

## 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?<sup>282</sup>

When working with “inebriates” there is a fundamental ethical question: Do people have the right to drink themselves to death?<sup>283</sup>

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.

<sup>282</sup> Submission 16, North Coast Regional Coordination Management Group, p3

<sup>283</sup> 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.<sup>284</sup>

**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.<sup>285</sup>

**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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<sup>284</sup> Submission 30, Kirketon Road Centre, p4

<sup>285</sup> 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.<sup>286</sup> 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.<sup>287</sup>

**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)

<sup>286</sup> 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

<sup>287</sup> 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.<sup>288</sup>

**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.<sup>289</sup>

**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.<sup>290</sup>

## 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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<sup>288</sup> Professor Terry Carney, Professor of Law, University of Sydney, Evidence, 8 April 2004, pp17-18

<sup>289</sup> Professor Hall, Professorial Fellow and Director, Office of Public Policy and Ethics, Institute for Molecular Bioscience, University of Queensland, Evidence, 29 April 2004, p2

<sup>290</sup> 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.<sup>291</sup> 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.<sup>292</sup> 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.<sup>293</sup> Other participants who proposed a comprehensive compulsory treatment model included the Police Association of NSW and the Mid Western Area Health Service.<sup>294</sup> 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:

<sup>291</sup> Submission 50, NSW Chapter of Addiction Psychiatry, p2

<sup>292</sup> Mr George Klein, Behavioural Scientist, Centre for Drug and Alcohol Medicine, Nepean Hospital, Evidence, 7 April 2004, pp52-54

<sup>293</sup> 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

<sup>294</sup> 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.<sup>295</sup>

- 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.<sup>296</sup>

- 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.<sup>297</sup> 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.'<sup>298</sup>

### **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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<sup>295</sup> Ms Taylor, Royal North Shore and Ryde Health Services, Evidence, 7 April 2004, p23

<sup>296</sup> Dr Richard Matthews, Acting Deputy Director General, Strategic Development, NSW Health, Evidence, 11 December 2003, p19

<sup>297</sup> Professor Carney, University of Sydney, Evidence, 8 April 2004, p21

<sup>298</sup> 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.<sup>299</sup>

**6.25** Representatives of NSW Health<sup>300</sup> and the Attorney General's Department<sup>301</sup> 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.<sup>302</sup>

**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.'<sup>303</sup>

**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.<sup>304</sup> 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'.<sup>305</sup>

<sup>299</sup> Emeritus Professor Ian Webster AO, NSW Expert Advisory Committee on Drugs, Evidence, 18 February 2004, p10

<sup>300</sup> Ms Michelle Noort, Director, and Mr David McGrath, Acting Deputy Director, Centre for Drug and Alcohol, NSW Health, Evidence, 29 April 2004, p15

<sup>301</sup> Mr Feneley, Attorney General's Department, Evidence, 11 December 2003, p7

<sup>302</sup> Judge Derek Price, Chief Magistrate, Local Court of New South Wales, Evidence, 26 November 2003, p10

<sup>303</sup> Mr Graeme Smith, Director, Office of the Public Guardian, Evidence, 7 April 2004, p41

<sup>304</sup> Dr Hester Wilce, Medical Practitioner, and Dr Ingrid van Beek, Director, Kirketon Road Centre, Evidence, 7 April 2004, pp1-3

<sup>305</sup> 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 bingeing 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.<sup>306</sup>

<sup>306</sup> 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.<sup>307</sup>

### **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.<sup>308</sup> 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.<sup>309</sup>
- 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.<sup>310</sup>

- 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.

<sup>307</sup> Mr McGrath, NSW Health, Evidence, 29 April 2004, p15

<sup>308</sup> 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

<sup>309</sup> Supplementary Submission 43, Emeritus Professor Ian Webster AO, NSW Expert Advisory Committee on Drugs, p6

<sup>310</sup> 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.<sup>311</sup>

- 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.<sup>312</sup>

- 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.<sup>313</sup>

### **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 intoxication 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.<sup>314</sup>

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<sup>311</sup> Dr Dore, Macquarie Hospital, Evidence, 4 March 2004, p9

<sup>312</sup> Professor Duncan Chappell, President, Mental Health Review Tribunal, Evidence, 29 April 2004, p41

<sup>313</sup> Mr Feneley, Attorney General's Department, Evidence, 11 December 2003, p4

<sup>314</sup> 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<sup>315</sup> 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.<sup>316</sup> 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,<sup>317</sup> 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.<sup>318</sup> 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'.<sup>319</sup> 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.<sup>320</sup>
- 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

