

Chapter 7 **A new legislative framework for involuntary care**

The development of an alternative legislative approach to the *Inebriates Act* needs ... to protect individual rights as far as possible; it needs to have clear criteria for its application; it needs to have clearly defined objects; it cannot force judicial officers into making medical decisions; it needs to complement other legislation; it needs to demonstrate that it has a purpose ... it should not remove individuals from the public gaze merely because they are unpleasant or upsetting family members.³⁴⁹

In Chapter 4, on the basis of the litany of criticisms of the *Inebriates Act*, the Committee recommended the Act's immediate repeal. In the previous chapter we explored the ethics of compulsory treatment and concluded that involuntary care may be justified for the purpose of reducing serious harm to the person with substance dependence. While we did not support coercion of non-offenders in the interests of others, we did identify the need for a mechanism to address the complex needs and antisocial behaviour associated with some people who have a severe substance dependence. In this chapter the Committee draws on the evidence of a range of participants to build the elements of the legislative framework that we believe should replace the Act. The chapter commences by establishing the scope and objects of the legislation, and the principles to underpin it. We then set out the criteria to be used, the length and features of involuntary care orders, and the various elements of the decision making process to be followed when an individual is considered for involuntary care, and a number of other safeguards to protect the rights of those subject to an order. Provision for a non-coercive mechanism targeting people with antisocial behaviour and complex needs arising from substance use is also discussed. The chapter concludes with recommendations in relation to the *Intoxicated Persons Act*.

Scope and objects of the proposed legislation

- 7.1 In the previous chapter the Committee established that involuntary care is justified for the purpose of protecting a person with substance dependence from serious harm. Such care is to be short term and limited to those who have experienced or are at risk of serious harm, and whose decision making capacity is considered to be compromised. Other aims of the intervention are assessing the person's needs, restoring their capacity to make an informed decision about their substance misuse, and where appropriate, providing an entry point for care and support under guardianship. The interventions provided should incorporate medical treatment including detoxification as appropriate to the person's needs, along with comprehensive assessment and the development of a treatment plan, and actively linking the person to voluntary services, with assertive follow-up on discharge.
- 7.2 In the absence of evidence to support the efficacy of compulsory treatment aimed at addressing substance dependence in the longer term, the Committee found against a system for that purpose.
- 7.3 After considering the ethics of involuntary interventions in the interests of others, we also found against the use of coercion in the interests of anyone other than the person with substance dependence, except as is already provided under law (for example child protection

³⁴⁹ Submission 23, Council of Social Service of NSW, p14

or criminal law). This was informed by a fundamental ethical principle in respect of any intrusion on the autonomy of a non-offender: that the person's interests must be paramount.

7.4 Nevertheless, the Committee did recognise the need for a non-coercive mechanism to address the complex needs and antisocial behaviour associated with some people who have a serious substance dependence. This was advocated by a range of participants including representatives of the Police Service, the Attorney General's Department, clinicians and academics. The roundtable discussion that we held with key stakeholders towards the end of the inquiry provided valuable information on a potential way forward in this area, and this is explored in detail later in this chapter.

Purpose and aims of the proposed legislation

7.5 Participants at the roundtable indicated broad support for a legislative model providing short term involuntary care to protect people at risk of serious harm, as recommended in the previous chapter.

7.6 In the discussion in Chapter 6 on involuntary interventions with the goal of harm reduction, the Committee concluded that the primary goal of involuntary care should be protection of the health and safety of the person with substance dependence. We also identified several secondary aims:

- 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 long term care and support under guardianship.

7.7 The Committee considers that the purpose and aims described above should be codified in the proposed legislation.

Recommendation 3

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.
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Alcohol and other drug dependence

7.8 There was broad agreement among inquiry participants that any new legislation enabling involuntary care be inclusive of any substance, in recognition that serious harm may arise from alcohol or other drugs, and that a distinction between the two is somewhat meaningless. As Dr Victor Storm, Psychiatrist and Clinical Director of Central Sydney Area Mental Health Services stated:

To do it by substance is probably not particularly helpful. The experience is that most people, even if they start off with one agent, will often use or abuse another agent if that agent is not available. It needs to be broad-based rather than agent-based legislation.³⁵⁰

7.9 The Committee considers that it is the harm, rather than the substance, that is the key issue, and that the legislation should be inclusive of any substance dependence.

Recommendation 4

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

Responsibility for the legislation

7.10 Given the therapeutic purpose of the proposed legislation, and its focus on the provision of medical care, the Committee considers that it will appropriately fall within the portfolio of the Minister for Health.

³⁵⁰ Dr Victor Storm, Clinical Director, Central Sydney Area Mental Health Service, Evidence, 27 November 2003, p45

- 7.11** We anticipate that policy and administration in relation to the legislation will be the responsibility of the Centre for Drug and Alcohol within NSW Health but that other agencies such as the Attorney General's Department, NSW Police, Department of Community Services, Department of Ageing, Disability and Home Care and other agencies will have a role to play in implementing the legislation.
- 7.12** The NSW Government submission to the inquiry states that in order to optimise the interface between agencies, the Committee might consider the development of interagency agreements on the respective roles of agencies:
- ... to ensure that an order results in an appropriate referral, assessment, intervention, treatment and rehabilitation pathway and that it is enforced effectively ... It might be appropriate to develop new interagency protocols, to provide a mechanism for moving patients through a compulsory treatment system where agreed treatment milestones were provided by each service stream. One possible model is the interagency protocol entered into under the Intoxicated Persons Act 1979 ... Regulations could also provide a statutory basis for such a protocol.³⁵¹
- 7.13** The Committee agrees that an interagency agreement articulating the respective roles of government agencies will be very important to the success of the proposed legislation, and to ensuring positive outcomes for those subject to it. At various points in this and the following chapter we identify a number of roles for particular agencies.

Recommendation 5

That the proposed legislation fall within the Health portfolio.

Recommendation 6

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

Stand-alone legislation

- 7.14** The Committee has considered whether provision for involuntary care for people with substance dependence at risk of serious harm is already made under other legislation. We understand that other bodies that have reviewed the *Inebriates Act* came to such a conclusion.

The Mental Health Act 1990

- 7.15** Alcohol or drug dependence alone is insufficient grounds to involuntarily admit a person under the *Mental Health Act*. The person must be considered to be 'mentally ill' or 'mentally disordered', but the legislation explicitly states that a person may not be deemed mentally ill or mentally disordered simply because they take or have taken alcohol or any other drug. Nevertheless, there is nothing to prevent a person who meets the criteria for the Committee's

³⁵¹ Submission 47, NSW Government, p25

model being brought under the *Mental Health Act* for detoxification where they satisfy the definition of mentally ill or mentally disordered.³⁵²

- 7.16** Dr Patfield of Bloomfield Hospital told the Committee that this frequently occurs.³⁵³ Other participants such as Dr Stephen Jurd of Northern Sydney Health and Professor Ian Webster reported that this may be true, but it is often very difficult to use the *Mental Health Act* for that purpose as people with alcohol problems, in particular, are often excluded from the mental health system.³⁵⁴ The case study of 'LT' from the Kirketon Road Centre in the previous chapter highlighted how the *Mental Health Act* could not be utilised to provide protection and care for a woman with cocaine induced delirium who was at significant risk of harm.
- 7.17** The majority of participants suggested that the *Mental Health Act* would serve as a useful *model* for new legislation for people with severe substance dependence at risk of serious harm, rather than being used to cater for that group as well. In addition, the Committee considers that it would be more in keeping with the current conceptualisation of alcohol and other drugs as separate from mental illness to have separate legislation.

The Guardianship Act 1987

- 7.18** In Chapter 2 when we outlined the provisions of the *Guardianship Act*, the Committee noted the very high threshold that applies before a guardianship order can be made: the person must have a permanent disability restricting them in one or more life activities, and as a result, the person must be totally or partially incapable of managing themselves. Moreover, that Act has a very different purpose and intent to that which the Committee is proposing: it seeks to maximise freedom rather than to provide coercive protection. Importantly, however, the *Guardianship Act* does capture those whose substance use has left them with substantial disability, for example those with significant cognitive damage arising from long term alcohol misuse.³⁵⁵ As reflected in Recommendation 3 above, one of the aims of short term involuntary care would be to provide an entry point, where appropriate, for people to be considered for guardianship.
- 7.19** The Committee considers that there is a need for stand-alone legislation to enable involuntary care. Such legislation would complement the *Mental Health* and *Guardianship Acts*.

Recommendation 7

That the proposed legislation be stand-alone legislation.

