Chapter 4 Time to repeal the Act

> The [Act] as it exists is difficult to implement and does not necessarily have any outcomes other than keeping people alive and sober for the time that they are in the clinic. The problems the [Act] is attempting to address are long-term, severe, and multifactorial. They are also extremely resistant to intervention.[168]

In the previous chapter the Committee documented the vast range of criticisms that inquiry participants levelled at the *Inebriates Act*, establishing that its archaic, punitive premise is matched by inflexible, poorly safeguarded provisions and a highly inappropriate requirement that people be detained in mental health facilities. This chapter makes use of some of the more qualitative information gathered through the inquiry to build a picture of the people being placed under inebriates orders, identifying that common to almost everyone is the presence of chaos, problematic behaviour and multiple needs. On the basis of the evidence, the Committee finds that the Act continues to be used primarily for the purpose of control. In the second half of the chapter we explore the outcomes of inebriates orders, and conclude that while the Act has resulted in harm reduction for some people, it has also in many cases achieved very little or has actually caused harm. On the basis of this analysis and the raft of criticisms documented in Chapter 3, the Committee concludes that the *Inebriates Act* is irredeemable and recommends that it be repealed and replaced at once with modern, safeguarded legislation reflecting the recommendations set out in subsequent chapters of the report.

Who are the people for whom inebriates orders have been sought?

4.1 In the absence of centrally collected data, the Committee has utilised the inquiry process to gather information on those made subject to the *Inebriates Act* from participants, primarily drug and alcohol professionals and members of the police service who have sought an order, along with psychiatrists and mental health administrators who have received people into gazetted hospitals. We note that the information gathered is impressionistic and anecdotal, and because admissions under the Act are so rare, it is difficult to draw strong, generalised conclusions about them. In some cases the examples are several years old and there is potential for some double-up in those cited. Moreover, the information is quite subjective such that, for example, those who seek orders may have a different perspective than those receiving them. Nevertheless, the examples we were given provide very useful insights into the use of the Act, and into the potential demand that might arise around any new legislation enabling involuntary treatment for people with substance dependence.

4.2 While there are several discernable categories of people made subject to the Act, common to almost all of the cases reported to the Committee was the theme of chaos and difficult behaviour. Rather than conforming to the stereotype of someone who is homeless and quietly destitute, those subject to the Act appear in the majority of cases to be visible and creating difficulties for their family or community. As Dr Joanne Ferguson, psychiatrist at Rozelle and Concord Hospitals put it, 'People coming to me under the *Inebriates Act* are those who are creating a problem for someone else.'[169] Correspondingly, the issue of difficult behaviour looms large in the various categories we have identified.

[168] Submission 16, North Coast Regional Coordination Management Group, p1

[169] Dr Joanne Ferguson, Staff Specialist Psychiatrist, Drug Health Services, Rozelle and Concord Hospitals, Evidence, 27 November 2003, p39

4.3 A second related theme was of people having multiple needs on top of their alcohol or drug dependence: those subject to the Act often also have mental health problems, significant cognitive damage, are socially isolated, homeless, and/or are coming into contact with the criminal justice system.

4.4 While there is a great deal of commonality between the four groups identified, the Committee believes it is valuable to identify and explore each one, as each raises distinct ethical issues in relation to compulsory treatment.

People at risk of serious harm, including those with alcohol related brain injury

4.5 In a modern context, the provision of humane protection for those at risk of serious harm might reasonably be seen as legitimating involuntary intervention. A number of participants told the Committee that they had sought or observed inebriates orders being made for people who had experienced or were at risk of significant harm as a result of their substance misuse. The person's health was in crisis, or he or she was perceived to be extremely vulnerable and at risk. Various cases were outlined of people whose drinking had resulted in coma, internal bleeding, physical collapse or other acute or life threatening conditions. Others cited examples of the non-acute but no less serious harm associated with brain damage arising from long term alcohol misuse.

4.6 Ms Kim Lewis, Drug and Alcohol Worker from Mid Western Area Health Service, told the Committee of four people she was aware of who had been placed under inebriates orders in the past ten years. All were sent to Bloomfield Hospital. The first was a woman in her early thirties who had been placed under an inebriates order three times over a three year period due to alcohol abuse. Because she was emaciated, had liver damage and suspected alcohol related brain injury, her health and safety were considered to be at significant risk. The second was a man in his mid thirties with bleeding oesophageal varices and liver damage arising from severe, long term alcohol dependence. Potentially complicating his health crisis was his dependence on methadone, with his clinic unable to establish maintenance because of his alcohol intoxication. In both these cases, the person's family was reportedly exhausted and had sought the order. The third person, also a man in his mid thirties, had alcohol related brain injury and liver damage and had been placed under an order three times in two years. He was also charged with public mischief due to multiple calls to Triple 0 and had been admitted to accident and emergency around 20 times in three months. A subsequent attempt to obtain a further inebriates order, while he was in hospital with internal bleeding, was not granted by the magistrate. The fourth person was a man in his late fifties also with alcohol related brain injury, whose health and safety were considered to be at risk. In this case, the doctor of the man's elderly mother approached the alcohol and other drug service to encourage her to seek the order, and he was detained for six months.[170]

4.7 Ms Lewis noted the multidimensional needs of this group and observed that common to each person was that their 'social world was out of control', that they were generally involved in public mischief or nuisance behaviour, and particularly, that their family relationships were breaking down or had already done so:

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[170] Ms Kim Lewis, Alcohol and Other Drugs Project Worker, Mid Western Area Health Service, Evidence, 25 March 2004, p30

> The interesting thing that we found is that if these people have good family support – a wife, a husband, a father, a brother or a sister they seem to be absent; we do not know of them. They are still as harmful within their homes, their families and their bodies, but we do not see them until they spill out to the community.[171]

4.8 Ms Andrea Taylor gave the Committee an example of someone she had placed under the Act in her previous role as a community mental health professional:

> One was a woman who dressed as a man, lived on the streets, was regularly brought into a proclaimed place, was being raped daily and was coming in with clothes ripped off and obvious trauma associated with rape and would do absolutely nothing about it. She had shocking peripheral neuropathy and was in her late thirties or early forties. It took me seven days to put her under the *Inebriates Act*. As a worker I could not stand by and watch that.[172]

4.9 Mr Faulkner Munroe told us that when he was manager of the proclaimed place in Moree he was instrumental in placing a number of people from the Aboriginal community under the Act. He generally did this in response to self neglect and social and financial vulnerability arising from cognitive damage:

> The experience we have had is with people who have drunk themselves to the point where they cannot manage themselves, their affairs or their money. We have placed people under the Act because we saw them being robbed without their knowledge - people would go to the bank and take their money - and they had to be picked up every night in an inebriated state in a park and brought to a refuge.[173]

