STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO THE INEBRIATES ACT

STATEMENT AND RESPONSE TO QUESTIONS

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1. Experience, Expertise and MHRT Role

I wish to thank the Committee for the invitation to appear before it in person. I understand that this invitation has been made to me in my capacity as the President of the MHRT, a position I have occupied now for a period of three years. I emphasise that the opinions that I am about to express are mine alone. I shall also seek to be responsive to the questions that have been provided to me in advance of my appearance today.

My personal professional background is in law and criminology. For a number of years I was the Director of the Australian Institute of Criminology. In that role I was involved in policy related research on drug and alcohol issues including a project conducted in association with the Australian National University's National Centre for Epidemiology and Population Health, for the development of a heroin maintenance trial. I also chaired a National Committee on Violence (NCV). The NCV was established by the Prime Minister in the wake of the Hoddle and Queen Street massacres in Melbourne in the late 1980s. In its report, Violence. Directions for Australia, the NCV made wide ranging recommendations for the adoption of violence prevention measures which included many relating to drug and alcohol issues.

Before joining the MHRT I was for a number of years a Deputy President of the Federal Administrative Appeals Tribunal. I am also currently a member of the New South Wales Law Reform Commission.

The MHRT is a quasi-judicial body constituted under the Mental Health Act 1990 (the Act). The Tribunal has some 33 heads of jurisdiction, considering the disposition and release of persons acquitted of crimes by reason of mental illness; determining matters concerning persons found unfit to be tried, and prisoners transferred to hospital for

treatment/ reviewing the cases of detained patients (both civil and forensic), and long-term voluntary psychiatric patients; hearing appeals against a medical superintendent's refusal to discharge a patient; making, varying and revoking community treatment and community counselling orders; determining applications for certain treatments and surgery; and making orders for financial management where people are unable to make competent decisions for themselves because of psychiatric disability.

In performing its role the Tribunal actively seeks to pursue the objectives of the Act, including delivery of the best possible kind of care to each patient in the least restrictive environment; and the requirements of the United Nations principles for the protections of persons with mental illness and the improvement of mental health care, including the requirements that "the treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff".

In general, when sitting a Tribunal panel is required by the Act to comprise a lawyer, who is the chair, as well as a psychiatrist and another qualified member representing the general community. We have more than 100part time members who participate in Tribunal hearings. There are also three full time members, of whom I am one, all of whom are lawyers. Only full time members are able to preside over forensic hearings.

The Tribunal is not bound by the rules of evidence but must have constant regard to the rules of natural justice and procedural fairness. Tribunal hearings are conducted, so far as is possible, in an informal and non-adversarial manner. In the last calendar year we conducted about 8,700 hearings. Of these hearings about 600 were forensic and the balance civil matters. Within the metropolitan areas of Sydney, Newcastle and Wollongong the majority of these hearings are conducted on a face to face basis while in more remote and rural areas hearings are conducted by means of videolink or by phone.

2. Involuntary Treatment under the Act

Since 1990 New South Wales has been fortunate to possess a comprehensive legislative statement, in the form of the Act, concerning the general rights of persons who suffer from a mental illness and their entitlement to appropriate treatment and care. Prior to the commencement of this Act the rights of the mentally ill were poorly defined

and often abused by a system which gave largely unfettered discretion to the medical profession to prescribe involuntary treatment, often in massive psychiatric hospitals.

While there are many deficiencies in the present Act, many of which were considered by the NSW Legislative Council Select Committee on Mental Health in its report published in late 2002, there would seem to be a quite widespread consensus that the present regime contained in the Act for involuntary treatment in the mental health system works quite well. Under this system a mentally ill or mentally disordered person, as defined in the Act, can only receive involuntary treatment if that is necessary for the person's own protection from serious harm, or for the protection of others from such harm. It is a requirement that this treatment must be provided in the least restrictive environment possible. A set of checks and balances is also established to ensure that decisions made about treatment are reviewed on a regular basis by independent and impartial bodies including the Tribunal. I shall say more about this review process later in this submission.

