SUBMISSION TO THE LEGISLATIVE COUNCIL

INQUIRY INTO THE

INEBRIATES ACT 1912

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EXECUTIVE SUMMARY

The Alcohol Summit in September 2003 has raised questions again concerning the efficacy and value of the Inebriates Act 1912. Several lively and heated discussions ensued among highly experienced and qualified professionals from the Alcohol & Drug Information Service (ADIS) and Gorman House Detoxification Unit. Initially all discussions highlighted the division within each individual as to whether the Inebriates Act is a valid form of treatment within the Alcohol & Other Drug field. Pros and cons could be seen for both engaging the Inebriates Act as a valid component of treatment, and for it remaining the minimal influence that it currently is. Further debate brought to light a majority body of thought that the Inebriates Act should remain as a difficult-to-access last resort for predominantly marginalised street people.

The general opinions below reflect the attitudes of the workers of the Alcohol & Drug Information Service and Gorman House. Specific opinions are those of the author.

INTRODUCTION

The Inebriates Act 1912 is an ongoing controversial topic. Having worked as an Alcohol & Other Drug professional in different organisations, which have embraced both harm minimisation and abstinence philosophies, the Act continues to be contemplated as to whether or not it is a viable form of treatment. When working in a Proclaimed Place which arguably houses drug and alcohol dependent people in the most dire of need, it was often discussed as a last resort for people who are unemployed, homeless, socially isolated, drug or alcohol dependent, and often suffering from mental illness, alcohol related brain injury, and/or other health problems. When working in a clinic that was primarily abstinence focused, discussions ensued as to whether the Inebriates Act could be used to stop the 'revolving door' phenomena of detoxification units. Now working in a call centre, it becomes apparent that members of the general public are looking at the Inebriates Act, as a desperate last measure to try and help loved ones with alcohol and drug issues.

When considering the validity of the Inebriates Act 1912, we need to assess its impact on the individual, the individual's family and society at large. The Act is contentious enough that it is inevitable it will influence our current political, legal, economic and social standings. Reflection must be given to the reasons behind the Act currently being seen as an outdated piece of legislation. Due thought should given to the implications of reinstating the Act as a legitimate and easily accessible form of treatment. The impact of the Act, whether it remains unchanged, is amended, or abolished, should be considered in terms of how each alternative will affect issues such as crime rates, limited resources, civil liberties, law, social responsibility and treatment outcomes.

The topics below highlight the discussions between staff of the Alcohol & Drug Information Service and Gorman House Detoxification Unit concerning the Inebriates Act 1912.

DISCUSSION TOPICS

a. Determining the definition of an Inebriate

The current definition is "Inebriate means a person who habitually uses intoxicating liquor or intoxicating or narcotic drugs to excess". The definition is ambiguous and in today's terms, nonsensical. Strict guidelines would need to be developed to define the terms "habitual" and "to excess".

b. Difficulty in invoking the Act

Currently it is a long and extravagant process to place a person under the Inebriates Act, and ultimately, magistrates involved will take the Inebriate's wishes into consideration. It is a contentious issue as to whether an Inebriate can truly give consent if under the influence of alcohol or other drugs.

c. Drug related crimes and consequences

There is no simple answer to drug related crimes. It is a multi faceted problem that has legal, political, social and economic outcomes whatever decisions are made. Legalisation of all drugs is always a hot topic when discussing drug related crimes. Perhaps the most pertinent question to ask though, is why are laws still aimed at users rather than importers and dealers?

d. Validity of committal if Inebriate is not ready to address the problem

Our national policy of harm minimisation is based on the idea that there is a continuum scale between substance abuse and total abstinence. There is little research to support the idea enforced treatment will have any therapeutic effect.

e. Voluntary versus involuntary committal

There does seem to be a lack of services where people can commit themselves for a period of time. There are a number of individuals who feel unable to make the commitment required to reach their own goals. If a person feels they are unable to help themselves, and if being detained (eg, maximum

security treatment centre) will help, then why is there not such a facility available? This differs from involuntary committal, because the Inebriate would initiate admission to such a facility, rather than a third party.

f. Consequences of absconding once committed or second offence

Currently, if a person committed under the Inebriates Act absconds from the facility to which they have been court ordered, a range of consequences can occur from it being ignored, discharging the person, or the police are able to arrest that person and return them to the facility. Further time at the facility may be imposed. Upon discharge from an institution where someone has been convicted of an alcohol or drug related offence within 12 months, the person may be committed again for up to three years. These consequences are harsh and outdated considering our current national policy of harm minimisation rather than enforced abstinence.

g. Legal status / entity of a rehabilitation

If rehabilitations were to regularly accommodate people committed under the Act, what are the legal requirements of that facility?

h. Treatment while committed under the Act

While a person may be committed to staying at an institution for a period of time, it is likely to be of little, if any, use if they do not undertake treatment. The following questions arise.

