History of the role of mental health services in Western Australia of managing problematic users of alcohol (draft)

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1 Keywords

Alcohol; Mental health; Treatment; Western Australia;

2 Background

This paper presents findings from an exploratory study of the history how the mental health system in Western Australia (WA) has managed problematic users of alcohol and the evolution of its role over the period from 1900 up to the present day.

The objective of the paper is to consider the legislation that established the framework for the mental health system to manage so-called 'inebriates,'[1] supported by an analysis of a range of information over the period extracted from departmental reports and other archival records, complemented by time series data compiled from admissions to hospitals and treatment services, to identify how inebriates have been managed in this State.

The exploratory nature of this research will consider the feasibility of the use of a range of legislative texts, historical materials, official records and statistical data to map the evolution of the role performed by the mental health system in managing problematic users of alcohol at different times over the period. The purpose of the research is to determine whether this body of information will support further research, including whether the detention and treatment of inebriates was a form of moral regulation that assuaged community concerns about the systems of control to regulate the use of alcohol. [2]

This proposition that regulation is necessary rests on a conflicted understanding about alcohol there is a limited 'freedom' to drink, which operates through a regulatory framework of liquor licensing and other legislation, as without controls alcohol represents a risk to social order and community well-being. A system of regulation is therefore inevitable, as it is a 'manifestation of an anxiety of freedom that haunts modern liberal forms of rule.'[3]

A clearer understanding of how controls operated will assist to identify changes in attitudes and beliefs about manifestations of problematic use of alcohol. This case study of the history of evolution of the mental health system in managing problematic users of alcohol involves an exploration of the concept of self-governance in relation to those unable to exercise their freedom to drink without harm to themselves or others.

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[1] The meaning of an 'inebriate' is defined as explicated in the legislative framework section.
[2] The term 'mental health services' is used in this paper as an overarching term of convenience to describe the history of psychiatric treatment of problematic users of alcohol and is meant to encompass historical terms such as 'asylum' and 'mental hospital'
[3] A Hunt, *Governing morals: a social history of moral regulation* (Cambridge, UK: Cambridge University Press, 1999), 215.

This exploratory study will draw upon the precepts of self-regulating and self-governing individuals stemming from the writings of Michel Foucault.[4] Specifically, Foucault's concept of governmentality and the individual has been expanded on in more recent research, such as that by Hunt[5] and Wouters,[6] to explain how mechanism of control evolve,

> 'from the nineteenth century's preoccupation with the promotion and formation of 'character' conceived of as set of external virtues ... to be mastered and incorporated into the self, (to the mid twentieth century's) … the pursuit of 'personality' … concerned with personal self-formation through self-discovery.'[7]

It has been argued there has been an insufficient understanding of the long-standing existence of methods of governance, which has its roots in the 'sumptuary impulse' which shows that we have always sought to regulate consumption, it being

> 'a ubiquitous feature of social life during the long road to modernity. (which is manifested) in the late twentieth century (in) protracted struggles … over the consumption of tobacco, alcohol and food additives … (which) usually involve some complex mix of external government, for example, by legislation and of self-government, whether it be by dieting, quitting or joining a self-help group.'[8]

3 Objectives and purpose

The analysis presented here supports and complements other research which has examined the management of problematic users of alcohol by the WA criminal justice system, in relation to public order consequences, especially the offence of public drunkenness.[9]

This research will have a number of objectives. As well as expanding our knowledge of the unique place the mental health system has played in providing institutional centric treatment and social control, it will outline how by the 1970s this approach was supplanted by a public health focussed approach, which has evolved into a model of stand-alone community-based specialist service providers. However, as this research is concerned with only part of a much larger problem, it should be understood as an incomplete picture of a much greater compendium of harms caused by problematic use of alcohol.

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[4] M Foucault, *The birth of the clinic: An archaeology of medical perception* (London, UK: Tavistock, 1976); M Foucault, "About the concept of the dangerous individual in 19th century legal psychiatry," in *Michel Foucault: Politics, philosophy, culture. Interviews and other writings 1977-1984*, ed. LD Kritzman (London, UK: Routledge, 1978); M Foucault, *Discipline and punish: The birth of the prison* (Harmondsworth, UK: Penguin, 1979); M Foucault, "Governmentality," in *The Foucault effect: Studies in governmentality*, ed. Burchell G; Gordon C & Miller P (London, UK: Harvester Wheatsheaf, 1991); M Foucault, *The government of self and others*, Lectures at the College de France 1982 - 1983, (NY: Palgrave MacMillan, 2010); M Foucault, *The courage of truth: The government of self and others II*, Lectures at the College de France 1983 -1984, (NY: Palgrave MacMillan, 2010).

[5] Hunt, *Governing morals: a social history of moral regulation*.

[6] C Wouters, "How civilizing processes continued: towards an informalization of manners and a third world personality," *Sociological Review* Monograph Series 7 (2011), http://dspace.library.uu.nl/bitstream/handle/1874/211510/SRM%20-%20HOW%20CP%27s%20CONTINUEDfinal.pdf?sequence=1.

[7] A Hunt, "The governance of consumption: sumptuary laws and shifting forms of regulation," *Economy and Society* 25(3) (1996): 410, https://doi.org/10.1080/03085149600000022.

[8] Hunt, "The governance of consumption: sumptuary laws and shifting forms of regulation."

[9] G Swensen, "The management of public drunkenness in Western Australia: policing the unpoliceable?," *Limina: A Journal of Historical and Cultural Studies* 23(1) (2017).

> 'Alcohol use is a leading risk factor for disease burden worldwide, accounting for nearly 10% of global deaths among populations aged 15–49 years, and poses dire ramifications for future population health in the absence of policy action today.'[10]

As alcohol use is associated with an array of profound social, health, law and order impacts, in this State as in many other English-speaking countries, a myriad of measures have been adopted over many years to try and regulate its use and ameliorate its harms, justifiably it can be described as being a 'wicked problem'.[11]

A recent policy development, which involves proposals in WA to target and compel problematic users of alcohol, as well as other drugs, to participate in treatment through interventions and intervention orders overseen by problem-solving courts, will be also referred to, as this appears to be a reversion to earlier policies related to inebriates and convicted inebriates.[12]

Whilst policy makers have characterised these recent proposals as innovative and cutting-edge approaches, it is suggested such claims are made in ignorance of the history of civil commitment which operated in WA that compelled treatment of problematic users.

It is argued, therefore, the research presented here is relevant to a debate about the role of compulsion in treatment, as outlined in the recent proposal, which involves the use of judicial authority, referred to as 'therapeutic jurisprudence', which governments have been resorting to solve social problems involving the use of drugs and other issues. [13]

It is important to recognise that the institutional-focussed system of managing problematic users of alcohol in the mental health system, evolved from earliest days of the State's establishment as a British colony in 1829. In the colonial period the State's nascent mental health system operated as a custodial system of care based on asylums to restrain and separate problematic alcohol users and those with other mental disorders from the broader community.[14]

From the colonial era until quite recently, the mental health system relied upon a perceived advantage, that unlike the criminal justice system, it was perceived as being able to potentially

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[10] GBD 2016 Alcohol Collaborators, "Alcohol use burden for 195 countries and territories, 1990-2016: a systematic analys for the Global Burden of Disease Study 2016," *Lancet* 392 (2018): 1026, https://doi.org/http://dx.doi.org/10.1016/S0140-6736(18)31310-2.

[11] Australian Public Service Commission, *Tackling wicked problems - a public policy perspective*, Australian Public Service Commission (Canberra, ACT, 2007), http://www.apsc.gov.au/__data/assets/pdf_file/0005/6386/wickedproblems.pdf; J Conklin, "Wicked problems and social complexity," in *Dialogue mapping: building shared understanding of wicked problems*, ed. Conklin J (NY: Wiley, 2005); A E Pennay, "'Wicked problems': the social conundrum presented by public drinking laws," *Drugs: Education, Prevention & Policy* 19(3) (2012).

[12] Corrective Services Minister, "First of its kind alcohol and other drug treatment prison announced (Media statement)," (9 March 2018). https://www.mediastatements.wa.gov.au/Pages/McGowan/2018/03/First-of-its-kind-alcohol-and-other-drug-treatment-prison-announced.aspx.

[13] A Freiberg, "Therapeutic jurisprudence in Australia: paradigm shift or pragmatic incrementalism?," *Law in Context* 20 (2002); M S King, "Applying therapeutic jurisprudence in regional areas - the Western Australian experience," *Murdoch University Electronic Law Journal* 10(2) (2003), www.murdoch.edu.au/elaw/issues/v10n2/king102nf.html; D B Wexler, "Reflections on the scope of therapeutic jurisprudence," *Psychology, Public Policy & Law* 1 (1995).

[14] A S Ellis, *Eloquent testimony: The story of the mental health services in Western Australia 1830-1975* (Perth, WA: University of Western Australia Press, 1984).

rehabilitate and reform 'inebriates', ie those with alcohol-caused problems. This belief in the system may have constrained support for the adoption of non-institutional methods of management in favour of continued reliance on the asylum, until community attitudes changed here as well as elsewhere, about treating alcohol-related problems in this manner.[15]

It was only since the mid 1970s that policies have been adopted which eschewed the role of the mental health system and instead create a separate public health model of care based on precepts such as for individual responsibility, self-control and self-regulation as well as education programs emphasising prevention and early intervention.[16]

4 Note about methodological issues

The growing interest in understanding the harms of alcohol, beyond the well-known law and order and crime consequences, has spurred the development of methodologies to quantify health-related consequences. An understanding of how these operate is a valuable requirement in order to identify and quantify consequences from problematic use of alcohol.

