Involuntary treatment of drug and alcohol dependence in New South Wales: an old Act and a new direction

Will new legislation address the dilemmas raised by a century-old Act for involuntary treatment of addiction?

In September 2012, the *Drug and Alcohol Treatment Act 2007* was adopted in New South Wales, to better manage people requiring involuntary treatment for substance dependence. The new Act formally replaced the outdated, century-old *Inebriates Act 1912* (NSW). Here, we explain why the new legislation was needed and what advances in management it will enable.

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The past 100 years

Involuntary treatment for alcohol dependence (see definitions in Box 1) was established in the 19th century in Australia, when state legislation "embodied the concept of alcoholism as a disease to be treated rather than a crime to be punished".[5] Confinement and rehabilitation (mental, physical and moral) were seen as necessary to cure alcoholism and drug addiction.[6] This view led to the passage of the first Inebriates Act in NSW in 1900, which was amended in 1909 and consolidated in 1912.[5,7]

The Inebriates Act defined an "inebriate" as "a person who habitually uses intoxicating liquor or intoxicating or narcotic drugs to excess". This definition potentially allowed for anyone with habitual substance use to be detained, if a magistrate agreed with the applicant and granted an order for control and treatment of the inebriate.

The 1912 Act was difficult to invoke because suitable applicants for orders for control and treatment of inebriates were often limited and difficult to coordinate. The Act stipulated that an applicant must be the alleged inebriate or a person he or she had authorised when sober; a member of the police of or above the rank of sergeant; or the spouse, a first-degree relative or a business partner of the inebriate.[3] Where families remained involved, making an application for involuntary care often heightened existing conflict, acting as a deterrent to proceed.

In 1929, in the absence of purpose-built facilities for detaining and treating inebriates, the large psychiatric hospitals in NSW were gazetted as institutions for the reception and treatment of these patients as a "stop-gap measure".[7,8] Until recently, seven gazetted psychiatric hospitals in NSW provided the only public facilities authorised to act in this role for orders involving periods longer than 28 days. Much criticism was directed at the perceived infringement of human rights by allowing the detention of inebriates in facilities for severely mentally ill patients, without mandatory legal review of the order and without evidence of effectiveness. The treatment that was provided was considered ad hoc, with no systematic evaluation studies conducted to determine outcomes.[2,5,8]

Furthermore, gazetted hospitals had no control over admissions under the Inebriates Act, with no formal process for legal review and no power to discharge the patient. An existing order could only be amended or repealed by an application to re-hear the matter before the magistrate who made the initial order.

Catalyst for change

In 2003, the NSW Summit on Alcohol Abuse highlighted a fundamental ethical issue in relation to alcohol dependence, namely: "when the state can legitimately intervene to treat a person against their will, and conversely, whether a person has the right to drink themselves to death".[2]

The withdrawal of basic human rights is often cited by clinicians who are reluctant to use involuntary treatment, viewing it as a violation of personal liberty and patient autonomy. Treatment is seen as only likely to be effective in individuals motivated to change, and addiction as a matter of individual choice.[4,9,10]

Reviews indicate that the evidence base to support involuntary treatment is limited. Studies are heterogeneous (in terms of substances used, referral methods, levels of coercion, treatment interventions and

1 Involuntary treatment, civil commitment and coercive treatment

Involuntary treatment refers to commitment to treatment where the individual (offender or non-offender) has no choice.[1] This includes treatment for substance dependence with a mandate based in legislation and/or government-implemented programs, such as court-mandated treatment of offenders and the civil commitment of non-offenders.

Civil commitment is a process undertaken outside the criminal justice system and refers to the "legally sanctioned, involuntary commitment of a non-offender into treatment [for drug or alcohol dependence]".[2] In Australia, civil commitment legislation for substance dependence exists in New South Wales (*Drug and Alcohol Treatment Act 2007*), Victoria and Tasmania, while the Northern Territory has involuntary treatment orders for alcohol and volatile substance dependence. Sweden and New Zealand also have civil commitment legislation.[3]

Coercive treatment occurs when an individual "is given the choice to choose between an opportunity to comply with addiction treatment or receive the 'alternative consequences' prescribed by the enforcement of the law, policy, or agency" (eg, prison or probation, loss of child custody, loss of employment or benefits).[4] ◆

outcome measures), with small patient numbers, poorly equivalent comparison groups and short follow-up periods. Randomised controlled trials are ethically and practically difficult to conduct, and there have been only a few, with small sample sizes. Overall, the evidence for effectiveness is inadequate and inconclusive. But, for some people, short-term involuntary treatment may reduce harm, including substance use and criminal activity.[1,3,11-13]

Coercive treatment — where an individual is given the choice of complying with treatment or receiving the "alternative consequences" (Box 1)[4] — is better studied and less contentious. A review of the evidence for coercive treatment concluded that most research demonstrates efficacy and cost benefits, including reduced substance use and criminality, and improved health and employment.[4] In contrast, another review argued that research has not clearly demonstrated long-term benefits of coercive treatment for the individual or the public, nor whether the benefits outweigh any negative consequences.[14]

For drug offenders, studies support the effectiveness of legally coerced treatment in the community, with those participating under "legal pressure" doing as well as those without.[15] However, compulsory drug treatment in prison is highly contentious, lacks rigorous evidence for effectiveness and is often abstinence-based, while evidence-based treatments such as opioid maintenance are excluded. Voluntary treatment in prison can be effective for recidivist offenders, when effective treatment choices and post-release care are provided.[15]

For people with severe substance dependence, individual choice and patient autonomy may be compromised by the cognitive and neurobiological consequences of substance misuse, including negative impacts on frontal lobe functioning. These effects may interfere with insight, motivation, impulse control and, ultimately, the ability to provide informed consent to treatment.[4,9,10,16]

Following a recommendation from the 2003 NSW Summit on Alcohol Abuse, an inquiry into the Inebriates Act was conducted by the Standing Committee on Social Issues of the NSW Legislative Council. The resulting 2004 report concluded that "in the majority of cases [the Inebriates Act] is used for the purpose of managing difficult behaviour, that is, for social control".[2] Such "difficult behaviour" included repeated low-grade offending causing disturbance to the community, as well as behaviour "impacting seriously on the wellbeing or safety of family members".