4.10 The Committee understands that alcohol related brain injury encompasses a range of conditions that may affect thinking patterns, memory, behaviour and personality, along with coordination, balance and peripheral nerve functioning. It may also be marked by challenging behaviour, poor impulse control, confusion, delirium and hallucinations. A major causal factor is the toxic effect that alcohol has on the central nervous system, but brain damage may also result from other problems associated with significant alcohol consumption such as thiamine (Vitamin B1) deficiency, poor nutrition, dehydration, poor circulation, metabolic problems and falls. Significantly, the ability to have insight into one's behaviour, to process new information and to develop new skills are often affected. In some cases, especially for younger people, cognitive damage is reversible with abstinence; in others the effect is permanent and may have a profound impact on daily functioning.[174] The Committee was advised that in the past, a significant portion of those placed under the Act who had a brain injury were assisted through formal programs at Rozelle Hospital specifically designed for this group, but that these programs no longer operate.[175]

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171 Ms Lewis, Mid Western Area Health Service, Evidence, 25 March 2004, p30

172 Ms Andrea Taylor, Manager, Quality and Risk Management Royal North Shore and Ryde Health Services, Evidence, 7 April 2004, p18

173 Mr Faulkner Munroe, Manager, Byamee Homeless Persons Service, Moree, Evidence, 24 March 2004, p29

174 'What is ARBI?' *http:www.arbias.org.au/arbi.htm* downloaded 20 May 2004; Dr Stephen Jurd, Area Medical Director and Addictions Psychiatrist, Drug and Alcohol Services, Northern Sydney Health, Evidence, 4 March 2004, pp3 and 13-14; Ms Tonina Harvey, Area Director, Drug and Alcohol Services, Northern Sydney Health, Evidence, 4 March 2004, p3

175 Ms Harvey, Northern Sydney Health, Evidence, 4 March 2004, p12

4.11 Ms Vi Hunt, Area Coordinator, Alcohol and Other Drug Services for New England gave a further example of a woman perceived to be at serious risk as a result of substance dependence and mental illness, for whom an order was obtained, but who was refused admission by the hospital:

> In the 12 years that I have been in the Alcohol and Other Drugs Service I have tried one person twice, so I can talk about that person. Obviously it is not something that we use frequently at all. The person who presented was a female in her early thirties. She had presented to the drug and alcohol service on numerous occasions. She also had a diagnosis of bipolar disorder. She had had a very high alcohol intake since the age of 18. When I say "high" I am talking about a cask of wine a day. She would go on a binge which would last four to six weeks. During that time there would be constant calls to drug and alcohol and mental health services. You would get her off the grog and you might get her into hospital for detoxification. She would go out and then we would start all over again. She lived alone. She had two parents and a brother. She had contact with her father, but her mother and her brother would have absolutely nothing to do with her. So she was really quite isolated. As I said, she had numerous admissions for detoxification, but she never stayed very long. She had a number of stays in the mental health unit because sometimes when she was drinking she would become quite suicidal and depressed - another reason for her to be in there. I know that on two occasions we put her under the *Inebriates Act*. Her father actually initiated that process.[176]

4.12 Most of the cases in this category related to alcohol dependence, but dependence on other drugs was identified in some. Ms Leonie Jefferson, Senior Aboriginal Drug and Alcohol Counsellor, Northern Rivers Area Health Service, cited an example of a 25 year old woman with a history of chaotic behaviour and polydrug use (including benzodiazepines and opioids), who had been diagnosed with a severe borderline personality disorder. She was admitted to Morisset Hospital under the Act because she was judged to be at risk.

4.13 In the experience of the practitioners we spoke with, the Act is resorted to only in extreme cases, where damage is manifest and risk palpable. As Ms Beth Burton from the New England Area Health Service told the Committee 'We are talking about damaged people. We would not use the Act until they are quite damaged. You are in fear of their health, or their life in some cases.'[177]

People with antisocial behaviour arising from substance dependence

4.14 A qualitatively different group are those who are reported to be placed under an inebriates order primarily because of the problems their behaviour is causing for their community. This group was emphasised by representatives from the gazetted hospitals, partly because of the major impact they have on other patients and the hospital environment. Dr Glenys Dore of Macquarie Hospital gave a number of examples:

> The gentleman was placed under the Act because he was being a repeated public menace. He was drinking heavily, all day every day; he was essentially drunk all day

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176 Ms Vi Hunt, Area Coordinator, Alcohol and Other Drug Services, New England Area Health Service, Evidence, 25 March 2004, p11

177 Ms Beth Burton, Clinical Nurse Consultant, Alcohol and Other Drug Services, New England Area Health Service, Evidence, 25 March 2004, p10

> every day. In that context, he was committing petty crimes and making a public nuisance of himself. The police were involved, his family was involved, and he was placed under the Act and sent here for three months.[178]
>
> This was a young woman in probably her mid-twenties who was placed under the *Inebriates Act* because she was out of control in the community, she was using a lot of drugs, a lot of alcohol, she was prostituting herself, she was becoming angry, violent, threatening, there was a concern that in an intoxicated state she might attack and harm someone. She came to the hospital—and it was very clear very early on that she had a severe personality disorder underlying all her problems, as well as a severe drug and alcohol dependence—and she was placed in [a long-stay ward]. I think she was on a nine-month order. It became clear very quickly that there was a risk that she might harm the other patients because she would become very angry, very explosive, very threatening and very intimidating.[179]

4.15 Dr Martyn Patfield, Medical Superintendent at Bloomfield Hospital, told the Committee that in his experience it is rarely a person's dependence per se that sees them sent to that facility. Rather, it is usually the result of *behaviour* associated with their substance misuse. Having reviewed the last 20 admissions to Bloomfield (representing around 10 individuals due to a number having multiple admissions under the Act), Dr Patfield estimated that in only three cases was it simply the person's severe dependence, and their family's desperate endeavours to help them, that saw them placed under the Act. By contrast, he thought that 12 admissions were a result of what he termed 'community burnout', where the individual might have had multiple hospital admissions, made many ambulance calls and had repeated contact with the police and the courts for public nuisance offences, domestic violence, being drunk and disorderly, and so on. Their criminality, where it exists, does not lead to a gaol sentence, but their community cannot cope with them any more, and the magistrate makes an inebriates order as a last resort. It appears that at least one of the people cited by Ms Lewis also fell into this category.

