Complex Needs at the Boundaries of Mental Health, Justice and Welfare: Gatekeeping Issues in Managing Chronic Alcoholism Treatment?

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A. Introduction

Intoxication and drug addiction which constitutes or is associated with criminality has recently spawned innovative collaborations across disciplines, as witnessed by the spate of north American style specialist 'drug court' initiatives (Indermaur & Roberts 2003), including those in the Australian states of Queensland, NSW, Victoria, South Australia and Western Australia (ALRC 2005:189). Although historically equally unresponsive to interventions, intoxication and addiction not involving criminality has attracted less recent interest. Especially neglected are the more complex needs of people with co morbid mental illness or social deficits, despite token recognition of the problem in documents like the national alcohol strategy issued by the Australian Ministerial Council on Drug Strategy (NEACA 2001:27–28).

Early laws about management of institutional care for people suffering from alcoholism took the form of licensing the private 'retreats' which provided care on a fee-paying basis (Baumohl & Room 1987; Lewis 1992:97). As with the regulation of the early private 'lunacy' retreats, admission was mainly able to be initiated by members of the family, or by close associates such as business partners. Usually the police were also given an initiating role in recognition of the public interest, and self-admission was also possible (Carney 1987); models largely carried forward in section 11 of the Victorian *Alcoholics and Drug-Dependent Persons Act 1968*.

In the closing quarter of the 19th century, JS Mill's 'harms principle' fashioned a legalistic model of mental health committal (Monahan 1977). This was characterised by narrowly restrictive definitions of mental illness, insistence on showing harm to self or others, independent external verification of the need for involuntary admission, and strong procedural guarantees (Carney 2003). That model was usually copied over into separate legislation governing civil committal of people suffering an addiction, where the 'harms' often sounded less compellingly as removal of people whose presence is disturbing to the

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populace (or a form of 'social renovation': Nilssen 2005:137). This utilitarian model stood mid-way between Kantian ideals of respect for individual autonomy, and welfare or medical interventions grounded in collective ethical obligations of 'care' (Nilssen 2005:135–136). We will return to this below.

Most jurisdictions later abandoned committal of addicts, and turned to other laws or other service systems to better cater to their needs. New South Wales was the exception in Australia. Victoria and Tasmania also retained committal, but in a 'renovated' re-enactment in 1968, following in the footsteps of New Zealand (1966) by joining Sweden and 32 US jurisdictions in retaining confidence in this option (NSW 2004c:27–29). Denmark (1933–1976) and Norway (1900–1993) also preserved variants of the care ethic until the 1970s and 1990s, while Denmark made provision in 1992 for people to volunteer for an 'irrevocable committal contract' and in 1993 Norway did likewise, backed by a responsibility for authorities to seek to persuade the person in the event of immediate risk when voluntary measures had failed, and a power to insist on treatment if their foetus was at risk (Nilssen 2005:138–140).

Among the alternatives to committal, many jurisdictions relied on short-term 'sobering up' laws, such as the 1979 law in NSW (Cornish 1985); or instead turned to generic use of mental health laws, as still occurs in London (Amor & Harding 2005). When adult guardianship laws were reformed and made more accessible (Carney & Tait 1997), it became possible for competence issues to be handled by empowering a guardian to act. However in 1990, New South Wales, in common with many jurisdictions (Queensland apart until 2000),[1] narrowed the scope of its mental health laws to make addiction a ground for *exclusion* from what was otherwise a more generous 'disorder of function' or consequence-based definitional gateway for mental health (Dawson 1996:65). A mental health gateway which defines mental illness quite widely as a condition which temporarily or permanently impairs a person's 'mental functioning' and which is accompanied by 'symptoms' such as delusions, hallucinations, serious disorders of thought form, a severe disturbance of mood, or sustained or repeated irrational behaviour.[2] Current NSW thinking is still opposed to broadening the definitions to encompass say drug induced psychosis, preferring to leave this to any addiction-specific committal provision (NSW 2004a:9). In practice the adult guardianship tribunal also determined that addiction was not a basis for exercising its possible jurisdiction over such cases (NSW 2004c:26).