³⁵² Submission 47, NSW Government, pp17-18; *Mental Health Act 1990*, s11

³⁵³ Dr Martyn Patfield, Consultant Psychiatrist, Medical Superintendent and Director of Acute Services, Bloomfield Hospital, Evidence, 4 June 2004, p13

³⁵⁴ Dr Stephen Jurd, Area Medical Director and Addictions Psychiatrist, Drug and Alcohol Services, Northern Sydney Health and Emeritus Professor Ian Webster AO, NSW Expert Advisory Committee on Drugs, Evidence, 4 June 2004, p14

³⁵⁵ Submission 44, Mr Nick O'Neill, President, Guardianship Tribunal, pp1-4 and 6

Principles

- 7.20** In Chapters 3 and 6 the Committee referred to the United Nations *Principles for the Protection and Care of People with Mental Illness* (hereafter the UN Principles), which set out the rights and freedoms of voluntary and involuntary patients, codifying the procedural framework for decisions to detain and treat a person without consent. While we do not consider alcohol or other drug dependence to be a mental illness, we recognise the parallels between the two and agree with Professor Carney that the Principles are sufficiently broad to cover both.³⁵⁶ Moreover, the purpose of the UN Principles - to protect the liberty and dignity of patients and ensure that they are treated with humanity and respect - is of clear relevance to those who are the focus of this inquiry. The Committee considers that these Principles should underpin the proposed legislation.
- 7.21** The UN Principles were reflected in many of the views put by participants, and some specifically referred to them. For example, in the NSW Government submission, the Attorney General's Department affirmed the principles of the least restrictive alternative, the right to independent review, the necessity for other safeguards, and the right to quality, evidence-based treatment.³⁵⁷

Recommendation 8

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.

Criteria for involuntary care

- 7.22** In keeping with the findings of the previous chapter, the Committee has identified four criteria to be met before a person may be subject to involuntary care. Each is to be explicitly considered during the decision making process discussed later in the chapter. The legislation would necessarily include definitions of the concepts used, where appropriate. Similarly, each would be clearly operationalised through guidelines for those involved in decision making.
- 7.23** As documented in Chapter 7, various participants argued that substance dependence or substance use alone did not justify involuntary intervention. In the interests of tightly focusing the proposed legislation on the appropriate group, and safeguarding against inappropriate use, the Committee considers that it should explicitly exclude the use of involuntary care for people simply using or dependent on substances.
- 7.24** The Committee has designed this legislative framework with adults in mind. We have received very little evidence about the appropriateness of applying the framework to minors. There is potentially a significant gap in relation to the treatment of minors with a substance dependence. The Committee believes this requires further investigation.

³⁵⁶ Professor Terry Carney, Professor of Law, University of Sydney, Evidence, 8 April 2004, p17

³⁵⁷ Submission 47, NSW Government, p23

Severe substance dependence

- 7.25 Like many inquiry participants, the Committee considers that involuntary care should be restricted to those with severe substance dependence. In keeping with the UN Principles, we believe that such a diagnosis should be based on an internationally accepted diagnostic tool, such as the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM IV).

Serious harm to self

- 7.26 The Committee considers it essential that a person have experienced or be at immediate risk of serious harm to self before involuntary care may be ordered. On the basis of feedback at the roundtable discussion, we believe that serious harm should not be limited to physical harm, but rather, should be interpreted holistically, as is the case under the *Mental Health Act*. Professor Webster put it in terms of a person's health or welfare being significantly impaired.³⁵⁸ Such harm may also include not just that arising through injury or illness, but also through self-neglect. Unlike under the *Mental Health Act*, we do not consider that harm to reputation is a valid consideration, given the subjective judgements that may be made in relation to substance use.

Lack of capacity

- 7.27 While some people with serious substance dependence will lack decision making capacity, others will not, and it is only when they do that intervention may be justified. In the previous chapter we documented a number of examples of how a lack of decision making capacity might manifest itself. In light of the seriousness of the decision to detain and treat a person against their will and the fundamental right of a person to make their own decisions, the Committee considers that specific consideration must be given to whether the person lacks the capacity to consent to treatment as a necessary precondition for involuntary care.

Treatment plan

- 7.28 The presence of an initial treatment plan setting out how the intervention is expected to benefit the person serves both to justify that detention and to ensure that coercion serves a therapeutic rather than a punitive purpose. In effect, it holds the state accountable for the action of placing a person in involuntary care.³⁵⁹ The Committee considers that the presence of an initial treatment plan, which includes a rationale for the recommended length of detention, should be an essential precondition to involuntary care. This initial plan would be developed on the basis of a medical examination, according to a process set out later in this chapter.

³⁵⁸ Professor Webster, NSW Expert Advisory Committee on Drugs, Evidence, 4 June 2004, p3

³⁵⁹ Professor Carney, University of Sydney, Evidence, 8 April 2004, pp18-19

Recommendation 9

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

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

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

Involuntary care orders

7.29 The Committee took detailed evidence on the various provisions for involuntary care for people with substance dependence at risk of serious harm that should be made under the proposed legislation.

Detention

7.30 Provision for detention against the person’s will was widely understood and supported by participants as a key element of involuntary care. Along with evidence-based clinical interventions, ‘containment in a safe environment’, as Dr Hester Wilce of the Kirketon Road Centre described it,³⁶⁰ was perhaps the most important element of involuntary care. Indeed, many saw this as critical for the purpose of protection from serious harm.

7.31 The Committee considers that the power of suitable facilities to detain would be an essential element of an involuntary care order. The need for the legislation to set out the responsibilities of facilities and staff in relation to detention is discussed in a later section.

Interventions provided

7.32 As outlined in the previous chapter, and in keeping with the goal and aims of the proposed legislation, a range of interventions may be provided to those subject to an order for

³⁶⁰ Dr Hester Wilce, Medical Practitioner, Kirketon Road Centre, Evidence, 7 April 2004, p5

involuntary care. These would necessarily entail evidence-based clinical interventions³⁶¹ provided in a medical setting. Consistent with participants' views and the UN Principles, patients would have the right to the best available care, with the least restrictive or intrusive treatment being provided, with the aim of preserving or enhancing their autonomy. The service framework to support such orders is set out in the following chapter.

- 7.33** Participants argued strongly that the interventions delivered must be determined on the basis of an assessment of the person's individual needs; they would also be set out in the initial treatment plan that necessarily preceded the order.
- 7.34** While the specific medical care, harm reduction and psychosocial interventions would vary according to the person's needs, several core interventions are to be provided:
- the person is to be given a comprehensive assessment, that is, assessment of their physical, psychological and social needs. This should also include neuropsychological assessment of cognitive functioning where appropriate.
 - on the basis of that assessment, a post-discharge treatment plan is to be developed, setting out the recommended treatment or services for the person once they leave involuntary care.
 - in accordance with the post-discharge treatment plan, the person is to be actively linked to the services and further treatments recommended for them, including to a general practitioner, and where necessary be supported to apply for guardianship.
- 7.35** The Committee understands that the process of applying for guardianship can be a lengthy, complex and labour-intensive process for staff who are assisting the person. Provision for time to enable this to occur is considered below, and the service implications are explored in Chapter 9.
- 7.36** In the Committee's view, these core interventions give expression to the human rights principles concerning involuntary care, and are vital to ensuring positive outcomes for the person subject to such care. Thus we consider that the Minister for Health should ensure that they are provided to all persons placed in involuntary care.

Length of orders

- 7.37** The Committee established in the previous chapter that intrusion for a short period was consistent with ethically sound intervention with the goal of protecting a person's health and safety. Ultimately, the length of time needs to balance the person's dual rights to minimal intrusion and to obtain maximum benefit from the intervention. The Committee believes the order should be for as short a period as is necessary to achieve the aims of an order, that is, to reduce harm through the provision of medical interventions, to stabilise the person and comprehensively assess them, to develop their treatment plan and to engage them in the voluntary service system.
- 7.38** While there was a significant range in the length of time that participants envisaged (advocates for a shorter period suggested anywhere between 3 days and a month), there was broad

³⁶¹ Submission 29, Network of Alcohol and Other Drugs Agencies, p11

agreement that the length should not be arbitrary, as under the *Inebriates Act*, but determined on the basis of a clinical assessment of the person's needs.

