Council of Social Service of New South Wales

66 Albion St, Surry Hills NSW
phone 02 9211 2599 **fax** 02 9281 1968
email info@ncoss.org.au **web** www.ncoss.org.au

abn 85001 797 137

14 November 2003

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

Dear Sir/Ms

Please find enclosed a submission prepared by the Council of Social Service of NSW (NCOSS) in relation to the Review of the Inebriates Act.

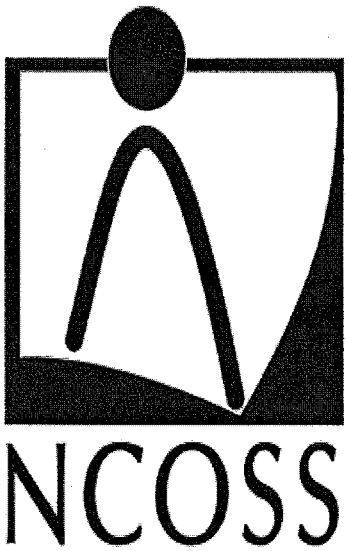
If you require further information, please contact Samantha Edmonds, Senior Policy Officer on tel (02) 9211 2599 or email at samantha@ncoss.org.au

Yours sincerely

Gary Moore
Director

Submission to the Legislative Council Standing Committee on Social Issues

Inquiry into the Inebriates Act 1912



November 2003

Council of Social Service of NSW (NCOSS), 66 Albion Street, Surry Hills 2010
Ph: 02 9211 2599, Fax: 9281 1968, email: samantha@ncoss.org.au

Background

There has been no substantial amendment made to the Inebriates Act since 1929. Its operations over the past 85 years have attracted much debate, but little appears to have been achieved in the care and management of those individuals who habitually use "intoxicating liquor or intoxicating or narcotic drugs to excess", through the use of the Act.

The first Act in New South Wales relating to care, control and treatment of persons with problems of addiction came into force in 1900. It was amended in 1909 and became consolidated as the Inebriates Act 1912. Dr Sinclair, the then Inspector General of the Insane, indicated that the origins of the legislation were primarily from the pressure of families of alcoholics on the government to obtain appropriate treatment facilities."[i]

The first NSW Inebriates Act (1900) did not include psychiatric hospitals (hospitals for the insane) in the list of institutions that could be used to house and treat inebriates. They were considered a possibility but were rejected as being unsuitable for this purpose. Instead the prison system, along with various private and charitable facilities, was used for this purpose. The 1912 Inebriates Act continued the same principle. Prior to 1929 the only State institution for inebriates was the Shaftesbury Institute (or Reformatory) under the control of the Prisons Department.

In 1927 with the passage of the Police Offences Amendment (Drugs) Act, increasing numbers of substance users were brought to the attention of the Police Department. They then put pressure on the government to create separate institutions for inebriates, which would 'not have the stigma of a gaol'.

The then Under Secretary of the Department of Health, recommended that the Government take the necessary steps to establish an institution under Section 9 of the Inebriates Act. He also recommended, however, that as a temporary measure only, to meet urgent cases, the mental hospitals at Callan Park, Gladesville, Parramatta, Kenmore, Rydalmere, Orange and Morisset and the Reception House, Darlinghurst be gazetted as institutions for inebriates "so that persons may obtain treatment as provided by Section 3 of the Act and where necessary they may be detained against their will".' The need for this was made more urgent by the Government's decision to close and demolish the Shaftesbury Institute.

In 1929 the mental hospitals were gazetted as the State Institutions for the reception, control and treatment of inebriates."[ii] However MacAvoy and Flaherty attribute the closure of the Shaftesbury Institute to its universal condemnation as a failure. They also make the note that the use of psychiatric hospitals as the sites to detain inebriates was not based on any claim that those institutions offered superior treatment or other rational grounds but merely by default as a result of a lack of appropriate facilities.