<sup>315</sup> 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

<sup>316</sup> Ms Beth Burton, Clinical Nurse Consultant, Alcohol and Other Drug Services, New England Area Health Service, Evidence, 24 March 2004, p14

<sup>317</sup> Mr Graeme Smith, Director and Ms Frances Rush, Regional Manager, Office of the Public Guardian, Evidence, 7 April 2004, p38

<sup>318</sup> Ms Harvey, Northern Sydney Health, Evidence, 4 March 2004, pp5-6

<sup>319</sup> Ms Vi Hunt, Area Director, Drug and Alcohol Services, New England Area Health Service, Evidence, 24 March 2004, p10

<sup>320</sup> 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.<sup>321</sup>

**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.’<sup>322</sup>

**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.<sup>323</sup>

**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.<sup>324</sup>

### **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,

<sup>321</sup> Dr Ferguson, Rozelle and Concord Hospitals, Evidence, 27 November 2003, p45

<sup>322</sup> 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

<sup>323</sup> Ms Sylvia Alberti, Manager, Forensic and Clinical Services and Senior Research Fellow, Turning Point Alcohol and Drug Centre, Evidence, 28 April 2004, p29

<sup>324</sup> Dr Wilce, Kerketon 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.<sup>325</sup> 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.<sup>326</sup>
- 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

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<sup>325</sup> Confidential evidence

<sup>326</sup> 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.<sup>327</sup>

- 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.<sup>328</sup> 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.<sup>329</sup>

- 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.<sup>330</sup>

### **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

<sup>327</sup> Professor Hall, University of Queensland, Evidence, 29 April 2004, p5

<sup>328</sup> Professor Carney, University of Sydney, Evidence, 4 June 2004, p5

<sup>329</sup> Tabled Document No 35, *Statement and Response to questions*, p4

<sup>330</sup> 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.’<sup>331</sup>

- 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.<sup>332</sup>

### *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.’<sup>333</sup> 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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<sup>331</sup> Mr Klein, Nepean Hospital, Evidence, 7 April 2004, p55

<sup>332</sup> Dr Ferguson, Rozelle and Concord Hospitals, Evidence, 27 November 2003, pp41-2

<sup>333</sup> Judge Price, Chief Magistrate, Evidence, 26 November 2003, p10



and that providing some relief would perhaps be an opportune by-product.<sup>334</sup> 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.<sup>335</sup>

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.<sup>336</sup>

**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.<sup>337</sup>

### *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.<sup>338</sup>

**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.

<sup>334</sup> Ms Noort and Mr McGrath, NSW Health, Evidence, 29 April 2004, p17

<sup>335</sup> Ms Noort, NSW Health, Evidence, 29 April 2004, p17

<sup>336</sup> Ms Noort, NSW Health, Evidence, 29 April 2004, p17

<sup>337</sup> Dr Matthews, NSW Health, Evidence, 11 December 2003, p28

<sup>338</sup> 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.<sup>339</sup>

- 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

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<sup>339</sup> 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.<sup>340</sup>

**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.<sup>341</sup> 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.<sup>342</sup>

**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.<sup>343</sup>

**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

<sup>340</sup> Assistant Commissioner Bob Waites, Commander, Greater Metropolitan Region and Corporate Spokesperson, Alcohol related Crime, NSW Police, Evidence, 27 November 2003, pp30-31

<sup>341</sup> Dr Martyn Patfield, Consultant Psychiatrist, Medical Superintendent and Director of Acute Services, Bloomfield Hospital, Evidence, 24 March 2004, p13

<sup>342</sup> Dr Patfield, Bloomfield Hospital, Evidence, 4 June 2004, p3

<sup>343</sup> 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.<sup>344</sup>

### **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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<sup>344</sup> 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.<sup>345</sup>
- 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.<sup>346</sup>

<sup>345</sup> NSW Government, *Outcomes of the NSW Summit on Alcohol Abuse 2003: Changing the Culture of Alcohol Use in New South Wales*, May 2004, p189

<sup>346</sup> 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'.<sup>347</sup>
- 6.88** Similarly, Mr Larry Pierce of the Network of Alcohol and other Drugs Agencies told the Committee:

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<sup>347</sup> 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.<sup>348</sup>

## 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.

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## 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.

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<sup>348</sup> Mr Pierce, Network of Alcohol and Other Drugs Agencies, Evidence, 27 November 2003, p53