- 7.39** Participants with clinical expertise in addictions indicated that the length of an order would necessarily be determined by the nature of the person's substance dependence and therefore the period of withdrawal, any other medical needs that must be attended to, and the presence of cognitive damage. They also stressed that it is only once a person has completed withdrawal and stabilised that a comprehensive assessment can occur.³⁶² Alcohol withdrawal may take three to five days and opiate withdrawal five days,³⁶³ but when a person is using other illicit substances, especially in combination, the length of withdrawal may be longer and is not necessarily known.³⁶⁴ The Committee understands that benzodiazepine withdrawal, for example, may take up to two weeks.
- 7.40** Clinicians also stressed the need for time to stabilise the person, assess them and engage them in the voluntary system. According to Dr Jurd, a person needs to be sober for at least a week before appropriate neuropsychological tests can be undertaken;³⁶⁵ as noted earlier, further time may be needed to apply for guardianship or make alternative care arrangements. Others emphasised that people with cognitive damage needed comparatively more time to learn new skills and be engaged in a process of change.³⁶⁶ Some participants also called for the ability to renew an order where it became clear that a person needed longer for the aims of the order to be met.³⁶⁷
- 7.41** From a legal perspective, the Committee was advised that it was important to establish a maximum period. Professor Carney advised that the most common approach was to set a limit, but empower the clinician to discharge the person before that period has elapsed where they consider that the person has recovered sufficiently.³⁶⁸ The initial treatment plan that necessarily informed the decision as to whether a person be subject to an order would specify the recommended length of the order.
- 7.42** On the balance of the evidence, the Committee considers that orders should be made for an initial period of 7 to 14 days, on the basis of a medical examination of the person's needs. We note that this is consistent with the Victorian legislation. The number of days that the person is to be detained would be specified in the medical report (including the initial treatment plan) that necessarily informed the legal decision as to whether a person is to be subject to involuntary care.

³⁶² Dr Jurd, Northern Sydney Health, Evidence, 4 June 2004, pp16-17; Dr Wilce, Kirketon Road Centre, Evidence, 7 April 2004, p7; Dr Joanne Ferguson, Psychiatrist, Drug Health Services, Rozelle and Concord Hospitals, Evidence, 27 November 2003, p41; Ms Tonina Harvey, Area Director, Drug and Alcohol Services, Northern Sydney Health, Evidence, 4 March 2004, p19

³⁶³ Professor Richard Mattick, Director, National Drug and Alcohol Research Centre, University of New South Wales, Evidence, 8 April 2004, p4

³⁶⁴ Dr Wilce, Kirketon Road Centre, Evidence, 7 April 2004, p7

³⁶⁵ Dr Jurd, Northern Sydney Health, Evidence, 4 June 2004, pp16-17

³⁶⁶ Mr David McGrath, Acting Deputy Director, Centre for Drug and Alcohol, NSW Health, Evidence, 29 April 2004, p16

³⁶⁷ Dr Wilce, Kirketon Road Centre, Evidence, 8 April 2004, p7

³⁶⁸ Professor Carney, University of Sydney, Evidence, 8 April 2004, p28

- 7.43** In exceptional circumstances, that is, where it is clinically determined that the person remains at risk of serious harm, or that their cognitive damage is such that additional time is required to achieve the aims of involuntary care, a further period of up to 14 days may be recommended. This would be subject to a further legal decision. The process of decision making in relation to involuntary care orders is discussed in a later section.
- 7.44** The periods of care that the Committee has recommended were broadly supported at the roundtable discussion, including by numerous clinicians.

Recommendation 12

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

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.

Contingency for failure?

- 7.45** When they appeared before the Committee, Ms Michelle Noort, Director of the Centre for Drug and Alcohol at NSW Health and Mr David McGrath, Deputy Director, stated a strong preference against a two week limit, and argued for a 'contingency for failure'. They suggested that two weeks was an insufficient period for a person to achieve substantial change, especially for those with cognitive damage. In order to prevent repeated use of short term orders, they sought a longer term mechanism, which they argued would cater to people's longer term needs and deliver better outcomes for the investment made.³⁶⁹

³⁶⁹ Ms Michelle Noort, Director, Centre for Drug and Alcohol, NSW Health and Mr McGrath, NSW Health, Evidence, 29 April 2004, pp15-16

7.46 When we visited Victoria, the Committee was advised that repeated use of compulsory detoxification was accepted, just as it is in the voluntary system, given the chronic relapsing nature of alcoholism.³⁷⁰ Dr Ian Kamerman, a general practitioner from the New England area and NSW Director of Australian College of Rural and Remote Medicine, like many other participants was pragmatic about detoxification and the opportunities it can present over time:

It does work from time to time and that is why I do not say that it is a waste of time, but the issue is hopefully each time you try it and each time you are closer to actually hooking them into a program, that is, getting them to hook into AA or NA, or hooking them into the alcohol and other drug workers and coming to see you on an ongoing basis, and pharmacotherapies such as naltrexone and acamprosate for use in keeping people off alcohol.³⁷¹

7.47 In considering the possibility of a ‘contingency for failure’, the Committee is mindful of the purpose of coercive intervention. In the previous chapter we established that there was no real evidence to indicate that a longer term system could help people achieve rehabilitation, and in the absence of this evidence, such a system was neither feasible nor ethically desirable. On the other hand, a system that aims to reduce harm and seeks to engage people in services voluntarily has realistic and widely supported outcomes, and is philosophically sound. Reducing harm in itself is a valuable outcome. In addition, the Committee considers that as with any chronic illness, the health system needs to find ways to engage with clients more effectively so as to minimise relapses, but should also accept that they are part of the nature of people’s disease.

7.48 Nevertheless, we believe that an important aspect of any evaluation of the proposed system is to consider both the outcomes of involuntary care orders and the rates of repeat orders. A number of recommendations in relation to evaluating our proposed legislative and service model are made at the conclusion of the report.

Community treatment orders?

7.49 A number of inquiry participants advocated the use of ‘community based coercion’ through community treatment orders (CTOs), as occurs in the mental health system. A CTO is a legal order made by a magistrate setting out the terms under which a person must accept medication, therapy, rehabilitation or other services while living in the community. It is implemented by a health care agency that has developed the person’s treatment plan. If a person breaches their CTO they may be detained in hospital for the remainder of the order.³⁷²

7.50 Participants suggested that CTOs could precede or replace an inpatient order, or be used as an after care or follow-up measure. Dr Patfield, for example, suggested they could be used to achieve a level of management over people with antisocial behaviour.³⁷³ Dr Kamerman suggested that CTOs would be especially helpful in rural areas, enabling a person to receive a

³⁷⁰ Evidence, 28 April 2004

³⁷¹ Dr Ian Kamerman, General Practitioner and NSW Director, Australian College of Rural and Remote Medicine, Evidence, 24 March 2004, p7

³⁷² Centre for Mental Health, *Mental Health Act Guide Book (Amended May 2003)*, NSW Health, December 2003, pp29-31

³⁷³ Dr Patfield, Bloomfield Hospital, Evidence, 4 June 2004, pp18-19

level of supervision in their own community, and that they could potentially be administered by general practitioners.³⁷⁴ The Committee was also told that CTOs have the strong advantage of making services accountable for delivering what is in a person's treatment plan.³⁷⁵

7.51 On the other hand, according to Professor Duncan Chappell, President of the Mental Health Review Tribunal, CTOs are an intrusive mechanism which relies on there being adequate resources in the community. Yet very often these resources are not available and the outcome is relapse and hospitalisation.³⁷⁶ His views were borne out in a recent evaluation of mental health CTOs in Victoria, which found they did not confer substantial benefit in harnessing and ensuring access to services.³⁷⁷ Professor Chappell was one of several participants who recommended against the use of CTOs for people with severe substance dependence.³⁷⁸

7.52 Some pointed out that CTOs may be less appropriate for drug and alcohol because of the relatively poor tool kit of pharmacotherapies in that field as compared with mental health. More fundamentally, a number of participants were concerned that given the very significant level of need among the client group we are focusing on, CTOs might be setting people up to fail.³⁷⁹ There was also a very strong concern from participants such as Mr Feneley of the Attorney General's Department and Mr Graeme Henson of the Local Court of NSW that CTOs were heavy handed and that failure to comply with an order might entail a 'criminalising' sanction. As Mr Henson stated:

I have real difficulties with the word "order" in this context as opposed to "plan". What role should the court play, for heavens sake, in forcing someone who has undertaken the legal act of consuming alcohol. It seems to me nonsensical.³⁸⁰

7.53 On the balance of evidence, the Committee considers that the legislation for involuntary care of people with severe substance dependence should not provide for community treatment orders. We do, however, see an important role for assertive follow-up, and this is explored in detail in the section on after care in the following chapter. Such a role, we consider, does not need to be reflected in the legislation.

Recommendation 14

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.

