

Chapter 3 Criticisms of the *Inebriates Act 1912*

The *Inebriates Act* is draconian legislation, with a stigmatising impact.⁹⁸

The *Inebriates Act* in its current state acts as an empty shell, not making available to either Police or family members of inebriates any suitable means of providing treatment to those who desperately require it.⁹⁹

In the previous chapter the Committee outlined the Act's provisions and the social context in which it was introduced over a century ago. The outdated premise of the Act forms the basis for many of the criticisms documented in this chapter, with those criticisms falling into three main areas: the Act's implications for human rights, its legal provisions, and its requirement for detention in mental health facilities. Each of these is explored in the following pages, drawing on the perspectives of a range of inquiry participants. Despite the diversity of interests represented, there is remarkable agreement on the Act's failings. The weight of evidence is that the Act is now an historical relic, sitting most uncomfortably in the present day health and justice systems, to the point where it undermines the capacity for people subject to it to access the assistance that will most benefit them.

The Act's premise

3.1 Many inquiry participants highlighted the anachronistic premise of the *Inebriates Act*, that there is a class of people who need to be controlled simply because they use alcohol or drugs to excess. As the NSW Government submission pointed out, the Act is simply aimed at containing people and limiting their access to drugs, and does not reflect the modern understanding of substance dependence, nor current day approaches to it, which emphasise harm reduction, management of misuse and access to appropriate treatment.¹⁰⁰ Indeed, the Act makes no mention of the treatment that those placed under it are to receive. As Mr Nick O'Neill, President of the Guardianship Tribunal put it:

[T]he *Inebriates Act* is based on the false premise that confinement in a place where alcohol or drugs are not available, of itself, will help those seriously affected.¹⁰¹

3.2 Despite its benevolent intentions, the Act is essentially punitive rather than therapeutic, treating dependence on a legal and widely available drug – alcohol – as if it were a criminal offence, and using 'treatment' as a means of social control rather than for the benefit of the person.¹⁰² Participants such as the Haymarket Foundation and the Network of Alcohol and Other Drugs Agencies (NADA) emphasised that this runs counter to our current understanding of substance dependence as a health issue, not a criminal justice issue.¹⁰³

⁹⁸ Submission 36, Law Society of New South Wales, p3

⁹⁹ Submission 40, Police Association of New South Wales, p12

¹⁰⁰ Submission 47, NSW Government, p7

¹⁰¹ Submission 44, Mr Nick O'Neill, President, Guardianship Tribunal, p7

¹⁰² Submission 9, The Shopfront Youth Legal Centre, p2; Submission 37, Centacare Sydney, Catholic Community Services, p3

¹⁰³ Submission 45, The Haymarket Foundation, p2; Submission 29, Network of Alcohol and Other Drugs Agencies, p7

- 3.3 Participants emphasised that our responses to addiction have improved greatly in recent years, and any legislation in this area needs to reflect that greater sophistication. Best practice in alcohol and other drug services takes an individualised approach, with treatments tailored to particular needs, depending on where the person's substance use falls along the continuum of dependence. According to NADA, the lack of flexibility available under the current Act serves to mitigate against best care for those subject to it.¹⁰⁴

Human rights

- 3.4 Implicit in many of the comments on the premise of the Act is a concern for human rights and civil liberties, most especially the rights to liberty, self determination and fair legal process. In turn, these concerns inform many of the criticisms of the specific provisions of the Act that are documented throughout this chapter. A significant proportion of inquiry participants also highlighted the human rights implications of compulsory treatment more broadly. That issue is fundamental to the Committee's inquiry and is explored in detail in Chapter 6.
- 3.5 The North Coast Regional Coordination Management Group questioned the legitimacy of the Act on the most basic of human rights principles:

One of the basic tenets of human rights is the freedom from arbitrary detention. The *Inebriates Act 1912* would appear to contravene basic principles of human rights in its arbitrary criteria for involuntary detention and treatment.¹⁰⁵

- 3.6 It also noted, as did Professor Terry Carney when he appeared before the Committee, that unlike the *Guardianship and Mental Health Acts*, the *Inebriates Act* does not conform to the United Nations *Principles for the Protection and Care of People with Mental Illness* to which Australia is a signatory.¹⁰⁶ These principles ensure that involuntary treatment occurs only in cases that satisfy strict criteria. While drug or alcohol dependence is not a mental illness, the two conditions are broadly comparable, and in Professor Carney's view, that instrument is broad enough to encompass both.¹⁰⁷ Relevant aspects of these principles which the Act appears to contravene include:

- Involuntary treatment may be given only on the condition that an independent authority is satisfied that the person lacks the capacity to consent or unreasonably withholds their consent, and that the proposed treatment is in the person's best interests. Alternatively, it may be given where a medical practitioner determines that it is urgently necessary to prevent imminent harm to the person or others. Such treatment shall not be prolonged beyond that which strictly necessary (Principle 11, paragraphs 6 and 8)
- Involuntary admission may only occur when a person is considered by a medical practitioner to be mentally ill, and as a result, that there is a serious likelihood of immediate or imminent harm to that person or to others, or that failure to admit the

¹⁰⁴ Submission 29, Network of Alcohol and Other Drugs Agencies, p5

¹⁰⁵ Submission 16, North Coast Regional Coordination Management Group, p2

¹⁰⁶ Submission 16, North Coast Regional Coordination Management Group, p2; Professor Terry Carney, Professor of Law, University of Sydney, Evidence, 8 April 2004, p17

¹⁰⁷ Professor Carney, University of Sydney, Evidence, 8 April 2004, p17

person is likely to lead to a serious deterioration in their condition or will prevent the giving of appropriate treatment (Principle 16, paragraph 1)