In 1932 the then NSW Inspector General of Mental Hospitals pointed out that it was undesirable to have inebriates associating with psychiatric patients and that provision of a special institution for inebriates was essential.

The 1957 Report on Psychiatric Treatment in NSW by Trethowan severely criticised the inadequacies of the Act. Then in 1969 J G Rankin, in his paper "Definitive treatment of alcoholism", rhetorically asked whether this legislation was "only a means of removing

society's misfits and rejects from public view, as it is the vagrant, homeless, unemployed chronic alcoholic who is caught up in the Act. In 1971, D.S Bell, during the development of a plan for a drug-dependence service for New South Wales, criticised the Inebriates Act for "merely consigning alcoholics to the limbo of country mental hospitals and that it provided treatment programmes under which relapse was the rule rather than the exception."

Over the last thirty years the case for the repeal of the Inebriates Act has been called on a number of occasions. In the mid-1960's the Act was reviewed and a draft response developed, but it was never progressed.

In the mid-1970's the NSW Health Commission again considered the Act. The issues at the time were outlined as:

1. The Health Commission is philosophically opposed to the use of legal constraints in any area of health care, other than in those areas of mental health or infectious disease where the sufferer is seen as an immediate danger to himself or others. Inebriates are not seen as falling within either of these categories.

2. Alternative methods and resources for the management of these persons are now available, and the appropriate use of these new resources is considered to be of greater value to the client than is committal under the Inebriates Act.

3. The concern of law enforcement authorities for the physical health of these persons is appreciated, and it is suggested the physical health needs of chronic alcoholics can be more effectively provided for through the resources now accessible through the Community Health Programme than through confinement in psychiatric institutions.

4. Historically the Inebriates Act has been used as much for social welfare purposes as for health purposes, and the continued use of health resources for this purpose is inappropriate and undesirable.

5. The possibility of ultimate rehabilitation is diminished rather than enhanced by compulsory removal from the community, to which the person must return, frequently with his problems compounded rather than alleviated by his detention.

In 1983 the Miscellaneous Acts (Mental Health) Repeal and Amendment Act No. 181 Schedule 1 called for the full repeal of the Inebriates Act. However that Act was repealed before Schedule 1 was commenced.

In 1989, after the Edwards Mental Health Act Review Committee recommended abolition of the Inebriates Act the then Minister for Health, the Hon Peter Collins MP, contacted the then Attorney General, The Hon John Dowd MP, calling for its repeal. However the Attorney General expressed concerns about repealing the legislation. It was then proposed that the Drug Offensive Council in conjunction with the Directorate of the Drug Offensive (now the Drug Programs Bureau), and representatives of the Attorney General's Department form a Working Party with a brief to investigate the continuing need for the retention of the Inebriates Act and to identify alternative legislative measures if the Act was to be repealed.

In September 1991 the Minister for Health, The Hon John Hannaford MLC again contacted the Attorney General, The Hon Peter Collins MP, to initiate another review in order to have the Act repealed. The Inebriates Act Review Committee, Chaired by the Director, Drug and Alcohol Directorate, was subsequently formed. It was asked to review the Inebriates Act, the Mental Health Act 1990, and the Disabilities Services and Guardianship Act 1987, to ensure that in the event of the repeal of the Inebriates Act there are appropriate safeguards and protection provided for in the latter two Acts.

In 1992, the Director Drug and Alcohol Directorate, NSW Health Department established an ad hoc review Committee to consider the Act, due to recent changes in the treatment of mental health, alcohol and other drug problems. The discussion paper from this Committee was never released.

1. Who has the Act Impacted Upon?

In 1991 the Health Department conducted a survey to compile data on admissions under the Act. It was identified that males were over-represented, Aboriginal people were over-represented (though it was also considered that they were under-identified in the data provided) and that 90% of admissions were unemployed persons who were in receipt of social security benefits.

In 1989/90 there were 95 admissions under the Act made to psychiatric hospitals and in 1990/91 there were 105. However the use of the Act was not increasing overall. The closure of hospitals and the reduction of available beds resulted in the remaining hospitals experiencing greater demand.

