutic purpose of the proposed legislation, and its focus on the provision of medical care, the Committee considers that it will appropriately fall within the portfolio of the Minister for Health.

[350] Dr Victor Storm, Clinical Director, Central Sydney Area Mental Health Service, Evidence, 27 November 2003, p45

7.11 We anticipate that policy and administration in relation to the legislation will be the responsibility of the Centre for Drug and Alcohol within NSW Health but that other agencies such as the Attorney General's Department, NSW Police, Department of Community Services, Department of Ageing, Disability and Home Care and other agencies will have a role to play in implementing the legislation.

7.12 The NSW Government submission to the inquiry states that in order to optimise the interface between agencies, the Committee might consider the development of interagency agreements on the respective roles of agencies:

> … to ensure that an order results in an appropriate referral, assessment, intervention, treatment and rehabilitation pathway and that it is enforced effectively … It might be appropriate to develop new interagency protocols, to provide a mechanism for moving patients through a compulsory treatment system where agreed treatment milestones were provided by each service stream. One possible model is the interagency protocol entered into under the Intoxicated Persons Act 1979 … Regulations could also provide a statutory basis for such a protocol.[351]

7.13 The Committee agrees that an interagency agreement articulating the respective roles of government agencies will be very important to the success of the proposed legislation, and to ensuring positive outcomes for those subject to it. At various points in this and the following chapter we identify a number of roles for particular agencies.

Recommendation 5

That the proposed legislation fall within the Health portfolio.

Recommendation 6

That the Government develop an interagency agreement setting out the respective roles and responsibilities of relevant agencies under the proposed legislation.

Stand-alone legislation

7.14 The Committee has considered whether provision for involuntary care for people with substance dependence at risk of serious harm is already made under other legislation. We understand that other bodies that have reviewed the *Inebriates Act* came to such a conclusion.

The Mental Health Act 1990

7.15 Alcohol or drug dependence alone is insufficient grounds to involuntarily admit a person under the *Mental Health Act*. The person must be considered to be 'mentally ill' or 'mentally disordered', but the legislation explicitly states that a person may not be deemed mentally ill or mentally disordered simply because they take or have taken alcohol or any other drug. Nevertheless, there is nothing to prevent a person who meets the criteria for the Committee's

[351] Submission 47, NSW Government, p25

model being brought under the *Mental Health Act* for detoxification where they satisfy the definition of mentally ill or mentally disordered.[352]

7.16 Dr Patfield of Bloomfield Hospital told the Committee that this frequently occurs.[353] Other participants such as Dr Stephen Jurd of Northern Sydney Health and Professor Ian Webster reported that this may be true, but it is often very difficult to use the *Mental Health Act* for that purpose as people with alcohol problems, in particular, are often excluded from the mental health system.[354] The case study of 'Michelle' from the Kirketon Road Centre in the previous chapter highlighted how the *Mental Health Act* could not be utilised to provide protection and care for a woman with cocaine induced delirium who was at significant risk of harm.

7.17 The majority of participants suggested that the *Mental Health Act* would serve as a useful *model* for new legislation for people with severe substance dependence at risk of serious harm, rather than being used to cater for that group as well. In addition, the Committee considers that it would be more in keeping with the current conceptualisation of alcohol and other drugs as separate from mental illness to have separate legislation.

The Guardianship Act 1987

7.18 In Chapter 2 when we outlined the provisions of the *Guardianship Ac*t, the Committee noted the very high threshold that applies before a guardianship order can be made: the person must have a permanent disability restricting them in one or more life activities, and as a result, the person must be totally or partially incapable of managing themselves. Moreover, that Act has a very different purpose and intent to that which the Committee is proposing: it seeks to maximise freedom rather than to provide coercive protection. Importantly, however, the *Guardianship Act* does capture those whose substance use has left them with substantial disability, for example those with significant cognitive damage arising from long term alcohol misuse.[355] As reflected in Recommendation 3 above, one of the aims of short term involuntary care would be to provide an entry point, where appropriate, for people to be considered for guardianship.

7.19 The Committee considers that there is a need for stand-alone legislation to enable involuntary care. Such legislation would complement the *Mental Health* and *Guardianship Acts*.

Recommendation 7

That the proposed legislation be stand-alone legislation.

352 Submission 47, NSW Government, pp17-18; *Mental Health Act 1990*, s11

353 Dr Martyn Patfield, Consultant Psychiatrist, Medical Superintendent and Director of Acute Services, Bloomfield Hospital, Evidence, 4 June 2004, p13

354 Dr Stephen Jurd, Area Medical Director and Addictions Psychiatrist, Drug and Alcohol Services, Northern Sydney Health and Emeritus Professor Ian Webster AO, NSW Expert Advisory Committee on Drugs, Evidence, 4 June 2004, p14

355 Submission 44, Mr Nick O'Neill, President, Guardianship Tribunal, pp1-4 and 6

Principles

7.20 In Chapters 3 and 6 the Committee referred to the United Nations *Principles for the Protection and Care of People with Mental Illness* (hereafter the UN Principles), which set out the rights and freedoms of voluntary and involuntary patients, codifying the procedural framework for decisions to detain and treat a person without consent. While we do not consider alcohol or other drug dependence to be a mental illness, we recognise the parallels between the two and agree with Professor Carney that the Principles are sufficiently broad to cover both.[356] Moreover, the purpose of the UN Principles - to protect the liberty and dignity of patients and ensure that they are treated with humanity and respect - is of clear relevance to those who are the focus of this inquiry. The Committee considers that these Principles should underpin the proposed legislation.

7.21 The UN Principles were reflected in many of the views put by participants, and some specifically referred to them. For example, in the NSW Government submission, the Attorney General's Department affirmed the principles of the least restrictive alternative, the right to independent review, the necessity for other safeguards, and the right to quality, evidence-based treatment.[357]

Recommendation 8

That the proposed legislation conform to the United Nations *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.* The legislation should stipulate that in any decision in relation to involuntary care, the person's interests should be paramount.

Criteria for involuntary care

7.22 In keeping with the findings of the previous chapter, the Committee has identified four criteria to be met before a person may be subject to involuntary care. Each is to be explicitly considered during the decision making process discussed later in the chapter. The legislation would necessarily include definitions of the concepts used, where appropriate. Similarly, each would be clearly operationalised through guidelines for those involved in decision making.

7.23 As documented in Chapter 7, various participants argued that substance dependence or substance use alone did not justify involuntary intervention. In the interests of tightly focusing the proposed legislation on the appropriate group, and safeguarding against inappropriate use, the Committee considers that it should explicitly exclude the use of involuntary care for people simply using or dependent on substances.

7.24 The Committee has designed this legislative framework with adults in mind. We have received very little evidence about the appropriateness of applying the framework to minors. There is potentially a significant gap in relation to the treatment of minors with a substance dependence. The Committee believes this requires further investigation.

356 Professor Terry Carney, Professor of Law, University of Sydney, Evidence, 8 April 2004, p17

357 Submission 47, NSW Government, p23

Severe substance dependence

7.25 Like many inquiry participants, the Committee considers that involuntary care should be restricted to those with severe substance dependence. In keeping with the UN Principles, we believe that such a diagnosis should be based on an internationally accepted diagnostic tool, such as the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM IV).

Serious harm to self

7.26 The Committee considers it essential that a person have experienced or be at immediate risk of serious harm to self before involuntary care may be ordered. On the basis of feedback at the roundtable discussion, we believe that serious harm should not be limited to physical harm, but rather, should be interpreted holistically, as is the case under the *Mental Health Act*. Professor Webster put it in terms of a person's health or welfare being significantly impaired.[358] Such harm may also include not just that arising through injury or illness, but also through self-neglect. Unlike under the *Mental Health Act*, we do not consider that harm to reputation is a valid consideration, given the subjective judgements that may be made in relation to substance use.

Lack of capacity

7.27 While some people with serious substance dependence will lack decision making capacity, others will not, and it is only when they do that intervention may be justified. In the previous chapter we documented a number of examples of how a lack of decision making capacity might manifest itself. In light of the seriousness of the decision to detain and treat a person against their will and the fundamental right of a person to make their own decisions, the Committee considers that specific consideration must be given to whether the person lacks the capacity to consent to treatment as a necessary precondition for involuntary care.

Treatment plan

7.28 The presence of an initial treatment plan setting out how the intervention is expected to benefit the person serves both to justify that detention and to ensure that coercion serves a therapeutic rather than a punitive purpose. In effect, it holds the state accountable for the action of placing a person in involuntary care.[359] The Committee considers that the presence of an initial treatment plan, which includes a rationale for the recommended length of detention, should be an essential precondition to involuntary care. This initial plan would be developed on the basis of a medical examination, according to a process set out later in this chapter.

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358 Professor Webster, NSW Expert Advisory Committee on Drugs, Evidence, 4 June 2004, p3

359 Professor Carney, University of Sydney, Evidence, 8 April 2004, pp18-19

Recommendation 9

That the proposed legislation stipulate the following criteria for involuntary care, all of which are essential:

- the person has a severe substance dependence
- the person has experienced or is at immediate risk of serious harm to self
- the person lacks the capacity to consent to treatment
- there is an initial treatment plan demonstrating that the intervention will benefit the person.

Recommendation 10

That the proposed legislation define 'serious harm' in the second criterion holistically, that is, in terms of a person's health and welfare.

Recommendation 11

That the proposed legislation explicitly exclude the use of involuntary care for people who are simply using or dependent on substances.

Involuntary care orders

7.29 The Committee took detailed evidence on the various provisions for involuntary care for people with substance dependence at risk of serious harm that should be made under the proposed legislation.

Detention

7.30 Provision for detention against the person's will was widely understood and supported by participants as a key element of involuntary care. Along with evidence-based clinical interventions, 'containment in a safe environment', as Dr Hester Wilce of the Kirketon Road Centre described it,[360] was perhaps the most important element of involuntary care. Indeed, many saw this as critical for the purpose of protection from serious harm.

7.31 The Committee considers that the power of suitable facilities to detain would be an essential element of an involuntary care order. The need for the legislation to set out the responsibilities of facilities and staff in relation to detention is discussed in a later section.

Interventions provided

7.32 As outlined in the previous chapter, and in keeping with the goal and aims of the proposed legislation, a range of interventions may be provided to those subject to an order for

[360] Dr Hester Wilce, Medical Practitioner, Kirketon Road Centre, Evidence, 7 April 2004, p5

involuntary care. These would necessarily entail evidence-based clinical interventions[361] provided in a medical setting. Consistent with participants' views and the UN Principles, patients would have the right to the best available care, with the least restrictive or intrusive treatment being provided, with the aim of preserving or enhancing their autonomy. The service framework to support such orders is set out in the following chapter.

7.33 Participants argued strongly that the interventions delivered must be determined on the basis of an assessment of the person's individual needs; they would also be set out in the initial treatment plan that necessarily preceded the order.

7.34 While the specific medical care, harm reduction and psychosocial interventions would vary according to the person's needs, several core interventions are to be provided:

- the person is to be given a comprehensive assessment, that is, assessment of their physical, psychological and social needs. This should also include neuropsychological assessment of cognitive functioning where appropriate.
- on the basis of that assessment, a post-discharge treatment plan is to be developed, setting out the recommended treatment or services for the person once they leave involuntary care.
- in accordance with the post-discharge treatment plan, the person is to be actively linked to the services and further treatments recommended for them, including to a general practitioner, and where necessary be supported to apply for guardianship.

7.35 The Committee understands that the process of applying for guardianship can be a lengthy, complex and labour-intensive process for staff who are assisting the person. Provision for time to enable this to occur is considered below, and the service implications are explored in Chapter 9.

7.36 In the Committee's view, these core interventions give expression to the human rights principles concerning involuntary care, and are vital to ensuring positive outcomes for the person subject to such care. Thus we consider that the Minister for Health should ensure that they are provided to all persons placed in involuntary care.

Length of orders

7.37 The Committee established in the previous chapter that intrusion for a short period was consistent with ethically sound intervention with the goal of protecting a person's health and safety. Ultimately, the length of time needs to balance the person's dual rights to minimal intrusion and to obtain maximum benefit from the intervention. The Committee believes the order should be for as short a period as is necessary to achieve the aims of an order, that is, to reduce harm through the provision of medical interventions, to stabilise the person and comprehensively assess them, to develop their treatment plan and to engage them in the voluntary service system.

7.38 While there was a significant range in the length of time that participants envisaged (advocates for a shorter period suggested anywhere between 3 days and a month), there was broad

361 Submission 29, Network of Alcohol and Other Drugs Agencies, p11

agreement that the length should not be arbitrary, as under the *Inebriates Act*, but determined on the basis of a clinical assessment of the person's needs.

7.39 Participants with clinical expertise in addictions indicated that the length of an order would necessarily be determined by the nature of the person's substance dependence and therefore the period of withdrawal, any other medical needs that must be attended to, and the presence of cognitive damage. They also stressed that it is only once a person has completed withdrawal and stabilised that a comprehensive assessment can occur.[362] Alcohol withdrawal may take three to five days and opiate withdrawal five days,[363] but when a person is using other illicit substances, especially in combination, the length of withdrawal may be longer and is not necessarily known.[364] The Committee understands that benzodiazepine withdrawal, for example, may take up to two weeks.

7.40 Clinicians also stressed the need for time to stabilise the person, assess them and engage them in the voluntary system. According to Dr Jurd, a person needs to be sober for at least a week before appropriate neuropsychological tests can be undertaken;[365] as noted earlier, further time may be needed to apply for guardianship or make alternative care arrangements. Others emphasised that people with cognitive damage needed comparatively more time to learn new skills and be engaged in a process of change.[366] Some participants also called for the ability to renew an order where it became clear that a person needed longer for the aims of the order to be met.[367]

7.41 From a legal perspective, the Committee was advised that it was important to establish a maximum period. Professor Carney advised that the most common approach was to set a limit, but empower the clinician to discharge the person before that period has elapsed where they consider that the person has recovered sufficiently.[368] The initial treatment plan that necessarily informed the decision as to whether a person be subject to an order would specify the recommended length of the order.

7.42 On the balance of the evidence, the Committee considers that orders should be made for an initial period of 7 to 14 days, on the basis of a medical examination of the person's needs. We note that this is consistent with the Victorian legislation. The number of days that the person is to be detained would be specified in the medical report (including the initial treatment plan) that necessarily informed the legal decision as to whether a person is to be subject to involuntary care.

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362 Dr Jurd, Northern Sydney Health, Evidence, 4 June 2004, pp16-17; Dr Wilce, Kirketon Road Centre, Evidence, 7 April 2004, p7; Dr Joanne Ferguson, Psychiatrist, Drug Health Services, Rozelle and Concord Hospitals, Evidence, 27 November 2003, p41; Ms Tonina Harvey, Area Director, Drug and Alcohol Services, Northern Sydney Health, Evidence, 4 March 2004, p19

363 Professor Richard Mattick, Director, National Drug and Alcohol Research Centre, University of New South Wales, Evidence, 8 April 2004, p4

364 Dr Wilce, Kirketon Road Centre, Evidence, 7 April 2004, p7

365 Dr Jurd, Northern Sydney Health, Evidence, 4 June 2004, pp16-17

366 Mr David McGrath, Acting Deputy Director, Centre for Drug and Alcohol, NSW Health, Evidence, 29 April 2004, p16

367 Dr Wilce, Kirketon Road Centre, Evidence, 8 April 2004, p7

368 Professor Carney, University of Sydney, Evidence, 8 April 2004, p28

7.43 In exceptional circumstances, that is, where it is clinically determined that the person remains at risk of serious harm, or that their cognitive damage is such that additional time is required to achieve the aims of involuntary care, a further period of up to 14 days may be recommended. This would be subject to a further legal decision. The process of decision making in relation to involuntary care orders is discussed in a later section.

7.44 The periods of care that the Committee has recommended were broadly supported at the roundtable discussion, including by numerous clinicians.

Recommendation 12

That the proposed legislation provide for the following elements of involuntary care orders:

- detention in an appropriate medical facility
- detention may be ordered for an initial period of 7 to 14 days, on the basis of a medical examination of the person, especially with regard to the nature of their substance dependence, other medical needs and the suspected presence of cognitive damage
- in exceptional circumstances, that is, where it is medically determined during the comprehensive assessment process that the person remains at risk of serious harm, a further period of detention for up to 14 days may be ordered, subject to a further legal decision
- treating clinicians are to be empowered to discharge the person before the period of the order has elapsed, where they consider that the person has recovered sufficiently to be released.

Recommendation 13

That the Minister for Health ensure that every person subject to involuntary care must, while in care, receive a comprehensive assessment which then forms the basis for a post-discharge treatment plan. On the basis of that plan, the person must then be actively linked to appropriate services and receive assertive follow-up.

Contingency for failure?

7.45 When they appeared before the Committee, Ms Michelle Noort, Director of the Centre for Drug and Alcohol at NSW Health and Mr David McGrath, Deputy Director, stated a strong preference against a two week limit, and argued for a 'contingency for failure'. They suggested that two weeks was an insufficient period for a person to achieve substantial change, especially for those with cognitive damage. In order to prevent repeated use of short term orders, they sought a longer term mechanism, which they argued would cater to people's longer term needs and deliver better outcomes for the investment made.[369]

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[369] Ms Michelle Noort, Director, Centre for Drug and Alcohol, NSW Health and Mr McGrath, NSW Health, Evidence, 29 April 2004, pp15-16

7.46 When we visited Victoria, the Committee was advised that repeated use of compulsory detoxification was accepted, just as it is in the voluntary system, given the chronic relapsing nature of alcoholism.[370] Dr Ian Kamerman, a general practitioner from the New England area and NSW Director of Australian College of Rural and Remote Medicine, like many other participants was pragmatic about detoxification and the opportunities it can present over time:

> It does work from time to time and that is why I do not say that it is a waste of time, but the issue is hopefully each time you try it and each time you are closer to actually hooking them into a program, that is, getting them to hook into AA or NA, or hooking them into the alcohol and other drug workers and coming to see you on an ongoing basis, and pharmacotherapies such as naltrexone and acamprosate for use in keeping people off alcohol.[371]

7.47 In considering the possibility of a 'contingency for failure', the Committee is mindful of the purpose of coercive intervention. In the previous chapter we established that there was no real evidence to indicate that a longer term system could help people achieve rehabilitation, and in the absence of this evidence, such a system was neither feasible nor ethically desirable. On the other hand, a system that aims to reduce harm and seeks to engage people in services voluntarily has realistic and widely supported outcomes, and is philosophically sound. Reducing harm in itself is a valuable outcome. In addition, the Committee considers that as with any chronic illness, the health system needs to find ways to engage with clients more effectively so as to minimise relapses, but should also accept that they are part of the nature of people's disease.

7.48 Nevertheless, we believe that an important aspect of any evaluation of the proposed system is to consider both the outcomes of involuntary care orders and the rates of repeat orders. A number of recommendations in relation to evaluating our proposed legislative and service model are made at the conclusion of the report.

Community treatment orders?

7.49 A number of inquiry participants advocated the use of 'community based coercion' through community treatment orders (CTOs), as occurs in the mental health system. A CTO is a legal order made by a magistrate setting out the terms under which a person must accept medication, therapy, rehabilitation or other services while living in the community. It is implemented by a health care agency that has developed the person's treatment plan. If a person breaches their CTO they may be detained in hospital for the remainder of the order.[372]

7.50 Participants suggested that CTOs could precede or replace an inpatient order, or be used as an after care or follow-up measure. Dr Patfield, for example, suggested they could be used to achieve a level of management over people with antisocial behaviour.[373] Dr Kamerman suggested that CTOs would be especially helpful in rural areas, enabling a person to receive a

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370 Evidence, 28 April 2004

371 Dr Ian Kamerman, General Practitioner and NSW Director, Australian College of Rural and Remote Medicine, Evidence, 24 March 2004, p7

372 Centre for Mental Health, *Mental Health Act Guide Book (Amended May 2003)*, NSW Health, December 2003, pp29-31

373 Dr Patfield, Bloomfield Hospital, Evidence, 4 June 2004, pp18-19

level of supervision in their own community, and that they could potentially be administered by general practitioners.[374] The Committee was also told that CTOs have the strong advantage of making services accountable for delivering what is in a person's treatment plan.[375]

7.51 On the other hand, according to Professor Duncan Chappell, President of the Mental Health Review Tribunal, CTOs are an intrusive mechanism which relies on there being adequate resources in the community. Yet very often these resources are not available and the outcome is relapse and hospitalisation.[376] His views were borne out in a recent evaluation of mental health CTOs in Victoria, which found they did not confer substantial benefit in harnessing and ensuring access to services.[377] Professor Chappell was one of several participants who recommended against the use of CTOs for people with severe substance dependence.[378]

7.52 Some pointed out that CTOs may be less appropriate for drug and alcohol because of the relatively poor tool kit of pharmacotherapies in that field as compared with mental health. More fundamentally, a number of participants were concerned that given the very significant level of need among the client group we are focusing on, CTOs might be setting people up to fail.[379] There was also a very strong concern from participants such as Mr Feneley of the Attorney General's Department and Mr Graeme Henson of the Local Court of NSW that CTOs were heavy handed and that failure to comply with an order might entail a 'criminalising' sanction. As Mr Henson stated:

> I have real difficulties with the word "order" in this context as opposed to "plan". What role should the court play, for heavens sake, in forcing someone who has undertaken the legal act of consuming alcohol. It seems to me nonsensical.[380]

7.53 On the balance of evidence, the Committee considers that the legislation for involuntary care of people with severe substance dependence should not provide for community treatment orders. We do, however, see an important role for assertive follow-up, and this is explored in detail in the section on after care in the following chapter. Such a role, we consider, does not need to be reflected in the legislation.

Recommendation 14

The Committee recommends against a longer term mechanism to deal with people who are placed under an involuntary care order on a number of occasions, and also against provision for community treatment orders.

374 Dr Kamerman, Australian College of Rural and Remote Medicine, Evidence, 24 March 2004, p19

375 Ms Toni Colby, MERIT Caseworker, Alcohol and Other Drugs Service, Tamworth, Evidence, 24 March 2004, p22

376 Professor Duncan Chappell, President, Mental Health Review Tribunal, Evidence, 29 April 2004, p36

377 Professor Carney, University of Sydney, Evidence, 7 April 2004, p28

378 Professor Chappell, Mental Health Review Tribunal, Evidence, 4 June 2004, p20

379 Ms Tonina Harvey, Area Director, Drug and Alcohol Services, Northern Sydney Health, Evidence, 4 June 2004, p25; Ms Kim Alcohol and Other Drugs Project Worker, Mid Western Area Health Service, Evidence, 25 March 2004, p40

380 Mr Graeme Henson, Acting Chief Magistrate, Local Court of New South Wales, Evidence, 4 June 2004, p19

The decision making process

7.54 In the Committee's view, the decision making process in relation to involuntary care orders is critical to the integrity of the proposed legislation. Unless the process is tightly defined, with the right parties responsible for key tasks, and with the necessary checks and balances, there is great risk that involuntary care may be used excessively, and that the rights of people will not be honoured.

7.55 In the previous chapter we established that the decision to detain and treat someone against their will is a weighty one and the state has a responsibility to ensure that such intrusion on people's autonomy is carefully considered and safeguarded. Many inquiry participants were concerned about ensuring a fair and impartial legal process, and the need for magistrates to have adequate input from medical practitioners when making their decisions. Many suggested that the decision making process in relation to involuntary patients under the *Mental Health Act 1990* would serve as a useful model for new legislation.

7.56 Balanced against the need to protect people's rights is the need for a workable and timely process. Many participants called for a process that was accessible and 'user-friendly' for families, treating staff, police, legal bodies and anyone else involved. The process needs to be flexible enough to respond to a range of situations, including those where urgent intervention is required. It also needs to ensure timely decisions, given the relatively short period of detention we are recommending, as well as the fact that depending on their substance dependence, people will enter and pass through withdrawal relatively quickly. We were also advised that the process needs to factor in time for a person to sober up, as they cannot be effectively examined while intoxicated.[381] In some cases, detention may be necessary to prevent further consumption of alcohol or other drugs, pending their medical examination. Once in withdrawal, the person is likely to require medical supervision. Care also needs to be taken that the process does not dictate a heavy handed approach for those people who do not require an urgent response or immediate containment.

Medical examination

7.57 A key criticism of the *Inebriates Act* documented in Chapter 3 was that the decision to detain a person, and for how long, was made with minimal medical input. It is crucial that the process of decision making about whether a person be subject to involuntary care, and for what period, be clinically driven, but with appropriate legal adjudication. The Committee envisages a process like that under the *Mental Health Act*, where detention may commence on the certificate of a medical practitioner, but may only continue subject to further medical examination(s) and review by a magistrate.

7.58 Provision for a clinically-driven process is consistent with the Committee's stated purpose of involuntary care: to protect a person's health and safety. It is also reflected in the criteria we have recommended be used in decisions of involuntary care: that the person has a severe substance dependence and has experienced or is at immediate risk of serious harm, that the person lacks capacity to consent to treatment, and that there is an initial treatment plan demonstrating that the proposed intervention will benefit the person. In the Committee's view, such decisions will necessarily be made, in the first instance, by a medical practitioner.

381 Ms Noort, NSW Health, Evidence, 29 April 2004, p22

7.59 While some stakeholders expressed a strong preference for only addictions specialists to undertake any medical examination informing the decision to detain, roundtable participants such as Dr Stephen Jurd indicated that this was just not possible in rural and many regional areas. This being the case, he suggested it would be better for the legislation to stipulate 'medical practitioner'.[382] The Committee considers that it is practical that the legislation enable any medical practitioners to conduct this examination, but that as far as possible, those with addictions expertise should be utilised.

Decision making and review

7.60 According to the UN principles, a person can only be detained for an initial short period on the basis of a medical examination, pending review by 'a judicial or other independent and impartial body'.[383] The role of this body is to protect the person's civil liberties by considering whether the medical evidence presented justifies the person being involuntarily detained.

7.61 While there was strong agreement among participants for a mechanism that immediately reviewed a medical practitioner's recommendation to detain, there was some variation in views as to the most appropriate body to do this. The Chief Magistrate of NSW, Judge Derek Price, advocated the *Mental Health Act*'s model of review by a magistrate which in his view works effectively and efficiently to safeguard people's rights. He also emphasised the benefits of a non-court based approach that offered greater privacy and sympathy.[384] Similarly, his colleague, Mr Graeme Henson, saw the magistracy as providing a sound check and balance, and one that is geographically accessible, given the presence of over 150 local courts across the state.[385] Other participants advocated review through a tribunal, which they saw as providing a greater safeguard by bringing a range of perspectives - community, legal and medical – to bear on the case.

7.62 Participants also varied as to whether the legal body should actually fulfil a review role, or a decision making one, where the person could not be detained until the recommendation of a medical practitioner was endorsed by a legal body. Roundtable participants such as Dr Patfield, Professor Carney and Professor Webster were concerned that provision for detention to commence on the basis of a medical certificate was 'too easy'. They argued for a tribunal to make the decision, having regard to a medical examination's recommendations, before detention could occur.[386]

7.63 Professor Duncan Chappell, President of the Mental Health Review Tribunal suggested that providing that the number of people with substance dependence subject to involuntary care is reasonably low, the MHRT could potentially fulfil a review role:

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382 Dr Jurd, Northern Sydney Health, Evidence, 4 June 2004, p29

383 United Nations, *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, Adopted by General Assembly Resolution 46/119 of 17 December 1991, Principles 16 and 17

384 Judge Price, Chief Magistrate, Local Court of New South Wales, Evidence, 26 November 2003, p3 and 14

385 Judge Price, Chief Magistrate, Evidence, 26 November 2003, p14; Mr Henson, Acting Chief Magistrate, Evidence, 4 June 2004, pp27-28

386 Dr Patfield, Bloomfield Hospital, Evidence, 4 June 2004, p29; Professor Carney, University of Sydney, Evidence, 4 June 2004, p30; Professor Webster, NSW Expert Advisory Committee on Drugs, Evidence, 18 February 2004, p6

> In my view it would be essential that this form of review be incorporated in any such legislation in order to provide the same type of protection to this category of person as already exists in the mental health system. I also believe that it would be possible for the review function to be conducted by the [MHRT] which already possesses the general expertise and experience required to deal with the sensitive issues that arise in this area … With adequate resources, and assuming that there would only be a very small caseload, it would be cost effective to add this area to the jurisdiction of the Tribunal.[387]

7.64 Dr Chappell explained that the Tribunal already has a number of members with addictions expertise, and is able to provide urgent reviews, and timely response in rural areas, through video and telephone hearings.[388] While mental health patients appear at a hearing before the MHRT there may also be alternative approaches more suited to the new legislation. Were a magistrate to fulfil the review function, Professor Chappell suggested that the Tribunal could be responsible for appeals and for decision making regarding applications for additional periods of detention in exceptional circumstances.

7.65 Other participants emphasised the need to ensure a system that worked as much in remote areas as metropolitan ones, and saw that the best way to achieve this was through magistrates rather than a tribunal.[389]

7.66 Whatever bodies are responsible for decision making and review, appropriate provisions need to be made to ensure that these proceedings occur in private. Both the Attorney General's Department and Chief Magistrate spoke against decision making in relation to involuntary care occurring in open court.[390] Under the *Mental Health Act*, magistrates' inquiries are generally conducted at the hospital where the person is detained. In addition, patients have the right to legal representation at a magistrate's inquiry.

Appeal

7.67 The UN Principles also stipulate that all involuntary patients have the right of appeal, and again this was seen by participants as a necessary element in any new legislation. As noted above, Professor Chappell indicated that appeal could potentially be made to the Presidential Member of the Mental Health Review Tribunal.[391] We understand this role could also be fulfilled by the Administrative Decisions Tribunal.

The Committee's view

7.68 Having explored the range of perspectives, the Committee considers that an appropriate decision making process that balances the imperatives for strong safeguards, flexible and

387 Tabled Document No 35, pp7-8

388 Professor Chappell, Mental Health Review Tribunal, Evidence, 29 April 2004, p39

389 Evidence, 4 June 2004

390 Mr Feneley, Attorney General's Department, Evidence, 11 December 2003, p10; Judge Price, Chief Magistrate, Evidence, 26 November 2003, p13

391 Professor Chappell, Mental Health Review Tribunal, Evidence, 4 June 2004, p29

timely response, and feasibility for large and small communities would have the following elements:

- detention may commence on the certificate of a medical practitioner, but may only continue subject to further medical examination(s) and review by a magistrate
- where possible, two medical practitioners are to be involved in this process, and as far as possible, at least one of them is to have expertise in addictions medicine
- review by a magistrate is to occur as soon as practicable, preferably within 3 days
- the right to legal representation in magistrates' inquiries
- the right of appeal.

7.69 We have noted participants' concerns that doctors cannot always be trusted to ensure that the best interests of the person are paramount when making such a decision. Nevertheless, we consider that a mechanism that is workable in rural areas and which enables an urgent response where necessary is required. Our recommendations concerning a focus on serious harm, and the criteria to be used, would necessarily require the decision to be made on medical grounds, and we anticipate that in many cases the person will require urgent medical care. Review by the magistracy as soon as possible after the decision, with legal representation, would mean that inappropriate detention was quickly identified and addressed. In addition, the criteria themselves, supported by strong guidelines for both medical practitioners and magistrates, would militate against inappropriate use. Further safeguards such as service monitoring are discussed later in this chapter. In addition, a system of centralised data collection on use of the legislation would feed into a formal evaluation of the legislation and provide a feedback loop to government agencies responsible for the legislation. The formal evaluation, which we later recommend occur within 5 years, would explicitly consider use of the legislation beyond its intended target group.

7.70 In the Committee's view, further consultation and consideration is necessary to refine this process. In particular, there is a need for both clinical and medico-legal perspectives to be brought to bear on the options, in order to develop the most effective and safeguarded approach. We note that the NSW Health review of the *Mental Health Act* is currently examining voluntary and involuntary admission procedures for mental health patients, as well as procedures and provisions in respect of magistrates' hearings. It is possible that valuable information on appropriate processes for the proposed legislation may emerge from that work.

7.71 The Committee believes that further consideration of the most appropriate decision making process will necessarily take into account a number of issues:

- The dual imperatives of providing strong safeguards with a workable and timely response
- The need for flexibility to ensure an urgent response where this is required and where it is not, that people's freedom and dignity is preserved
- The desirability of a localised approach, notwithstanding the fact that rural and regional areas will necessarily have less access to medical practitioners, legal bodies and appropriate facilities.

7.72 We revisit the proposal for a localised panel in the discussion on complex needs later in this chapter.

Recommendation 15

That the decision making process in relation to involuntary care include the following elements:

- detention may commence on the certificate of a medical practitioner, but may only continue subject to further medical examination(s) and review by a magistrate
- where possible, two medical practitioners are to be involved in this process, and as far as possible, at least one of them is to have expertise in addictions medicine
- review by a magistrate is to occur as soon as practicable, preferably within 3 days
- the right to legal representation in magistrates' inquiries
- the right of appeal
- formal proceedings to occur in private.

Who may seek an order?

7.73 There was general support among participants for anyone to be able to apply for an order. As Dr Wilce put it:

> Anyone should be able to say, "I want this person to be assessed." So a family member, the doctor, the local police officer, or whoever, but the only people that can do the assessment and that scheduling should be addictions specialists.[392]

7.74 Participants such as Dr Ferguson, Ms Jefferson and Dr Dore all thought it was very important that family members be able to apply.[393] Some made the case for people to seek an order for themselves, as was documented in relation to the *Inebriates Act* in Chapter 4, and as occurs frequently under the New Zealand legislation. The Alcohol and Drug Information Service made a reasoned case for this, explaining that some people feel unable to make the commitment required to reach their own goals, but if they believe being detained will help, such a mechanism should be available.[394]

7.75 The Committee is open to self-committal, as long as the person is judged to be at risk of serious harm. In such cases, the criterion that the person is considered to lack the capacity to consent, would presumably be waived. Consideration would also need to be given to whether

392 Dr Wilce, Kirketon Road Centre, Evidence, 7 April 2004, p7

393 Dr Ferguson, Rozelle and Concord Hospitals, Evidence, 4 June 2004, p20; Ms Leonie Jefferson, Senior Aboriginal Drug and Alcohol Counsellor, Northern Rivers Area Health Service, Evidence, 27 November 2003, p6; Dr Glenys Dore, Addictions Psychiatrist and Deputy Medical Superintendent, Macquarie Hospital, Evidence, 4 March 2004, p14

394 Submission 22, Alcohol and Drug Information Service, St Vincents Hospital, pp3-4

this would facilitate 'queue jumping' in an environment of limited access to services. In a later section of this chapter we consider the potential for an advanced care directive provision.

7.76 The Committee considers that detention may be requested for an individual by a broad range of parties, including a relative or friend, police, medical practitioner, drug or alcohol professional or magistrate. Nevertheless, the Committee considers that the process would still commence with certification by a medical practitioner.

Recommendation 16

That the proposed legislation enable requests for involuntary care orders in respect of a person at risk of harm to be made by a range of parties including a relative or friend, member of the police service, medical practitioner, drug or alcohol professional or magistrate.