- The right to best available care (Principle 1, paragraph 1)
- Determination of mental illness is to be made in accordance with internationally accepted medical standards (Principle 4, paragraph 1)
- The right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment (Principle 9, paragraph 1)
- Treatment be based on an individually prescribed plan (Principle 9, paragraph 2)
- Treatment be directed towards preserving and enhancing personal autonomy (Principle 9, paragraph 4)
- Involuntary admission or retention shall initially be for a short period as specified by domestic law for observation and preliminary treatment pending review (Principle 16, paragraph 2)
- Various other provisions for review, procedural safeguards, access to information and complaints (Principles 17, 18, 19 and 21).¹⁰⁸

3.7 Those working in the mental health system, familiar with safeguards and provisions under the *Mental Health Act 1990*, readily noted the contrast between the two Acts. Reverend Rennie Smith, Uniting Care Chaplain at a gazetted hospital, stated in his submission:

The lack of clarity about legal responsibilities and human rights should be reason enough to overhaul the *Inebriates Act* to bring it in line with ground breaking reforms represented within the current Mental Health Act that was introduced in the 1990s.¹⁰⁹

3.8 Many of these human rights concerns are focused on the processes required by the Act, and are detailed in following sections. These concerns are, moreover, long held. When reviewing the 1958 *Mental Health Act*, Dr G Edwards noted that the *Inebriates Act*:

contained very broad commitment criteria ... There was no onus on the judge or magistrate to satisfy himself that the person was unable to manage his affairs as was required when determining unsoundness of mind under the Lunacy Act. As well, there was certainly no requirement for the judge or magistrate to consider issues of dangerousness to self or others when making an order.¹¹⁰

¹⁰⁸ United Nations, *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, Adopted by General Assembly Resolution 46/119 of 17 December 1991

¹⁰⁹ Submission 41, Uniting Care NSW ACT, p2

¹¹⁰ Edwards GA, Mental illness and civil legislation in New South Wales, MD Thesis, University of Sydney, quoted in MacAvoy MG and Flaherty B, 'Compulsory treatment of alcoholism: the case against', *Drug and Alcohol Review*, 1990, Vol 9, pp267-72, p268

Disproportionate use in relation to Aboriginal people

- 3.9** A further aspect to the human rights concerns is one expressed by many stakeholders over the years, that the Act is used disproportionately against Aboriginal people.¹¹¹ It is also seen to be used excessively in relation to people of marginalised socio-economic status and people in rural areas.
- 3.10** Anxieties that the Act is a vehicle for discrimination against Aboriginal people were particularly strong, and are apparently justified in light of the figures from Bloomfield cited at the end of the previous chapter, which showed that over one third of inebriates admissions in the last ten years were Aboriginal people. Participants were also very concerned that the Act enables prolonged detention in contradiction of recommendations of the Royal Commission into Aboriginal Deaths in Custody, and in spite of the broad understanding that incarceration is personally and culturally traumatic for Indigenous people. Similarly, stakeholders noted that there is inadequate provision for culturally appropriate service provision under the Act.¹¹²
- 3.11** Representatives of gazetted hospitals shared these concerns. Associate Professor Paul Fanning of the Mid Western Area Health Service told the Committee that Aboriginal people sent to gazetted hospitals tend to isolate themselves and experience their order as incarceration:

So for Aboriginal people, coming to Bloomfield is as big a problem now as it was 30 or 40 years ago. The stigma is still greater. They see it in a way that they are coming in to do time and they are being locked up. They do not see themselves necessarily as coming here for treatment.¹¹³

Legal provisions

- 3.12** Many aspects of the specific provisions of the Act have been criticised. These include the absence of meaningful criteria, its overly judicial decision making process, its inadequate safeguards, practical unworkability, the inability to enforce orders, and a range of obsolete or outdated provisions. These are dealt with in turn below.

Definition and criteria

- 3.13** The term ‘inebriate’ is itself anachronistic and value laden. A number of participants pointed to the Act’s broad definition of ‘an inebriate’ based simply on using substances ‘to excess’. The NSW Government’s submission notes that this definition could potentially apply to a substantial number of people.¹¹⁴ As Dr Stephen Jurd, Addictions Psychiatrist and Area Medical Director, Drug and Alcohol Services, Northern Sydney Health told the Committee, ‘theoretically I could get drunk for the next three weekends and I could go in under the *Inebriates Act*.’ An appropriate definition would be highly targeted, clinically based and include

¹¹¹ Supplementary Submission 43, Emeritus Professor Ian Webster AO, Chair, NSW Expert Advisory Committee on Drugs, p3

¹¹² Tabled document No 7, *Responses to proposed questions*, p4

¹¹³ Associate Professor Fanning, Area Director, Mid Western Area Mental Health Service, Evidence, 24 March 2004, p8

¹¹⁴ Submission 47, NSW Government, p8

a time dimension, he suggested.¹¹⁵ Mr John Feneley, Assistant Director General of the Attorney General's Department, also observed the potential for inappropriate orders, noting that the definition does not assist magistrates to distinguish between someone who is temporarily intoxicated and a person who has a severe and chronic condition.¹¹⁶ Participants such as the North Coast Regional Coordination Management Group were concerned that this broad definition means that the Act is open to abuse, whether 'maliciously or by well-meaning misinformed people'.¹¹⁷ Clear criteria focusing on those at serious risk would both assist decision makers and help obviate misuse of such legislation.

Decision making process

3.14 Clearly, the decision to detain someone for treatment against their will is a serious one and the decision making process needs to be fair, transparent and effective in furnishing desirable outcomes for those subject to it. Many criticisms were levelled at this aspect of the Act.

