Illawarra Health
Better Services, Better Health

Area Executive

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

Dear Director

Re: Inquiry - Inebriates Act 1912

Thank you for the opportunity to make a submission to the Inquiry into the Inebriates Act 1912. A submission from Illawarra Health is attached. It has been prepared in consultation with our Drug and Alcohol Service experts. I look forward to hearing about the results of your Inquiry into this important issue.

Yours sincerely

Dr Liz Gale
Chief Executive Officer

Encl.

cc. Di Knight, Area Director, Drug Alcohol and HIV/AIDS Services

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Comments on the review of the Inebriates Act 1912

The original Act is legislation of its day. It does not take into account the social complexity of alcohol abuse or the medico-legal requirements of our day. Further, alcohol remains legally and easily assessable and socially acceptable. Intoxication is an accepted part of general culture and an increasing prominent aspect of youth culture. It therefore needs to be treated as 'enforced harm minimisation' rather than a criminal offence. Inebriation is a public health problem with the option of a legal/ non-criminal remedy.

To suggest some broad conceptual parameters and one overarching principle for ensuring the Act is relevant to 2003-2004.

The principles are:

1. Containment/crisis management/ prevention of harm to the inebriate/ andor others
2. .Medical stabilisation/detoxification
3. Assessment for appropriateness of long term rehabilitation/ and or nursing home care
4. Living skills training and vocational guidance.

The overarching principle must be that the Court and the Police, in conference with Drug and Alcohol specialists, can dictate and enforce bail conditions based on and around the above four stages and that the legislation leaves sufficient 'space' to tailor treatment protocols and care regimes to individual clients circumstances and needs based on case manager assessment and reassessment.

These principles operate on the assumption that while recovery is characterised by initial medical intervention and supervision it is a social rather than medical model involving motivation to change, and access to services.

Success of any revision of the Act is also based on the assumption that the best practice model involves a seamless transfer of the client between these stages:

1. Intervention/stabilisation
2. Detoxification
3. Rehabilitation and or care
4. Long-term living skills training

The issues of point 1: Containment/crisis management/ prevention of harm to the inebriate/ and or others, is potentially the most difficult to implement given the scarcity of resources - police, acute detoxification/medical beds/ Emergency

Department activity, and confusion about the use of special 'proclaimed places' (Homeless Shelters).

Recommendation that Medicated Detoxification Units be resourced to manage intoxicated clients who qualify under the Act as 1. At risk to themselves or others 2. Habitual inebriates 3. Social nuisances/ the socially isolated/ or the at risk, as bailed by the Court under the Act and that dedicated beds be set aside as such.

A further recommendation is that the idea of a non-medial setting 'proclaimed place' be abandoned as an unacceptable medico-legal risk.

Appropriate acute/stabilisation and assessment beds would need to have 'lock-up status' so that profoundly intoxicated, brain-damaged, and or un-cooperative clients could not abscond until they were contained and detoxed, assessed and referred according to the bail conditions under the terms of the Act.

A good outcome of the review of the Act is that the government recognise there is a need to allocate the appropriate resources and training.

The benefits in terms of reduced policing costs, Emergency Department assessments, hospital admissions, and reduced damage to person and property, would be substantial.