Chapter 1 Introduction

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

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

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

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

Background to the inquiry

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The purpose of the inquiry

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

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

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

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

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

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

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

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

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

Terminology

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

The broader context

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

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

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

11 Submission 47, NSW Government, pp5-6

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

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

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

The nature and prevalence of dependence

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

What is substance dependence?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

How prevalent is substance dependence?

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

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

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

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

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

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

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

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

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

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

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

Key questions for the inquiry

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

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

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

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

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

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

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

- Is dependence on alcohol and narcotic drugs a significant enough condition for society to intervene to remove people's liberty in order to legally enforce assessment, detoxification and treatment? If so, under what conditions should this happen?

- Should there be a minimum and/or maximum time for committal under any compulsory treatment legislation? If so, how should this time be determined and what controls do there need to be to protect patients?

- Should legislation for the compulsory treatment of people who are addicted to alcohol or other drugs include additional provisions to protect the committed person? If so, what additional protection do these people need?

- Is it appropriate for people to be compulsorily detained in the interests of their relatives? If not, what should the rationale for compulsory treatment be?

- Should compulsory treatment apply to treatment in non-institutional settings such as community programs or day programs?

- Should there continue to be a process of certifying institutions for the purpose of treatment under the Act or should any agency be able to provide compulsory treatment?

- If it is decided that compulsory treatment should be continued should all drug and alcohol treatment organisations be required to accept people referred by the Courts? How would this work in practice?[25]

Previous reviews of the Act

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

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

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25 Submission 47, NSW Government, pp5-6

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conduct of the inquiry

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

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

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

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

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

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

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

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

The structure of this report

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

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

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

Next steps

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

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

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

Part One