Considerations for Aboriginal people

7.77 Having taken evidence from a number of people from Aboriginal communities and services, the Committee is mindful of the need for a decision making process that is culturally appropriate. This need is even greater in light of the prevalence of severe substance dependence among some Indigenous people, the disproportionate use of the *Inebriates Act* in relation to them, and the personal and cultural trauma associated with detention. As Ms Tonina Harvey of Northern Sydney Health stated:

> The legislation should allow opportunities for those communities to develop their own culturally appropriate responses. That is important; we can't make this an all-Anglo approach.[395]

7.78 Ms Leonie Jefferson, Senior Aboriginal Drug and Alcohol Counsellor with the Northern Rivers Area Health Service, stressed the need for family and community involvement in decision making. She told the Committee:

> [T]here would have to be a lot of consultation on the treatment provision with the appropriate people – family, medical practitioners and all those associated with that work ... we do really need an appropriate assessment model … with the family, the community and the elders, as they have much more knowledge of the person - rather than the medical model.[396]

7.79 Ms John Williams, Senior Policy Officer with the Aboriginal Health and Medical Research Council, endorsed Ms Jefferson's view and suggested that a process based on the circle sentencing models being piloted in the criminal justice system could provide a sensitive and effective process as well as important safeguards to ensure non-discriminatory use of the legislation. These circles could potentially include Aboriginal peers, the person's family, their doctor, Aboriginal drug and alcohol workers and Aboriginal health workers.[397]

395 Ms Harvey, Northern Sydney Health, Evidence, 4 March 2004, p22

396 Ms Jefferson, Northern Rivers Area Health Service, Evidence, 27 November 2003, pp9-10

397 Mr John Williams, Senior Policy Officer, Aboriginal Health and Medical Research Council, Evidence, 27 November 2003, pp10-11; Tabled document No 7, *Responses to proposed questions*, p5

7.80 The Committee considers that it will be important for government agencies to consult with Indigenous communities in order to ensure that the decision making process in Recommendation 15 be implemented in a culturally sensitive manner. It may be appropriate for this to be incorporated into the regulations that accompany the legislation.

Recommendation 17

That NSW Health and the Attorney General's Department consult with Indigenous communities in order to ensure that the decision making process in Recommendation 15 is implemented in a culturally sensitive manner.

Other safeguards

7.81 In keeping with the imperative to prevent net-widening and protect the rights of those subject to involuntary care, a number of further safeguards were advocated by participants.

Official visitors

7.82 Service monitoring through an official visitors system was broadly endorsed by participants such as the Network of Alcohol and Other Drugs Agencies and the Alcohol and Drug Information Service, who saw such a mechanism as an important form of scrutiny, aimed at ensuring both quality of care and the protection of civil liberties. Professor Webster readily agreed, but pointed to the need to strengthen existing mechanisms in New South Wales, perhaps by linking them together:

> I am strongly supportive of the idea of having an external community-based oversight inspection system of some kind. I think the official visitors system could be much stronger in the mental health system. I am just wondering if there is not perhaps an instrument of Government which ought to establish some form of official visiting idea which extends across a number of domains, rather than just being categorised into groups … The inclination I think by Government, or certainly by departments, is to set the official visitors aside and not to have a great deal of regard to them. My view is that they ought to be strengthened …[398]

7.83 Supporting Professor Webster's suggestion, Professor Carney advised that in Victoria, the official visitors systems provided for under various acts are coordinated through the Office of the Public Advocate, which is required to report to parliament each year on the program.[399]

7.84 The Committee considers that monitoring via official visitors would be an essential element of any new legislation enabling involuntary care, and sees value in doing this through an existing official visitors system, thereby enabling greater efficiency and at the same time strengthening that system.

[398] Professor Webster, NSW Expert Advisory Committee on Drugs, Evidence, 4 June 2004, p31

[399] Professor Carney, University of Sydney, Evidence, 4 June 2004, p31

Recommendation 18

That the Government provide for a system of official visitors to monitor service provision and the rights of patients under involuntary care orders. In determining the most appropriate mechanism, consideration should be given to the potential to augment an existing official visitors system to fulfil the function in relation to this group.

Guidelines and training for decision makers

7.85 In the Committee's view, a critical aspect of the implementation of the proposed legislation will be the development and dissemination of guidelines for those parties involved in the decision making process, including magistrates, medical practitioners, and the review body. In addition, drug and alcohol workers and other professionals who might seek an application would need to be educated on the legislation and its procedures.

7.86 Given their central decision making role in the process, the Committee envisages that guidelines for magistrates will be particularly important. We understand that these would appropriately be prepared and disseminated by the Judicial Commission. In addition, we consider that an appropriate strategy to educate medical practitioners on the process would need to be developed.

Recommendation 19

That the Government request that the Judicial Commission develop an education program for magistrates in relation to the proposed legislation.

Recommendation 20

That as part of an implementation strategy for the proposed legislation, the Government develop an appropriate information and education strategy targeting medical practitioners with addictions expertise, other medical practitioners and drug and alcohol practitioners, in relation to involuntary care orders and the decision making process pertaining to them.

Regulations for service providers and facilities providing involuntary care

7.87 In Chapter 3 the Committee noted that witnesses such as Dr Joanne Ferguson of Rozelle and Cumberland Hospitals were critical of the absence of clarity in the *Inebriates Act* concerning the responsibilities of the treating service and staff in relation to those placed under an order, including in relation to use of restraints.[400] The Committee considers that the proposed new legislation would necessarily contain regulations in relation to the responsibilities and powers of the services where people are detained.

[400] Dr Ferguson, Rozelle and Concord Hospitals, Evidence, 27 November 2003, p41

Recommendation 21

That the proposed legislation make provision for regulations to articulate the responsibilities of treating services and staff.

Other provisions

Police powers

7.88 The Committee envisages that some people for whom an order is sought may attend a medical examination or enter detention without resistance; others will necessarily be subject to force. In order to preserve the dignity of the person, we consider that as far as possible the person should be delivered into care through informal means, for example, with the help of a drug and alcohol worker or other service provider, or a family member. Where necessary, police should be empowered to detain the person in order to deliver them to into care.

7.89 In the NSW Government submission to the inquiry, NSW Police are reported as noting that where a person is a danger to themselves or others, or at risk of causing damage to property or committing an offence, police should have a role in locating and returning them to the appropriate facility.[401] The Committee heard from police representatives that the responsibility for transporting patients subject to the *Inebriates Act* is very burdensome, especially in light of the long distances to travel to gazetted facilities, and that new legislation could potentially have significant implications for their resources.[402] The issue of transporting people under an order is discussed further in Chapter 8. Matters relating to detention in police cells are discussed at the end of this chapter in the section dealing with the *Intoxicated Persons Act.*

7.90 The Committee considers it necessary that police be empowered to detain a person subject to a decision in relation to involuntary care, and where necessary, to take the person to an appropriate facility where they are to be examined. In addition, we consider that in the event that a person under an involuntary care order absconds from a facility where they are being detained, that the police should be empowered to return the person to that facility. Any further police responsibilities should be developed in consultation with the NSW Police.

Recommendation 22

That the proposed legislation empower police to detain a person and deliver them to an appropriate facility where they are to be medically examined regarding their need for involuntary care, and in the event that they abscond from care, to return the person to the facility where they are being detained.

401 Submission 47, NSW Government, p11

402 Assistant Commissioner Bob Waites, Commander, Greater Metropolitan Region and Corporate Spokesperson, Alcohol related Crime, NSW Police, Evidence, 27 November 2003, p22

'Mandatory assessment' as an outpatient

7.91 Dr Ferguson made the case for an additional mechanism before the point of detention, whereby people could be legally ordered to undergo an assessment without having to enter care. She saw this as a valuable means to respond to the concerns of family members where the person did not necessarily require detention:

> I want to take a step back before we put people in an institution and I wonder if we can develop some alternatives at that point so that, if perhaps someone came to a court system because the family was concerned that they had a drug and alcohol dependence and there was some immediate risk, they could be instructed to get a mandatory assessment, and that might happen either as an inpatient or as an outpatient.[403]

7.92 Dr Ferguson also saw that such a mechanism would serve to cull people at an earlier stage, channelling them towards appropriate services, and minimising the need for detention.[404]

7.93 The Committee sees merit in the idea of a mechanism that did not detain people but nevertheless responded to family members' concerns, where the person could undergo an initial assessment and have a treatment plan developed, and be presented with the opportunity to engage in the voluntary system, with a minimal level of coercion.

7.94

Recommendation 23

That provision for court ordered outpatient assessment through which a person may undergo an initial assessment and have a treatment plan developed with a minimal level of coercion be considered, and if appropriate, included in the proposed legislation.

Advanced care directives

7.95 As noted earlier, significant demand in relation to the *Inebriates Act* and the Victorian compulsory treatment legislation has come from people who have voluntarily sought an order. A number of inquiry participants raised the possibility that new involuntary care legislation allow for a mechanism that enables people to specify in advance, while they are competent to make a decision, that they would like coercive intervention should the need arise. Such mechanisms differ from self-committal in that they involve a legal document that a person signs in advance. Terms such as 'living will', 'advanced care directive', 'enduring power of attorney', 'Ulysses agreement' and 'representation agreement' were used to describe such a tool. Dr Wilce of the Kirketon Road Centre spelt out how it might work in practice, emphasising that where possible, it is preferable to have people involved in such decisions:

> … ideally … they would come to us when they were well and rational and say, "I want to stop this." At that point for us to say, "What we can do for you is if you sign this we can put you into a safe place for a month. You will not be allowed to leave that place. There will be times when you feel you want to do that. How about we try this

403 Dr Ferguson, Rozelle and Concord Hospitals, Evidence, 4 June 2004, p20

404 Dr Ferguson, Rozelle and Concord Hospitals, Evidence, 4 June 2004, p24

> because you, at the moment, know that you are not able to contain your dependency and you do things that you do not wish to do because of your illness? How about you sign this? You make a living will that says that you will attend this place?" That is one option when the person is rational that they be involved in that decision.[405]

7.96 According to Professor Carney, advanced care directives would be consistent with the ethical framework underpinning the Committee's model, and would in fact be highly progressive.[406] He explained the elements of such mechanisms, but warned that they are not always honoured:

> When a person has capacity, he or she can execute a document that usually empowers a group of friends or family members to override his or her objections to doing what has been set out in the instruments. It allows a person to tailor-make the length and form of any intervention that is to occur should he or she relapse. It has already been used extensively in relation to schizophrenia – another chronic relapsing condition … It would need to be document that the person executed in consultation with not only their family, who would be the honest brokers and wield the power, but also with service providers. Quite commonly a person who presents is told that he or she is a no-win case and that there are other more pressing priorities, and a reason is found not to assist them. So service access must be tackled too.[407]

7.97 The Committee considers that there would be significant value in including provision for an advanced care directive in the proposed legislation. This would necessarily be a separate provision as it would mean that the person would not be subject to the same criteria as for involuntary care.

Recommendation 24

That the Government make provision for advanced care directives to be included in the proposed legislation.

Data collection and legislative review

7.98 In the discussion on the decision making process we suggested that a system of centralised data collection on use of the legislation be established, to enable monitoring by government agencies on use of the legislation, and to feed into a formal evaluation of the legislation. We consider that this mechanism would be essential to such an experimental system, especially in light of its implications for human rights. The NSW Chapter of Addiction Psychiatry stated in its submission:

> Deprivation of liberty is such a serious issue that the use of compulsory treatment requires the development and ongoing maintenance of a central register of all individuals that are committed under the proposed new *Inebriates Act*. This register could include a system where individuals are followed up to determine the effectiveness of treatment under [the Act]. Outcomes that could be monitored include

405 Dr Wilce, Kirketon Road Centre, Evidence, 7 April 2004, p7

406 Professor Carney, University of Sydney, Evidence, 8 April 2004, p24

407 Professor Carney, University of Sydney, Evidence, 8 April 2004, p24

> days to relapse, other medical problems including hospital admissions, and markers for psychosocial disability including legal, financial, relationship and accommodation factors.[408]

7.99 The Committee considers that the proposed legislation should be formally reviewed after a reasonable time, perhaps five years, to examine its effectiveness, whether it is being used as envisaged, and how it might be improved. The model the Committee is proposing is a significant departure from the current system, is necessarily experimental, and is likely to make significant demands within the legal and health systems. In addition, it involves significant encroachment on the autonomy of citizens of this State. For all these reasons, the Committee believes the new legislation must be formally evaluated.

7.100 Specific aspects of the evaluation should include:

- demographic and social characteristics of people subject to an order
- circumstances precipitating the order
- the parties who sought the order
- length of orders and length of time in care
- outcomes of legal review
- use and outcomes of appeal
- interventions provided while in care
- client outcomes achieved by discharge and upon follow-up
- use of the legislation in respect of Aboriginal people.

7.101 Further issues relating to service provision to be considered in an evaluation are identified in the following chapter.

Recommendation 25

That the Government establish a system of centralised data collection on use of the proposed legislation for the purpose of monitoring and evaluation.

[408] Submission 50, NSW Chapter of Addiction Psychiatry, p2

Recommendation 26

That the Government evaluate the proposed system of involuntary care within five years of commencement of the legislation. The evaluation should consider:

- demographic and social characteristics of people made subject to an order
- circumstances precipitating the order
- the parties who sought the order
- length of orders and length of time in care
- outcomes of legal review
- use and outcomes of appeal
- interventions provided while in care
- client outcomes achieved by discharge and upon follow-up
- use of the legislation in respect of Aboriginal people.

People with antisocial behaviour and complex needs

7.102 In addition to a system catering to people at risk of serious harm, in the previous chapter the Committee recognised the need for a mechanism to address the complex needs and antisocial behaviour associated with some people who have a serious substance dependence. We envisaged that this would be a non-coercive system that honours both the interests of the person and the community.

7.103 Professor Terry Carney of the University of Sydney and Professor Arie Freiberg of Monash University both suggested that any legislation to replace the *Inebriates Act* should draw on the provisions of Victoria's *Human Services (Complex Needs) Act 2003* (hereafter the *Complex Needs Act).*[409] Professor Carney stated a preference against detention and involuntary care, noting the high and multiple needs among the group of people in question. In his view, their needs would be much better met through the service system, including strong case management.[410]

7.104 Professor Freiberg noted the relevance of the Victorian legislation for 'people who are pre-criminal' and 'those really hard end cases which cycle in and out of re-notifications, the people you may not want to send to court but they are too difficult for just the voluntary services, even when they are cooperating',[411] and outlined its purpose and ambit:

> The *Human Services (Complex Needs) Act*, which came in in 2003 … is a non-conviction, semi-coercive mechanism where they are aiming to facilitate the delivery of welfare services, health services, mental health services, disability services, drug and alcohol treatment services and housing support services to certain people with multiple and

409 Professor Carney, University of Sydney, Evidence, 8 April 2004, p24; Professor Freiberg, Criminologist and Dean of Law, Monash University, Evidence, 18 February 2004, p53

410 Professor Carney, University of Sydney, Evidence, 8 April 2004, p24

411 Professor Freiberg, Monash University, Evidence, 18 February 2004, p53

> complex needs by providing for the assessment of such circumstances and the development and implementation of appropriate care plans through the mechanism of a multiple and complex needs panel. That is not a court, but it deals with people who have these prerequisites: if you have a mental disorder within the meaning of the *Mental Health Act* or acquired brain injury or intellectual impairment or are alcohol or drug dependent within the meaning of our Act, and the person has exhibited violence or dangerous behaviour that has caused serious harm to himself or herself or some other person, is exhibiting such behaviour and risks serious harm and is in need of intensive supervision and support and would derive benefit from receiving coordinated services in accordance with a care plan.[412]

7.105 The legislation was developed as a mechanism to achieve better and more cost effective outcomes for a small group of clients with extremely high and multiple needs who consumed significant resources, perhaps hundreds of thousands of dollars, across a number of human service systems.[413] For example, a person might have an intellectual disability *and* a serious mental illness *and* be a chaotic substance user, with profoundly disturbed behaviour placing others at significant risk, and bringing the person into contact with the criminal justice system. The key elements of the legislation are a regional gateway and referral process, a multiple and complex needs panel, a multidisciplinary assessment service which develops the individual's care plan, and intensive case management services.[414] Professor Carney emphasised the benefits of the model's statutory provision for holistic assessment, overcoming privacy laws and the compelling of agencies to deliver what is in a person's plan. [415]

7.106 Commenting at the roundtable discussion on a proposed legislative model providing for short term involuntary care to protect people from serious harm, Professor Carney expressed some comfort with the model, given its philosophical framework and principles. However, he held that the elements of the *Complex Needs Act* would be a more effective way to respond to *both* those at risk of harm and those with antisocial behaviour or complex needs.[416]

7.107 The Committee is aware that an initiative aimed at addressing complex needs across government agencies is under development and consideration by government in New South Wales. This is targeting people with disability with challenging behaviour who are coming into contact with the criminal justice system. We note that this, like the Victorian *Complex Needs Act*, entails significant resources and is highly targeted towards a small group of people with exceptionally high needs, catering to perhaps fewer than fifty clients per year. As was acknowledged by participants at the roundtable, any measure attempting to deal with antisocial behaviour or complex needs arising from substance dependence would be likely to attract much greater demand.[417]

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412 Professor Freiberg, Monash University, Evidence, 18 February 2004, p53

413 To be eligible, a person must appear to have two or more of the following conditions: a mental disorder, intellectual impairment, acquired brain injury, drug or alcohol dependence *and* meet the other criteria identified by Professor Freiberg: *Multiple and Complex Needs Initiative*, Ms Lyndall Grimshaw, Department of Human Services, Presentation to the Complex Clients Symposium, 27 February 2004

414 Department of Human Services, *Responding to People with Multiple and Complex Needs: Phase 1 Report*, Department of Human Services, July 2003

415 Professor Carney, University of Sydney, Confidential evidence, 4 June 2004, pp5 and 22-23

416 Professor Carney, University of Sydney, Evidence, 4 June 2004, pp22-23

417 Professor Webster, NSW Expert Advisory Committee on Drugs, Evidence, 4 June 2004, p24

7.108 In a discussion after the roundtable, Professor Carney suggested that key elements of the *Complex Needs Act* could be grafted onto the legislative framework for the Committee's proposed model of involuntary care, but that they should be tailored to respond to a larger group of people with lower grade needs. In particular, he saw value in a localised decision making body that holistically assessed people and acted as a filter, channelling them towards involuntary care and/or non-coercive services as appropriate to their needs. This panel would also be empowered to obtain personal information about the individuals referred to it.[418] Such a panel could potentially be comprised of a general practitioner, social worker and a representative of a human service agency. As a localised body it would also have an understanding of the resources available within a community to meet the person's needs. Inserted into the decision making process recommended earlier in this chapter, before the decision to invoke involuntary care, this body would also provide a further safeguard against inappropriate use of such orders.

The Committee's view

7.109 The Committee sees merit in this suggestion, but we do not consider that we have collected enough evidence to make informed recommendations in respect of legislation to address complex needs. We are hesitant to recommend a statutory response when there may be non-legislative means of addressing the key problem of improving service provision. While we are aware that a similar non-legislative initiative is under development in New South Wales, we are privy to very limited information about this and thus are not in a position to assess whether it might overlap with or complement what might be suggested in relation to our target group.

7.110 In addition, we believe that further consultation with a range of government and service provider stakeholders is essential in relation to how the model might be operationalised in rural areas. Particular thought needs to be given to who would be responsible for assessment and care coordination. Finally, in the absence of clarity about these potential mechanisms, we are eager to minimise the risks of delaying or detracting from those areas where we are confident of our recommendations for new legislation.

7.111 We also note that Victoria has both the *Complex Needs Act* and the legislation enabling involuntary detoxification and assessment, the *Alcoholics and Drug Dependent Persons Act*. These are seen by government stakeholders as complementary statutes, with the latter providing a valued mechanism for involuntary intervention for a small group.[419]

7.112 While we have drawn a limit around what this Committee can do in relation to formulating a way forward for people with complex needs and antisocial behaviour arising from substance dependence, we believe that further investigation and consideration by government must occur before the most appropriate policy position can be determined. We strongly believe that this must occur within a cross-agency context, necessarily involving each of the human service agencies and the Attorney General's Department.

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418 Telephone conversation between Professor Carney, University of Sydney and Senior Project Officer, 25 June 2004. This mechanism would combine the provisions in parts 2 and 4 of the *Complex Needs Act*, establishing them at the local or regional level.

419 Evidence, 28 April 2004

7.113 Were, as Professor Carney has suggested, a localised assessment and decision making body added to the proposed legislation for involuntary care as a gateway and filtering mechanism, the Committee anticipates that further thought would need to be given to both the eligibility criteria and the decision making process set out in this chapter.

7.114 Looking more broadly than a legislative mechanism, the Committee considers that there is a need for government agencies to collaborate specifically for the purpose of developing the most appropriate policy response to non-offenders with complex needs and challenging behaviours arising from substance misuse. As noted in the previous chapter, a number of initiatives are underway that may consider this issue, such as the remote town trials to address alcohol, inhalant and illicit drug issues in two small communities, and the Reducing Alcohol Related Harm in Rural Communities project. According to the NSW Government response to the Alcohol Summit, a steering committee made up of representatives of a number of government agencies is developing the proposal for the remote town trials.

7.115 In the Committee's view, there is a need for a high level cross-agency committee to consider the issues identified in this report in relation to complex needs and challenging behaviour, in order to determine the most appropriate non-coercive policy response to address their needs. This work should necessarily involve the Attorney General's Department, The Office of Drug Policy in The Cabinet Office, NSW Police, NSW Health, Department of Housing, Department of Community Services and other relevant agencies.

Recommendation 27

That the Attorney General's Department, The Cabinet Office, NSW Police, NSW Health, the Department of Community Services, the Department of Housing and other relevant agencies collaborate in a cross-agency task force to determine the most appropriate non-coercive policy response to address the complex needs and antisocial behaviour associated with some non-offenders who have a serious substance dependence. In particular, this forum should investigate the feasibility of grafting onto the proposed legislation elements of the Victorian *Human Services (Complex Needs) Act*. Consideration should be given to:

- how the elements might be modified to respond to a larger group of people with substance dependence but lower grade needs than those targeted by the Victorian legislation
- provision for a regionalised or localised decision making body that holistically assesses people's needs and channels them towards involuntary care and/or other services as appropriate to their needs
- provision to enable sharing of client information
- requirement of agencies to deliver what is in a person's care plan
- cross-agency initiatives already under development in New South Wales
- whether a legislative mechanism is required
- how the mechanism should be operationalised in rural areas.

7.116 In Chapter 9 we make recommendations on the services required to support our proposed legislative framework, many of which we anticipate will assist people with complex needs.

The *Intoxicated Persons Act 1979*

7.117 While the terms of reference for the inquiry did not ask the Committee to investigate the *Intoxicated Persons Act*, the interface between that Act and the *Inebriates Act* meant that a number of issues in relation to the former were brought to our attention. The provisions of the *Intoxicated Persons Act* are summarised in paragraph 2.59 to 2.61 (CHECK). The problems coalesce around the abolition of proclaimed places when the Act was amended in 2000, and the shortage of appropriate services to take intoxicated people in many areas.

7.118 A number of difficulties surrounding current arrangements for the management of people under the *Intoxicated Persons Act* were raised at the Alcohol Summit. The Issues Paper prepared for the Summit's Alcohol and the Justice System Working Group stated:

> An inter-agency protocol was developed by stakeholder agencies to deal with intoxicated persons (by and large homeless inebriates). A number of accommodation services have been able to offer appropriate services to intoxicated people. However, there are parts of NSW where the protocol is less effective due to lack of suitable services.
>
> Even when community accommodation places (such as those provided through the Supported Accommodation Assistance Program – SAAP) are available, they are often unable to accept aggressive and violent people. Some intoxicated persons can be disruptive towards carers and other residents, many of whom are women escaping domestic violence.
>
> In regional areas this is a particular issue for police. They report operational difficulties in relation to transporting and holding intoxicated persons in police cells. Police are generally reluctant to place intoxicated persons in police cells, as this increases the risk of self-harm or even death.[420]

7.119 The Alcohol Summit made several recommendations in relation to this issue:

> The legal framework and supported accommodation arrangements existing under the Intoxicated Persons Act should be reviewed with a view to reducing the use of police cells for detaining intoxicated persons and exploring more community-based options for intoxicated persons. The Review should consider the reasons for, and impact of, the repeal of proclaimed places.[421]
>
> It is preferable that intoxicated persons not be detained in police cells, rather the Government should fast-track the state wide rollout of intoxicated persons services to support the diversion of intoxicated persons.[422]

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420 NSW Summit on Alcohol Abuse, *Working Group 9: Alcohol and the Justice System – Issues Paper*, p7

421 NSW Summit on Alcohol Abuse, *Communique*, Recommendation 9.37, pp40-41

422 NSW Summit on Alcohol Abuse, *Communique*, Recommendation 8.60, p35

> Urgently expand the number of intoxicated persons services (culturally specific principles should apply state-wide), which will take intoxicated persons, particularly in inner-city, rural and remote communities that do not have these facilities.[423]

7.120 The Government response to the Alcohol Summit does not indicate specific action in relation to these recommendations, nor any additional funding or policy change. Nevertheless, evidence before the Committee indicates the continued need for action in this area.

7.121 A critical issue is that only police have the power to detain at present. Assistant Commissioner Bob Waites explained the difficulties that current arrangements under the Act create for them:

> When the *Intoxicated Persons Act* was invoked it was seen as a good tool to assist with some of the social issues. Unfortunately, the provision of proclaimed places never occurred at the level that was expected - in fact, there are now none. When confronted by people who are intoxicated to such a degree that they are unable to care for themselves or are in danger, the police have two choices. First, the offender can be placed in a police cell. We do not want to do that and we avoid it at all costs because of the potential for self-harm. Secondly, if they are taken to places such as Matthew Talbot Hostel they will not be accepted if they are violent or argumentative. We either take them back to a police cell or ignore the issue. Officers move them on and hope they do not get into trouble. They are the issues we deal with on the street … A consequence is that these people, who are very vulnerable, are left on the street. That is a concern because they are very often victims of crime.[424]

7.122 Assistant Commissioner Waites and his colleague Superintendent Frank Hansen indicated that the greatest problem is the management of people when they are violent. Intoxicated persons services will not accept people who are violent and in any case, are not able to detain them.[425] Other participants pointed to the absence of any intoxicated persons services in many non-metropolitan areas. Assistant Commissioner Waites called for appropriate intoxicated persons services 'in every town in New South Wales' that are able to respond to this difficult group, to avoid the need to detain people in cells.[426]

7.123 Other participants agreed that detention in police cells is highly undesirable, noting that police do not possess the health-related skills to monitor people effectively, as they are required to do. In addition, this monitoring is resource-intensive for police. Dr Matthews of NSW Health stated:

> The current system of intoxicated persons in police cells is extremely problematic. The police are ill-equipped. In many of the 24-hour cell complexes custody is now the responsibility of the Department of Corrective Services and people are de facto but not legally being handed over to that body for care. We have limited nursing services in about eight of those 24-hour cells, but even with the nursing services the facilities are not set up appropriately to provide a place to care for people.[427]

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423 NSW Summit on Alcohol Abuse, *Communique*, Recommendation 8.61, p35

424 Superintendent Waites, NSW Police, Evidence, 27 November 2003, p20

425 Superintendent Frank Hansen, Manager, Drug and Alcohol Coordination, State Crime Command, NSW Police, Evidence, 27 November 2003, p32

426 Superintendent Waites, NSW Police, Evidence, 27 November 2003, p21

427 Dr Matthews, NSW Health, Evidence, 4 June 2004, p6

7.124 The submission from the Network of Alcohol and Other Drugs Agencies (NADA) gives some insight into the perspective of service providers who run intoxicated persons services:

> Staff at [former] Proclaimed Places are not medically trained to deal with severe alcohol withdrawal and anecdotal information provided by staff reveals that those people who are intoxicated and delivered [to the service] by police can be very angry and aggressive, posing a threat to staff and those that have self-referred.[428]

7.125 Mr Larry Pierce, Director of NADA explained the shift that has taken place in that sector as a result of the abolition of proclaimed places:

> Some of our member agencies - and we worked closely with them when we were doing the submission - identified the fact that prior to the amendment of the … *Intoxicated Persons Act* a number of years ago, the real problem was that although the staff at proclaimed places had the same [powers] as police to detain people, unlike police they were not trained to do that, and they were not resourced or equipped to do that. There were all sorts of occupational health and safety problems for those staff to do that, and in a general sense it made the mood, if you like, in the proclaimed places much darker and more dangerous, given that the aim of the proclaimed place is to provide safety and overnight accommodation for intoxicated people. Since that shift away from the staff having the power to detain people, most of the proclaimed places are now turning to a focus on the client. We give them a bed and pyjamas, and we give them a bit of food before they leave, but what else can we do? Can we provide a level of assessment? Can we provide alternative activities? Can we look at moving these people towards a decision to engage in treatment? Can we have a look at the primary health care issues of these people? So they are moving to that sort of approach, which is much better.[429]

7.126 Ms Val Dahlstrom, Area Manager of Aboriginal Health in New England reported that rather than detain people in cells, police are taking them home as they are encouraged to do under the legislation, but this is leading to increased domestic violence.[430]

7.127 Responding to the sensitivities of detention of Indigenous people in police cells, Mr John Williams of the Aboriginal Health and Medical Research Council proposed an innovative solution:

> What we are suggesting is we have 43 Aboriginal Medical Services throughout the State. In each of those 12 regions we think a culturally appropriate community controlled shelter, an appropriate shelter, could be staffed under the auspices of the community controlled health sector working with the Area Health Service to provide such a place in remote areas where people can be taken because you cannot go putting such a place into every community, but you could put such a place in every region within a reasonable distance for people to be taken to.
>
> The immediate problem might have to be a cell if there is no transportation available. These are some of the problems we do have but again, the police are not trained and

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428 Submission 29, Network of Alcohol and Other Drugs Agencies, p13

429 Mr Larry Pierce, Director, Network of Alcohol and Other Drugs Agencies, Evidence, 27 November 2003, pp54-55

430 Ms Val Dahlstrom, Area Manager, Aboriginal Health, New England Area Health Service, Evidence, 4 June 2004, p9

> if they are going to use that as the only recourse then we think that medical people or registered nursing sisters or Aboriginal medically trained staff who would be available to constantly check these people because if they have not being charged there is no obligation to do two hourly checks. That only occurs if they are charged, not necessarily if they are only there to sleep it off. And that is a risk.[431]

7.128 On the basis of our terms of reference, the Committee has not considered these issues in detail. Nevertheless, we recognise the need for the Government to address them and most particularly, to develop and resource a workable alternative to detention of intoxicated persons in police cells. We thus endorse the recommendations of the Alcohol Summit, that the *Intoxicated Persons Act* be properly reviewed and that greater provision be urgently made for appropriate service arrangements.

Recommendation 28

That the Government review the legal framework and supported accommodation arrangements existing under the *Intoxicated Persons Act* with a view to reducing the use of police cells for detaining intoxicated persons and exploring more community-based options for intoxicated persons. The review should consider the reasons for, and impact of, the repeal of proclaimed places.

Recommendation 29

That the Government urgently expand the number of intoxicated persons services which will take intoxicated persons, particularly in inner-city, rural and remote communities that do not have these facilities.

[431] Mr Williams, Aboriginal Health and Medical Research Council, Evidence, 27 November 2003, pp11-12

Chapter 8 A service framework for involuntary care

> I should say that we should not do any of this if we have not got a way of helping these people. There is no point in making a decision like this if we have not got places or environments where people can be cared for. I think that this is probably fundamental: Is society prepared to provide the support? It ought to, but is it able or prepared to provide an environment where people who are so vulnerable or harmed can get some support?[432]

In the previous chapter the Committee set out the elements of a new legislative framework for involuntary care aimed at protecting the health and safety of people with severe substance dependence. In this chapter we identify the key elements of the service framework that will necessarily underpin the legislation: evidence-based services and treatment guidelines, integrated service delivery, and investment in specific services. Before we discuss these elements, we explore the critical issues of the need to resource the new system of involuntary care, and where that care should be provided. The chapter concludes with the recognition that involuntary care should be conceptualised along a continuum of high quality, accessible, holistic and humane care. Underpinning the discussion is the principle stated earlier in the report: that when intervening without a person's consent we need to maximise the benefits to that person. Involuntary care must be used as an opportunity to do the most good.

A new service framework

8.1 In Chapter 6 we established the ethical basis for a system of short term involuntary care for people at risk of serious harm, for the purpose of protecting their health and safety. The care would necessarily entail evidence-based medical interventions, provided in a medical setting. While treatment, harm reduction and psychosocial measures would be tailored to a person's needs, several core interventions are envisaged: containment in a safe place; where necessary, medicalised withdrawal; comprehensive assessment, including neuropsychological assessment where required; the development of a post-discharge treatment plan; referral and support to engage people in the voluntary system and other services, including care and support under guardianship where necessary; and assertive follow-up. In Chapter 7 we noted that such intervention would necessarily involve detention. We also recommended that the period of care be 7 to 14 days, but that in exceptional circumstances, a further period of up to 14 days may be ordered.

8.2 In Chapter 6 we also documented the need for non-coercive mechanisms to assist people who have complex needs and challenging behaviours associated with their substance dependence. In doing so, we noted both the difficulties that this particular group create for families and communities, and also the multidimensional nature of their needs. The service system struggles to respond to this group because their needs traverse the boundaries of government agencies. We also noted that there is inadequate investment in the range of human services that are likely to assist them.

8.3 After exploring how a mechanism to assist people with complex needs and/or antisocial behaviour could be operationalised through legislation, in Chapter 7 we recommended the

[432] Emeritus Professor Ian Webster AO, NSW Expert Advisory Committee on Drugs, Evidence, 18 February 2004, p6

establishment of a cross-agency task force to determine a policy position on this issue. We also recommended that this task force consider providing within the proposed legislation elements of Victoria's *Human Services (Complex Needs) Act 2003*, to establish a localised decision making body that holistically assesses people and acts as a filter, channelling them towards involuntary care where this is required and/or non-coercive services, as appropriate to their needs.

8.4 We now turn to the service framework that must underpin the legislative mechanisms we have recommended. Our primary focus is on the system of short term involuntary care that we have recommended in previous chapters. At various points in the discussion we also discuss responses to people with complex needs.

8.5 The Committee has identified three key elements essential to an effective service framework for involuntary care:

- evidence-based services and treatment guidelines
- integrated service delivery
- investment in specific services.

8.6 Before the Committee explores and makes recommendations on each of these elements in turn, we explore two fundamental and related issues: the need to resource the new system of short term involuntary care, and where people in involuntary care should be placed.

Resourcing the system

8.7 Inquiry participants readily recognised that in order to work effectively, any new system of involuntary care must be adequately resourced. Having undertaken their review of the literature on compulsory treatment, Ms Amy Swan and Ms Sylvia Alberti of Turning Point Drug and Alcohol Centre told the Committee that this is borne out in research: benefits to those made subject to coercion are maximised through investment in appropriate services. They also stated, conversely, 'if you don't have the systemic support, that's where it doesn't work well.'[433] Likewise, Professor Hall warned that a well resourced system could be expected to achieve good outcomes, but that such programs are typically not well funded.[434]

8.8 Several witnesses, like Professor Webster at the start of this chapter, noted the moral imperative to provide high quality services when a person is detained. Others such as the Law Society of New South Wales suggested that sufficient services will not only ensure that needs are addressed, but also that people's rights are protected.[435]

8.9 In its submission, Illawarra Health observed the particular challenges associated with resourcing a system of short term intervention such as that recommended by the Committee.