Even when these alternative pathways of mental health or guardianship are open, they offer choices which are not always straightforward for this group of people, who not infrequently experience co morbid conditions (Crome 1999); so professionals agonize over what is best (Connell 1999). This is not unique to the addictions of course. Similar dilemmas are encountered by professionals in other fields, such as in deciding whether to use the law to insist on treatment of severe anorexia nervosa, and if so, whether to use guardianship or mental health laws (Carney, Tait, Saunders, Touyz & Beumont 2003; Carney, Tait, Wakefield, Ingvarson & Touyz 2005).

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1 Mental illness is now defined as a 'condition characterised by a clinically significant disturbance of thought, mood, perception or memory', but a person must not be found to be mentally ill merely because a person takes alcohol or drugs: *Mental Health Act 2000* (Qld) ss 12(1), (2)(g). The *Mental Health Act 1974* (Qld) expressly 'incorporated' people with addictions.

2 Personality disorders continue to struggle to fit within this gateway, and some doubts were expressed about anorexia even after the Mental Health Tribunal found that it was caught if there was a serious risk of harm, by virtue of being a 'severe disturbance of mood' (NSW 2004a:8).

Complex needs clients have always taxed the law and service systems, but this has been compounded by service reorganisation, including neoliberal outsourcing of services ('new public management', see: Carpenter 2000; Hartman 2005)). Neoliberal governance relegates the state to setting policy goals and provision of funding for services which are mainly tendered out to private sector providers. Along with greater reliance on personal responsibility and civil society (non-government volunteer services), these measures remove the state from responsibility for service delivery: or in the well worn rowing metaphor, it transforms the state from one which both did the 'steering' and the 'rowing', to one which merely 'steers'.

This paper examines the differing ways in which Australian jurisdictions have recently responded to the challenges posed, with New South Wales favouring a 'minimalist' or short-term intervention model (NSW 2004c), while Victoria devised 'complex needs' legislation to allow cross-system assessment and management. The main effects of this are that funding schemes increasingly favour single dimension or purist service systems which target just *one* attribute or problem (Brown & Murphy 2000; Green 2001), and that services face declining budgets. Trends towards ignoring the needs of multi-problem or high need groups like the homeless which the recent US 'Mayors Covenant', struck in January 2005 by 61 city leaders (Mayors Covenant 2005), believe may be reversed by utilising the very same new public management techniques, but at the *meta level*. Their scheme contends that it is possible to harness private sector and civil society interests by crafting a city-wide commitment by business and other community stakeholders towards eliminating homelessness within a decade (Durham 2005; Looking Homeward 2005), as advocated in 2000 by the National Alliance to End Homelessness (National Alliance 2000). A bold claim which is yet to be tested.

B. Many medicines, few cures?:[3] Choosing a legislative model

Australia has mainly experimented with three models.

The most durable of those models has been civil commitment, while the most recent and creative model is that of facilitating coordination of social services and management of complex needs. About two thirds of the way through the journey between the 1870 origins of civil commitment and the present day, a third model was tried, that of detoxification laws.

1. Civil committal?

Civil committal had a very chequered history in Australia, peaking in the early decades of the 20th century (though patient volumes remained modest), falling into virtual disuse in the 1930s and 1940s, before enjoying a brief rediscovery in the 1960s (Lewis 1992:114, 198). New South Wales retained its *Inebriates Act 1912* (NSW), based on models from the 1870s (Carney 1987:8–16). 'Modernised' committal laws were also enacted in the late 1960s in three Australasian jurisdictions: *Alcoholics and Drug Dependent Persons Act 1968* (Vic); *Alcohol and Drug Dependency Act 1968* (Tas) and the *Alcoholism and Drug Addiction Act 1966* (NZ).

These jurisdictions maintain quite low volumes of committals to the present time, but other Australian States and territories repealed all equivalent laws, after passing through phases where the mental health facilities were the primary vehicle for residential care of

3 Benjamin Franklin *Poor Richard* (1734).

addicts under those laws in any event (Lewis 1992:ch 6, 198). This left mental health legislation (or child welfare legislation) as the only committal avenue, with Western Australia one of the few to utilise those avenues (NSW 2004c:28). Queensland until 2000 was one of the rare jurisdictions to expressly *include* dependence as though it were a mental illness at law (s5(2) *Mental Health Act 1974*), though the provision was rarely used prior to its repeal.

