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

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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

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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