Northern Sydney **Health**
better health: from the Harbour to the Hawkesbury

Area Mental Health
Cameron Building, Macquarie Hospital
Wicks Road, North Ryde NSW 2113
PO Box 169 North Ryde NSW 1670
Telephone: (02) 9887 5589
Facsimile: (02) 9887 5678

18 November 2003

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

www.parliament.nsw.gov.au

Dear Sir/Madam,

Inquiry into the Inebriates Act

I attach below two commentaries on the Inebriates Act for the Inquiry's consideration. These views come from experienced clinicians, one working in a community and the other in a hospital setting.

Yours sincerely,

Dr Nick O'Connor
Director Area Mental Health

13.11.03

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

Dear Sir/Madam,

RE: INQUIRY INTO THE INEBRIATES ACT 1912

Thank you for your request for submissions in relation to the efficacy of compulsory treatment of people with severe alcohol and/or drug dependence.

I am a psychiatrist who has specialised in Adult General Psychiatry as well as Addiction Medicine. I work at Macquarie Hospital, a large psychiatric hospital which is one of the few institutions in New South Wales licensed to receive patients under the Inebriates Act 1912. I am therefore able to comment on the implications of this Act for both the individual patient and the institutions involved in their care. I also work in a private drug and alcohol clinic where I see clients with severe D & A problems. I have also worked in both Mental Health and Addiction Medicine in New Zealand, which has an existing act in place for the compulsory treatment of people with severe addiction problems. I am therefore able to comment on the implications of a much broader, compulsory act than we have currently in Australia.

Limitations of the Current Act

Individuals who are placed under the Inebriates Act by a Magistrate are automatically sent to a gazetted psychiatric hospital for treatment. The receiving institution has no control over this situation. This poses many problems:

- Magistrates do not consult with treating clinicians or hospital administrators before committing someone to a 3-12 month confinement in a psychiatric hospital. Already over-loaded units in psychiatric hospitals are placed in the position of trying to find a bed for a patient who is not able to be released for a long period of time from the Act.
- Patients are sent to large psychiatric hospitals under the Inebriates Act which do not have treatment programs specifically set up for such patients. The treatment programs are set up for the severely mentally ill who mainly have chronic schizophrenia. This means that Inebriates are being incarcerated for long periods of time in institutions which are not able to offer them the kind of comprehensive treatment programs they should have access to. Because the numbers of Inebriates are small (usually one or two patients at any one time), it is not possible to channel limited psychiatric resources into developing specialised programs for them. They cannot be sent elsewhere for programs because no other treatment services are able to accept them under the Inebriates Act.
- The treatment environment of a large psychiatric hospital does not meet the standards for best practice for someone who is detoxifying and in recovery from an addiction disorder. Ideally, those under the Act should be placed with other patients with addictive disorders in a low stimulation environment, not with patients who are psychotic and severely mentally unwell.
- Clinicians have no control over the Inebriates Act. The only way the Act can be revoked is by taking the matter before the Magistrate at the local court and having

him/her revoke the Order. This means that if there are problems with someone under the Inebriates Act, clinicians are unable to exercise any clinical judgement about the patient's placement or discharge from the hospital. For example, if someone under the Inebriates Act is clearly unable to respond to a treatment plan, and is threatening other mentally ill patients on the unit because of antisocial behaviour, it is not possible to discharge that patient from the hospital without going to the local court to ask for the Order to be revoked. There is also no guarantee the Magistrate will agree to revoke the Order if the patient continues to have problematic drug and alcohol use.

- Patients with severe mental illness who require containment and rehabilitation sometimes have to wait long periods to get a bed a psychiatric hospital. Some of these beds are not accessible for many months when someone is on the Inebriates Act.