3.15 There was broad agreement among legal and health stakeholders that the Act's provision for decision by a magistrate with minimal medical input was most undesirable. Dr Peter Tucker, Clinical Director of Mental Health Services for Western Sydney Area Health Service, highlighted the 'fundamental incongruity' in a court of law prescribing medical treatment.¹¹⁸ As Legal Aid NSW put it:

All that is required is a certificate of a medical practitioner that the person is an inebriate, together with the corroborative evidence of one other person, and personal inspection of the inebriate by the Magistrate. There is no requirement that the medical practitioner have any specialist qualifications, and very little guidance is provided to the medical practitioner by the definition of inebriate in the Act. There is no requirement for the medical practitioner to certify that the inebriate will benefit from an order being made.¹¹⁹

3.16 Both the Attorney General's Department and NSW Health echoed this concern,¹²⁰ with the former pointing to the need to carefully assess the person's health and other circumstances and ensure that they satisfy appropriate benchmarks:

It does not address the broader issues such as whether people are incapable of taking care of their own affairs, whether their health problems in the short and long-term may be danger to themselves and bring about their likely death, and whether they are a danger to themselves in some other way or to family members. It does not address in any holistic way the [individual's needs].¹²¹

¹¹⁵ Dr Stephen Jurd, Medical Director and Addictions Psychiatrist, Drug and Alcohol Services, Northern Sydney Health, Evidence, 4 March 2004, p2

¹¹⁶ Mr John Feneley, Assistant Director General, Policy and Crime Prevention, Attorney General's Department, 11 December 2003, p3

¹¹⁷ Submission 16, North Coast Regional Coordination Management Group, p1

¹¹⁸ Submission 33, Western Sydney Area Health Service, p33

¹¹⁹ Submission 46, Legal Aid NSW, p5

¹²⁰ Submission 47, NSW Government, p8

¹²¹ Mr Feneley, Attorney General's Department, Evidence, 11 December 2003, p 3

3.17 The Chief Magistrate indicated that the current provisions are undesirable for magistrates as well. For example, while the length of an order is determined on the evidence, there are no guidelines for how this is to be done, so it is a matter of the magistrate's discretion.¹²² As such decisions are weighty and have significant consequences for the individual concerned, it is critical that they be transparent and consistent.

3.18 Like psychiatrist Dr Joanne Ferguson,¹²³ the Chief Magistrate also questioned the desirability of a court-based process which can be disempowering and embarrassing for the person and their family:

One of my criticisms of the *Inebriates Act* is that it is a court-based application ... In my view it is a very difficult process for both the inebriate and those who care for and are concerned for 'the inebriate' ... there is a better and more sympathetic way for the justice system to deal with people who have essentially what is a medical problem.¹²⁴

3.19 The Act's establishment of magistrates as all-powerful in this decision making process is the source of great frustration for the administrators and clinicians of psychiatric hospitals where people under an inebriates order are placed. Magistrates are not required to consult with a hospital before committing a person to be detained there for a lengthy period. Already facing high demand for beds, facilities are then forced to immediately make one available for someone outside their client group. For these administrators, this seems highly unreasonable and impacts on their duty of care to other patients.¹²⁵

3.20 Just as the treating doctors have no role in the decision to detain a person, they also have no ability to discharge them:

Clinicians have no control over the *Inebriates Act*. The only way the Act can be revoked is by taking the matter before the Magistrate at the local court and having him or her revoke the Order. This means that if there are problems with someone under the *Inebriates Act*, clinicians are unable to exercise any clinical judgement about the person's placement or discharge from the hospital. For example, if someone ... is clearly unable to respond to a treatment plan, and is threatening other mentally ill patients on the unit because of antisocial behaviour, it is not possible to discharge that patient from the hospital without going to the local court to ask for the Order to be revoked. There is also no guarantee the Magistrate will agree ...¹²⁶

3.21 Several mental health administrators agreed it can be very difficult to have the magistrate reverse the decision, as well as very time consuming. Associate Professor Paul Fanning of Bloomfield Hospital told the Committee:

The magistrates do not want to rescind the order. If they have sent someone here for six months they do not want that person necessarily to be out of here before six

¹²² Judge Price, Chief Magistrate, Local Court of New South Wales, Evidence, 26 November 2003, p5

¹²³ Dr Joanne Ferguson, Staff Specialist Psychiatrist, Drug Health Services, Rozelle and Concord Hospitals, Evidence, 27 November 2003, p41

¹²⁴ Judge Price, Chief Magistrate, Evidence, 26 November 2003, p3

¹²⁵ Submission 50, NSW Chapter on Addiction Psychiatry, p1; Submission 33, Western Sydney Area Health Service, p2; Dr Victor Storm, Clinical Director, Central Sydney Area Mental Health Services, Evidence, 27 November 2003, p35

¹²⁶ Submission 35, Dr Glenys Dore, Northern Sydney Health, p3

months because of [the difficulty the person's behaviour is causing for their home community.] They believe this is the best place for treatment. We therefore end up chasing magistrates across the State trying to find the one who gave the order. We try to convince them into giving a rescission. When push comes to shove sometimes they co-operate but sometimes they say, "No way. That patient is in the right place."¹²⁷

- 3.22** Receiving hospitals also reported that referrals from magistrates are generally marked by poor communication, with supporting documentation that might assist treatment being extremely rare. Dr Patfield of Bloomfield Hospital told the Committee, 'Of the 20 [most recent admissions] I have been through there was only one where the supporting affidavits came with the order'; sometimes not even the order is supplied.¹²⁸ This creates a sense for the hospitals that the motivation for orders is not so much the person's health and welfare as containment.
- 3.23** Other problems associated with the placement of people under inebriates orders in psychiatric hospitals are documented in a later section of this chapter.