Elsewhere, as in section 122 of the *Liquor Act 1980* in the Northern Territory, there are remnants of much earlier 'place of safety' models (repealed in Tasmania in 1966 but partly continued in ss58, 60 of the *Alcohol and Drug Dependency Act 1968* (Tas)). Place of safety models permit chronic drunkenness offenders to be brought before a court and placed on an order requiring acceptance of treatment (NSW 2004c:27–28). A model which it appeared the recently re-elected Northern Territory government in 2005 may revive in some form ('AM' 16 June 2005).

2. Detoxification?

The NSW *Alcohol Summit* in 2003 made several recommendations to improve handling of detoxification, including review of the *Inebriates Act* (rec 9.35), avoidance of use of police cells for detoxification under the *Intoxicated Persons Act* (rec 9.37) by way of a roll-out of diversion (rec 8.60), and enhanced provision of community services, especially in rural areas (rec 8.51). It also called for a re-assessment of the repeal of non-government-run 'proclaimed places' under that legislation, and establishment of sobering up places (rec 4.29), as well as provision of better housing for the homeless (rec 4.18).

Detoxification laws had their origin nearly 40 years ago in the US President's Commission Report: '*The Challenge of Crime in a Free Society*'. That Report called for the repeal of criminal laws about drunkenness and their replacement by a civil response, the centrepiece of which was to be a detoxification unit. Currently in Australia, NSW, South Australia and the ACT are the main exponents of detoxification laws. NSW enacted the *Intoxicated Person's Act 1979* (NSW), later shifted to become Part 16 of the *Law Enforcement (Powers and Responsibilities) Act 2002* (NSW). South Australia had earlier adopted the *Public Intoxication Act 1984* (SA), which repealed the former *Alcohol and Drug Addicts (Treatment) Act 1961* (SA). While in 1994 the ACT enacted the *Intoxicated Persons (Care and Protection) Act 1994* (ACT).

The core provisions of these laws authorise short-term detention of a person previously liable to be charged with (and subsequently fined/detained) in respect of being drunk, or drunk and disorderly, in public. For instance, section 206 of the NSW *Law Enforcement (Powers and Responsibilities) Act 2002* provides authority to detain in an 'authorised place' a person found intoxicated in a public place who needs physical protection due to their intoxication (s206(1)(b)), or who is 'behaving in a disorderly manner, or in a manner likely to cause injury to the person or another person, or damage to property' (s206(1)(a)).

Placements are designed to tap into civil society where possible, by returning the person to their family or some other carer, or by placing them with a non-government service provider. The NSW section therefore goes on to provide for the person to 'taken to and released into the care of a responsible person willing immediately to undertake the care of the intoxicated person' (s206(3)).

Retention for a short period in an 'authorised place of detention' is permitted under the legislation, but only where temporary care is needed while a responsible person is located (s206(4)(a)), or where the person is too violent for a responsible person to be able to offer care and control (s206(4)(c)). The third situation where detention is authorised is where:

> a responsible person cannot be found to take care of the intoxicated person or the intoxicated person is not willing to be released into the care of a responsible person and it is impracticable to take the intoxicated person home ... (s206(4)(b)).

In NSW the law originally made provision for designation of shelters, run by not-for-profit agencies such as the Salvation Army, as 'proclaimed places' authorised to hold those unable to be released home or to the care of a 'responsible person'. However in 2000 this alternative to being 'cared for' in police cells was removed (NSW 2004c:26), apparently on the basis of practical issues encountered by these agencies in exercising their power to detain (NSW 2004c:135–37). For its part, Government identified loftier goals, stating that it was moving away from proclaimed places in favour of a 'new scheme', because such places:

> had a tendency to *entrench the lifestyle* of this group of people [and was therefore replacing it with] a new scheme where individuals could be *better linked with treatment and support* to help them stop their alcohol or drug addictions and move towards independent living (NSW 2004b:Section 8, item J of the Government response, emphasis added).