2. Repeal of the Act

NCOSS argues that as a result of the 2003 NSW Alcohol Summit Recommendation in relation to the Inebriates Act 1912, and in consideration of the above information government use this opportunity to repeal the Act.

The Intoxicated Person's Act is the appropriate Act to use as an alternative, however there are a number of amendments that need to be made to the Intoxicated Person's Act in light of the outcomes of the Alcohol Summit, released in the communiqué document of August 2003.

Recommendation:

1. That the Inebriates Act 1912 is repealed.

2. That the Intoxicated Persons Act is the appropriate legislative mechanism with amendments based on the findings of the Alcohol Summit.

3. Amendments Required to the Intoxicated Persons Act 1979

3.1 Determination of Intoxification:

Throughout the literature and in the various pieces of legislation the identification of someone as intoxicated is vague and uncertain. In the Inebriates Act a person is determined to be an inebriate if they "*habitually use intoxicating liquor or intoxicating or narcotic drugs to excess*". Under the Intoxicated Person's Act an intoxicated person is identified as "*a person who appears to be seriously affected by alcohol or another drug or a combination of drugs.*" These are both very broad definitions and are open to the criticisms of either under inclusiveness or over inclusiveness, depending on the circumstances at hand.

In the Alcohol Summit Communiqué document sections 8.1 and 8.2 there is a call for Intoxification to be defined. In section 8.1 it states "*Intoxification by alcohol or other drugs should be defined in relevant legislation in order that the levels of Intoxification can be more confidently gauged through direct observation, and the responsible service of alcohol requirements applied confidently by both servers and police.*" Section 8.2 describes how this can be done by stating " *Inter-departmental consultation is required in relation to the development of a definition of Intoxification, which should not confuse Intoxification with disability or brain injury or other medical conditions such as diabetes, asthma, and which should address industry concerns about allegations of discrimination".*

Recommendation

3. NCOSS recommends that the relevant departments, consumers, professionals, Non-Government Organisations, ATSI and CALD representatives, be called together to develop a working definition of Intoxification that can be used within the Intoxicated Persons Act and other pieces of related legislation.

3.2 Assessment

The important issue is that there are no specific or defined sets of assessment criteria that are to be applied to an individual before an Order is made under the Inebriates Act. As long as the magistrate is satisfied that the individual "habitually uses intoxicating liquor or intoxicating or narcotic drugs to excess" an order can be made.

In contrast the Victorian Alcoholics and Drug Dependent Person's Act is states that 'two medical practitioners have to have certified in writing that the person is an alcoholic and the medical officer in charge of the unit is of the same opinion then the person can be admitted to treatment".

In the draft framework for rehabilitation for mental health, developed by the Mental Health Implementation Group as a result of the NSW Government Action Plan, it states that that "individualised, baseline and periodic multidisciplinary assessment of functional ability, using a recognised functional assessment measure" should form the first step, and an ongoing process, in the continuum of care. This is principle can also be applied to the assessment and treatment of people who are intoxicated.

It was agreed during NCOSS consultations, in preparation for this submission, that the Emergency Department in a hospital is not the appropriate setting for assessment, and that after triage there should be referral to specialist Intoxicated Persons Service.

Recommendation:

4. Further consultation takes place with the relevant people and organisations to determine the best and most appropriate methods of assessment for intoxicated persons.

3.3 Detention of Intoxicated Person's:

Currently under the Intoxicated Person's Act the police can either release the person into the care of a responsible person or can hold the person in an authorised place of detention. An authorised place of detention is identified within the Act as a "police station or a detention centre within the meaning of the Children (Detention Centres) Act 1987". Previously this included Proclaimed Places, however these services can no longer 'detain' an intoxicated person and anecdotal information provided to NCOSS confirms that once the police leave, the intoxicated person leaves the service's premises.

NCOSS supports the view that alcoholism is a health and social issue not a criminal issue and that there needs to be a move to an effective continuum of care in the health sytem and away from criminality.