Poor safeguards

- 3.24** Underpinning the range of criticisms about criteria and decision making is the widespread concern that there should be strict safeguards to protect the rights of people subject to compulsory treatment. The absence of procedural protections in the *Inebriates Act* was a prominent concern for representatives of the Attorney General's Department:

... if someone is not an offender today and there is otherwise no reason for them to be brought to the attention of authorities, then anything that looks like denying them their liberty, even for a short period of time, needs to have some strict safeguards put around it.¹²⁹

- 3.25** Unlike in the *Mental Health Act*, the people's rights are very limited and do not form the basis for the *Inebriates Act's* provisions. Some participants emphasised the vulnerability of substance dependent people to abuse of the Act, especially in the light of the stigma of dependence and the impact the person's behaviour may be having on their family or community.
- 3.26** The Committee was told of several instances where people's rights were compromised under the Act. Hospital Chaplain, the Reverend Rennie Schmid told us that one of the people he had supported was placed under an order for 12 months by his brother and sister (see case study of Barry later in this chapter). Rather than being concerned for Barry's best interests, he believed they were motivated by embarrassment and a desire to have him out of their lives for a time. Also, while the Act stipulates that 'The inebriate shall be afforded an opportunity of being heard in objection',¹³⁰ Reverend Schmid reported that this man was given no such opportunity. The Committee was concerned when an Aboriginal man we spoke with who was under an order at that time told us he had no idea how he came to be at the hospital or why

¹²⁷ Submission 11, Dr Martyn Patfield, Bloomfield Hospital, p2

¹²⁸ Dr Martyn Patfield, Consultant Psychiatrist, Medical Superintendent and Director of Acute Services, Bloomfield Hospital, Evidence, 25 April 2004, p3

¹²⁹ Mr Feneley, Attorney General's Department, Evidence, 11 December 2003, p7

¹³⁰ The Act, s3(3)

he was sent. After he appeared in court the police came and picked him up, and out of curiosity he went with them, only to find himself in a paddy wagon and on his way.¹³¹

- 3.27** A number of participants such as Dr Glenys Dore of Macquarie Hospital highlighted the absence of a review mechanism under the Act:

There is no review process. The only review process is if the patient asks for the order to be appealed and it is placed back before the magistrate. But nobody else has any control over that order. There is no tribunal. For example, with the *Mental Health Act* we would have the Mental Health Review Tribunal that would come in at specified periods and there would be a hearing, the case would be put by both the patient, their legal representative, their family and the treating clinicians about whether it was appropriate for that person to stay in hospital or not stay in hospital. There is no forum to do that under the *Inebriates Act* unless you specifically request to go back to court.¹³²

- 3.28** In addition, Dr Ferguson told us that unlike the *Mental Health Act*, which is clear that staff are required to contain patients and that this may, where necessary, involve use of physical restraints, the responsibilities of staff are not articulated in the *Inebriates Act*. As a consequence, some are concerned that they may be considered to have acted inappropriately if they do restrain someone.¹³³

Cumbersome to use

- 3.29** As well as the widespread concerns about the decision making process required under the Act and the absence of safeguards, many participants reported that the process of seeking an inebriates order is cumbersome, extremely inefficient and frustrating. The Police Association and various drug and alcohol and mental health service providers all testified to this protracted and complicated process, which involves ensuring that the necessary paperwork is completed by the individuals stipulated and then having the matter listed for court. While these requirements are being met, the person often remains in the community, not getting the help they need and potentially continuing to place themselves or others at risk. When the matter comes before the magistrate, the person may be unable to be located, with the hearing continuing in their absence. It then becomes the responsibility of the police to act on the order when the person is found.¹³⁴ Clearly, the process works against the timely response required in situations of crisis. Several participants told us, moreover, that because the process is so unworkable it means that the Act is invoked less than it might be.¹³⁵ As one rural drug and alcohol worker told us about a case that she had observed:

¹³¹ Confidential evidence

¹³² Dr Glenys Dore, Addictions Psychiatrist and Deputy Medical Superintendent, Macquarie Hospital, 4 March 2004, p4

¹³³ Dr Ferguson, Rozelle and Concord Hospitals, Evidence, 27 November 2003, p41

¹³⁴ Submission 40, Police Association of New South Wales, p4; Submission 35, Northern Sydney Health, p4; Submission 22, Alcohol and Drug Information Service, p5

¹³⁵ Submission 40, Police Association of New South Wales, p4; Mr John Williams, Senior Project Officer, Aboriginal Health and Medical Research Council, Evidence, 27 November 2003, p8

The feedback that I got showed it was just not worth all the rigmarole - the doctor, the family and the magistrate's hearing. It just was not worth it in the end.¹³⁶

- 3.30** The following case study provided by Ms Leonie Jefferson, Senior Aboriginal Drug and Alcohol Counsellor with the Northern Rivers Area Health Service, highlights the potential consequences when the necessary cooperation of all parties is unable to be secured.

Tom

Tom was a 45 year old Aboriginal man, whose first contact with me was at a previous service in Sydney. This man had a long history (over 10 years) of heroin dependence, with occasional periods on low dose methadone. When I encountered Tom in the Northern Rivers, he was drug free and stable, living with his long-term partner, who had no history of dependent drug use. About 12 months after this encounter, I spoke to Tom in Nimbin, still drug free, from my observation and his statement. Soon after this meeting, Tom began to drink heavily, and was eventually homeless and living on the streets in Nimbin. He rapidly lost any control over his substance use, and was consuming anything he could buy legally (including methylated spirits) or illegally (heroin and methadone). Attempts were made to get him into treatment, and away from the environment, by invoking the *Inebriates Act*, initiated by Nimbin needle and syringe program workers. This met with some difficulty, as the local police had (I'm told) used their transport budget, and this was the only way to transport Tom to Morisset, near Newcastle, which was the only clinic that functioned within the *Inebriates Act*. Two weeks after the moves to invoke the Act were initiated, Tom was found dead by opioid overdose beside the local river.