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433 Ms Sylvia Alberti, Manager, Forensic and Clinical Services and Senior Research Fellow, Turning Point Alcohol and Drug Centre, Evidence, 28 April 2004, p32; Ms Amy Swan, Research Fellow, Turning Point Alcohol and Drug Centre, Evidence, 28 April 2004, p28

434 Professor Wayne Hall, Professorial Fellow and Director, Office of Public Policy and Ethics, Institute for Molecular Bioscience, University of Queensland, Evidence, 29 April 2004, p4

435 Submission 36, Law Society of New South Wales, p4

It identified acute care interventions to address harm as potentially the most difficult goal to implement, given the scarcity of resources in relation to detoxification beds, medical beds, emergency department activity, and police.[436]

8.10 A major message from participants, whether service providers, administrators, ethicists or clinicians, was that implementing a better system of involuntary care should not be at the expense of voluntary drug and alcohol patients, whether by diverting resources away from them or undermining the quality of care they receive. As Professor Hall put it:

> The bigger question is the availability of treatment for people seeking it voluntarily … We have to remind ourselves when we are proposing to pull people off the streets and treat them for their own good that there are plenty of people who want to be treated who we are not accommodating.[437]

The shortage of alcohol and other drug services

8.11 The shortage of alcohol and other drug services became clear to the Committee when we spoke with drug and alcohol service staff in metropolitan, regional and rural areas. Participants acknowledged the significant injection of funds that occurred after the Drug Summit, but pointed to their waiting lists for detoxification and rehabilitation services.[438] As Dr Stephen Jurd of the Herbert Street Clinic told us, 'Currently we are exploding at the seams with voluntary clientele'.[439]

8.12 The Committee was particularly concerned by the challenges faced by rural communities in providing timely and accessible drug and alcohol services. As Ms Didi Killen, Area Coordinator of Drug and Alcohol Services in the Mid West Area told the Committee, drug and alcohol services share the same challenges of service delivery in rural areas as other agencies, such as delivering services over large geographical areas, having to factor in transport, and attracting and retaining appropriately skilled staff.[440] Participants in the New England area also told us about a lack of general practitioners and reliance on outreach. When talking to participants in both these areas we were struck by the poor availability of detoxification services. As Ms Vi Hunt told the Committee:

> Through the New England Area Health Drug and Alcohol Service we have five drug and alcohol teams across the area, all of which provide outreach services. So we do try to provide some services to most towns. As far as other drug and alcohol services are concerned, there is no detoxification unit as such. If clients wish to undergo inpatient detoxification they do it through the public hospitals. We have two non government organisation [NGO] rehabilitation services - one in Armidale and one in Moree. Some NGO facilities provide limited drug and alcohol services, such as the Salvation Army.

436 Submission 26, Illawarra Health, p2

437 Professor Hall, University of Queensland, Evidence, 29 April 2004, p11

438 Ms Diane Paul, Manager, Detoxification Unit, Herbert Street Clinic, Evidence, 4 March 2004, p27; Ms Toni Colby, MERIT Caseworker, Alcohol and Other Drugs Service, Tamworth, Evidence, 24 March 2004, p1

439 Dr Stephen Jurd, Area Medical Director, Drug and Alcohol Services and Addictions Psychiatrist, Northern Sydney Health, Evidence, 4 March 2004, p25

440 Ms Didi Killen, Coordinator, Alcohol and Other Drugs Program, Mid Western Area Health Service, Evidence, 25 March 2004, p24-25

> They tend to be in places like Tamworth and also in Armidale. Once you get out into the smaller towns it is very limited. There are not a lot of services around.[441]

8.13 While some hospitals provide detoxification, we were told that others do not, so people may have to travel some distance to access these services, possibly after lengthy negotiations between drug and alcohol workers and the hospital. On the other hand, we were told that in small communities, general practitioners often have admitting rights whereby they can arrange for someone to receive detoxification.[442] Some rural participants highlighted the need for specific detoxification services, while others sought greater provision of hospital beds specifically allocated for detoxification. They also noted that where hospital detoxification is provided, patients need to be appropriately linked to other drug and alcohol and primary care services to meet their psychosocial needs.[443] Some also noted that hospital based detoxification is less than ideal:

> The hospital experience of detoxification is very unsatisfactory for a lot of our clients because most people can handle the physical withdrawal, but what about the social-psychological factors? We can detoxify our clients from drugs and alcohol but the issue is keeping them off them. It is very unsatisfactory to be put on the general ward of a hospital with other patients with numerous physical complaints and with nursing staff who may or may not have limited experience and expertise in dealing with these clients, and we are looking at a whole range of clinical specialist expertise in dealing with their cravings, their withdrawal symptoms, coming to terms with their grief, loss, remorse and guilt for their lifestyle. There are many multifaceted issues and I find that unsatisfactory when we put our patients in a public hospital in a normal bed.[444]

8.14 Looking at the broader alcohol and drug system across New South Wales, the Committee was told that there is greater provision for illicit drug treatment as opposed to alcohol treatment, perhaps because of the political imperatives of addressing illicit substance misuse and the investment that has flowed through diversion programs targeting that group. Professor Mattick of the National Drug and Alcohol Research Centre, for example, told us that there has been a shift away from funding alcohol services to illicit drugs, despite the substantially greater prevalence of alcohol misuse. He also explained that many detoxification programs around the State were closed some years ago in the mistaken belief that people who were dependent on alcohol could have their needs met through less intensive measures.[445]

8.15 In light of the shortage of services, the Committee is, like several participants, concerned about the capacity of the existing drug and alcohol system to absorb involuntary clients. We are aware that pressure and displacement has already occurred in the voluntary system as a result of diversionary programs such as MERIT. Ms Val Dahlstrom, Area Manager of Aboriginal Health in New England, and other people from the Indigenous community in

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441 Ms Vi Hunt, Area Coordinator, Alcohol and Other Drug Services, New England Area Health Service, Evidence, 24 March 2004, p1

442 Dr Ian Kamerman, General Practitioner and NSW Director, Australian College of Rural and Remote Medicine, Evidence, 24 March 2004, p8

443 Dr Kamerman, Australian College of Rural and Remote Medicine and Ms Colby, Alcohol and Other Drugs Service, Tamworth, Evidence, 24 March 2004, pp8-9

444 Ms Colby, Alcohol and Other Drugs Service, Tamworth, Evidence, 24 March 2004, p8

445 Professor Richard Mattick, Director, National Drug and Alcohol Research Service, University of New South Wales, Evidence, 8 April 2004, p6

Moree spoke of how clients diverted from the court system into treatment took up much needed voluntary services and also had a negative impact on other clients.[446]

The Committee's view

8.16 In this environment of an existing shortage of services, the Committee is concerned that involuntary care might be seen as a prioritisation system, where involuntary clients are simply given higher priority, such that some voluntary clients lose access to the system. Like many inquiry participants, we consider that involuntary care should not be at the expense of voluntary clients, whether by diverting resources away from them or undermining the quality of care they receive. In addition, we believe that in order to operate effectively, to achieve optimal outcomes for those subject to care and to protect their rights, involuntary care needs to be well resourced in its own right.

Recommendation 30

That the Government provide additional resources to fund the proposed system of involuntary care for people with severe substance dependence.

Where should involuntary care be provided?

The absence of demand data

8.17 Unfortunately, there is very little information available on which to estimate the numbers of people who might be placed in care. While the Committee identified at least 45 people being placed under an inebriates order in the last three years, no participants were able to offer a sound estimate of demand that might arise under new legislation. Representatives of the Kirketon Road Centre indicated that they would use involuntary care in extremely rare circumstances: out of 150,000 attendances at their service (whose clientele is generally people with an illicit substance dependence) in the last three and a half years, there were only three people for whom they believed involuntary care would have been appropriate.[447] By contrast, Mr George Klein of the Centre for Drug and Alcohol Medicine at Nepean Hospital conservatively estimated that 3% of his service's caseload could be suitable.[448] Dr Stephen Jurd had a 'stab in the dark' at 100 to 200 people a year across the State.[449] Thus participants' estimates were rough and varied significantly.

446 Ms Val Dahlstrom, Area Manager, Aboriginal Health, New England Area Health Service and Mr Faulkner Munroe, Manager, Byamee Homeless Persons Service, Evidence, 24 March 2004, pp25-26

447 Dr Hester Wilce, Medical Practitioner, Kirketon Road Centre, Evidence, 7 April 2004, p5

448 Mr George Klein, Behavioural Scientist, Centre for Drug and Alcohol Medicine, Nepean Hospital, Evidence, p56

449 Dr Stephen Jurd, Northern Sydney Health, Evidence, 4 March 2004, p24

Which facilities?

8.18 Although the Committee sought the views of participants on the most appropriate environment in which to place people under an order, no obvious solution emerged. While many called for a system of involuntary care, few indicated they would be willing to be the ones to provide it.

8.19 In the NSW Government submission, NSW Health stated that, given the necessity for withdrawal of this client group to be managed by health professionals, there are four options for where care might occur: a specialist medicated detoxification facility; a general hospital bed; an outreach detoxification service to non government agencies funded through the Supported Accommodation Assistance Program (SAAP); or a designated purpose built facility.[450] Given the evidence presented in relation to the *Inebriates Act*, the Committee does not consider that mental health facilities are an appropriate option.

8.20 There was broad agreement that any facilities chosen would need to be locked and equipped to provide the medical care required during the period of withdrawal and stabilisation, and to meet other acute care needs. Similarly, the services would need to have the appropriate alcohol and other drugs skills base to assist the person to make the most of the opportunity to gain insight and engage in a process of change. In addition, the services would necessarily have the capacity for the critical steps of actively linking people to services, as well as providing follow-up, which are core activities in the Committee's model.

8.21 There was less agreement among participants as to whether involuntary patients should be integrated with voluntary clients, or if they should have their own service, perhaps in purpose built facilities. Participants from Moree argued strongly for stand-alone facilities, having seen the problems arising from placing diversion clients with voluntary clients in a rehabilitation service, with the former undermining the care and motivation of those who choose to be there.[451] A number spoke of involuntary clients sometimes having disruptive behaviours, challenging the motivation of voluntary clients, and sometimes leading them astray.[452] Associate Professor Paul Fanning pointed to the need to adequately provide for the 'disinhibition and antisocial behaviour during the acute and recovery stage' likely to characterise many of the people who might be placed under the proposed involuntary care legislation.[453]

8.22 When we asked people working under the system in Victoria, where people receive compulsory treatment in a regular detoxification service with other clients, participants noted the beneficial effect that voluntary clients can have on involuntary ones. They also argued that many voluntary clients are 'coerced' into being there, for example by family members, case managers and so on, so that the term 'voluntary' client was somewhat artificial.[454] When we

450 Submission 47, NSW Government, p25

451 Mr Bill Grose, Community member, Evidence, 24 March 2004, pp34-35; Ms Dahlstrom, New England Area Health Service, Evidence, 4 June 2004, p9

452 Ms Diane Paul, Herbert Street Clinic, Evidence, 4 March 2004, pp8-9

453 Email from Associate Professor Fanning, Area Director, Mid Western Area Mental Health Service, to Senior Project Officer, 1 June 2004, p1

454 Evidence, 28 April 20041

asked NSW Health representatives whether they thought co-location was appropriate, they indicated that they did not have a definitive view but that it would be possible do so.[455]

8.23 Participants also had views on whether detention and care should be provided locally. A number of participants such as the NSW Section of Addiction Psychiatry envisaged a system of 'two or three small specialised tertiary drug and alcohol treatment units' developed specifically for people under the new legislation.[456] On the other hand, one of the problems with the *Inebriates Act* was that people were necessarily sent a long way from home. Rural and regional participants argued strongly for a localised approach as far as possible, so that people did not have to leave their support base and cope with reintegration when they returned.[457]

8.24 The Network of Alcohol and Other Drugs Agencies (NADA) suggested that a new, specialised service model, with appropriate staffing, be established specifically to provide medical care in accordance with the Committee's proposed legislation:

> NADA proposes that the initial period of treatment should take place in a medical setting, in order to address the health needs of the person as they go through detoxification. To this end it is believed that the appropriate initial treatment setting could be an Intoxicated Persons Service, attached to a Hospital, that can conduct the initial assessment of the person's condition, and provide medical interventions if needed and ongoing treatment if required. This service should also have the power to detain people for compulsory treatment.[458]

8.25 In the NSW Government submission, NSW Health rightly states that the likely cost of any model will depend on the number of people within the ambit of any new legislation, and that a cost-benefit assessment of options will be required.

8.26 While the Committee expects that the use of new legislation will be significantly higher than for the *Inebriates Act* in recent years, we have no reliable estimate of demand. We consider that gaining a reasonable estimate will be an essential first step in planning the implementation of our recommended model.

8.27 While acknowledging the difficulties arising from co-locating voluntary and involuntary clients, the Committee considers that this is probably the only feasible option at this stage. In the absence of demand data to justify the establishment of a specific service, and in light of the very reasonable concern that people be treated close to home, the Committee favours a localised model. We believe that it is alienating and disempowering enough to be put into care, but to be sent a long way from home would make it more so.

8.28 Given the agreed need for medical care and specialised drug and alcohol expertise, we consider that detoxification services are the only real option for where people might be placed. While as we have already indicated, detoxification units do not exist in many rural areas, they at least have reasonable coverage across the State, and we do not consider that hospital-based

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455 Mr David McGrath, Acting Deputy Director, Centre for Drug and Alcohol, NSW Health, Evidence, 29 April 2004, p18

456 Submission 50, NSW Section of Addiction Psychiatry, p2

457 Ms Vi Hunt, Area Director, Drug and Alcohol Services, New England Area Health Service, Evidence, 24 March 2004, p10; Mr Lloyd Duncan, Byamee Homeless Persons Service, Evidence, 24 March 2004, p40

458 Submission 29, Network of Alcohol and Other Drugs Agencies, p12

detoxification would be appropriate for the purpose of involuntary care. In order to ensure reasonably local access, it may be appropriate for perhaps two detoxification services per area health service (with their new boundaries as at August 2004) to be designated for the purpose of receiving people into involuntary care, while also providing for their voluntary clientele. Keeping rural communities in mind, and given their historically greater demand under the *Inebriates Act*, the number of facilities receiving people in rural areas may need to be greater.

8.29 The Committee acknowledges the challenges of using already existing detoxification services and co-locating involuntary and voluntary clients. In the first instance, provision would need to be made for locked environments, with consideration given to the logistics of how to physically co-locate both detained and voluntary patients. Providing secure facilities would necessarily require capital funding. Such a system would also require careful consideration of occupational health and safety issues, staff training, and achieving cultural change among providers of voluntary services. Provision would also need to be made to ensure that key elements of linking clients to services, supporting them to access guardianship, and providing assertive follow-up, could all be provided. This will be made more complicated as some detoxification services are non government agencies and some are funded by the Commonwealth.

8.30 While she did not disagree with using existing detoxification services, Dr Ferguson, who works in such a service at Rozelle and Concord Hospitals, warned of the practical challenges of integrating an involuntary system into existing drug and alcohol services:

> How do we do this in the current withdrawal services … ? Within the government sector, the hospitals where we run withdrawal services, we would not have the facilities to contain anybody. We don't and haven't for 40 years operated on that sort of an approach. Staffing would have to change; functionally it would have to change, it would have to be contained and there would have to be police back-up to bring people back, so in fact you are talking about a major upgrade of facilities to contain what could be anything from a few people a year to many people, so in fact the practical application of a locked model is very hard and the costs are quite high.[459]

8.31 A number of other participants such as Dr Jurd emphasised that in order to achieve the necessary cultural change in 'vigorously voluntary' drug and alcohol services, both resources and leadership at all levels will be required.[460] Dr Patfield warned of the occupational health and safety issues, the high costs associated with running a contained unit, and the difficulties of attracting staff to undertake such work.[461]

8.32 Other participants such as Dr Mark Doverty of Southern Area Health Service and the North Coast Regional Coordination Management Group pointed to the need for further consultation to occur in relation to demand for involuntary treatment and the best services to respond. Dr Doverty stated in his submission:

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459 Dr Joanne Ferguson, Staff Specialist Psychiatrist, Drug Health Services, Rozelle and Concord Hospitals, Evidence, 4 June 2004, p24

460 Dr Jurd, Northern Sydney Health, Evidence, 4 June 2004, p14

461 Dr Martyn Patfield, Consultant Psychiatrist, Medical Superintendent and Director of Acute Services, Bloomfield Hospital, Evidence, 4 June 2004, p25

> … modern alcohol and drug detoxification units across the state are not designed for the involuntary treatment of such patients. This is an issue that requires debate, research and deliberation. There does not appear to be a ready made answer or solution to this problem, the scale of which is not accurately known. It would be valuable to conduct a statewide review/consultation process to determine the possible levels of and likely use of involuntary treatment centres, and the most appropriate deployment of such centres and associated resources. This is indeed a very complex matter.[462]

8.33 We are also mindful that the model of care we are recommending is more holistic and less clinical than might ordinarily be provided in a detoxification service. In particular, we envisage a need for 'welfare' functions associated with referral to other services such as housing and supported accommodation and strong follow-up. As we have stated, these will require resourcing: for example, we understand that there is little capacity for assertive follow-up in drug and alcohol services at present.[463]

8.34 Given these considerations, the Committee believes that further work needs to be done before the most appropriate service arrangements can be determined, and we consider that this would best be done by the Centre for Drug and Alcohol in NSW Health. First, a reasonable estimate of demand for involuntary care, using the essential criteria we have stipulated, is required. In addition, a scoping study of all detoxification services in the State would be necessary to inform the decision as to where people should be detained and treated. Such a study should also identify the necessary capital work to be done to provide for locked environments. This work should then form the basis for a decision as to the most appropriate service arrangements for the provision of involuntary care. The Committee understands that a statewide review of current levels of alcohol related harm and the need for treatment is underway and will form the basis for the *NSW Drug Treatment Services Development Plan 2006-2015*.[464] It may be appropriate and valuable for the proposed survey and scoping study to be linked to this review.

8.35 The Committee also considers that, subject to a better estimate of demand, there may be some merit in NADA's proposal for a purpose built unit, perhaps located in the inner city where it might offer a range of other medical services to intoxicated people who would otherwise be sent to hospital emergency departments, which we understand to be quite problematic. We anticipate that there may be greater demand for involuntary care in the inner city, given the relatively high concentration of homeless people in that area. This service could also detain a person immediately where necessary, as is discussed in the following section. Given our strong preference for a localised approach, we do not, however, consider that such a unit should offer a statewide service. We encourage NSW Health to consider this option as an inner-Sydney service.

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462 Submission 34, Southern Area Health Service, p3

463 Ms Andrea Taylor, past Deputy Director, Ryde Community Mental Health Service and present Manager, Quality and Risk Management, Royal North Shore and Ryde Health Services, Evidence, 7 April 2004, p22; Mr Larry Pierce, Director, Network of Alcohol and Other Drugs Agencies, Evidence, 4 June 2004, p9

464 NSW Government, *Outcomes of the NSW Summit on Alcohol Abuse 2003: Changing the Culture of Alcohol Use in New South Wales*, May 2004, p55

Recommendation 31

That NSW Health immediately undertake:

- a detailed survey of all drug and alcohol services in New South Wales, and facilities where people are currently detained under the *Inebriates Act*, to estimate the likely annual demand for involuntary care
- a scoping study of all detoxification services in New South Wales to determine where people could be detained and treated, and identify the work necessary to provide for locked environments.

This information should then be used to determine the most appropriate service arrangements for the provision of involuntary care.

Recommendation 32

That involuntary care be provided according to a localised model making use of existing medical detoxification facilities.

Recommendation 33

That in light of the information gathered through Recommendation 31, NSW Health should consider the potential for a purpose built facility in the inner city.

Aboriginal communities

8.36 The Committee recognises the need to develop an appropriate service model for Aboriginal communities, as we did in the previous chapter when discussing the decision making process in relation to involuntary care. The unique and complex problems associated with substance use in many Indigenous communities, and the sensitivities associated with detention of Indigenous people, are broadly understood.

8.37 All the Aboriginal community representatives we spoke with, including the peak body for Aboriginal Medical Services, the Aboriginal Health and Medical Research Council (AHMRC), called for more community controlled drug and alcohol services.[465] For example, Ms Val Dahlstrom, Area Manager of Aboriginal Health in New England called for an enhancement to existing residential rehabilitation programs, and the establishment of a 'half way house' to support the transition back to community living. She also called for better access to detoxification.[466]

8.38 A number of participants also noted that unless an initiative is owned by the Aboriginal community it will not succeed. Taking a broader perspective on the problem than short term harm reduction, Ms Dahlstrom told the Committee about a strategy she was hoping to establish in a small community:

465 Tabled Document No 7, p5

466 Ms Dahlstrom, New England Area Health Service, Evidence, 24 March 2004, p24

> [We are] trying to develop a community response, so that we have got a built in support system in the community for those people who consistently indulge, for want of a better word, in domestic violence, drug and alcohol abuse and child abuse, and I guess that is the reason why we are actually looking at it as a community, expecting the community to look at these issues to try and do something about it because … no government agency can get in and the people who make a difference are the people who are actually in there. Police cannot make a difference, doctors cannot make a difference, we cannot make a difference … we need to … get community members there to take responsibility for what is happening in their towns.[467]

8.39 Participants said that ideally, Aboriginal people are catered for through community-controlled services. As Mr John Williams of the AHMRC stated, 'The most efficient, cost effective, outcome oriented and appropriate manner is through the community itself, properly resourced and trained.'[468] However, there was a recognition that Aboriginal-specific services for involuntary care are not feasible, both because of the relatively small size of the target group, and the shortage of appropriately trained Aboriginal staff. Mr Williams told the Committee that area health services and mainstream services are better resourced to carry out many health services:

> We feel strongly that the Aboriginal community should take responsibility and we think the best way to do that would be through community-controlled health services associated with [Aboriginal Medical Services]. But every Aboriginal person has the right to go to mainstream services, and many choose to do so. I do not think the duplication of processes is a good idea; I think they should be complementary … People feel much more at home with an Aboriginal Medical Service. I think the analogy would be extended to these sorts of centres, not acting in a vacuum but working closely in partnership. Access is the next stage. We must work with the area health service, which has the expertise and the professional workers whom we can tap into and refer issues to.[469]

8.40 Dr Matthews of NSW Health also emphasised a partnership approach, with agreements between area health services and other agencies and community-controlled organisations. He saw Aboriginal Medical Services (AMS) and Land Council involvement as essential.[470]

8.41 The Committee was told that if Aboriginal people are to receive care in mainstream services, a culturally appropriate approach to care is essential. For example a greater emphasis on family involvement would be required.[471] Along with the creation of partnerships, other strategies that were identified as enabling cultural appropriateness included the employment of Aboriginal staff, cultural awareness training for non-Aboriginal staff, monitoring, links to supportive networks of AMSs and community organisations, and ensuring that services are 'hinged within an Aboriginal health context'.[472] Participants also suggested that the use of

467 Ms Dahlstrom, New England Area Health Service, Evidence, 4 June 2004, p21

468 Mr John Williams, Senior Policy Officer, Aboriginal Health and Medical Research Council, Evidence, 27 November 2003, p14

469 Mr Williams, Aboriginal Health and Medical Research Council, Evidence, 27 November 2003, p14

470 Dr Richard Matthews, Acting Deputy Director General, Strategic Development, NSW Health, Evidence, 11 December 2003, p25

471 Ms Louise Peckham, Aboriginal Health Education Officer, Alcohol and Other Drugs Services, New England Area Health Service, Evidence, 24 March 2004, p20

472 Tabled Document No7, p6

Elders to watch over people while in care,[473] and liaison with workers from the Aboriginal community would be important strategies. In addition, family and community members will need support and liaison to understand the purpose and process of involuntary care.[474]

8.42 The Committee considers that in implementing the model of involuntary care, NSW Health will need to recognise and incorporate the needs of Indigenous people, in consultation with Indigenous communities.

Recommendation 34

That in implementing the Committee's proposed model of involuntary care, NSW Health recognise and incorporate the needs of Indigenous people, in consultation with Indigenous communities.

Culturally and linguistically diverse communities

8.43 Thought also needs to be given to implementation of the proposed model in non-English speaking communities. The Community Relations Commission's submission indicates that there are some communities, for example in the Maori and other Islander communities, 'where alcohol problems are considered to be endemic and a significant anti-social issue affecting community harmony and family relationships'. It also notes that use of alcohol is taboo in some cultures, such that significant substance use problems may be denied by communities.[475] The Committee also understands that detention and involuntary care may be highly traumatic for people who have been subject to state-sanctioned torture or trauma. In any case, it is vitally important that anyone subject to involuntary care and their family fully understand what will happen.

8.44 The Community Relations Commission indicated that it will be important to ensure that support is available to family members when a person is placed in involuntary care, and that they are adequately informed about what will happen to the person while detained. They suggested that provisions should be made to 'ensure that the person has access to culturally appropriate community support services and bilingual medical services.'[476]

8.45 The Committee considers that the needs of culturally and linguistically diverse communities will also need to be addressed during implementation.

473 Ms Leonie Jefferson, Senior Aboriginal Drug and Alcohol Counsellor, Northern Rivers Area Health Service, Evidence, 27 November 2003, p12

474 Ms Hunt and Ms Peckham, New England Area Health Service, Evidence, 24 March 2004, p20

475 Submission 12, Community Relations Commission, p2

476 Submission 12, Community Relations Commission, p2

Recommendation 35

That in implementing the Committee's proposed model of involuntary care, NSW Health recognise and incorporate the needs of culturally and linguistically diverse communities, in consultation with them.

Where should people be placed in the short term?

8.46 According to the decision making process we have recommended, a person may be detained on the certificate of a medical practitioner, but this may only continue subject to a further medical examination and a decision as to whether the person is to be subject to involuntary care. As established in the previous chapter, this medical examination must only take place once a person is no longer intoxicated. We envisage that once a person is examined and determined by a medical practitioner to meet the four criteria for involuntary care, the person is to be immediately taken to a medical detoxification facility. The Committee was advised that specialist detoxification units generally do not admit people while they are intoxicated because they can have a significant impact on other clients.[477]

8.47 Representatives of NSW Health emphasised the need for the Committee to consider where a person is to be placed during this window period. Understandably, there was a concern that hospital beds already in demand not be used for 'holding' someone while they sober up.[478]

8.48 Given the tight targeting of the proposed legislation, which requires the presence or threat of serious harm, many people for whom an order is sought will require acute care, and where this is the case, a hospital is an appropriate environment. We have also suggested that where people do not require urgent detention, they should not be immediately detained. However, some people for whom an order is sought may require detention in order to prevent them from further consuming alcohol or drugs, so that they can be examined. In addition, people generally require monitoring by someone with appropriate medical knowledge (although not necessarily a doctor) as they sober up and enter withdrawal. Ms Leonie Jefferson, an Aboriginal drug and alcohol counsellor, explained to the Committee:

> Hospitals are not really a suitable place unless they are extremely ill. A more appropriate place is one that is designed for people to sober up and that has a staff of qualified people to oversee how they are going. Sometimes they might be ill and you are not sure, so you need to monitor that. If they are going to fit, you have to get them to the appropriate care. You have to be able to do all that sort of stuff. You cannot just put them in a place with unskilled or unqualified people and leave them there.[479]

8.49 As established in the previous chapter's section on the *Intoxicated Persons Act*, there are few options as to where person may be placed for this purpose, not all of which currently enable detention. The first is police cells, which would require the provision of medical or nursing assessment during the period of detention. Other alternatives include SAAP funded intoxicated persons services, mental health facilities, detoxification facilities and other services

477 Submission 47, NSW Government, p24

478 Ms Noort and Mr McGrath, NSW Health, Evidence, 29 April 2004, pp21-22

479 Ms Jefferson, Northern Rivers Area Health Service, Evidence, 27 November 2003, p5

with drug and alcohol expertise such as residential rehabilitation services. In rural areas, the absence of appropriate facilities becomes even more problematic, and may also require transport to be arranged.

8.50 The Committee agrees that this issue will need to be resolved in order for the proposed legislation to work effectively, not least to ensure the safety of those for whom involuntary care is considered. We agree that hospital beds should, as far as possible, not be used for any purpose other than acute care. We suggest that the most appropriate way to resolve this issue would be through the development of area protocols, such as those for the management of intoxicated persons. In many cases those already existing agreements could address this need with minimal adjustment.

Recommendation 36

That NSW Health lead a process of developing interagency protocols at the area health service level about the management of persons for whom involuntary care is being determined, during the intoxication phase.

Transport

8.51 Earlier in this chapter we stated our strong preference for a localised model of involuntary care, given the concern of rural participants that people should be treated close to home. Nevertheless, given the absence of appropriate facilities in many geographical areas, we acknowledge that the proposed model is likely to entail significant travel for some. In Chapter 3 we noted that current arrangements under the *Inebriates Act* create substantial practical problems for service providers and police, who are often required to transport the person to hospitals a significant distance away. If a person has acute care needs we envisage that they will need to be transported by ambulance.

8.52 Assistant Commissioner Bob Waites of NSW Police told the Committee that transport is a major issue for police, in relation to people who are in custody and particularly people who are subject to the *Mental Health Act*. He feared that under a new Act the problem would expand, and explained why transport creates such difficulties for police:

> The great difficulty is that most country towns have virtually one vehicle working at any one time. Obviously, when somebody has to be transferred to a larger centre an immense distance away, you cannot use that vehicle because you would then have no police resources to look after the general issues of concern to the community. So what has to occur is that, when that vehicle is finishing its shift and the next crew start, they dispatch that vehicle on an overtime basis. So we are then paying time and a half and double time to convey people immense distances, sometimes up to six and twelve hours … So obviously there is a reluctance at the local level - whether it be by the sergeant who is running the local station, or the local inspector - to be involved in that if they can avoid it, because of the budgetary cost of it, because of the likelihood of injury to officers and damage to resources, and in some cases the fear of the futility of

> it because in some cases where people are transported to a centre they are assessed and released and are back in the community two or three days later.[480]

8.53 The Committee is aware that the role of police in transporting patients is currently under discussion as part of NSW Health's review of the *Mental Health Act*.[481]

8.54 Likewise, participants such as the North Coast Regional Coordination Management Group and Mr Owen Atkins highlighted similar issues around resourcing, staff time and occupational health and safety when drug and alcohol or other workers escort patients in rural areas.[482]

8.55 In light of these important concerns, the Committee does not take for granted the capacity for the police or other services to transport people subject to involuntary care. We believe it important that NSW Health and NSW Police come to a formal agreement regarding this issue. It may also be helpful for specific budgetary provision to be made for transport for this purpose.

Recommendation 37

That the interagency agreement on respective roles and responsibilities under the proposed legislation referred to in Recommendation 6 address transport of people under an involuntary care order. In determining this responsibility, consideration should be given to establishing a budget specifically for the purpose of funding such transport.

Evidence-based services and treatment guidelines

8.56 At the beginning of this chapter the Committee identified three key elements essential to an effective service framework for involuntary care. The first of these is evidence-based services and treatment guidelines.

8.57 In previous chapters the Committee established the consensus among inquiry participants for an evidence-based approach to involuntary care. Participants felt very strongly that when a person is subject to coercion they have the right to high quality services tailored to their individual needs. Involuntary care is to be used as an opportunity to do the most good for the person. This position was reflected in the Government's submission to the inquiry, which noted the evidence-based policy underpinning drug and alcohol initiatives, and suggested as a key principle to be built into the proposed legislation:

> A right to treatment and quality treatment should be ensured, and there should be an evidence base to support the treatment provided.[483]

480 Assistant Commissioner Bob Waites, Commander, Greater Metropolitan Region and Corporate Spokesperson, Alcohol related Crime, NSW Police, Evidence, 27 November 2003, p22

481 NSW Health, *Review of the Mental Health Act 1990 – Discussion Paper 2: The Mental Health Act 1990*, July 2004, pp13-14

482 Submission 16, North Coast Regional Coordination Management Group, p3; Submission 2, Mr Owen Atkins, Homeless Persons Support Team, Narrabri District Community Aid Services, p3

483 Submission 47, NSW Government, p23

8.58 The Committee ruled out the possibility of a compulsory treatment system aimed at rehabilitation, on the basis of the absence of evidence to indicate that this would be effective. By contrast, our rationale for involuntary intervention for the purpose of protecting health and safety was that when harm is present, the capacity to benefit the person through medical care is self-evident. We have stipulated that involuntary care is to be provided in an appropriate setting where medical care can be delivered. Such care will necessarily make use of evidence-based, high quality withdrawal, drug and alcohol and other medical care.

8.59 In keeping with this framework, a number of participants suggested that the legislation should be complemented by guidelines to ensure the quality of care provided when people are subject to the Act. The NSW Government submission stated:

> NSW Health has suggested that implementation would benefit from guidelines concerning the nature of treatment provided under compulsory treatment orders.[484]

8.60 The Committee understands that guidelines are used in many clinical areas to ensure the uniform implementation of best practice and thereby to maximise positive outcomes for patients. Guidelines, such as those for the management of people with substance dependence, are necessarily evidence-based. The Committee proposes that guidelines taking a more holistic and multidisciplinary approach and setting out the pathway of care for involuntary clients will be very important to implementing the legislation. The guidelines should operationalise, amongst other things, the key elements of involuntary care that we have established, that is, comprehensive assessment and the development of a treatment plan, referral to appropriate services, and assertive follow-up. Ms Tonina Harvey of Northern Sydney Health also noted how important it was to engage families and carers in the process of treatment, both in order to support them in their own right, and to empower them in caring for their loved ones:

> … guidelines need to be established for the care and management of people under Inebriates orders and their families and carers because I believe they get left out of the equation a lot. They certainly need to be supported through this process if the aim is to make these patients voluntary and to have them supported within a home environment, I think we need to address those issues.[485]

8.61 The guidelines would also articulate the rights and responsibilities of staff in relation to detention of clients and providing treatments without consent.

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484 Submission 47, NSW Government, p17

485 Ms Tonina Harvey, Area Director, Drug and Alcohol Services, Northern Sydney Health, Evidence, 4 March 2004, p27

Recommendation 38

- That in order to ensure quality of care and optimal outcomes for those subject to the proposed legislation, NSW Health develop and publish guidelines for the treatment of people in involuntary care. The guidelines should address:
- the key elements of involuntary care, that is, comprehensive assessment and the development of a treatment plan, referral to appropriate services, and assertive follow-up
- how families and carers are to be engaged in the process of involuntary care
- the rights and responsibilities of staff.

Integrated service delivery

8.62 The second element of the proposed service framework is a strategy to ensure integrated service delivery or coordinated care.

8.63 Many participants identified the need for coordination and integration in relation to those placed in involuntary care. In previous chapters the Committee discussed this imperative in relation to people with complex needs and antisocial behaviour. The same principle applies to those who require short term involuntary care. Professor Webster warned of the danger of too much focus on detoxification services and acute care, arguing that the whole system needs to respond to the client group of people with severe substance dependence. He also noted that the success of the Committee's proposed model will rest on providing coordinated, joined up services and ensuring a 'chain of care'.[486] Similarly, participants such as Dr Victor Storm highlighted the multidimensional nature of people's needs, such that they might have other physical and mental health problems and require housing and other support services:

> There is not much future if you have nowhere to live, even if you deal with all your addiction problems. There are other elements that are part of the social infrastructure that are required to assist people who have already had a pretty disastrous period in their life and we need to integrate all those in the recovery.[487]

8.64 Echoing the Committee's concern that involuntary care be used as an opportunity to do the most good for a person, Ms Frances Rush, a Regional Manager with the Office of the Public Guardian put it well when she stated:

> In that sense it is about a web of care. It is not just a case of containing someone and then releasing them. It is trying to provide an integrated service across where they live, their communities and families … [488]

8.65 Participants also noted that follow-up and after care are important aspect of service coordination and integration. In particular, they emphasised the importance of linking clients

[486] Professor Webster, NSW Expert Advisory Committee on Drugs, Evidence, 4 June 2004, p8

[487] Dr Victor Storm, Clinical Director, Central Sydney Area Mental Health Service, Evidence, 27 November 2003, pp46-47

[488] Ms Frances Rush, Regional Manager, Office of the Public Guardian, Evidence, 7 April 2004, p50

to general practitioners and case managers. Professor Webster also pointed to the potential in the idea of a 'nominated person' or mentor to support, watch over and advocate for the person over time:

> That idea was having a nominated person who could take some special relationship with the person or become, in a sense, the person's "parent" … someone who would ensure that the person would get access or be followed up or get proper nourishment.[489]

8.66 The nominated person would not so much be a professional as a community member, for example an Elder in the Aboriginal community. He or she and the person with the substance dependence would mutually agree on this supportive relationship, so that in a sense, each would be accountable to the other.