4.16 Dr Patfield estimated that another five of the 20 admissions were instances where, in his view, the *Inebriates Act* had been used, sometimes cynically, to avoid the legal consequences of offensive behaviour. In some cases a solicitor had suggested that the magistrate give an inebriates order instead of a custodial sentence; in other cases the patient had asked for it. He offered an example of a person who he believed had done this. The man, who was on methadone, initially came to the hospital under section 33 of the *Mental Health (Criminal Procedure) Act* following a charge of break and enter. While he was diagnosed with an antisocial personality disorder he was not believed to be mentally ill, and was refused admission. Four days later he was sent back to the hospital, this time under a one month inebriates order. He was angry that he had not been admitted the first time and seemed to feel 'entitled' to a diagnosis of mental illness, which he thought would lead to financial assistance and possibly assist him in relation to two pending court cases. After his order expired he was discharged and then returned a couple of months later with a shorter term inebriates order. Again it seemed to Dr Patfield he was manipulating the system.[180]

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178 Dr Glenys Dore, Addictions Psychiatrist and Deputy Medical Superintendent, Macquarie Hospital, Evidence, 4 March 2004, p1

179 Dr Dore, Macquarie Hospital, Evidence, 4 March 2004, p6

180 Dr Martyn Patfield, Consultant Psychiatrist, Medical Superintendent and Director of Acute Services, Bloomfield Hospital, Evidence, 25 March 2004, p2

4.17 This analysis led Dr Patfield to conclude:

> [I]n most cases, the person really has been sent to be held in custody for behaviour which their home community will not tolerate and where criminal charges and custody in gaol is an option but not one that is preferred … In any event the hospital is being used as a defacto gaol after a sentencing process which has few legal safeguards … My chief contention is that the Act is currently being used by the courts to contain behaviour … It should be acknowledged that if an *Inebriates Act* exists, it is to provide a sanction against unacceptable behaviour and to provide respite and protection for the communities in which these people live.[181]

4.18 Representatives of the Police Service verified that low-grade offending behaviour, as reflected in the largest group seen by Dr Patfield, is a primary catalyst for inebriates orders. From their perspective, this remedy is used with benign intentions, in the absence of more appropriate and effective measures, to help address the person's problems and protect the community to some degree. As Assistant Commissioner Bob Waites told the Committee:

> Some officers in the country in recent times have given me examples of trying to use the *Inebriates Act* to assist homeless people who are living on the proceeds of crime simply because they need to support themselves. They have utilised the Act by coercing these people - or convincing them - to go to court and then getting a doctor's certificate so that they can be placed in care.[182]

4.19 Both the Assistant Commissioner and the Police Association associated this behaviour with people who are continually intoxicated with alcohol. Typically they are committing 'crimes of subsistence' associated with their substance misuse such as shoplifting, trespass, offensive behaviour, being drunk and disorderly and so on. As such, they are more 'everyday nuisances' than serious offenders.[183] It is likely that such behaviour is a greater problem in small communities because it is more visible.

4.20 Providing some insight into the absence of effective options for this group, the Police Association reported that the police find conventional law enforcement measures powerless against nuisance behaviour, with 'move along' provisions providing only a short term solution, imposition of fines impractical, and gaol neither effective in addressing the problem, nor an option that is preferred by the courts.[184] Assistant Commissioner Waites stressed the absence of treatment and support options for this group, especially in rural areas.[185] Both bodies saw use of the Act for this purpose as appropriate and gave the Committee the impression that if the Act were more workable, and was more widely understood to have retained its powers, it would be utilised by Police for this purpose more often.

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181 Submission 11, Dr Patfield, Bloomfield Hospital, p4

182 Assistant Commissioner Bob Waites, Commander, Greater Metropolitan Region and Corporate Spokesperson on Alcohol related Crime, NSW Police, Evidence, 27 November 2003, p19

183 Assistant Commissioner Waites, Evidence, 27 November 2003, p20; Submission 40, Police Association of New South Wales, p2

184 Submission 40, Police Association of New South Wales, p9

185 Assistant Commissioner Waites, NSW Police, Evidence, 27 November 2003, p21

People whose behaviour is impacting on their family

4.21 A very similar group to the previous one is those people whose behaviour is impacting on their family in some way. In fact, many people may be grouped in both this and the previous category. While the previous one focused on 'public' nuisance, this group is noted for its impact in the private sphere. The orders may be sought by family members desperate to help their loved one, or the person's substance use may be impacting seriously on the wellbeing or safety of family members. Sometimes the motivation for invoking the Act may be less altruistic. People in this category fall along a continuum in terms of the impact they have on others.

4.22 Dr Stephen Jurd, Area Medical Director and Addictions Psychiatrist, Drug and Alcohol Services, Northern Sydney Health, cited a case from several years ago, memorable for belying the 'inebriate' stereotype:

> The Phoenix Unit's previous incarnation was Bridgeview House, which was a ward of Macquarie Hospital. It was closed and the Phoenix Unit opened at Manly. I was the director at Bridgeview House … I remember it was a little unsettling that one of the patients was a middle-aged Turramurra mother of three teenage children who had terrible trouble and had been to a few private hospitals. She kept relapsing and in his desperation her husband got an inebriates order. She stayed for two or three months in Bridgeview House and apparently did quite well in the program. It was an open facility at the time. She actively participated in the program and I had some hope that she would be okay on discharge.[186]

4.23 Dr Joanne Ferguson told the Committee that impact on families was common among the cases she has seen, implying that sometimes such orders are inappropriate:

> I would like to talk about some of the cases that came to Rozelle. They have some common themes. The common theme I have found is that the patients create difficulties for their families. A 38-year-old mother of two who ran her own business and used to get drunk a couple of times a week would continually fight with her relatives and her ex-husband. They were embarrassed by her performance. She stopped drinking about eight months prior to her presentation. They had been taking her to see a psychiatrist, and the psychiatrist suggested an inebriates order, then the family worked on statements. When she came to the hospital she did not have an alcohol problem and I could not make a diagnosis of alcohol dependence. She was comfortable and happy to stay. It was useful for her but it was not an effective treatment.[187]

4.24 A more profound impact on family was evident in a case study from Cumberland Hospital provided by Dr Peter Tucker of Western Sydney Area Mental Health Service:

> For example, a woman in her thirties came to us who was noted to have abused alcohol in the preceding 12 months in the context of a marital breakdown. There had been aggression, apprehended violence orders, damage to property, rage and violence towards family members. The local community mental health team had also been involved. There was a history of treatment for anxiety and depression over the preceding 10 years but close questioning shortly before admission revealed that she

[186] Dr Jurd, Northern Sydney Health, Evidence, 4 March 2004, p11

[187] Dr Ferguson, Rozelle and Concord Hospitals, Evidence, 27 November 2003, p39

> had been drinking since her mid teens, drinking heavily by the age of 20 and drinking very heavily in the preceding year. Her life was clearly very disturbed. There was no doubt about that.[188]