3. Justification for Compulsory Treatment

I have had the benefit of reading a number of the submissions made to the Committee by people who are far more expert in this area than myself. In particular I found quite compelling the views expressed by Professor Ian Webster about the role for compulsory treatment of people with severe drug or alcohol dependence. I suspect that the philosophical basis for Professor Webster's recommendation, which would only permit external intervention to prevent severe harm to the person and to avert the risk of death, is based upon the views of John Stuart Mill and Jeremy Bentham. I share these utilitarian views. I also believe that attention must be given to the issue of capacity of persons with severe drug or alcohol dependence to make decisions about their own fate. The testimony given by Professor Terry Carney is especially relevant on this point.

4. When Compulsory Treatment?

I have already indicated what my general view is about a rationale for compulsory treatment for people with severe drug and alcohol problems. In so doing I should indicate that I have profound doubts about the ability of such treatment to secure a change in an individuals' behaviour. The evidence referred to in the submissions made by the Kirketon Road Centre (KRC) and by Professor Webster indicate that there is little,

if any, rigorous scientific support for the effectiveness of compulsory assessment and treatment in those jurisdictions which do allow this type of intervention. In particular, the experience in Sweden would seem to offer little support for the success of mandatory drug and alcohol treatment programmes.

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.

5. What Legislative Model?

I have mentioned the Act has proven to be a quite successful model for dealing with mental health issues in New South Wales for over a decade. However I would not suggest that it should now assimilate within its statutory confines those who would have formerly been dealt with under the Inebriates Act. I think it would be more appropriate to have a separate legislative framework for any form of compulsory treatment for people with severe drug and alcohol problems. The Act could provide a suitable model for such new legislation, including the review system put in place to ensure that the civil liberties of all of those involved are not infringed.

I recognise that in taking this view I may be taken to task for failing to have due regard to the inexorable linkages which exists in so many cases between mental illness and the use of drugs and alcohol. My own experience over three years in presiding over hundreds of Tribunal hearings suggests that a significant proportion of the clients appearing before the Tribunal have a dual diagnosis of mental illness and a substance dependence. Controversy and debate continues to surround the question of cause and effect in this arena but the fact remains that many of those who receive involuntary treatment for their mental illness, whether in detention or in the community, also require some form of rehabilitative therapy for their drug and alcohol related problems. The mental health system is at present neither tasked nor resourced to deal with this therapeutic need. As a result, a relapse often occurs in the person's mental state because they resume drug and alcohol use once released from the constraints of involuntary detention.

I note that Professor Webster in his submission has drawn attention to this particular problem and has emphasised the need for a coordinated approach to treatment across the spectrums of mental illness, drug and alcohol related health conditions. I would agree with this view, but still feel that a separate legislative framework is needed in order, among other things, to minimise the risk of net widening. The need for coordinated treatment should not result in the extension of compulsory treatment through an amplified Act.

6. Decision Making under the Act

I have attached to this statement a diagram which traces this processes of review provided for under the Act for mentally ill persons (MIP). I can elaborate upon this diagram in my oral testimony but in general the initiation of any move for involuntary treatment of a person suffering from a mental illness, or a mental disorder, commences with the issue of a certificate by a medical practitioner or another accredited person. Detention can also be requested by relatives or friends, or made after apprehension by the Police or on the order of a Court. Once such action has occurred the person will be taken to and detained in a hospital where an examination process is then commenced. This examination must take place as soon as practicable but not more than twelve hours after a person's arrival at the hospital. The examination must be conducted by a medical practitioner. If that practitioner certifies that the person remains mentally ill, or is mentally disordered, a second examination must then be conducted by another medical practitioner. One of these practitioners must be a psychiatrist. It should also be noted that at the time of these examinations information must be given to the detained person about their legal rights and other entitlements under the Act.

If a person is not discharged from the hospital by the medical superintendent, or reclassified as a voluntary patient, then they must be brought, as soon as is practicable, before a Magistrate. At the time of doing this the medical superintendent must also ensure that any relatives or near friends and guardians are advised of the person's continuing detention, unless that person objects.

