Submission
No 53

INQUIRY INTO INEBRIATES ACT 1912

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Theme:

Summary

MID WESTERN AREA HEALTH SERVICE

RESPONSE TO THE STANDING COMMITTEE ON SOCIAL ISSUES INQUIRY INTO THE INEBRIATES ACT OF 1912

TERM OF REFERENCE	COMMENTS
1. How does the provision of compulsory assessment and treatment under the Act affect you and your clients?	• The Act is used for people whose alcohol behaviours do not allow them to make a rational decision to seek and follow through with treatment AND they are at detrimental level of risk to themselves / others / community. Other impacting factors may include ARBD, Korsakov or other brain injuries (falls, violence etc). • The clients are generally not motivated to change; therefore to use the Act is contrary to Alcohol & Other Drug worker's usual practice (I.e. based on the clients motivation). • When working with "inebriates" there is a fundamental ethical question: Do people have the right to drink themselves to death? Generally A&OD services adhere to the harm minimisation philosophy, therefore even if the client returns to pre-accommodation drinking on discharge, s/he has had the opportunity to make rational decisions about whether to make changes – this opportunity would not have otherwise presented itself. In the overall picture, clients accommodated under the Act generally relapse when returned into 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. • At times A&OD workers have been *expected* to pursue the Inebriate Order by others: (e.g. friends / family / health and non-health services). The question is "Whose role is it?" Locally the decision has been to provide limited education to the referring family member or service about the Act, so that they might follow up. • It is reasonable to assume that the alcohol-dependent person who would be a likely candidate for the Act already has a long history with NSW Health. This is likely to include inpatient admissions, visits to accident & emergency department, one-on-one worker time with allied-health, and worker time used to follow-up on discharge. There is a cost savings on the health service in short and medium term after such a person has had a rest from abusive behaviours at a Schedule 5 facility. • In addition to Health Services, the people most often considered under the Act are also most likely to be associated with high levels of contact with the three 000 services, NSW housing, NSW DoCS, & NSW Court system. There are also other costs that accompany the likely candidates for the Act when they are left in crisis in the community. These costs are immeasurable – such as emotional / health / financial costs to themselves & their families.

2. What is your/ your agency's experience of the appropriateness and effectiveness of the Act in dealing with people with severe alcohol and /or drug dependence who a) have not committed an offence	• In a non-metropolitan/industrial community , one centre has encountered-three different severely alcohol-dependent clients in the past eight years have given rise to six episodes of consideration under the Act. All resulted in admission to a Schedule 5 facility. In general, these people travel well in a structured and secure environment where access to alcohol is denied and they become more aware of their detrimental situations during periods of sobriety. The longer-term outcomes varied for each of the three individuals, one is deceased (of non-alcohol related injury), and one chooses to drink but claims that there were benefits from "time-out" in a Schedule 5 facility. The third person, after discharge and relapse, then chose to seek long-term accommodation at a A&OD residential facility rather than be considered again under the Inebriate Act. • 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
b) have committed offences	• "Alcohol related" crimes have complex social determinants, and so treating the individual is only one of the issues – the community as a whole has to decide what level of "alcohol related" behaviours it wishes to tolerate. • Those in gaol who have alcohol problems could and should have their issues addressed, but not principally at Psychiatric Institutions under the Act. It may be suitable to use a process like MERIT for drinkers, but this will take money, and some 'teeth'. The relapse rate to alcohol in people treated in the community will be very high, so close monitoring and support will be crucial.