4.25 In an example presented by the Police Association, the application did not result in an inebriates order as no bed was available, but the case is noteworthy as it illustrates the vulnerability of some family members and the resort to formal intervention that they may require:

> This situation involved an 85-year-old lady at Castle Hill. The woman had an alcoholic son in his fifties who couldn't or wouldn't work, was constantly drinking and who would defecate throughout the house. The mother had tried everything to have him removed from the house. Her efforts included asking him to leave; directing him to leave and eventually in desperation, seeking help from her doctor. It was the doctor who then contacted the police, asking for their assistance with eventual action taken under the *Inebriates Act*.[189]

People who place themselves under the Act

4.26 The final category of people placed under the *Inebriates Act* are those who have in fact initiated the order themselves. While self-imposed civil commitment seems a contradiction in terms, it is not uncommon under the *Inebriates Act*. When we visited Bloomfield Hospital, the Committee spoke with a man who had done this with the help of a friend who was a policeman. He had previously been placed under an order involuntarily, but sought one himself this time as his living circumstances and health were rapidly deteriorating.[190]

4.27 A number of other examples of self-committal were conveyed to the Committee, including by Ms Manda Bishop of the Alcohol and Drug Information Service, from her experiences working at what was then an inner-Sydney proclaimed place, the Albion Street Lodge (ASL).

> XX was a long-term alcohol and drug user in his late thirties. He had been using since he was ten years old and had over 1000 admissions at ASL. He was an intelligent man with mild brain damage. He felt frustrated with his current lifestyle and saw the *Inebriates Act* as a last option. He asked me to facilitate it for him … YY was watching with interest as XX had been going through this process and had decided he too wanted to be committed under the *Inebriates Act*. A man in his early forties, he was more a seasonal user of ASL rather than a regular one. He used alcohol rarely, but was a regular heroin user. With YY, we went through the same actions as XX, but he was court ordered to a different facility.[191]

4.28 It seems that some people initiate the Act as a means of imposing an external source of control upon themselves. Presumably many have tried voluntary services with limited success; presumably they also have a reasonable degree of insight and motivation. The potential for

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188 Dr Peter Tucker, Medical Superintendent, Cumberland Hospital and Director, Clinical Services (East), Western Sydney Area Mental Health Service, Evidence, 27 November 2003, p35

189 Submission 40, Police Association of New South Wales, p13

190 Confidential evidence

191 Submission 22, Alcohol and Drug Information Service, pp7-8.

some provision for voluntary orders to be retained was raised by a number of inquiry participants, and is explored in detail in Chapter 8.

Discussion

4.29 The Committee has identified four overlapping groups of people made subject to inebriates orders: those who have experienced or are at risk of serious harm, including those with alcohol related brain injury; those whose antisocial behaviour impacts on their community; those whose behaviour impacts on their family; and lastly, those who have initiated the order themselves. Each of these groups raises separate ethical issues which need to be considered and resolved in determining whether involuntary intervention is ethically justified, in what circumstances, and what that treatment might involve. Only when that ethical position is resolved can an appropriate legislative and service framework be developed, with consideration of the implications for resources and service delivery. These issues are examined in Chapters 6, 7 and 8.

4.30 Some important issues emerge from the analysis of those subject to the Act at the present time. The first arises from the observation that in many cases, use of the Act is consistent with its anachronistic and punitive premise: to put people away for a time when they are causing trouble. The evidence before the Committee is that in a minority of cases the *Inebriates Act* is used solely for the humane purpose of protection from serious harm. In the majority of cases it is used for the purpose of managing difficult behaviour, that is, for social control.

4.31 It may be that the Act is resorted to in such cases for benevolent reasons, under the assumption that appropriate drug and alcohol treatment is available in mental health facilities. However, the previous chapter showed that this assumption is ill-founded, and that detainment of people under inebriates orders alongside those with serious mental illness may seriously affect the wellbeing of both groups. Alternatively, it may be that the Act is invoked for less benign reasons, to simply remove a difficult person to another place for a time. In either case, given the inherent faults of the Act, the effect is control.

4.32 In this context we note our strong concern, reflected in the evidence presented in previous chapters, that the Act is used disproportionately in relation to Aboriginal people. Incarceration has long been used as a tool to control Indigenous people. While significant work is being done in the criminal justice and health arenas in relation to Aboriginal communities, every effort must be made to ensure that any legislation enabling detention does not result in discriminatory outcomes.

4.33 There is evidence that the Act is being used as an alternative to criminal detention. Over the past few decades there has been an important shift away from criminalisation and incarceration of low grade offenders. That shift has accelerated in recent years with the development of diversion programs, primarily for illicit drug users, that offer community based coercive treatment for certain offenders. Evidence before the Committee suggests that there is a group whose behaviour, in the absence of appropriate community based supports, is a problem for people's family or community. The 'public nuisance' behaviour associated with severe alcohol dependence is experienced as particularly troublesome in rural areas where people are more visible and there are fewer services to assist them. The most appropriate response to this 'antisocial behaviour' group - coercive or non-coercive - has not yet been determined at a policy level.

4.34 In the meantime, the Committee is very concerned that people for whom gaol is deemed inappropriate because their offences do not justify such punishment are in effect being incarcerated under the *Inebriates Act*. Where the Act is being used as an alternative to punishment for more serious crimes, the Committee believes this is highly inappropriate.

4.35 The Committee also found some evidence of unwarranted use of the Act by family members, again in response to difficult behaviour. There were, however, instances where a person's behaviour was profoundly impacting upon others, where the Act appeared to be invoked to protect them from harm.

4.36 This analysis points to a number of ethical issues in relation to compulsory treatment, including to what extent the problems arising from severe substance dependence are best managed within a voluntary framework, and how the potentially competing rights of the person versus their family or community are to be weighed. At what point is involuntary intervention justified, and when do we accept that we are ethically bound to tolerate a person's substance use and resulting behaviour and simply provide the opportunity for them to choose to change?

4.37 The Committee also notes that it is very easy to judge people for their antisocial behaviour and consider them fully responsible for the sometimes significant trouble they cause. Yet we know, and many of the examples in this chapter attest, that in many cases the person's behaviour is beyond their immediate control, being the result of physical addiction, brain damage or mental illness. Our ethical, legislative and service frameworks must necessarily be informed by understanding and compassion.