Inability to enforce orders

- 3.31** The inability to obtain a timely order was linked to a further issue of the inability to enforce orders that are made. The Chief Magistrate highlighted this problem at the Alcohol Summit and when he appeared before the Committee. As the Act makes no provision for the Court to enforce an order, if a hospital refuses to admit a person under an inebriates order, the Court's hands are tied; it has no sanctions to force the hospital to comply. Similarly, the Act contains no penalties for non-offenders who break a recognizance made under the Act. The Chief Magistrate's strong concern is that when an order of the local court is rendered ineffectual in this way, which the Act is powerless to prevent, the justice system is undermined.¹³⁷
- 3.32** From the perspective of a number of inquiry participants, this situation prevents people from obtaining necessary interventions. In his submission, Mr Tim O'Neill of the Wagga Wagga Command of the Police Service, cited a recent example of having sought an order for a woman with alcohol related brain damage. While the magistrate made the order, police were advised that none of the gazetted hospitals would detain her - he was told the woman would 'come in through the front door and be let out the back door' - and she was also refused admission to the local hospital. The Police were very dissatisfied that, having sought and gained a remedy to assist a very vulnerable person, it could not be carried out.¹³⁸ Similarly, alcohol and other drug workers such as Mr Owen Atkins reported that it was not uncommon

¹³⁶ Ms Beth Burton, Clinical Nurse Consultant, Alcohol and Other Drug Services, New England Area Health Service, Evidence, 24 March 2004, p11

¹³⁷ Judge Price, Chief Magistrate, Local Court of New South Wales, address to the NSW Summit on Alcohol Abuse, Report of Proceedings, Second Day, 27 August 2003, p13; Judge Price, Chief Magistrate, Evidence, 26 November 2003, p5

¹³⁸ Submission 19, NSW Police Service, Wagga Wagga Command, p2

for the person to return home quickly as they were not in any real sense detained. Again this frustrates workers, especially after the taxing process of actually obtaining an order.¹³⁹ Ms Vi Hunt, Area Coordinator, Alcohol and Other Drug Services, New England Area Health Service, told the Committee of how she was involved in obtaining an order on two occasions for a woman who was seriously ill and at risk as a result of substance dependence and mental illness:

On both occasions [the hospital] had the Act revoked and they sent her on the next train home. So from my experience it was difficult. We could go through the process, get somebody under the *Inebriates Act* and into treatment, but when we got that person there, there was just not a capacity or a willingness to keep that person there.¹⁴⁰

- 3.33** For some inquiry participants such as the Police Association there is a strong belief that the Act is ineffective in providing an important safety net for people at significant risk of harm.¹⁴¹

Inflexibility

- 3.34** As well as being cumbersome, from the perspective of the magistracy the Act is also inflexible. The Chief Magistrate pointed to the ‘legal gymnastics’ sometimes required for magistrates to effect an order for a particular person. If, for example, a suitable service or facility which is not a gazetted hospital is found for a person, but they are to be treated for more than 28 days, this is not technically permissible under the Act. Similarly, a private hospital, which is not classed as a ‘prescribed residence’ under the Act, is not able to prevent an inebriate from leaving the facility. As well as working against arrangements in the best interest of the person, according to the Chief Magistrate, this can also lead to legal arguments and does not make for an efficient and effective court system.¹⁴²

Offender provisions

- 3.35** Perhaps reflecting the practical irrelevance of the Act for the current criminal justice system, few participants made specific criticism of the Act in relation to offenders.
- 3.36** In its 1996 review of sentencing provisions in New South Wales, the Law Reform Commission recommended the repeal of all aspects of the *Inebriates Act* that have a bearing on sentencing. In the Commission’s view, the Act enables punishment disproportionate to the criminality of an offence, and when this does not occur, the Act provides no more than is available to a sentencing court anyway.¹⁴³ In its submission to this inquiry the Law Society noted its support for the Commission’s recommendation.¹⁴⁴

¹³⁹ Submission 2, Mr Owen Atkins, p2

¹⁴⁰ Ms Vi Hunt, Area Coordinator, Alcohol and Other Drug Services, New England Area Health Service, Evidence, 24 March 2004, p11

¹⁴¹ Submission 40, Police Association of New South Wales, p12

¹⁴² Judge Price, Chief Magistrate, 26 November 2003, p10-11

¹⁴³ NSW Law Reform Commission, *Sentencing*, Report 79, December 1996, pp233-235

¹⁴⁴ Submission 44, Law Society of New South Wales, p3

3.37 The Attorney General's Department advised the Committee that the offender provisions 'may at some stage have been used as an option for sentencing people to treatment rather than imprisonment, but have not been used for many years'.¹⁴⁵ The Department of Corrective Services has no record of any offender, among all those received into custody in NSW, incarcerated under the Act since the mid 1980s; Corrections Health is also unaware of any use of the Act's offender provisions in recent years.¹⁴⁶

3.38 There was broad agreement among the Attorney General's Department, Department of Corrective Services and Chief Magistrate that these aspects of the Act are obsolete and better dealt with under other legislation.¹⁴⁷ The Chief Magistrate noted that section 11 of the Act, which forms the basis for the offender provisions, goes back to the time when public drunkenness was an offence, which it ceased to be in 1979. As he succinctly put it to the Committee, 'The law has moved on.'¹⁴⁸

Other provisions

3.39 Various inquiry participants noted a number of further obsolete, rarely used or undesirable provisions in the *Inebriates Act*:

