

Standing Committee on Social Issues

**Report on the**  
***Inebriates Act 1912***

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House

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## Terms of reference

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

- (1) The *Inebriates Act 1912* and the provision of compulsory assessment and treatment under that Act;
- (2) The appropriateness and effectiveness of the Act in dealing with persons with severe alcohol and/or drug dependence who have not committed an offence and persons with such dependence who have committed offences;
- (3) The effectiveness of the Act in linking those persons to suitable treatment facilities and how those linkages might be improved if necessary;
- (4) Overseas and interstate models for compulsory treatment of persons with severe alcohol and/or drug dependence including in Sweden and Victoria;
- (5) Options for improving or replacing the Act with a focus on saving the lives of persons with severe alcohol and/or drug dependence and those close to them; and
- (6) Any other related matter.

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

## Committee membership

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

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## Chair's foreword

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

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

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

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

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

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

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

**Jan Burnswoods MLC**  
**Chair**

## Executive summary

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

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

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

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

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

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

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

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

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

### **Ethical basis**

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

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

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

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

### **The proposed legislation**

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

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

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

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

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

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

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

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

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

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

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

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

### **The service framework**

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

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

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

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

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



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

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

### **Key themes**

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

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

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

## Summary of recommendations

### Recommendation 1

Page 66

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

### Recommendation 2

Page 105

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

### Recommendation 3

Page 108

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

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

### Recommendation 4

Page 108

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

### Recommendation 5

Page 109

That the proposed legislation fall within the Health portfolio.

### Recommendation 6

Page 109

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

### Recommendation 7

Page 110

That the proposed legislation be stand-alone legislation.

### Recommendation 8

Page 111

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

### Recommendation 9

Page 113

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

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

### Recommendation 10

Page 113

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

**Recommendation 11***Page 113*

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

**Recommendation 12***Page 116*

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

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

**Recommendation 13***Page 116*

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

**Recommendation 14***Page 118*

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

**Recommendation 15***Page 123*

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

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

**Recommendation 16***Page 124*

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

**Recommendation 17***Page 125*

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

**Recommendation 18***Page 126*

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

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

**Recommendation 19***Page 126*

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

**Recommendation 20***Page 126*

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

**Recommendation 21***Page 127*

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

**Recommendation 22***Page 127*

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

**Recommendation 23***Page 128*

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

**Recommendation 24***Page 129*

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

**Recommendation 25***Page 130*

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

**Recommendation 26***Page 131*

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

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

**Recommendation 27***Page 134*

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

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

**Recommendation 28***Page 138*

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

**Recommendation 29***Page 138*

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

**Recommendation 30***Page 143*

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

**Recommendation 31***Page 148*

That NSW Health immediately undertake:

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

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

**Recommendation 32***Page 148*

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

**Recommendation 33***Page 148*

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

**Recommendation 34***Page 150*

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

**Recommendation 35***Page 151*

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

**Recommendation 36***Page 152*

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

**Recommendation 37***Page 153*

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

**Recommendation 38***Page 155*

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

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

**Recommendation 39***Page 157*

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

**Recommendation 40***Page 157*

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

**Recommendation 41***Page 158*

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

**Recommendation 42***Page 159*

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

**Recommendation 43***Page 160*

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

**Recommendation 44***Page 163*

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

**Recommendation 45***Page 163*

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

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

**Recommendation 46***Page 164*

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

**Recommendation 47***Page 164*

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

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

**Recommendation 48***Page 173*

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

**Recommendation 49***Page 177*

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

**Recommendation 50***Page 184*

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

**Recommendation 51***Page 185*

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

**Recommendation 52***Page 189*

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

**Recommendation 53***Page 190*

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

**Recommendation 54***Page 193*

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

**Recommendation 55***Page 194*

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

## Glossary

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

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