4.38 A related theme is that of complex needs. The multidimensional aspects to people's difficulties was readily apparent in the cases outlined, and was noted by several inquiry participants. Both Professor Ian Webster, Chair of the NSW Expert Advisory Committee on Drugs and Terry Carney, Professor of Law, University of Sydney, observed that by the time a person comes to be considered for compulsory treatment, their needs are high and complex.[192] This means that by their very nature, the problems of those subject to inebriates orders are not easily addressed. These people, by and large, sit at the extreme end of the substance misuse spectrum: their dependence is severe and long term; it is seriously impacting on their health, relationships and functioning, and indeed their ability to address their addiction and change their lives. This raises the important question of how much can legitimately be expected of this group, especially when severe alcohol dependence is regarded as a chronic relapsing condition, and where many lack the personal, social and indeed cognitive resources to change.

4.39 Our analysis also points to the difficulty that the service system has in responding to people whose needs traverse the boundaries of several systems, such as the alcohol and other drugs system, the disability service system, and the mental health system. As Professor Webster observed:

> These are people who have not fitted with any of the services. [Government has] altered barriers or put up barriers or we have not been prepared to engage with them

[192] Emeritus Professor Ian Webster AO, Chair, NSW Expert Advisory Committee on Drugs, Evidence, 18 April 2004, p13; Professor Terry Carney, Professor of Law, University of Sydney, Evidence, 8 April 2004, p22

> … They are mixed up, they are complicated, they have got several things happening at one time.[193]

4.40 The following case study of Esther illustrates this difficulty well.

Esther

Esther was a 54 year old homeless woman living in a rural centre. She was known to have Korsakoff's syndrome, and as a result, had extremely volatile behaviour with huge changes in personality: one day she would be irrational, emotional and aggressive, and the next, according to Sister Anne of the Society of St Vincent de Paul, 'this beautiful, intelligent person would appear'. While Esther was an alcoholic, she would often go weeks without drinking.

She had a son, Michael, who was in his late twenties and had a mild intellectual disability, as well as his own substance dependence. He was in and out of prison. Esther and Michael spent a lot of time together, but had a very mercurial, tumultuous relationship.

Over a period of about a year, Esther sought assistance from the St Vincent de Paul welfare service run by Sister Anne, sometimes every day. Esther's behaviour when she came into centre was very difficult: she was highly emotional, very demanding, abusive to staff and other clients, often paranoid, and at other times, quite depressed. She often needed calming down as well as practical assistance with things that were upsetting her, but attempts to help her to access health and other services had little success.

Sister Anne tried to help her to get stable accommodation as she was continually in crisis, moving between refuges, caravan parks, in and out of town and so on. The staff at the women's refuge said that they would go on stress leave if she returned because the havoc she had already caused there. On many occasions Sister Barbara believed Esther required hospitalisation, but despite her paranoia, confusion and threats of suicide, the mental health service determined that she did not. Her diagnosis of Korsakoff's meant that technically, she did not have a mental illness. The Police were reluctant to get involved. The Salvation Army found her some short term accommodation, but again this did not last.

Over a period of months, as Esther's erratic and aggressive behaviour continued, further attempts to engage health or other services, in Sister Anne's words, 'got nowhere'. The Aged Care Assessment Team (ACAT) got involved, but could find no suitable place for her. At a meeting Sister Anne and a priest organised with the local member of parliament, police, health services and the Salvation Army, the police raised the possibility of seeking an inebriates order but did not pursue it as it was felt she did not fit its criteria.

One day, Sister Anne received a call from a psychiatrist at Rozelle Hospital who had admitted Esther after she was removed from a train in Sydney. Sister Anne detailed Esther's story and was greatly relieved when the psychiatrist agreed Esther really needed help. 'Finally', she thought, 'We might be able to get her the help she needs.' A few days later, Sister Anne received a call from the priest to say Esther was on her way home on the train. When Sister Anne spoke to the psychiatrist he told her that when he had tested Esther for dementia she had scored 29 out of 30, so he was not able to keep her in the hospital. Once again she did not meet the right criteria.

At some stage, Esther was also diagnosed with lung cancer. Sister Anne and the ACAT arranged for her case to be considered by the Guardianship Tribunal and her finances were placed under the management the Office of the Protective Commissioner. She was also given a Housing Department placement, but within weeks was moved because her behaviour was so disruptive for others. She was very unhappy in this second public housing facility, where she and other residents, who had similarly difficult behaviours, were continually in conflict.

Her story continued in much the same way for several months, with Sister Anne and others struggling to support her as much as they could. Sadly, she died a few months ago.

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[193] Professor Webster, NSW Expert Advisory Committee on Drugs, Evidence, 4 June 2004, p8

4.41 The importance of overcoming service boundaries and providing a 'joined up' response is increasingly recognised by government, but achieving it is no easy task. At the same time, there are groups such as those with significant alcohol related brain injury who have been defined out of any service system, despite their profound level of need and vulnerability. The case study of Esther highlights just how difficult it can be for a person to access the supports they require, and indeed how their difficult behaviour contributes to this situation. In this context, a critical question emerges concerning the extent to which the problems the *Inebriates Act* is being used to address are really problems arising from poor policy and service delivery.

4.42 A final, related question concerns the effectiveness of compulsory treatment as an intervention. What does research tell us it achieves? This knowledge base must feed into the ethical discussion, and is the focus of Chapter 6. In the meantime, the second half of this chapter explores the effectiveness of the *Inebriates Act*. What does the evidence before the Committee tell us about the outcomes for people placed under the Act?

What does the Act achieve for those placed under an order?

4.43 Having considered the range of circumstances precipitating the placement of people under an order, the Committee now turns to an analysis of the outcomes for those people, again based on the cases reported to us. Participants varied in their observations on the effectiveness of the Act: some believed that it had been beneficial, others harmful; still others saw both costs and gains. As with the observations documented in the first half of this chapter, the information given to the Committee was anecdotal and somewhat subjective, with different perspectives evident between those who had initiated an inebriates order and those who had admitted someone under one.

Beneficial outcomes

4.44 There were a few examples put before the Committee where the Act was seen to have resulted in substantial benefit to the person.