The same degraded fate met the even more ambitious (and socially meritorious) 'hierarchy' principle enshrined in legislation in some jurisdictions such as South Australia, which had originally established an 'order' of preferred civil society placements (Carney 1987:244 [the 1978 amendment in SA]). This filtering proved to be too sophisticated to work in practice (Cornish 1985; Carney 1987:245 [dropped in SA in 1984]).

The 'priority ranking' idea does survive in the ACT however, where up to 8 hours of custody under the *Intoxicated Persons (Care and Protection) Act 1994* (ACT) is subject to there being *no other acceptable alternative,* in the form of release to a responsible person or to a 'licensed place' for provision of care (ss4(2), (6)). The person is free to leave these places at any time in the ACT (s7(a)), though police are to be notified if the person is a danger to themselves or others (s9). This legislation deals with public management issues by making admission conditional on the person agreeing to hand over their clothes and possessions for safekeeping, and acceptance of a search (s6A). But significantly, it directs that neither police nor licensed places may 'allow a person to remain' for more than 12 or 15 hours respectively (ss4(4), 11).

3. Complex needs?

Dual diagnoses and the lack of services to meet complex needs clients have been canvassed previously in NSW (NSW Health 2000), without much progress.

People with 'complex needs' were found to account for the greatest share of demand for committal under specialist addictions laws like the New South Wales *Inebriates Act 1912* (NSW 2004c:100), but the recent Parliamentary Report remained 'unconvinced' that such 'coercion and involuntary mechanisms are the most appropriate or effective solution for this group' noting that it was too easy to make moral judgements based on their repetitive or socially disturbing behaviour, and concluding that it was wrong to criminalise people who had not committed a crime, and whose behaviour may be outside their control (NSW 2004c:102).

This has its echo in the recent qualitative study of Sweden's civil committal institutions when it observed that:

> To create a programme that would seem more like treatment than preventive detention and to keep the clients in it took considerable inventiveness on the part of the care providers. Since 'proper' treatment is voluntary, it was necessary to try and 'remove' the coercion stain and work as though it did not exist. Such attempts naturally collided, however, with

> the continual arrival of new clients who were at least unenthusiastic about being institutionalised, with clients escaping, with the reappearance of some clients in ... repeated placements and with the fact that the care providers themselves seldom saw any clearly positive results of their work (Billinger 2005:62).

That reasoning is the genesis of the service coordination approach.

The most innovative legal answer to the challenge of service coordination in Australia is the state of Victoria's *Human Services (Complex Needs) Act* (Vic) *2003*. This legislation accepts that there are a small number of people who suffer from multiple deficits and co morbid conditions, the management of which does not lend itself to any *single* service system. In other words, it recognises the strength of the critique of the trend towards service specialisation, and the associated service 'silo' effect (Green 2001), which leads to individuals 'falling through the cracks' between service systems, as a Quebec study found (Brown & Murphy 2000). This is not a new discovery, as the NSW Parliamentary inquiry observed: '[t]he importance of overcoming service boundaries and providing a 'joined up' response is increasingly recognised by government, but achieving it is no easy task' (NSW 2004c:58).

The Victorian legislation takes this one step further, bringing the law back into play in a limited way, by constituting a cross-agency 'assessment panel' to which complex needs cases would be referred.[4] The legislation directs the panel to draw up 'care plans' for each client. Those individual care plans not only must map out the way greater coordination and continuity of care is to be achieved, but also must *commit* the resources necessary to realise that plan. The law targets service providers rather than their clients. Canadian commentators advanced a 'community network' solution for similar problems in Quebec (Brown & Murphy 2000:1077). They identified three main dimensions of an optimal service system, under the catchy rubric of 'contribution, coordination and continuity'. At base, their scheme was designed to marshal needed resources for a group of vulnerable multi-problem clients whose needs are poorly met. This was also the focus of the initial optimism associated with US 'right to treatment' litigation which sought to use litigation to leverage greater access to resources and services for the mentally ill (Perlin, Gould & Dorfman 1996:748–55; Rees 2003). These hopes were dashed however: results in the US were disappointing, and the rights proved difficult to operationalise. The Quebec plan therefore proposed placing greater weight on *extra-legal* coordination of efforts in order to achieve a more holistic and integrated approach to service delivery to these clients.