³⁷⁴ Dr Kamerman, Australian College of Rural and Remote Medicine, Evidence, 24 March 2004, p19

³⁷⁵ Ms Toni Colby, MERIT Caseworker, Alcohol and Other Drugs Service, Tamworth, Evidence, 24 March 2004, p22

³⁷⁶ Professor Duncan Chappell, President, Mental Health Review Tribunal, Evidence, 29 April 2004, p36

³⁷⁷ Professor Carney, University of Sydney, Evidence, 7 April 2004, p28

³⁷⁸ Professor Chappell, Mental Health Review Tribunal, Evidence, 4 June 2004, p20

³⁷⁹ Ms Tonina Harvey, Area Director, Drug and Alcohol Services, Northern Sydney Health, Evidence, 4 June 2004, p25; Ms Kim Alcohol and Other Drugs Project Worker, Mid Western Area Health Service, Evidence, 25 March 2004, p40

³⁸⁰ Mr Graeme Henson, Acting Chief Magistrate, Local Court of New South Wales, Evidence, 4 June 2004, p19

The decision making process

- 7.54** In the Committee's view, the decision making process in relation to involuntary care orders is critical to the integrity of the proposed legislation. Unless the process is tightly defined, with the right parties responsible for key tasks, and with the necessary checks and balances, there is great risk that involuntary care may be used excessively, and that the rights of people will not be honoured.
- 7.55** In the previous chapter we established that the decision to detain and treat someone against their will is a weighty one and the state has a responsibility to ensure that such intrusion on people's autonomy is carefully considered and safeguarded. Many inquiry participants were concerned about ensuring a fair and impartial legal process, and the need for magistrates to have adequate input from medical practitioners when making their decisions. Many suggested that the decision making process in relation to involuntary patients under the *Mental Health Act 1990* would serve as a useful model for new legislation.
- 7.56** Balanced against the need to protect people's rights is the need for a workable and timely process. Many participants called for a process that was accessible and 'user-friendly' for families, treating staff, police, legal bodies and anyone else involved. The process needs to be flexible enough to respond to a range of situations, including those where urgent intervention is required. It also needs to ensure timely decisions, given the relatively short period of detention we are recommending, as well as the fact that depending on their substance dependence, people will enter and pass through withdrawal relatively quickly. We were also advised that the process needs to factor in time for a person to sober up, as they cannot be effectively examined while intoxicated.³⁸¹ In some cases, detention may be necessary to prevent further consumption of alcohol or other drugs, pending their medical examination. Once in withdrawal, the person is likely to require medical supervision. Care also needs to be taken that the process does not dictate a heavy handed approach for those people who do not require an urgent response or immediate containment.

Medical examination

- 7.57** A key criticism of the *Inebriates Act* documented in Chapter 3 was that the decision to detain a person, and for how long, was made with minimal medical input. It is crucial that the process of decision making about whether a person be subject to involuntary care, and for what period, be clinically driven, but with appropriate legal adjudication. The Committee envisages a process like that under the *Mental Health Act*, where 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.
- 7.58** Provision for a clinically-driven process is consistent with the Committee's stated purpose of involuntary care: to protect a person's health and safety. It is also reflected in the criteria we have recommended be used in decisions of involuntary care: that the person has a severe substance dependence and has experienced or is at immediate risk of serious harm, that the person lacks capacity to consent to treatment, and that there is an initial treatment plan demonstrating that the proposed intervention will benefit the person. In the Committee's view, such decisions will necessarily be made, in the first instance, by a medical practitioner.

³⁸¹ Ms Noort, NSW Health, Evidence, 29 April 2004, p22

7.59 While some stakeholders expressed a strong preference for only addictions specialists to undertake any medical examination informing the decision to detain, roundtable participants such as Dr Stephen Jurd indicated that this was just not possible in rural and many regional areas. This being the case, he suggested it would be better for the legislation to stipulate ‘medical practitioner’.³⁸² The Committee considers that it is practical that the legislation enable any medical practitioners to conduct this examination, but that as far as possible, those with addictions expertise should be utilised.

Decision making and review

7.60 According to the UN principles, a person can only be detained for an initial short period on the basis of a medical examination, pending review by ‘a judicial or other independent and impartial body’.³⁸³ The role of this body is to protect the person’s civil liberties by considering whether the medical evidence presented justifies the person being involuntarily detained.

7.61 While there was strong agreement among participants for a mechanism that immediately reviewed a medical practitioner’s recommendation to detain, there was some variation in views as to the most appropriate body to do this. The Chief Magistrate of NSW, Judge Derek Price, advocated the *Mental Health Act’s* model of review by a magistrate which in his view works effectively and efficiently to safeguard people’s rights. He also emphasised the benefits of a non-court based approach that offered greater privacy and sympathy.³⁸⁴ Similarly, his colleague, Mr Graeme Henson, saw the magistracy as providing a sound check and balance, and one that is geographically accessible, given the presence of over 150 local courts across the state.³⁸⁵ Other participants advocated review through a tribunal, which they saw as providing a greater safeguard by bringing a range of perspectives - community, legal and medical – to bear on the case.

7.62 Participants also varied as to whether the legal body should actually fulfil a review role, or a decision making one, where the person could not be detained until the recommendation of a medical practitioner was endorsed by a legal body. Roundtable participants such as Dr Patfield, Professor Carney and Professor Webster were concerned that provision for detention to commence on the basis of a medical certificate was ‘too easy’. They argued for a tribunal to make the decision, having regard to a medical examination’s recommendations, before detention could occur.³⁸⁶

7.63 Professor Duncan Chappell, President of the Mental Health Review Tribunal suggested that providing that the number of people with substance dependence subject to involuntary care is reasonably low, the MHRT could potentially fulfil a review role:

³⁸² Dr Jurd, Northern Sydney Health, Evidence, 4 June 2004, p29

³⁸³ 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, Principles 16 and 17

³⁸⁴ Judge Price, Chief Magistrate, Local Court of New South Wales, Evidence, 26 November 2003, p3 and 14

³⁸⁵ Judge Price, Chief Magistrate, Evidence, 26 November 2003, p14; Mr Henson, Acting Chief Magistrate, Evidence, 4 June 2004, pp27-28

³⁸⁶ Dr Patfield, Bloomfield Hospital, Evidence, 4 June 2004, p29; Professor Carney, University of Sydney, Evidence, 4 June 2004, p30; Professor Webster, NSW Expert Advisory Committee on Drugs, Evidence, 18 February 2004, p6

In my view it would be essential that this form of review be incorporated in any such legislation in order to provide the same type of protection to this category of person as already exists in the mental health system. I also believe that it would be possible for the review function to be conducted by the [MHRT] which already possesses the general expertise and experience required to deal with the sensitive issues that arise in this area ... With adequate resources, and assuming that there would only be a very small caseload, it would be cost effective to add this area to the jurisdiction of the Tribunal.³⁸⁷

- 7.64** Dr Chappell explained that the Tribunal already has a number of members with addictions expertise, and is able to provide urgent reviews, and timely response in rural areas, through video and telephone hearings.³⁸⁸ While mental health patients appear at a hearing before the MHRT there may also be alternative approaches more suited to the new legislation. Were a magistrate to fulfil the review function, Professor Chappell suggested that the Tribunal could be responsible for appeals and for decision making regarding applications for additional periods of detention in exceptional circumstances.
- 7.65** Other participants emphasised the need to ensure a system that worked as much in remote areas as metropolitan ones, and saw that the best way to achieve this was through magistrates rather than a tribunal.³⁸⁹
- 7.66** Whatever bodies are responsible for decision making and review, appropriate provisions need to be made to ensure that these proceedings occur in private. Both the Attorney General's Department and Chief Magistrate spoke against decision making in relation to involuntary care occurring in open court.³⁹⁰ Under the *Mental Health Act*, magistrates' inquiries are generally conducted at the hospital where the person is detained. In addition, patients have the right to legal representation at a magistrate's inquiry.

Appeal

- 7.67** The UN Principles also stipulate that all involuntary patients have the right of appeal, and again this was seen by participants as a necessary element in any new legislation. As noted above, Professor Chappell indicated that appeal could potentially be made to the Presidential Member of the Mental Health Review Tribunal.³⁹¹ We understand this role could also be fulfilled by the Administrative Decisions Tribunal.