1. What kind of treatment would be most beneficial for people committed under the Inebriates Act?
2. How can you force a person to actively participate in treatment?

i. What will happen once a person is discharged?

There is a distinct lack of services for people being discharged from rehabilitation. This is a crucial time for people as they have often been in treatment for a long time with constant support, activities and interventions to keep them on track of their goals of abstinence. Once discharged, not only do they not

have the emotional and structural support, but also they often have to make huge lifestyle changes in order to separate from their previous way of living. These changes can leave people feeling isolated, lonely, bored and frustrated. It is a time when relapse is very common.

j. Processing issues

Currently there are issues with all processes committing someone under the Inebriates Act 1912. These range from the logistics of gathering information and getting the Inebriate to court; to reluctance from magistrates in hearing and ruling on these cases, lack of appropriate beds, keeping the Inebriate from absconding, treatment effectiveness, and post treatment support.

k. Bed availability

There is a shortage of treatment beds available in all areas. When someone is committed to a treatment facility against their will for a period of time, it has to be questioned as to whether that bed would be better kept for someone who is really wanting to address their substance use problems.

l. Behaviour modification

It is a contentious issue as to whether behaviour can be modified if a person is involuntarily committed to a treatment facility. With the exception of aversion therapy, which requires a negative consequence for an action, it is unlikely that behaviour can be modified within this context, if human will is not engaged.

m. Alcohol Related Brain Injury

In chronic alcohol users, the issue of alcohol related brain injury (ARBI) arises, questioning whether behaviour modification is in fact possible. ARBI can result in learning difficulties, which could make it almost impossible for an Inebriate to learn new ways of living. In addition, there are very few services available that can adequately deal with ARBI issues.

n. Civil liberties

The strongest argument that rose against the Inebriates Act was about civil liberties. The purpose of the Act states it is "An Act to consolidate the Acts providing for the care, control, and treatment of inebriates, and for purposes incidental to the abovementioned objects." An Inebriate may well argue that they are able to care for, control and treat themselves. There is no defining measure as to whether an Inebriate is or is not doing the aforementioned. An Inebriate may well ask that if he or she is not hurting anyone but his or her self, why should it be up to someone else to dictate their value system?

o. Self responsibility

Leading on from civil liberties is the issue of taking responsibility for oneself. Forcing someone into treatment may result as an act of kindness for one person, but disempowering for the next. As a society, it makes better social and economic sense to be promoting a culture of self-responsibility rather than one of reliance on authority and government.

p. Social responsibility

There is certainly a social responsibility on how best to assist people with long-term alcohol and other drug problems. My standing is that resources could be better used, by improving preventative measures and treatment outcomes for people seeking assistance.

q. Drink driving offences

This one was particularly difficult to debate. Many workers can see the sense in committing Inebriates who continue to drink and drive. There are so many messages out there now of the reasons why people should not drink and drive. The issue here is that not everyone who drinks and drives has an ongoing problem with alcohol. Improvements could include on-the-spot tests for other drugs, as well as a range of penalties for driving under the influence of substances, rather than just fines and loss of license.

r. Possibility of hidden agendas of persons trying to commit another

A very real concern that was raised was people who may misuse the Inebriates Act to schedule people for their own reasons e.g. financial gain.

PAST EXPERIENCE IN SCHEDULING PEOPLE UNDER THE ACT

On a personal note, I have had direct experience in scheduling people in my capacity as a welfare worker for Albion Street Lodge (ASL) in the mid 1990's. I was instrumental in placing two people under the Inebriates Act and a further one under the Guardianship Act. In all three cases, they were voluntary committals. I will outline the cases briefly to demonstrate some of the pertinent issues.

Case 1: XX was a long-term alcohol and drug user in his late thirties. He had been using since he was ten years old and had over 1000 admissions at ASL. He was an intelligent man with mild brain damage. He felt frustrated with his current lifestyle and saw the Inebriates Act as a last option. He asked me to facilitate it for him. It took several weeks to get together medical certifications from doctors and a police sergeant. During this time, I rang all known treatment services to ask about availability of beds for persons under the Inebriates Act. All services stated they were not able to accommodate this. Once we had the papers together, it was a case of finding a morning when XX was at ASL and not too intoxicated to face the judge. We went to court and were seen by a magistrate. Upon hearing our request, the magistrate was reluctant to say the least. He had not had dealings with this before. The first question he was XX was whether this was a voluntary action on his part. XX stated yes. The magistrate passed the order for 3 months and ordered XX to be committed to AA hospital. This was one of the treatment services that had initially said they would not be able to take XX. I took XX to the hospital, and announced to staff that XX had been court ordered to them and they had to find him a place. They had no beds in their detoxification unit and he was placed in the long-term psychiatric unit for three weeks. XX then moved to the rehabilitation unit and the rest of his stay was relatively uneventful. Upon discharge after three months, XX was taken to his newly acquired flat

that had been set up with food, furniture etc. Within 24 hours, XX was intoxicated and knocking on ASL's door.