At the same time, it was also acknowledged that the Act was used because there were few alternative options, and that the interventions provided had sometimes benefited patients.[2] In all, the report made 55 recommendations, including that the Inebriates Act be repealed and replaced with new legislation.[2,7]

The new Act — trialled and beyond

The Drug and Alcohol Treatment Act was drafted to replace the Inebriates Act and provides a very specific and detailed definition of who meets the criteria for involuntary treatment. Section 9 of the Act specifies that a "dependency certificate" allowing for involuntary treatment may be issued only if an accredited medical practitioner is satisfied that each of four conditions exist:

- the person has a severe substance dependence (ie, the person has a tolerance to the substance, shows withdrawal symptoms when stopping or reducing use, and has lost the capacity to make decisions about his or her substance use and personal welfare due primarily to dependence on the substance), and
- care, treatment or control of the person is necessary to protect the person from serious harm, and
- the person is likely to benefit from treatment but has refused it, and
- no other appropriate and less restrictive means for dealing with the person are reasonably available.

The accredited medical practitioner may also consider any potential for serious harm to children or other dependants of the person.

Once a dependency certificate is issued, the person may be detained for treatment under the Act. The Act allows for up to 28 days of initial treatment and up to 3 months of treatment for substance-related brain injury. As the person's cognition improves, enhanced decision-making abilities may facilitate treatment engagement.[2] The Act also provides a framework for regular legal reviews and allows accredited medical practitioners to discharge a patient when he or she no longer meets the criteria for involuntary treatment.

The NSW Government outlined a plan to trial the Drug and Alcohol Treatment Act in one area health service before repealing the Inebriates Act. Consequently, in February 2009, a new four-bed Involuntary Treatment Unit (ITU) was opened in the Drug and Alcohol Service at Nepean Hospital to trial the revised legislation. During the 18-month trial period, 35 patients were admitted to the ITU under the new legislation (Box 2), compared with a total of 28 admissions into gazetted units in NSW in 2009 under the Inebriates Act (David McGrath, Director, Mental Health and Drug and Alcohol Office, NSW Health, personal communication). From 1999 to 2009, a total of 195 patients were admitted to the seven gazetted units in NSW under the Inebriates Act, suggesting there may be a much greater demand for involuntary treatment than past experience has indicated.

In September 2012, following the trial, two ITUs commenced operation under the Drug and Alcohol Treatment Act in NSW — one rural (based at Bloomfield Hospital in Orange) and one urban (based at Royal North Shore Hospital in Sydney). Both units will accept patients

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2 Nepean Involuntary Treatment Unit activity during 18-month trial period from February 2009

- 89 referrals from within the Western Sydney Area Health Service
- 81 people assessed
- 42 dependency certificates issued
- 35 patients admitted
- 42 discharges (five patients were admitted twice, and one patient three times) ◆

referred from anywhere within NSW. Systematic evaluation of these two units will be important to determine their impact and effectiveness in both the short and longer term.

In conclusion

Where involuntary treatment is to occur in non-custodial environments, it is essential that loss of liberty be balanced by access to appropriate treatment.[5] Compared with the Inebriates Act of 1912, the Drug and Alcohol Treatment Act of 2007 provides a more appropriate legal framework for the assessment, detention and review of patients in suitable treatment facilities in NSW. Treatment provided under this Act for people with severe substance dependence will need to focus on stabilisation, comprehensive assessment, provision of evidence-based care, and coordination of comprehensive aftercare.

Competing interests: Glenys Dore is the Clinical Director of the Northern Sydney Drug and Alcohol Service, where one of the new ITUs is based. Robert Batey has advised NSW Health about involuntary treatment for substance dependence and was involved in setting up the ITU trial in his former role as Clinical Advisor, Addiction Medicine.

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Following the outcome of the 2013 election for the positions of Chair of Council and Treasurer, pursuant to the Articles of Association, nominations are now invited for election to the Federal Council of one Ordinary Member as a Nominee of each of the following Craft Groups:

- Anaesthetists
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1. Nominees elected to these positions shall hold office until the conclusion of the May 2014 AMA National Conference.
2. A nominee must be an Ordinary Member of the AMA and a member of the relevant Craft Group for which the nomination is made.
3. The nomination must include the name and address of the nominee and the date of nomination. It may also include details of academic qualifications, the nominee's career and details of membership of other relevant organisations.
4. Each nomination must be signed by the Ordinary Member nominated AND must be signed by two other Ordinary Members of the AMA Craft Group for which the nomination is made.
5. Nominations should be addressed to the Returning Officer (marked "Private and Confidential") and to be valid must be received at AMA House, 42 Macquarie Street, Barton, ACT 2600 no later than 5.00pm Wednesday 17 July 2013.
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