The Committee's view

- 7.68** Having explored the range of perspectives, the Committee considers that an appropriate decision making process that balances the imperatives for strong safeguards, flexible and

³⁸⁷ Tabled Document No 35, pp7-8

³⁸⁸ Professor Chappell, Mental Health Review Tribunal, Evidence, 29 April 2004, p39

³⁸⁹ Evidence, 4 June 2004

³⁹⁰ Mr Feneley, Attorney General's Department, Evidence, 11 December 2003, p10; Judge Price, Chief Magistrate, Evidence, 26 November 2003, p13

³⁹¹ Professor Chappell, Mental Health Review Tribunal, Evidence, 4 June 2004, p29

timely response, and feasibility for large and small communities would have 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.

7.69 We have noted participants' concerns that doctors cannot always be trusted to ensure that the best interests of the person are paramount when making such a decision. Nevertheless, we consider that a mechanism that is workable in rural areas and which enables an urgent response where necessary is required. Our recommendations concerning a focus on serious harm, and the criteria to be used, would necessarily require the decision to be made on medical grounds, and we anticipate that in many cases the person will require urgent medical care. Review by the magistracy as soon as possible after the decision, with legal representation, would mean that inappropriate detention was quickly identified and addressed. In addition, the criteria themselves, supported by strong guidelines for both medical practitioners and magistrates, would militate against inappropriate use. Further safeguards such as service monitoring are discussed later in this chapter. In addition, a system of centralised data collection on use of the legislation would feed into a formal evaluation of the legislation and provide a feedback loop to government agencies responsible for the legislation. The formal evaluation, which we later recommend occur within 5 years, would explicitly consider use of the legislation beyond its intended target group.

7.70 In the Committee's view, further consultation and consideration is necessary to refine this process. In particular, there is a need for both clinical and medico-legal perspectives to be brought to bear on the options, in order to develop the most effective and safeguarded approach. We note that the NSW Health review of the *Mental Health Act* is currently examining voluntary and involuntary admission procedures for mental health patients, as well as procedures and provisions in respect of magistrates' hearings. It is possible that valuable information on appropriate processes for the proposed legislation may emerge from that work.

7.71 The Committee believes that further consideration of the most appropriate decision making process will necessarily take into account a number of issues:

- The dual imperatives of providing strong safeguards with a workable and timely response
- The need for flexibility to ensure an urgent response where this is required and where it is not, that people's freedom and dignity is preserved
- The desirability of a localised approach, notwithstanding the fact that rural and regional areas will necessarily have less access to medical practitioners, legal bodies and appropriate facilities.

7.72 We revisit the proposal for a localised panel in the discussion on complex needs later in this chapter.

Recommendation 15

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.
-

Who may seek an order?

7.73 There was general support among participants for anyone to be able to apply for an order. As Dr Wilce put it:

Anyone should be able to say, "I want this person to be assessed." So a family member, the doctor, the local police officer, or whoever, but the only people that can do the assessment and that scheduling should be addictions specialists.³⁹²

7.74 Participants such as Dr Ferguson, Ms Jefferson and Dr Dore all thought it was very important that family members be able to apply.³⁹³ Some made the case for people to seek an order for themselves, as was documented in relation to the *Inebriates Act* in Chapter 4, and as occurs frequently under the New Zealand legislation. The Alcohol and Drug Information Service made a reasoned case for this, explaining that some people feel unable to make the commitment required to reach their own goals, but if they believe being detained will help, such a mechanism should be available.³⁹⁴

7.75 The Committee is open to self-committal, as long as the person is judged to be at risk of serious harm. In such cases, the criterion that the person is considered to lack the capacity to consent, would presumably be waived. Consideration would also need to be given to whether

³⁹² Dr Wilce, Kirketon Road Centre, Evidence, 7 April 2004, p7

³⁹³ Dr Ferguson, Rozelle and Concord Hospitals, Evidence, 4 June 2004, p20; Ms Leonie Jefferson, Senior Aboriginal Drug and Alcohol Counsellor, Northern Rivers Area Health Service, Evidence, 27 November 2003, p6; Dr Glenys Dore, Addictions Psychiatrist and Deputy Medical Superintendent, Macquarie Hospital, Evidence, 4 March 2004, p14

³⁹⁴ Submission 22, Alcohol and Drug Information Service, St Vincents Hospital, pp3-4

this would facilitate ‘queue jumping’ in an environment of limited access to services. In a later section of this chapter we consider the potential for an advanced care directive provision.

- 7.76** The Committee considers that detention may be requested for an individual by a broad range of parties, including a relative or friend, police, medical practitioner, drug or alcohol professional or magistrate. Nevertheless, the Committee considers that the process would still commence with certification by a medical practitioner.

Recommendation 16

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.

Considerations for Aboriginal people

- 7.77** Having taken evidence from a number of people from Aboriginal communities and services, the Committee is mindful of the need for a decision making process that is culturally appropriate. This need is even greater in light of the prevalence of severe substance dependence among some Indigenous people, the disproportionate use of the *Inebriates Act* in relation to them, and the personal and cultural trauma associated with detention. As Ms Tonina Harvey of Northern Sydney Health stated:

The legislation should allow opportunities for those communities to develop their own culturally appropriate responses. That is important; we can't make this an all-Anglo approach.³⁹⁵

- 7.78** Ms Leonie Jefferson, Senior Aboriginal Drug and Alcohol Counsellor with the Northern Rivers Area Health Service, stressed the need for family and community involvement in decision making. She told the Committee:

[T]here would have to be a lot of consultation on the treatment provision with the appropriate people – family, medical practitioners and all those associated with that work ... we do really need an appropriate assessment model ... with the family, the community and the elders, as they have much more knowledge of the person - rather than the medical model.³⁹⁶

- 7.79** Ms John Williams, Senior Policy Officer with the Aboriginal Health and Medical Research Council, endorsed Ms Jefferson's view and suggested that a process based on the circle sentencing models being piloted in the criminal justice system could provide a sensitive and effective process as well as important safeguards to ensure non-discriminatory use of the legislation. These circles could potentially include Aboriginal peers, the person's family, their doctor, Aboriginal drug and alcohol workers and Aboriginal health workers.³⁹⁷

³⁹⁵ Ms Harvey, Northern Sydney Health, Evidence, 4 March 2004, p22

³⁹⁶ Ms Jefferson, Northern Rivers Area Health Service, Evidence, 27 November 2003, pp9-10

³⁹⁷ Mr John Williams, Senior Policy Officer, Aboriginal Health and Medical Research Council, Evidence, 27 November 2003, pp10-11; Tabled document No 7, *Responses to proposed questions*, p5

- 7.80** The Committee considers that it will be important for government agencies to consult with Indigenous communities in order to ensure that the decision making process in Recommendation 15 be implemented in a culturally sensitive manner. It may be appropriate for this to be incorporated into the regulations that accompany the legislation.

Recommendation 17

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.

Other safeguards

- 7.81** In keeping with the imperative to prevent net-widening and protect the rights of those subject to involuntary care, a number of further safeguards were advocated by participants.

Official visitors

- 7.82** Service monitoring through an official visitors system was broadly endorsed by participants such as the Network of Alcohol and Other Drugs Agencies and the Alcohol and Drug Information Service, who saw such a mechanism as an important form of scrutiny, aimed at ensuring both quality of care and the protection of civil liberties. Professor Webster readily agreed, but pointed to the need to strengthen existing mechanisms in New South Wales, perhaps by linking them together:

I am strongly supportive of the idea of having an external community-based oversight inspection system of some kind. I think the official visitors system could be much stronger in the mental health system. I am just wondering if there is not perhaps an instrument of Government which ought to establish some form of official visiting idea which extends across a number of domains, rather than just being categorised into groups ... The inclination I think by Government, or certainly by departments, is to set the official visitors aside and not to have a great deal of regard to them. My view is that they ought to be strengthened ...³⁹⁸

- 7.83** Supporting Professor Webster's suggestion, Professor Carney advised that in Victoria, the official visitors systems provided for under various acts are coordinated through the Office of the Public Advocate, which is required to report to parliament each year on the program.³⁹⁹
- 7.84** The Committee considers that monitoring via official visitors would be an essential element of any new legislation enabling involuntary care, and sees value in doing this through an existing official visitors system, thereby enabling greater efficiency and at the same time strengthening that system.

³⁹⁸ Professor Webster, NSW Expert Advisory Committee on Drugs, Evidence, 4 June 2004, p31

³⁹⁹ Professor Carney, University of Sydney, Evidence, 4 June 2004, p31

Recommendation 18

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.