When a person is brought before a Magistrate that judicial officer must conduct an inquiry. If the Magistrate finds that they are not a mentally ill person, this will result in

discharge. If they are found to be mentally ill then an adjournment is possible in the matter up to a period of fourteen days or the Magistrate can make what is termed a Temporary Patient Order (TPO) up to a maximum of three months, or a Community Treatment Order (CTO) for up to a maximum of six months. Rights of appeal to the Tribunal are given for decisions made by the Magistrate, as well as by the medical superintendent.

If the person remains in hospital for a further period they must then be brought before the Tribunal which is required to review their status. The Tribunal must decide whether or not they are suffering from a mental illness which requires treatment, either in the setting of a hospital or in the community. In making this decision the Tribunal must have regard to the risk of harm to self or others posed by the person as well as the need to ensure that the least restrictive environment is selected for the treatment that is required.

Once a person has a received two Temporary Patient Orders requiring them to be detained in hospital for treatment they may become a Continuing Treatment Patient, if a further order for detention is made. Once the person is a Continuing Treatment Patient they must be reviewed by the Tribunal once each six months. If, on the other hand, they are discharged into the community on a CTO the Tribunal must consider any application for an extension of that order by the local treating agency. Community Treatment Orders can only be made for persons who are first detained in a hospital. Community Counselling Orders may be made for persons who are not detained, but are in the community.

7. Review Process

I have already made mention of the general way in which the Tribunal approaches its hearings and the structure of the Tribunal panels (see 1 above). Tribunal hearings are listed on the basis of applications made by treating hospitals and community health care agencies. Since any involuntary treatment, whether in hospital or in the community, requires external review once the initial examination period has been traversed, there is a need for the Tribunal to provide a timely and accessible process. Applications for review are made directly by a treating hospital, or a community health care agency. Cases are usually listed for hearing within a short time of the application being received – usually no more than a few days after lodgement depending upon the hearing

schedule for a particular location. The Tribunal is also able to accept emergency applications through its regularly scheduled video and phone hearings which are conducted from the Tribunal's Gladesville premises.

The Tribunal has sought to schedule no more than twelve cases each day in its civil list and eight in its forensic jurisdiction in order to ensure that adequate time is available to give a fair and appropriate hearing. In general patients must appear before the Tribunal. Patients also have a right to legal representation. In the case of persons involuntarily detained in hospital, legal assistance is available without merit review through the Mental Health Advocacy Service. The Advocacy Service is not available in applications for CTOs – something which both the Advocacy Service and the Tribunal regret but which is a product of the lack of resources.

It is not uncommon for relatives and friends of the patient to attend hearing which are open to the public unless a request is made, and upheld by the Tribunal, for them to be closed. There are also constraints on the reporting of details of hearings in the media.

The Tribunal operates to the greatest degree possible in an informal manner. It is reliant upon evidence being presented to it in order to make a determination about an appropriate outcome in each case. This means that treating teams are required to attend hearings and to present their case in each application..

There would seem to be no reason why the same process of review by a Tribunal should not be applied as well to any new legislation designed to extend involuntary treatment to people with severe drug and alcohol problems. Indeed, in my view it would be essential that this form of review should 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 Tribunal which already possesses the general expertise and experience required to deal with the sensitive issues which arise in this area. The Tribunal has to review as part of its daily business, patients who come before it with dual diagnosis problems and who need access to rehabilitation not only for their mental illness but also for their drug and alcohol dependence. With adequate resources, and

assuming that there would only be a very small case load, it would be cost effective to add this area to the jurisdiction of the Tribunal.

8. Net Widening

There is an undoubted potential, to be avoided at all costs, for net widening resulting from a new compulsory treatment system of the type envisaged. I note from the submission of the KRC that from their experience only a very small number of persons would quality for compulsory treatment. The two case studies that they have provided are most instructive and also point to the failure of the existing mental health system to cope with this sutuation. I believe that net widening could be averted by a combination of factors including the following:

1. Prescribing a very tight definition of the circumstances in which compulsory treatment could be ordered. I would limit such treatment only to life threatening situations.
2. Requiring a comprehensive review process of the type already explained.
3. Setting a sunset clause in any new legislation which would require an external and objective appraisal of the outcomes of any new Act before deciding whether or not to extend its' life span.
4. Subjecting any compulsory treatment programmes to rigorous scientific examination in order to determine their effectiveness.