As discussed later in this document neither police cells nor detention centres are suitable or appropriate places of detention for an intoxicated person. One issue being that none of the staff within these services are medically trained to deal with the health conditions associated with ongoing Intoxification or to assist a person through detoxification. This is especially true if the person has a dual diagnosis of mental illness and alcohol or other drug use.

In Section 8.60 of the Communiqué from the Alcohol Summit it states, " *It is preferable that intoxicated persons not be detained in police cells, rather the Government should fast-track the state wide roll out of intoxicated persons services to support the diversion of intoxicated persons.*"

In section 8.61 this is expanded as "*Urgently expand the number of intoxicated persons services (culturally specific principles should apply state wide), which will take intoxicated persons, particularly in inner-city, rural and remote communities that do not have these facilities."*

In the Victorian Koori Alcohol and Drug Plan, 2003-2004, Koori community alcohol and drug resource centres are funded through Aboriginal community controlled health organisations and have been established as an alternative to incarceration in police cells for people found drunk in public. These are offered under a variety of models.

Discussions with relevant organisations show that there is some support for detention of intoxicated persons in some cases, where the person is at risk of self harm or harm to others. This is discussed later in this document under treatment. However in relation to the Intoxicated Person's Act it is agreed that any detention of a person under compulsory

treatment, must be within a specialist health service that is attached to a hospital rather than within the criminal justice system and that each specialist health service must be adequately resourced.

Recommendations

5. That Section 5 of the Intoxicated Person's Act should be amended to reflect recommendations 8.60 and 8.81 of the Alcohol Summit Communiqué and that appropriate resources and funding are made available to develop and operate specialist services in an a culturally appropriate manner.

6. That intoxicated persons services are fast tracked, as called for in the Alcohol Summit Communiqué, and that intoxicated persons are diverted to these services and away from the criminal justice system.

7. That compulsory treatment is worthy of further consideration, however further extensive consultation with relevant professionals, consumers, NGOs and other groups, needs to take place to determine what the appropriate length of time is for this detention and to consider specific rural, remote and cultural issues.

8. That any move to compulsory treatment must be properly resourced and that in the absence of effective resourcing for treatment systems, the option of compulsory treatment cannot be introduced.

3.4 Official Visitors:

Official Visitors under both the NSW Mental Health Services Act and the Victorian Drug Dependent Person's Act 1968, have a role to play in ensuring the safety, treatment, respect and rights of people who are being treated on a compulsory basis. Under Victorian Legislation Official Visitors 'are not employees in the public service or medical officers of the department' and can visit any treatment centre as 'often as the person thinks fit but not less than once a month'. Official Visitors can visit without notice and may inspect any section of the centre of building and make inquiries of any employee or detainee concerning that person's detention.

Recommendation:

9. That the Intoxicated Person's Act is amended to include the position of Official Visitors within intoxicated persons' services and that their role is in the safe guarding of intoxicated persons, ensuring effective and quality service provision and reporting their findings to parliament.

3.5 Victorian and Swedish Legislation

While certain aspects of the Victorian legislation would be useful to apply in NSW, there is still a level of 'criminality' associated with alcohol or drug dependence as opposed to the view that it is a health condition.

NCOSS and the organisations with which we consulted support the view that drug and alcohol dependence are a 'health' issue not a criminal justice issue.

NCOSS is against the application of Swedish legislation within NSW due to the diversion between the NSW and Swedish political, cultural, historical and racial contexts.

4. THE ALCOHOL AND OTHER DRUGS SERVICES IN NSW

NSW is by far the biggest state in regards to the number of Alcohol and Other Drug (AOD) services, with more than 100 non-government and approximately 120 government treatment services. This sector is primarily administered through the NSW Health System. Currently the NSW government's budget for alcohol and drug programs is approximately $223 million dollars

The Drug Programs Bureau is the central policy unit within NSW Health and is responsible for the development and implementation of the governments Plan of Action on Drugs, which was developed after the 1999 Drug Summit. The Drug Programs Bureau was responsible for the development of the Drug Treatment Services Plan, which outlines the models of service delivery, quality assurance, monitoring and reporting, and evaluation for the statewide treatment services system.