Guidelines and training for decision makers

- 7.85** In the Committee's view, a critical aspect of the implementation of the proposed legislation will be the development and dissemination of guidelines for those parties involved in the decision making process, including magistrates, medical practitioners, and the review body. In addition, drug and alcohol workers and other professionals who might seek an application would need to be educated on the legislation and its procedures.
- 7.86** Given their central decision making role in the process, the Committee envisages that guidelines for magistrates will be particularly important. We understand that these would appropriately be prepared and disseminated by the Judicial Commission. In addition, we consider that an appropriate strategy to educate medical practitioners on the process would need to be developed.
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Recommendation 19

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

Recommendation 20

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.

Regulations for service providers and facilities providing involuntary care

- 7.87** In Chapter 3 the Committee noted that witnesses such as Dr Joanne Ferguson of Rozelle and Cumberland Hospitals were critical of the absence of clarity in the *Inebriates Act* concerning the responsibilities of the treating service and staff in relation to those placed under an order, including in relation to use of restraints.⁴⁰⁰ The Committee considers that the proposed new legislation would necessarily contain regulations in relation to the responsibilities and powers of the services where people are detained.

⁴⁰⁰ Dr Ferguson, Rozelle and Concord Hospitals, Evidence, 27 November 2003, p41

Recommendation 21

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

Other provisions**Police powers**

- 7.88** The Committee envisages that some people for whom an order is sought may attend a medical examination or enter detention without resistance; others will necessarily be subject to force. In order to preserve the dignity of the person, we consider that as far as possible the person should be delivered into care through informal means, for example, with the help of a drug and alcohol worker or other service provider, or a family member. Where necessary, police should be empowered to detain the person in order to deliver them to into care.
- 7.89** In the NSW Government submission to the inquiry, NSW Police are reported as noting that where a person is a danger to themselves or others, or at risk of causing damage to property or committing an offence, police should have a role in locating and returning them to the appropriate facility.⁴⁰¹ The Committee heard from police representatives that the responsibility for transporting patients subject to the *Inebriates Act* is very burdensome, especially in light of the long distances to travel to gazetted facilities, and that new legislation could potentially have significant implications for their resources.⁴⁰² The issue of transporting people under an order is discussed further in Chapter 8. Matters relating to detention in police cells are discussed at the end of this chapter in the section dealing with the *Intoxicated Persons Act*.
- 7.90** The Committee considers it necessary that police be empowered to detain a person subject to a decision in relation to involuntary care, and where necessary, to take the person to an appropriate facility where they are to be examined. In addition, we consider that in the event that a person under an involuntary care order absconds from a facility where they are being detained, that the police should be empowered to return the person to that facility. Any further police responsibilities should be developed in consultation with the NSW Police.

Recommendation 22

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.

⁴⁰¹ Submission 47, NSW Government, p11

⁴⁰² Assistant Commissioner Bob Waites, Commander, Greater Metropolitan Region and Corporate Spokesperson, Alcohol related Crime, NSW Police, Evidence, 27 November 2003, p22

‘Mandatory assessment’ as an outpatient

- 7.91** Dr Ferguson made the case for an additional mechanism before the point of detention, whereby people could be legally ordered to undergo an assessment without having to enter care. She saw this as a valuable means to respond to the concerns of family members where the person did not necessarily require detention:

I want to take a step back before we put people in an institution and I wonder if we can develop some alternatives at that point so that, if perhaps someone came to a court system because the family was concerned that they had a drug and alcohol dependence and there was some immediate risk, they could be instructed to get a mandatory assessment, and that might happen either as an inpatient or as an outpatient.⁴⁰³

- 7.92** Dr Ferguson also saw that such a mechanism would serve to cull people at an earlier stage, channelling them towards appropriate services, and minimising the need for detention.⁴⁰⁴

- 7.93** The Committee sees merit in the idea of a mechanism that did not detain people but nevertheless responded to family members’ concerns, where the person could undergo an initial assessment and have a treatment plan developed, and be presented with the opportunity to engage in the voluntary system, with a minimal level of coercion.

7.94

Recommendation 23

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.

Advanced care directives

- 7.95** As noted earlier, significant demand in relation to the *Inebriates Act* and the Victorian compulsory treatment legislation has come from people who have voluntarily sought an order. A number of inquiry participants raised the possibility that new involuntary care legislation allow for a mechanism that enables people to specify in advance, while they are competent to make a decision, that they would like coercive intervention should the need arise. Such mechanisms differ from self-committal in that they involve a legal document that a person signs in advance. Terms such as ‘living will’, ‘advanced care directive’, ‘enduring power of attorney’, ‘Ulysses agreement’ and ‘representation agreement’ were used to describe such a tool. Dr Wilce of the Kirketon Road Centre spelt out how it might work in practice, emphasising that where possible, it is preferable to have people involved in such decisions:

... ideally ... they would come to us when they were well and rational and say, “I want to stop this.” At that point for us to say, “What we can do for you is if you sign this we can put you into a safe place for a month. You will not be allowed to leave that place. There will be times when you feel you want to do that. How about we try this

⁴⁰³ Dr Ferguson, Rozelle and Concord Hospitals, Evidence, 4 June 2004, p20

⁴⁰⁴ Dr Ferguson, Rozelle and Concord Hospitals, Evidence, 4 June 2004, p24

because you, at the moment, know that you are not able to contain your dependency and you do things that you do not wish to do because of your illness? How about you sign this? You make a living will that says that you will attend this place?" That is one option when the person is rational that they be involved in that decision.⁴⁰⁵

- 7.96** According to Professor Carney, advanced care directives would be consistent with the ethical framework underpinning the Committee's model, and would in fact be highly progressive.⁴⁰⁶ He explained the elements of such mechanisms, but warned that they are not always honoured:

When a person has capacity, he or she can execute a document that usually empowers a group of friends or family members to override his or her objections to doing what has been set out in the instruments. It allows a person to tailor-make the length and form of any intervention that is to occur should he or she relapse. It has already been used extensively in relation to schizophrenia – another chronic relapsing condition ... It would need to be document that the person executed in consultation with not only their family, who would be the honest brokers and wield the power, but also with service providers. Quite commonly a person who presents is told that he or she is a no-win case and that there are other more pressing priorities, and a reason is found not to assist them. So service access must be tackled too.⁴⁰⁷

- 7.97** The Committee considers that there would be significant value in including provision for an advanced care directive in the proposed legislation. This would necessarily be a separate provision as it would mean that the person would not be subject to the same criteria as for involuntary care.

Recommendation 24

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

Data collection and legislative review

- 7.98** In the discussion on the decision making process we suggested that a system of centralised data collection on use of the legislation be established, to enable monitoring by government agencies on use of the legislation, and to feed into a formal evaluation of the legislation. We consider that this mechanism would be essential to such an experimental system, especially in light of its implications for human rights. The NSW Chapter of Addiction Psychiatry stated in its submission:

Deprivation of liberty is such a serious issue that the use of compulsory treatment requires the development and ongoing maintenance of a central register of all individuals that are committed under the proposed new *Inebriates Act*. This register could include a system where individuals are followed up to determine the effectiveness of treatment under [the Act]. Outcomes that could be monitored include

⁴⁰⁵ Dr Wilce, Kirketon Road Centre, Evidence, 7 April 2004, p7

⁴⁰⁶ Professor Carney, University of Sydney, Evidence, 8 April 2004, p24

⁴⁰⁷ Professor Carney, University of Sydney, Evidence, 8 April 2004, p24

days to relapse, other medical problems including hospital admissions, and markers for psychosocial disability including legal, financial, relationship and accommodation factors.⁴⁰⁸

7.99 The Committee considers that the proposed legislation should be formally reviewed after a reasonable time, perhaps five years, to examine its effectiveness, whether it is being used as envisaged, and how it might be improved. The model the Committee is proposing is a significant departure from the current system, is necessarily experimental, and is likely to make significant demands within the legal and health systems. In addition, it involves significant encroachment on the autonomy of citizens of this State. For all these reasons, the Committee believes the new legislation must be formally evaluated.

7.100 Specific aspects of the evaluation should include:

- 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.

7.101 Further issues relating to service provision to be considered in an evaluation are identified in the following chapter.

Recommendation 25

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

⁴⁰⁸ Submission 50, NSW Chapter of Addiction Psychiatry, p2

Recommendation 26

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 made 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.
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People with antisocial behaviour and complex needs

7.102 In addition to a system catering to people at risk of serious harm, in the previous chapter the Committee recognised the need for a mechanism to address the complex needs and antisocial behaviour associated with some people who have a serious substance dependence. We envisaged that this would be a non-coercive system that honours both the interests of the person and the community.