8.67 Larry Pierce of NADA told the Committee that the building blocks for integrated service delivery in relation to drug and alcohol treatment already exist, but that the Government's framework has not yet changed the way agencies actually work together. As we noted elsewhere in our report, the importance of overcoming service boundaries and providing a 'joined up' service response is increasingly recognised by government, but achieving it is no easy task:

> If you look at what has been happening in New South Wales since the 1999 Drug Summit you will see that a framework is very much in place. The overall policy deems that alcohol and drug problems are a whole of government issue that affects not only the police or the Attorney General's Department but also housing, social welfare, education, family services and so on. There is already a clear framework for the way forward … What has not happened and what needs to happen is the implementation of an integrated planning process between NSW Health, DOCS, DADHC, Juvenile Justice, the Police and the Attorney General's Department, just to name the major players. In many ways, particularly from a non government point of view looking in, those agencies are still silos that have their turf, and within that there is turf within turf - for example, the alcohol and drug system and the mental health system. In reality, practice and organisational changes are not up with this very good government policy and framework. The framework is there and we know what the policy and plans should look like … But the reality is that departments and program areas are still too siloed.[490]

8.68 In the previous chapter we recommended that the Government develop an interagency agreement setting out the respective roles and responsibilities of relevant agencies under the proposed legislation. The Committee considers that agreement at the policy level will be fundamental to the success of the new legislation, but that measures must also be taken at the local level to ensure cross-agency coordination and collaboration. We suggest that local protocols at the area health service level be developed for this purpose. These will be based on the statewide agreement, but will allow for local variations and also establish the role of non government agencies. We also consider that the treatment guidelines recommended in the previous section, which are necessarily focused on the care that people receive, should reflect the need for interagency collaboration around individual clients.

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489 Professor Webster, NSW Expert Advisory Committee on Drugs, Evidence, 4 June 2004, p18

490 Mr Pierce, Network of Alcohol and Other Drugs Agencies, Evidence, 27 November 2003, p60

Recommendation 39

That interagency protocols be developed in each area health service setting out the roles and responsibilities of government and non government agencies in relation to involuntary care.

Recommendation 40

That the treatment guidelines to be developed by NSW Health in Recommendation 38 also reflect the need for interagency collaboration.

Investment in specific services

8.69 The third and final essential element in a new service framework for involuntary care is investment in specific services. Earlier in this chapter we highlighted the need for greater investment in detoxification services, especially if they are to be the facilities where involuntary clients are placed. Participants identified a number of other service areas where investment is critical if the proposed framework of involuntary care is to be effective. Significantly, several of these focused on people with alcohol related brain damage.

Neuropsychological testing

8.70 At various points in this report the Committee has stipulated that while in involuntary care, people must undergo a comprehensive assessment, including, where appropriate, neuropsychological assessment of their cognitive ability. The Committee was advised that a proper assessment is necessary to establish the grounds for guardianship for those who require it. In addition, as Ms Harvey told us, for people with less severe impairment, a diagnosis of brain damage can actually assist a person's recovery:

> There are degrees of damage … If you can measure the degree of damage and work with a person's deficit it gives them something tangible to work with. I have seen significant life changes made by people who have been diagnosed with a brain injury who can say, "It is not just me; maybe there is something I can do." That is a big relief for the person and his or her family because often they blame the individual. That gives them something is hang to on and the ability to go forward.[491]

8.71 Dr Jurd explained that a diagnosis also enables treatment to be tailored to the person's needs. While a person without brain injury can be given lots of information and use therapies focused on cognitive skills, people with cognitive disability will need to be steered down a 'slower stream' using modified psycho-social and other treatment tools.[492]

8.72 Despite the benefits of neuropsychological testing, Dr Jurd and Ms Harvey indicated that it is very difficult to access, and that there is a resistance to using it routinely because it is expensive and arduous for both the person doing the testing and the person being tested. Associate Professor Fanning in the Mid Western Area Health Services noted that there are

491 Ms Harvey, Northern Sydney Health, Evidence, 4 March 2004, p14

492 Dr Jurd, Northern Sydney Health, Evidence, 4 March 2004, p14

particular problems in accessing these skills in rural areas, and forewarned the Committee of difficulties in ensuring these assessments within the statutory time limits we have proposed.[493]

8.73 The Committee considers that given the important place we are envisaging for neuropsychological testing in the provision of involuntary care, it will be vitally important that these services are available. We recommend that NSW Health develop a strategy to enhance the availability of these services across the State. It may be appropriate that practitioners with neuropsychological skills are 'flown in' to rural areas when required. We understand that in Victoria, a non government agency, ARBIAS Acquired Brain Injury Services, is contracted to provide preliminary neurological examinations and full neuropsychological assessments for people with brain injury on a consultancy basis.[494]

Recommendation 41

That NSW Health develop a strategy to ensure the availability of neuropsychological testing services for people subject to involuntary care.

Programs for people with alcohol related brain injury

8.74 A number of participants called for the reinstatement of drug and alcohol treatment models specifically designed for people with alcohol related brain injury, such as the one that formerly operated at Rozelle Hospital. Ms Harvey, who used to work in that program, explained that it was staffed by a multidisciplinary team comprising psychiatrists, nurses, nurses' assistants, welfare officers and occupational therapists.[495] The model responded to the poor insight, motivation and learning skills that are typical of those with alcohol related brain damage, providing not just drug and alcohol treatment but also living skills development and intensive support. Ms Harvey told the Committee:

> We had two alcohol related brain damage units dealing with people with mild to moderate damage. A high percentage of people going through the program were subject to inebriates orders. Often they were on an order for the first three months of treatment. Some left after three months of treatment and some stayed longer because they felt they needed to … It was a highly effective program because there were options available for people to be managed according to their needs. They came into detoxification on an inebriates order, and if they were chaotic and absconding they would go to the acute admission ward for a short period and be dealt with by drug and alcohol liaison people. When they settled down in their withdrawal they had a mental state examination and it was determined whether they had any alcohol related brain damage. A recovery program was then developed for them.[496]

8.75 The Committee was told that while the Rozelle program achieved reasonable outcomes, it was expensive to run, and was wound down in the context of a broad shift of funding away from

493 Email from Associate Professor Fanning, Area Director, Mid Western Area Mental Health Service, to Senior Project Officer, 1 June 2004, p1

494 What is ABI and ARBIAS, *http://www.arbias.org.au/arbias.htm*

495 Ms Harvey, Northern Sydney Health, Evidence, 4 March 2004, p24

496 Ms Harvey, Northern Sydney Health, Evidence, 4 March 2004, p12

alcohol and towards illicit drugs. Alluding to the 'moral' dimension that can affect policy in this area, or perhaps just the lack of priority afforded to chronic alcoholism, Dr Jurd told the Committee, 'we do not spend that kind of money on alcohol dependent people'. Given that this treatment model is 'rehabilitative' in nature, we believe it would be appropriately resourced by NSW Health. We note the significant resources channelled towards rehabilitation of people with traumatic brain injury, which stand in stark contrast to those directed towards this group.

8.76 In terms of provision of such services, one mechanism is the use of a consultancy service providing specialist support to mainstream treatment and other service providers who have clients with acquired brain injury. This model is operating in Victoria through the non government agency ARBIAS. The service enhances the capacity of mainstream service providers by educating them on how to tailor their services to people with brain injury, for example, by providing a structured environment, reducing demands on cognitive functioning and dealing with challenging behaviour. When we visited Victoria we heard more about this approach from Ms Robin Fisher, Manager of Drug Treatment Service Operations with the Department of Human Services:

> … it is about what is appropriate within the alcohol and drug service; what sorts of skill sets our alcohol and drug clinicians need to have in order to be sensitive to the different sorts of presentations and how we need to modify our services to ensure that we are embracing those clients and they are not being rejected simply because they are seen as being too difficult. I think we have made a real breakthrough in that area in the past two or three years.[497]

8.77 The Committee sees strong potential in a model of this nature as it would be much more cost effective than a purpose built facility, and would potentially benefit a greater number of people across the State. The consultants would resource and train detoxification and treatment teams and a broad range of other service providers. They would also prove an important resource for family members and carers. If this consultancy service were to target drug and alcohol treatment and other health services, we believe it would be appropriately funded by NSW Health. If it also served as a resource to agencies providing longer term care and support to people as a result of their disability we consider it appropriate that the service be jointly funded by NSW Health and the Department of Ageing, Disability and Home Care (DADHC).

Recommendation 42

That NSW Health re-establish specific treatment and living skills development services for people with significant cognitive impairment arising from their substance use.

[497] Ms Robin Fisher, Manager of Drug Treatment Service Operations, Department of Human Services, Evidence, 28 April 2004, p23

Recommendation 43

That NSW Health and the Department of Ageing, Disability and Home Care establish a consultancy service providing specialist support to mainstream treatment and other service providers to enable them to work more effectively with people with alcohol related brain injury.

Supported accommodation for people with alcohol related brain injury

8.78 The case studies of Esther on page 57 and Margaret on page 94 highlight the gap into which people with alcohol related brain injury fall, especially in relation to accommodation. Very often their behaviour is such that they require containment and supervision.

8.79 When they appeared before the Committee, representatives of the Office of the Public Guardian stressed the need for long term care and support for people with alcohol related brain damage, telling us that the absence of these services affects the Office of the Public Guardian's ability to fulfil its duty of care. As Mr Graeme Smith stated:

> I think the area of greatest concern for the Public Guardian is access to appropriate supported accommodation services for people who have acquired a disability as a result of long-term dependence on alcohol or drugs … They are a group of people who typically fall between the gaps, so to speak. They are people for whom health services generally have nothing to offer. They are not long-term providers of supported accommodation. The State disability agencies do not provide direct services for people with brain injury. They do fund non government agencies in some circumstances to provide services for people with a brain injury, but, historically, people with a brain injury associated with long-term alcohol abuse have fallen into the area of responsibility of the State health authorities, and therefore the State disability agencies are reluctant to provide designated funds for that group of people. So it is an area of what might be termed dispute between the two agencies.[498]

8.80 Mr Smith explained to the Committee that in the absence of more appropriate accommodation options, people requiring high levels of care and/or supervision are typically placed in aged care facilities. While there are a small number of nursing homes that have specialised in providing for the client group of people with a brain injury, the demand for their services is much greater than the supply.[499] Ms Beth Burton, who presented the case study of Margaret, explained that nursing homes with a 'confused and disturbed elderly unit' have proved useful, but they are not widely available, and are often reluctant to take people with brain injury because of their agitation and volatility.[500] These environments are also much less than ideal for people who are not frail aged. As the Public Guardian's submission states, these facilities:

> … are not designed to support residents who are physically able, younger than the average resident and requiring a high level of supervision. Staff are typically unskilled

498 Mr Graeme Smith, Director, Office of the Public Guardian, Evidence, 7 April 2004, p34

499 Mr Smith, Office of the Public Guardian, Evidence, 7 April 2004, p34

500 Ms Beth Burton, Clinical Nurse Consultant, Alcohol and Other Drug Services, New England Area Health Service, Evidence, 24 March 2004, p12

> in the management of people with acute and chronic substance dependency and the range of appropriate diversionary activities is limited.[501]

8.81 When a person is placed in an inappropriate facility, there is often a breakdown in their care arrangements. The case study of Eddie below highlights the absence of appropriate accommodation options for this group.

Eddie

Eddie is a 58 year old man with alcohol related brain damage arising from a 20 year dependence on alcohol. He also had a mental illness and problems with his physical health. He has a long history of homelessness and frequent short term admissions to hospitals and rehabilitation centres.

Eddie was brought before the Guardianship Tribunal because people were extremely concerned that he would die on the street. He was being beaten up regularly and was having trouble fending for himself. His health had deteriorated to the point that he needed to have a number of operations, including being provided with an ileostomy bag. The Office of the Public Guardian arranged, with his agreement, for Eddie to be admitted to a secure nursing home for three months or so, while he underwent his operations. He needed a stable placement long enough to have his health problems addressed.

Because of his behaviour he was placed in a secure dementia-specific unit in the nursing home. Once he was detoxified he found it very distressing to be held there with patients who had dementia. The staff did everything they could to try to contain him but they could not. He would scale the wall of the secure unit every day, but would voluntarily return at night. Because he could not be effectively contained and continued drinking, his health continued to be at risk.

Ideally, he would have been placed in a secure facility where he could gain appropriate care, and be in an environment where he was reasonably happy.

The Public Guardian looked for other alternatives, but in the absence of any, it sought to have him placed under the *Inebriates Act*. Representatives of the gazetted hospital advised against this as they felt he would be more at risk there, because of his acute health needs, than he would be in a general hospital.

Not long afterwards, Eddie was hit by a car and both his legs were fractured. Ironically, because he was no longer able to run away, he was able to get the treatment he required.

8.82 Professor Webster was also very concerned that there be adequate provision for a 'place' for people with alcohol related brain injury. While society has developed systematic responses for people with similar conditions and resulting behaviours, such as people with dementia and severe mental illness, he observes that for people with 'chronic inebriation and brain impairment' 'there is neglect and deliberate exclusion.'[502] He saw the provision of humane shelter, health care and nutrition as fundamental needs in relation to this group:

> And it is in shelter, a place where the person has some security – for at least the medium term – where the basic necessities of life are available – that is the critical issue.[503]
>
> The greatest deficiency in our social systems is the availability of living and housing environments for people affected by these problems.[504]

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501 Submission 49, Office of the Public Guardian, p4

502 Supplementary Submission 43, Professor Ian Webster, NSW Expert Advisory Committee on Drugs, p5

503 Submission 43, Professor Ian Webster, NSW Expert Advisory Committee on Drugs, p5

8.83 Our Committee recognised the need for action in this area when we undertook our inquiry into residential and support services for people with a disability. In our Final Report, released in November 2002, we recommended that DADHC acknowledge people with brain injury as part of the target group for the Disability Services Program, under which supported accommodation and a range of other programs are funded. We also recommended that DADHC, in collaboration with NSW Health, Treasury and a number of other agencies, develop a funding and policy framework to strategically address the needs of people with brain injury, in order to improve their access to the range of disability and mainstream support services, and to brain injury specific services. We noted that the framework should consider, in particular, living skills and behaviour/social skills development services and accommodation, respite, case management and other services.[505]

8.84 Ms Rush of the Office of the Public Guardian called for the development of different models of care and accommodation according to the range of people's individual needs. While some people will need confinement for a relatively short period in order to get well, others will need long term accommodation, supervision and support in a safe place. She stated:

> It is looking at different models that still meet their needs and looking at the dignity of the person still being maintained.[506]

8.85 The Committee is very concerned that people with brain injury continue to be excluded from eligibility for disability programs in this State. We understand that 'drug or alcohol related brain injury' is a specific exclusion criterion for emergency access to DADHC services through the Service Access System.[507] However, the Department has a clear statutory responsibility for this group under section 5 of the *Disability Services Act 1993*, which states that the target group for that Act is people with a disability however that disability arises.[508] We also note that people with acquired brain injury are eligible for Commonwealth provisions such as the Disability Support Pension.

8.86 We consider that DADHC should acknowledge its responsibility towards people with disability, no matter how that disability was acquired. In doing so, it should enable people with alcohol related brain injury to access supported accommodation.

8.87 Case studies such as that of Esther on page 57 also show the need for behaviour support for people with alcohol related brain injury. While Esther eventually gained accommodation through the Department of Housing, her initial placement broke down because of the impact her disruptive behaviour had on those around her. She was very unhappy in her second placement, with people with similar needs, because she found other residents' behaviour difficult, and they did hers. The Committee understands that DADHC operates a Behaviour Intervention Service for people with an intellectual disability who are at risk of moving to a more restricted environment because of challenging or offending behaviours. The Committee

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504 Submission 43, Professor Ian Webster, NSW Expert Advisory Committee on Drugs, p9

505 Standing Committee on Social Issues, *Making it Happen: Final Report on Disability Services*, Report 28, November 2002, p45

506 Ms Rush, Office of the Public Guardian, Evidence, 7 April 2004, p42

507 Department of Ageing, Disability and Home Care, *Service Access System Decision Rules – Requests for Support*, Document Number 2004/PM/8, November 2003.

508 s 5, *Disability Services Act 1993*

considers it appropriate that people with acquired brain injury should also have access to this service.

8.88 We reiterate our recommendations from our *Final Report on Disability Services.*

Recommendation 44

That the Department of Ageing, Disability and Home Care acknowledge its responsibility towards people with acquired brain injury, including those with alcohol related brain injury, as part of the target group for the Disability Services Program.

Recommendation 45

That the Department of Ageing, Disability and Home Care, in collaboration with NSW Health, Treasury and other relevant agencies, develop a funding and policy framework for strategically addressing the needs of people with brain injury, in order to improve their access to the range of disability and mainstream support services, and to brain injury specific services. In particular, this framework should consider:

- Living skills and behaviour/social skills development services
- Accommodation, respite, case management and other services.

Support for families and carers

8.89 Many participants called for greater provision of support for families and carers. At various points throughout this report we have noted the profound impact that a person's substance dependence can have on their family, as was highlighted at the Alcohol Summit. Earlier in this chapter we recommended that guidelines for the treatment of people in involuntary care should address how families and carers are to be engaged in the process.

8.90 Ms Diane Paul of the Herbert Street Clinic told us that most of the calls to their service are made by family members concerned about their loved one being 'out of control'. She reported:

> They stress that there is no support for them out there and they do not know where to turn because the drug and alcohol services are busy enough dealing with the actual client. There are not a lot of services for the families, and I think that needs to be addressed.[509]

8.91 Participants such as Mr Pierce of NADA and Dr Jurd indicated that while significant progress has been made in this area, more work is yet to be done.[510] As Mr Pierce stated:

> Anybody who knows the drug and alcohol field will know that the inclusion of families and family-oriented programs is a pretty recent arrival to drug and alcohol

[509] Ms Diane Paul, Herbert Street Clinic, Evidence, 4 March 2004, p27

[510] Mr Pierce, Network of Alcohol and Other Drugs Agencies, Evidence, 27 November 2003, p53; Dr Jurd, Northern Sydney Health, Evidence, 4 June 2004, p32

> treatment. After the 1999 [Drug] Summit – it was reaffirmed at the Alcohol Summit – government made a very clear statement of priority, saying, "Families are a target group; families are important to support. Drug and alcohol services ought to be made more family-friendly, they ought to interact and engage with families and offer family support." More work must be done to reorient drug and alcohol services to be family friendly, and probably more dedicated resources are needed for specific family support interventions.[511]

8.92 The Government response to the Alcohol Summit indicates that the new statewide *Drug and Alcohol Treatment Services Development Plan 2006-2015* will address recommendations of the Summit in relation to:

- Strengthening and increasing funding for family-based approaches
- Introducing a 'visitors program' allowing families a role in developing responsive services
- Supporting telephone and other linking services that can provide information, peer-support, advice and referral to parents and family members.

8.93 The Committee considers it vitally important that this commitment to families be fulfilled.

Recommendation 46

That the *Drug and Alcohol Treatment Services Development Plan 2006-2015* provide for greater engagement of families in treatment, and enhance provisions specifically aimed at supporting families and carers.

8.94 In light of the discussion at several points throughout this chapter we consider the evaluation of the proposed legislation, which we recommended in Chapter 7, should also address a number of issues related to service provision. These include service coordination and integration, identification of service gaps, and the experience of families and carers.

Recommendation 47

That the evaluation of the proposed legislation in Recommendation 26 also consider:

- service coordination and integration
- service gaps
- the experience of families and carers.

A continuum of services

8.95 As a final comment on the service framework to underpin the proposed legislation, we note that participants were eager to ensure that provision for involuntary care be seen as part of a

[511] Mr Pierce, Network of Alcohol and Other Drugs Agencies, Evidence, 27 November 2003, p53

continuum of services, covering prevention, early intervention and harm management, with an emphasis on ensuring access to treatment well before a person reaches the point of needing involuntary intervention. As Professor Matthews stated:

> I think coercive treatment is required for the few who need it and better treatment access is required for the many who do not fit into a coercive framework to stop them from progressing to more serious stages. Part of the discussion I had before coming here was whether the direction of focusing on coercive treatment is necessary but misses the other part of the discussion - which is if you intervene earlier and catch people earlier perhaps they will not need coercive treatment later because they will not progress to having severe problems. In considering that there is a need to look across a range of interventions throughout people's lives, not just at the end.[512]

8.96 Professor Hall emphasised the range of measures needed to provide humane protection to those with significant dependence:

> The conclusion we ought not jump to is that civil commitment is the only one to achieve this goal. I think there are a lot of other ways, eg proclaimed places and other forms of intervention that give time out for people who are heavy drinkers that attempt to reduce the harm are a good idea. I would be very supportive of them. It is a question of whether they have to be accompanied by coercion or whether they ought to be services that are more readily available in areas where heavy drinkers congregate and where they are to be found. I think we need to look at a range of options rather than simply either coercing treatment or leaving people to the mercies of the street.[513]

8.97 The Committee agrees with inquiry participants that the proposed legislation must be seen as one measure within a much broader spectrum of services and provisions in relation to drug and alcohol problems. Government policy needs to ensure that services are provided along the continuum of substance misuse. We need to be working hard on prevention, while ensuring timely access to services when treatment is required, and humane and compassionate care when this is needed. As we have noted throughout this report, an holistic approach that seeks to address the totality of people's needs is essential.

8.98 We strongly believe that there needs to be enough community-based services, for example accommodation, case management, mental health services and general welfare services, to ensure that people who require support get the assistance they need to live with dignity. It is no longer acceptable to control people with drug and alcohol problems by institutionalising them for a time. However, history has shown that initiatives to remove people from institutions have not been accompanied by sufficient investment in community based supports. As Professor Carney told the Committee:

> [The de-institutionalisation process] has left the responsibility with civil society. It has largely abnegated responsibility to provide assistance to the vulnerable population. That was never the intention of de-institutionalisation. The intention was to allow people to operate in the community and for governments to continue to invest the

512 Professor Mattick, National Drug and Alcohol Research Centre, Evidence, 8 April 2004, p11

513 Professor Hall, University of Queensland, Evidence, 29 April 2004, p4

> same number of dollars that used to be invested in institutional care in the more effective community-based care. I am speaking internationally …[514]

8.99 We think it very likely that many people with complex needs and antisocial behaviour would not be such thorns in the sides of their family and community were they to have access to supports that meet their needs. Similarly, we suspect that many of the people for whom involuntary care is sought would not reach that point were they adequately supported in the community. Each of the case studies presented in this report highlights the vulnerability and multidimensional needs of people with severe substance dependence. A humane and compassionate response to them will recognise and respond to these needs. It is vitally important that the government comes to grips with this issue, especially in relation to housing and shelter, one of the most basic of human needs.

8.100 Our final comments are focused on provisions for people with alcohol dependence. We note our concern that there has been a shift away from alcohol towards illicit drugs treatment, especially given the prevalence of alcohol related problems and harms in the community. It is vitally important that adequate provision is made for all substance dependencies. There may be political pressure to address illicit substance dependence, but there are also social and moral imperatives to address alcohol dependence.

8.101 Relative to many other client groups, people with alcoholism have been given little priority. This is borne out in comparison with services for people with other addictions, people with other chronic conditions, and people with disabilities acquired through other means. As the comments of Professor Webster and Dr Jurd earlier in this chapter indicate, value judgements about people with alcohol dependence appear to have influenced both drug and alcohol and disability policy in this State. Whether these value judgements have been explicit or implicit, attitudes about 'deservingness' of support still seem to be with us. While these value judgements were characteristic of the *Inebriates Act 1912*, they have no place in policy in the early 21st century.

[514] Professor Carney, University of Sydney, Evidence, 7 April 2004, p29

Chapter 9 Offenders

A large proportion of offences committed are related to offenders' abuse of, or dependence on, drugs or alcohol. In the case of dependence on illicit drugs, the expense of the habit often gives rise to the need to steal to raise funds to buy drugs and otherwise support the user. By contrast, alcohol dependence is commonly associated with assaults and drink driving. In such cases as these, the community may best be served by treating the dependencies of the offenders rather than incarcerating them. It is in these circumstances that compulsory treatment of offenders is contemplated.

Compulsory treatment of offenders can occur at several stages of the criminal justice system. Defendants can be diverted into treatment prior to entering a plea, as part of bail conditions, after conviction, as a condition of a suspended sentence, or whilst on parole.

This chapter provides an examination of the provisions of the *Inebriates Act* that relate to offenders, and considers whether the new legislative framework that replaces the Act should include provisions for offenders. Alternative existing court-based treatment programs for offenders are surveyed and evaluated, and areas requiring further treatment options are considered. First, however, the Committee examines the effectiveness and ethics of compulsory treatment of offenders.

Compulsory treatment of offenders

9.1 Before commencing this section, we note that the term 'compulsory treatment' in this section generally refers to situations in which offenders are given the option to choose between undertaking a treatment program or traditional criminal justice system approaches such as imprisonment. It should perhaps more correctly be referred to as coerced or mandated treatment, however the term 'compulsory treatment' is that used in our terms of reference, and we use the terms interchangeably.

9.2 Recent years have seen a growing commitment to the principles of therapeutic jurisprudence, which can be explained as follows:

> It is a mental health approach to law that uses the tools of behavioural sciences to assess the law's therapeutic impact and, where consistent with other important values, to reshape the law and legal processes in ways that can improve the psychological functioning and social well-being of those affected.[515]

9.3 Professor Freiberg identified five elements of court-focused therapeutic jurisprudence: judicial supervision; the availability of treatment; a multi-disciplinary approach; a system of rewards and sanctions; and procedural justice.[516] It is in this context that the trend toward diversion programs and compulsory treatment of offenders has developed.

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515 Winnick B, cited by Professor Arie Freiberg, Criminologist and Dean of Law, Monash University, Evidence, 18 February 2004, p44

516 Professor Freiberg, Monash University, Evidence, 18 February 2004, p44

The effectiveness of compulsory treatment of offenders

9.4 Generally speaking, there is a better evidence base for compulsory treatment in relation to offenders than for non-offenders. The available evidence suggests that compulsory treatment of offenders with drug and alcohol problems can be effective. The literature review conducted by the Turning Point Alcohol and Drug Centre in Victoria provided an overview of research studies that examined outcomes of court-mandated treatment, offering a range of conclusions about its effectiveness, with advantages identified by a number of studies.[517]

9.5 The studies overviewed by Turning Point Alcohol and Drug Centre indicated that court-mandated clients have treatment outcomes that are comparable to those of voluntary clients. Court-mandated treatment was reported to have reduced offending rates and improved the psychosocial status of participants. In relation to retention in treatment, mandated clients remained in treatment 'at least as long as voluntary clients', with some studies revealing that they are retained in treatment longer.[518]

9.6 Providing an overview of the evidence of outcomes of compulsory treatment, Professor Wayne Hall told the Committee:

> Very broadly, it suggests that coercion of offenders results in better retention in treatment and probably no worse outcome, so it does not appear to impair outcomes. Therefore there is probably some benefit, in some circumstances, in coercing some offenders into treatment.[519]

9.7 Professor Ian Webster drew a distinction between enforced drug and alcohol treatment (in which offenders are not given any choice about participating in treatment) and treatment undertaken by offenders in an environment of constrained choice. He advised that enforced treatment within the criminal justice system 'has poor results, although these are better when there is a sustained and continuing programme that continues into community settings'.[520]

9.8 As we documented in previous chapters in relation to non-offenders, an important concern raised during the inquiry relating to compulsory treatment programs for offenders is the potential impact on voluntary clients. One inquiry participant gave evidence that:

> People who do go into the rehabilitation centres from the courthouse have an effect on the people who are there who genuinely want to sober up. They cannot. They find it very hard because of the people who are coming from the courts to the rehabilitation centres.[521]

9.9 A similar concern was raised by a service provider:

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517 Turning Point Alcohol and Drug Centre, *The Alcoholics and Drug-dependent Persons Act (ADDPA) 1968: A Review*, March 2004, pp17-18

518 Turning Point Alcohol and Drug Centre, *The Alcoholics and Drug-dependent Persons Act (ADDPA) 1968: A Review*, March 2004, p17

519 Professor Wayne Hall, Office of Public Policy and Ethics, Institute for Molecular Bioscience, University of Queensland, Evidence, 29 April 2004, pp2-3

520 Submission 43, Professor Ian Webster, p6

521 Mr Faulkner Munroe, Evidence, 24 March 2004, p26

> In my opinion they should not be taking court referrals unless there is a guarantee that they want to get sober, or that they are committed to getting sober. This going in because it is going to save them from going to gaol just does not work. It is a waste of the system. I think it is an abuse of the system. It should not be allowed.[522]

9.10 Others consider that there are benefits in mixing voluntary and mandated clients:

> I think it is actually good and that there is a benefit to having a balance of clientele. We find that people who come with no orders and who are doing it for themselves or for their family - it might have come to a push because of a relationship or something or a child order, or something not necessarily legal - they actually add a calming influence to the units in terms of they are usually older and usually a little bit wiser and they have had other life experiences. Some of the other people who come on orders might come with what I always call a chip on their shoulder. They come through the door with the attitude.
>
> They actually settle down if they are given time and learn to talk to other people and find out that this is not such a bad place and they can be treated humanely and with respect if they treat other people with respect, and so forth. We do occasionally see change. It is not very often that people just get up and walk out, but certainly it is more of the case when they are forced to come here than when they voluntarily come. But I think the mix is good. You may as well put people in gaol if you are going to separate them. Why not have the people undergoing rehabilitation in gaols and spend money there in the first place if you are going to have a special place for people who have been put on orders like MERIT or court and bail. You may as well have them in gaol and do it.[523]

9.11 In addition, there is a risk that access to voluntary programs could be affected if compulsory programs are under-resourced:

> … the major concern I would have would be ensuring that this system is adequately resourced so that it was not at the expense of the voluntary treatment system. We have to think clearly in considering the involuntary treatment and its potential impact on the quality of treatment provided for people who request assistance with their addiction. If that is not properly resourced, that can be a real issue and I think there are issues I will come to later on, the circumstances in which the treatment is provided. If we end up having locked wards where people are compulsorily treated and they are the same sorts of locations as people seeking voluntary treatment, I think that can have adverse effects on the attractiveness of treatment both for patients and also for staff who work in those sorts of treatment centres.[524]

9.12 Under-resourcing is also a potential risk for the compulsory programs themselves, according to Professor Mattick:

> The difficulty with introducing coercive treatment is that it is likely that over time it will not be particularly well run and if it is going to be introduced, it needs to be well resourced, implemented and humane. There are tensions between the criminal justice and health systems in terms of how they deal with individuals who may not meet the

522 Ms Val Dahlstrom, Area Manager, Aboriginal Health, New England Area Health Service, Evidence, 24 March 2004, p26

523 Ms Christine McInnes, Program Director, Lyndon Withdrawal Unit, Evidence, 25 March 2004, p44

524 Professor Hall, University of Queensland, Evidence, 29 April 2004, p2

> expectations of treatment. But around the world there are examples of coercive treatments and they have tended to last for a number of years and then they gradually get rundown and disappear.[525]

9.13 These comments underscore the importance of adequately resourcing treatment programs, both voluntary and compulsory. The Committee notes that, arising from the Alcohol Summit, NSW Health is auditing existing drug and alcohol treatment services and reviewing the level of unmet need for treatment across the State. The review will be completed in 2005 and will:

> … enable better planning and more flexible targeting of clinical services to areas of need, including population groups with specific needs [and] will enhance access to services and better support the Government's Diversion Program, including adult and young offenders who may elect voluntarily to access treatment.[526]

9.14 The review will form the basis for a new *NSW Drug Treatment Services Development Plan 2006-2015*.

9.15 An evaluation of specific treatment programs for offenders in New South Wales is found later in this chapter.

The ethics of compulsory treatment of offenders

9.16 Compulsory treatment of offenders raised few ethical objections amongst inquiry participants. The fact that offenders, through their offences, have manifestly impacted on others reduces the dilemma: as we noted in Chapter 6, intervention against a person's will is justified under criminal law on the basis that offenders have harmed others. The dilemma is also reduced by the evidence that compulsorily treating offenders has had some success. Moreover, there is an element of choice for offenders about entering treatment – albeit a very constrained choice – as an alternative to traditional criminal justice sanctions.

9.17 Several inquiry participants commented on this degree of choice for offenders:

> Although there is a coercive element, they are given some choices, some of which are more pleasant than others. Secondly, they have to consent through the process of treatment, which is sometimes hard. They can say, "I am not going to do this any more. I would rather go back to gaol", and some of them do. It is much easier to go to gaol.[527]

9.18 Another witness noted:

> While they have been bonded to treatment, they choose to take that bond.[528]

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525 Professor Richard Mattick, Director, National Drug and Alcohol Research Centre, University of NSW, Evidence, 8 April 2004, p8

526 NSW Government, *Outcomes of the NSW Summit on Alcohol Abuse*: *Changing the Culture of Alcohol Use in New South Wales*, May 2004, p224

527 Professor Freiberg, Monash University, Evidence, 18 February 2004, p48

528 Ms Tonina Harvey, Area Director, Drug and Alcohol Services, Northern Sydney Health, Evidence, 4 March 2004, p9

9.19 Mr Scantleton, who was involved in establishing a trial treatment program for offenders in northern New South Wales, told the Committee:

> The threat of breach action, and particularly the involvement of the criminal justice system, can be very useful in helping people to keep them in treatment when they might otherwise want to drop out. It is an interesting concept of coercion when it is a voluntary program. It certainly does not present any problems for me from an ethical point of view but it is something which has enabled us to have far more significant outcomes. [529]

9.20 Other participants, such as Professor Freiberg, noted that, conversely, offenders' choices in relation to treatment could be seen to have elements of coercion. Referring to Richard Fox's argument in *The Compulsion of Voluntary Treatment*, Professor Freiburg told the Committee:

> He makes the point that there is a continuum of coercion and it is really not helpful to make a clear dichotomy. If you said, "Do you want to be locked up in gaol or go on this treatment", is it really voluntary consent? "Do you want to do this or go to gaol?" Is it voluntary? "Do you want to be hung or quartered?" … I do not think you should get hung up about coercive versus non-coercive. I think it is a continuum.[530]

9.21 The Committee notes that the World Health Organisation has endorsed mandated treatment of offenders in certain circumstances:

> I guess if we look first at the situation of legally coerced treatment … the position I took there was the one set out in 1986 by the World Health Organisation that it was ethically justified to provide treatment for a person who was drug and alcohol dependent who had been convicted of an offence to which their drug dependence contributed, and that that treatment be undertaken under threat of imprisonment if they fail to comply with these conditions.[531]

9.22 Professor Mattick outlined the circumstances in which he considered compulsory treatment for offenders to be appropriate:

> The general sense that we have is that coercive treatment would be appropriate as an alternative to prison where there are demonstrable, diagnosable problems or where the individual chooses treatment rather than going to prison.[532]

9.23 Similarly, Professor Wayne Hall advised:

> I regard that as ethically acceptable if the following conditions were met: that there was judicial oversight of the system - so there was a member of the judiciary, whether a magistrate or a judge, who took the evidence and was involved in the decision; and that the offenders were given a constrained choice - as they were not sentenced to a particular form of treatment they had the choice on the first instance of whether they want to be treated or not, and if they chose not to then they would be processed in

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529 Mr John Scantleton, Manager, MERIT Program, Northern Rivers Area Health Service, Evidence, 18 February 2004, pp6-17

530 Professor Freiberg, Monash University, Evidence, 18 February 2004, p46, citing Richard Fox's argument in 'The Compulsion of Voluntary Treatment', *Criminal Law Journal*, Vol 16, 1992

531 Professor Hall, University of Queensland, Evidence, 29 April 2004, p1

532 Professor Mattick, National Drug and Alcohol Research Centre, Evidence, 8 April 2004, p7

> the usual way by the criminal justice system and that might involve imprisonment. If they chose treatment then they ought to have a choice on the type of treatment rather than be sentenced to a particular variety of one. The other condition is that humane and effective treatment had to be provided. I think there has been a real concern about the way in which a lot of these systems have operated.[533]

9.24 While the compulsory treatment of offenders is relatively uncontroversial, the use of the *Inebriates Act* as the legislative basis for such treatment was not generally supported through the inquiry, as the next section discusses.