The Alcoholism and Drug Addiction Act 1966 (New Zealand)

New Zealand has an Act which is independent to the Mental Health Act, called The Alcoholism and Drug Addiction Act. This enables the detainment and treatment of individuals with severe alcohol and drug problems. Generally, those placed under the Act would be individuals whose alcohol or drug problem is placing them at serious risk of harm to self or to others. Unlike Australia, a much wider range of institutions are able to take patients under this Act. Not only can they be placed in a hospital setting but some Drug and Alcohol Rehabilitation programs will accept them for treatment. In theory this means someone could have a detoxification in an acute setting and then be transferred (if accepted) to an appropriate rehabilitation program for treatment. Alternatively, patients can be transferred into the community where they can remain under the Act and have enforced treatment (similar to a Community Treatment Order in Australia). For example, a patient with Alcohol Dependence could be under a community treatment order with conditions which include taking Disulfiram (Antabuse) administered by the Drug and Alcohol Service on a daily basis.

Such an Act would not be workable in Australia at present due to the severe lack of resources in the Drug and Alcohol area.

Potential to Improve Inebriates Act 1912

Rather than introduce a new Act, my suggestion is that the current Act be revised in several key ways:

a. More control should be given to clinicians to admit and discharge patients under the Act, with a Tribunal (similar to the Mental Health Act Tribunal) being set up to oversee the placement of individuals under the Act. This would remove the onus of decisions being placed solely on the Magistrate without any consultation with gazetted hospitals.
b. That the number of institutions able to accept patients under the Act be expanded to include appropriate rehabilitation centres and detoxification units.
c. That the Act expand to include a community-based treatment order which enables compulsory treatment as an outpatient. In order to do this, existing Drug and Alcohol Services would need to be expanded.

Thank you very much for your consideration of these matters.

Yours faithfully,

Dr Glenys Dore,
Consultant Psychiatrist.

Drug and Alcohol Specialist.

Ryde Community Mental Health Service
39-41 Fourth Avenue
Eastwood
NSW 2122

Ph: 02 9858 7889
Fax: 02 98587866

Comment

To: The Director, Standing Committee on Social Issues
Parliament House
Macquarie Street
Sydney 2000

From: Andrea Taylor
Deputy Director
Ryde Community Mental Health Service

Date: November 5, 2003

Subject: Inebriates Act 1912

Context
This Act has been utilised by the writer of this comment on a number of occasions in the following roles: drug and alcohol worker, proclaimed place/refuge worker and within my current role in mental health over an approximate 20 year period.

Comment on the Act

1. The process of placing a person under the Inebriates Act is often cumbersome and avoided. It can be protracted whilst identified individuals under the Act complete reports and or statements in relation to the persons behaviour, and await a magistrates hearing.
2. Whilst Point 1 is being attended to the person with whom the Inebriate Act is being applied for has the opportunity to continue to wreck havoc with family, neighbours, employers etc and potentially end up in the criminal justice system.
3. When the issue comes before a Magistrate the person in question is often unable to be found and thus the hearing continues in their absence.
4. It then becomes the responsibility of Police to enact the order when they can find the person in question.

Post an Inebriate Order being Granted Issues

1. There is a lack of appropriate facilities for people to be placed within. Previously a number of units at Rozelle Hospital and other like hospitals would accommodate them but this is no longer the case. These units were established to provide specialist care to people with long term alcohol related brain damage.
2. Currently persons who are placed under the Inebriates Act are located in Mental Health locked inpatient beds which further exacerbates the pressure on these beds.
3. People placed under these orders should have the right to receive specialist care and rehabilitation in relationship to their abuse/misuse of substances to establish a

foundation for possible change of behaviour once discharged from the order. Unfortunately the provision of this type of care in a mental health facility is not available as often there is only one person on an order at any one time competing for resources with people with a mental illness. Therefore the facility is acting as a temporary containment unit and is not therapeutic.

4. Approximately 13 years ago it was not unusual for an order to be granted for six to twelve months. A time when a difference could be foreseeable. My experience of the current orders is now around one month. Not a long time to attempt to undo what is often a life time of learning.
5. Follow up of individuals post discharge is variable and does not appear to have consistency.

Recommendations

1. Consideration be given to:
    a. Redeveloping the process of application for ease of use. The Mental Health Act 1990 could be considered to give some grounding as a template
    b. The development of treatment models for persons placed under the Inebriates Act
    c. Persons requiring locked inpatient care to have specialist facility with trained staff
    d. The implementation of comprehensive discharge planning processes and integration with their local relevant service.