Case 2: YY was watching with interest as XX had been going through this process and had decided he too wanted to be committed under the Inebriates Act. A man in his early forties, he was more a seasonal user of ASL rather than a regular one. He used alcohol rarely, but was a regular heroin user. With YY, we went through the same actions as XX, but he was court ordered to a different facility. YY absconded after about 1 month and remained in hiding for several months after that, fearful he was going to be arrested and taken back to the facility.

Case 3: ZZ was a man in his late 60's who had become so incapacitated through his alcohol use he needed assistance to walk, even with the use of his cane. It got to the point where he was unable to walk in or out of ASL unassisted. He approached me and asked if he could go under the Inebriates Act. After looking into it, it became more an issue for the Guardianship Act. They were hesitant though to commit him because he was only in his 60's. After assessments and doctor's recommendations, he was placed at a facility, which allowed people to have an occasional drink (the only one in the state at the time). The facility was high security so he was unable to wander off. It was supposed to be a permanent arrangement. After a few months, ZZ regained much of his health and was able to start walking unassisted again. At this point he decided he wanted to leave and took action that allowed him to do so. He too, returned to the streets.

These men were, by all counts, people who perhaps should have benefited most from being forced to stay in a treatment facility. But despite mandatory confinement, treatment and constant support, at best, it could be seen as their bodies had a rest from substance use and a chance to recover somewhat.

RECOMMENDATIONS

These recommendations are made in the spirit of putting forward some of the opinions of people working at the coalface of the Alcohol & Other Drug field. These people who are committed and dedicated professionals, deal with these difficult issues on a daily basis, but their voices are rarely heard.

1. If a person is arrested and consequently charged with an alcohol or drug related crime, compulsory assessment could be part of any sentence the magistrate hands down, as assessment is often an intervention in itself.

2. Treatment could remain an alternative to going to prison for non-violent drug related crimes, with an understanding that if treatment is not completed, then the consequence of that will be to complete their sentence in gaol.

3. For non-offenders, assessment and treatment should not be compulsory.

4. Drink or drug related driving offences – harsher laws eg mandatory education courses AND loss of license on first offence. A range of other penalties implemented.

5. The Inebriates Act 1912 remains as it is currently – a difficult-to-enforce piece of legislation for people who voluntarily want to be confined for their own safety, treatment and rehabilitation.

6. Increased preventative measures e.g. education, early family interventions, creating a society more conducive to solid family relationships.

7. Funding for halfway houses between detoxification and rehabilitation. The waiting gap between these two facilities is often when relapse occurs.

8. Longer term treatment.

9. Longer term counselling. Recognition at public health levels of other forms of therapy other than CBT.

10. One of the problems people repeatedly report is that while they are in a rehabilitation facility in the country, it is much easier to abstain from drugs until they return to their communities. Isolation and loneliness are often triggers for relapse. It would make sense to consider rehabilitations in central locations e.g. Kings Cross, where people are taught how to live within their own communities without drug use.

11. If the Act was to be enforced on a somewhat regular basis, it was suggested that victim impact statements form an essential component of the committal process.

12. Whatever outcome for the Inebriates Act eventuates, it should remain as part of a multifaceted approach to Alcohol & Other Drug treatment, and not become a tool to be used indiscriminately without due thought and process. Alternatives should always be considered in conjunction with the Inebriate. Consideration also needs to be given to treatment for family and friends affected by the use of a loved one, as this may well be where the real problem lies in many cases.

CONCLUSION

My stance is that the Inebriates Act 1912 has certain merit in being a last resort for long-term substance users that could be deployed at their request. For any other purpose, it would need definitive parameters to outline its use in an appropriate and functional way. I believe that should the Act be reinstated, it needs thorough examination as to why it is not currently used widely as an enforced form of treatment for people with alcohol and other drug problems. Benefits to involuntary treatment need to be weighed carefully against the consequences of removing people's civil liberties. Certainly, stringent monitoring and ongoing assessment should be implemented of both Inebriates in treatment and societal response.

The Inebriates Act potentially has a place in the treatment of chronic problematic alcohol and other drug use, however not at the expense of preventative measures or other forms of treatment that have been proven to be more effective.