Assessment of the *Inebriates Act's* offender provisions

Offender provisions under the *Inebriates Act*

9.25 As outlined in Chapter Two, Part 3 of the *Inebriates Act* relates to 'inebriates' convicted of certain offences. Where an 'inebriate' has been convicted of an offence of which drunkenness is a contributing factor, or if the offence involves assault of women, cruelty to children, attempted suicide, or wilful damage to property related to drunkenness, the Act allows a magistrate to conditionally discharge the offender. The conditions may include a recognizance or 12 months incarceration in an institution.

Problems with the offender provisions

9.26 Of all the comments received by the Committee relating to the offender provisions of the Act, none were positive. In fact, witnesses were in agreement that the offender provisions were rarely, if ever, used as they are outdated and have been superseded by more appropriate mechanisms. The NSW Chief Magistrate, Judge Price, advised the Committee:

> Part 3 is not used. It is out of date and it is simply not resorted to by the courts because of all the other methods of dealing with persons for whom alcohol has been an ingredient of an offence. Section 11 and the sections go back to the times when there was an offence of drunkenness. That went out in 1979 and there is no longer an offence of public drunkenness. The law has moved on. However, part 3 is still there but it is not resorted to. When I say that the Act ought to be repealed, part 3 is archaic and part 2 is in many of its aspects as well, and it should be replaced by modern legislation.[534]

9.27 The Committee heard that alternative pathways are in place for diverting offenders into treatment:

> There are many other methods of dealing with people where alcohol is an ingredient of the offence … To answer your general question in relation to drug-dependent people, the justice system is not inert in dealing with that problem. It has been proactive in recent years with the Drug Court, the Youth Drug Court, the Magistrate's Early Referral Into Treatment, Circle Sentencing and, so far as alcohol is concerned, the Sober Driver Program. For many years, probation and parole have been doing

533 Professor Hall, University of Queensland, Evidence, 29 April 2004, pp1-2

534 Judge Derek Price, Chief Magistrate, Local Court of New South Wales, Evidence, 26 November 2003, pp7-8

> good work with specific alcohol and drug dependence programs in trying to keep people out of gaol. Magistrates frequently place people on good behaviour bonds conditional on their accepting the supervision and guidance of the New South Wales Probation Service.[535]

9.28 The Attorney General's Department concurred with this assessment:

> As far as offenders go, we have a very well developed jurisprudence in relation to the role that courts can play in directing and diverting people to appropriate care. Part of the Department's view is that you do not need to have an *Inebriates Act* in relation to offenders because there is ample provision in the current law to deal with any offender who comes before the court and who can be referred to appropriate treatment as a condition of bail, a bond or whatever. The courts do that every single day; they are very well acquainted with it. We have some very sophisticated programs at the moment in terms of the youth and adult drug courts and the Magistrates Early Referral Into Treatment [MERIT] Program, which is a much more well-developed, program-based, multidisciplinary way of looking at these problems. That is yet another example of the court playing a direct role, with other government agencies, in taking the opportunity that is presented when someone comes before the court on a charge to look at them holistically and ask, "How can we reduce offending in the long run by dealing with a person's substance abuse problem?"[536]

The Committee's view

9.29 Based on the evidence and submissions before it, the Committee considers that the offender provisions of the *Inebriates Act* have very little to recommend them. The mechanisms for treatment of offenders in the Act represent a very outmoded approach to drug and alcohol dependence, and to options for diversion under the criminal justice system. It is the Committee's firm view that provisions relating to offenders should not be included in the new legislation which we have recommended to replace the *Inebriates Act*.

Recommendation 48

That no provisions relating to offenders be included in the new legislation that replaces the *Inebriates Act*.

9.30 As several participants referred the Committee to the alternative treatment mechanisms for offenders, a brief evaluation of those alternatives is provided below. While these diversionary programs are not strictly within the Committee's terms of reference, it is important that the Committee, having recommended against re-enactment of offenders provisions, be confident that alternative treatment for offenders is readily available.

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535 Judge Price, Chief Magistrate, Evidence, 26 November 2003, p11

536 Mr John Feneley, Assistant Director General, Policy and Crime Prevention, Attorney General's Department, Evidence, 11 December 2003, p10

Alternative programs for offenders

The Drug Court

9.31 The Drug Court of New South Wales is a specialist court that aims to reduce the level of criminal activity resulting from drug dependency by diverting offenders into court-supervised treatment. The Court commenced operation at the Parramatta Court Complex on 8 February 1999 and was initially funded as a two year trial.

9.32 Participants in the program are referred from both the District and the Local Courts after a successful assessment. The specific eligibility criteria are that a person must:

- be a willing participant
- be 18 years of age or over
- be dependent on the use of prohibited drugs
- have indicated that he or she will plead guilty to the offence
- be likely to be sentenced to full-time imprisonment if convicted
- reside within the specified catchment area or have been referred from a court within this area.[537]

9.33 Offenders charged with violent offences, sexual offences and certain drug trafficking offences are ineligible to participate.[538]

9.34 At present, an average of four offenders per week enter the program.[539] Participants in the program have typically repeatedly committed property related offences:

> As to who turned up on the Drug Court program, mostly people who had long criminal records for break enter and steal, motor vehicle theft, fraud, those sorts of offences were characteristic, people who were going to go to gaol because of their long criminal record but for whom their present offence, the offence that had brought them before the Drug Court, did not explicitly involve violence.[540]

9.35 When appearing at a participating Local or District Court, offenders who appear to meet the eligibility criteria are referred to the Drug Court for an initial screening by Drug Court Registry staff.[541] The offender then appears at the Drug Court and inquiries about eligibility, including an evaluation of drug dependency, are made.

9.36 Eligible participants are then remanded by the Drug Court for a period of up to 2 weeks for detoxification and completion of a detailed assessment, including a mental health review, by

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537 www.lawlink.nsw.gov.au/drugcrt About the Drug Court of New South Wales, accessed 02/02/04

538 www.lawlink.nsw.gov.au/drugcrt About the Drug Court of New South Wales, accessed 02/02/04

539 www.lawlink.nsw.gov.au/drugcrt About the Drug Court of New South Wales, accessed 02/02/04

540 Dr Don Weatherburn, Director, NSW Bureau of Crime Statistics and Research (BOCSAR), Evidence, 18 February 2004, p37

541 www.lawlink.nsw.gov.au/bocsar1.nsf/pages/cjb52text, accessed on 22/9/03

Corrections Health. A personalised treatment plan is devised in consultation with a Drug Team consisting of health and legal specialists.[542] Following this, the offender reappears before the Drug Court, and enters a guilty plea, receiving a suspended sentence and signing an undertaking to abide by the program conditions.

9.37 While treatment plans vary between individuals, all include evidence-based therapy, social support and the development of living skills, regular reporting to the Court, and regular testing. Programs are at least 12 months long. To complete the program the participants must show progress in their program and engagement in their treatment, achieve previously set reintegration goals, have had no drug use for at least three months (or have demonstrated preparedness to re-engage in treatment in the event of a relapse) and must not have been charged with any offence in the previous six months.[543] During the period February 1999 to October 2003, 100 participants successfully graduated from the program.[544]

9.38 Early termination of the program can occur at the participant's request, or if the Court decides that the participant is unlikely to make any further progress in the program, or that further participation poses an unacceptable risk to the community that the offender will re-offend.[545]

Assessment of the Drug Court

9.39 Inquiry participants generally were supportive of the Drug Court, and considered that it had been successful on a number of fronts. Having conducted the formal evaluation of the Drug Court pilot, Dr Don Weatherburn of the Bureau of Crime Statistics and Research was well placed to comment on its effectiveness. He advised the Committee that:

> The evidence generally is strongly in favour of drug court programs. There are some negative findings but they are outweighed by positive findings in well-conducted studies. If you read Wayne Hall's review in the Australian New Zealand Journal of Criminology where he goes through a sea of coercive treatment programs, I think he draws the conclusion that if they are adequately resourced - and that is a key point - if they are adequately resourced they are effective. The mere fact that they involve some degree of coercion does not necessarily make them ineffective.[546]

9.40 Problems identified in the evaluation of the Drug Court, which were most apparent early in the pilot, included:

- tensions between the courts and treatment providers over urine sampling
- problems with sanctions being harsh
- an unrealistic requirement that participants be drug free for six months to graduate (later changed)

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542 www.lawlink.nsw.gov.au/bocsar1.nsf/pages/cjb52text, accessed on 22/9/03

543 www.lawlink.nsw.gov.au/drugcrt Drug Court Programs, Goals and Measures, September 2002, s 3.8, accessed 04/08/04

544 www.lawlink.nsw.gov.au/drugcrt Extract from the 2003 Annual review, accessed 04/08/04

545 www.lawlink.nsw.gov.au/drugcrt About the Drug Court of New South Wales, accessed 02/02/04

546 Dr Weatherburn, BOCSAR, Evidence, 18 February 2004, p41

- a lack of after-care support.[547]

9.41 Dr Weatherburn briefed the Committee on the Bureau of Crime Statistics and Research's findings about the success of the Drug Court against specific measures:

> The results at a glance, people who went to the Drug Court program generally took longer to their first offence, if they had a first offence, than people who received conventional sanctions. Treated subjects, that is to say people in the Drug Court program, generally appeared less often than did people given conventional sanctions. The Drug Court turned out to be slightly cheaper than conventional sanctions, although I should say right at this point it had the potential to be substantially cheaper than conventional sanctions … The salient point here is that at any given point in time there is a larger proportion of Drug Court participants who still have not offended than there is in the control group. Of course, as time passes both groups, fewer and fewer of them have managed to survive without an offence up to the follow-up period 500 days later, where you still have 40 per cent that did not re-offend.[548]

9.42 Outcomes relating to health and social functioning were also positive:

> The health of Drug Court participants who stayed on the program definitely improved. Their social functioning improved. That is to say they had more stable relationships, more chance of being in a job, more stable addresses, and their income from illegal sources dropped sharply, although I should add that assessment is based on self-report. It was to some extent backed up by the results of urine tests that were conducted.[549]

9.43 Dr Weatherburn explained that the Drug Court is also cost-effective:

> It is about as cost effective, in terms of time to first offence, to put someone in gaol as it is to leave them free and put them in the community. In terms of the rate of offending, it is more cost effective to have them on the Drug Court program.[550]

9.44 Practitioners who work with the Drug Court participants, such as Professor Webster, were also supportive of the program:

> The Drug Court idea, like many people I was apprehensive about it, but having experienced seeing people in it and how they had responded to it and the opportunities that were given to them in the associated programs with it and the way it has been run, I feel quite positively about it, and I was rather surprised at the results, although they were positive, in the analysis, they were not more positive than they had been.[551]

9.45 In a confidential session, it was suggested to the Committee that the Drug Court program should be geographically expanded, as it is now covering only about one-third of Sydney's

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547 Dr Weatherburn, BOCSAR, Evidence, 18 February 2004, p36

548 Dr Weatherburn, BOCSAR, Evidence, 18 February 2004, p32

549 Dr Weatherburn, BOCSAR. Evidence, 18 February 2004, p34

550 Dr Weatherburn, BOCSAR, Evidence, 18 February 2004, p34

551 Emeritus Professor Ian Webster AO, Chair, NSW Expert Advisory Committee on Drugs, Evidence, 18 February 2004, p14

population, and ballots are needed to select which of the eligible candidates are able to participate in the program. It was suggested that three drug courts would be required to cover the whole of Sydney, with one in Wollongong and one in Newcastle. The program could be extended to smaller towns by having half a day each week set aside for Drug Court matters.

9.46 Dr Weatherburn also considered it feasible to extend the program to other areas of the state:

> I just think it is a demonstrably effective, if not spectacularly effective, program and I see no reason why it should not be extended.[552]

9.47 The Committee did not receive any evidence indicating the Government's intentions about rolling-out the Drug Court program to other areas of the State. The positive evaluation and the comments of inquiry participants certainly suggest to us that geographic expansion of the program is worth considering. The current restriction of the program to Western Sydney is inequitable in terms of access in regional and rural areas, limiting the program's capacity to benefit many more individuals and communities. The Committee also notes that, due to lack of resources, the Drug Court is unable to provide places to all eligible candidates, and has been obliged to select participants by ballot. We consider it undesirable that a lottery should have any place in the allocation of places in a rehabilitative program of this nature.

9.48 The Committee therefore recommends that the Government assess the feasibility of expanding the Drug Court program with a view to making it accessible to eligible offenders throughout New South Wales. The Committee has made a further recommendation about extending eligibility to the Drug Court later in this chapter (see Recommendation 51).

Recommendation 49

That the Government assess the feasibility of expanding the Drug Court program with a view to making it accessible throughout New South Wales.

Magistrates Early Referral into Treatment (MERIT)

9.49 The Magistrates Early Referral Into Treatment program was established as a pilot in 2000 in the Northern Rivers region of New South Wales, following a recommendation from the 1999 Drug Summit.[553] The objective of the program is to divert drug offenders into treatment programs, with the intended outcomes including decreased drug-related crime, decreased illicit drug use and improved health and social functioning for participants. After a successful pilot, roll out of the program across the State commenced in 2001.[554]

9.50 The Committee heard that MERIT complements the work of the Drug Court, focusing on offences at the local court level rather than the more serious offences dealt with by the Drug Court. Under MERIT, a defendant charged with a drug-related offence can be referred to

552 Dr Weatherburn, BOCSAR, Evidence, 18 February 2004, p41

553 Tabled Document No 9, *NSW MERIT Program*, April 2002, p3

554 Tabled Document No 9, p4

undertake treatment as part of bail conditions.[555] The referral takes place prior to the defendant entering a plea, with the matter adjourned until after the defendant completes the program, at which time the case is heard and finalised.[556] The most common charges against participants entering the program are theft and related offences and drug offences, with these constituting over half (52%) of all charges against MERIT participants.[557] The majority of participants were heroin users, with 62% identifying it as a problem drug for them.[558]

9.51 Eligibility is limited to adult offenders with treatable illicit drug use problems who have committed non-violent, non-indictable offences and are eligible for bail. Unlike the Drug Court, participants are not required to plead guilty to be eligible. However, they must be motivated to engage in treatment.[559]

9.52 A defendant can be referred to the program by police, magistrates, legal representatives, probation and parole, by the defendants themselves or by their families. Referred clients are rigorously assessed by specialist workers engaged by NSW Health who operate independently of the courts. Assessment includes psychosocial information, criminogenic background, family background, mental health issues, drug use patterns and 'readiness to change'.[560] A recommendation is then made to the court, and the magistrate determines whether the defendant enters the program.[561]

9.53 Following acceptance into the program, an extensive personalised treatment plan is developed, and a contract for attendance and other requirements is agreed to. Treatment programs are typically three months long and are very intensive. In addition to drug treatment, participants' secondary needs (such as education, health, medical, housing and living skills) are identified and addressed.[562]

9.54 Urine analysis is used to assess participants' drug use, which is used for therapeutic purposes, but is not provided to the courts. Unannounced home visits also occur.[563] Judicial supervision is a crucial aspect of the program, with the defendant returning to the court to report on progress, to receive encouragement where appropriate or to be reminded of the consequences of non-compliance. Participants who do not comply with the program or their bail conditions, or who commit further offences, are breached from the program and may have bail withdrawn.[564]

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555 Tabled Document No 9, pp4-5

556 John Scantleton et al, *'MERIT', a cooperative approach to addressing drug addiction and recidivism*, MERIT Conference Paper, Perth, May 2002, p1

557 NSW Attorney General's Department, *MERIT Annual Report*, 2002, p6

558 Scantleton et al, '*MERIT', a cooperative approach to addressing drug addiction and recidivism*, p6

559 Tabled document No 9, pp3-5

560 Mr John Scantleton, Manager, Magistrates Early Referral into Treatment (MERIT) Program, Northern Rivers Area Health Service, Evidence, 18 February 2004, pp6-17

561 Magistrate Jeff Linden, *Magistrates Early Referral into Treatment Program*, Judicial Officers Bulletin, Vol 14 No 5, June 2003, p34

562 Tabled document No 9, pp9-10

563 Mr Scantleton, MERIT Northern Rivers, Evidence, 18 February 2004, pp6-17

564 Tabled document No 9, p12

9.55 At the completion of the program, clients are re-assessed and a comprehensive report and relapse-prevention plan are developed. At the final hearing, the magistrate is provided with the report about the defendant's participation, and sentencing occurs, during which the magistrate has discretion to consider the defendant's compliance or non-compliance with the program.[565]

Evaluation of MERIT

9.56 The evidence received by the Committee, and the formal evaluations we considered, all indicate that MERIT has been successful across a number of measures. It should be noted, however, that success does not necessarily equate with abstinence for all participants:

> When we started MERIT over 12 months ago we set our standards really high. We thought that, if we were to break the drug crime cycle, they had to stop using drugs. It was pretty clear very quickly that that was not going to occur. Somebody who was using $200 worth of cannabis a day might have ended up using $10 worth of cannabis a day after being on the MERIT program and probably was no longer breaking into my house to steal my money to pay for those drugs.[566]

9.57 Nevertheless, Mr Scantleton told the Committee that a considerable proportion of MERIT graduates achieve abstinence:

> 32 per cent of the clients who are completing the program are attaining abstinence from all illicit drugs, which is quite significant given the background of these people…[567]

9.58 Other performance measures are also encouraging. In relation to commission of further offences, a study of 96 graduates was conducted in April 2002, an average of 13 months they after completed of the program. The study found that:

> Of those people, 60% had no legal action against them during the time of that 13 months and 40.6% had not come under any police notice whatsoever including intelligence reports. So, if they were seen by police or not seen by police to be down town with someone else who is a known drug user, criminal, whatever, is the type of information which is generally included in intelligence reports. At that point in time we were very happy with those outcomes.[568]

9.59 By comparison, non-completers of the program were twice as likely to re-offend as program graduates.[569]

9.60 The health and well-being of participants also improved, particularly psychological health, and social skills were enhanced:

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565 Tabled document No 9, pp12-13

566 Ms Toni Colby, MERIT Caseworker, Alcohol and Other Drugs Service, Tamworth, New England Area Health Service, Evidence, 21 March 2004, p21

567 Mr Scantleton, MERIT Northern Rivers, Evidence, 18 February 2004, pp6-17

568 Mr Scantleton, MERIT Northern Rivers, Evidence, 18 February 2004, pp18-19

569 Mr Scantleton, MERIT Northern Rivers, Evidence, 18 February 2004, p19

> In summary, it indicated there were significant improvements in drug use, health and social functioning. Where heroin was a drug of choice there was a significant reduction in the heroin use. The participants reported substantial improvements in life skills, family relationships and self-esteem.[570]

9.61 Criminologist Professor Arie Freiberg, whilst supportive of the early intervention approach, considered that serious interventions such as MERIT should not occur as part of bail (when the defendant has not been convicted of any crime), but should occur as part of sentencing:

> My argument is not with the intention, which is to provide services to people who might have alcohol or drug or other problems. It is that bail has been asked to do the job that sentencing is supposed to do. I think it is an improper legal foundation for serious interventions in people's lives. At heart I am a civil libertarian. The state can intervene when you have broken the law. Prior to that it can only intervene for certain purposes. Bail is to make sure you come back to court. I have no objections to providing help for people on bail, such as alcohol and drug help, if it is solely for the purpose of ensuring you will turn up for court. If it is a long term intervention, it is an improper legal foundation.[571] … Do not get me wrong, I think the earlier you deal with people the better, but have the right tools to go with it.[572]

9.62 However, others considered that the program was operating well without the need for new legislation:

> From a legal perspective, legislation to underpin MERIT is not required. MERIT works under the bail system. The amendment to the *Bail Act*, section 36 which allowed treatment to be undertaken for 12 months, is seen to be quite adequate. There is some talk about providing legislation but I really do not think it is necessary. MERIT fits in very well with the shift from the adversarial criminal justice system to therapeutic jurisprudence, allowing the court to address the causes of crime.[573]

Additional programs for offenders

9.63 This section examines suggestions for additional programs for offenders with drug and alcohol problems. A particular issue is the comparative lack of diversionary options for alcohol related offenders as opposed to drug dependent offenders.

Extension of diversionary programs to offenders with alcohol dependence

9.64 In spite of the frequency with which alcohol problems are connected with offending behaviour, at present (except as detailed below) offenders for whom alcohol is the primary drug problem are excluded from the MERIT and Drug Court programs.

9.65 Speaking at the NSW Alcohol Summit in 2003, the NSW Chief Magistrate noted the link between alcohol consumption and the commission of offences:

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570 Mr Scantleton, MERIT Northern Rivers, Evidence, 18 February 2004, p19

571 Professor Freiberg, Monash University, Evidence, 18 February 2004, pp49-50

572 Professor Freiberg, Monash University, Evidence, 18 February 2004, p51

573 Mr Scantleton, MERIT Northern Rivers, Evidence, 18 February 2004, pp21-22

> The excessive consumption of alcohol … is a substantial factor in bringing persons into contact with the Justice System.[574]

9.66 He reported that in 2002, mid-range drink driving was the most common offence for persons sentenced in the Local Court. The second most common was common assault, an offence frequently committed under the influence of alcohol.[575]

9.67 According to the manager of the Northern Rivers MERIT program, the exclusion of alcohol related offences has particular repercussions:

> [Alcohol] was an exclusion criteria, and that is a particular issue which probably prevented a lot of Aboriginal people coming in, although particularly with Koori people we were very flexible as far as that criteria went.[576]

9.68 A number of inquiry participants proposed that offenders with serious alcohol problems should be eligible to access the MERIT and Drug Court programs, given the benefits of these programs for both participants and the broader community. The Committee notes that this was a recommendation of the 2003 Alcohol Summit.

9.69 Professor Freiberg commented that, theoretically, there is no reason why alcohol related offences should not be treated the same way as drug-related ones:

> To me, a lawyer, the key is that you have a substance abuse problem, whether it be drug or alcohol related. If that is a contributing factor to the commission of offences, then whatever the treatment is, whether it is detox or methadone, whatever it is, it is the reduction of the criminal behaviour, and one hopes improvement of the health outcomes, which is the key. I do not see any theoretical difference between the two.[577]

9.70 In fact, Professor Freiberg considers that the prevalence of alcohol related crime makes diversionary programs for alcohol more critical, even in comparison to illicit drug-related crime:

> Really, if you look at the data, and you look back a hundred years or further, and look at the date of your *Inebriates Act*, alcohol is 50 or a 100 times more serious in its prevalence in the commission of crime, especially violent crime, than drugs, and we have ignored it because it is so deeply entrenched in our society it is disingenuous to say otherwise.[578]

9.71 The Shopfront Youth Legal Centre was critical about the lack of diversionary options for offenders with alcohol problems:

> However, notwithstanding the fact that alcohol abuse is linked to the commission of numerous crimes, the NSW justice system has failed to institute adequate diversionary programs for offenders suffering from alcohol abuse.[579]

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574 Submission 1, Judge Derek Price, Chief Magistrate, Attachment 1, p1

575 Submission 1, Judge Derek Price, Chief Magistrate, p3

576 Mr Scantleton, MERIT Northern Rivers, Evidence, 18 February 2004, p22

577 Professor Freiberg, Monash University, Evidence, 18 February 2004, p52

578 Professor Freiberg, Monash University, Evidence, 18 February 2004, p49

579 Submission 9, Shopfront Youth Legal Centre, p4

9.72 Judge Price proposed early in the Inquiry that persons with alcohol problems be eligible for MERIT:

> I have referred also to the Magistrates Early Referral Into Treatment [MERIT] Program, which is a pre-plea diversion program for offenders with illicit drug problems. That is now in use in more than 50 per cent of courts. It is being gradually rolled out across the State. I suggest that it be extended to offenders with alcohol problems. The extension of MERIT in such a way would have the advantage of linking offenders at an early stage to services, government or private, that may assist in stabilising their lifestyles, just as with those with drug problems, and address the cause of their alcohol use.[580]

9.73 Ms Chris McInnes, Program Director at Lyndon Withdrawal Unit in Orange is supportive of extending the MERIT program to alcohol abusers, though she does identify some practical challenges:

> We have often wanted to make referrals to MERIT, but they could not take them because they were not illicit drug users. They fit the criteria beautifully. It will open up far more referrals because we know that alcohol is a bigger problem in this area. Drink driving offences are increasing … We will have to look closely at whether they do residential rehabilitation or outpatient treatment. Many people with alcohol problems work. We must consider those things. We could have after-work lessons, lectures, groups, treatment, therapy or whatever.[581]

9.74 Mr Scantleton has in the past sought funding to trial a MERIT-based treatment program for alcohol related offenders. However he is aware of a number of difficulties likely to be faced in the extension of diversionary programs to alcohol:

> The disadvantages include the legality of alcohol use in our society … There is less of an inclination to cease drinking as it is legal. Many of the undesirable behaviours associated with alcohol may be hidden, particularly domestic violence. The program would need to develop specific strategies to deal with this. From a management perspective, alcohol users present with more violent tendencies and I would be concerned as to how to best effect treatment whilst providing a safe working environment for staff.[582]

9.75 There was also support for extending the Drug Court program to include offenders with alcohol abuse problems, although witnesses who spoke to the Committee explained that different, alcohol-specific programs would need to be established.

9.76 While supportive of the principle of extending the Drug Court to include offenders with alcohol problems, Dr Weatherburn also noted potential difficulties, including the numbers of likely referrals:

> There are some specific issues that come up in the context of trying to deal with alcohol related crime by a Drug Court process. One of them is that there are vast numbers of people involved. A Drug Court which is at the moment barely adequate

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580 Judge Price, Chief Magistrate, Evidence, 26 November 2003, pp11-12

581 Ms Christine McInnes, Program Director, Lyndon Withdrawal Unit, Evidence, 25 March 2004, p43

582 Tabled Document No 19, Mr John Scantleton, *Proposed Questions*, p4

> to meet the existing demands it faces would have to be dramatically expanded if you were going to try and include people with alcohol related problems in that program.[583]

9.77 The frequent co-existence of violence and alcohol was another challenge identified by Dr Weatherburn:

> … it is easy to find people who are heroin addicted and who have committed non-violent property crimes; it is somewhat harder to find people who are addicted to alcohol who have not committed a violent offence. Well, if not politically fraught, at least there are bigger public safety issues associated with taking someone who has committed a violent offence and who might be otherwise suitable for gaol and placing them in a treatment program in the community.[584]

9.78 The Committee understands that some progress is being made in trialling the diversion of alcohol related offenders. In response to the Alcohol Summit's recommendations, the Government has commenced a trial of a new alcohol diversion scheme in the mid-West of the State at Orange and Bathurst Local Courts, and is also enabling the MERIT program at Broken Hill to target adult offenders with alcohol problems. These programs will be subject to an evaluation that will form the basis of decisions about whether to roll out the program more widely.[585]

9.79 The Committee heard that there are some concerns about the levels of resources available to the pilots. Mr Scantleton gave evidence that:

> The Committee might be aware that the MERIT funding was held up late last year and early this year and as a consequence of that a lot of the experienced staff in the mid west have actually left the program. So their skills base is probably not desirable to run a challenging program like that. I visited the mid-West area and, whilst they have an NGO out there that provides a detox facility and rehab, I think the area generally is a bit light on in terms of some of the other infrastructure to support the likes of an alcohol program like that. So I think one way or the other it is going to be quite challenging.
>
> They have also been requested to start the program in two courts, Orange and Bathurst, and both of those are fairly busy courts and there will be a lot of people referred to the program. I think it is going to be very challenging. It will be challenging in any area but I think it will be more challenging in that area because of unfortunate circumstances and the lack of infrastructure.[586]

9.80 The Committee strongly supports the trial to extend MERIT to alcohol and considers it has great potential to be implemented more widely in the future. Given the evidence about the sparse access to services and lack of resources, particularly in rural areas, we urge the Government to adequately fund alcohol and drug services to support these programs. Failure to do so would make success of the trials very unlikely.

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583 Dr Weatherburn, BOCSAR, Evidence, 18 February 2004, pp38-39

584 Dr Weatherburn, BOCSAR, Evidence, 18 February 2004, pp38-39

585 NSW Government, *Outcomes of the NSW Summit on Alcohol Abuse*, p224

586 Mr Scantleton, MERIT Northern Rivers, Evidence, 18 February 2004, p28

Recommendation 50

That the Committee support the planned trial extension of MERIT to alcohol in the mid-West and Broken Hill, and recommends that the Government ensure that the programs are adequately resourced.

9.81 In relation to the Drug Court the Government has indicated that it does not support the proposal to include alcohol related offences. The proposal was considered by the Drug Court Monitoring Committee (chaired by the Attorney General's Department) in September 2003, following the recommendations of the 2003 Alcohol Summit. It recommended against extending the role of the court for reasons that included:

- The category of offenders dealt with by the Court. Drug Court clients are non-violent illicit drug dependent offenders predominantly convicted of acquisitional crimes.
- Alcohol related offenders facing custodial sentences are typically persons who have committed violent offences including domestic violence or are repeat drink drivers.
- The need for quite different treatment responses. Clinicians have advised that offenders with serious alcohol problems require significantly different treatment interventions and should not generally be combined with illicit drug offenders.
- The existence of appropriate court based intervention programs for two identified groups of alcohol related offenders. Programs such as Alcohol Interlock Program, Sober Driver Program and the Traffic Offender Program are available for drink drivers. The Probation and Parole Service of the Department of Corrective Services also conducts anger management programs for violent offenders.
- The view that non-dependent alcohol related offenders may be better dealt with in pre-sentence programs such as MERIT.[587]

9.82 The Committee is not convinced that these are sufficient grounds for excluding alcohol related offenders from the Drug Court program, given the potential benefits to the community arising from the inclusion of alcohol. As witnesses noted, the relevant consideration is that substance dependence or abuse is contributing to the offending behaviour; the nature of the substance is irrelevant in principle. The need for linkages to treatment and improvements in psycho-social situation and health are as relevant for people with severe alcohol problems as they are for people with dependence on illicit drugs.

9.83 The fact that 'quite different treatment responses' are required for offenders with serious alcohol problems should not, in our opinion, rule out such offenders from accessing and benefiting from the programs; it merely indicates the need for different interventions to be offered in the programs. Presumably this occurred when the Youth Drug and Alcohol Court and the MERIT pilot project began allowing access for offenders with alcohol problems. The

[587] NSW Government, *Outcomes of the NSW Summit on Alcohol Abuse*, p226

existing court based intervention programs for some alcohol related offenders should not be a reason for excluding alcohol related offences from the Drug Court either. Rather, we believe the availability of such existing programs could be considered for utilisation by the Drug Court.

9.84 Given the ineligibility of violent offenders accessing the Drug Court, the violent nature of many alcohol related offences may well exclude many alcohol-affected offenders. The Committee does not suggest that the exclusionary rules relating to violence be altered. Rather, we propose that having alcohol as the primary drug problem should no longer, of itself, be a basis for exclusion.

9.85 The Committee therefore recommends that a pilot project be developed to trial the inclusion of alcohol related offenders in the Drug Court program as long as the offenders meet the other eligibility criteria. This will clearly require the provision of relevant alcohol-focused treatment programs. The pilot should be subject to a rigorous evaluation, which should form the basis for decision making about rolling out the program state-wide. In such circumstances, the Drug Court would appropriately be renamed the Drug and Alcohol Court.

Recommendation 51

That a pilot project be developed to trial the inclusion in the Drug Court program of alcohol related offenders who meet the other eligibility criteria. This should include the provision of relevant alcohol-focused interventions.

Extension to young offenders

9.86 The extension of diversionary treatment programs for juvenile offenders was also flagged during the hearings. In relation to MERIT, Mr Scantleton gave evidence that 'a lot of people would like to see MERIT for juveniles'.[588] He noted that some potential obstacles exist in the 'level of maturity' of many juveniles:

> If you were to run a MERIT style program for juveniles I think it would be very challenging for young people who have not got to the point where they realise they have got a drug problem. They are still in party mode; they have not reached that stage where they say, "Hell, my life has fallen apart". Until people get to that stage you are not going to get that level of insight and consequently you are not going to get the level of motivation to want to do something about it. I think it will eventually come, but when it comes I think it will be very challenging for the people who do it. A lot of the juveniles I have dealt with over the years are pretty fearless and rarely have insight into what some of their issues are.[589]

9.87 A number of diversionary programs have been developed for juvenile offenders in recent years. In the response to the Alcohol Summit, the Government noted that it had:

588 Mr Scantleton, MERIT Northern Rivers, Evidence, 18 February 2004, pp21-22

589 Mr Scantleton, MERIT Northern Rivers, Evidence, 18 February 2004, p23

> … established a continuum of diversion programs to deal with young offenders coming into contact with the criminal justice system. These programs provide a range of interventions and treatment responses depending on the seriousness of the offence and the treatment needs of the young offender.[590]
>
> Young offenders, who commit less serious offences, including alcohol related offences, may be diverted from the criminal justice system by police or the Children's Court under the Government's *Young Offenders Act 1997* through a scheme of police warnings, formal cautions and youth justice conferences.

9.88 The Committee notes that the Youth Drug Court already covers young offenders with problematic drug and alcohol related behaviour and dependency, and has been re-named the Youth Drug and Alcohol Court. The program targets both licit and illicit drug use, including the use of inhalants, binge drinking, and injecting drug use:

> More serious offenders with drug or alcohol related problems may be dealt with in the Youth Drug and Alcohol Court and be referred to judicially supervised treatment and other programs.[591]

9.89 Judge Price identified additional programs under consideration for juveniles:

> There is also scope to provide intensive court supervision, in relation to children in particular, which relevantly identifies high-risk, persistent offenders who abuse alcohol and require comprehensive long-term management. This program is under consideration at present, particularly with older juveniles. Their alcohol use is identified and they are effectively case managed by the judicial officer. They keep coming back before the judicial officer to see whether they are complying. It is not just a question of being put on a bond and being let go; they are case managed effectively and they are under the intensive supervision of the court.[592]

9.90 From the evidence before the Committee about programs underway or being considered, it does not appear necessary to make recommendations in relation to young offenders with drug and alcohol problems.