C. Gatekeepers, Pathways, Principles and Pragmatism

Socio-legal scholars have long recognised that laws and systems will not be effective unless they speak to the values, processes and expectations of the communities sought to be engaged or 'regulated'. It is suggested that this remains one of the largest of the unresolved challenges in addressing complex needs populations. 'New regulation' theorists argue that there may also be mileage in studying the web of connections and incongruencies between different spheres of law/regulation (Parker, Scott, Lacey & Braithwaite 2004:3), and this too has some limited resonance, as we will now explain.

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4 The Tasmanian civil committal legislation also established an Alcohol and Drug Dependency Tribunal, to exercise powers under that Act: *Alcohol and Drug Dependency Act 1968* (Tas) ss 7–11. Likewise Part 9.3 of the *Drugs of Dependence Act 1989* (ACT) constitutes 'Treatment assessment panels' to adjudicate on the need for treatment orders.

Work on the way adult guardianship and mental health laws are invoked in order to compel anorexic young women to undertake treatment, revealed complex relationships between formal and informal systems of regulation, with law rarely invoked unless 'heavier' forms of informal coercion (including 'moral blackmail'), proved inadequate (Carney, Tait, Wakefield, Ingvarson & Touyz 2005). As reported elsewhere (Carney, Ingvarson & Tait 2006), 'control' (or management) is exercised diffusely, through disciplinary practices embedded in everyday clinic life (such as daily routines of eating and washing, behavioural 'contracts', surveillance and measuring, staff interactions, visits and activities). Here the regulatory regime not only touched on such 'practices' but actively targeted 'identities' (including self-image, and attitudes to the body) and what Goffman called the 'moral career' of the patient (Goffman 1961:119; Aneshensel 1999), such as learning the 'patient role', or to 'be' an 'anorexic'.

This phenomenon is also evident in selected social settings catering to people with complex addictions, such as in the informal regulatory web of expectations found in boarding houses, homeless shelters and hospital emergency departments. Extraneous factors, such as lack of fit between property tenure laws and the housing needs of homeless clients, or limited charitable objects of welfare agencies, can also skew policy outcomes (Barr & Glover-Thomas 2005). However these intersections with the social and cultural norms of regulation are perhaps rather less apt to the complex needs group targeted by the specialist addictions, detoxification or 'care/services management' laws reviewed here, because they are often socially marginalised, dispersed or 'alienated' from mainstream institutions and supports. As in Quebec and elsewhere, they are often homeless (Appelbaum 1992; Brown & Murphy 2000). Nor is it a coincidence that over a 10 year period, Aborigines comprised more than a third of all committals to the main hospital receiving people under the NSW *Inebriates Act* (NSW 2004c:22).

1. Gate-keepers and pathways?

The dispersal of the population of people with multiple needs, and their association with forms of 'challenging' or disturbing behaviour, poses two main risks. There is a risk both that laws and service systems will be used as a form of social street-sweeping (or 'net widening'), and paradoxically also a risk that less troublesome people will be left to fend for themselves. Both type one *and* type two errors are possible.

Police and health workers are the two groups most likely to come into contact with such people, so the minimisation of those risks may lie in taking advantage of the culture of these two possible gatekeepers.

For their part, police respond to conduct which sufficiently threatens 'public peace' or harmony, criminal actions, and serious harm to self. As the agency least able to simply leave cases to be picked up by other public agencies, police will utilise options like temporary placement in police cells where a threat to good order cannot be abated by other means. But if there is an insufficient breach of the peace, intervention is unlikely, unless the threat of self-harm is very grave. That is why detoxification laws operate differently from the loftier 'welfare' intentions of their Parliamentary authors.

Health workers on the other hand, respond to diagnostic indicia of possible health needs. Where beds and resources are sufficiently plentiful, they are trained to maintain therapeutic engagement until the risk of illness has been satisfactorily resolved. When in doubt, health investigations continue. In a system grounded in beneficence, patient consent, and conforming behaviours, disruptive patients pose management difficulties which the health system is ill-equipped to handle, aside from the more florid mental illnesses managed under

the *Mental Health* laws. Other patients, with other needs, are catered for instead. That is why medical management options for people with complex needs or chronic addictions rarely achieve the lofty 'health care' expectations of their authors.