One of these has been the development of diagnostic descriptions of alcohol-related mental disorders over a number of years, since the first edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) published in 1952.[17]

The DSM has been refined and nomenclature has been revised since its formal adoption in 1952. In the current version, DSM-V, this includes disorders such as alcohol dependence, a withdrawal syndrome also described as the DTs (delirium tremens), Korsakov's psychosis and alcoholic psychosis, which necessitate treatment.[18]

In addition to the group of alcohol-caused mental disorders as recognised by the DSM system, there are a spectrum other adverse health effects related to the problematic use of alcohol, identified by the International Classification of Diseases and Causes of Death (ICD) system.[19] The ICD system operates in a different manner, in that it identifies a broad spectrum of conditions wholly caused by alcohol such as alcoholic cirrhosis, alcoholic cardiomyopathy, pancreatitis and alcoholic gastritis, as well as accidents and other conditions partly caused by alcohol.[20]

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[15] J Baumohl, "On asylums, homes and moral treatment: the case of the San Francisco Home for the Care of the Inebriate 1859-1870," *Contemporary Drug Problems* 13 (1986).

[16] M J Ashley and J G Rankin, "A public health approach to the prevention of alcohol related health problems," *Annual Review of Public Health* 9 (1988).

[17] American Psychiatric Association, "DSM: history of the manual." http://www.psychiatry.org/practice/dsm/dsm-history-of-the-manual.

[18] Alcohol.org, "Alcohol-induced psychotic disorder," (8 January 2018). https://www.alcohol.org/comorbid/psychotic-disorder/; T Chikritzhs et al., *Alcohol-related codes: mapping ICD-9 to ICD-10* (Perth, WA: National Drug Research Institute, Curtin University, 2002).

[19] I M Moriyama et al., *History of the statistical classification of diseases and causes of death*, National Center for Health Statistics, Centers for Disease Control and Prevention (Washington, DC, 2011), https://www.cdc.gov/nchs/data/misc/classification_diseases2011.pdf.

[20] Royal Australasian College of Surgeons, "Alcohol-related harm: Position paper," (2016). https://www.surgeons.org/media/20784483/2016-08-02_pos_rel-gov-025_alcohol_related_harm.pdf; National Health and Medical Research Council, "Revision of the Australian guidelines to reduce health risks from drinking alcohol 2009," (2018). https://nhmrc.gov.au/about-us/news-centre/revision-australian-guidelines-reduce-health-risks-drinking-alcohol-2009; National Health Preventative Health Taskforce, *Preventing alclohol related harm in Australia: a window of opportunity*, Department of Health & Ageing (Canberra, ACT, 2008); Chikritzhs T; Evans M; Gadner C; Liang W; Pascal R; Stockwell T & Zeisser C, *Australian alcohol aetiologic fractions for injuries*

5 Introduction

The colonial era of managing problematic users of alcohol, existed from establishment of WA as a British colony in 1829 until the late 1890s and was predicated on a particular notion about the causes and therefore remedies for problematic users of alcohol:

> 'Until the mid-nineteenth century habitual drunkenness was commonly viewed as self-inflicted sin or vice punishable as a crime. By the 1860s a new view, of habitual drunkenness as a disease, had emerged.'[21]

By the latter half of the colonial era the management of inebriates had been assigned to the Fremantle Asylum as a separate institution from Fremantle Prison.[22] There were also developments in other Australian jurisdictions which informed policy makers in WA as to the nature of reforms that were adopted in this State concerning how to deal with problematic alcohol use. One such example was the Royal Commission on Asylums for the Insane and inebriate in Victoria in 1884 -1886 which

> 'concluded that inebriety was a disease – dipsomania – that could be cured by subjecting the inebriate to the discipline of the asylum. The legal problem was to distinguish between those who had a craving for drink but were responsible for their actions and those dipsomaniacs who had lost control and deserved humane reformative action rather than punishment.'[23]

A multi-layered system of social controls existed from the inception of the Swan River Colony in 1829, well before the colony was proclaimed a British penal colony in 1849. The rationale for increased social controls was especially driven by concerns about crime and social order after WA became a penal colony, which resulted in a total of 9,720 convicts being transported from the United Kingdom (UK) between 1851 and 1868. [24]

From its inception WA has been characterised as a place with high levels of alcohol-related social, law and order and health problems which the hospitals, mental health services, the police, prisons and the courts were expected to ameliorate as best they could. An account in Stannage's 1981 seminal history of WA gives a sense of the adverse impact of the heavy level of alcohol consumption from the inception as a British colony in 1829.

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treated in emergency departments, National Drug Research Institute, Curtin University (Perth, WA, 2011), http://www.dao.health.wa.gov.au/DesktopModules/Bring2mind/DMX/Download.aspx?Command=Core_Download&EntryId=701&PortalId=0&TabId=211; A Van Diemen et al., *Methodology for developing Western Australian specific alcohol-related aetoiological fractions*, Epidemiology Branch, Public Health Division, Department of Health Western Australia (Perth, WA, 2017), https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Population%20health/PDF/Specific-Alcohol-related-Aetiological-Fractions-Report.pdf.

[21] S Garton, "Once a drunkard always a drunkard: Social reform and the problem of 'habitual drunkenness' in Australia, 1880-1914," *Labour History* 53 (1987): 38.

[22] S Piddock, "A place for convicts: the Fremantle Lunatic Asylum, Western Australia and John Conolly's 'ideal' asylum," *International Journal of Historical Archaeology* 20 (2016); P Maude, "Treatment of Western Australia's mentally ill during the early colonial period, 1826 - 1865," *Australaisan Psychiatry* 21(4) (2013).

[23] Garton, "Once a drunkard always a drunkard: Social reform and the problem of 'habitual drunkenness' in Australia, 1880-1914," 42.

[24] J S Battye, *Western Australia: a history from its discovery to the inauguration of the Commonwealth*, Fascimile edition reprinted 1978, (Perth, WA: University of Western Australia Press, 1924); A Hasluck, *Unwilling emigrants: A study of the convict period in Western Australia* (Sydney, NSW: Angus and Robertson, 1969).

> 'Alcohol and social reaction to it was at the root of the crime problem in Western Australia. … This was in no way exceptional. Indeed, from the 1830s drink had been a serious community problem in Swan River. The coroners' records show that many of the "death by drowning" and "death by misadventure" cases occurred as a result of bouts of drunkenness … Derelict women and men wandered drunken and homeless through the streets of the towns before being arrested and imprisoned overnight, to be charged with being "drunk and disorderly", "resisting arrest" and so on the next day.'[25]

There were three types of institutions which could be involved in managing problematic users of alcohol in the colonial era – Fremantle Prison, Fremantle Asylum and poorhouses. As has been sanguinely observed,

> '(t)he struggling colony could not waste time on people who did not contribute to society and the absence of treatment options or people who were skilled to provide such treatments resulted in restraint and custodial management.'[26]

From the establishment of the Swan River Colony in 1829 it was evident there was a need for a separate facility to manage people with mental disorders, as the first recorded account of a mentally ill person requiring treatment involved Dr Nicholas Langley. Dr Langley was the appointed surgeon, who during the course of the voyage on a ship with the convoy of first settlers in 1829 became very agitated and on disembarkation became so violent he was required to be confined on the hulk of a wrecked merchant ship at Fremantle.[27]

Therefore, Fremantle Prison performed the function of housing people with mental illness until the opening of the Fremantle Asylum in 1865. The need for a purpose built-facility to manage of mentally ill people became a matter of greater concern to the colony after it was proclaimed a British penal colony in 1849 and started to receive convicts in 1850, a number of who were 'lunatics', whose mental illness substantially impaired their social functioning.[28]

In the colonial era a number of poorhouses were established to provide some form of relief, begrudgingly and on a very restrictive basis, for homeless and unemployed people who were denied rations or 'outdoor relief'. The provision of 'indoor relief' involved submission to systems of discipline in both the men's and women's poorhouses, refracted through gendered arrangements, on the basis these individuals' predicaments were due to their lack of self-discipline, poor choices and weakness of will.[29]

The stimulus for the Female Poorhouse can be traced to economic factors and after the cessation of the transportation of convicts in 1868, when the former convict depots were converted into institutions to provide a place for homeless individuals.[30] The poorhouses, such as the Mount Eliza poorhouse established on a site on Mounts Bay Road west of the city

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[25] J E Thomas, "Crime and society," in *A new history of Western Australia*, ed. Stannage CT (Perth, WA: University of Western Australia Press, 1981), 642.
[26] Maude, "Treatment of Western Australia's mentally ill during the early colonial period, 1826 - 1865," 399.
[27] P Maude, "Treatment of Western Australia's mentally ill during the early colonial period, 1826 - 1865," *Australasian Psychiatiry* 21(4) (2013).
[28] M McPherson, "A class of utterly useless men: Convict lunatics in Western Australia," *Studies in Western Australian History* 24 (2006).
[29] K Abbott and C Chesney, "'I am a poor woman': gender, poor relief and the poorhouse in late ninteenth and early twentieth century Western Australia," *Studies in Western Australian History* 25 (2007).
[30] P Hetherington, *Paupers, poor relief and poor houses in Western Australia 1829 - 1910* (Perth, WA: University of WA Press, 2009).

at the foot of Kings Park, were highly regulated according to rules prescribed in regulations under an 1882 act concerned with the maintenance and running of poorhouses.