Domestic violence

9.91 Another issue raised during the Inquiry concerns alcohol related domestic violence, particularly in situations where assault charges are not laid. Chief Magistrate Judge Price proposed that apprehended domestic violence orders should be reformed to require offenders to be compelled to undertake an alcohol treatment program if alcohol is a significant component of their abusive behaviour:

> I refer to apprehended domestic violence orders. A large number of matters that come before the local courts are applications for apprehended domestic violence orders. Frequently they are alcohol related, as I referred to in my paper. The link between alcohol use and domestic violence is readily apparent. Last year we made 16,046 final domestic violence orders. One of my recommendations is that the court's

590 NSW Government, *Outcomes of the NSW Summit on Alcohol Abuse*, p226

591 NSW Government, *Outcomes of the NSW Summit on Alcohol Abuse*, p226

592 Judge Price, Chief Magistrate, Evidence, 26 November 2003, p15

> power to make apprehended domestic violence orders be extended to enable the court to make an order in appropriate cases where an offender undertakes a compulsory program to deal with his or her alcohol use.[593]

9.92 It is worth noting that domestic violence is caused by a range of factors, and would not simply disappear if alcohol were absent. This is a point strenuously made by the Wirringa Baiya Aboriginal Women's Legal Centre:

> One point I would like to make clear is that some people and government organisations think that alcohol and substance abuse cause domestic violence, sexual assault and child sexual assault. This is not true. Domestic violence, sexual assault and child sexual assault are premeditated and deliberate and the victims are most often women and children. This is distressing for services such as ours as we all know that alcohol is not the cause of the violence.[594]

9.93 Legislative amendment would be required to enable treatment orders of the kind proposed by Judge Price to be made as part of an apprehended domestic violence order:

> At present, apprehended domestic violence orders are preventive. You make an order that, for example, one person must not approach another, go near the home, or assault, molest or interfere in any way with the person who seeks the protection of the order. But nothing positive is being done at that early stage. The legislation does not permit a positive order to be made.
>
> I recommend that section 562AE of the *Crimes Act* be amended so that when an apprehended domestic violence order is made the court can order the offender to undertake a compulsory program to deal with the alcohol problem, which is the cause of the problem. Very good work is being done along the lines of intensive education, such as the sober driver program, which goes into the causes of alcohol use and the commission of the offence. That type of intensive education program could well be extended into the compulsory program that the court could make in relation to the apprehended domestic violence situation.[595]

9.94 Judge Price envisaged a treatment order to be appropriate wherever alcohol contributed to domestic violence, arguing that he did not think it unreasonable for a court to require a perpetrator of domestic violence to attend a rehabilitation program if there were evidence that alcohol was a significant cause of the need for the apprehended violence order. Failure to attend treatment would be considered an offence.[596]

9.95 The NSW Police considered that Judge Price's proposal could be feasible:

> Under the current legislation for apprehended violence orders, with some amendment to the law, it could be a condition of the order that the offender gets treatment. The

593 Judge Price, Chief Magistrate, Evidence, 26 November 2003, pp11-12

594 Submission 39, Wirringa Baiya Aboriginal Women's Legal Centre, pp1-2

595 Judge Price, Chief Magistrate, Evidence, 26 November 2003, pp11-12

596 Judge Price, Chief Magistrate, Evidence, 26 November 2003, pp14-15

> offender has not committed an offence at that stage. There has been a threat or the proposal that there may be a threat.[597]

9.96 However, it is also clear that there may be ethical concerns connected with compelling treatment for individuals who have not been convicted of any offences.

9.97 The Committee notes that the justice system already provides for some responses to domestic violence. Apprehended Violence Orders can be used to protect families and where assaults occur, charges can be laid. The current regime is set out in the Government's response to the Alcohol Summit:

> The Government strongly supports the current statutory regime under Part 15A of the *Crimes Act 1900* which establishes powers for the courts to give orders for the protection of victims of domestic violence, including alcohol related domestic violence … At present, the courts are empowered to make orders on the perpetrators of domestic violence which prohibit or restrict that person's actions. The courts may also issue a warrant for that person's arrest to protect the personal safety of the victim.[598]

9.98 However, it appears that there are no preventative or diversionary measures in place that deal with alcohol as a contributor to family violence. The Government has advised that new initiatives are under consideration, including Judge Price's proposal relating to Apprehended Violence Orders:

> The Attorney General has referred the issue of empowering the courts to order domestic violence defendants to undertake compulsory alcohol treatment to the Apprehended Violence Legal Issues Coordinating Committee. This Committee is chaired by the Criminal Law Review Division of the Attorney General's Department and includes the Chief Magistrate with representatives from NSW Police, Department of Community Services, Department of Corrective Services, Office of the Public Prosecutor, Judicial Commission of NSW, NSW Legal Aid Commission and community representatives. NSW Health will also be consulted with regard to the impact on local treatment services.
>
> This Committee will be asked to report by early 2005 on legislative proposals to amend the *Crimes Act 1900* to link drug and alcohol treatment with the way defendants may be dealt with under Part 15A of the *Crimes Act 1900* where drug and alcohol abuse is a factor.[599]

9.99 A proposal for an integrated Domestic Violence court is also being examined:

> The Government is developing proposals to trial a new integrated *Domestic Violence Court Intervention Model* in two locations, including one rural or regional location. This will benefit victims and families affected by domestic violence.
>
> In addition to better supporting the victims of domestic violence through the criminal justice process, the model is intended to enhance the police and court capacity to

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597 Assistant Commissioner Bob Waites, Commander, Greater Metropolitan Region and Corporate Spokesperson, Alcohol related Crime, Evidence, 27 November 2003, p29

598 NSW Government, *Outcomes of the NSW Summit on Alcohol Abuse*, p236

599 NSW Government, *Outcomes of the NSW Summit on Alcohol Abuse*, p236

> successfully prosecute perpetrators by improved policing and prosecution practices, increased collaboration between legal and welfare agency responses and development of specialist knowledge and expertise for magistrates and other stakeholders.
>
> The model is being developed by an interagency working group led by the Attorney General's Department's Violence Against Women Specialist Unit with representatives from Local Courts, NSW Police, Department of Corrective Services' Probation and Parole Service, Department of Community Services and the Women's Domestic Violence Court Assistance Program. The Attorney General will report to the Government in 2005 on final proposals for the trials.[600]

9.100 The Committee did not receive sufficient evidence about the proposals under consideration to enable us to undertake a detailed analysis. However, we consider it crucial that the link between alcohol and family violence be addressed as a matter of priority, and encourage the consideration of therapeutic justice programs that seek innovative responses to this problem. The Committee urges the Attorney General to consider, as a matter of priority, the reports relating to the Domestic Violence Court Intervention Model and the issue of Apprehended Violence Orders and alcohol treatment due in 2005 as identified above.

Recommendation 52

That, given the importance of addressing the link between alcohol and family violence, the Attorney General consider, as a matter of priority, interagency task force reports due in 2005 relating to the Domestic Violence Court Intervention Model and the issue of Apprehended Violence Orders and alcohol treatment.

Post-program support

9.101 A final matter worth briefly discussing is the provision of post-program support for people graduating from MERIT. All participants have a relapse prevention plan developed, which refers them to community-based services, however there is no formal ongoing support. Mr Scantleton gave evidence that this lack of post-program support has been identified as a problem by participants themselves:

> The participants are quite critical of the [MERIT] program in that when it ends it ends and they effectively have no more program support. Quite clearly there is a need for post-program, after care type support program.[601]

9.102 This was also an area for improvement identified by the evaluation of the Lismore MERIT Pilot Program. The evaluation noted that the nature of MERIT as a closely supervised and directive program meant that many participants could do well during the program, but might be unable to sustain their achievements on their own. The lack of community based treatment services was identified as contributing to the problem. The evaluation report noted that a few months after exiting the program, only 53% of participants were in treatment. [602]

600 NSW Government, *Outcomes of the NSW Summit on Alcohol Abuse*, p238

601 Mr Scantleton, MERIT Northern Rivers, Evidence, 18 February 2004, pp21-22

602 Tabled Document No 22, *Evaluation of the Lismore MERIT Pilot Program*, Final Report, October 2003, p101

9.103 Mr Scantleton proposed that more formal after-care support should be incorporated into the program for some at-risk participants:

> In some cases where there is a high risk of a person re-offending we might write in the report that at some future time this person might benefit from more formal support with a counselling role, and if the person is convicted the court might put them on a supervised bond as a result of those comments, but generally speaking it is quite well acknowledged in a lot of information that an after care program would be desirable.[603]

9.104 While not having definite views about the MERIT post-program support process, Dr Weatherburn noted generally that a lack of after-care could be problematic:

> I think it is desirable not simply, once a person has shown they are capable of doing without drugs or substantially reducing their drug consumption and certainly eliminating crime, to just wave goodbye at the door of the court as if there were no further risks at hand.[604]

9.105 The Committee notes that it has only received limited information about the need for post-program support for MERIT participants. However it seems logical that participants completing a short term, intensively supervised treatment program will need ongoing support. The Committee considers that the level of need for post-MERIT program support should be assessed and appropriate programs should to be developed to address this unmet need.

Recommendation 53

That the level of need for post-program support for MERIT graduates be assessed and appropriate programs be developed to address the unmet need.

Compulsory Drug Treatment Correctional Centre (CDTCC)

9.106 In early 2003, the Government announced a proposal to establish a compulsory drug treatment correctional centre. The legislation was passed through Parliament in June this year.[605] Regulations containing the details of the program have not yet been developed. According to the second reading speech, the Government anticipates that the CDTCC will be operational by the end of 2005.[606]

9.107 The Committee heard that the CDTCC is to be targeted at long term offenders with a history of recidivism and severe drug dependency, seeking to:

> … make a significant impact on their criminal behaviour and also provide them with an opportunity for longer-term rehabilitation and social reintegration.[607]

603 Mr Scantleton, MERIT Northern Rivers, Evidence, 18 February 2004, pp21-22

604 Dr Weatherburn, BOCSAR, Evidence, 18 February 2004, p42

605 *Compulsory Drug Treatment Correctional Centre Act 2004* No42 (NSW), assented to 6 July 2004

606 Graham West MP, Legislative Assembly New South Wales, *Hansard*, 23 June 2004, p9966

607 Mr Geoff Barnden, Director, Office of Drug Policy, The Cabinet Office, Evidence, 11 December 2003, p11

9.108 According to the second reading speech, the program:

> is aimed at breaking the drug-crime cycle. Eligible offenders to the program will be sent to a special correctional facility dedicated to abstinence-based treatment, rehabilitation and education. There will be intensive judicial case management of these offenders in close partnership with the correctional authorities as well as with health and other service providers. The Compulsory Drug Treatment Program will build on the productive justice and health system linkages already established for programs such as the Drug Court program. Offenders will be gradually reintegrated back into the community and targeted with support after the completion of their program and even beyond parole.
>
> The aim is to achieve better outcomes for the State's most desperate and entrenched criminal addicts, assisting them to become drug and crime free, to take personal responsibility and to achieve a more productive lifestyle.[608]

9.109 Offenders will be eligible for the program if they have been convicted and sentenced to imprisonment for an offence related to drug dependency following at least three other convictions for offences in the previous five years. The offender's sentence must be long enough to complete an 18-month to three-year drug treatment program. Offenders convicted of murder, manslaughter, sexual assault, firearms-related offences or commercial drug trafficking will not be eligible, nor will those with serious mental illnesses that could prevent or restrict the person's active participation in the program.[609]

9.110 The second reading speech also outlined the three stages of compulsory drug treatment detention:

> Stage one, closed detention, where inmates will be incarcerated in the Compulsory Drug Treatment Correctional Centre for intensive drug treatment and rehabilitation; stage two, semi-open detention, where offenders will live at the centre but spend time outside in employment, training or other approved programs; and stage three, community custody, which is similar to home detention. During this stage, the offender will move to semi-open independent living but remain under intensive supervision, including electronic monitoring.[610]

9.111 Personal treatment plans will be drawn up to form the basis of each offender's treatment and rehabilitation program. Social skills, preparation for the job market, management of debt and leisure time will also be taught to the inmates.[611]

9.112 At the time we were taking evidence, the final details of the Bill were not yet known. The few witnesses who commented on the proposed Compulsory Drug Treatment Correctional Centre therefore usually made only general comments, as indicated below.

9.113 Professor Carney gave evidence that he supported the proposal in principle:

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608 Graham West MP, Legislative Assembly New South Wales, *Hansard*, 23 June 2004, p9966

609 Graham West MP, Legislative Assembly New South Wales, *Hansard*, 23 June 2004, p9966

610 Graham West MP, Legislative Assembly New South Wales, *Hansard*, 23 June 2004, p9966

611 Graham West MP, Legislative Assembly New South Wales, *Hansard*, 23 June 2004, p9966

> Yes, there is certainly merit in offering services to people who suffer from an addiction and are going to be detained because of an offence that they have committed. There are clearly strong humanitarian, medical, ethical and many other arguments to be made in favour of basically offering rehabilitation opportunities within a person's period of incarceration.[612]

9.114 He noted some reservations, arguing that offenders should be entitled to choose whether they participate in the program,[613] a point also made by Professor Ian Webster, due to the absence of evidence that 'enforced treatment' is successful:

> … Enforced treatment does not have good evidence of success, and it is often based on fallacious notions of what can influence behaviour of a person dependent on substances.
>
> However, where the treatment offers a 'constrained choice' and does attempt to tailor 'treatment' to the needs and characteristics of the individual, accepts that objectives need to be medium to long-term and that a chain of follow-up and engagement are essential, it is possible that compulsory treatment of offenders will work.
>
> I accept the proposal being developed by the NSW Government, on the basis that it is fully informed of all the issues, is carefully and humanely planned and above all is subject to critical external scrutiny and evaluation.[614]

9.115 Professor Carney also stated the opinion that inmates' participation in the program should not extend beyond the duration of their criminal justice orders:

> I support any measure that offers any kind of treatment option *within* the duration of the deprivation of liberty that would otherwise have been imposed on the basis of the gravity of the offence that has triggered the person's presence within a correctional facility or under any correctional order. I have given the references to the superior case law in this country and overseas. That indicates that as a matter of common law principle it has always been the case that it is wrong to extend treatment beyond that period that would otherwise have been provided had the person been treated as an offender and sentenced in the ordinary way.[615]

9.116 The Redfern Legal Centre submission expressed concern with the emphasis on abstinence as the basis for treatment in the CDTCC:

> RLC notes with some concern the announcement by the Premier on 28 October 2003 to trial a Drug Prison in which repeat drug offenders would be locked up and undergo intensive treatment that will demand total abstinence, with not even substitutes like methadone generally available.
>
> The cruelty and pain potentially inflicted on a person by forcing them to go "cold turkey" raises human rights issues. There may also be serious questions about the

612 Professor Terry Carney, Professor of Law, University of Sydney, Evidence, 8 April 2004, pp29-30

613 Professor Carney, University of Sydney, Evidence, 8 April 2004, pp29-30

614 Submission 43, Professor Ian Webster, p7

615 Professor Carney, University of Sydney, Evidence, 8 April 2004, pp29-30

> effectiveness of such treatments in rehabilitating persons with substance dependence.[616]

9.117 Asked about whether offenders with alcohol problems would be eligible for the CDTCC, Mr Geoff Barnden, Director of the Office of Drug Policy at The Cabinet Office responded:

> I think we would take advice from our health colleagues. But I would say the treatment modalities and regimes would be very different and the issues would probably be very different. Although, of course, as we know, in all these areas there is a huge number of co-morbidity issues and the use of drugs right across the spectrum by people with these sorts of problems, and issues of dual diagnosis and multiple drug use are often interlinked. Whilst I am saying it is primarily focused on illicit drugs, many of these people, I imagine, also have alcohol related issues.[617]

9.118 The Committee notes that the *Compulsory Drug Treatment Correctional Centre Act* does not appear to encompass treatment of offenders with serious alcohol problems. This confirms the information in the Government submission, which states that the CDTCC will not cover offenders affected by alcohol.[618]

Committee comment on the proposed CDTCC

9.119 While noting our general support for the concept of a therapeutic correctional centre, we do not believe that we have received enough evidence to be able to discuss the proposed Compulsory Drug Treatment Correctional Centre at length.

9.120 Nevertheless, we do wish to comment on two particular aspects of the CDTCC. The first, as identified by the Redfern Legal Centre, is the suggestion that there will be a focus on abstinence-based therapy. We note, however, that we do not have details about the nature of the treatment likely to be provided at the CDTCC, nor the extent to which pharmacotherapies will or will not be used. There can be no doubt that abstinence is a legitimate objective for drug and alcohol interventions. However, this should not undermine the application of evidence-based treatment, including pharmacotherapies such as methadone, where this is indicated as the appropriate treatment option.

Recommendation 54

That the Government ensure that the full range of evidence-based interventions are available at the Compulsory Drug Treatment Correctional Centre.

9.121 The second point we wish to raise is the exclusion of alcohol related offenders from the CDTCC. As we previously noted in relation to the Drug Court, the significant community benefits to be achieved in the treatment of drug-dependent offenders are equally applicable to offenders with serious alcohol problems. The Committee can see no logical basis for distinguishing between alcohol and other drugs in determining the eligibility for admission to

616 Submission 18, Redfern Legal Centre, p9

617 Mr Barnden, The Cabinet Office, Evidence, 11 December 2003, p12

618 Submission 47, NSW Government, p16

the CDTCC. We acknowledge that the inclusion of alcohol related offenders would require additional programs and approaches at the CDTCC, but consider that the potential benefits to the individuals and the community warrant the additional expenditure this would entail. Such a program would not necessarily be required to be located at the same venue, and an alternative name could be considered.

Recommendation 55

That the Government reconsider the exclusion of offenders with serious alcohol problems from participation in the Compulsory Drug Treatment Correctional Centre.

Appendix 1 Submissions

No	Author
1	Judge Derek Price, Chief Magistrate, Local Court of New South Wales
2	Mr Owen Atkins, Coordinator, Homeless Persons Support Team, Narrabri District Community Aid Services Inc
3	Mr Jim Sheedy
4	Ms Toni Jackson
5	Mr Peter Cochran
6	Ms Susan Weisser, Director, Health Service Development, Greater Murray Area Health Service
7	Dr Keith Suter, Consultant, Social Policy, Wesley Mission, Sydney
8	Ms Gillian Calvert, Commissioner, NSW Commission for Children & Young People
9	Ms Jane Sanders, Solicitor and Ms Jane Irwin, Solicitor, The Shopfront Youth Legal Centre
10	Dr Andrew Byrne
11	Dr Martyn Patfield, Consultant Psychiatrist, Medical Superintendent and Director of Acute Services, Bloomfield Hospital
12	Mr Stepan Kerkyasharian AM, Chairperson, Community Relations Commission
13	Ms Louise Voigt, Chief Executive Officer & Director of Welfare, Barnardos
14	Ms Maria Bisogni, Deputy President, Mental Health Review Tribunal
15	Names suppressed
16	Mr Terry Clout, Chairperson, Human Services Sub-Committee, North Coast Regional Coordination Management Group
17	Submission withdrawn
18	Ms Helen Campbell, Director, Redfern Legal Centre
19	Mr Tim O'Neill, Duty Officer, Wagga Wagga Command, NSW Police Service
20	Sister Barbara Webber, Society of St Vincent de Paul, Micah House, Wagga Wagga (partially confidential)
21	Ms Silvia Alberti, Manager, Forensic Services, Turning Point Alcohol & Drug Centre
22	Ms Manda Bishop, Manager, Alcohol & Drug Information Service, St Vincents Hospital
23	Mr Gary Moore, Director, Council of Social Service of New South Wales
24	Ms Annabel Senior, Operations Manager, Community Services, Regional & Rural Service, Mission Australia
25	Mr Barry Johnson, State Manager, Aboriginal and Torres Strait Islander Services NSW State Office

26	Dr Liz Gale, Chief Executive Officer, Illawarra Area Health Service
27	Mr Daniel Harvey, Policy Officer, Victorian Department of Human Services
28	Dr Elizabeth Dodd
29	Mr Larry Pierce, Executive Director, Network of Alcohol and Other Drugs Agencies
30	Dr Ingrid van Beek, Director, Kirketon Road Centre
31	Mrs B A Cardwell, State President, Woman's Christian Temperance Union of New South Wales Inc
32	Mr Eddie Billett
33	Associate Professor Steven Boyages, Chief Executive Officer, Western Sydney Area Health Service
34	Dr Mark Doverty, Director, Aboriginal Health and Alcohol & Drug Services, Southern Area Health Service
35	Dr Nick O'Connor, Director, Northern Sydney Area Mental Health
36	Mr Robert Benjamin, President, The Law Society of New South Wales
37	Father John Usher, Director, Centacare, Catholic Community Services Sydney
38	Ms Jaye Newland
39	Ms Trisha Frail-Gibbs, Coordinator, Wirringa Baiya Aboriginal Women's Legal Centre
40	Mr Greg Chilvers, Director, Research and Resource Centre, Police Association of New South Wales
41	Reverend Harry Herbert, Executive Director, Uniting Care NSW ACT
42	Ms Jenna Bateman, Executive Officer, Mental Health Co-ordinating Council
43	Emeritus Professor Ian Webster AO, Chair, NSW Expert Advisory Committee on Drugs; Chair, Alcohol Education and Rehabilitation Foundation; Visiting physician, Matthew Talbot Hostel; Physician in drug and alcohol, Liverpool Hospital
44	Mr Nick O'Neill, President, Guardianship Tribunal
45	Mr Kevin Rozzoli, Chairperson, Haymarket Foundation Inc.
46	Mr Steve O'Connor, Deputy Chief Executive Officer Legal, Legal Aid New South Wales
47	NSW Government (submitted by Hon John Della Bosca MLC, Special Minister of State and Hon Bob Debus MP, Attorney General)
48	Ms Clover Moore MP, Member for Bligh
49	Mr Graeme Smith, Acting Director, Office of the Public Guardian
50	Dr Mark Montebello, Addictions Psychiatrist and Chair, NSW Section of Addiction Psychiatry
51	Mr W Grant, Acting Commissioner, Health Care Complaints Commission
52	Dr Keith Suter, Chair Alcohol Awareness Week Network, Wesley Mission
53	Ms Didi Killen, Area Director, Alcohol and Other Drug Services, Mid Western Area Health Service

Appendix 2 Witnesses

Date and Location	Name	Position and Organisation
26 November 2003 Parliament House, Sydney	**Judge Derek Price**	Chief Magistrate, Local Court of New South Wales
27 November 2003 Parliament House, Sydney	**Mr John Williams**	Senior Policy Officer, Aboriginal Health and Medical Research Council
	Ms Leonie Jefferson	Senior Aboriginal Drug and Alcohol Counsellor, Northern Rivers Area Health Service
	Assistant Commissioner Bob Waites	Commander, Greater Metropolitan Region and Corporate Spokesperson, Alcohol related Crime, NSW Police
	Superintendent Frank Hansen	Manager, Drug and Alcohol Coordination, State Crime Command, NSW Police
	Dr Victor Storm	Clinical Director, Central Sydney Area Mental Health Service
	Dr Peter Tucker	Medical Superintendent, Cumberland Hospital and Director, Clinical Services (East), Western Sydney Area Mental Health Service
	Dr Joanne Ferguson	Staff Specialist Psychiatrist, Drug Health Services, Rozelle & Concord Hospitals
	Mr Larry Pierce	Executive Director, Network of Alcohol and Other Drugs Agencies
11 December 2003 Parliament House, Sydney	**Mr John Feneley**	Assistant Director General, Policy and Crime Prevention, Attorney General's Department
	Mr Geoff Barnden	Director, Office of Drug Policy, The Cabinet Office
	Dr Richard Matthews	Acting Deputy Director General, Strategic Development, NSW Health
18 February 2004 Parliament House, Sydney	**Emeritus Professor Ian Webster AO**	Chair, NSW Expert Advisory Committee on Drugs; Chair, Alcohol Education and Rehabilitation Foundation; Visiting Physician, Matthew Talbot Hostel; Physician in Drug and Alcohol, Liverpool Hospital

Date and Location	Name	Position and Organisation
18 February 2004 Parliament House, Sydney	**Mr John Scantleton**	Manager of the MERIT (Magistrates Early Referral into Treatment) Program, Northern Rivers Area Health Service
	Dr Don Weatherburn	Director, NSW Bureau of Crime Statistics and Research
	Professor Arie Freiberg	Criminologist and Dean of Law, Monash University
4 March 2004 Royal North Shore Hospital	**Ms Tonina Harvey**	Area Director, Drug and Alcohol Services, Northern Sydney Health
	Dr Stephen Jurd	Area Medical Director and Addictions Psychiatrist, Drug and Alcohol Services, Northern Sydney Health
	Ms Diane Paul	Manager, Detoxification Unit, Herbert Street Clinic
	Mr Owen Brannigan	Manager, Phoenix Unit Residential Rehabilitation Program
Macquarie Hospital, Ryde	**Dr Glenys Dore**	Addictions Psychiatrist and Deputy Medical Superintendent
	Reverend Rennie Schmid	Uniting Church Chaplain
24 March 2004 Aboriginal Health Offices, Moree	**Ms Vi Hunt**	Area Coordinator, Alcohol and Other Drug Services, New England Area Health Service
	Dr Ian Kamerman	General Practitioner and NSW Director, Australian College of Rural and Remote Medicine
	Ms Beth Burton	Clinical Nurse Consultant, Alcohol and Other Drug Services, Tamworth
	Ms Louise Peckham	Aboriginal Health Education Officer, Alcohol and Other Drug Services, New England Area Health Service
	Ms Toni Colby	MERIT (Magistrates Early Referral into Treatment) Caseworker, Alcohol and Other Drugs Service, Tamworth
25 March 2004 Bloomfield Hospital, Orange	**Dr Martyn Patfield**	Consultant Psychiatrist, Medical Superintendent and Director of Acute Services, Bloomfield Hospital
	Associate Professor Paul Fanning	Area Director, Mid Western Area Mental Health Service

Date and Location	Name	Position and Organisation
	Dr John Hoskin	Former Medical Superintendent, Bloomfield Hospital
25 March 2004 Bloomfield Hospital, Orange	**In Camera Evidence**	In camera evidence was heard from two witnesses
	Ms Didi Killen	Coordinator, Alcohol and Other Drugs Program, Mid Western Area Health Service
	Ms Kim Lewis	Alcohol and Other Drugs Project Worker, Mid Western Area Health Service
	Ms Chris McInnes	Program Director, Lyndon Withdrawal Unit
7 April 2004 Parliament House, Sydney	**Dr Ingrid van Beek**	Director, Kirketon Road Centre
	Dr Hester Wilce	Medical Practitioner, Kirketon Road Centre
	Ms Andrea Taylor	Past Deputy Director, Ryde Community Mental Health Service; Present Manager Quality and Risk Management, Royal North Shore and Ryde Health Services
	Mr Graeme Smith	Director, Office of the Public Guardian
	Ms Frances Rush	Regional Manager, Office of the Public Guardian
	Mr George Klein	Behavioural Scientist, Centre for Drug and Alcohol Medicine, Nepean Hospital
8 April 2004 Parliament House, Sydney	**Professor Richard Mattick**	Director, National Drug and Alcohol Research Centre, University of New South Wales
	Professor Terry Carney	Professor of Law, University of Sydney
28 April 2004 Parliament House, Melbourne	**Ms Sylvia Alberti**	Manager, Forensic and Clinical Services and Senior Research Fellow, Turning Point Alcohol and Drug Centre
	Ms Amy Swan	Research Fellow, Turning Point Alcohol and Drug Centre
	Ms Janet Farrow	Executive Director, Uniting Care Moreland Hall
	Ms Donna Ribton-Turner	Manager, Withdrawal Services, Uniting Care Moreland Hall
29 April 2004 Parliament House, Sydney	**Professor Wayne Hall**	Professorial Fellow and Director, Office of Public Policy and Ethics,

Date and Location	Name	Position and Organisation
		Institute for Molecular Bioscience, University of Queensland
29 April 2004 Parliament House, Sydney	**Ms Michelle Noort**	Director, Centre for Drug and Alcohol, NSW Health
	Mr David McGrath	Acting Deputy Director, Centre for Drug an Alcohol, NSW Health
	Professor Duncan Chappell	President, Mental Health Review Tribunal

Appendix 3 Site visits and public consultations

Date	Location
11 December 2003	Matthew Talbot Hostel, Woolloomooloo
11 December 2003	Albion Street Lodge, Surry Hills
11 December 2003	William Booth House, Surry Hills
19 February 2004	NSW Drug Court, Parramatta
4 March 2004	The Herbert Street Clinic, Royal North Shore Hospital
4 March 2004	Macquarie Hospital, Ryde
24 March 2004	Aboriginal Health Offices, Moree
25 March 2004	Bloomfield Hospital, Orange

Public consultation at Moree 24 March 2004

Date	Name	Organisation
24 March 2004 Aboriginal Health Offices, Moree	Bill Toomey	Aboriginal Health
	Bruce Boney	Aboriginal Health
	Janice Cutmore	Aboriginal Health
	Leona Quinnell	Aboriginal Health
	Val Dahlstrom	Aboriginal Health
	Richard Swan	Aboriginal Health (D&A Worker)
	Therese Stacey	Aboriginal Health Moree
	Dianne Tighe	Aboriginal Liaison Officer
	Faulkner Munroe	Byamee Homeless Persons
	Lloyd Duncan	Byamee Homeless Persons
	William Agrobe	Byamee Homeless Persons
	Robert Draper	Community Member
	Bill Grose	Community Member
	Jillian Knox	Moree Local Aboriginal Land Council
	David Roberts	NSW Police
	Dennis McLaughlan	NSW Police
	Jane Adams	NSW Police, Inverell
	Donna Taylor	Pius X Aboriginal Corporation

Appendix 4 Applications under the *Inebriates Act*

Table 1: Applications under the *Inebriates Act*, 2001

Court	Sex of person for whom order sought	Sex of applicant	Date of Application	Date and result
Cessnock	Female	Police	27 Nov 01	27 Nov 01: Recognizance for 12 months
Hornsby	Male	Male	20 Jul 01	20 Jul 01: Committed to Macquarie Hospital for not less than 6 months and not more than 12 months
Downing Centre	Female	Female	15 Oct 01	22 Mar 02: Defendant to undertake counselling at the Langton Centre
Manly	Male	Female	12 Apr 01	12 Apr 01: Order for 3 months at Macquarie Hospital
Manly	Male	Police	27 Jul 01	27 Jul 01: Order for 3 months at Macquarie Hospital
Manly	Male	Police	9 Nov 01	9 Nov 01: Order for 3 months at Macquarie Hospital
Moss Vale	Female	Male	19 Jun 01	19 Jun 01: Order to be placed in care at Corella Lodge, Prairiewood for a period not exceeding 28 days
Taree	Male	Male	26 Nov 01	26 Nov 01: Withdrawn
Tweed Heads	Female	Male	2 May 01	2 May 01: Order for 3 months at John Fletcher Hospital, Newcastle
TOTAL 9 APPLICATIONS				

Source: Tabled Document No 2, Judge Derek Price, Chief Magistrate, Local Court of New South Wales, Memo and accompanying information on orders made by the Local Court under the *Inebriates Act 1912*

Table 2: Applications under the *Inebriates Act*, 2002

Court	Sex of person for whom order sought	Sex of applicant	Date of Application	Date and result
Balmain	Female	Male	26 Jun 02	1 Jul 02: Order for 6 months at Rozelle Hospital. Relisted 10 Jul 02 to rescind order; application to rescind refused. 28 Aug 02: Further application to rescind granted, defendant released on bond for 12 months.
Burwood	Female	Male	18 Nov 02	18 Nov 02: Adjourned from Balmain. Bond allowed for entry into Salvation Army Bridge Program
Burwood	Male	Police	26 Mar 02	25 Mar 02: Order for 3 months at Cumberland Hospital
Dubbo	Male	Police	30 May 02	30 May 03: Order for 4 weeks at Bloomfield Hospital
Dubbo	Male	Police	8 Jul 02	8 Jul 02: Order for 6 weeks at Bloomfield Hospital
Dubbo	Male	Police	11 Oct 02	11 Oct 02: Order for 6 weeks at Bloomfield Hospital
Hornsby	Male	Male	19 Jul 02	9 Aug 02: Defendant to be remanded into custody to enable medical practitioner to examine and assess if an inebriate. Warrant to bring into custody issued.
Kempsey	Female	Female	7 Aug 02	20 Aug 02: Order made. 21 Aug 02: annulment application lodged. 24 Sep 02 application refused.
Kempsey	Male	Male	5 Nov 02	5 Nov 02: Order made for detainment for 4 weeks
Downing Centre	Male	Male	22 Jan 02	11 Mar 03: Withdrawn
Manly	Male	Female	21 Mar 02	28 Mar 02: Order made
Manly	Male	Male (self)	20 Aug 02	20 Aug 02: Order for 8 weeks at Rozelle Hospital

Parramatta	Male	Police	27 May 02	27 May 02: Defendant to attend Centre for Addictive Medicine at Westmead for assessment, with Centre to provide report. 28 Jun 02: Defendant to Cumberland Hospital for 7 months
Parramatta	Male	Female	9 Aug 02	9 Aug 02: Order to Cumberland Hospital for period not exceeding 3 months. Relisted 19 Aug 02: Recognizance for 12 months
Parramatta	Male	Female	20 Dec 02	20 Dec 02: Ordered to remain in care and control of applicant for 28 days
Raymond Terrace	Female	Female	12 Aug 02	26 Aug 02: Withdrawn as case being dealt with by Guardianship Tribunal
Raymond Terrace	Male	Female	5 Sep 02	5 Sep 02: Withdrawn
TOTAL 17 APPLICATIONS				

Source: Tabled Document No 2

Table 3: Applications under the *Inebriates Act*, January to November 2003

Court	Sex of person for whom order sought	Sex of applicant	Date of Application	Date and result
Bathurst	Male	Police	26 Jun 03	26 Jun 03: No order made
Coffs Harbour	Female	Police	5 Sep 03	5 Sep 03: Order for 1 month. 17 Oct 03 order discharged (ie completed)
Dubbo	Female	Police	10 Jan 03	23 Jan 03: Application not served; did not proceed to court
Dubbo	Female	Police	27 Jun 03	27 Jun 03: Order for 6 weeks at Bloomfield Hospital
Hornsby	Male	Police	3 Jun 03	13 Jun 03: Order for 3 months at Macquarie Hospital. Relisted 25 Aug 03: application to rescind granted
Manly	Male	Female	18 Feb 03	18 Feb 03: Order made as per application. Appeal lodged 30 Jun 03. Appeal dismissed.
Newcastle	Female	Police	16 Oct 03	16 Oct 03: Adjourned back to Coffs Harbour
Parramatta	Female	Male	7 Feb 03	7 Feb 03: Interim order made, with applicant to have care and control. 19 Feb 03 withdrawn
Ryde	Female	Male	28 Aug 03	28 Aug 03: Order for 3 months at Macquarie Hospital
Wagga Wagga	Female	Police	16 May 03	16 May 03: Order made and then later rescinded
Waverley	Female	Female	17 Jul 03	17 Jul 03: Order for 3 months at Rozelle Hospital
TOTAL 11 APPLICATIONS				

Source: Tabled Document No 2

Table 4: Admissions to Bloomfield Hospital under the *Inebriates Act,* 1994 to March 2004

Year	Inebriates admissions	Male	Female	Aboriginal	Total admissions
1994	20	19	1	9	610
1995	14	10	4	4	610
1996	13	11	2	4	655
1997	23	18	5	16	727
1998	9	5	4	2	806
1999	6	3	3	0	803
2000	13	12	1	2	937
2001	7	6	1	1	983
2002	13	13	0	2	1001
2003	4	2	2	2	1095
2004	3	1	1	1	249 (to end of Feb 04)
	125	**100**	**24**	**43**	**8476**

Source: Tabled Document No 22, Dr Martyn Patfield, Consultant Psychiatrist, Medical Superintendent and Director of Acute Services, Bloomfield Hospital, 'Inebriates breakdown of statistics'

Appendix 5 Minutes

Standing Committee on Social Issues

Meeting 9, 12 November, Room 1108, 1.15 pm.

1. **Members present**

   Jan Burnswoods MLC (Chair)
   The Hon Robyn Parker MLC (Deputy Chair)
   The Hon Catherine Cusack MLC
   The Hon Dr Arthur Chesterfield-Evans MLC
   The Hon Ian West MLC
   The Hon Kayee Griffin MLC

2. **…**

3. **…**

4. **…**

5. **Inquiry into the *Inebriates Act 1912***

   The Committee discussed the direction of the inquiry.

6. **Adjournment**

   The Committee adjourned at 2.30 pm, *sine die*.

   Tanya Bosch
   Director

Meeting 12, 26 November 2003, Waratah Room, 2.00 pm.

1. **Members present**

   Jan Burnswoods MLC (Chair)
   The Hon Robyn Parker (Deputy Chair)
   The Hon Dr Arthur Chesterfield-Evans MLC
   The Hon Ian West MLC

2. **Apologies**
   The Hon Catherine Cusack MLC
   The Hon Kayee Griffin MLC

3. **Inquiry into the *Inebriates Act 1912*, public hearing**

   The public and the media were admitted.