The short point is that the complex needs group ends up being over-represented in the criminal justice (summary offences/public disorder) or compulsory treatment populations like those governed by the *Inebriates Act* (NSW 2004c:103). The attraction of the *Complex Needs Act* model as a response to this dilemma, is that it allows for cases of possible complex needs to be referred centrally for panel investigation at the behest of any interested party in possession of sufficient information to warrant the referral. Given the chronic pattern of interactions with a variety of different services and agencies, it is only by the panel being granted access to the full 'pool' of information, held elsewhere in relation to such a person, that it becomes possible for a more balanced 'gateway' decision to be made about their need for on-going management and coordination, and for state agencies to be made accountable for service delivery.

Another possible intake avenue is to modify mechanisms for responding to acute, serious threats posed to life and health, so that they serve as a marshalling yard for identifying possible needs for ongoing services. That is where the wide catchment of intoxicated persons laws might play a part.

So what model is best?

2. Principles and Pragmatism?

Common ground about the underlying principles which should inform legislation and services in this area is difficult to locate, because interventions and therapies generally yield less than promising results, undermining the case for soft paternalism based on retrospective consent after recovery.

Utilitarian liberal foundations for highly paternalist civil commitment laws like the NSW *Inebriates Act* or Sweden's *Care of Alcoholics, Drug Abusers and Abusers of Volatile Substances (Certain Cases) Act 1981* ('LVM' as amended in 1989), rest on a showing of specific harms to family or the person; but the closeness of the harms principle to the criminal model (e.g. guarding against family violence) and the lack of obvious direct benefits, render it problematic (Nilssen 2005:143), along with its somewhat problematic administration by a *lay* committee appointed by elected representatives (Billinger 2005:56). Purist insistence on respect for individual autonomy, as in Denmark's *Act on the Detention of Drug Abusers in Treatment 1992* (as amended in 1998), with its voluntary 'contracts', arguably is unduly libertarian, paying inadequate regard to the short-term effects of intoxication in displacing capacity for informed choice (Nilssen 2005:142). So a middle-ground akin to the Norwegian law which gives some weight to an 'ethic of care' has its attractions, despite its 'blurring' of the line between coercion and voluntariness (Nilssen 2005:143).

Apart from the long-standing and almost universal view that sobering up laws are preferable to the high volume street sweeping function and 'revolving door' of criminalising public drunkenness (Nimmer 1971), the greatest policy consensus is found in respect of short-term interventions to avert immediate and grave threats to a person's life where the person has lost the capacity to decide (NSW 2004c:95–96, 103). This is the rationale for Norway's 'duty to persuade' approach (Nilssen 2005:142). Involuntary short-term intervention can arguably be justified to preserve life in such circumstances, on the same ethical basis as that which authorises pumping the stomach of a person who enters a hospital emergency ward with a drug overdose (Beumont & Carney 2003; 2004).

The greatest practical attraction of this model is its wide catchment. It takes advantage of the wide coverage and close public interaction offered by the police. This means that a person with complex needs living in a remote country town is not disadvantaged in the way they would be if services hinged on geographic proximity to a residential treatment facility authorised to receive patients under addiction committal orders, or if they relied on access to a specialist public hospital unit.[5] In addition to preserving life for the time being, another possible ethical justification for such action lies in the argument that it can guarantee that the person possesses, or has time to regain, an 'informed mind' about whether to accept or reject any longer-term treatment or services to assist in managing or alleviating their condition: a 'capacity restoration' twist on the so-called 'soft paternalism' (or Gerald Dworkin's retrospective 'thank you' justification for intervention: Nilssen 2005:136)). Clients can be provided with information to which previously they might not have had access, and the detoxification interlude can restore any diminished decision-making capacity lost during acute stages of intoxication. That was the apparent basis for the 'choice' point provided in the 'detoxification plus' legislation found in the Tasmanian Act, where an additional period of custody was able to be authorised if longer-term needs were identified during the sobering up period.