These regulations were designed to discipline those indigent persons who sought to stay there by setting out in some detail the amount of food, daily schedules of activities and the nature of the work, punishments for failure observe rules etc.

The Mount Eliza poorhouse was replaced by a purpose-built institution further away at Freshwater Bay, which opened in 1906. The Mount Eliza and other poorhouses housed a sizeable population of poor and destitute people, who had found themselves in the predicament of homelessness due to long-standing sustained use of alcohol.

> 'The Mount Eliza buildings were sold in 1908 with the exception of one wooden building which was transferred by horse and dray to the new site. For many years it housed alcoholics and other noisy patients. Known as The Bungalow', it is now the main Occupational Therapy department and is all that remains of the original depot.'[31]

At the beginning of the twentieth century a statutory framework was adopted that defined 'inebriates' as a population of problematic alcohol users who could be confined, which emphasised the primacy of the asylum and semi-rural recuperative farm for their rehabilitation. Such individuals could also be compelled by court as a sentence if convicted of an alcohol-related offence, to 'inebriate homes', which emphasised the values of reform, rehabilitation and punishment, as also occurred in other jurisdictions.[32]

A separate framework for managing mental health problems began to evolve from the late 1920s, separate from Claremont Asylum, resulted in an unusual bifurcated system of treating mental disorders in WA, based on two different statutory provisions. This arrangement is considered in more detail in the following section.

This occurred as a reform in response to a quite scathing review by a Royal Commission in 1922 that had identified the profound shortcomings of the asylum-centric system that existed for some time:

> 'There is no marked line dividing sanity from insanity; there are degrees intervening which must be recognised and provided for. Beyond the observation wards at the Perth and Kalgoorlie Hospitals (which are insufficient for the purpose), there is no institution in Western Australia which can deal effectively with this important question; there is, so to speak, nothing between sanity and Claremont.
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> The Perth and Kalgoorlie observation wards more or less fulfil the function performed by the Darlinghurst Reception House in Sydney, which deals very largely with acute alcoholic cases and a comparatively small proportion of cases of early mental disorder.'[33]

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[31] A T Whyntie, "Sunset Hospital: it's history and function," *Early Days: Journal of Royal Western Australian Historical Society* 8(5) (1981): 66.

[32] V Berridge, "Punishment or treatment? Inebriety, drink and drugs, 1860-2004," *Lancet* 364, Suppl 1 (2004).

[33] Royal Commission In Lunacy, *Report and appendices (Angwin chairman)*, Western Australian Parliament (Perth, WA, 1922), 7, http://www.parliament.wa.gov.au/intranet/libpages.nsf/WebFiles/Royal+Commissions+-+Report+and+appendices+of+the+royal+commission+in+lunacy/$FILE/Report+and+appendices+of+the+royal+commission+in+lunacy.pdf.

There was a major reform in the mid 1970s, which supplanted the long-standing reliance on institutional arrangements in the form of the 'asylum' or 'mental hospital' by of entirely new structure completely separate from the mental health system.

The mid 1970s reform was a major shift in treatment philosophy, away from one largely concerned with of the model that had operated for some years, of 'drying out' and recuperation through maintenance of abstinence. This approach had prevailed between 1900 and the mid 1970s and was transformed into a model which championed early intervention and reliance on community-based organisations to engender attitudinal and behavioural change towards lower risk drinking.

This was conceived as managing all problematic users of alcohol overseen by a stand-alone statutory body, the Alcohol and Drug Authority. The impetus for this reform was triggered by a Royal Commission in the early 1970s, which though curiously it largely focussed on concerns about illicit drug use and barely considered the much larger problem involving the use of alcohol, included commentary that treatment for 'alcoholics' optimally should be based on voluntary admission.[34]

A number of developments since the early 1990s will also be considered. One of these the decriminalisation of public drunkenness, a reform that had particular relevance to Indigenous people and which resulted in a long overdue investment in the growth and differentiation of Indigenous specific services. Another recent development has been a major administrative reform which involved the absorption of the ADA back into the Mental Health Commission.[35]

This may mark the beginning of a new era which could again characterise problematic users of alcohol and other drugs as having a mental disorder. If this is the case, it can be argued this is a reversion to elements of the administrative arrangements that existed prior to the mid 1970s, as government has recently claimed is a policy, "the first of its kind", that will involve court-ordered confinement for the purposes of prison-based treatment related to alcohol and other drugs.[36]

We have good reason to be concerned this mental health services centric policy will undermine the key feature of voluntarism that has been a key facet of the system of specialist alcohol and drug services and has been an integral part of treatment since the mid 1970s. This policy also involves the amalgamation of both mental health and alcohol and other drug treatment services into one functional department, instead of two completely separate statutory organisations.[37]

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[34] Royal Commission Into the Treatment of Alcohol and Drug Dependents, *Report (Williams Chairman)*, Government Printer (Perth, WA, 1973), http://www.parliament.wa.gov.au/intranet/libpages.nsf/WebFiles/Report+of+the+Honorary+Royal+Commission+appointed+to+inquire+into+and+report+upon+the+treatment+of+alcohol+and+drug+dependents+in+Western+Australia/$FILE/Treatment+of+alcohol+and+drug+dependents+1.pdf.

[35] Minister for Mental Health, "Agency to tackle drug issues and mental health (Media statement)," (1 July 2015). https://www.mediastatements.wa.gov.au/Pages/Barnett/2015/07/Agency-to-tackle-drug-issues-and-mental-health.aspx; H Morton, "DAO joins Mental Health Commission (Media statement)," (10 April 2013). http://www.mediastatements.wa.gov.au/pages/StatementDetails.aspx?listName=StatementsBarnett&StatId=7287.

[36] Minister for Corrective Services, "First of its kind alcohol and other drug treatment prison announced (media statement)," (9 March 2018). https://www.mediastatements.wa.gov.au/Pages/McGowan/2018/03/First-of-its-kind-alcohol-and-other-drug-treatment-prison-announced.aspx.

[37] Morton, "DAO joins Mental Health Commission (Media statement)."

6 Inebriates - Legislative framework

This section will briefly trace the legislative arrangements that were instituted to manage problematic users of alcohol, from the colonial era up to the recent past, who for a significant amount of this period were either confined or infrequently voluntarily admitted to a mental hospital under provisions related to 'inebriates' or under mental health legislation.

In summary there were a number of legislative arrangements for the institutional treatment of problematic alcohol users adopted over the period up to the mid 1970s -

- broader provisions mental health legislation such as the *Lunacy Act 1871*, the *Lunacy Act 1903* and the *Mental Health Act 1962* concerned with the admission of people with mental disorders to mental health facilities;
- provisions in the *Lunacy Act 1903* and *Inebriates Act 1912* concerned with 'inebriates;'
- the *Mental Treatment Act 1927* which established a framework for the voluntary admission of individuals with mental disorders which included the possibility of detoxification of alcohol dependent persons; and
- under the *Convicted Inebriates Rehabilitation Act 1963* to commit 'convicted inebriates' to a prison-based rehabilitation regime.

The approach since the mid 1970s will also considered separately as this involved a major shift in approach, with the mental health system largely ceasing to manage any problematic users of alcohol as it was supplanted by the establishment of a public health approach overseen by the Alcohol and Drug Authority.

Until the major reforms in the 1970s, the mental health system largely managed those with problematic use of alcohol by two pathways which involved coercion -

- as declared 'inebriates' (defined as a "person who habitually uses intoxicating liquor to excess") who were sentenced for up to 12 months by a court under the *Inebriates Act 1912*, either by an application by the police or family members; or
- those committed under either the *Lunacy Act 1903* or the *Mental Health Act 1962* as they had an alcohol-related mental disorder.

6.1 Lunacy Act 1871

The colony's first legislative arrangement concerned with inebriates was the *Lunacy Act 1871* which established a process for either a medical practitioner, or two justices, to commit a "lunatic". A lunatic was referred to as being either a "person of unsound mind" or an "idiot" and who was "not under care and control" to an asylum or proclaimed place for "treatment" as deemed necessary by the asylum's Superintendent Medical Officer.

Problematic users of alcohol were therefore, likely to within under the meaning of being a 'lunatic'. The preamble to this act suggests its primary objective was not so much about treatment as for maintaining social order, stating the legislation was

> 'to provide for the safe custody of, and prevention of crimes by, persons dangerously insane; for the care and maintenance of persons of unsound mind; for the care and management and disposal of the property and estates of such persons.'

6.2 Lunacy Act 1903

The first comprehensive legislative framework for dealing with mental disorders occurred at the beginning of the twentieth century with the *Lunacy Act 1903*, The Act included provisions for managing problematic users of alcohol, described as 'habitual drunkards' in Part 4:

> Section 26. Application may be made to a Judge for an order of Application for detention by the following persons and in the following, cases –
>
> (1) By the habitual drunkard himself declaring that he is willing to submit to curative treatment under the order of the Court; or
> (2) By the parent, husband, wife, child, or friend of such habitual drunkard, in cases –
>
> > (a) Where such person is suffering or has been recently suffering from delirium tremens or other dangerous physical effects of habitual drunkenness; or
> > (b) Where such person, through habitual drunkenness, has recently been wasting his means and been neglecting his business or insufficiently providing for his family, or a wife has been wasting the means of her husband; or
> > (c) Where such person has recently, under the influence of drink, used or threatened violence towards himself or any member of his family.