4.45 Reflecting on the outcomes for the four people at risk of serious harm cited at the beginning of this chapter, Ms Kim Lewis reported broadly positive outcomes for three out of the four people, despite the absence of appropriate programs for them while detained. The young woman in her thirties who was sent to Bloomfield three times, according to Ms Lewis, 'ended up eventually grateful that someone had made the choice for her when she was unable to do so herself … she started making some different choices for her life'.[194] Similarly, the man who was using both methadone and alcohol continued to use substances but, realising how he had placed himself at risk, sought to reduce the harm associated with his substance use. Ms Lewis also reported that the man in his late fifties who had alcohol related brain injury had been placed in a nursing home soon after completing his order. She told the Committee that he is not drinking, is reported to be happy, and his relationships with family have improved, although he did have some setbacks along the way:

[194] Ms Lewis, Mid Western Area Health Service, Evidence, 25 March 2004, p31

> The last case involved an older person who had one long stay here for five and a half months. His family were burnt out and his GP approached us because his mother had … Alzheimer's. He was 58 when the GP came to us. His family were furious with him because he continued to drink and his elderly mother was caring for him. The family was busted up because of it. When she became unwell the GP said we had to do something. We encouraged the family to go through with the order. After he was here for five and a half months they were reunited and got to know him again. When he came out he did not make it back to [to his home town] on the train or bus. He drank all the way home and [his family] refused to deal with him. They moved him to an aged care facility and they visit him twice a week. The family is not fragmented now … I have phoned [the nursing home] and he is doing well and does not want to leave. He is involved in activities … They have an outing once a fortnight to a hotel where they have dancing, pool and light beer. I do not know whether he goes, but he knew the option was there when he went in. They told me he never misses a cigarette break.[195]

4.46 The fourth person, notorious for his multiple hospital admissions and ambulance calls, chose to enter a residential rehabilitation program after the magistrate refused to have him admitted under the Act a fourth time. He remained in that program for five and a half months, but then left and is now presumed to be drinking. Summing up the outcomes for all four clients, Ms Lewis concluded:

> I have noted that they all commented that they did not really want to die. The language is different, but they have all given me the message that they did not want to die. They knew they were drinking themselves to death, but it was not their ultimate goal. They were grateful to be alive.[196]

4.47 Commenting on these same cases, the Mid Western Area Health Service stated:

> From our limited experience, we have found that the Act does have a place with a focus on saving the lives of people with severe alcohol dependence and those close to them. (i.e. it is a short-term life saving intervention).[197]

4.48 Reporting a positive story among many negative ones, Dr Patfield cited the case of a 68 year old man with frontal lobe damage and gait disturbance typical of long term alcohol misuse, who was also socially isolated. His son had sought the order out of concern for his father's wellbeing and liaised with the hospital throughout his father's stay. Not long after his admission the man himself said that he was glad he had been admitted. According to Dr Patfield, 'Plans were made for appropriate discharge, and the file notes suggest that things have worked out pretty well.'[198]

4.49 Many of those who commented on the outcomes of placement under the Act were perhaps best described as pragmatic. They were realistic about what the Act could achieve, especially for people whose needs were so complex and entrenched. Participants stressed the benefits of giving people a break from harmful substance use, and perhaps also some respite for their

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[195] Ms Lewis, Mid Western Area Health Service, Evidence, 25 March 2004, pp31-32

[196] Ms Lewis, Mid Western Area Health Service, Evidence, 25 March 2004, p32

[197] Submission 53, Mid Western Area Health Service, p5

[198] Dr Patfield, Bloomfield Hospital, Evidence, 25 March 2004, p4

families or communities. As Mr Owen Atkins and the Mid Western Area Health Service stated, respectively:

> [Alcohol and other drugs] staff in the wider team saw the value of Inebriates Orders as an effective means of giving the person "time out" from their destructive lifestyles, but not necessarily as a useful treatment. Our experience with Inebriates Orders was that most clients returned to their previous lifestyles within a very short time after their return home.[199]

> Clients accommodated under the Act generally relapse when returned to the community (better outcomes could be achieved if a structured plan were to be used, including neuropsych assessment, appropriate medication and perhaps even assertive case management after discharge). However, in the short term, respite from abusive alcohol use benefits clients' health, families, carers and communities.[200]

4.50 A number of participants commented on how readily people regained their physical health when forced to abstain as a result of an order: depending on their symptoms prior to detention, within a short period they return to a healthy weight, and can walk and even talk more easily. For some, involuntary treatment has also provided the opportunity to have more incidental but still serious physical problems addressed. Dr Richard Matthews, Acting Deputy Director General, Strategic Development, NSW Health indicated to the Committee that he recognised the value in such outcomes:

> This is where the *Inebriates Act* probably functioned as a harm reduction measure in the past because individuals went into the Schedule 5 hospitals for a period where they had no alcohol and they got an adequate diet and some care. Over the period they were in there that actually improved their health. Providing those sorts of beds for that sort of thing to happen is something that we should importantly be doing.[201]

Harmful outcomes

4.51 There were a number of cases where participants cited harmful outcomes following detention under an inebriates order. Several case studies, including that of Barry in Chapter 3, testified to the extremely unpleasant, even traumatic, experience that placement in a psychiatric facility can be for those who do not have a serious mental illness, even more so when detention extends over a long period. According to Reverend Rennie Schmid, who documented Barry's story in his submission, Barry felt very disempowered and experienced anxiety and depression as a result of the environment he was placed in; he was fearful of other patients and frustrated at his inability to access treatment. He isolated himself with little choice but to simply sit through the 12 months of his order. Barry's experience accorded with the views of some other participants. For example, in his submission Mr Jim Sheedy stated:

> Only on one occasion have I supported a recommendation to use the *Inebriates Act*, which was on a mental health patient in a rural setting. I will never do so again under the current conditions. The person in question suffers from a severe mental illness

[199] Submission 2, Mr Owen Atkins, p1

[200] Submission 53, Mid Western Area Health Service, p1

[201] Dr Richard Matthews, Acting Deputy Director General, Strategic Development, NSW Health, Evidence, 11 December 2003, p21

> and multiple addictions. The addictions are more life threatening and cause greater social harm than the mental illness. Community Treatment Orders proved ineffectual. While under 6 months containment under the *Inebriates Act* there were systems failures. For example, it was made overtly clear that this type of patient was not wanted at the designated hospital and according to urine screens there was no difficulty in obtaining drugs while supposedly in care. We deprived a citizen of his liberty for 6 months, taking him against his will to an institution he finds extremely stressful to cope in, only to provide poor clinical and social outcomes. Even though we had good intentions we failed this individual.[202]

4.52 Other harms reported to the Committee included a patient who had severely lacerated his arm while attempting to escape from the hospital where he was detained by digging and climbing under a fence.[203] We were also told of two different people who had 'gone underground' after absconding from their facility, thus cutting themselves off from potential supports out of fear of being returned, and in effect, becoming fugitives.[204] Such drastic actions, as described in the case study of Susan below, speak of just how negative and counterproductive the experience of being placed under the Act can be. Such a stressful experience cannot assist the person's recovery; at worst, it may badly undermine it. It is sadly ironic that in Susan's case the order was voluntarily sought.

Susan

Susan was a young woman in her early twenties who was involved in placing herself under the *Inebriates Act* and was given a three month order. Both she and her family felt that this was the best thing to do. She was initially placed in the acute ward, and needed a brief period of detoxification. Hospital staff also felt that it was not going to be appropriate to place her in a locked long-stay ward so they arranged for her to be placed in an open ward. She was the only female there. There were 19 others who were all young men with schizophrenia, and she found it very frightening. She felt the patients were bizarre and that she had nothing in common with them. She had a number of underlying psychological problems which psychiatric staff started to piece together with input from her case managers in the community and from the drug and alcohol services. It seemed that she had serious problems with depression and anxiety and probably a history of sexual abuse.