As previously mentioned, the greatest weakness is that police administer such laws through the prism of 'peace and good order' rather than that of public health and community services. The unobtrusive and socially isolated complex needs clients are at greatest risk of continuing neglect of their needs under this system. People visible enough, or disruptive enough, to come to attention would not be at the same risk of being overlooked were it not for the allied problem of the scarce supply of knowledgeable advisors such as community nurses/local medical practitioners who might serve as gatekeepers, instead effectively leaving decisions to be taken by say local magistrates on police advice. A situation leading to neglect of their needs as well.

Influenced in part by the Victorian model where the *Complex Needs* legislation exists side-by-side with a short-term (7–14 day) assessment/detoxification option under its 1968 addiction committal laws (NSW 2004c:96, 133), the NSW Parliamentary enquiry recommended enacting free-standing legislation (to be administered by the Health Department) authorising 7–14 days of involuntary detention in a medical facility for detoxification, assessment and post-discharge forward-planning for people with severe substance dependence who were unable to consent to treatment when experiencing an immediate risk of serious harm (NSW 2004c:113–116). To balance clinical necessities with respect for rights, admission would initially be a clinical decision, subject to later review by a magistrate, with rights of appeal (NSW 2004c:122). Court-ordered, out-patient assessment and planning was also recommended as an additional avenue, along with private planning by way of 'advance directives' (NSW 2004c:128). This is a useful step forward, but gaps remain, as suggested below.

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5 The NSW Government response to the Alcohol Summit recognised this when it conceded that its preferred 'coordinating protocols' approach would require significant adaptation in remote regions:

> In some parts of the State it is anticipated that alternative approaches may be required, because of issues of distance and isolation. In the Far West for example, one local protocol for this entire region is not practicable. The alternative approach that is being developed is one of tailoring service arrangements to the needs of specific communities, including Indigenous communities. At the present time, former proclaimed places in Bourke, Brewarrina and Walgett are continuing to operate but the Department of Community Services is working with them to help them realign to better link to health and support services (NSW 2004b:Section 8, item J of the Government response).

D. Conclusion

Civil committal laws for people with addictions have been broadly drawn in the past, catering to a variety of concerns in addition to a person who has lost the capacity to rationally decide about or consent to treatment, and who faces an imminent threat to life or grave impairment of their health.

In its review of the *Inebriates Act,* the NSW Legislative Council's *Social Issues Committee* rejected the use of coercion for these wider purposes, such as to achieve 'rehabilitation' (problematic because of the poor results); relief of concerns, stress or harm experienced by family carers; or to control disturbing behaviours (NSW 2004c:87–103). It was decided that such purposes were neither ethically sustainable, nor consistent with international principles governing the mentally ill (for a review, Gostin & Gable 2004). Principles especially pertinent given that committal laws for addicts traditionally mimic prevailing models for mental health committal (NSW 2004c:85, 111).

The NSW Report instead sought to replicate the work of Victoria's complex needs panel, but by the different (non-legislative) route of insisting that such issues be canvassed by and incorporated in the proposed 'post-discharge treatment plan' required to be drawn up during any short period of detoxification and assessment (NSW 2004c:114). While recognising that resource mobilisation and client welfare may call for quite 'assertive' forms of post-discharge management, it was concluded that community treatment orders (out-patient treatment orders) should not be the vehicle for achieving this (for a recent survey of community treatment order models, see Dawson 2005). This was on the grounds that they were too intrusive, unduly normative, and carried unfortunate connotations in the event of non-compliance (NSW 2004c:118).

The NSW inquiry found 'merit' in Victoria's complex needs legislation, but felt that further consultation was needed in light of work in train for an 'across-government' plan for its replication by *extra-legal* means, and the possible complementary nature of Victoria's package of complex needs and civil committal provisions (NSW 2004c:133). A high level working party was therefore recommended to give further consideration to these issues (id, 134).