   His Honour, Judge Derek Price, Chief Magistrate of the Local Court of New South Wales, sworn and examined.

The witness tendered a folder of documents in support of his evidence.

Resolved, on the motion of Mr West, that the Committee accept the documents.

Questioning concluded and the witness and the public withdrew.

4. Adjournment

The Committee adjourned at 3.40 pm until 9.30am, 27 November 2003.

Tanya Bosch
Director

Meeting 13, 27 November 2003, Jubilee Room, 9.30 am.

1. Members present

Jan Burnswoods MLC (Chair)
The Hon Robyn Parker (Deputy Chair)
The Hon Dr Arthur Chesterfield-Evans MLC
The Hon Catherine Cusack MLC
The Hon Kayee Griffin MLC
The Hon Ian West MLC

2. Inquiry into the *Inebriates Act 1912*, public hearing

The public and media were admitted.

Mr John Williams, Senior Policy Officer, Aboriginal Health and Medical Research Council, and Ms Leonie Jefferson, Senior Aboriginal Drug and Alcohol Counsellor, Northern Rivers Area Health Service, affirmed and examined.

Ms Jefferson tendered a document of case studies and a submission from the North Coast Regional Co-ordination Management Group, in support of her evidence.

Mr Williams tendered a document containing his answers to proposed questions.

Resolved, on the motion of Mr West, that the Committee accept the documents.

Questioning concluded and the witnesses withdrew.

Assistant Commissioner Bob Waites, Commander, Greater Metropolitan Region and Corporate Spokesperson, Alcohol related Crime, NSW Police, and Superintendent Frank Hansen, Manager, Drug and Alcohol Coordination, State Crime Command, NSW Police, sworn and examined.

Questioning concluded and the witnesses withdrew.

The Committee adjourned at 12.20 pm and resumed at 1:45 pm.

Dr Peter Tucker, Psychiatrist and Clinical Director of Mental Health Services, Western Sydney Area Health Service, Dr Victor Storm, Psychiatrist and Clinical Director of Mental Health Services, Central

Sydney Area Health Service, and Dr Joanne Ferguson, Psychiatrist, Drug Health Services, Central Sydney Area Health Service, affirmed and examined.

Questioning concluded and the witnesses withdrew.

Mr Larry Pierce, Executive Director, Network of Alcohol and Other Drugs Agencies, affirmed and examined.

Questioning concluded and the witness and the public withdrew.

3. Adjournment

The Committee adjourned at 4.20 pm until 9.30am, 11 December 2003.

Tanya Bosch
Director

Meeting 14, 11 December 2003, Jubilee Room, 9.35 am.

1. Members present

Jan Burnswoods MLC (Chair)
The Hon Robyn Parker (Deputy Chair)
The Hon Catherine Cusack MLC
The Hon Kayee Griffin MLC
The Hon Ian West MLC

2. Apologies

The Hon Dr Arthur Chesterfield-Evans MLC

3. Inquiry into the *Inebriates Act 1912*, public hearing

The public and media were admitted.

Mr John Feneley, Assistant Director General, Policy and Crime Prevention, Attorney General's Department, and Mr Geoff Barnden, Director of Drug and Alcohol Policy, the Cabinet Office, sworn and examined.

Mr Barnden tendered a document, 'A brief guide to evaluation for NSW drug summit programs', in support of his evidence.

Mr Feneley tendered the documents, 'Judicial Officers' Bulletin', June 2003, 'NSW MERIT Program', and 'New South Wales Drug Court Evaluation: Cost Effectiveness' in support of his evidence.

Resolved, on the motion of Mr West, that the Committee accept the documents.

Questioning concluded and the witnesses withdrew.

Dr Richard Matthews, Acting Deputy Director General, Strategic Development, NSW Health, sworn and examined.

Questioning concluded and the witness and the public withdrew.

Resolved, on the motion of Ms Parker, that in order to better inform all those who are participating in the inquiry process, the Committee make use of its powers granted under paragraph 16 of the resolution establishing the Standing Committees, and section 4(2) of the Parliamentary Papers (Supplementary Provisions) Act 1975, to publish submissions 1 to 47, excluding submissions 15, 17 and 20.

Resolved, on the motion of Ms Parker, to publish submissions 15 and 20 whilst suppressing the names in them.

4. Inquiry into the *Inebriates Act 1912*, site visit to Matthew Talbot Hostel

The Committee was briefed by Mr Bernard Cronin, Executive Manager, and Ms Sue Bowen, Ms Megan Groves and Mr Brett Macklin, staff of the Matthew Talbot Hostel.

The Committee left Wooloomooloo to travel to Surry Hills.

5. Inquiry into the *Inebriates Act 1912*, site visit to Albion Street Lodge

The Committee was briefed by Ms Janice Jones, Chief Executive Officer of the Haymarket Foundation and Ms June Lewis, Director of the Albion Street Lodge.

6. Inquiry into the *Inebriates Act 1912*, site visit to William Booth House

The Committee was briefed by Major Colin Lingard, Manager, Mr Mike Bartley, Drug and Alcohol Worker, and Garry, a client of William Booth House.

7. Adjournment

The Committee returned to Parliament House at 5.00 pm and adjourned sine die.

Tanya Bosch
Director

Meeting 15, 18 February 2004, Jubilee Room, 9.35 am.

1. Members present

The Hon Robyn Parker MLC (Acting Chair)
The Hon Catherine Cusack MLC
The Hon Kayee Griffin MLC
The Hon Ian West MLC
The Hon Dr Arthur Chesterfield-Evans MLC

2. Apologies

Ms Jan Burnswoods MLC

3. …

4. Inquiry into the *Inebriates Act 1912*, deliberative

Resolved, on the motion of Mr West, that in order to better inform all those who are participating in the inquiry process, the Committee make use of its powers granted under paragraph 16 of the resolution establishing the Standing Committees, and section 4(2) of the Parliamentary Papers (Supplementary Provisions) Act 1975, to publish submissions 48 to 52.

5. Inquiry into the *Inebriates Act 1912*, public hearing

The public and media were admitted.

Emeritus Professor Ian Webster AO, Medical Practitioner, affirmed and examined.

Questioning concluded and the witness withdrew.

Mr John Scantleton, Manager, Magistrates Early Referral Into Treatment (MERIT) Program, Northern Rivers Area Health Service, affirmed and examined.

Mr Scantleton tendered the PowerPoint slides for his presentation, 'MERIT: Magistrates Early Referral Into Treatment' and the documents, 'Evaluation of the Lismore MERIT Pilot Program: Final Report, Department of Rural Health, Northern Rivers University, October 2003', 'Program Activity Summary for Statistics from Program, NRAHS MERIT, 01 Jul 2000 to 31 Jan 2004', and written answers to his proposed questions, in support of his evidence.

Resolved, on the motion of Ms Griffin, that the Committee accept the documents.

Questioning concluded and the witness withdrew.

The Committee adjourned at 12.40 pm and resumed at 2:10 pm.

Dr Don Weatherburn, Director, NSW Bureau of Crime Statistics and Research, affirmed and examined.

Dr Weatherburn tabled the PowerPoint slides for his presentation in support of his evidence.

Resolved, on the motion of Ms Griffin, that the Committee accept the document.

Questioning concluded and the witness withdrew.

Professor Arie Freiberg, Dean of the Faculty of Law, Monash University, affirmed and examined.

Professor Freiberg tendered the documents, 'Problem-Oriented Courts, Innovative Solutions to Intractable Problems?, Journal of Judicial Administration', 'Between Bail and Sentence: The Conflation of Dispositional Options', 'Drug Courts in Australia: The First Generation', 'The Compulsion of Voluntary Treatment in Sentencing', 'Therapeutic Jurisprudence in Australia: Paradigm Shift or Pragmatic Incrementalism?', 'Human Services (Complex Needs) Act 2003', 'Responding to people with multiple and complex needs: Phase one report, Department of Human Services, July 2003', 'Sentencing Pathways' and 'Drug Related Sentencing Hierarchy', in support of his evidence.

Resolved, on the motion of Ms Griffin, that the Committee accept the documents.

Questioning concluded and the witness and the public withdrew.

6. Adjournment

The Committee adjourned at 4.40 pm until 10.15 am, 19 February 2004.

Julie Langsworth
Director

Meeting 16, 19 February 2004, 10:15 am.

1. **Members present**

The Hon Robyn Parker MLC (Acting Chair)
The Hon Dr Arthur Chesterfield-Evans MLC
The Hon Catherine Cusack MLC
The Hon Kayee Griffin MLC
The Hon Ian West MLC

2. **Apologies**

Ms Jan Burnswoods MLC

3. **Inquiry into the *Inebriates Act 1912*, site visit to the Drug Court of New South Wales, Parramatta**

The Committee was briefed by Senior Judge Neil Milson and observed the Drug Court in session, presided by Judge Ian Barnett.

4. **Adjournment**

The Committee returned to Parliament House at 12:45 pm and adjourned sine die.

Julie Langsworth
Director

Meeting 17, 26 February 2004, Room 812, Parliament House, 10:35 am

1. **Members present**

Jan Burnswoods (Chair)
The Hon Robyn Parker (Deputy Chair)
The Hon Dr Arthur Chesterfield-Evans MLC
The Hon Catherine Cusack MLC
The Hon Kayee Griffin MLC
The Hon Ian West MLC

2. **…**

3. **…**

4. **Inquiry into the *Inebriates Act 1912*, deliberative**

The Chair noted her appreciation for the Hon Robyn Parker MLC acting as Chair for the Committee hearings on 18 and 19 February 2004 during Ms Burnswood's absence.

The Secretariat briefed the Committee on the regional trip on the 24 and 25 March 2004 and future hearings.

5. Adjournment

The Committee adjourned at 11.00 am.

Julie Langsworth
Acting Director

Meeting 19, 4 March 2004, The Herbert Street Clinic, Royal North Shore Hospital, 10.00am

1. Members present

Jan Burnswoods (Chair)
The Hon Robyn Parker (Deputy Chair)
The Hon Dr Arthur Chesterfield-Evans MLC
The Hon Ian West MLC

2. Apologies

The Hon Catherine Cusack MLC
The Hon Kayee Griffin MLC

3. Inquiry into the *Inebriates Act 1912*, site visit and hearing at the Herbert Street Clinic, Royal North Shore Hospital

The Committee undertook a tour of the Herbert Street Clinic, an alcohol and other drug service, led by Dr Stephen Jurd, Addictions Psychiatrist and Area Medical Director, Drug and Alcohol Services, Northern Sydney Area Health Service.

Dr Stephen Jurd, Ms Tonina Harvey, Ms Diane Paul and Mr Owen Brannigan, sworn and examined.

Dr Jurd tendered the document, 'ANSWERS', in support of his evidence.

Resolved, on the motion of Mr West, that the Committee accept the document.

Questioning concluded and the witnesses withdrew.

The Committee left the Herbert Street Clinic to travel to Macquarie Hospital.

4. Inquiry into the *Inebriates Act 1912*, site visit and hearing at Macquarie Hospital

The Committee undertook a tour of Macquarie Hospital, a psychiatric hospital to which people under an inebriates order may be sent, led by Dr Glenys Dore, Addictions Psychiatrist and Deputy Superintendent, Macquarie Hospital.

Dr Glenys Dore, affirmed and examined.

Reverend Rennie Schmid, Mental Health Chaplain, Macquarie Hospital, sworn and affirmed.

Questioning concluded and the witness withdrew.

5. Adjournment

The Committee adjourned at 5.00 pm sine die.

Merrin Thompson
Senior Project Officer

Meeting 21, 24 March 2004, Site visit to Moree

The Committee met at 8.30am at Bankstown for the flight to Moree.

1. Members present

Jan Burnswoods (Chair)
The Hon Dr Arthur Chesterfield-Evans MLC
The Hon Ian West MLC
The Hon Kayee Griffin MLC
The Hon Greg Pearce MLC

2. Apologies

The Hon Robyn Parker MLC

3. Hearing - Inquiry into the *Inebriates Act 1912*

The Chair opened the meeting at 11.00am, held at the Aboriginal Health Offices, Moree.

Ms Louise Peckham, Aboriginal Health Education Officer, Alcohol and Other Drug Services, Community Health Centre, Moree, sworn and examined.

Mr Ian Kamerman, General Practitioner, Bingara, Visiting Medical Officer in Addiction Medicine, New England Area Health Service, New South Wales Director of the Australian College of Rural and Remote Medicine, affirmed and examined.

Ms Beth Burton, Clinical Nurse Consultant, Alcohol and Other Drug Services, New England Area Health Service, Tamworth, affirmed and examined.

Ms Toni Colby, MERIT Caseworker, Alcohol and Other Drug Services, New England Area Health Service, Tamworth, affirmed and examined.

Ms Vi Hunt, Area Coordinator and Registered Nurse, Alcohol and Other Drug Service, New England Area Health Service, affirmed and examined.

Questioning concluded and witnesses withdrew.

4. Adjournment

The Committee adjourned at 12.45pm for an informal lunch with hearing participants and community representatives, and reconvened at 1.45pm.

5. Public consultation – Inquiry into the *Inebriates Act 1912*

The Committee met with Ms Val Dahlstrom, Area Manager, Aboriginal Health, New England Area Health Service, and the following community representatives: Mr Faulkner Munroe, Byamee Homeless Persons; Mr Richard Swan, Aboriginal Health; Ms Jane Adams, NSW Police, Inverell; Ms Leona Quinnell, Aboriginal Health; Ms Dianne Tighe, Aboriginal Liaison Officer; Mr Dennis McLaughlan, NSW Police; Mr David Roberts, NSW Police; Mr Bill Grose, community member; Ms Therese Stacey, Aboriginal Health, Moree; Mr Lloyd Duncan, Byamee Homeless Persons; Mr Bill Toomey, Aboriginal Health; Mr Bruce Boney, Aboriginal Health; Ms Janice Cutmore, Aboriginal Health; Mr William Agrobe, Byamee Homeless Persons; Mr Robert Draper, community member; Ms Jillian Knox, Moree Local Aboriginal Land Council; Ms Donna Taylor, Pius Aboriginal Corporation.

6. Adjournment

The Committee adjourned at 4.10pm.

Julie Langsworth
Acting Director

Meeting 22, 25 March 2004, Site visit to Orange

The Committee met at 7.30am for the flight to Orange.

1. Members present

Jan Burnswoods (Chair)
The Hon Dr Arthur Chesterfield-Evans MLC
The Hon Ian West MLC
The Hon Kayee Griffin MLC
The Hon Greg Pearce MLC

2. Apologies

The Hon Robyn Parker MLC

3. **Hearing - Inquiry into the *Inebriates Act 1912***

The Chair opened the meeting at 10.00am, held at Bloomfield Hospital, Orange.

Dr Martyn Patfield, Consultant Psychiatrist, Medical Superintendent and Director of Acute Services, Bloomfield Hospital, sworn and examined.

Associate Professor Paul Fanning, Director, Mental Health Services and Acting Director, Clinical Services, Mid Western Area Mental Health Services, sworn and examined.

Dr John Hoskin, Semi-retired Psychiatrist, former Medical Superintendent, Bloomfield Hospital, sworn and examined.

Dr Patfield tendered 2 documents containing statistical information, in support of his evidence.

Resolved, on the motion of Ms Griffin, that the Committee accept the documents.

Questioning concluded and witnesses withdrew.

The public withdrew.

4. *In camera* briefing - Inquiry into the *Inebriates Act 1912*

The Committee deliberated.

The Committee met with 2 people to discuss issues relating to the *Inebriates Act* 1912.

The in camera briefing concluded and the 2 people withdrew.

5. Adjournment

The Committee adjourned at 12.15pm for an informal lunch with hearing participants and reconvened at 1.15pm.

6. Hearing – Inquiry into the *Inebriates Act 1912*

Ms Diedre Killen, Co-ordinator, Alcohol and Other Drugs Program, Mid Western Area Health Service, affirmed and examined.

Ms Kim Lewis, Alcohol and Other Drugs Project Worker, Mid Western Area Health Service, affirmed and examined.

Ms Christine McInnes, Program Director, Lyndon Withdrawal Unit, affirmed and examined.

Ms Lewis tendered a confidential document, in support of her evidence.

Resolved, on the motion of Dr Chesterfield-Evans, to accept the document, and that the document remain a confidential Committee document.

Questioning concluded and the witnesses withdrew.

7. Adjournment

The Committee adjourned at 3.15pm for the flight to Bankstown airport.

Julie Langsworth
Acting Director

Meeting 23, 7 April 2004, Jubilee Room, 9.30 am

1. Members present

Jan Burnswoods (Chair)
The Hon Robyn Parker, MLC (Deputy Chair)
The Hon Dr Arthur Chesterfield-Evans MLC
The Hon Ian West MLC
The Hon Kayee Griffin MLC
The Hon Greg Pearce MLC

2. Hearing - Inquiry into the *Inebriates Act 1912*

The public and the media were admitted.

Dr Ingrid van Beek, Director, and Dr Hester Wilce, Medical Practitioner, Kirketon Road Centre, affirmed and examined.

The witnesses withdrew.

Ms Andrea Taylor, Manager, Quality and Risk Management Unit, Royal North Shore and Ryde Health Services, affirmed and examined.

The witness tendered a document in support of her evidence.

Resolved, on the motion of Mr West, that the Committee accept the document.

Questioning concluded and the witness and the public withdrew.

The Committee adjourned at 12.30 pm and resumed at 1:45 pm.

3. Deliberative - Inquiry into the *Inebriates Act 1912*

Resolved, on the motion of Mr West, that the minutes of meeting numbers 19, 20, 21 and 22 be adopted.

Resolved, on the motion of Ms Griffin that, in accordance with section 4 of the Parliamentary Papers (Supplementary Provisions) Act 1975 and under the authority of Standing Order 252, the Committee authorises the Clerk of the Committee to publish the transcript of evidence given by witnesses Ms Kim Lewis and Ms Christine McInnes who appeared before the Committee at the public hearing on 25 March 2004 subject to the suppression of certain confidential information identified by the Committee.

The Secretariat briefed the Committee on future activities in relation to this inquiry.

Resolved, on the motion of Mr Pearce, that the Secretariat liaise with the Chair and Deputy Chair to finalise the witnesses for this inquiry.

Resolved, on the motion of Dr Chesterfield-Evans, that the Secretariat arrange a site visit to the Phoenix Unit at Manly, subject to the availability of Members.

4. Hearing – Inquiry into the *Inebriates Act 1912*

Mr Graeme Smith, Director, and Ms Frances Rush, Regional Manager, Sydney Metropolitan South East, Office of the Public Guardian, sworn and examined.

The witnesses withdrew.

Mr George Klein, Behavioural Scientist and Senior Health Education Officer, Centre for Drug and Alcohol Medicine, Nepean Hospital, affirmed and examined.

Questioning concluded and the witness and the public withdrew.

5. Adjournment

The Committee adjourned at 4:45 pm.

Merrin Thompson
Senior Project Officer

Meeting 25, 28 April 2004, Legislative Council Committee Room, Parliament House, Melbourne.

The Committee met at 7am at Sydney Airport for the flight to Melbourne. The meeting in Melbourne commenced at 10.10am.

1. Members present

Jan Burnswoods (Chair)
The Hon Robyn Parker, MLC (Deputy Chair)
The Hon Dr Arthur Chesterfield-Evans MLC
The Hon Ian West MLC
The Hon Kayee Griffin MLC

2. Apologies

The Hon Greg Pearce MLC

3. **Private briefing - Inquiry into the *Inebriates Act 1912***

The Committee participated in a private meeting with the Reference Group for the Victorian Department of Human Services' Review of the Alcoholics and Drug Dependent Persons Act 1968, together with: Paul G McDonald (Chair), Director, Drugs Policy and Services Branch, DHS, Daniel Harvey, Policy Adviser, Alcohol, Tobacco & Koori Drug Policy Unit, DHS, Robin Fisher, Manager, Drug Treatment Service Operations, DHS, Lyndall Grimshaw, Acting Manager, Complex Clients, DHS, Francene McCartin, Director, Juvenile Justice Custodial Services, DHS, Jennifer Giles, Legal Officer, Health Team, DHS, Sarah Dowling, Legal Officer, Policy & Services Development Unit, Corrections Victoria, Leanne Barnes, A/Manager Drug Policy & Projects, Corrections Victoria, Janet Farrow, Executive Director, Uniting Care Moreland Hall, Donna Ribton-Turner, Manager Withdrawal Services, Uniting Care Moreland Hall and Bruce Paterson, Project Officer, Mental Health Branch, DHS.

Mr McDonald provided the Committee with a document to support his presentation and the document, The Alcoholics and Drug-dependent Persons Act (ADDPA) 1968: A Review, March 2004, prepared by Turning Point Alcohol & Drug Centre.

Mr Dan Harvey provided the Committee with a document to support his presentation.

4. Adjournment

The Committee adjourned at 12.30pm for an informal lunch with meeting participants and reconvened at 1.15pm.

5. **Hearing - Inquiry into the *Inebriates Act 1912***

Ms Sylvia Alberti, Manager, Forensic and Clinical Services and Senior Research Fellow and Ms Amy Swan, Research Fellow, Turning Point Alcohol and Drug Centre briefed the Committee on the literature review on compulsory treatment for the Victorian review.

Ms Alberti provided 2 documents to support her presentation.

Questioning concluded and the participants withdrew.

Ms Janet Farrow, Executive Director and Ms Donna Ribton-Turner, Manager, Withdrawal Services, Uniting Care Moreland Hall, briefed the Committee on service provision in Victoria.

Ms Ribton-Turner provided 1 document to support her presentation.

Questioning concluded and the participants withdrew.

6. Adjournment

The Committee adjourned at 3.30pm for the flight to Sydney.

Julie Langsworth
Acting Director

Meeting 26, 29 April 2004, Jubilee Room, Parliament House, Sydney, 9.35am

1. Members present

Jan Burnswoods (Chair)
The Hon Robyn Parker, MLC (Deputy Chair)
The Hon Dr Arthur Chesterfield-Evans MLC
The Hon Ian West MLC
The Hon Kayee Griffin MLC
The Hon Greg Pearce MLC

2. **Deliberative - Inquiry into the *Inebriates Act 1912***

Resolved, on the motion of Ms Parker, that a roundtable consultation take place on Friday 4 June 2004 to discuss potential legislative and service models in relation to people with severe alcohol and drug dependence, and that the following people be invited to participate by attending the roundtable meeting or providing written comments: Professor Terry Carney, Sydney Law School, Professor Ian Webster, Chair, NSW Expert Advisory Committee on Drugs, Dr Stephen Jurd, Herbert Street Clinic, Ms Tonina Harvey, Northern Sydney Health, Dr Martyn Patfield, Bloomfield Hospital, Dr Joanne Ferguson, Rozelle Hospital, Mr Larry Pierce, Network of Alcohol and Drug Agencies, Dr Ian Kamerman, Rural GP, Representative from NSW Health, Representative from the Attorney General's Department, Ms Val Dahlstrom, Area Manager, Aboriginal Health, New England Area Health Service, Judge Derek Price, Chief Magistrate, Local Court of NSW, Professor Duncan Chappell, President, Mental Health Review Tribunal, Dr Paul Fanning, Director, Medical Services, Mid Western Area Health Services, Ms Vi Hunt, Area Coordinator, Alcohol and Other Drug Services, New England Area Health Service, Dr Ingrid van Beek, Director, Kirketon Road Centre, Dr Hester Wilce, Medical Practitioner, Kirketon Road Centre, Mr Grahame Smith, Office of the Public Guardian, Ms Didi Killen, Coordinator, Alcohol and Other Drugs Program, Mid Western Area Health, as well as other relevant people identified by the Secretariat.

Resolved, on the motion of Dr Chesterfield-Evans, under paragraph 16 of the resolution establishing the Standing Committees, and section 4(2) of the Parliamentary Papers (Supplementary Provisions) Act 1975, to publish submission 53.

Resolved, on the motion of Dr Chesterfield-Evans, that in accordance with section 4 of the Parliamentary Papers (Supplementary Provisions) Act 1975 and under the authority of Standing Order 252, the Committee authorises the Director to publish the evidence taken at the Melbourne briefings on 28 April 2004 from Ms Sylvia Alberti, Manager, Forensic and Clinical Services and Senior Research Fellow and Ms Amy Swan, Research Fellow, Turning Point Alcohol and Drug Centre; and Ms Janet Farrow, Executive Director and Ms Donna Ribton-Turner, Manager, Withdrawal Services, Uniting Care Moreland Hall.

Resolved, on the motion of Mr West, to accept the documents presented to the Committee at the Melbourne briefing on 28 April 2004.

3. Hearing - Inquiry into the *Inebriates Act 1912*

Professor Wayne Hall, Professorial Fellow and Director, Office of Public Policy and Ethics, Institute for Molecular Bioscience, University of Queensland, affirmed and examined.

Questioning concluded and the witness withdrew.

Ms Michelle Noort, Director, Centre for Drug and Alcohol, sworn and examined.

Mr David McGrath, A/Deputy Director, Centre for Drug and Alcohol, sworn and examined.

Questioning concluded and the witnesses withdrew.

Professor Duncan Chappell, President, Mental Health Review Tribunal, affirmed and examined.

Professor Chappell tendered a document to support his evidence.

Resolved, on the motion of Mr West, that the Committee accept the document.

Questioning concluded and the witness withdrew.

4. Adjournment

The Committee adjourned at 1.30pm.

Julie Langsworth
Acting Director

Meeting 28, 10 May 2004, Room 1153, Parliament House, Sydney, 1.35pm

1. Members present

Jan Burnswoods (Chair)
The Hon Robyn Parker, MLC (Deputy Chair)
The Hon Dr Arthur Chesterfield-Evans MLC
The Hon Ian West MLC
The Hon Kayee Griffin MLC (until 2.30pm)
The Hon Greg Pearce MLC

2. Minutes

Resolved, on the motion of Ms Parker, that the Committee adopt Minutes 25, 26 and 27.

3. Deliberative - Inquiry into the Inebriates Act 1912

The Committee deliberated.

Resolved, on the motion of Dr Chesterfield-Evans, that in accordance with section 4 of the Parliamentary Papers (Supplementary Provisions) Act 1975 and under the authority of Standing Order 223, that the Committee authorize the Clerk of the Committee to publish the transcript of evidence given by Mr George Klein who appeared before the Committee at the public hearing on 7 April 2004, subject to the suppression of two paragraphs containing potentially identifying information.

4. …

5. Adjournment

The Committee adjourned at 2.30pm and reconvened at 2.40pm to travel by train to Redfern.

6. …

The Committee visited the Redfern/Waterloo area for the purpose of better understanding the area the subject of the terms of reference.

7. Adjournment

The Committee adjourned at 4.30pm.

Julie Langsworth
Acting Director

Meeting 29, 18 May 2004, Jubilee Room, Parliament House, Sydney, 9.00am

1. Members present

Jan Burnswoods (Chair)
The Hon Robyn Parker, MLC (Deputy Chair)
The Hon Dr Arthur Chesterfield-Evans MLC
The Hon Ian West MLC
The Hon Kayee Griffin MLC
The Hon Greg Pearce MLC

2. …

3. …

4. …

5. …

6. …

7. Confirmation of Minutes 28

Resolved, on the motion of Mr West, that the Committee adopt Minutes 28.

8. …

9. Deliberative – Inquiry into *Inebriates Act*

The Secretariat briefed the Committee on the roundtable discussion to be held on 4 June 2004.

The Committee deliberated.

Resolved, on the motion of Ms Griffin, that in order to better inform all those who are participating in the inquiry process, the Committee make use of powers granted under Standing Order 223 and section 4 of the Parliamentary Papers (Supplementary Provisions) Act 1975, to publish all non-confidential tabled documents tendered during the inquiry into the *Inebriates Act 1912*.

10. Adjournment

The Committee adjourned at 4.40pm to reconvene at 10.00am, Wednesday 19 May 2004.

Julie Langsworth
Acting Director

Meeting 32, 26 May 2004, Redfern Town Hall, Parliament House, 10.15am

1. Members present

Jan Burnswoods (Chair)
The Hon Robyn Parker, MLC (Deputy Chair)
The Hon Dr Arthur Chesterfield-Evans MLC
The Hon Ian West MLC
The Hon Kayee Griffin MLC
The Hon Greg Pearce MLC

2. …

3. Deliberative - Inquiry into the *Inebriates Act*

The Acting Director informed the Committee that a briefing paper had been prepared by Ms Merrin Thompson, Senior Project Officer, entitled Potential Legislative and Service Model For A New Compulsory Treatment System in order to guide the discussion at the Roundtable on Friday 4 June 2004.

The Committee deliberated.

Resolved, on the motion of Dr Chesterfield-Evans that, the briefing paper prepared by the Secretariat entitled Potential Legislative and Service Model For A New Compulsory Treatment System be circulated on a confidential basis to the participants in the Roundtable on 4 June 2004.

4. Adjournment

The Committee adjourned at 3.55pm, to reconvene at 10.00am on 4 June 2004 in the Jubilee Room, Parliament House.

Julie Langsworth
Acting Director

Meeting 33, 4 June 2004, Jubilee Room, Parliament House, 10.05am

1. Members present

Jan Burnswoods (Chair)
The Hon Robyn Parker, MLC (Deputy Chair)
The Hon Dr Arthur Chesterfield-Evans MLC
The Hon Ian West MLC
The Hon Kayee Griffin MLC
The Hon Greg Pearce MLC

2. Private briefing - Inquiry into the *Inebriates Act* 1912

The Committee held a private briefing on issues related to the inquiry into the *Inebriates Act* attended by: Acting Chief Magistrate Graeme Henson, Local Court of New South Wales; Emeritus Professor Ian Webster, Medical Practitioner and Chair, NSW Expert Advisory Committee on Drugs; Professor Terry Carney, Director of Research, Faculty of Law, the University of Sydney; Professor Duncan Chappell, President, Mental Health Review Tribunal; Mr Larry Pierce, Director, Network of Alcohol and Drug Agencies; Dr Stephen Jurd, Medical Director, Drug and Alcohol Services, Northern Sydney Health; Dr Martyn Patfield, Medical Superintendent and Director of Acute Services, Bloomfield Hospital; Dr Joanne Ferguson, Staff Specialist Psychiatrist, Drug Health Services, Rozelle and Concord Hospitals; Ms Val Dahlstrom, Area Manager, Aboriginal Health, New England Area Health Service; Mr John Feneley, Deputy Director General, Policy and Crime Prevention, Attorney General's Department; Dr Richard Matthews, A/Deputy Director General, Strategic Development, NSW Health; Mr David McGrath, Deputy Director, Centre for Drug and Alcohol, NSW Health.

Questioning concluded and the participants withdrew.

Luncheon adjournment.

3. Confirmation of Minutes 28, 29, 30, 31, 32

Resolved, on the motion of Mr Pearce, that the Committee adopt Minutes 28, 29, 30, 31, 32

4. …

5. …

6. …

7. Adjournment

The Committee adjourned at 4.50pm, to reconvene at 1.30pm on 7 June 2004 in the Jubilee Room, Parliament House.

Julie Langsworth
Acting Director

Meeting 42, 24 August 2004, Room 1108, Parliament House, 10.10am

1. Members present

Jan Burnswoods (Chair)
The Hon Robyn Parker, MLC (Deputy Chair)
The Hon Ian West MLC
The Hon Kayee Griffin MLC
The Hon Greg Pearce MLC
The Hon Dr Arthur Chesterfield-Evans MLC

2. Deliberative - Inquiry into the *Inebriates Act 1912*

Consideration of Chair's draft report

The Chair submitted her draft report which, having been circulated to each member of the Committee, was accepted as having been read.

The Committee proceeded to consider the draft report.

Chapter 1 read.

Resolved, on the motion of Mr Pearce, that Chapter 1 be adopted.

Chapter 2 read.

Resolved, on the motion of Dr Chesterfield-Evans, that Chapter 2 be adopted.

Chapter 3 read.

Resolved, on the motion of Mr West, that Chapter 3 be adopted.

Chapter 4 read.

Resolved, on the motion of Ms Griffin, that Chapter 4 be adopted.

Chapter 5 read.

Resolved, on the motion of Ms Parker, that Chapter 5 be adopted.

Chapter 6 read.

Resolved, on the motion of Ms Griffin, that paragraphs 6.68 and 6.69 be amended to read:
'At the roundtable discussion with key stakeholders, participants spoke of the need for measures to help address antisocial behaviour, primarily out of a concern for the impact it has on others, and the importance of supporting families and communities.'
'Participants suggested that the problems associated with such behaviour may partly have emerged out of measures to divert people with drug and alcohol problems and mental illness from the criminal justice system. They envisaged some practical difficulties in developing a workable preventative model in rural areas, given the finite resources and limited services that exist there. Nevertheless, they argued that any new model must necessarily address the needs of small communities.'

but that in the event that the witness authorises the use of his quotes, that they be included.

Resolved, on the motion of Ms Parker, that Chapter 6 as amended be adopted.

Chapter 7 read.

Resolved, on the motion of Mr Pearce, that the heading 'Exclusions' above paragraph 7.27 be deleted, that paragraphs 7.27 and 7.28 be moved to the paragraph following paragraph 7.22, and that paragraph 7.28 be amended to read:

'The Committee has designed this legislative framework with adults in mind. We have received very little evidence about the appropriateness of applying the framework to minors. There is potentially a significant gap in relation to the treatment of minors with a substance dependence. The Committee believes this requires further investigation.'

Resolved, on the motion of Dr Chesterfield-Evans, that the second dot point in Recommendation 11 be deleted.

Resolved, on the motion of Mr Pearce, that the second sentence in paragraph 7.55 be amended to read:

'Many inquiry participants were concerned about ensuring a fair and impartial legal process, and the need for magistrates to have adequate input from medical practitioners when making their decisions.'

Resolved, on the motion of Mr Pearce, that Recommendation 16 be deleted.

Resolved, on the motion of Ms Parker, that Recommendation 18 be amended to read:

'That NSW Health and the Attorney General's Department consult with Aboriginal communities in order to ensure that the decision making process in Recommendation 15 be implemented in a culturally sensitive manner.'

Resolved, on the motion of Ms Parker, that paragraph 7.80 be amended as follows:

'The Committee considers that it will be important for government agencies to consult with Aboriginal communities in order to ensure that the decision making process in Recommendation 15 be implemented in a culturally sensitive manner. It may be appropriate for this to be incorporated into the regulations to accompany the legislation.'

Resolved, on the motion of Ms Griffin, that Chapter 7 as amended be adopted.

Chapter 8 read.

Resolved, on the motion of Ms Parker, that paragraph 8.42 be amended to read:

'The Committee considers that in implementing the model of involuntary care, NSW Health will need to recognise and incorporate the needs of Indigenous people, in consultation with Aboriginal communities.'

Resolved, on the motion of Ms Parker, that Recommendation 35 be amended to read:

'That in implementing the Committee's proposed model of involuntary care, NSW Health recognise and incorporate the needs of Indigenous people, in consultation with Aboriginal communities.'

Resolved, on the motion of Ms Parker, that paragraph 8.45 be amended to read:

'The Committee considers that the needs of culturally and linguistically diverse communities will also need to be addressed during implementation.'

Resolved, on the motion of Ms Parker, that Recommendation 36 be amended to read:

'That in implementing the Committee's proposed model of involuntary care, NSW Health recognise and incorporate the needs of culturally and linguistically diverse communities, in consultation with them.'

Resolved, on the motion of Dr Chesterfield-Evans, that Chapter 8 as amended be adopted.

Chapter 9 read.

Resolved, on the motion of Ms Parker, that paragraphs 9.93 and 9.94 be reversed.

Resolved, on the motion of Mr West, that Chapter 9 as amended be adopted.

