PO Box 533
Wentworthville NSW 2145
Australia
Phone (02) 9845 7000
Fax (02) 9689 2041

Western Sydney HEALTH
Area Health Service

Our Ref: Trim 03/1337

18 November, 2003

Ms Jan Burnswoods MLC
Chair
Standing Committee on Social Issues
Parliament House
Macquarie Street
SYDNEY NSW 2000

Dear Ms Burnswoods,

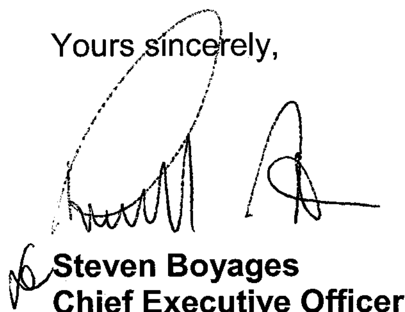
RE: INQUIRY INTO THE INEBRIATES ACT 1912

I refer to your letter dated 30 September, 2003 concerning the Inquiry into the Inebriates Act 1912. Thank you for the opportunity to comment on the Act and the inquiry terms of reference.

Please find attached a submission prepared by the Western Sydney Area Mental Health Service on behalf of our Area Health Service. I understand that Dr. Jon Currie, Director, Western Sydney Drug & Alcohol Service has also provided a submission to your office.

Please accept my apologies for the delay in providing our submission and thank you once again for the opportunity to comment.

Yours sincerely,



Steven Boyages
Chief Executive Officer

INQUIRY INTO THE INEBRIATES ACT 1912

The NSW Inebriates Act (1912) appears to have as its guiding principle the benevolent paternalistic protection of certain members of society from themselves. It is best known for its provision which allows a Magistrate to commit an "inebriate" into a "licenced" state institution for up to twelve months. Other provisions which include committing the person to a public or private hospital, to the house of a friend, or to enter into a recognizance to abstain, are rarely used.

Possible reasons to use an Inebriates Act

1. Containment

It is well known that mental health beds in NSW, especially those which are capable of providing "containment", are in extremely short supply with great pressure for admission of acutely mentally ill persons so that they may be treated, relieving their acute mental distress as well as reducing their risk of harming themselves or others. Length of stay in such "closed" beds, being at a premium, is kept at a minimum, usually a few days. The Inebriates Act presupposes the existence of places which are expressly for the containment of inebriates but such places have never existed in the Act's ninety year lifetime. In the past there was enough capacity in mental institutions, which were largely "closed", for them to provide the limited number of places sought for inebriates, but this is no longer the case and our own institution (Cumberland) is "open" except for a small number of intensive psychiatric care beds, and is frequently full. A single Inebriates Act referral occupying a "containment" bed for, say, three months, would prevent perhaps twenty-five acutely ill psychiatric patients from receiving life-saving treatment in that setting during that period. Importantly, there is little or no evidence to show that simple containment of inebriates for such periods has any outcome on addictive behaviour following discharge.

2. Treatment

It is possible that some benefit could accrue from the delivery of an appropriate treatment programme under coercion. Furthermore such measures are not unacceptable to the public or even "inebriates" themselves. In running a long-term inpatient treatment programme for alcoholics (many of whom had alcohol-related brain damage) at Rozelle Hospital some ten years ago, I had the experience of receiving letters from patients expressing gratitude for their commitment under the Inebriates Act, and also observed the phenomenon of persons seeking commitment of themselves under the Act.

However treatment programmes for primary substance use disorders, such as would be appropriate for "inebriates", are not available in mental institutions. Residential alcohol rehabilitation programmes are available elsewhere, mainly set up by non-government and church organizations, but would rarely if ever be delivered in a coercive mode. It

may be useful if coercive alcohol treatment programmes were available, but I am not aware of any now in NSW. In the future it may be that proposals for coercive treatment programmes for addiction could be successfully argued. Of course if treatment is the aim of Inebriates Act committment there is a fundamental incongruity wherein a court of law is in the business of prescribing medical treatment, i.e. admission to a facility. By comparison, the Mental Health (Criminal Procedures) Act in Sect 33 provides for a person to be taken to a facility *for assessment*, and admission only on the basis of such assessment.

What may be possible and reasonable within the terms of the present Inebriates Act would be commitment of an inebriate for assessment in a general hospital drug and alcohol facility, providing the opportunity for acute medical/detox management if required, and some motivational interviewing and introduction of options for the inebriate. Hospital Drug and Alcohol services would have a position on this which would need to be considered.

Current operation of the Inebriates Act

Magistrates have committed inebriates to mental hospitals without concern for the capacity of those hospitals to take them. I have had a magistrate express surprise to me that a mental hospital could be full. The same magistrate made the comparison that if they sent someone to gaol they would have to take them. The impression is that Magistrates assume no responsibility for the availability of accommodation in the places to which persons are ordered. However hospitals certainly can be full in which case they can take no more admissions. The hospital is then in the anomalous position of being required to fulfil an impossible order from a court.

Normally referral to a hospital follows a telephone call to the person responsible for admissions and bed management to ensure the availability of a bed. Sometimes mentally ill persons are brought directly to mental hospitals by police for assessment under the Mental Health Act; if admission is deemed necessary and no bed is available, there ensues a time consuming and often frustrating search by the duty staff for a bed at another hospital. This happens daily and nightly at mental hospitals around the state. Thus if courts are to be in the business of prescribing admission, leaving aside the question of the appropriateness of this, they need in our view to put themselves into this referral system somehow, which will mean allocation of resources to find an available place for their inebriate. It seems unreasonable for a court to make an Order without obtaining some assurance that it could actually be carried out.

Another issue is the inherent lack of time flexibility in the Court system, which differs from Health which operates 24 hours a day 7 days a week. This hinders communications with the courts and any sort of planning. This we would see as another reason why the Court is not well set up to prescribe and arrange medical treatment.

Conclusion and recommendations

The Act is well and truly out of date and its use in 2003 grates abominably against the mental health system, creating impossible situations which lead to frustrations for relatives, patients, and public health employees. There is a lack of facilities, programmes and procedures to support the Act. The concept of locking inebriates away needs to be replaced with the notion of treatment provision.

As long ago as October 1988 a national workshop on the compulsory treatment of alcoholism was held in Queanbeyan, NSW. This led to a series of recommendations. There was consensus that an option of compulsory treatment should be retained, mainly for alcohol problems (not other drugs). Harm minimization and constructive intervention were stressed. It was recommended that such an option be reserved for severe cases, be minimally restrictive, and entail formal legal review. It should be coupled with a treatment programme, and evaluative review systems be set up.

Fifteen years later the recommendations are still apt. There needs to be some avenue for concerned relatives, friends and carers to obtain help for a person who is drinking chronically, dangerously, and potentially terminally. There is in our view a place for coercion, although society's views must prevail here. If there is coercion there must be reasonable assurance that what is done is helpful. In particular there must be treatment programmes based as far as possible on evidence, and properly funded and resourced. Most importantly any intervention involving health facilities and resources must have its entry criteria and intake system controlled by those health facilities, so that they may manage their programmes effectively and safely. Courts should not prescribe treatment or hospital admission.

Peter Tucker
M.B.,B.S., B.Sc.(Med), F.R.A.N.Z.C.P., F.A.Ch.A.M.
Medical Superintendent, Cumberland Hospital
Director, Clinical Services (East), WSAMHS