NETWORK OF ALCOHOL AND OTHER DRUGS AGENCIES
funded by NSW Health

13th November 2003

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

Dear Sir/Madam,

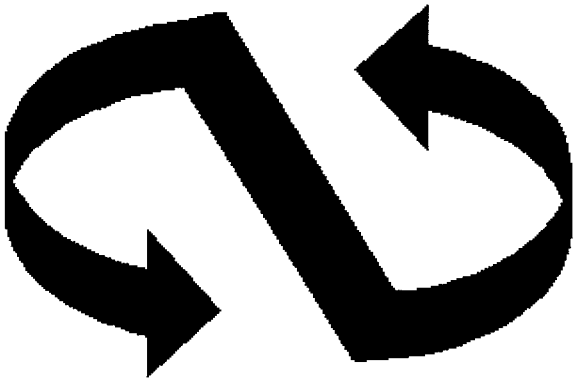
Please find attached a copy of the Network of Alcohol and other Drugs Agencies' submission to the Inquiry into the Inebriates Act 1912.

Should you have any queries please feel free to contact me on the number below.

Yours sincerely

Larry Pierce
Executive Director

295 Cleveland St Surry Hills NSW 2010 | PO Box 2345, Strawberry Hills 2012
tel. (02) 9698 8669 | fax. (02) 9690 0727
email. admin@nada.org.au | web. www.nada.org.au



NETWORK OF ALCOHOL AND DRUG AGENCIES Inc.

Submission to the NSW Legislative Council, Standing Committee on Social Issues

ON THE INQUIRY INTO THE INEBRIATES ACT 1912.

November 2003

1. INTRODUCTION

This is a NADA position paper on the NSW Legislative Council, Standing Committee on Social Issues Inquiry into the NSW Inebriates Act 1912 (the Act). It has been developed in consultation with The Chief Executive Officer of the Haymarket Foundation and NCOSS.

1.1 THE INEBRIATES ACT 1912

The purpose of this legislation is to provide for the care, control and treatment of inebriates. An inebriate is defined under the Act as a person who habitually uses intoxicating liquor or intoxicating or narcotic drugs to excess.

Section 3 of the Act allows the Court to make certain orders in relation to inebriates. An order may be sought by an inebriate or a person authorised by that inebriate while sober; a first degree relative; or a partner in business of an inebriate. An order may also be sought by a police officer, of the rank of sergeant or above, at the request of an attending medical practitioner, relative or justice. If the Court is satisfied that the person in respect of whom the application is made is an inebriate, it may order that the inebriate:

(i) enter into a recognisance (which may be forfeited) to abstain for a specified period of twelve months or more;

(ii) be placed under the care and control of a named person, at a specified address (house, hospital or institution) for up to twenty-eight days;

(iii) be placed in a licensed institution or a State institution (Schedule V Hospital) for up to twelve months;

(iv) be placed under the care and charge of an attendant(s), or of a guardian for up to twelve months.

A breach of a condition of recognisance entered into by an inebriate under the Act may render the inebriate liable to an order to be placed in a State institution for the remainder of the recognisance.

The Court must personally examine the inebriate and view a certificate from an uninvolved medical practitioner that the person is an inebriate. Persons can be remanded for up to seven days for medical examination and those who escape from remand may be arrested and returned.

Orders made under the Act can be extended up to twelve months on the order of a Supreme Court or District Court Judge.

In addition, under section 11 of the Act a Court may, commit a person to a State Institution (under the Comptroller-General of Prisons) for treatment where the person is convicted of an offence of which drunkenness is an ingredient or an offence involving assaulting women, cruelty to children, attempted suicide or wilful damage to property and it appears that drunkenness was a contributing cause of such an offence.

1.2 BACKGROUND

The major problem with Inebriates Act is the fact that there has been no substantial amendment made to the 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. This fact was highlighted most poignantly during the recent NSW Alcohol Summit.

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."[(1)]

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 hard-core drug addicts 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 Shaftesbury Institute.(2)

NADA argues that It is clear from an analysis of the governmental and departmental records that the identification of Psychiatric hospitals as the appropriate sites to detain "inebriates" was not based on any claim that these institutions offered superior treatment or other evidence based grounds, but merely by default.

A 1997 NSW Health Discussion on the Inebriates Act paper pointed out that 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 above report further states that 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 four decades 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 developed, but it was never progressed.
In the mid-1970's the NSW Health Commission was again considering the issue. 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.

The 1997 NSW Health Discussion Paper notes that 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 to thoroughly investigate the continuing need for the retention of the Inebriates Act and of identifying alternative measures were it to be decided that the Inebriates Act should 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 and 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.

The 1997 Discussion Paper further notes that in 1992, the Director Drug and Alcohol Directorate,

NSW Health Department established an ad hoc review Committee to review the Act, due to recent changes in the treatment of mental health, alcohol and other drug problems. However the discussion paper from this Committee was never released.

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

1.3 USE OF THE ACT

The only really sure thing that can be said about the effect of the Act is that those individuals placed under Inebriate Orders are guaranteed medical attention, food and shelter. This is provided by the specialist medical and nursing staff of psychiatric hospitals in New South Wales. It is also provided by staff of Proclaimed Places throughout the state. There can be no guarantee that treatment for substance dependence will be provided or that assessment for alcohol related brain damage will be made. These interventions are not always within the range of skills possessed by staff in psychiatric hospitals and clearly not in the skills capacity of the staff of Proclaimed Places.

The Act itself has numerous provisions for the care and control of "inebriates", other than detention in a psychiatric hospital. It seems to be the case that these other provisions are never or rarely used. The provisions for recognisance, the seven day custody for more careful medical examination, the appointment of a guardian, and those provisions relating to "inebriates" convicted of certain offences, seem to be overlooked in the determination of care and control when the Act is invoked.

