Mid Western Area Mental Health Services

Mid Western Area HEALTH service

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5 November 2003

The Director
Standing Committee on Social Issues
Parliament House
Macquarie Street
SYDNEY NSW 2000

Dear Sir/Madam,

Please find attached my Submission to the Standing Committee on Social Issues – Inquiry into the *Inebriates Act 1912*.

Yours sincerely,

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Consultant Psychiatrist
Medical Superintendent/
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SUBMISSION TO THE STANDING COMMITTEE ON SOCIAL ISSUES - INQUIRY INTO THE *INEBRIATES ACT.*

Dr Martyn Patfield,
Consultant Psychiatrist,
Medical Superintendent and Director of Acute Services,
Bloomfield Hospital, Orange.

Summary:

The Inebriates Act is no longer an appropriate instrument to deal with those who abuse alcohol and other substances. It leads to misuse of psychiatric facilities and it is not helpful for those it purports to serve.

The Inquiry into the Inebriates Act, 1912 will attempt to consider the role of compulsory treatment in the management of those with substance dependence. There is clearly a consensus that the means for such treatment provided by the Inebriates Act as it currently operates are not adequate for the purpose.

The later items in the terms of reference focus on possibilities for improvement and this is, of course, where the enquiry should lead.

However, because of my particular role in a facility which accommodates people placed under the provisions of the Inebriates Act, and because this has given me a close insight into the way the Act currently operates in practice, I will focus on this. My hope is that the committee will be left in no doubt that there must be change.

The Inebriates Act was promulgated at a time when large stand alone psychiatric hospitals were the main form of delivery of services to psychiatric patients but were also called upon to care for many other categories of people who the general community was either unwilling or unable to tolerate – homeless, epileptics, unmarried mothers, "inebriates" and others. The social changes and approaches to treatment over the last 40 years have been broadly discussed and are widely understood. However, the Inebriates Act has not been amended. It is still invoked with the implicit expectation that the facilities, role and capacities (for example, the capacity to contain) have not changed since 1912.

In the last 3 years at Bloomfield Hospital, there have been 25 people sent here under the Inebriates Act. Ostensibly, they have been sent here for "treatment". Whether this is the primary reason for referral must be doubted. Firstly, the hospital has never been asked about the treatment provided (there is no specific programme for those sent as inebriates).

Secondly, examination of the background history leading up to referral, reveals that the primary reason for being placed under the Inebriates Act is not the person's substance abuse per se, but rather their intolerable, often frankly illegal behaviour.

Thirdly, and most importantly, it is clear that as the hospital has no say over whether people present, are admitted or when they are discharged, it cannot be the case that the treating team has a significant input into how a case is managed. In general terms, for any condition, hospitalisation is a broad treatment modality chosen after a discussion between doctor and patient. However, in the case of "inebriates", the treatment is prescribed by a magistrate. There is therefore a discrepancy between the description of these people in the language of a medical model, and the exclusion of medical input in the most fundamental decisions concerning those "treated" under the Inebriates Act. (Admittedly there is a supporting affidavit from a doctor – though none of these doctors have ever discussed matters with the hospital and usually their affidavit it sought in order to satisfy the legal requirement rather than the doctors being the prime movers).

Hospital staff have always tried to help the people referred in any way possible and on a few occasions the hospitalisation has been beneficial (though would have been better managed either voluntarily or under the Mental Health Act). Where there has been benefit, it has usually been because of the person suffering from a problem incidentally found after admission but which was not related to the reason for referral. In the majority of cases however, the hospitalisation has achieved no more than provide a place for abstinence. This may be a worthy goal. However, I would raise two issues. Firstly, a hospital is a very expensive place for someone to live while they simply abstain. Secondly, given the open nature of the wards in a modern psychiatric facility, there is no guarantee of abstinence and in the case of Bloomfield, there is a licensed premises on the grounds (the Country Club of the Orange Ex-Services Club) and this is visited from time to time by those under the Inebriates Act. (Normally, such behaviour by patients leads to discharge but, as explained, the hospital has no power to discharge.)

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 or 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 We have no power to discharge these patients and an explanation of these problems has often not been met with sympathy from the magistrate who alone has the power to discharge.

I have from time to time discussed individual cases with referring courts. I believe that the magistrates have generally acted in good faith after perceiving that the person before them has been heavily using substances (though on one occasion I cared for a man who had not actually had any alcohol for many years – his behaviour, misinterpreted as alcoholism, was actually due to dementia). Nevertheless,

in most cases, the person has really 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 one not preferred. Some "inebriates" have asked themselves for an Inebriates order as an alternative to gaol, some have had this option recommended by their legal counsel. In any event, the hospital is being used as a defacto gaol after a sentencing process which has few legal safeguards. There are worrying similarities with the use of psychiatric hospitals in the soviet era.

My chief contention is that the Act is currently used by the courts as a way to contain behaviour. It may be reasonable for the courts to have the power to invoke sanctions against this behaviour. If so, it would also be very reasonable to provide appropriate input from Drug and Alcohol services where appropriate. However, the current situation leads to a misuse of psychiatric facilities, an expensive form of custody and ultimately to the problems of the people involved not being managed effectively.

The vast majority of those who are detained under the Inebriate's Act are able to make choices about their behaviour and are responsible for it. (There are a small minority who, due to brain damage sustained through alcohol or trauma, have impaired planning abilities and judgement to the extent that their ability to choose abstinence is significantly impaired. These form a special group and represent a small percentage of those placed under the Act).

It should be clearly acknowledged that if an inebriate's 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. Such behaviour may require detention in specific facilities. Input from health services would be appropriate but we should not pretend that there exists a treatment which can be forced on people which will reliably, or even usually, change their attitude to using substances like alcohol or other drugs. Rather than an illness model, it may be more appropriate to acknowledge that these people can learn and change, through sanctions which operate flexibly in response to behaviour, rather than through an inflexible response to a purported, intangible illness.

Alternatively, if we are to continue with an Act based implicitly on an illness model, then those delivering the treatment should be centrally involved in the decision to consider admission, to determine the conditions of care and to discharge.

Martyn Patfield,