NSW Health has divided the State into 17 Area Health Services (AHS), each of which has a Drug Health Services program with a Drug and Alcohol Director. Each Area Health Service has been required to develop an Alcohol and Drug Strategic Plan under the policy framework of the NSW Health Drug Treatment Services Plan. The AOD directors work closely with the Drug Programs Bureau, through the NSW Health Drug and Alcohol Council, to advise on strategies and receive and information on statewide initiatives, resource allocation and direction.

Each Area Health Service also has an NGO Coordinator who primarily sits in the financial or operational departments and may or may not have direct connections with the Directors of Drug Health Services for that Area. The NGO Coordinators role is to liaise between the AHS and NGOs.

Funding for Alcohol and Drug NGO's, which are historically core-funding grants, comes primarily through NSW Health's NGO Grants Administration Program. These funds are provided to the Area Health Serves who then administer the grant payments to the NGO's they 'host'. Specific drug program funding (new state drugs money) is also provided through the Drug Programs Bureau to NGO's through Area Health Services.

There is a well-established peak organisation to support the AOD NGO's, the Network of Alcohol and Drug Agencies Inc. (NADA), which is centrally funded through NSW Health's NGO grants program. NADA has a detailed triennial funding and performance agreement with the Drug Programs Bureau in relation to statewide policy and planning priorities for NGO's and assists the Area Health Services to support their host NGO's.

There are varying degrees of partnerships between the government and non-government sector in relation to service delivery, administrative, infrastructure and client issues.

4.1 Detoxification

The inflexibility of the current Inebriates Act raises a number of significant problems for clinicians. One problem area is the issue of detoxification. Some "inebriates" are in need

of detoxification when they arrive under the orders. In most cases this is not a problem, however there are some cases where the withdrawal episode is likely to be an acute medical emergency.

The current inflexibility of orders made under the Inebriates Act mitigates against best care because variations to orders must go before the same Magistrate or Judge, the timeframe for which falls outside health imperatives. Many clinicians have requested that, prior to orders being made, the Magistrate or Judge confer with the clinical experts in the hospital for which the order is forecast. This would allow the order under consideration to better meet the needs of the individual in question.

There are varying guidelines, debates and reasons given for the length of time that a person takes to go through detoxification. In the NSW Detoxification Guidelines the onset and duration of alcohol withdrawal syndrome varies from 24 – 48 hours for people with mild withdrawal, 24 – 72 hours for people with a moderate withdrawal and in severe cases of withdrawal this can commence within 24 – 48 hours of stopping and can last up to three days, however in some cases it can last to 14 days. The duration and severity of the withdrawal can also be impacted upon by other drug dependence or severe alcohol dependence.

In the United States people are held for detoxification from 4 – 7 days regardless of the intensity of the withdrawal and within Victoria it is 7 – 14 days, with the provision for a longer period if needed.

NCOSS argues that detoxification is only the first stage in the treatment process and that short-term detoxification is only a precursor to ongoing treatment. Detoxification on its own is not successful in addressing alcoholism.

Other issues raised with NCOSS include the possibility that the threat of alcoholism being viewed as criminal is widened if coercion is in place and people do not want to stay there, or if the service is inappropriate, especially for Aboriginal people and other cultural groups. NCOSS is not supportive of police being able to force people back into detoxification, however it is acknowledged that particularly in rural and remote towns the police maybe only people available to do this.

The issue of compulsory detoxification is fraught with a number of human rights issues; the rights of the individual to care, safety and treatment; the rights of the community to public safety and the rights of the family member or carer. These need to be carefully balanced when considering compulsory detention and detoxification, which is why NCOSS believes that broader and well considered consultation needs to take place before determining the length and duration of compulsory treatment and how the individual's rights will be protected.