The inquiry also backed the concerns expressed at the August 2003 NSW *Alcohol Summit* about the lack of alternatives under the *Intoxicated Persons Act* following abolition of non-government agency 'proclaimed places' placements, effectively leaving police cells as the only option should a person not be suitable for discharge to a 'responsible person', but with police now very reluctant to detain people under that power, given the risk of self-harm while in custody (NSW 2004c:138). A critique that Government was leery about accepting, given the degree of 'community disorder' created by some intoxicated people. Instead (mistakenly) placing its faith in police-agency 'protocols' and priority services for people detained in the cells.[6]

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6 Government explained that there was an *Intoxicated Persons Protocol* describing 'roles and responsibilities' operating at local level between NSW Police, the Department of Community Services and NSW Health, in 10 of 17 Area Health Services, and that it was:

> considering proposals to expand to intoxicated persons detained in police cells the existing 1999 Drug Summit initiative under which medical services are provided by the Corrections Health Service to 'refused bail' persons in ten priority police stations at Surry Hills, Newcastle, Port Macquarie, Dubbo, Moree, Parramatta, Lismore, Wollongong, Campbelltown and Penrith (NSW 2004b:Section 8 item J of the Government response).

Given that a revitalised *Intoxicated Persons Act* might have served as a prime additional 'feeder pool' for the small group of people for whom the proposed new free-standing 'assessment and discharge planning' legislation is designed to cater,[7] and given also that 'whole of government' coordination of services and supports for the even smaller number of people in need of longer-term 'complex needs care' may founder on the rocks of inadequate resources, or inadequate will, it remains to be seen whether the proposed new NSW scheme is optimal.

Government arguably has uncritically accepted its own high-flown rhetoric about the efficacy of 'protocols' and 'service transformation' contained in its response to the critique in the Alcohol Summit to the effect that:

> Many former proclaimed places are now operating as Intoxicated Persons Units within the ... Supported Assistance and Accommodation Program [where] they still provide safe shelter, food and a shower for intoxicated persons but are also gradually being realigned to also provide their clients with access to case management, treatment and other support services.... The five Intoxicated Persons Units in the inner city are developing a combined Alcohol and Drug Strategy to manage the transition from providing 'sobering up services' to coordinated case management, outreach services, day programs and linkages to detoxification and rehabilitation services. Individual services are also being realigned to focus on particular groups ... [to] provide a continuum of care for homeless intoxicated persons in the inner city (NSW 2004b: Section 8 item J of the Government response).

Provision has been made for limited 'evidence-based' evaluation of monitoring data by the 'Senior Officers Coordinating Committee on Drugs and Alcohol', and by the Cabinet 'Standing Committee on Drugs and Alcohol' (NSW 2004b:Section 8 item J), but I would argue that the data set is too limited and that the 'evaluation' lacks arms-length objectivity.

Certainly the NSW model is well grounded ethically and is much better thought out at the practical level than was the commendably altruistic but 'optimistic' model proposed for Quebec (Brown & Murphy 2000). Its shakiest components remain its choice of 'catchment', and its partial deferral of the hard question of using the law to help extract scarce government resources and services for a low status, but very vulnerable group of people, as in Victoria's complex needs law. The Parliamentary inquiry was acutely aware of these challenges, and minced no words in expressing how difficult they would be to achieve (NSW 2004c:Chap 8), but ultimately it was obliged to leave these questions for further work within government.

This may be its greatest mistake. Complex needs clients arguably need purpose designed laws which both facilitate service coordination and which also render state agencies accountable for the delivery of those services.

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7 The NSW Alcohol Summit endorsed detoxification as an entry point into a graded system of care (Rec 6.16) to which Government responded that this was recognised in the *NSW Drug Treatment Services Plan 2000-2005* (including home and ambulatory detoxification) and referring to three new residential detoxification programs at Lismore, Wyong and Nepean hospitals, before foreshadowing the work still to be undertaken on cross-agency coordination (NSW 2004b).

Legislation

Intoxicated Persons (Care and Protection) Act 1994 (ACT).

Intoxicated Persons Act 1979 (NSW).

Law Enforcement (Powers and Responsibilities) Act 2002 (NSW).

Health Act 1937 (Qld), Part 4, div 4.

Alcohol and Drug Dependency Act 1968 (Tas).

Public Intoxication Act 1984 (SA).

Drugs of Dependence Act 1989 (ACT).

Sentencing Act 1991 (Vic) s 18Z.

Drug Rehabilitation (Court Diversion) Act 2000 (Qld).

Alcoholics and Drug-Dependent Persons Act 1968 (Vic).

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