Susan hated participating in any of the programs at the hospital. She did not feel that they were relevant for her and she did not want to mix with the other patients. She was also quite phobic about groups and she started indicating that she might be thinking about running away. She asked one of the psychiatrists what would happen if she went underground, and whether the hospital could lock her up again after the period of her order had passed.

She sought the support of the hospital to return to the magistrate to vary the order, but on the basis of the hospital's past experience with the *Inebriates Act*, she was advised that she needed to make enough progress to persuade the court that she was doing well, but that her needs would be better met in another environment. Up until that time she had not made good progress in her treatment.

Before the hospital could place Susan back on a locked ward, or make other arrangements for her, she ran away, going underground for the rest of her order. She would ring her family from time to time but was not seen or heard from again until the order expired.

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202 Submission 3, Mr Jim Sheedy, p1

203 Submission 46, Legal Aid NSW, p7

204 Dr Glenys Dore, Addictions Psychiatrist and Deputy Medical Superintendent, Macquarie Hospital, Evidence, 4 March 2004, p3; Submission 22, Alcohol and Drug Information Service, p7

4.53 A number of participants suggested less tangible harms arising from placement under the Act, questioning the capacity of inebriates orders to substantially assist people, especially in the light of the Act's emphasis on containment, the absence of appropriate treatment, and the costs for individuals in terms of their loss of liberty and autonomy. Dr Ferguson cited two examples, highlighting the counterproductive effects of detention under the Act on people's motivation:

> Another patient this year had conflict within her family related to issues in addition to alcohol use. She did not want to be there but agreed to the order. As a result she would not engage with me in a conversation about it. She went into rehabilitation and we went back to the magistrate to get the order changed and there was recognizance to the court, but that was not effective. Because she felt forced into treatment she took a long time to get over her feelings of resentment. That is an important component. People will come to treatment - they reach the point at which the consequences force them into treatment - but when it is imposed they take a long time to get over the resentment and they feel a loss of autonomy.[205]

> Another case involved someone bothering a magistrate by repeatedly presenting as drunk and disorderly in a park and so on. That person came without a doctor's note from the magistrate. She was Aboriginal and homeless and had multiple other problems. She had some cognitive impairment, but I think that was due to alcohol abuse. She had a nice stay in hospital for three months but would not discuss her alcohol problems and did not want to go into rehabilitation. It was a good intervention in that she looked a lot better at the end of three months, but it did not address her real problems - homelessness, isolation from her family and so on. We could not touch the real problems because she did not want to be there.[206]

4.54 In this context the Committee again notes our concern for the profoundly disturbing effect that detention can have for Indigenous people.

Ambivalence

4.55 Finally, a number of participants were clearly ambivalent about the outcomes they had observed. Mr Lloyd Duncan from the Aboriginal community in Moree said that he feels now that while it was wrong to send people away from their community, and it did not address their addiction, it did do some good:

> We used to take them to Newcastle, but they stopped that. When they came back they would be fat. We must have put six or seven years on their lives. They came back fat and healthy.[207]

4.56 Ms Manda Bishop reported on the two people she had helped place under an inebriates order, both of whom were voluntary committals outlined in the relevant section earlier in this chapter. She described how the first person, a man in his late thirties with a serious alcohol dependence who had been a long term client of Albion Street Lodge, had passed through his order uneventfully and was given the opportunity for a fresh start:

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205 Dr Ferguson, Rozelle and Concord Hospitals, Evidence, 27 November 2003, p35

206 Dr Ferguson, Rozelle and Concord Hospitals, Evidence, 27 November 2003, p39

207 Mr Lloyd Duncan, Byamee Homeless Persons Service, Evidence, 24 March 2004, p40

> Upon discharge after three months, XX was taken to his newly acquired flat that had been set up with food, furniture etc. Within 24 hours, XX was intoxicated and knocking on [Albion Street Lodge's] door.[208]

Robert

Robert was a man in his 40s with a long history of excessive alcohol and other drug use. On a number of occasions Robert had entered his mother's house and collapsed. On each of these occasions she had him admitted to the local hospital. Robert was also found collapsed at a boarding house. There was significant concern that during one of these episodes Robert would die by drowning in his own vomit.

Robert was, at this time, also on a high dose of methadone. He had broken his wrist in a bad fall while intoxicated and required further surgery. The doctors were unwilling to perform this surgery due to his constant intoxication.

In 1995 a 12 month inebriates order was made at the request of his mother. Initially Robert was detained in an acute ward in a psychiatric hospital. The hospital felt that this was clearly inappropriate as he had no mental illness and they had no treatment for him.

Arrangements were made for Robert to be accepted into a residential therapeutic community. An application was made to the Magistrate who had made the initial order for discharge to allow this to take place. The Magistrate did not revoke the order but amended it to allow Robert to conditionally reside in the community. Any breaches of the community's rules or use of alcohol was to be reported to him and the release would be revoked. It is doubtful whether the Magistrate in fact had the power to amend the order in this way. Robert broke a condition of his release almost immediately and was quickly returned to hospital for the balance of the order.

Robert made an application to the Supreme Court for the order to be revoked. The Court declined to do this, but amended the order to allow Robert to be detained in hospital or a suitable residential rehabilitation service approved by the medical superintendent. As no suitable alternative was found, Robert spent the balance of the 12 months in locked wards of the psychiatric hospital. There was no suitable program for Robert, and he was discharged to private accommodation at the end of the period.

Robert has also been the subject of a guardianship order (later revoked) and an ongoing financial management order. On at least one occasion since his release from hospital Robert was unable to attend the Guardianship Tribunal hearings because he was so intoxicated he could not get out of his mother's car. He has also been extremely intoxicated on occasions when he has telephoned the Mental Health Advocacy Service solicitor. As against that, he has also had periods when he claimed to be alcohol free for six months or more.

The Commission is unaware of Robert's long term progress.

It is probable that Robert's life was saved by the initial inebriates order.

However, once the crisis had passed Robert received no appropriate treatment and was detained in a locked ward with severely psychotic people. This provided no benefit to Robert, but he did occupy a badly needed hospital bed.