A number of suggestions were made to NCOSS during consultations on the Act on how determinations could be made for compulsory detoxification. This included a multidisciplinary committee consisting of a medical practitioner, nurse, drug and alcohol worker and a legal representative or an assessment team led by a nurse practitioner utilising appropriate screening instruments. This again would need further consultation to determine what the best and most effective method would be and is discussed further under Assessment.

Recommendation:

10. That further intensive consultation with professionals, health workers, Departments, consumers, community, NGOs and legal services needs to take place to consider issues such as how a person who requires compulsory treatment is identified and how long the period of detention lasts, amongst other issues, when addressing the compulsory detention of people. Special consideration needs to be given to rural, remote, Aboriginal and cultural issues.

4.2 Treatment Strategies

"*One of the most widely quoted statistics is that every dollar spent on treatment generates seven dollars worth of 'downstream' savings, primarily through the health care and criminal justice systems*"[iii]

The Drug Treatment Services Plan, mentioned above, also describes current programs and initiatives, which will contribute to the achievement of the desired health outcomes. Some of the important initiatives in key areas related to consideration of "inebriates" are:

(i) Encouragement and support for research into alcohol and other drug use and its management.

(ii) The expansion and improvement of the range of alcohol and other drug treatment services.

Treatment issues raise important questions about the role of the health system in NSW in relation to its responsibility for the protection of health, the creation and/or maintenance of healthy environments and treatment for illness of all people in the state.

It is well recognised that there is a continuum of drug use which can present a range of problems for individuals and communities which will range from mild to severe. The range of treatment options that exist in New South Wales to address this range of problems is substantial in comparison with other Australian States and Territories.

4.3 Psychiatric Hospitals as Treatment Services for Intoxicated People:

The issue of the appropriateness of psychiatric hospitals as venues for intervention with "inebriates" has been in question since at least 1900. In 1932 the NSW Inspector General of Mental Hospitals pointed out that it was undesirable to have inebriates associating with psychiatric patients. Many present day clinicians still have that view.

The report to the Minister for Health from the Mental Health Act Implementation Monitoring Committee in August 1992 commented on the Inebriates Act in a section on "Missing Services". The Review Sub-Committee did not consider that psychiatric hospitals are an appropriate place for these people unless they also have a mental illness.

One argument commonly put forward is that, as substance related disorders are listed in the Diagnostic and Statistical Manual of Mental Disorder, the DSM IV, then psychiatric hospitals are the most appropriate site for treatment to be offered. However, this argument ignores the cautionary statement made in that manual which states that, "*It is to*

be understood that inclusion here,..... does not imply that the condition meets legal or other nonmedical criteria for what constitutes mental disease, mental disorder, or mental disability."

While today it is acknowledged that there is a definite link between alcoholism, or drug addiction, and mental health issues (referred to as dual diagnosis), the response needs to be one of combined service delivery and treatment as opposed to treating one disorder then another. At present mental health services do not adequately treat a person's drug issues and drug services do not adequately treat mental health issues. Both types of services need to be properly resourced and the staff skilled in both types of issues before appropriate treatment can be given. Therefore it is still inappropriate for people with alcoholism to be placed in a psychiatric hospital, regardless of dual diagnosis or not, unless these issues are addressed. The issue of dual diagnosis and a lack of cohesive service delivery was an issue raised repeatedly throughout the Legislative Council Select Committee on Mental Health inquiry into mental health services in NSW.

Recommendation

11. There is additional funding provided for the purposes of establishing integrated service programs for those people with a dual diagnosis of mental illness and a substance use disorder.

4.4 Intoxicated Persons Services

As stated previously it is recognised that there is a continuum of drug use, which can present a range of problems for individuals, and communities, which will range from mild to severe. The range of treatment options that exist in New South Wales to address this range of problems is substantial in comparison with other Australian States and Territories.