7.103 Professor Terry Carney of the University of Sydney and Professor Arie Freiberg of Monash University both suggested that any legislation to replace the *Inebriates Act* should draw on the provisions of Victoria's *Human Services (Complex Needs) Act 2003* (hereafter the *Complex Needs Act*).⁴⁰⁹ Professor Carney stated a preference against detention and involuntary care, noting the high and multiple needs among the group of people in question. In his view, their needs would be much better met through the service system, including strong case management.⁴¹⁰

7.104 Professor Freiberg noted the relevance of the Victorian legislation for 'people who are pre-criminal' and 'those really hard end cases which cycle in and out of re-notifications, the people you may not want to send to court but they are too difficult for just the voluntary services, even when they are cooperating',⁴¹¹ and outlined its purpose and ambit:

The *Human Services (Complex Needs) Act*, which came in in 2003 ... is a non-conviction, semi-coercive mechanism where they are aiming to facilitate the delivery of welfare services, health services, mental health services, disability services, drug and alcohol treatment services and housing support services to certain people with multiple and

⁴⁰⁹ Professor Carney, University of Sydney, Evidence, 8 April 2004, p24; Professor Freiberg, Criminologist and Dean of Law, Monash University, Evidence, 18 February 2004, p53

⁴¹⁰ Professor Carney, University of Sydney, Evidence, 8 April 2004, p24

⁴¹¹ Professor Freiberg, Monash University, Evidence, 18 February 2004, p53

complex needs by providing for the assessment of such circumstances and the development and implementation of appropriate care plans through the mechanism of a multiple and complex needs panel. That is not a court, but it deals with people who have these prerequisites: if you have a mental disorder within the meaning of the *Mental Health Act* or acquired brain injury or intellectual impairment or are alcohol or drug dependent within the meaning of our Act, and the person has exhibited violence or dangerous behaviour that has caused serious harm to himself or herself or some other person, is exhibiting such behaviour and risks serious harm and is in need of intensive supervision and support and would derive benefit from receiving coordinated services in accordance with a care plan.⁴¹²

- 7.105** The legislation was developed as a mechanism to achieve better and more cost effective outcomes for a small group of clients with extremely high and multiple needs who consumed significant resources, perhaps hundreds of thousands of dollars, across a number of human service systems.⁴¹³ For example, a person might have an intellectual disability *and* a serious mental illness *and* be a chaotic substance user, with profoundly disturbed behaviour placing others at significant risk, and bringing the person into contact with the criminal justice system. The key elements of the legislation are a regional gateway and referral process, a multiple and complex needs panel, a multidisciplinary assessment service which develops the individual's care plan, and intensive case management services.⁴¹⁴ Professor Carney emphasised the benefits of the model's statutory provision for holistic assessment, overcoming privacy laws and the compelling of agencies to deliver what is in a person's plan.⁴¹⁵
- 7.106** Commenting at the roundtable discussion on a proposed legislative model providing for short term involuntary care to protect people from serious harm, Professor Carney expressed some comfort with the model, given its philosophical framework and principles. However, he held that the elements of the *Complex Needs Act* would be a more effective way to respond to *both* those at risk of harm and those with antisocial behaviour or complex needs.⁴¹⁶
- 7.107** The Committee is aware that an initiative aimed at addressing complex needs across government agencies is under development and consideration by government in New South Wales. This is targeting people with disability with challenging behaviour who are coming into contact with the criminal justice system. We note that this, like the Victorian *Complex Needs Act*, entails significant resources and is highly targeted towards a small group of people with exceptionally high needs, catering to perhaps fewer than fifty clients per year. As was acknowledged by participants at the roundtable, any measure attempting to deal with antisocial behaviour or complex needs arising from substance dependence would be likely to attract much greater demand.⁴¹⁷

⁴¹² Professor Freiberg, Monash University, Evidence, 18 February 2004, p53

⁴¹³ To be eligible, a person must appear to have two or more of the following conditions: a mental disorder, intellectual impairment, acquired brain injury, drug or alcohol dependence *and* meet the other criteria identified by Professor Freiberg: *Multiple and Complex Needs Initiative*, Ms Lyndall Grimshaw, Department of Human Services, Presentation to the Complex Clients Symposium, 27 February 2004

⁴¹⁴ Department of Human Services, *Responding to People with Multiple and Complex Needs: Phase 1 Report*, Department of Human Services, July 2003

⁴¹⁵ Professor Carney, University of Sydney, Confidential evidence, 4 June 2004, pp5 and 22-23

⁴¹⁶ Professor Carney, University of Sydney, Evidence, 4 June 2004, pp22-23

⁴¹⁷ Professor Webster, NSW Expert Advisory Committee on Drugs, Evidence, 4 June 2004, p24

7.108 In a discussion after the roundtable, Professor Carney suggested that key elements of the *Complex Needs Act* could be grafted onto the legislative framework for the Committee's proposed model of involuntary care, but that they should be tailored to respond to a larger group of people with lower grade needs. In particular, he saw value in a localised decision making body that holistically assessed people and acted as a filter, channelling them towards involuntary care and/or non-coercive services as appropriate to their needs. This panel would also be empowered to obtain personal information about the individuals referred to it.⁴¹⁸ Such a panel could potentially be comprised of a general practitioner, social worker and a representative of a human service agency. As a localised body it would also have an understanding of the resources available within a community to meet the person's needs. Inserted into the decision making process recommended earlier in this chapter, before the decision to invoke involuntary care, this body would also provide a further safeguard against inappropriate use of such orders.

The Committee's view

- 7.109** The Committee sees merit in this suggestion, but we do not consider that we have collected enough evidence to make informed recommendations in respect of legislation to address complex needs. We are hesitant to recommend a statutory response when there may be non-legislative means of addressing the key problem of improving service provision. While we are aware that a similar non-legislative initiative is under development in New South Wales, we are privy to very limited information about this and thus are not in a position to assess whether it might overlap with or complement what might be suggested in relation to our target group.
- 7.110** In addition, we believe that further consultation with a range of government and service provider stakeholders is essential in relation to how the model might be operationalised in rural areas. Particular thought needs to be given to who would be responsible for assessment and care coordination. Finally, in the absence of clarity about these potential mechanisms, we are eager to minimise the risks of delaying or detracting from those areas where we are confident of our recommendations for new legislation.
- 7.111** We also note that Victoria has both the *Complex Needs Act* and the legislation enabling involuntary detoxification and assessment, the *Alcoholics and Drug Dependent Persons Act*. These are seen by government stakeholders as complementary statutes, with the latter providing a valued mechanism for involuntary intervention for a small group.⁴¹⁹
- 7.112** While we have drawn a limit around what this Committee can do in relation to formulating a way forward for people with complex needs and antisocial behaviour arising from substance dependence, we believe that further investigation and consideration by government must occur before the most appropriate policy position can be determined. We strongly believe that this must occur within a cross-agency context, necessarily involving each of the human service agencies and the Attorney General's Department.

⁴¹⁸ Telephone conversation between Professor Carney, University of Sydney and Senior Project Officer, 25 June 2004. This mechanism would combine the provisions in parts 2 and 4 of the *Complex Needs Act*, establishing them at the local or regional level.

⁴¹⁹ Evidence, 28 April 2004

- 7.113** Were, as Professor Carney has suggested, a localised assessment and decision making body added to the proposed legislation for involuntary care as a gateway and filtering mechanism, the Committee anticipates that further thought would need to be given to both the eligibility criteria and the decision making process set out in this chapter.
- 7.114** Looking more broadly than a legislative mechanism, the Committee considers that there is a need for government agencies to collaborate specifically for the purpose of developing the most appropriate policy response to non-offenders with complex needs and challenging behaviours arising from substance misuse. As noted in the previous chapter, a number of initiatives are underway that may consider this issue, such as the remote town trials to address alcohol, inhalant and illicit drug issues in two small communities, and the Reducing Alcohol Related Harm in Rural Communities project. According to the NSW Government response to the Alcohol Summit, a steering committee made up of representatives of a number of government agencies is developing the proposal for the remote town trials.
- 7.115** In the Committee's view, there is a need for a high level cross-agency committee to consider the issues identified in this report in relation to complex needs and challenging behaviour, in order to determine the most appropriate non-coercive policy response to address their needs. This work should necessarily involve the Attorney General's Department, The Office of Drug Policy in The Cabinet Office, NSW Police, NSW Health, Department of Housing, Department of Community Services and other relevant agencies.

Recommendation 27

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 the 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.
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- 7.116** In Chapter 9 we make recommendations on the services required to support our proposed legislative framework, many of which we anticipate will assist people with complex needs.