4.57 The second person, a heroin user, absconded one month into his order and went underground. A third person, a man in his late 60s with significant cognitive damage, initially sought an inebriates order but a guardian was appointed for him instead, and he was found permanent accommodation in a secure aged care facility. However, after a few months, during which he regained much of his health and mobility, he decided to leave and took action to enable this to occur. Like the other two men, he returned to the streets. Ms Bishop reflected

[208] Submission 22, Alcohol and Drug Information Service, p7

on these outcomes, juxtaposing the men's complex needs with their right to self determination:

> These men were, by all counts, people who should have benefited most from being forced to stay in a treatment facility. But despite mandatory confinement, treatment and constant support, at best, it could be seen that their bodies had a rest from substance use and a chance to recover somewhat.[209]

4.58 Similarly, Legal Aid NSW reported the case of Robert, reproduced on the previous page, that illustrates how complex and entrenched some people's needs may be, and how blunt the *Inebriates Act* is as a mechanism to address them.

4.59 A more unusual comment on outcomes – in this case for the community - was made in the Mid Western Area Health Service submission. This comment is particularly interesting in the light of the previous discussion about behaviour and the use of the Act in rural areas to contain people whose behaviour cannot be tolerated:

> The use of the *Inebriates Act* may impair the development of local resources and responses, and there is the likelihood that the process may confirm a sense of hopelessness, especially in small communities, when the only "treatment" is the Act, and that 'it' does not seem to do much in the long term … as the Act stands it is of limited help, used only as a last resort, but at the same time it may hinder the development of more appropriate local resources.[210]

Discussion

4.60 In summary, the outcomes for people placed under inebriates orders, as reflected in the evidence before the Committee, are mixed. Some participants stressed positive outcomes, others negative, while some identified both. In the Committee's view it is noteworthy that we were given few, if any, examples of people who successfully overcame their substance dependence as a result of an order. At best, the Act was a circuit breaker, giving people time out from harmful substance use, restoring their health and providing an opportunity to reflect on and perhaps reduce the harm associated with their substance use. For a few the Act was a stepping stone towards long term care. It is also significant that several people were noted to have expressed appreciation that someone intervened to protect them from serious harm.

4.61 At the same time, the Committee has found that placement under the Act was not beneficial to numerous people. In some cases, not only did it not achieve anything positive, it actually caused psychological harm, and/or drove some to the extreme of escaping and going underground. Some simply sat out the time of their order, deprived of their freedom for a long time, with the very fact that they were detained undermining their preparedness to address the real problems behind their order. Thus the evidence before the Committee indicated that inebriates orders have been counterproductive in some cases.

4.62 In the Committee's view all of the positive outcomes reported to us are important and legitimate. They do, however, need to be weighed against the potential costs to the person in terms of their loss of liberty, the environment in which they are placed, and their access to

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[209] Submission 22, Alcohol and Drug Information Service, p8

[210] Submission 53, Mid Western Area Health Service, pp2-3

appropriate treatments. The placement of people in mental health facilities, in particular, has emerged as a critical issue. In many of the cases where both tangible or more subtle harms were reported, this was identified as the cause.

4.63 A further important issue, we believe, is the length of time that people are detained under the Act. Many of the positive outcomes reported could surely be achieved within a much shorter period.

4.64 Interestingly, given the extent to which the Act is used to manage difficult behaviour, few people commented on whether it was effective in addressing that in the longer term. In Dr Patfield's view it is not, but it is effective in providing a break for the person's community or family for a time. Again this raises the question of how the competing rights of the person and their family or community are to be balanced.

4.65 In the Committee's view, the modest harm reduction benefits that the Act confers stand in contrast to the level and complexity of people's need. In considering the ethics of compulsory treatment we need to be clear about the purpose of involuntary interventions, and realistic about what they can achieve. Similarly, we need to be very mindful of people's right to self determination. Thus our analysis of the outcomes reported to the Committee raises the fundamental question of what the legitimate goals of compulsory treatment should be. Can we expect compulsory treatment to result in long term abstinence and/or changed behaviour, or should we limit our goals to saving lives in the short term and minimising harm? These issues form the basis for the ethical discussion that takes place in Chapter 6.

Repeal the *Inebriates Act*

4.66 The Committee reiterates our finding in the previous chapter that on the basis of the raft of criticisms documented there, the Act is an historical relic that grates against the current health and justice systems and actually cuts people off from the specialised drug and alcohol interventions that can assist them. The evidence in this chapter also indicates that some are placed under the Act in the absence of more appropriate services. It also reveals both positive and harmful outcomes for those placed under inebriates orders. We have concluded that despite a widespread understanding to the contrary, the *Inebriates Act* is used less for humane purposes than for the purpose of detention and control. Where harm reduction aims have been achieved this has been in spite of the Act's archaic and punitive premise.

4.67 Quoting from the findings of a draft discussion paper prepared by NSW Health in 1997, the Network of Alcohol and Other Drugs Agencies and the Council of Social Services of New South Wales summarised the faults of the *Inebriates Act* and called for it to be repealed:

- The Act offers little benefit to the community or to those individuals who are chronically substance dependent;
- The Act treats [intoxication] as a criminal rather than a health issue;
- Most of the provisions of the Act are rarely used;
- There are no appropriate facilities which can provide a secure environment as called for by the Act;

- The Act is used in a discriminatory manner – primarily against unemployed Aboriginal males;
- The Act infringes the civil rights of individuals without providing appropriate checks and balances;
- The Act cannot be amended in a way which would allow it to be consistent with current legislation and practice.[211]

4.68 While the vast majority of inquiry participants supported some sort of involuntary regime to enable carefully safeguarded involuntary intervention for people with serious substance dependence in certain circumstances, the vast majority also called for the Act's repeal. Like the Committee, they recognised the Act as draconian and ultimately unhelpful, and saw the value in starting afresh. This call came from a broad range of stakeholders, from legal bodies to the fill range of health professionals. As the NSW Chief Magistrate put it, 'It is my view that the Act ought to be repealed, and we should start again'.

4.69 As noted at the start of this report, despite much criticism and numerous formal reviews, the *Inebriates Act* has remained in effect, partly out of a concern as to what would happen without it in situations of extreme risk of harm. The Committee is very concerned to ensure that this situation not be allowed to continue. We consider that the *Inebriates Act* is irredeemable and must be repealed. We call for the development of new legislation, matched with an appropriate service framework, based on our consideration of the ethical issues in relation to compulsory treatment. At the same time, we are mindful of the need to ensure that there is an adequate safety net to capture those who might be at immediate risk before new legislation comes into effect. Thus we strongly encourage the Government to develop the new legislative and service framework as a matter of priority. Our recommendations for this new regime are set out in Chapters 6, 7 and 8.

Recommendation 1

That the *Inebriates Act 1912* be repealed and replaced at once with legislation reflecting subsequent recommendations of this report.

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211 Submission 29, NCOSS, pp13-14; Submission 29, NADA, pp13-14