The issue of appropriate treatment, under the current legislative regime, is confounded by the inflexibility of orders made under the Inebriates Act. Most of the hospitals currently gazetted for Inebriate Orders do not have staff sufficiently trained to deal with intensified or compulsive drug use and neither are the police suitably trained to deal with these issues. There is also a perception that health services are unable, or unwilling, to assist an intoxicated person where that person is a possible danger to him or herself or others.

The NSW Health Drug Programs Bureau has a goal of developing a comprehensive and integrated network of services having the capacity to provide tailored treatment and rehabilitation programmes to the diverse groups assessed as compulsive and/or dependent substance users. The components of a service network should include: public, private and NGO sector community based services.

One misconception that has perpetuated is that treatment is *always* optimally delivered in a residential setting. This is not the case and has been strongly debated. A comprehensive overview of this issue is canvassed in The National Quality Assurance in the Treatment of Drug Dependence Project (National Drug Strategy Monographs No's: 19, 20, 21). The decision about the setting for treatment needs to take account of a number of important factors about the individual in question.

The Quality Assurance Project made the following recommendation:

"Most interventions for alcohol problems which are carried out on an inpatient/residential basis can be equally well delivered on a outpatient/non-residential basis. In some circumstances however, the availability of inpatient/residential treatment will be essential, especially for clients in need of closely supervised detoxification; those with severe alcohol-related brain damage who cannot function independently; those who show severe deterioration, malnourishment or social instability and who require shelter for humanitarian reasons; and possibly those who have repeatedly relapsed to drinking after intervention and whose home environment cannot support non-drinking."

Treatment needs to take account of the particular characteristics of the individual concerned. It is poor treatment to make decisions based on generalities or unsupported assumptions about individual need. There is a distinction between treatment for substance dependence and the welfare needs of those individuals. While a resolution of welfare needs might be necessary to achieve changes in drug use behaviour, they are not sufficient. In many cases the meeting of general welfare needs have been confused with treatment for the drug use behaviour. The consequence being that many individuals receive an intervention, which does not meet criteria that are both necessary and sufficient to deal with the range of presenting problems.

While the setting of treatment has a strong bearing on outcome, it is a distinct issue and is not sufficiently a determinant of the outcome of treatment.

However in stating this, and in consultation with key stakeholders from across the NGO sector, NCOSS is aware that the initial period of detoxification should take place within a medical setting, in order to address the health needs of the person as they go through detoxification. To this end it is believed that the appropriate initial treatment setting should be an Intoxicated Persons Service, attached to a Hospital, that can conduct the initial assessment of the person's condition, and provide medical interventions if needed and ongoing treatment if required. This service could also have the power to detain people for compulsory detoxification, however this is discussed later in this paper under Detoxification.

Recommendations:

12. Interventions should be evidence based clinical interventions followed by discharge planning, community living and accommodation support. As stated in the NSW Health – NSW Drug Treatment Services Plan, p8. "*Good practice involves cross-sectoral approaches, integrated service delivery and the use of comprehensive assessments and treatment plans.*" Formal links must be established between Aboriginal and Torres Strait Islander Services, Mental Health, child and family services etc. if interventions are to be effective.

13. That appropriate funding and resources and skilled staff are provided for the development of Intoxicated Persons Services with the provision to be able to detain and provide compulsory treatment of an intoxicated person, however further consultation needs to take place with the relevant professionals, consumers, NGOs and other groups to determine what the appropriate length of time is for this detention and to consider specific rural, remote and cultural issues.

4.5 Proclaimed Places

Under the Department of Community Services a network of proclaimed places were established to deal with acute intoxication where the individual is posing a risk of harm to themselves and/or others. However with the recent review of Proclaimed Places these services have changed from one where intoxicated persons could be detained to a safe place for voluntary admissions.
Staff at Proclaimed Places are not medically trained to deal with severe alcohol withdrawal and anecdotal information provided by staff reveals that those people who are intoxicated and delivered by the police can be very angry and aggressive, posing a threat to staff and those that have self-referred.