The undefined reference in the *Lunacy Act 1903* to 'habitual drunkard' suggests this would have been understood as the meaning contained in the *Police Act 1892*, being someone who had multiple convictions for public drunkenness.

Section 27 of the *Lunacy Act 1903* provided could grant an order of committal to a hospital of up to 12 months, in which case they were required to have evidence from not less than two medical practitioners and other persons if necessary, subject to the proviso they were held in "a ward, division, or compartment thereof in which lunatics are not detained for curative treatment".

The *Lunacy Act 1903* specified that someone could not remain in a reception home for more than six months and that they needed to be admitted as a 'voluntary boarder'. For admission to occur as a voluntary border, ie to a facility other than Claremont Hospital, "a person had to have enough insight into his own behaviour and feelings to know that he was ill and needed treatment, and the ability to decide for himself to seek admission."[38]

6.3 Inebriates Act 1912

When the *Inebriates Act 1912* was passed we find for the first time a definition of an 'inebriate' being 'a person who habitually uses intoxicating liquor or intoxicating narcotic drugs to excess.' (Section 2).

This legislation also had a potentially expansive coverage, in that problematic users of alcohol who appeared before the courts, who arguably may not have been alcohol dependent nor exhibited other alcohol-caused mental disorders, but if alcohol was a factor in their offending, could have been committed for treatment in a mental health hospital instead of being fined or imprisoned. [39]

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[38] Ellis, *Eloquent testimony: The story of the mental health services in Western Australia 1830-1975*, 84.

[39] This provision with respect to offenders was replicated in the the *Convicted Inebriates Rehabilitation Act 1963*.

> 'Where a person is convicted summarily or on indictment of an offence, and drunkenness is an element, or was a contributing cause of such offence, and on inquiry it appears that the offender is an inebriate, the Court may, in its discretion, order the offender to be placed, for a period of not exceeding twelve months, in an institution established for the reception of convicted inebriates'. Section 7(1)

The *Inebriates Act 1912* in other respects replicated similar provisions as in the 1903 act of the three pathways for committal for up to 12 months –

a) on the application by the person themselves, or
b) by the spouse, siblings or adult children or a business partner, or
c) by a medical practitioner.

The legislation also permitted under Section 12(2), that a person released may have conditions on the license of release, which could be for a period of up to 12 months, including that the person be 'of good behaviour, and abstain from taking or using any intoxicating liquor or intoxicating or narcotic drug'.

The Fremantle Asylum was at that time and continued to be the principal place where those with a mental illness, as well as those found to be 'inebriates', were confined for 'treatment'. The early colonial administrators appear to have regarded a 'lunatic asylum' in terms of how the Royal Bethlem Royal Hospital in London confined and managed so-called 'lunatics'.[40]

There were two key institutions that loomed large in the colonial era in WA to enforce social order, the Fremantle Prison and the Fremantle Asylum, opened in 1859 and 1865, respectively. It has been observed from its earliest times the colony of WA relied heavily on custodial arrangements to manage social problems, evidenced by construction of the Round House in 1831, just two years after settlement.

> 'In Western Australia, the first permanent building was not a church, not an inn, nor a private house. It was a gaol. This gaol, ostensibly designed for criminals, also served as a place for the containment of lunatics.'[41]

Construction commenced in 1903 of the Claremont Hospital for the Mentally Insane and it was not until 1909 when the last patients were transferred to the Claremont Hospital, that the Fremantle Asylum ceased to operate as a quasi-hospital and reformatory.

These early legislative measures suggest policy makers in the first decade of the twentieth century sought to bring about social reform, evidenced by the passage of the *Prisons Act 1903* which tempered the harshness of the *Prisons' Discipline Act 1880* relation to the conduct of prisons and to improve the treatment of mental illness through the *Lunacy Act 1903*.[42]

The Claremont Hospital for the Mentally Insane was renamed the Claremont Mental Hospital in 1933 and in 1967 after the word 'Mental' was removed from its title it became known as the Claremont Hospital.

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[40] https://en.wikipedia.org/wiki/Bethlem_Royal_Hospital

[41] N Hudson-Rodd and G A Farrell, "The Round House Gaol: Western Australia's first lunatic asylum," *Australian and New Zealand Journal of Mental Health Nursing* 7 (1998): 154.

[42] R Virtue, "Lunacy and social reform in Western Australia 1886-1903," *Studies in Western Australian History* 1 (1977).

In 1972 Claremont Hospital was partially decommissioned and divided into two institutions, Graylands Hospital which treated acute patients and Swanbourne Hospital which focussed on persons with psychogeriatric disorders and adult patients with developmental disabilities.

6.4 Mental Treatment Act 1927

The *Mental Treatment Act 1927* enabled a parallel system for treating alcohol-related mental disorders to exist after the establishment of the 'Heathcote Reception Home' in February 1929. This facility was not referred to as an 'asylum' because of the perceived stigma of Claremont Asylum, but instead operated under a separate statute, the *Mental Treatment Act 1927*, which provided for the voluntary admission of people with a range of mental illnesses.

The genesis for the *Mental Treatment Act 1927* was the development of a different system for care of war veterans with psychiatric disorders, who had been admitted initially to the Claremont Asylum on their return from the war, in accordance with principles of different care in the *Mental Treatment Act 1917,* to mitigate community perceptions that returned service men were stigmatised if they were committed to Claremont Asylum.

This involved a prevalent form mental illness, now understood as post-traumatic stress disorder (PTSD), in returning service men from World War I, which at that time was referred to as 'shell shock', although it was recognised as a form of hysteria, a disorder considered as exclusively involving women.[43] By 1918 a separate institution, Stromness Hospital, was constructed with Commonwealth funding provided to the State, to only treat veterans with mental illnesses. Stromness Hospital operated from 1918 to 1926 and after its closure, patients were transferred to Lemnos Hospital, a new purpose-built facility which operated until 1995.

As the number of returning service men showing signs of PTSD increased, with possibly at least one in five men who developed the condition, this required changes in views about causality, which posited that 'shell shock was a disease of manhood rather than an illness that came from witnessing, being subjected to and partaking in incredible violence', because it was held:

> 'Soldiers were archetypically heroic and strong. When they came home unable to speak, walk or remember, with no physical reason for those shortcomings, the only possible explanation was personal weakness. Treatment methods were based on the idea that the soldier who had entered into war as a hero was now behaving as a coward and needed to be snapped out of it.'[44]

This dual legislative arrangement linked to specific hospitals meant that indigent and less well-off individuals with alcohol-related and other forms of mental illness were likely to be committed to the Claremont Asylum under Lunacy Act legislation, whereas those admitted to Heathcote were voluntary admissions under the *Mental Treatment Act 1927*.

6.5 Mental Health Act 1962

The *Mental Health 1962*, which commenced in July 1966, repealed the *Inebriates Act 1912*. However, was replaced by a system of coercive management of problematic users of alcohol

[43] M C McDonald, M Brandt, and R Blum, "From shell-shock to PTSD, a century of invisible war trauma," (4 April 2017). http://theconversation.com/from-shell-shock-to-ptsd-a-century-of-invisible-war-trauma-74911.
[44] McDonald, Brandt, and Blum, "From shell-shock to PTSD, a century of invisible war trauma."

was established under the *Convicted Inebriates Rehabilitation Act 1963*, which commenced on 18 December 1963.

The *Mental Health Act 1962* was repealed by the *Mental Health Act 1996*, which commenced on 13 November 1997. This meant that in 1997 the final remnant of legislation concerned with "inebriates", which had existed for more than 90 years in mental health legislation in this State, since the *Lunacy Act 1903*, was finally removed.

There was a provision in within Section 19 of the Mental *Health Act 1962*, which authorised the establishment of hospitals and services for a range of facilities, one of which in Section 19(1)(f), involved the establishment of "centres to provide for the institutional care and treatment of inebriates and drug addicts". There is no record of gazettal of such a facility being established or conducted for the purpose of providing treatment as contemplated in Section 19(1)(f).

6.6 Convicted Inebriates Rehabilitation Act 1963

There was a further group, so-called 'convicted inebriates,' who could if they had been convicted of a minor (ie summary) criminal offence where 'drunkenness' was an element or contributing factor under the *Convicted Inebriates Rehabilitation Act 1963*, be sentenced to 'clinical treatment and rehabilitation': Section 6(1).

The *Convicted Inebriates Rehabilitation Act 1963* established a system to rehabilitate 'convicted inebriates' by the imprisonment of those who had been convicted of an offence where a court had found that drunkenness was either a contributory cause or element of the offence. This resembled a system of quasi civil commitment and required these individuals to serve a period a specified period of time at Karnet Prison, a low security farm-based prison.

Even though convicted inebriates were housed in a designated facility within the prison, they were treated as prisoners through an amendment was made to the *Prisons Act 1903* by the *Prisons Act Amendment Act 1962*, which added Part VIB, which commenced on 25 January 1963. This amendment enabled "convicted inebriates", ie those sentenced under the *Convicted Inebriates Rehabilitation Act 1963*, to be subject to the prison's disciplinary framework.[45]

It should be noted the mental health system also continued to be a destination for problematic users of alcohol as inebriates until the introduction of the *Mental Health Act 1962*, which commenced in July 1966.