- Recognizances have little credibility as an effective tool for addressing serious substance misuse¹⁴⁹
- There is no supervising board, as required under section 29, currently in operation
- Section 18 enables a court to order that the expenses associated with the care, charge and maintenance of an inebriate be paid out of his or her property
- The financial penalties provided in sections 21, 25 and 26 are out of date and probably unnecessary¹⁵⁰
- The state institutions for 'inebriates convicted of certain offences' provided for in section 13 were never established
- There are outdated references to the *Vagrancy Act 1902*, the *Lunacy Act 1898* and to 'release on license'.¹⁵¹

¹⁴⁵ Submission 47, NSW Government, p12

¹⁴⁶ Submission 47, NSW Government, p12

¹⁴⁷ Submission 47, NSW Government, p15-16; Judge Price, Chief Magistrate, Evidence, 26 November 2003, pp7-8

¹⁴⁸ Judge Price, Chief Magistrate, Evidence, 26 November 2003, pp7-8

¹⁴⁹ Judge Price, Chief Magistrate, *NSW Summit on Alcohol Abuse: Report of Proceedings*, Second Day, Wednesday 27 August 2003, p13; Submission 9, Shopfront Youth Legal Centre, p2

¹⁵⁰ Submission 47, NSW Government, p9

¹⁵¹ Submission 36, Law Society of New South Wales, p2

Detention in mental health facilities

3.40 Much has been said throughout this inquiry about the inappropriateness of the Act's provision for compulsory treatment for alcohol or other drug dependence to occur within psychiatric hospitals. Clearly, this longstanding fundamental problem must be addressed.

3.41 The Committee has found that there is universal agreement that psychiatric hospitals are an inappropriate setting for the detention and treatment of this group. In its submission to the inquiry the Government formally acknowledged the need to address this issue:

NSW Health considers that the psychiatric institutions which are in the schedule of gazetted institutions for compulsory treatment of non-offenders under section 9 of the Act are not suitable repositories for such persons.¹⁵²

3.42 For the Chief Magistrate these placements are no less problematic, but as he told the Committee, 'the courts have no alternative under this legislation'.¹⁵³ As noted in Chapter 2, the model of care now operating in mental health facilities is vastly different to that when the Act was passed, and indeed mental health facilities were never seen as an appropriate environment for the Act's purpose.

3.43 Inquiry participants told us that there are several aspects to this problem in the present day. First, the Act places psychiatric hospitals in the invidious position of having to contain people for long periods for whom they do not offer appropriate services and requires them to fulfil a custodial role that they are not necessarily equipped for. In addition, mental health facilities have become highly specialised environments that cater to people with severe mental illness, particularly chronic schizophrenia, and generally do not provide the specialised services required by people with severe substance dependence:¹⁵⁴

Because the numbers of Inebriates are small (usually one or two patients at any one time), it is not possible to channel limited psychiatric resources into developing specialised programs for them. They cannot be sent elsewhere for programs because no other treatment services are able to accept them under the *Inebriates Act* ... The treatment environment of a large psychiatric hospital does not meet the standards of best practice for someone who is detoxifying and in recovery from an addiction disorder. Ideally, those under the Act should be placed with other patients with addictive disorders in a low stimulation environment, not with patients who are psychotic and severely mentally unwell.¹⁵⁵

3.44 Thus these hospitals are unable to fulfil the right to quality treatment that is implicit in ethically sound involuntary care, and the Act itself prevents the making of more suitable arrangements. The case study of Barry on the following page powerfully illustrates how inappropriate and ineffective such placements can be, and indeed how they may actually undermine recovery.

¹⁵² Submission 47, NSW Government, p17

¹⁵³ Judge Price, Chief Magistrate, Evidence, 26 November 2003, p10

¹⁵⁴ Dr Dore, Macquarie Hospital, Evidence, 4 March 2004, p3; Submission 47, NSW Government, p18

¹⁵⁵ Submission 35, Northern Sydney Health, p2

Barry

Barry was placed in a psychiatric facility for 12 months under the *Inebriates Act 1912*. He was presented to a magistrate by his sister and brother and a member of the police force. Barry had been taken from a general hospital to the court after receiving intensive care for a coma that had resulted from his abuse of alcohol. Medical authorities had not expected him to recover. His alcoholism was well documented and he admitted he was an alcoholic and would drink anything when he was on a binge. He had no history of violence and no charges against him; nor was he mentally ill. Barry felt he had been disadvantaged by his family bringing him before the magistrate while he was physically and emotionally weak and disoriented from his near-death experience.

After some time at the hospital, Barry was given leave and allowed to make day trips as his condition improved and as is normal practice within the mental health system. During one of these excursions he was devastated to learn of the death of a good friend. He again turned to alcohol. Under pressure from Barry's sister and brother and the threat of legal action the hospital placed him in a locked ward for severely mentally ill people. He stayed there for the remainder of his sentence, over 250 days. During this time he was unable to find a way for his circumstances to be reviewed within the legal system.

The hospital felt constrained by the law to keep him in the locked ward. Barry often expressed his concern at the level of violence he witnessed in other patients and felt he always had to be on guard. He also found it difficult to communicate with those who were constantly disordered, delusional or hallucinating. Barry became lonely and had to develop ways of protecting himself and his belongings.

As a high functioning person, Barry found the rehabilitation programs on the ward inappropriate and not useful. He retreated into reading books. As time went on he became frustrated as he saw fellow patients move into open wards despite behaviours that were well below his level of functioning. He felt trapped by the ward and the lack of rehabilitation opportunities he had there. The ward had become his prison. His situation added anxiety and depression to an otherwise model patient.