Other issues arise from the closure of some services resulting in increased demand for services that remain open. There has also been an expansion of programs being offered by Proclaimed Places including linkage to drug and alcohol services, case management and outreach, and providing assistance into community housing. Therefore providing a continuum of care to people who are voluntary and meeting their ongoing treatment and welfare needs.

Proclaimed Places still have a role to play for intoxicated persons and the unique nature of the service should continue to assist those people that are willing to seek assistance and support and to provide another option for intoxicated persons after the initial medical intervention of detoxification. Involvement should remain voluntary and this program should be offered as an option to people who are on compulsory detention for detoxification as a part of their treatment process.

Recommendation:

11. Proclaimed Places continue to be funded and that funding is increased to be able to offer a range of programs for those people who do not require compulsory detoxification and as an option for ongoing treatment after detention.

5. SUMMARY AND CONCLUSION.

In summary, NCOSS strongly supports the position to the Standing Committee on Social Issues that the Inebriates Act 1912 is repealed as:

- The Act offers little benefit to the community or to those individuals who are chronically substance dependent;
- The Act treats Intoxification 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 or practice.

Despite the problems with the Inebriates Act and the provisions of other legislation, there was clearly a view among those organisations consulted during the course of preparing this submission, that it is important to have some form of Court ordered intervention for those individuals deemed to be using alcohol and other drugs in a fashion that places themselves or others at risk of serious harm. This should be an act of last resort by the State whose role is in providing care and protection to a group of vulnerable individuals. The intervention would not be a punishment for offensive behaviour, or for a breach of societal norms. It would not represent an alternative to gaol, or worse, some form of "treatment Gaol".

The NSW Government's Social Justice Strategy is an important policy document, which should guide the development of objectives for such legislation. The concept of social justice for the NSW Government is built on several principles:

- **Equity** - there should be fairness in the distribution of resources, particularly for those most in need;

- **Rights** - greater equality of rights should be established and promoted and there should be improved accountability for decision makers;

- **Access** - all people should have fairer access to the economic resources, services and rights essential to improving their quality of life; and

- **Participation** - all people should have the fullest opportunity to genuinely participate in the community and be consulted on decisions, which affect their lives.

However, unless the Government is willing to provide adequate funding and resources and to consult more widely and thoroughly with the relevant stakeholders, the option of compulsory treatment based on the above principles cannot be introduced at this stage.

The development of alternative legislative approach to the Inebriates Act needs to take into consideration a number of important factors, including the findings of the Alcohol Summit. It needs to protect individual rights as far as possible; it needs to have clear criteria for its application; it needs to have clearly defined objects; it cannot force judicial officers into making medical decisions; it needs to complement other legislation; it needs to demonstrate that it has a purpose/ it should not merely remove individuals from the public gaze merely because they are unpleasant or upsetting family members.

In order to initiate interventions that fit with evidence based treatment interventions, definitive assessment criteria need to be developed that can be applied to evidence in an objective way, in order to determine the ability of an individual to manage their own affairs.

An appropriate legislative instrument needs to clearly identify which Departments and/or agencies will be responsible for managing these individuals and the human and financial resources required to do so effectively.

6. Organisations Consulted

Community Restorative Centre Inc.
LWCHC
Country Women's Association of NSW
Royal Australasian College of Physicians
NSW Users and Aids Association
NSW Association of Alcohol and other Drug Agencies
Haymarket Foundation
Mental Health Coordinating Council
ISJA
Justice Action
Aboriginal Health and Medical Research Council
The Salvation Army
Aids Council of NSW.

i. MacAvoy M G & Flaherty B, "Compulsory treatment of alcoholism: the case against". Drug and Alcohol Review 1990, 9, 267 - 271

ii. Shea P, Letter from Executive Director Gladesville Hospital, to Mental Health Act Monitoring Committee, 14 November 1990.

[iii] *(Holder et al 96; Glossop et al 98)"* In New Zealand's National Alcohol Strategy 2000 – 2003. p.39.