The 1963 reform meant that whereas up to December 1963 inebriates were confined in a mental health facility or in a designated inebriate "reception home" under the terms of a court order, from 1964 "convicted inebriates" were managed by the prison system. The system of sentencing of problematic users of alcohol to designated low security prison for "treatment" operated between 1964 and November 1974, until the *Alcohol and Drug Authority Act 1974* was passed by the WA Parliament and commenced on 29 November 1974.

[45] This provision remained in the Prisons Act 1903, until it was repealed and replaced by a new piece of legislation, the Prisons Act 1981.

7 The 1900s to mid 1970s

Over the period from 1900 until the early 1970s, the Claremont Asylum performed a pivotal role in relation to managing those acutely or chronically affected by use of alcohol, by 'drying out' such persons, involving if necessary restraint and control.

Because problematic users were committed by either an order of a court or by a medical practitioner to a mental health facility, this resulted in secondary harm due to stigmatisation of those treated, which most likely deterred a much larger population of problematic users, including those with acute disorders as well as those who were not alcohol dependent from seeking treatment.
It is likely there was a similar outcome in WA as has been reported occurred in other Australian jurisdictions in that the inebriate legislation had a disproportionate effect on the lives of working Australians.

> 'By the First World War the efforts of reformers had resulted in longer periods of prison and mental hospital incarceration for those working-class inebriates deemed to be suffering the disease of habitual drunkenness.'[46]

Furthermore, as well as this class bias in relation to those who more likely to be committed, it is also conceivable that committal may have served other purposes, such as to reform those seen to have failed in other social responsibilities. As noted in Great Britain, '(t)he power to commit offenders to inebriate reformatories was heavily implemented in cases of neglect and child cruelty.'[47]

Initially, from 1914 up until 1918, male inebriates were sent to the Inebriate Section established as part of a farm-based facility, Whitby Falls Asylum, south of the Perth metropolitan area. However, it was evident from early on from comments in annual reports of the Inspector General of the Insane, that this was not found to be a satisfactory arrangement from the mental health services perspective, such as observed in the 1917/1918 annual report:

> 'Those at Whitby, who were committed Under Sections 7 and 8 of the Act, usually adopt an attitude of passive resistance, refuse treatment, and, generally speaking, are subordinate, and I have throughout found myself in an awkward position.'

Female inebriates were sent to Greenplace, a metropolitan facility for women with mental disorders, which opened in 1916. However, this arrangement for women inebriates also seemed to be problematic, as after closure of the Inebriates Section at Whitby Falls in July 1918, males as well as females, were committed under the *Lunacy Act 1903* to either of the two gazetted 'inebriate homes' operated by the Salvation Army or to the Claremont Asylum.

However, in spite earlier enthusiasm, by the late 1920s these two inebriate homes had closed.

> 'On the 31st December 1923, there were seven male inmates resident in the Salvation Army Home at Claremont and 10 females in the Inebriates Home, Lincoln Street, Perth. During the year there were 49 admissions to Claremont and 33 to Perth.

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[46] Garton, "Once a drunkard always a drunkard: Social reform and the problem of 'habitual drunkenness' in Australia, 1880-1914," 53.
[47] Berridge, "Punishment or treatment? Inebriety, drink and drugs, 1860-2004," 4.

> The above figures disclose a very marked increase in the number of inebriates treated at the Salvation Army Homes. The admissions at the Claremont Home show an increase of 123 per cent, sand the Perth Home 175 per cent. This increase is entirely due to the magistrates sending to the homes persons for only quite short periods.
>
> The Inebriates Homes were provided for the treatment of inebriates and the object has largely been defeated by the short periods ordered, and it is obviously impossible to treat an inebriate for a short period of time, say three weeks. It is very evident that a period of three weeks by any stretch of imagination cannot be considered as treatment, but is intended as a punishment.'[48]

A longer term understanding of how the mental health system managed problematic users of alcohol can be gleaned from the annual number of inpatient admissions to mental hospitals for alcohol-related mental disorders, as recorded in the annual reports of mental health services,[49] is contained in Figure 1, which has a breakdown by gender and shows a predominance of male admissions over the period 1904/1905 to 1977/1978.[50]

Figure 2 shows that alcohol-related admissions to mental hospitals represented a substantial component of all types of admissions, constituting up to about one in three of all admissions in the first decade of the twentieth century, and for the remainder of the period representing about 15% of all admissions.

Figure 3 is concerned with the annual counts of admissions of inebriates to the 'inebriate homes which operated in the 1920s and subsequently to mental hospitals plus the counts of 'convicted inebriates' who were committed to the Karnet Prison under the *Convicted Inebriates Rehabilitation Act 1963.*

People with alcohol related mental disorders could also be admitted voluntarily or committed to the mental ward at Perth Public Hospital, which provided inpatient short term stay and assessment facility for the reception of those suffering from a variety of acute mental disorders, until 1929 when Heathcote Hospital was opened and it assumed responsibility for detoxification of alcohol dependent persons.[51]

The impact on the adoption of the ICD 9CM and ICD 10 classification systems on annual counts of alcohol-related mental disorders will be considered in the following section.

It should also be noted there were periods of increased restrictiveness on the availability of alcohol because of perceived national security and emergency concerns related to World War I, the Great Depression and World War II, which probably reduced levels of alcohol problems.

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[48] Annual report of Inspector General of the Insane 1925/1926

[49] The term 'mental health services', is a more recent term, which is used for convenience and simplicity.

[50] Annual reports contain detailed appendix tables with breakdowns of admissions by various mental disorders. However, some caution needs to be exercised in interpretation of some of these breakdowns, as the WA mental health services followed a hybrid system of classification of mental disorders up to 1966/1967. In the period from 1967/1968 to 1969/1970 the ICD 8 classification was adopted, which was supplanted by the ICD 9CM classification in the period 1970/1971 to 1977/1978 and since 1978/1979 the ICD 10 system has been used. The increases in annual counts of alcohol-caused mental disorders from the mid 1960s are related to changes in the way this data was captured through the introduction of the Hospital Morbidity Data System. As well as expanded diagnostic categories, the data refers to admissions for these disorders in all public and private hospitals, compared to the approach up to 1966/1967, which was based on admissions to just mental hospitals.

[51] The Colonial Hospital was established in 1855 and renamed the Perth Public Hospital and the Perth Hospital, being renamed Royal Perth Hospital in 1946.

The prison system, like the mental health system, also struggled with performing its role as a destination for the involuntary detention of problematic users of alcohol, as observed by the Deputy Comptroller General of Prisons in the 1911 annual report with respect to the imprisonment of female inebriates:

> 'Visits to the Female Prison exemplify the futility of imprisoning the inebriate for short sentences. Experience suggests that the system is worse than useless – it is harmful. The short sentence merely affords a means of recuperation, and the prisoner goes out of the prison gate physically fortified for further depredation.
>
> The Home of the Good Shepherd and the Salvation Army authorities, which have done much to assist the administration, have been approached with a view to accepting for treatment this unfortunate class, and it is hoped shortly to recommend you to declare certain portions of those institutions as prisons, where female inebriates can be given reformative opportunities.'[52]

There were protracted negotiations during the 1920s between the Prisons Department and the Inspector General of the Insane with respect to which department should incur the cost of those sentenced to the Salvation Army homes for inebriates.[53] One example is an extract from correspondence in a file note to the Under Secretary of the Colonial Secretary's Office from the Inspector General of Institutions for Inebriates:

> 'We are receiving a large number of admissions under the Inebriates Act to the Salvation Army Homes for a period of twenty-one days. Patients sent to these Homes are supposed to be sent there for treatment, but twenty-one days does not appeal to me as a period in which treatment can be of any effect.
>
> It looks to me as if it is more a punishment than treatment, in which case the inebriate should be sent to Fremantle Prison. I do not think that our vote on the Estimates was ever intended to provide for such short treatment.'[54]

This push back by the mental health system in managing problematic users of alcohol under the inebriates legislation was also echoed in how the courts became increasingly reluctant to support committal except if it had some demonstrable benefit for the individual concerned.

> 'A man suffering from deliriums tremens or otherwise in a maniacal condition from the direct effect of alcohol is a fit subject for admission to an institution. It is well recognised, and has been judicially determined, that, so far as insanity is concerned, a man may be insane from the temporary effects of alcohol as well as from other causes. His receipt into hospital is a perfectly correct procedure; but it is equally certain that there is nothing in the Lunacy Act to justify the detention of any man merely because of a well-founded belief that

[52] Annual report on the prisons year: ended 31 December 1911, 6.

[53] With respect to mental health services, there was not a departmental administrative arrangement until the Mental Hospitals Department was created on January 1950, which operated until December 1953, when it was supplanted by the Mental Health Services Department. On July 1984 the Mental Health Services Department was merged along with the Public Health Department and the Department of Hospital and Allied Services to form the Health Department of WA.

[54] State Records Office. Inebriates Act – increase in the number of inebriates committed to institutions for short periods. Item 1920-0234.

he will have recourse to alcohol, even though in all probability he will become violent and a danger to his wife.

The protection of a wife against a drunken husband lies in the criminal law, and such protection as is given by other legislation directed to the specific purpose. So far as such criminal law and other legislation may prove to be an insufficient protection, there is no reason to suppose that the Legislature would be backward in enlarging its scope.