Executive summary read.

Resolved, on the motion of Mr West, that the fourth paragraph be read:

'On the basis of this analysis we conclude that the *Inebriates Act* is fundamentally flawed and recommend that it be immediately repealed and replaced with an entirely new framework of involuntary care for a small and tightly defined group of people with drug and alcohol dependence.'

Resolved, on the motion of Ms Griffin, that the executive summary as amended be adopted.

Resolved, on the motion of Mr Pearce, that pursuant to Standing Order 229 the Committee consider the Chair's Foreword for approval.

Chair's Foreword read.

Resolved, on the motion of Mr West, that the Chair's Foreword be adopted, with leave given to the Chair to alter the text to make reference to a witness if necessary.

Resolved, on the motion of Dr Chesterfield-Evans that the Draft Committee report as amended be the report of the Committee and be signed by the Chair and presented to the House in accordance with Standing Orders 230 and 231.

Resolved, on the motion of Mr Pearce, that pursuant to the provisions of section 4 of the Parliamentary Papers (Supplementary Provisions) Act 1975 the Committee authorises the publication of all non-confidential minutes, correspondence, submissions and tabled documents.

Resolved, on the motion of Mr West, that in accordance with Standing Order 233 the Committee authorises the publication of those excerpts from confidential transcripts that appear in the report.

Resolved, on the motion of Ms Parker, that the Committee Secretariat be permitted to correct typographical, stylistic and grammatical errors in the report prior to tabling.

Resolved, on the motion of Ms Parker, that Merrin Thompson, Senior Project Officer, be thanked for her contribution to the report.

3. …

4. Adjournment

The Committee adjourned at 1.15pm sine die.

Merrin Thompson
Senior Project Officer

Appendix 6 The *Inebriates Act* 1912

Inebriates Act 1912.

Reprint history (since 1972):

Reprint No 114 January 1975

Reprint No 221 December 1978

Reprint No 325 March 1981

Reprint No 46 April 1992

Reprint No 510 September 2002

An Act to consolidate the Acts providing for the care, control, and treatment of inebriates, and for purposes incidental to the abovementioned objects.

Part 1 Preliminary

1 Name of Act, repeals and savings

(1) This Act may be cited as the *Inebriates Act 1912*.

(2) The Acts mentioned in Schedule 1 are hereby repealed; but such repeal shall not prejudice or affect the validity or duration of any certificate, licence, permit, or authority lawfully granted, or order lawfully made under any such Act. All licences granted under any such repealed Act shall be held in all respects, and all renewals thereof shall be applied for, under and subject to the provisions of this Act, unless hereinafter otherwise specially provided for.All boards and persons appointed under the Acts hereby repealed and holding office at the time of the passing of this Act shall remain in office as if this Act had been in force at the time they were appointed and they had been appointed hereunder, and this Act shall apply to them accordingly.All institutions licensed or established under the provisions of any Act hereby repealed, and being so licensed or established at the time of the passing of this Act, shall be deemed to have been licensed or established under this Act.All rules and regulations made under the authority of any Act hereby repealed and being in force at the passing of this Act shall be and continue in force hereunder, and shall be deemed to have been made under the authority of this Act.

2 Definitions

For the purposes of this Act:
Inebriate means a person who habitually uses intoxicating liquor or intoxicating or narcotic drugs to excess.
Institution means a place licensed under this Act or established by the Government for the reception, control, and treatment of inebriates.
Narcotic drug does not include tobacco, cigars, or cigarettes.
Spouse means:
(a)a husband or wife, or
(b)the other party to a de facto relationship within the meaning of the *Property (Relationships) Act 1984*,
but where more than one person would so qualify as a spouse, means only the last person so to qualify.
State institution means institution established by the Government as aforesaid.

Part 2 Applications to commit inebriates

3 Order for control of inebriates

(1) It shall be lawful for the Supreme Court or a District Court Judge or a Magistrate, on the application of:and on proof to the satisfaction of the Court, Judge or Magistrate that the person in respect of whom the application is made is an inebriate, to order:

(a) an inebriate or any person authorised in writing in that behalf by an inebriate while sober,

(b) the spouse, or a parent, or a brother, sister, son, or daughter of full age, or a partner in business of an inebriate, or

(c) a member of the police force of or above the rank of sergeant acting on the request of a duly qualified medical practitioner in professional attendance on the inebriate, or on the request of a relative of the inebriate, or at the instance of an authorised officer within the meaning of the *Criminal Procedure Act 1986*,

(d) that the inebriate enter into a recognizance (or, in the case of an order by the Supreme Court, other security), with or without sureties, that he will abstain from intoxicating liquor and intoxicating or narcotic drugs for the period therein mentioned, not being less than twelve months, or

(e) that the inebriate be placed for any period mentioned in the order not exceeding twenty-eight days under the care and control of some person or persons to be named in the order, in the house of the inebriate, or in the house of a friend of the inebriate, or in a public or private hospital, or in an institution, or in an admission centre, or

(f) that the inebriate be placed in a licensed institution or a State institution established under section 9 for such period not exceeding twelve months as may be mentioned in the order, or

(g) that the inebriate be placed for any period not exceeding twelve months, to be mentioned in the order, under the care and charge of an attendant or attendants to be named in the order, and who shall be under the control of the Court or Judge or Magistrate making the order, or of a guardian who is willing to act in that capacity:

Provided that no such order shall be made except:

(i) on production of the certificate of a legally qualified medical practitioner that the person in respect of whom the application is made is an inebriate together with corroborative evidence by some other person or persons, and

(ii) on personal inspection of the inebriate by the Court or Judge or Magistrate, or by some person appointed by him in that behalf.

(1A) The Court, Judge or Magistrate to which or to whom an application is made under subsection (1) may, before determining the application, remand the person in respect of whom the application is made into such custody as the Court, Judge or Magistrate may order for a period not exceeding 7 days to enable that person to be examined by a legally qualified medical practitioner for the purpose of assisting in determining whether or not that person is an inebriate.

(1B) A person who escapes from the custody of a person into whose custody he has been remanded under subsection (1A) may be arrested and returned to that custody.

(2) Every medical practitioner who signs any certificate under or for the purposes of this Act shall specify therein the facts upon which he has formed his opinion that the person to whom such certificate relates is an inebriate, and shall distinguish in such certificate facts observed by himself from facts communicated to him by others, and no such order shall be made upon any certificate which purports to be founded only upon facts communicated by others.

(3) The inebriate shall be afforded an opportunity of being heard in objection. The Court, Judge or Magistrate may direct that the inebriate shall be brought before him in open court or in private.

(4) On the order of the Supreme Court or of a District Court Judge, any period mentioned in an order made under paragraph (f) or paragraph (g) of subsection (1) may from time to time be extended for further periods not exceeding twelve months each. The inebriate shall be afforded an opportunity of being heard in objection to any such order.

4 Powers and duties of guardian

(1) Where an inebriate is placed as aforesaid under the charge and care of a guardian, the guardian:

(a) shall prescribe for the inebriate a place of residence in New South Wales, either in the house of the inebriate or in that of the guardian,

(b) shall provide for the inebriate such medical attendance as may be necessary,

(c) may deprive the inebriate of intoxicating liquor and intoxicating or narcotic drugs, and prevent him from obtaining them,

(d) may prevent the inebriate from leaving the prescribed residence, unless attended by a responsible person,

(e) may require the inebriate to submit to the attendance of such nurses or attendants as the guardian thinks necessary,

(f) may warn persons against supplying the inebriate with intoxicating liquor or intoxicating or narcotic drugs.

Any person warned in writing under paragraph (f) who supplies the inebriate with any intoxicating liquor or intoxicating or narcotic drug shall be liable to a penalty not exceeding 0.5 penalty unit.

(2) On application, by or on behalf of the Minister, to the Supreme Court or a District Court Judge or any Magistrate, a guardian may be removed, and on like application by the guardian he may be relieved of and discharged from his guardianship. In either case, the Court, Judge, or Magistrate may appoint another guardian, or may make an order under section 3.

5 Voluntary recognizances

(1) Any person may enter into a recognizance, with or without sureties, before a Magistrate that he will abstain from intoxicating liquor and intoxicating or narcotic drugs for the period therein mentioned, not being less than twelve months.An application to enter into a recognizance under this section shall be in the form of Schedule 2.

(2) A Magistrate, before a recognizance is taken before him under this section or under section 3, shall satisfy himself that the person before him understands the nature and effect of the recognizance, and the consequences of its breach, and shall sign a certificate to that effect in the form of Schedule 3.

6 Private hearing

The hearing of any application under either of the three last preceding sections may, at the request of the alleged inebriate, or where the application is made by him, be in private.

7 Forfeiture of recognizances

Subject to section 17A, if, during the period specified in a recognizance taken under any of the preceding provisions of this Act, it is proved to any Magistrate that the person bound thereby has failed to observe any of the conditions of the recognizance, the Magistrate before whom such proof is given may forfeit the recognizance.

8 Medical practitioner who is also applicant not to sign certificate—order not to be made upon certain certificates

A medical practitioner who is an applicant under this Act for an order in respect of an inebriate shall not sign a certificate under or for the purposes of this Act in respect of such inebriate.

If on the production of the certificate of a medical practitioner in respect of an inebriate it appears to the Court, Judge, or Magistrate that the said medical practitioner, or his father, brother, son, partner, or assistant:
(a)is the superintendent or medical officer of any institution, or a regular professional attendant therein, or
(b)is wholly or in part the proprietor, licensee, mortgagee, or lessee of any institution, or
(c)is interested in the payments to be made by or on account of any inebriate received into any institution,
an order that the inebriate be placed in such institution shall not be made upon such certificate.

9 Institutions for inebriates committed under sec 3

(1) The Governor may establish institutions for the reception, control, and treatment of inebriates who have, under section 3, been ordered to be placed in an institution established under this section, and of inebriates who, in pursuance of this Act or any Act hereby repealed, have been transferred to any such institution, and shall appoint for every such institution a superintendent and such officers as he may deem necessary.Such officers shall be appointed in the same manner as officers in hospitals for the insane.The establishing of any such institution, and a description of the land included within the limits thereof shall be notified in the Gazette.

(2) Such institutions shall, subject to this Act, be under the care, direction, and control of the Minister for Health.

(3) The enactments of the *Lunacy Act 1898*, mentioned in Schedule 4, shall, mutatis mutandis, apply to such institutions, and to inebriates detained therein.In so applying such enactment:

hospital or ***hospital for the insane*** shall be read as and mean an institution established under this section.
insane patient, or ***patient***, shall be read as and mean an inebriate in any such institution.
this Act shall be taken to refer to the *Inebriates Act 1912*.

9A Fees and charges not payable in respect of certain persons

During the period within which the Agreement executed and approved under the provisions of the *Mental Institution Benefits Agreement Act 1949* is in force:
(a)no means test shall be imposed on and no fees shall be charged to or in respect of qualified persons in mental institutions established for the reception, control and treatment of inebriates,
(b)except with the concurrence of the Commonwealth of Australia, no charge shall be made to or in respect of qualified persons for services or comforts for which it was not customary to make a charge as at the first day of November, one thousand nine hundred and forty-eight.

In this section the terms ***qualified person*** and ***mental institution*** shall have the meanings respectively ascribed thereto in the aforesaid Agreement.

10 Penalty for interfering with such institutions

Whosoever without lawful authority:

(a)is found within the boundaries of an institution established under the last preceding section, or
(b)in any manner communicates or attempts to communicate with any inebriate therein,
shall be liable to a penalty not exceeding 0.5 penalty unit, or to imprisonment for any term not exceeding three months, o
to both penalty and imprisonment.

Part 3 Convicted inebriates

11 Inebriates convicted of certain offences

(1) Where a person is convicted before a Magistrate, or on indictment:and on inquiry it appears that the offender is an inebriate, the court may either:

(i) of an offence of which drunkenness is an ingredient, or

(ii) of assaulting women, cruelty to children, attempted suicide, or wilful damage to property, and it appears that drunkenness was a contributing cause of such offence,

(a) sentence the offender according to law, or

(b) discharge the said offender conditionally on his entering into a recognizance, with or without sureties, that during the period named by the court, not being less than twelve months:
(i)he will be of good behaviour,
(ii)he will not take or use any intoxicating liquor or intoxicating or narcotic drugs,
(iii)he will, once at least in every three months, report his address and occupation to the principal officer of police at the place where such conviction was had, or at such other place as the Commissioner of Police may appoint, such report being made either personally or by letter, unless the Minister directs that the report be made personally, in which case it must be made in that mode only,
(iv)he will not do or omit to do any act whereby the recognizance would become forfeited, or

(c) order the said offender to be placed for a period of twelve months in a State institution established under section 13:
Provided that such order shall only be made on the production of such certificate and on such evidence and inspection as in the case of an order made under section 3.

(2) On the order of the Supreme Court or of a District Court Judge, such period may from time to time be extended for further periods not exceeding twelve months each.

(3) Where the inebriate is physically unfit to travel to the institution named in such order, the court making the order may direct that he be placed for immediate medical treatment for such time as it thinks fit in a gaol, or lock-up, or in a hospital, or private house, under the supervision of the police.

12 Forfeiture of recognizances

Subject to section 17A, if, during the period specified in any such recognizance, the offender so discharged:
(a)is proved to any Magistrate to have contravened any of the conditions of the recognizance, or
(b)is charged by a member of the police force with getting his livelihood by dishonest means, and being brought before any Magistrate, it appears to such Magistrate that there are reasonable grounds for believing that he is getting his livelihood by dishonest means, or
(c)on being charged with an offence punishable on indictment or summary conviction, and on being required by the Magistrate before whom he is charged to give his name and address, refuses to do so, or gives a false name or a false address, or
(d)is convicted of any offence against the *Vagrancy Act 1902*,
the Magistrate before whom such proof is given, or before whom the said offender is so charged or convicted, may forfei the recognizance and order the offender to be placed in a State institution established under section 13 for the remainde of the period mentioned in the recognizance.

13 Institutions for inebriates committed under sec 11

(1) The Governor may establish institutions for the reception, control and treatment of inebriates who have, under sectior 11, been ordered to be placed in a State institution, or who, in pursuance of this Act or any Act hereby repealed, have been transferred to any such institution.

(2) The Governor may appoint a Visiting Magistrate, who shall exercise in respect of a State institution the same powers and jurisdiction as are conferred on a Visiting Magistrate in respect of a correctional centre under the *Crimes (Administration of Sentences) Act 1999*.

(3) The Commissioner of Corrective Services shall, subject to the control of the Governor, have the care, direction, and control of such institution and the custody of all persons placed therein.

(4) All the keepers and under-keepers of such institutions and the assistants of such keepers and under-keepers and all other persons required and employed for the safety and care of such institutions and of the inebriates detained therein shall be nominated and appointed by the Commissioner of Corrective Services, subject to the approbation of the Governor.

Part 4 General and supplemental

14 Release on licence

The Governor may release on licence any person detained in a State institution, and may revoke such licence.

The conditions of the licence shall be that the licensee shall, for a period therein specified, not exceeding twelve months, be of good behaviour and abstain from taking or using any intoxicating liquor or intoxicating or narcotic drugs.

Any such licence shall be revoked by a Magistrate on proof in a summary way before him that the licensee has been guilty of a breach of any condition of the licence; or the licence may be revoked by the Governor at his discretion.

Where a licence is revoked as aforesaid, the person released on licence may be taken by any member of the police force and returned to the State institution, and may be detained there during the remainder of the period for which he was placed in the institution.

15 Release

The Supreme Court or a District Court Judge may order that any person detained in an institution be released on such conditions (if any) as he may impose.

16 Committal on second offence

Where a person has, after the ninth day of September, one thousand nine hundred and nine, been discharged from a State institution, or released on licence, or discharged under section 11 on recognizances, and within twelve months thereafter has been convicted for an offence of which drunkenness is an ingredient, and has subsequently and during the said twelve months been charged with any offence mentioned in section 11, the court before which he is so charged may, in dealing with him under that section, order him to be placed in a State institution for a period not exceeding three years.

17 Form of recognizance

A recognizance taken under this Act shall be in the form of Schedule 5.

17A Forfeiture of securities under recognizances

The provisions of Part 7A of the *Bail Act 1978* and Part 7 of the *Fines Act 1996* apply to the forfeiture of any security under a recognizance under this Act and to the recovery of any security so forfeited in the same way as they apply to the forfeiture of bail money and to the recovery of any bail money so forfeited.

18 Order as to property and treatment of inebriate

The Supreme Court, District Court Judge, Magistrate or court making an order in respect of an inebriate, may in the same or any subsequent order direct that the expense of the care, charge, and maintenance of the inebriate be paid out of any property of the inebriate, and may fix the amounts to be so paid, and the amounts so fixed may be recovered from the inebriate in any court of competent jurisdiction at the suit of the person under whose care, charge, or control the inebriate has been placed, or the owner of the licensed institution in which the inebriate is or has been detained, or when the inebriate is detained in a State institution, at the suit of the Minister.

19 Court may make orders as to property of inebriate who is incapable

(1) Where it is proved to the satisfaction of the Supreme Court that any inebriate the subject of an order under this Act is incapable of managing his affairs, the Court may make all proper orders for rendering the property and income of the inebriate available for the payment of his debts and for the maintenance and benefit of himself and his family; and may make orders for the care and management of his property in all respects as if he were an insane person within the meaning of the *Lunacy Act 1898*; and may, if necessary, appoint any person, either with or without security, to undertake

the care and management of his property under the order and direction of the Court.

(2) The person so appointed shall, subject to the said orders and directions and to the rules of Court, have the same powers and be subject to the same obligations and control as a committee of the estate of an insane person, and the powers and provisions contained in the *Lunacy Act 1898* relating to the management and administration of the estates of insane persons shall apply to the estates of such inebriates.

20 Directions; variation, renewal and rescission of orders

(1) Where the Supreme Court, by any Judge or master or by any registrar or other officer, makes an order or gives a direction with respect to an inebriate, the Supreme Court, by the same Judge, master, registrar or officer, may, at the same time or afterwards:

(a) give such directions as the Court thinks fit as to the control of the inebriate, and

(b) vary, renew or rescind the order or direction.

(2) A District Court Judge or Magistrate making an order with respect to an inebriate may at the same time or afterwards:

(a) give such directions as he thinks fit as to the control of the inebriate, and

(b) vary, renew or rescind the order or direction.

(3) The Supreme Court may:

(a) give such directions as the Court thinks fit as to the control of any inebriate the subject of an order under this Act, and

(b) vary, renew or rescind any order or direction made under this Act.

20A Appeal

(1) An appeal shall not lie to the Court of Appeal from a decision or order of the Supreme Court under this Act, except by leave of the Court of Appeal.

(2) Subsection (1) does not apply to a decision or order of the Supreme Court under section 19 or subsection (3) of section 20.

21 Order shall authorise attendant to prevent supply of intoxicant to inebriate

The order of the Supreme Court or a District Court Judge or a Magistrate made under this Act shall be sufficient authority for the carrying out by any persons of any directions therein contained; and where the order is that the inebriate be placed under the care and charge of an attendant it shall authorise and direct the attendant to prevent any person from supplying the inebriate while under his charge with any intoxicating liquor or with any drug or instrument which may be used for the purpose of producing a state of inebriation. And any such attendant who neglects to comply with any such direction shall be liable to a penalty not exceeding 0.1 penalty unit.

22 Inebriate not to leave State

When by the order of the Supreme Court, a District Court Judge or a Magistrate an inebriate has been placed under the charge of an attendant, the inebriate shall not be allowed to leave the State of New South Wales during the continuance of such order, unless permitted to do so by some variation or amendment of the order.

23 Inebriate escaping from custody may be arrested

Any inebriate who escapes from the institution in which, or from the attendant under whom, he has been placed may be arrested and returned to his former custody under the order made.

24 Inspection of places where inebriates are under control

It shall be lawful for the Secretary of the Department of Health or an officer of the Department of Health authorised by that Secretary in that behalf to inspect any inebriate the subject of an order under section 3 and any place where an inebriate is under control, and he shall have power to enter at all reasonable times any such place for the fulfilment of this duty. It shall also be the duty of all police officers or constables to assist the person under whose care an inebriate has been placed by an order under section 3, to compel the inebriate to comply with the directions of such order.

25 Persons supplying inebriate with intoxicant liable to penalty

Any person who supplies an inebriate, being the subject of an order under this Act, with intoxicating liquor, or any drug or instrument which may be used for the purpose of producing a state of inebriation shall be liable to a penalty not

exceeding 0.5 penalty unit.

26 Penalty for publishing report

Any person who publishes a report of any proceedings under this Act, except by permission of the Judge, Master or Magistrate adjudicating, shall be liable to a penalty not exceeding 1 penalty unit.

27 Rules of Court

(1) Rules of court may be made under the *Supreme Court Act 1970* for carrying out the provisions of this Act so far as they relate to the powers or duties of the Supreme Court.

(2) Rules of court may be made under section 152 of the *District Courts Act 1912*:

(a) for regulating the form and mode of proceeding under this Act before a District Court Judge, and

(b) for carrying out the provisions of this Act so far as they relate to the powers or duties of a District Court Judge.

(3) Subsections (1) and (2) do not limit the rule-making powers conferred by the *Supreme Court Act 1970* or by the *District Courts Act 1912*.

28 Governor may license institutions for inebriates and may make regulations

The Governor may license institutions for the reception, control, and treatment of inebriates, and may make regulations:
(a)for the issue and revocation of such licences,
(b)for the regulation, management, and inspection of licensed institutions, and of institutions established by the Government, and providing for the proper and suitable employment of persons detained in such institutions,
(c)for determining the fees payable by inebriates placed in any institution,
(d)for the control and discipline of inebriates and the discipline of officers and attendants under this Act, whether in institutions or otherwise,
(e)providing for the release of inebriates from State institutions on licence, and for the retaking of inebriates who break the conditions of any such licence, and for returning them to such institutions,
(ea)for regulating the form and mode of proceeding under this Act before a Magistrate, and
(f)for carrying out the provisions of this Act generally and in particular so far as they relate to the powers or duties of a Magistrate,
and may in these regulations impose any penalty not exceeding 1 penalty unit for any breach of the same.

29 Supervising board

(1) There shall be a supervising board for inebriates (in this Act referred to as the ***supervising board***) consisting of two persons, each of whom is an officer of the Department of Health from time to time nominated by the Minister for Health, and the Commissioner of Corrective Services.

(2) The supervising board:

(a) may, subject to this Act, recommend the removal of inebriates from one State institution to another State institution,

(b) may, at the request of the Minister, inquire into the administration of any institution, examine the inebriates therein detained, and shall report to the Minister as to any matter arising from such inquiry or examination.

30 Removal of inebriates from State institutions

(1) The Minister may, on the recommendation of the supervising board, direct the removal of any inebriate from any one State institution to another State institution.

(2) Every such order shall be in duplicate, and one copy shall be delivered to the superintendent of the institution from which the inebriate is ordered to be removed, and the other shall be delivered to the superintendent of the institution into which the inebriate is ordered to be removed; and such order for removal shall be a sufficient authority for the removal of such inebriate, and also for his reception into the institution into which he is ordered to be removed and for his detention therein.

(3) A copy of the order or other proper authority with which such inebriate was received into the institution from which he is removed, together with an abstract of his treatment and progress certified by the superintendent of such institution, shall be delivered with one copy of the said order of removal to the superintendent of the institution to which such inebriate is removed.

31 Proceedings for acts done in carrying out provisions of Act

(1) No proceedings shall lie against any person for or on account of any act, matter, or thing done or commanded to be

done by him, and purporting to be done for the purpose of carrying out the provisions of this Act, if that person has acted in good faith and with reasonable care.

(2)

(3) Proceedings as aforesaid may, on application to the Supreme Court, be stayed upon such terms as to costs or otherwise as the Court may think fit, unless the Court is satisfied that there is reasonable ground for alleging want of good faith or reasonable care.

32 Recovery of penalties

All penalties imposed by this Act or by any regulations made thereunder or by any Act hereby repealed may be recovered before a Local Court.

Schedules

Schedule 1

(Section 1 (2))

Reference to Act
Short title
Act No 32, 1900
Inebriates Act 1900
Act No 2, 1909
Inebriates (Amendment) Act 1909

Schedule 2

(Section 5)

I, , of hereby apply to enter into a recognizance that I will abstain from intoxicating liquor and intoxicating or narcotic drugs for the period of months.
(Signature of applicant.)Witness—
The day of 19.

I, , of hereby apply to enter into a recognizance that I will abstain from intoxicating liquor and intoxicating or narcotic drugs for the period of months. (Signature of applicant.)Witness— The day of 19.

Schedule 3

(Sections 3, 5)

This is to certify that came before me and entered into a recognizance to abstain from intoxicating liquor and intoxicating or narcotic drugs for a period of months, and that before his entering into such recognizance I explained to him the nature of the same and the consequences of the breach thereof.
Magistrate.The day of 19.

This is to certify that came before me and entered into a recognizance to abstain from intoxicating liquor and intoxicating or narcotic drugs for a period of months, and that before his entering into such recognizance I explained to him the nature of the same and the consequences of the breach thereof. Magistrate.The day of 19.

Schedule 4

Enactments of the *Lunacy Act 1898* applied to certain institutions

Section 15—Amendment of orders and certificates.Section 27—Register of patients.Section 28—Medical journal.Section 29—Entries of deaths, discharges etc.Section 30—Notice of deaths.Section 78—Visits of Inspector-General.Section 79—Inquiries by Inspector-General.Section 81—Annual Report by Inspector-General.Section 139—Relative may agree for maintenance of patient.Section 142—Order upon relations of patient for his support.Section 143—Application for maintenance supported by affidavit.Section 144—Proceedings on complaint under section 142.Section 145—Arrears of maintenance.Section 146—Procedure if amount unpaid.Section 147—The foregoing of arrears.Section 171—Superintendent may plead general issue etc.Section 173—Illtreatment of insane.Section 174—Penalty on escape.Section 176—Visit by Inspector-General and official visitors.Section 177—Letters of patients.

(Section 9)

Schedule 5

(Section 17)

New South Wales,
to wit.
Be it remembered that on the day of 19, of (and of) personally came before me, one of His Majesty's justices of the peace, and acknowledged themselves (or himself) to owe to our Sovereign Lord the King the sum of to be made and levied of their several (or his) goods and chattels, lands, and tenements respectively to the use of our said Lord the King, His Heirs, and Successors if the said shall, during a period of months from the date of the presents, fail to [here set out conditions of recognizance].
Taken and acknowledged the day and year first abovementioned at in the said State, before me—
Magistrate.

New South Wales, to wit. Be it remembered that on the day of 19, of (and of) personally came before me, one of His Majesty's justices of the peace, and acknowledged themselves (or himself) to owe to our Sovereign Lord the King the sum of to be made and levied of their several (or his) goods and chattels, lands, and tenements respectively to the use of our said Lord the King, His Heirs, and Successors if the said shall, during a period of months from the date of the presents, fail to [here set out conditions of recognizance]. Taken and acknowledged the day and year first abovementioned at in the said State, before me— Magistrate.

Historical notes

Table of Acts

Inebriates Act 1912 No 24. Assented to 26.11.1912. This Act has been amended as follows:
Editorial note.
The Act was to be repealed by the *Miscellaneous Acts (Mental Health) Repeal and Amendment Act 1983 No 181*, Sch 1, but that Act was repealed before Sch 1 was commenced.
1935
No 13
Police Regulation (Amendment) Act 1935. Assented to 13.3.1935.
1937
No 35
Statute Law Revision Act 1937. Assented to 23.12.1937.
1949
No 43
Mental Institution Benefits Agreement Act 1949. Assented to 16.11.1949.
1965
No 33
Decimal Currency Act 1965. Assented to 20.12.1965.
Date of commencement of sec 4, 14.2.1966, secs 1 (3), 2 (1) and the *Currency Act 1965* (Commonwealth), sec 2 (2).
1970
No 52
Supreme Court Act 1970. Assented to 14.10.1970.
Date of commencement, Part 9 excepted, 1.7.1972, sec 2 (1) and GG No 59 of 2.6.1972, p 2018. Amended by *Supreme Court (Amendment) Act 1972 No 41*. Assented to 11.4.1972.
1972
No 48
Reprints Act 1972. Assented to 9.10.1972.
No 63
Health Commission Act 1972. Assented to 23.11.1972.
Date of commencement of Sch, Part 1, 30.4.1973, sec 2 (c) and GG No 53 of 27.4.1973, p 1428.
1974
No 18
Defamation Act 1974. Assented to 10.4.1974.
Date of commencement, 1.7.1974, sec 2 and GG No 79 of 28.6.1974, p 2381.
1977
No 19
Notice of Action and Other Privileges Abolition Act 1977. Assented to 24.3.1977.
Date of commencement, 19.8.1977, sec 2 and GG No 92 of 19.8.1977, p 3541.
1979
No 68
Inebriates (Amendment) Act 1979. Assented to 11.5.1979.
Date of commencement of sec 3, 17.3.1980, sec 2 (2) and GG No 45 of 14.3.1980, p 1143.
1982

No 138
Miscellaneous Acts (Health Administration) Amendment Act 1982. Assented to 15.12.1982.
Date of commencement of Sch 1, 17.12.1982, sec 2 (2) and GG No 177 of 17.12.1982, p 5869.
1987
No 48
Statute Law (Miscellaneous Provisions) Act (No 1) 1987. Assented to 28.5.1987.
Date of commencement of Sch 32, except as provided by sec 2 (13), 1.9.1987, sec 2 (12) and GG No 136 of 28.8.1987, p 4809.
1993
No 47
Statute Law (Penalties) Act 1993. Assented to 15.6.1993.
Date of commencement, assent, sec 2.
1998
No 107
Criminal Procedure Legislation Amendment (Bail Agreements) Act 1998. Assented to 9.11.1998.
Date of commencement of Sch 3.7, 1.10.2000, sec 2 and GG No 127 of 29.9.2000, p 10810.
1999
No 4
Property (Relationships) Legislation Amendment Act 1999. Assented to 7.6.1999.
Date of commencement of Sch 2.13, 28.6.1999, sec 2 and GG No 72 of 25.6.1999, p 4082.
No 31
Statute Law (Miscellaneous Provisions) Act 1999. Assented to 7.7.1999.
Date of commencement of Schs 4 and 5, assent, sec 2 (1).
No 94
Crimes Legislation Amendment (Sentencing) Act 1999. Assented to 8.12.1999.
Date of commencement of Sch 4.31, 3.4.2000, sec 2 (1) and GG No 42 of 31.3.2000, p 2487; date of commencement of Sch 4.119, 1.1.2000, sec 2 (1) and GG No 144 of 24.12.1999, p 12184.
2001
No 121
Justices Legislation Repeal and Amendment Act 2001. Assented to 19.12.2001.
Date of commencement of Sch 2, 7.7.2003, sec 2 and GG No 104 of 27.6.2003, p 5978.
2003
No 82
Statute Law (Miscellaneous Provisions) Act (No 2) 2003. Assented to 27.11.2003.
Date of commencement of Sch 2.13, assent, sec 2 (2).

This Act has also been amended pursuant to an order under secs 8 (2) and 9 (3) of the *Reprints Act 1972 No 48* (formerly *Acts Reprinting Act 1972*). Order dated 2.1.1975, and published in GG No 12 of 10.1.1975, p 85, declaring that the *Inebriates Act 1912* is an enactment to which sec 8 (2) and sec 9 (3) of the *Acts Reprinting Act 1972* apply.

Table of amendments

No reference is made to certain amendments made by the *Decimal Currency Act 1965* and the *Reprints Act 1972*.
Part 1, heading
Ins 1999 No 31, Sch 5.48 [2].
Sec 2
Am 1999 No 4, Sch 2.13 [1]; 2001 No 121, Sch 2.127 [1].
Part 2, heading
Ins 1999 No 31, Sch 5.48 [3].
Sec 3
Am 1970 No 52, Second Sch (am 1972 No 41, Second Sch); 1979 No 68, sec 3; 1999 No 4, Sch 2.13 [2]; 1999 No 31, Sch 4.42 [1] [2]; 2001 No 121, Sch 2.127 [2].
Sec 4
Am 1970 No 52, Second Sch (am 1972 No 41, Second Sch); 1993 No 47, Sch 1; 1999 No 31, Sch 4.42 [1] [2].
Sec 5
Am 1970 No 52, Second Sch (am 1972 No 41, Second Sch); 1999 No 31, Sch 4.42 [1] [2].
Sec 7
Am 1998 No 107, Sch 3.7 [1]; 2001 No 121, Sch 2.127 [3].
Sec 8
Am 1970 No 52, Second Sch (am 1972 No 41, Second Sch); 1999 No 31, Sch 4.42 [2].
Sec 9
Am 1972 No 63, Sch; 1982 No 138, Sch 1.
Sec 9A
Ins 1949 No 43, sec 4 (1).
Sec 10

Am 1993 No 47, Sch 1; 1999 No 94, Sch 4.119.
Part 3, heading
Ins 1999 No 31, Sch 5.48 [4].
Sec 11
Am 1935 No 13, sec 7 (1); 1970 No 52, Second Sch (am 1972 No 41, Second Sch); 1999 No 31, Sch 4.42 [1].
Sec 12
Am 1998 No 107, Sch 3.7 [2]; 2001 No 121, Sch 2.127 [4].
Sec 13
Am 1999 No 94, Sch 4.31 [1] [2]; 2003 No 82, Sch 2.13.
Part 4, heading
Ins 1999 No 31, Sch 5.48 [5].
Sec 14
Am 2001 No 121, Sch 2.127 [5].
Sec 15
Am 1970 No 52, Second Sch (am 1972 No 41, Second Sch).
Sec 17A
Ins 1998 No 107, Sch 3.7 [3].
Sec 18
Am 1970 No 52, Second Sch (am 1972 No 41, Second Sch); 1999 No 31, Sch 4.42 [2].
Sec 19
Am 1970 No 52, Second Sch (am 1972 No 41, Second Sch).
Sec 20
Subst 1970 No 52, Second Sch (am 1972 No 41, Second Sch). Am 1999 No 31, Sch 4.42 [2].
Sec 20A
Ins 1970 No 52, Second Sch (am 1972 No 41, Second Sch).
Sec 21
Am 1970 No 52, Second Sch (am 1972 No 41, Second Sch); 1993 No 47, Sch 1; 1999 No 31, Sch 4.42 [2].
Sec 22
Am 1970 No 52, Second Sch (am 1972 No 41, Second Sch); 1999 No 31, Sch 4.42 [2].
Sec 24
Am 1972 No 63, Sch; 1982 No 138, Sch 1.
Sec 25
Am 1993 No 47, Sch 1.
Sec 26
Am 1970 No 52, Second Sch (am 1972 No 41, Second Sch). Subst 1974 No 18, Sch 1. Am 1993 No 47, Sch 1; 1999 No 31, Sch 4.42 [2].
Sec 27
Subst 1970 No 52, Second Sch (am 1972 No 41, Second Sch).
Sec 28
Am 1937 No 35, Second Sch; 1970 No 52, Second Sch (am 1972 No 41, Second Sch); 1987 No 48, Sch 32; 1993 No 47, Sch 1; 1999 No 31, Sch 4.42 [2].
Sec 29
Am 1972 No 63, Sch; 1982 No 138, Sch 1.
Sec 31
Am 1970 No 52, Second Sch (am 1972 No 41, Second Sch); 1977 No 19, Sch 1.
Sec 32
Am 1999 No 31, Sch 4.42 [3].
Sch 3
Am 1999 No 31, Sch 4.42 [4].
Sch 5
Am 1965 No 33, First Sch; 1970 No 52, Second Sch (am 1972 No 41, Second Sch); 1999 No 31, Sch 4.42 [5].
The whole Act
Am 1999 No 31, Sch 5.48 [1] (each heading that is not a sec heading, a Sch heading or a heading in a Sch omitted).