TERM OF REFERENCE	COMMENTS
3a How effective is the Act in linking people with severe alcohol and /or drug dependence <u>who have **not** committed an offence</u> to suitable treatment facilities and how might those linkages be improved if necessary;	• Very poor at present. There is a reluctance to use the Act, for a variety of reasons, so if the question is "could the Act be used more often", then more people need to be made aware of this option. As noted above, as the Act currently 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. • "...to suitable treatment facilities" implies that Psychiatric hospitals are suitable, many may not be as: o they do not appear to consider this as core business, o they do not have the specific services or facilities, o mental health is not the best paradigm in which to understand and treat A&OD problems, notwithstanding the fact that many of these people have mental health problems. o The clients themselves often have difficulty with the groups/programmes as they have difficulty relating to the Mental Health focus and don't feel they belong or that the topics aren't relevant. These clients may also feel apprehensive about being in the same ward as "crazy people" and this can lead to disruptions. • A dedicated Unit, with mental health and A&OD workers and a blended working model, would be appropriate, but would need money and commitment. • The Inebriates Act is more effective than relying on the Public Guardian to make decisions for "inebriates" to be accommodated at a rehabilitation facility, which generally work on motivation to attend i.e. clients' *choice*.
3b. How effective is the Act in linking people with severe alcohol and /or drug dependence <u>who have committed an offence</u> to suitable treatment facilities and how might those linkages be improved if necessary	• People with alcohol and/or other drug problems who have committed an offence need treatment whilst incarcerated. A scheme like Magistrates Early Referral Into Treatment could be appropriate –depending on the crime committed eg. possession/self admin as apposed to armed robbery: both offenders may have an issue with dependence, which could benefit from rigorous evidence based treatment, but there are also other issues within the person and the community to be considered.

4. Can you recommend any overseas and/ or interstate models for compulsory treatment of people with severe alcohol and/or drug dependence?	• 'Compulsory treatment' may be seen, by some, as inherently contradictory. We have not assessed any other models in depth but consider that any model adopted needs to address the following: • There is a need to separate crime and A&OD problems completely and not confuse the issue more with drug courts and the like. From a health perspective, possession and self-administration is not a crime, and so when a person presents with illicit drug use issues, the paradigm can remain strictly health care. It gets confusing when people are charged and it is then difficult to promote health when the motivation is, for example, a Court report • Those incarcerated for more serious crimes who also have an A&OD problem should get the best treatment, using all possible modalities including good mental health assessment, literacy etc, as this is an ideal opportunity to reduce the risk of relapse in individuals who are usually characterised by chaotic behaviour outside detention, and often very difficult to engage, assess and help. • The Alcohol Summit highlighted the fact that there is a substantial group of people in the community whose A&OD use is killing them in front of a caring but apparently powerless family. As a community we need to get rid of the stigma associated with these problems, as with mental health, but meanwhile what do we do?

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5. What ooptions do you suggest for improving or replacing the Act with a focus on saving the lives of people with severe alcohol and/or drug dependence and those close to them?	• 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). • We have also found the Public Guardian to be ineffectual in this situation. The Public Guardian, has powers to decide upon residential and medical issues, however they have proven ineffectual in 'making' alcohol dependent people seek treatment, because A&OD services tend to work with people who are motivated to make changes – not non-compliant referrals. • Further, the Protective Commissioner is a two-edged sword. One side provides budgetary stability by controlling the "inebriate's" expenditure - therefore life commitments are met. The other side limits "spending" money – which can lead to more detrimental choices of becoming intoxicated (methylated spirits). • There is a need to remove the stigma attached to alcohol/drug dependence. It is a health issue, but unfortunately it is too often used as a political football and/or viewed as a moral weakness. • General health workers need to better look after patients with A&OD problems, and view these problems as legitimate health issues. • There is a substantial co-morbidity between mental health and A&OD problems that is yet to be addressed. • Community support processes need to be better valued and developed. At present community values and standards are too often used to market and encourage the increased consumption of alcohol, TAB or other products, but there is also an opportunity to use them to limit excessive behaviour in most people. • Involuntary treatment may be justified when a person is so chronically intoxicated that they are mentally disordered. If we use this strategy, though, we are obliged to offer the best treatment, as we are obliged in those with psychosis, and understand the often chronic, remitting and relapsing nature of these problems. It is critical that if a person is deprived of their liberty for being intoxicated, treatment and management strategies offered need to be the most effective known.

6. Do you have any other related comments? Please insert additional sheets if required	• The Inebriates Act provisions have presented a contentious issue within NSW Health services: A&OD & Community Mental Health. A&OD services could justify short-term health & other benefits for the client (as previously documented) while in the past, Mental Health have argued (1) that the 'short-term' nature makes their use ineffective (2) these clients could be a risk to other inpatients (3) these clients do not have a mental health diagnosis. • Some A&OD clients have co-morbid psychotic mental health diagnosis while most have mood related disorders. DSMIV (Diagnostic and Statistical Manual of Mental Disorders [fourth ed.] 1994 pp. 175 –272) includes approx 100 pages entitled "Substance Related Disorders" that could justify the "inebriate" being accommodated at a Schedule 5 facility.	

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