It is quite clear that there is nothing in the Lunacy Act which would justify those administering the Act in detaining, from humanitarian motives, for an indefinite period, a man who is not insane according to the ordinary scientific tests, but who may and probably will become temporarily insane if given access to alcohol.

Putting it other words, mental hospitals are not institutions for preventing alcoholics from having access to alcohol.'[55]

The changes away from institutional-based treatment of inebriates which had started in the 1960s, parallels the reforms which had occurred in how mental illness was understood which resulted in an emphatic shift to community-based approaches. This reform, referred to as 'deinstitutionalisation' of mental hospitals, commenced in earnest in the 1960s occurred because of changing attitudes towards mental illness, exemplified by the anti-psychiatry movement, which eschewed the labelling of social problems as medical problems and the use of involuntary treatment.

The deinstitutionalisation of the treatment of mental illness which started to occur from the late 1960s was facilitated by the development of effective psychotropic medications that became widely used and largely obviated the need for restraint and confinement. There were other impetuses for deinstitutionalisation, such as the existence of populations of patients who had spent much of their lives in the hospital, the high cost of institutional treatment and growing evidence of the brutalisation and degradation endemic in institutions elsewhere.[56]

We should be cognisant that the substantial power of committal to the mental health system did not operate in isolation from other repressive mechanisms that enabled the confinement of a wide group of individuals, not just problematic users of alcohol. For example, there were a suite of provisions in the *Police Act 1892,* which imposed escalating terms of imprisonment for repeat offenders, so called "habitual drunkards."

In effect this meant the powers available through the criminal justice and the mental health systems over the 75-year period to the mid 1970s sustained a framework of coercive and punitive measures which targeted problematic users of alcohol, predicated on the belief that without strict controls, the unfettered use of alcohol posed a serious risk to social order and the stability of the family.

In addition to the repressive provisions in both mental health and police legislation, provisions were also present in other legislation, which also controlled the use of alcohol, such as restrictions on Sunday trading hours of hotels, the closure of hotels on holidays in the

[55] In re X (an inebriate), 43 295-96 295 (Supreme Court of Victoria 19 March 1937, 1937).

[56] Such as the findings of the Chelmsford Royal Commission chaired by Justice Slattery in the late 1980s, which exposed the activities of the infamous Dr Harry Bailey and Dr John Herron and their use of 'deep sleep therapy' over the period from the early 1960s to the late 1970s at Chelmsford Private Hospital: <https://en.wikipedia.org/wiki/Chelmsford_Royal_Commission>

Christian calendar, the creation of extended opening hours in mining regions and extended hours of trading through special classes of licenses.

The perceived threat of alcohol to social order was reflected in other policy areas, such as in matrimonial matters, where alcoholism was a ground for divorce under the State's *Matrimonial Causes and Personal Status Code 1948*:

> 'In the case of a husband defendant, habitual drunkenness for four years or more and during that period habitually leaving the plaintiff without means of support or being guilty of habitual cruelty towards her; and in the case of a wife defendant, habitual drunkenness for four years or more and during that period habitually neglecting her domestic duties or rendering herself unfit to discharge them.' Section 15(g)

Perhaps one of the most restrictive regimes related to alcohol operated through 'native welfare' legislation, which targeted Indigenous people as they were regarded as being especially susceptible to alcohol and incapable of using it safely. This involved a combination of measures, such as the creation of 'dry areas' to exclude Indigenous people from gazetted towns and prescribed zones in the State where Indigenous people were legally not able to consume alcohol.[57]

An especially pernicious illustration of controls over Indigenous people in WA were a collection of so-called "native citizenship" laws, such as the *Natives (Citizenship Rights) Act 1944*, whereby an Indigenous person could apply to a magistrate for 'citizenship'.

This necessitated renunciation of indigenous associations and required ongoing compliance evidenced by 'adopting the manners and habits of civilised life', with the ever-present threat of revocation of the certificate of citizenship, such as if an Indigenous person was convicted of drunkenness or offences under the *Native Administration Act 1905-1941*.[58]

The *Alcohol and drug Authority 1974* legislative reform meant that from December 1974 problematic users of alcohol in this State could not be sentenced to a regime of court ordered rehabilitation in a prison or any other facility, even though the power remained in the *Convicted Inebriates Rehabilitation Act 1963* until it was repealed in November 1989.

The *Convicted Inebriates Rehabilitation Act 1963*, which operated for a decade, until the commencement of the ADA in 1974, sought to establish a system of civil commitment for those charged with alcohol-related public order offences for compulsory 'treatment' in a unit within Karnet Prison, a low security prison.

There has only been one review by the Convicted Inebriates Board, which had administrative oversight of the arrangement, which in a 1969 review, considered that of the 353 'patients' admitted to Karnet prison in the first six years of operation, there had been a 'successful recovery rate of 20%'.

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[57] P Biskup, "White-Aboriginal relations in Western Australia: an overview," *Comparative Studies in Society and History* 10(4) (1968); E Egglestone, *Fear, favor or affection: Aborigines and the criminal law in Victoria, South Australia and Western Australia* (Canberra, ACT: Australian National University Press, 1976); A Haebich, *For their own good: Aborigines and government in the Southwest of Western Australia, 1900 - 1940* (Perth, WA: University of Western Australia Press, 1988); P Hasluck, *A survey of native policy in Western Australia, 1829 - 1897* (Melbourne, VIC: Melbourne University Press, 1942).

[58] C Tatz, "Genocide in Australia," *Journal of Genocide Research* 1(3) (1999): 332, https://doi.org/https://doi.org/10.1080/14623529908413964.

However, reservations were expressed about the co-location of the Inebriates Section within the prison

> 'During this period the position has gradually arisen where the rehabilitation and interest in the .alcoholic seems to have become the work of the Board and its Welfare Officer, with the staff at Karnet hardly being involved in this aspect; and again this seems to have arisen from the circumstances of trying to run a prison rehabilitation centre and an alcoholics rehabilitation centre under the same administration, and trying to apply the one set of procedures to both sections; yet the needs are extremely different.'[59]

7.1 Statistical summary

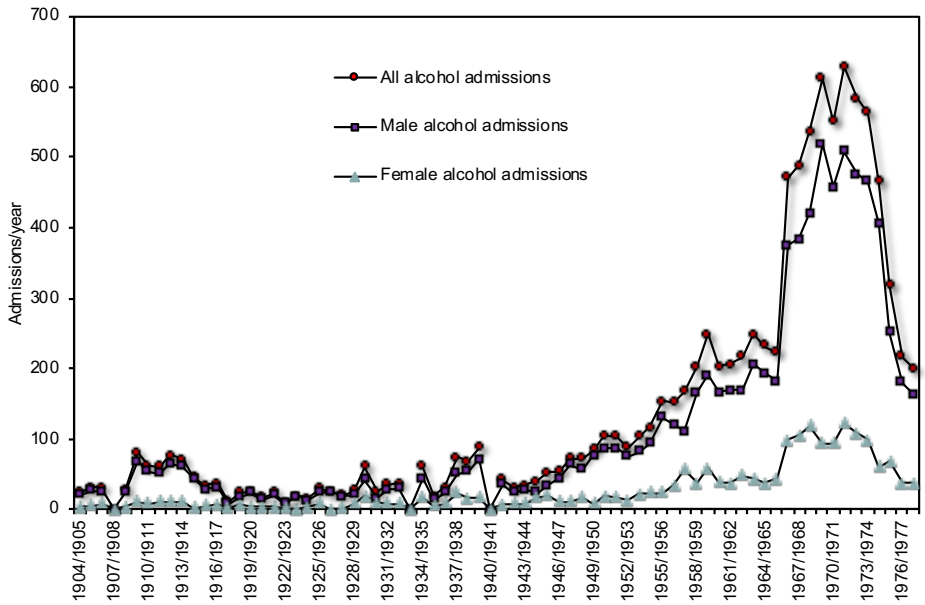

Figure 1: Number of inpatient admissions for alcohol-caused mental disorders by gender, WA, 1904/1905 – 1977/1978

[59] Inebriates Advisory Board, *A review of six years activity* (Perth, WA: Inebriates Advisory Board, Chief Secretary's Department, August 1969), 15.