With support from the social worker and other staff, Barry tried to initiate his own rehabilitation program. However, drug and alcohol services would not visit him in hospital, as they required clients to attend their offices. The hospital administration were reluctant to allow Barry to attend Alcoholics Anonymous (AA) because they were unsure whether they had a legal obligation to keep him within the hospital. They were also concerned that they did not have sufficient staff to escort Barry to AA. At the same time, Barry was concerned about the anonymity of AA meetings and that it may not be acceptable for staff to sit in on them. Attempts were made to try and get him into a training program, but again this was frustrated by the legal ambiguity of letting him attend classes in the community. The Housing Department had concerns about providing accommodation because Barry would not be under a mental health community treatment order or rehabilitation plan after his twelve month order was completed.

As the time approached for Barry's release, it became clear that the hospital would not be able to offer any support after he left the facility's care. The Department of Housing did provide resources for some trial accommodation. Various staff gathered furniture and other equipment to help support Barry. Once free of hospital, he could attend counselling with drug and alcohol services and pursue educational opportunities through the Commonwealth Rehabilitation Service. The hospital chaplain was the only staff member who could appropriately continue support in the community.

In the end, Barry was imprisoned in the hospital without a formal rehabilitation plan that could be sustained into the community. After being sober for the best part of a year, he re-entered the community with some human support, shelter and food, but with the same vulnerabilities that he had when he was first placed in the hospital.

Barry struggled for about three months to establish himself in the community. He slipped once, but recovered quickly with support. He seemed to cope through AA, drug and alcohol counselling and regular pastoral support. One weekend his addiction again took hold. He consumed four bottles of methylated spirits and died in the loneliness of his flat.

- 3.45** The two people under inebriates orders with whom the Committee spoke appeared to be simply being housed and were not able to access programs that they themselves thought would assist them to deal with their dependence. They were also extremely bored, with no meaningful activities to occupy their time.¹⁵⁶
- 3.46** In addition, the Act is fundamentally at odds with the philosophy underpinning the mental health system:

The whole ethos of mental health institutions is towards wellness and to identify and offer support to patients as they take charge of their lives. Staff use containment only when the patient is at risk of self harm, harming other people, or that a person's reputation is at risk as a result of their illness. Consequently, mental health institutions are NOT run like prisons. The emphasis is on promoting freedom and self responsibility as soon as a person recovers from their illness or is appropriately managed through a rehabilitation plan. Community support is defined and enacted as a duty of care and as a natural outcome of the rehabilitation process ... Hospitals are not gaols. The staff is not trained and the facilities are not designed to respond to criminal containment. Patients are vulnerable.¹⁵⁷

- 3.47** Further, the placement of people under inebriates orders exacerbates the shortage of mental health beds. Dr Peter Tucker of Cumberland Hospital has estimated that a single referral under the Act for 3 months prevents up to 25 acutely ill psychiatric patients from accessing inpatient treatment.¹⁵⁸
- 3.48** Each of the representatives of gazetted hospitals we spoke to questioned the appropriateness of many orders and the capacity of the system to benefit those subject to them. The perceived effectiveness of the Act is explored in detail in Chapter 4. Dr Tucker gave an example, pointing also to the negative effects that such a heavy handed Act can have on motivation:

A man in his sixties was given a three-month order ... This person was plausible and denied a serious drinking problem. He was reluctant to take anti-craving medication and felt that he could control his drinking. He normally lived with a close family member, to whom he paid rent. He is an example of somebody who just sat there for three months. He had no insight or motivation to go anywhere with his treatment.¹⁵⁹

- 3.49** Various administrators also emphasised the 'poor fit' between those sent under inebriates orders and the models of care operating in psychiatric hospitals, such that they are mixed with other patients in ways that are not ideal for anyone.¹⁶⁰ Of particular concern to the Committee are reports that some people under an order have placed the wellbeing and safety of other patients at risk. Representatives of two hospitals reported that people under an inebriates order had supplied illicit drugs to other patients (whose illness might be adversely affected by

¹⁵⁶ Confidential evidence

¹⁵⁷ Submission 41, Rev Rennie Schmid, Uniting Care NSW ACT, pp2-3

¹⁵⁸ Submission 33, Western Sydney Area Health Service, p2

¹⁵⁹ Dr Peter Tucker, Medical Superintendent, Cumberland Hospital and Director, Clinical Services (East), Western Sydney Area Mental Health Service, Evidence, 27 November 2003, p35

¹⁶⁰ Associate Professor Fanning, Mid Western Area Mental Health Service, Evidence, 24 March 2004, p8

these substances) and one reported allegations of a sexual assault.¹⁶¹ In his submission, Dr Patfield stated:

A more serious issue, however, is the detrimental effect that such patients can have on the care of other patients. A number of these patients have brought drugs into the hospital and many are disdainful of the hospital and its staff and choose not to behave in a considerate and reasonable manner. This has a dreadful effect on staff morale and produces a disheartening environment for mentally ill patients who are in hospital for treatment rather than containment. They have been sent because their behaviour has not been tolerated in their home communities but they are sent to a place where they reside with some of the most vulnerable members of our society.¹⁶²

3.50 Dr Patfield gave the committee an example:

One of them is an example of someone who was a particular danger to the hospital. He was a young fellow of about 25 who had had five recent admissions to the hospital under the *Mental Health Act* ... as being mentally disordered. That was usually after violence and agitation, probably as a result of speed or overdoses. He was sent down from a major town in our catchment area always after he had been threatening and aggressive towards people - usually hospital staff. He was sent down as [mentally disordered] and he quickly became quite rational again. As per the requirements of the Act he was discharged very quickly. He had been repeatedly very threatening to hospital staff in the town from which he came. Eventually an inebriates order was secured. This man's drugs were heroin and cocaine ... He arrived here, absconded the next day from the ward and was returned by police. During his stay there were considerable fears for the safety of one patient, because this fellow was constantly threatening and intimidating him. He made numerous threats to kill staff. During his stay there was an allegation of sexual assault by a woman who had been admitted six weeks after delivery with post-partum depression. We do not know whether or not he did sexually assault her; we think he probably did. He was dealing with his associates over the back fence of our special care unit. Eventually, because he was well connected in the town where he had come from, he secured a stay of his inebriates order. Luckily, he went after one week, because we were starting to have industrial problems as he was so dangerous to staff here. After he was discharged the hospital was very heavily criticised by health staff at the referring hospital because they felt that we had not kept him secure enough; therefore, their staff were at risk. But they did not seem to pay much attention to the safety of our staff and patients. It was a very frightening time for us.¹⁶³

3.51 The case study of Michael on the following page illustrates the contorted process one hospital had to use to have a patient removed because of the risks he posed to other patients.

