



NCOSS RESPONSE TO THE NSW LEGISLATIVE COUNCIL STANDING COMMITTEE REPORT ON THE INEBRIATES ACT 1912

The Report on the Inebriates Act 1912 of the Standing Committee on Social Issues is a well considered first step in the discussion of a very complex issue, but considerable resources will be needed to make a genuine and lasting difference to those affected by substance dependencies.

Since 1932 there have been ongoing criticisms of the Act and from the 1970's onwards repeated calls have been made to have the act repealed. NCOSS agrees with the Report that it is time that the government acted on these calls. NCOSS welcomes the Report's recommendation for the abolition of the Inebriates Act 1912 which has no place in the modern health care system. NCOSS agrees that the Act should be repealed and replaced with a more targeted, safe guarded and time limited system of involuntary care for a small and tightly defined group of people with drug or alcohol dependence.

One major concern is where will the resources come from to deliver the proposed involuntary services and the new individualised post discharge treatment plans when current drug and alcohol rehabilitation, counselling and support services are inadequately resourced. Without extra funds the danger is that money will be shifted from voluntary services to involuntary services, therefore increasing the risk that more people will fall under the involuntary system as they will be unable to access treatment or support.

One option that could be considered is to resource the proposed new services through revenue raised by the liquor tax. However care must be given that this is additional funding utilised to provide additional resources for involuntary treatment rather than to replace the Government's responsibility in addressing substance abuse within society through central revenue. Consideration must also be given to the concern that this would be using the money raised through the selling of the product that causes the addiction. Another option would be to co-locate involuntary services with current voluntary services, which would reduce infrastructure costs. However NCOSS agrees that a review of current available drug and alcohol (D&A) treatment and rehabilitation services and locations needs to be done to identify gaps in the service delivery system. For example NCOSS has been informed that on the far South Coast of NSW there are no local D&A services, which results in people having to travel long distances to services or just not getting services.

NCOSS agrees with the codified aims in the report with a focus on harm minimisation and a holistic approach to treatment and care. As stated in the report, and supported by NCOSS, "*We conclude that we do not support compulsory treatment aimed at rehabilitation or addressing people's substance dependence in the longer term; nor do we support coercive treatment in the interests of others. However, we do consider that coercion may be justified in certain circumstances for the purpose of reducing serious harm to self.*" (xiii). As commented by the Committee, "*rather than simply locking people up for a time in an inappropriate setting, we must ensure that involuntary care is used as last resort, that the rights of those subject to it are well protected, and that they derive real benefit from such intrusion on their autonomy.*" (xvii)

It is unfortunate that the specific needs of youth are not addressed in the Report and that these are left as a gap with recommendations for further investigation. It would be beneficial to see the Committee, in collaboration with relevant individuals and services, take on a role to look at the needs of youth with substance dependencies and how these can be addressed.

The Report acknowledges that there are complex ethical issues to be considered, *"it is unfeasible to recommend policy with a poor evidence base, and it is also unethical to intervene against someone's will when it is unknown whether the intervention is likely to benefit them."* (83) However the Report goes on to discuss recommendations about the use of compulsory treatment, even though the evidence for the use of compulsory treatment does not present a strong case for its effectiveness. The Committee themselves state, *"In the Committee's opinion, the absence of any substantial evidence base for benefits of compulsory treatment raises serious questions about the ethics and cost effectiveness of instituting a compulsory treatment regime"*. (82)

However the Report then goes on to state that there are *"Three distinct potential goals for coercive interventions: addressing substance dependence, harm reduction and protecting the interests of others."* (83) NCOSS would only support legislating for compulsory treatment for the target group as defined in the Report if the new legislation had a strong foundation in human rights and that the UN Principles for the Protection and Care of People with a Mental Illness are used as its basis.

NCOSS agrees that compulsory treatment should not be aimed at long term behavioural change or rehabilitation. That is, to remove a person from immediate danger and to enable them to have a safe place, especially where that person has lost their capacity, as a result of their dependence, to make decisions about their health and safety. It is agreed that the only reason for compulsory treatment would be to assess the person and to restore their capacity to make decisions as far as possible, and to then assist the person in making an informed choice about their dependency. NCOSS would also like to see safeguards put in place to ensure that a refusal for treatment is not perceived as a lack of capacity to consent.

NCOSS is supportive of involuntary treatment being enforced as per the Mental Health Act 1990, under direction from a medical practitioner followed by further assessment and review by a medical practitioner and a magistrate. However NCOSS believes that it would be beneficial if doctors and magistrates were required to attend regular training on the specific issues related to substance dependency, mental illness and disability. There should also be a timeframe stipulated as to the maximum amount of time that can lapse before the Magistrate reviews a decision. Stating as soon as possible after admission is open to too much interpretation.

The core interventions as detailed in the Report are well thought out and address the person's needs while in care and once leaving care. However, NCOSS has a number of questions in relation to this:

- Who would be responsible for follow up on post-discharge treatment and access to services by the person?
- How will the issues of housing and homelessness and dual diagnosis (that is Mental Illness and Substance Dependency or Intellectual Disability and Substance Dependency) be addressed, given that the SAAP system is under resourced and not designed to deal with this client group.

- What happens if the person chooses not to have assertive follow up, when would assertive follow up go from support and ongoing treatment to a compulsory community intervention – almost like a community treatment order?

The Report argues for inclusion of Aboriginal people within planning processes for compulsory treatment within their communities. NCOSS believes that the processes for planning and implementation within indigenous communities should be legislated as a participatory process between the government and Aboriginal communities at a local level. Unfortunately policy and guidelines have not always proven effective in encouraging this to happen.

While NCOSS understands the need to utilise police for transport, one of the issues that has arisen is, (as raised by the police) what happens in rural/remote areas where there may only be one car and one officer – and the closest facility is a number of hours of drive away – therefore removing the police officer from key responsibilities. Use of the Police encourages the perception of criminality and could have a negative effect on the person with a substance dependency. These are non-offenders and being treated in manner that could be associated with offending behaviour.

Finally NCOSS recommends that the Government's Expert Advisory Group on Drugs Chaired by Ian Webster be given the task of overseeing the development of the new legislation and the involuntary system of treatment services. Ian was an author of a previous iteration of the mental health act and is well versed in the patient rights component of the mental health legislation.