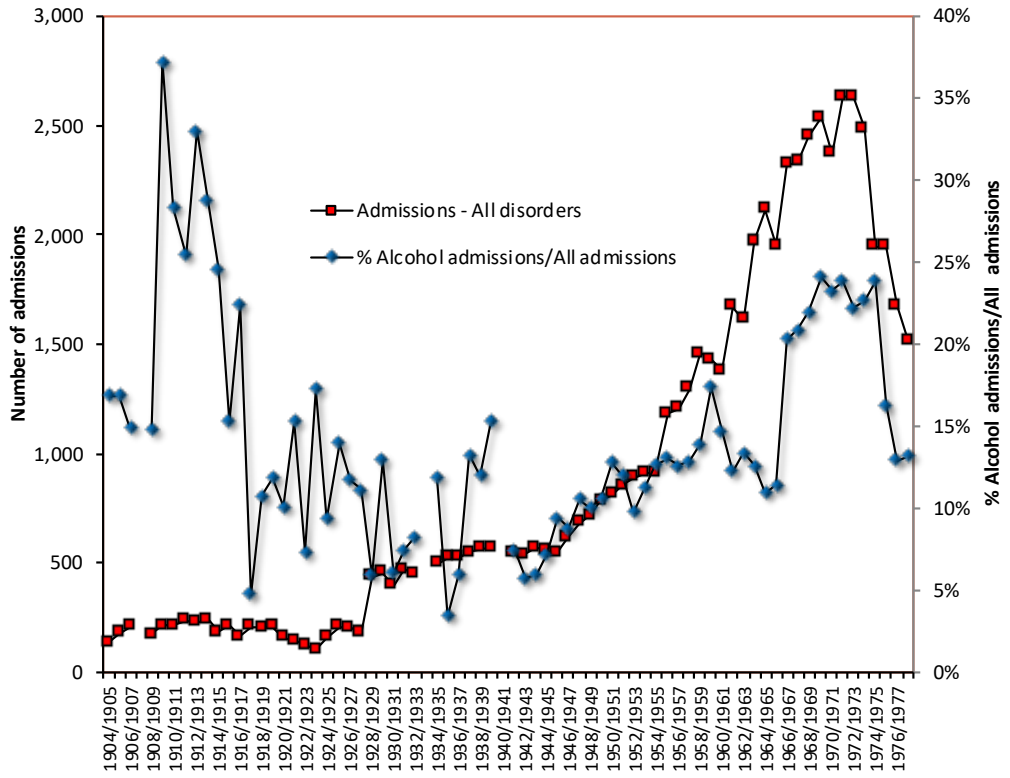

Figure 2: Number of inpatient admissions for all mental disorders, alcohol-caused mental disorders & % of alcohol mental disorders of all mental disorders, WA, 1904/1905 – 1977/1978

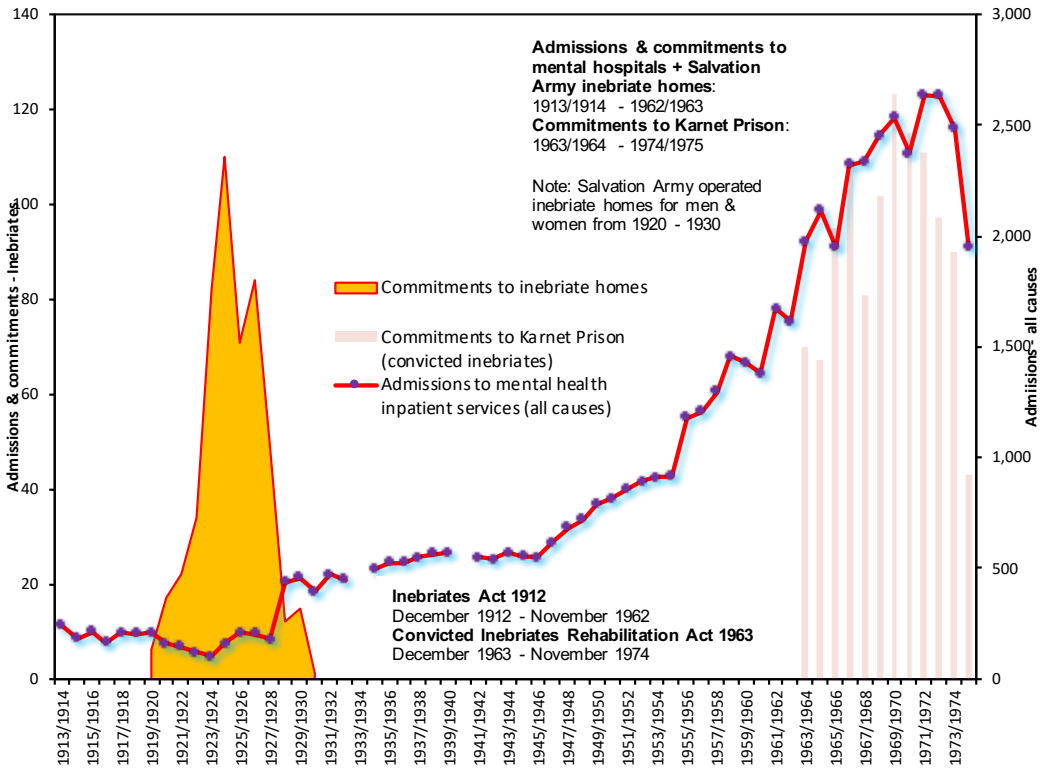

Figure 3: Number of admissions & commitments of inebriates to mental hospitals & inebriate homes, WA, 1913/1914 – 1974/1975

8 Mid 1970s – 1990s (ADA reforms)

The *Alcohol and Drug Authority Act 1974* ushered in the abolition of the Convicted Inebriates Board and creation of the ADA. This framework realized a long-held goal for the treatment of problematic alcohol users, as well as other forms of drug use, to be undertaken by a specialist multi-level system of services, focusing especially on recruiting early stage problematic users of alcohol, compared to the approach foisted on the mental health system of treating individuals who had been long-term alcohol users.[60]

The formation of the ADA established a medically-based system to detoxify alcohol dependent persons, who were admitted voluntarily to metropolitan specialist inpatient and outpatient facilities operated by the ADA.

The 1974 reform crystallised a reform by Mental Health Services that alcohol dependent persons should no longer to be admitted to a psychiatric facility, in line with a shift in medical opinion in Australia and elsewhere for treatment of alcoholism as a mental illness.[61] This meant with the establishment of the ADA in 1974, custodial facilities ceased to exist in WA to detain and detoxify alcohol dependent persons that previously occurred under the inebriate legislative framework.

Another factor which spurred the development of a separate specialist medically-oriented treatment system in WA, was the election of the Whitlam Federal Labor Government in December 1972. This resulted in additional funding being provided by the Federal Government to WA and the other States, through the Community Health Program established by the *Hospitals and Health Services Commission Act 1973* (a Commonwealth piece of legislation).

The specialist alcohol and other drug treatment system developed by the ADA required that an individual needed to demonstrate sufficient 'motivation' to be admitted to a program. This approach meant some groups of alcohol dependent individuals, such as homeless and Indigenous persons, were likely to experience difficulty in being admitted for treatment, as treatment was defined in health and social objectives to improve an individual's capability to have a functional life, rather than to just detoxify or 'dry out' as a goal of itself.

The ADA established an inpatient detoxification unit, Aston Hospital, which the Hon. RLJ Williams MLC, then Chairman of the ADA, described in these terms:

> 'We do not cure anybody there; we detoxify them; that is, we remove all the toxic substances which may be in their bodies due to alcohol or drugs. The treatment modality is acute clinical.'[62]

The ADA had inherited responsibility for the management of the Byford Inebriates Centre which had previously been operated by the Department of Corrections as a "prison farm" for the reception of inebriates sentenced by the courts under the *Convicted Inebriates*

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[60] A S Ellis, *Investigation into drugs and alcohol: Final report*, Health Department of Western Australia (Perth, WA, 1971); Ellis, *Eloquent testimony: The story of the mental health services in Western Australia 1830-1975*.
[61] B Kissin and H Begleiter, eds., *The biology of alcoholism. Volume 5: Treatment and rehabilitation of the chronic alcoholic* (NY: Plenum Press, 1977); L G Kiloh and Bell D S, eds., *29th International Congress on Alcoholism and Drug Dependene, Sydney, February 1970* (Melbourne, VIC: Butterworths, 1971).
[62] Williams RLJ. MLC. 'Debate on Appropriation Bill (Consolidated Revenue Fund) (No. 2)'. *Hansard Legislative Council,* 25 October 1977, 2534.

Rehabilitation Act 1963. The ADA renamed the facility Quo Vadis and had it classified as a hospital, so that the cost of stay of patients to be covered through the State's participation in national hospital funding arrangements.

> 'The development of Quo Vadis is a comprehensive one and includes updating of the extensive property which consists of 126 acres. The therapeutic procedures in force at this hospital are of less intensity to those which exist at the Ord Street Hospital and are geared towards the long-term resocialisation of the patient through group techniques and work orientated activities.'[63]

In addition to establishing Aston Hospital for the express purpose of short-term detoxification, the ADA also opened a medium term stay live-in facility, Ord Street Hospital, for those who had completed detoxification and were desirous of developing life skills and engaging in psychological focussed programs. The third leg of the ADA's residential treatment option was Quo Vadis Hospital for longer term rehabilitation coupled with daily activities related to the farm.

Whereas over about the first ten years of the ADA's existence it actively expanded and established a comprehensive suite of client services, in the nature of residential detoxification, outpatient clinics and regional programs, by the mid 1980s this had started to be dismantled with the progressive devolution of services to a range of non-government organisations (NGOs) and the closure of both Quo Vadis and Ord Street Hospitals.

> 'Another era drew to a close on 29 June 1984 when the Authority officially closed the Quo Vadis centre at Byford. The Authority considered that the services provided at Quo Vadis could be provided more efficiently by a non-government agency and negotiated with a number of agencies to this end. Successful negotiations have been concluded with the Salvation Army, which has an Alcohol Rehabilitation Centre at Seaforth (Gosnells).'[64]

The ADA experienced fierce local community opposition when it relocated its main outpatient service, Carrellis Centre, from West Perth to Mount Lawley in 1986, in the renovated former Annexe of Royal Perth Hospital, based on concerns about illicit drug users attending the Centre. The Minister for Health issued a directive in response to this community opposition, such that 'usage of the facility was restricted to treating only those 'persons affected by alcohol problems – whether they be dependents, co-dependents, or persons with a drink problem.'[65]

However, by the late 1990s the ADA located its remaining clinical services to the site of the Central Drug Unit in East Perth, which was renamed in April 1999 Next Step Specialist Drug and Alcohol Services was registered under the *Business Names Act 1962*. This change sought to rebrand the ADA's residual clinical services in East Perth as a short stay inpatient detoxification hospital, described in the 2007/2008 Annual Report of the Drug and Alcohol Office.