The *Intoxicated Persons Act 1979*

- 7.117** While the terms of reference for the inquiry did not ask the Committee to investigate the *Intoxicated Persons Act*, the interface between that Act and the *Inebriates Act* meant that a number of issues in relation to the former were brought to our attention. The provisions of the *Intoxicated Persons Act* are summarised in paragraph 2.59 to 2.61 (CHECK). The problems coalesce around the abolition of proclaimed places when the Act was amended in 2000, and the shortage of appropriate services to take intoxicated people in many areas.
- 7.118** A number of difficulties surrounding current arrangements for the management of people under the *Intoxicated Persons Act* were raised at the Alcohol Summit. The Issues Paper prepared for the Summit's Alcohol and the Justice System Working Group stated:

An inter-agency protocol was developed by stakeholder agencies to deal with intoxicated persons (by and large homeless inebriates). A number of accommodation services have been able to offer appropriate services to intoxicated people. However, there are parts of NSW where the protocol is less effective due to lack of suitable services.

Even when community accommodation places (such as those provided through the Supported Accommodation Assistance Program – SAAP) are available, they are often unable to accept aggressive and violent people. Some intoxicated persons can be disruptive towards carers and other residents, many of whom are women escaping domestic violence.

In regional areas this is a particular issue for police. They report operational difficulties in relation to transporting and holding intoxicated persons in police cells. Police are generally reluctant to place intoxicated persons in police cells, as this increases the risk of self-harm or even death.⁴²⁰

- 7.119** The Alcohol Summit made several recommendations in relation to this issue:

The legal framework and supported accommodation arrangements existing under the *Intoxicated Persons Act* should be reviewed 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.⁴²¹

It is preferable that intoxicated persons not be detained in police cells, rather the Government should fast-track the state wide rollout of intoxicated persons services to support the diversion of intoxicated persons.⁴²²

⁴²⁰ NSW Summit on Alcohol Abuse, *Working Group 9: Alcohol and the Justice System – Issues Paper*, p7

⁴²¹ NSW Summit on Alcohol Abuse, *Communique*, Recommendation 9.37, pp40-41

⁴²² NSW Summit on Alcohol Abuse, *Communique*, Recommendation 8.60, p35

Urgently expand the number of intoxicated persons services (culturally specific principles should apply state-wide), which will take intoxicated persons, particularly in inner-city, rural and remote communities that do not have these facilities.⁴²³

7.120 The Government response to the Alcohol Summit does not indicate specific action in relation to these recommendations, nor any additional funding or policy change. Nevertheless, evidence before the Committee indicates the continued need for action in this area.

7.121 A critical issue is that only police have the power to detain at present. Assistant Commissioner Bob Waites explained the difficulties that current arrangements under the Act create for them:

When the *Intoxicated Persons Act* was invoked it was seen as a good tool to assist with some of the social issues. Unfortunately, the provision of proclaimed places never occurred at the level that was expected - in fact, there are now none. When confronted by people who are intoxicated to such a degree that they are unable to care for themselves or are in danger, the police have two choices. First, the offender can be placed in a police cell. We do not want to do that and we avoid it at all costs because of the potential for self-harm. Secondly, if they are taken to places such as Matthew Talbot Hostel they will not be accepted if they are violent or argumentative. We either take them back to a police cell or ignore the issue. Officers move them on and hope they do not get into trouble. They are the issues we deal with on the street ... A consequence is that these people, who are very vulnerable, are left on the street. That is a concern because they are very often victims of crime.⁴²⁴

7.122 Assistant Commissioner Waites and his colleague Superintendent Frank Hansen indicated that the greatest problem is the management of people when they are violent. Intoxicated persons services will not accept people who are violent and in any case, are not able to detain them.⁴²⁵ Other participants pointed to the absence of any intoxicated persons services in many non-metropolitan areas. Assistant Commissioner Waites called for appropriate intoxicated persons services 'in every town in New South Wales' that are able to respond to this difficult group, to avoid the need to detain people in cells.⁴²⁶

7.123 Other participants agreed that detention in police cells is highly undesirable, noting that police do not possess the health-related skills to monitor people effectively, as they are required to do. In addition, this monitoring is resource-intensive for police. Dr Matthews of NSW Health stated:

The current system of intoxicated persons in police cells is extremely problematic. The police are ill-equipped. In many of the 24-hour cell complexes custody is now the responsibility of the Department of Corrective Services and people are de facto but not legally being handed over to that body for care. We have limited nursing services in about eight of those 24-hour cells, but even with the nursing services the facilities are not set up appropriately to provide a place to care for people.⁴²⁷

⁴²³ NSW Summit on Alcohol Abuse, *Communique*, Recommendation 8.61, p35

⁴²⁴ Superintendent Waites, NSW Police, Evidence, 27 November 2003, p20

⁴²⁵ Superintendent Frank Hansen, Manager, Drug and Alcohol Coordination, State Crime Command, NSW Police, Evidence, 27 November 2003, p32

⁴²⁶ Superintendent Waites, NSW Police, Evidence, 27 November 2003, p21

⁴²⁷ Dr Matthews, NSW Health, Evidence, 4 June 2004, p6

- 7.124** The submission from the Network of Alcohol and Other Drugs Agencies (NADA) gives some insight into the perspective of service providers who run intoxicated persons services:

Staff at [former] Proclaimed Places are not medically trained to deal with severe alcohol withdrawal and anecdotal information provided by staff reveals that those people who are intoxicated and delivered [to the service] by police can be very angry and aggressive, posing a threat to staff and those that have self-referred.⁴²⁸

- 7.125** Mr Larry Pierce, Director of NADA explained the shift that has taken place in that sector as a result of the abolition of proclaimed places:

Some of our member agencies - and we worked closely with them when we were doing the submission - identified the fact that prior to the amendment of the ... *Intoxicated Persons Act* a number of years ago, the real problem was that although the staff at proclaimed places had the same [powers] as police to detain people, unlike police they were not trained to do that, and they were not resourced or equipped to do that. There were all sorts of occupational health and safety problems for those staff to do that, and in a general sense it made the mood, if you like, in the proclaimed places much darker and more dangerous, given that the aim of the proclaimed place is to provide safety and overnight accommodation for intoxicated people. Since that shift away from the staff having the power to detain people, most of the proclaimed places are now turning to a focus on the client. We give them a bed and pyjamas, and we give them a bit of food before they leave, but what else can we do? Can we provide a level of assessment? Can we provide alternative activities? Can we look at moving these people towards a decision to engage in treatment? Can we have a look at the primary health care issues of these people? So they are moving to that sort of approach, which is much better.⁴²⁹

- 7.126** Ms Val Dahlstrom, Area Manager of Aboriginal Health in New England reported that rather than detain people in cells, police are taking them home as they are encouraged to do under the legislation, but this is leading to increased domestic violence.⁴³⁰

- 7.127** Responding to the sensitivities of detention of Indigenous people in police cells, Mr John Williams of the Aboriginal Health and Medical Research Council proposed an innovative solution:

What we are suggesting is we have 43 Aboriginal Medical Services throughout the State. In each of those 12 regions we think a culturally appropriate community controlled shelter, an appropriate shelter, could be staffed under the auspices of the community controlled health sector working with the Area Health Service to provide such a place in remote areas where people can be taken because you cannot go putting such a place into every community, but you could put such a place in every region within a reasonable distance for people to be taken to.

The immediate problem might have to be a cell if there is no transportation available. These are some of the problems we do have but again, the police are not trained and

⁴²⁸ Submission 29, Network of Alcohol and Other Drugs Agencies, p13

⁴²⁹ Mr Larry Pierce, Director, Network of Alcohol and Other Drugs Agencies, Evidence, 27 November 2003, pp54-55

⁴³⁰ Ms Val Dahlstrom, Area Manager, Aboriginal Health, New England Area Health Service, Evidence, 4 June 2004, p9

if they are going to use that as the only recourse then we think that medical people or registered nursing sisters or Aboriginal medically trained staff who would be available to constantly check these people because if they have not being charged there is no obligation to do two hourly checks. That only occurs if they are charged, not necessarily if they are only there to sleep it off. And that is a risk.⁴³¹

- 7.128** On the basis of our terms of reference, the Committee has not considered these issues in detail. Nevertheless, we recognise the need for the Government to address them and most particularly, to develop and resource a workable alternative to detention of intoxicated persons in police cells. We thus endorse the recommendations of the Alcohol Summit, that the *Intoxicated Persons Act* be properly reviewed and that greater provision be urgently made for appropriate service arrangements.

Recommendation 28

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

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.

⁴³¹ Mr Williams, Aboriginal Health and Medical Research Council, Evidence, 27 November 2003, pp11-12