Submission for the Standing Committee on Social Issues inquiry into Inebriates Act 1912

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[redacted]

Regarding this inquiry;
I would like to place a submission regarding this Act, and in particular, the actual functions/ implementation and uses of the Act via Inebriate Orders. I am making this submission from a background in the Homelessness field (4 years) and the A & OD field (6 years) in this region. Although I have worked in both fields in Sydney for approximately 10 years prior to coming to this region, I had nothing to do with the Inebriates Act during that period.

My Experience with the Inebriate Orders:

In my time as the A & OD worker with Community Health I made use of Inebriate Orders a number of times. In my time working with the Homeless Persons Support Team I have not made any use of the Act but have had several occasions in which it might have been useful.

The catchment hospital for this region (the one that took Inebriates) was Morriset Hospital's Karioki House. The hospital had been openly resisting taking Inebriates for the entire time that I was working with Community Health. Their case was, I think, that Inebriate Orders were not useful given that the client was, by default, non-compliant and resistant to treatment. Their programme required active participation by their clients and they had no infrastructure in place to prevent a client simply waling away from the facility. (Other than the default one of sheer walking distance to town)

They had requested that all Orders indicate that the client would not be forcibly detained at their facility. They also requested that orders be for no longer than three months. Curiously, when my clients requested that an Order be taken out on them because they no longer felt competent to make their own decisions, Karaoki House staff would refuse the order as the client could, in their estimation, enter their programme not as an inebriate but as a normal programme participant.

Police, health staff, NGO's, other agencies and the public used to frequently request that Inebriate Orders be made out on a number of individuals.
The reasons for these requests would vary from real concern for the survival of an individual to a felt need to remove someone who is perceived as a public nuisance. Members of family would sometimes request Orders be made with a view to forcing treatment on unwilling participants.

A & OD staff in the wider team saw the value of Inebriate Orders as an effective means of giving clients "time out" from their destructive lifestyles, but not necessarily as a useful treatment. Our experience with Inebriate Orders was that most clients returned to their previous lifestyles within a very short time after their return home.

A common experience with making out Inebriate Orders was that the client would return home quickly (as they were not in any real sense detained). It was commonly said (although I never actually had this experience) that the client would beat the transporting

staff back to the region.

Transport indeed has become a major issue. It was policy (Health) that any client be transported by two staff. The journey took approximately 4 hours in both directions with intake at the hospital taking up to another hour. Having the staff and the vehicle free to make the trip increasingly became problematic.

Towards the end of my time at Community Health the pressure to utilise such Orders diminished to occasional ones taken out by family, family GPs and the police. These orders usually didn't involve Community health staff and were rare due to the obstacles previously discussed.

My own view rapidly coalesced to using the Inebriate Orders only if a client requested them, as long as there was support from family or similar personal networks in the client's life and, that taking the Order out would be more effective for a client over a voluntary placement in a rehabilitation unit.
Support from family etc, usually included facility to transport the client to Karaoki House, or occasionally to Bloomfield Hospital (Orange).

I tended towards the A & OD team view that they provided "time out" as I had no experience of long term successful outcomes when using the Orders. This may be because of the decisions made in deciding which cases would have an Order made out and which ones wouldn't. Ie; Only extreme cases who were willing to go but felt unable to self manage. That is, they felt that they should be compelled in some way by the legal system to undergo treatment.

Other issues in taking out an order were the simple co-ordination issues of completing detoxification, and timing detox completion with admission to the Inebriate facility. This could be problematic as Orders could be unpredictable, coming from a wide catchment, and could compete for the same spot in the programme.

Conflicting Values and Beliefs between hospital staff at Morriset and those involved in making out the Order could also interrupt or halt the order. For example, hospital staff preferred clients admitted to their facility voluntarily whereas, those involved in the Order were, by default, involved in an involuntary process. This often created a "crack" through which most clients could leave the facility with no repercussions. Eg: the client goes to Karaoki House as an Inebriate, is discharged shortly afterwards due to non-compliance. Client is, for one reason or another, taken before the courts who notice that client should still be away on an Inebriate Order. Client can factually state that s/he was discharged from the facility. The courts were rarely in a position to follow this up very far and rarely did so.

In my current work I have seen a number of cases where a facility such as an Inebriate Order could have been useful, given the client's constant intoxication, homelessness and poor health. One such client has since died despite the best efforts of health staff and my own team.

Homeless people present a special set of cases in considering Inebriate Orders. They are often heavy users of alcohol and other substances. Not only due to a need to disguise emotion and memory but as simple tools for getting through a cold or unpleasant night. Taking out an Inebriate Order might, at first glance appear to be a useful option, but in many cases would represent ineffective attempts at social control. The real issues relate to

the client's most fundamental needs and their capacity to self manage their behaviours. Ie; If accommodation is provided, will their intoxication and health threatening behaviours begin to change?

Sometimes effective and inter-agency case management can address the client's needs and sometimes the client's behaviours are too entrenched and something similar to an Inebriate Order could be more useful.

Conclusions:
I have had some small experience with these orders (there would be many workers out there with a wider range and depth of experience with using this Act) and a lot of discussion about the Orders.
I would suggest that;

The Act be reviewed in such a way that any alternative be clearly articulated. What its purposes are, the driving Values and Beliefs and the specifics of to whom the alternatives could apply.

It seems that the original Act developed in a milieu where intoxication was perceived very differently. There was a poorer understanding of the need for an individual's commitment to the process of rehabilitation, effectiveness or lack of effectiveness in different treatment regimes, and a greater emphasis on social controls.

There are a number of effective treatment services and models available to those who require them. At the same time, there appears to be a need for some clients to be compelled to undergo treatment.

I wonder whether Inebriate Orders or whatever replaces them couldn't be linked to the Guardianship Board or a similar body.

If the primary need for using such an Order is the client's incompetence then perhaps this is the best avenue for making such decisions. The Board tend to make their decisions on a complete profile for the client's needs. This profile would be provided by those most fit to make an accurate and useful assessment. (ie; A & OD worker, GP, other relevant staff) This is as opposed to the minimal information required for the current order. Further, the client would not be subjected to the court system, but to a different process. Many clients who are subject to Inebriate Orders have very little respect for the court system whereas, the Guardianship process is both respectful to the client and tends to be respected (although not always appreciated) by those involved in its processes.

If the body managing the process changes, then so should the infrastructure supporting it. Catchment facilities may need to specialist facilities or have developed the capacity to manage both voluntary and involuntary clients. Such facilities should be based on best practice and be reviewed regularly. This is important as there tends to be an emotional leaning towards just having a programme without exploring its effectiveness.

A very real need for any such facility or group of facilities is a clear understanding of the problems presented by simply getting a client to such facilities. Transport is a huge issue for remote areas, involving distance, vehicles, OH&S issues, staffing and time devoted to transporting the client. Transport is further compounded by co-ordinating detoxification to vacancy.

The other issue here is the change in drug use. The original Inebriate Orders were taken out in a milieu of alcohol intoxication as a primary problem. Whatever changes are made to the Act should take into account that many people are incompetent through their use of other substances and, frequently, a raft of other issues such as homelessness, brain damage, mental illnesses, acute family dysfunction and physical health problems.