Section 13 details the provision of institutions under the control of the Comptroller-General of Prisons (now the Commissioner for Corrective Services), where "inebriates" convicted of certain offences can receive treatment. There are no such institutions provided. The system of visiting Magistrates does not cover "inebriates", nor does the Official Visitors Program have jurisdiction over "inebriates".

If the aim of the intervention is merely to provide detention outside of a prison, then the use of the Act can be said to be appropriate. NADA believes that it is inappropriate to expect an overburdened mental health system to provide specialist medical and nursing staff to operate a supported accommodation program.

1.4 INFLEXIBILITY OF ORDERS

The inflexibility of current orders raises a number of significant problems for clinicians and service providers. 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. Psychiatric hospitals and Proclaimed Places are not equipped to act as acute care units and individuals in need of such care should be moved to an appropriate facility. The current inflexibility of orders 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 and service providers 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.

1.5 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.

2. REPEAL OF THE ACT

In light of the above background information NADA calls for the repeal of the Inebriates Act 1912.

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

RECOMMENDATION:

That the Inebriates Act 1912 is repealed and replaced with the Intoxicated Persons Act, which has been amended along the lines of the recommendations from the Alcohol Summit 2003, and the Summit Communiqué document.

2.1 AMENDMENTS TO THE INTOXICATED PERSONS ACT 1979

Determination of Intoxication

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 not particularly useful in being able to apply this legislation.

The Alcohol Summit Communiqué document section 8.1 and 8.2 clearly calls for Intoxication to be defined. In section 8.1 it states "*Intoxication by alcohol or other drugs should be defined in relevant legislation in order that the levels of Intoxication 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 Intoxication, which should not confuse Intoxication with disability or brain injury or other medical conditions such as diabetes, asthma, and which should address industry concerns about allegations of discrimination".*

RECOMMENDATION

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

2.3 ASSESSMENT

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, as hospital closure and contracting of available beds resulted in the remaining hospitals experiencing greater demand.

The important issue is that there are no specific or defined sets of 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 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 something that can be applied to the assessment and treatment of people who are intoxicated.

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

In 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".

2.4 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 NADA by member agencies that were formerly Proclaimed Places confirms that intoxicated people escorted to the proclaimed place by police usually refuse to enter or leave once the police have departed.

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

NADA 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 within the health system and away from criminal justice system.

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.

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."*

Discussions with relevant organisations show that there is support for detention of intoxicated persons in some cases. This is discussed later in this document under treatment. However in relation to the Intoxicated Person's Act it is agreed that there should be some provision for the detention of a person under compulsory treatment, within a purpose designed specialist health service.

RECOMMENDATIONS

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

2. 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.

3. There is provision made within the Intoxicated Persons Act for the detention and compulsory treatment of an intoxicated person within an Intoxicated Persons Service, 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.

2.5 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:

That the relevant changes are made to the Intoxicated Person's Act so that a new section detailing the role of Official Visitors within intoxicated persons services is included, as a way of safe guarding intoxicated persons and ensuring that services are providing an effective and quality service.

3. THE ALCOHOL AND OTHER DRUGS SERVICES IN NEW SOUTH WALES

In NSW the specialist AOD treatment sector is primarily administered through the NSW Health System. NSW Health is the lead government agency for the states drug and alcohol service system and 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 state-wide treatment services system.

NSW Health has divided the State into 17 Area Health Services, 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 information on state-wide 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. Alcohol and Drug NGO's funding is comes primarily through NSW Health's NGO Grants Administration Program, and these are the historical core funding grants. These grant funds are then provided to the Area Health Serves who 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.

NSW is by far the biggest state in regards to the number of services with more than 100 non government and approximately 120 government treatment 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 funded through NSW Health's NGO grants program centrally. NADA has a detailed triennial funding and performance agreement with the Drug Programs Bureau in relation to state-wide policy and planning priorities for NGO's and assists the Area Health Services to support their hosted 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.

The Drug Treatment Services Plan also describes current programs and initiatives which will contribute to the achievement of the desired 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.

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.

This raises an important issue 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.

The issue of appropriate treatment 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.

3.1 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.*"

Currently it is acknowledged in the specialist alcohol and drug and mental health fields 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

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.

3.2 INTOXICATED PERSONS SERVICES

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 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.

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, NADA proposes that the initial period of treatment 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 should also have the power to detain people for compulsory treatment, however this is discussed later in this paper under Detoxification.

RECOMMENDATIONS

1. 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.

2. 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.

3.3 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. NADA contends 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 NADA raises 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. NADA 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 are the 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 NADA 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 NADA during its 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

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.

3.4 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 those 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

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 treatment and as an option for ongoing treatment after detention.

4. SUMMARY AND CONCLUSION.

In summary, NADA strongly puts the position to the Standing Committee on Social Issues that the Inebriates Act 1912 be repealed. This is because:

- The Act offers little benefit to the community or to those individuals who are chronically substance dependent;
- 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. Advice to date suggests that amendments or new regulations to improve the clinical management are ultra vires;

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.

NADA argues that this is not necessarily treatment.

It would be an act of last resort by the State 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 jail, or worse, some form of "treatment Jail".

The development of alternative legislative approach to the Inebriates Act needs to take into consideration a number of important factors. 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 criteria are needed 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.

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.

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.

REFERENCES

1 &2 MacAvoy M G & Flaherty B, "Cumpulsory Treatment of Alcoholisim: the case against". Drug and Alcohol Review 1990, 9, 267-271.