9. Service Monitoring

I do not feel qualified to comment at large upon the mechanisms that might be applied to ensure quality of service within the treatment framework of any new compulsory scheme. I do believe that the external review by a Tribunal can assist in this process, but it cannot be the predominant mechanism. Evidence based research of the effectiveness of programmes offered for treatment is also part of the same mechanism.

10. Community Treatment Orders (CTO)

There is much debate in the mental health system about the effectiveness and appropriateness of CTOs and CCOs as treatment modalities. Many of the issues associated with such orders have been discussed in the Legislative Council's Select Committee Report on the Mental Health System. There is also a current review of the Act being conducted by the Department of Health which is considering a number of

proposals to change the way in which these orders are administered, including extending their length of operation from six to twelve months and allowing CTOs to be made directly in the community rather than only after detention in a hospital.

Against this background it is perhaps unwise to offer assertive views on the appropriateness of these orders for severe substance dependence although orders of this type are obviously of a much less restrictive nature than any treatment provided while a person is in involuntary detention. The principle objection I have at present to CTOs and CCOs is that they are dependent upon the provision of adequate resources in the community to manage and fulfil treatment plans. All too often these resources are not available with the outcome is relapse and readmission to hospital on a continuing basis. The same situation could well prevail if any extension was made to the reach of these orders to deal with severe substance dependence.

There is also the problem which I raised earlier about the linkage of drug and alcohol rehabilitation with existing CTOs for mental health clients. There are serious questions about the legality of including a provision for such drug and alcohol treatment in the current schema for CTOs. Severe sanctions also apply if a person breaches such a condition. A breach may not require return to a hospital but often this is the only available outcome. The same problem would presumably arise if CTOs were to be introduced for compulsory drug and alcohol treatment.

11. Cocaine Use

I have read the submission made by the KRC concerning the gap in the Act's capacity to enable involuntary detention for people with a short lived but repeated psychosis resulting from cocaine use. I would have thought that the definition of a mentally disordered person under the Act would have been sufficient to ensure that a person in this situation would be able to be detained and treated on a involuntary basis for a short period. It has been suggested that the mentally disordered provisions in the Act do not work well and that there may be a need to extend the time for which a mentally disordered person can be detained. This is a subject which is being considered as part of the current review of the Act. However, what I believe is really happening is that the mental health system does not have the capacity to deal with difficult patients like the one described in the case study from KRC. Accordingly, a person like this tends to be

bounced from one agency to another with none claiming responsibility. The solution to this is the coordination of the respective services in a way which ends these treatment boundary disputes.

12. Unified or Separate Systems?

I remain rather ambivalent about whether there should be a unified compulsory treatment system, or separate systems for those with mental illness, alcohol and other drug problems. While believing that the legislation providing for such compulsory treatment should remain separate I am inclined towards the view that the only way in which the multi various problems which already affect the majority of mental health clients cannot be dealt with is through a unified health system that can provide a range of both voluntary and involuntarily treatment. The present Balkanised system often allows treatment agencies to avoid their responsibilities by contending that a particular individual does not fall within their treatment regime category. This would certainly seem to have been the case in relation to the few attempts made over recent years to utilise the provisions of the existing Inebriates Act in order to direct persons to mental health facilities for involuntary treatment.

There will obviously need to be a comprehensive review conducted of the facilities which can be made available to deal with any new compulsory treatment scheme for persons with severe drug dependence. There may well be some comparative models from other jurisdictions which could be utilised in the development of an appropriate system for New South Wales.

13. Outcome

From the submissions which I have read I would envisage that little, if any, purpose would be achieved by this Inquiry if it simply tinkered with the provisions of the existing Inebriates Act. Rather, this legislation should in my view be scrapped and replaced by a new legislative model which can draw upon the provisions and experience of the Mental Health aCT in New South Wales. On balance I think that there is a case to be made for the compulsory treatment of persons with a severe drug dependence who are placed in or create a life threatening situation. I would hope that this Inquiry would be able to identify and adopt best practice in this area without in any way diminishing the

overarching harm minimisation approach which has served this country well, in contrast with prohibitionist and allied models espoused elsewhere.