¹⁶¹ Dr Dore, Macquarie Hospital, Evidence, 4 March 2004, p1; Dr Patfield, Bloomfield Hospital, Evidence, 24 March 2004, p2

¹⁶² Submission 11, Dr Martyn Patfield, Bloomfield Hospital, p2

¹⁶³ Dr Patfield, Bloomfield Hospital, Evidence, 24 March 2004, p2

Michael

Michael was sent to a psychiatric hospital under the *Inebriates Act* for three months because he was drinking very heavily, committing petty crimes and being a public nuisance. He started out in the acute care unit, and was assessed to see if he could be placed in an open ward for people with schizophrenia. The only other option was for him to be placed in a locked ward for people with long term, serious mental illness, but the hospital was at pains to avoid that, as they saw it as an extremely inappropriate place for Michael, who did not have alcohol related brain damage and did not have another major mental illness.

After the initial detoxification period, he went to the open ward. According to the hospital, the difficulties that quickly arose were based on the fact that he had no mental illness but had to live with almost twenty young people who were experiencing psychosis, and thus were often hallucinating, thought disordered, difficult to talk to, and were generally mentally unwell. Michael did not feel that he had anything in common with them, and was very derogatory towards them, calling them morons and so on. All the hospital's programs were geared towards that patient group, and he understandably did not feel that the programs were helpful for him. The hospital tried to accommodate his needs by arranging for him to attend Alcoholics Anonymous, which was helpful.

According to the hospital, Michael did pretty well in the ward in terms of his drinking. While he could come and go from the ward, and there was a bottle shop nearby, breathalyser tests showed that he wasn't drinking. But soon reports came in from a number of the young patients independently, saying that Michael was dealing drugs on the unit. He was bringing marijuana into the unit and selling it to the patients with schizophrenia. The hospital was very distressed to hear of this, in light of the well known effects that cannabis can have in triggering psychosis. Despite a number of the patients having complained about this, none wanted to lay a complaint or to be named, so the hospital could not ask the police to become involved. Nor could they remove him from the hospital because he was under a three-month order. As a last resort he was transferred to the locked ward for seriously mentally ill patients to at least remove him from the vulnerable young patients. He was very angry and he denied that he was dealing in drugs.

The hospital took Michael's case back to the magistrate. The hospital did not believe it could successfully argue for him to be removed because he was dealing to other patients, but was able to argue that he had been in the hospital under the *Inebriates Act* for about 2½ months, that he had made progress in terms of his alcohol dependency, that he had not been drinking, had had leave, was on anti-craving medication, was attending Alcoholics Anonymous, was attending drug and alcohol relapse prevention programs. They argued that it was appropriate for him to be discharged because he was doing well and because we had a treatment plan set up in the community. The magistrate agreed to rescind the order, two weeks early.

The poor spread of facilities across the State

3.52 There was broad criticism of the poor spread of treatment facilities across the State, which means that those under an order are often forced to travel great distances. NSW Health identified this as problematic,¹⁶⁴ as did the Chief Magistrate:

[The poor coverage across the State] is a major difficulty with orders for applicants who are outside the metropolitan area, and that is one of the matters that troubles magistrates. There are not available beds, to put it that way, within a reasonable geographic location. Consider the situation, for example, at Wilcannia or Broken Hill, or somebody going down south to Tumut or Cooma. One does not need a lot of imagination to understand, amongst other things, the difficulties for relatives and the difficulties of access for seeing the person ...¹⁶⁵

¹⁶⁴ Submission 47, NSW Government, p18

¹⁶⁵ Judge Price, Chief Magistrate, Evidence, 26 November 2003, p6

- 3.53** Similarly, Dr Victor Storm, Clinical Director of Central Sydney Area Mental Health Service, commented that when people are cut off from their normal environment and support networks it is very hard to integrate any ongoing treatment once their order is completed.¹⁶⁶
- 3.54** The issue of distance also creates the substantial practical problem of transporting those under orders to hospital. This is a significant issue, consuming substantial resources both for police and health staff.¹⁶⁷

Conclusion

- 3.55** This chapter has outlined the many criticisms of the *Inebriates Act* and the interventions it compels for those made subject to it. Key among these are the Act's poor regard for human rights, its disproportionate use in relation to Aboriginal people, its inadequate safeguards, its unworkability and inflexibility, and its provision for people to be detained in mental health facilities where they have limited access to appropriate alcohol and other drug services and can impact on the wellbeing of other patients. The evidence put forward by inquiry participants is that the *Inebriates Act* not only has a draconian premise; it can prevent an humane and helpful response when this is required. This claim is further investigated in the following chapter, which looks in detail at those made subject to the Act, and the outcomes it achieves for them.

¹⁶⁶ Dr Victor Storm, Clinical Director of Central Sydney Area Mental Health Service, Evidence, 27 November 2003, p35

¹⁶⁷ Submission 2, Mr Owen Atkins, p2