> 'Next Step provides a supervised, medical drug and alcohol withdrawal service for clients requiring withdrawal from licit (including alcohol) and illicit drugs at Moore Street, East Perth. The facility has 17 beds, 4 of which are dedicated for the provision of services to Aboriginal people. (page 21)

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[63] Annual report, Alcohol and Drug Authority, 1974/1975 (draft unpublished), 5.
[64] Annual report, Alcohol & Drug Authority, 1983/1984, 5.
[65] Annual report, Alcohol and Drug Authority, 1985/1986, 7.

In the latter part of 2007 the ADA commenced the implementation of a new model of service delivery, whereby it established co-located services to provide a regionalised delivery of services, branded as Community Drug Service Teams (CDSTs). This involved the ADA renting the actual premises and assuming overall management and responsibility of the facility and the employment of medical and nursing personnel. The majority of the remaining of the staff who provided counselling and welfare related services were employed by the CDST.

The first such service, the South Metropolitan CDST, was described as follows:

> 'Improvement of treatment services advanced considerably with the establishment of the South Metro Community Drug Service that integrated DAO's Next Step medical services with the community drug service team managed by Palmerston.
>
> This enabled a new service location to be established in Rockingham and a comprehensive range of treatment to be offered more effectively to clients throughout the southern corridor. The success of this approach has informed planning for the integration of all metropolitan community drug service teams with DAO Next Step services to occur in the latter half of 2007 and will result in several new service locations.' [66]

However, in this era, as public drunkenness remained an offence, the criminal justice system continued to be an important residual destination for those arrested for public drunkenness. This resulted in a type of a "revolving door", also identified in the United States and elsewhere, such that intoxicated and alcohol dependent individuals were detained overnight in police lock up and until their appearance the next morning before a Magistrate on a charge of public drunkenness and or closely related public order offences.[67]

When these individuals appeared before a Magistrate they usually received a small fine and if unable to pay the fine, they could serve the time in prison in lieu of paying the fine. Another approach for dealing with those charged with public drunkenness was after being conveyed by the police to the lock up, that they could be granted bail in the form of a self-recognizance. This was typically set at low token amount and if the individual failed to appear at court when the matter was listed for hearing, his or her bail was estreated and thus treated as defacto payment of the outstanding fine.

The selective admission criteria used by the ADA for entry to its specialist alcohol and other drug treatment system meant in effect there was a two-stream approach to managing problematic users of alcohol, those who were perceived as motivated and those who had chronic and extended histories of alcohol use and associated complex social and medical

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[66] Annual report, Drug and Alcohol Office, 2006/2007, 7.

[67] R W Fagan and A L Mauss, "Padding the revolving door: an initial assessment of the Uniform Alcoholism and Intoxication Treatment Act in practice," *Social Problems* 26 (1978-1979); D M Gallant et al., "The revolving door alcoholic: An impasse in the treatment of the chronic alcoholic," *Archives of General Psychiatry* 28 (1973); K Lovald and H R Stub, "The revolving door: reactions of chronic drunkenness offenders to court sanctions," *Journal of Criminal Law, Criminology & Police Science* 59(4) (1968); D J Pittman and C W Gordon, *Revolving door: A study of the chronic police case inebriate* (New Haven, Connecticut: Yale Center of Alcohol Studies, 1958); P M Saeta and W M Smiland, "Public inebriate health: the legislature and the revolving door," *Pacific Law Journal* 1 (1970).

problems attending a small number of non-government organisations (NGOs) and programs run by the Salvation Army.[68]

A number of major reforms since the 1990s have reshaped the role of the ADA, which have resulted in the withdrawal of Government as a provider of services except in a role as a limited operator of a short term inpatient medical detoxification unit. Instead government has increasingly concentrated on training, funding of services provided by NGOs and oversight of community-based education programs concerning alcohol and other drugs (except tobacco control).

8.1 Statistical summary

Figure 4 refers to the period, from 1967/1968 to 2009/2010. It shows how changes in classification systems and the introduction of more fine-grained definitions, may have affected how different alcohol-caused mental disorders are identified.

For instance, it can be seen that annual counts for Acute intoxication (F10.0), first appeared in the year 1998/1999, even though the ICD 10 system had been operating since 1978/1979. Figure 4 shows with respect to Alcohol dependence (303 in ICD 9CM and F10.2 in ICD 10) that there was a marked decline from an annual peak of more 2,700 admissions in 1976/1977 and 1977/1978, to nearly 450 in 1994/1995, with some growth since to about 1,700 admissions per year.

A breakdown of the data over this period by gender, which is not shown here, indicates that with respect to both male and female admissions, the greatest growth appears to have involved two sub-groups – Acute intoxication and Dependence. Whereas the two lowest counts for admissions involving Non-dependent abuse (305.0 – 305.3 and F10.1) and Alcoholic psychosis (291 and F10.3 – F10.) have remained relatively constant.

Figure 5 is concerned with admissions to treatment programs provided by specialist treatment agencies, covering the period from the commencement of the ADA, from 1975/1976 to 2015/2016. The interpretation of this data is problematic as the agency did not operate a comprehensive data system, nor did NGO treatment providers funded by the ADA provide data concerning admissions for some time.

Since 2001/2002 data has been obtained from annual reports published by the Australian Institute of Health and Welfare (AIHW) based on data provided by each jurisdiction concerning a range of treatment agencies. The alcohol and other drug treatment system data (AODTS) reports contain a mixture of both inpatient and outpatient data, whereas the data in Figure 5 for the period up to the late 1990s is ADA only data concerning inpatient statistics.

However, in spite of these limitations the important trend in Figure 6 is of how alcohol represented in the order of 50% of annual admissions for all type of drug problems for treatment presentations at the ADA up to 1994/1995. In fact, in the first part of the period up to the early 1980s, alcohol problems represented three quarters or more of all admissions at the ADA.

[68] Notably, a Perth-based residential program run by ACRAH (the Association for the Care and Rehabilitation of Homeless Persons) was the exception to the requirement that an individual should engage in a treatment program, as it permitted actively drinking alcohol dependent individuals to live at its facility in Mount Lawley.

Although alcohol as a proportion of all admissions declined to about one in three admissions by 1999/2000, more recently this has increased somewhat.

There are also other caveats in reliance on data in the AODTS annual reports, as in recent years agencies in WA and some other jurisdictions have recorded increases in cannabis related admissions, when in fact these have most been due to court diversion programs for minor cannabis offenders as part of requirements to attend educational programs.

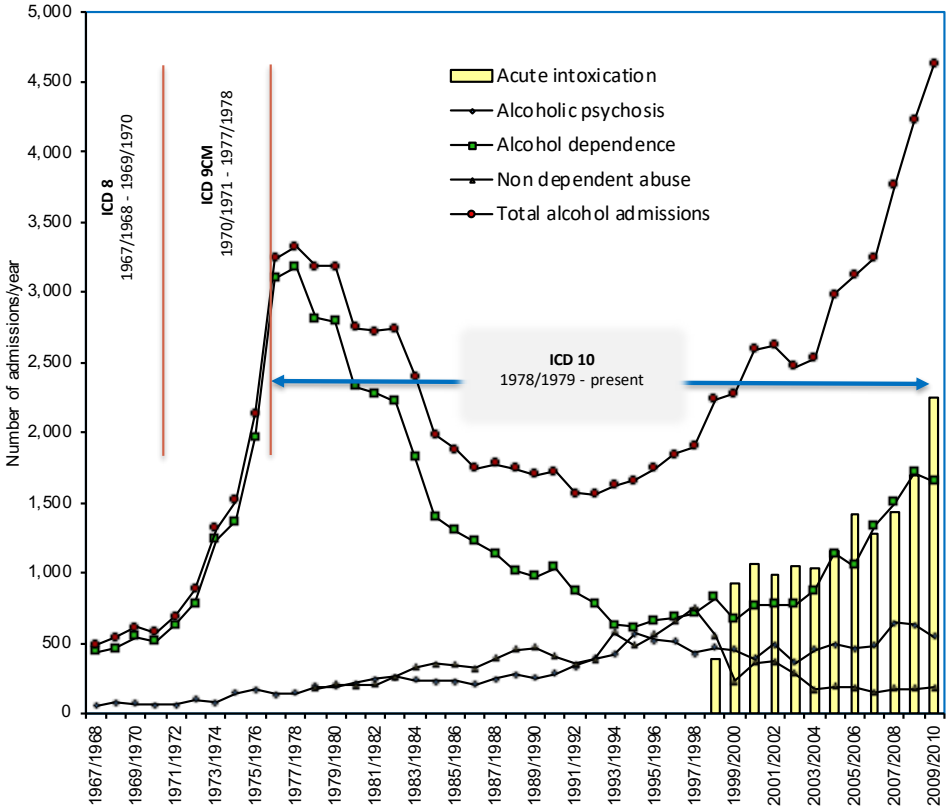

Figure 4: Number of inpatient admissions for alcohol-caused mental disorders by ICD sub-groups, WA, 1967/1968 – 2009/2010

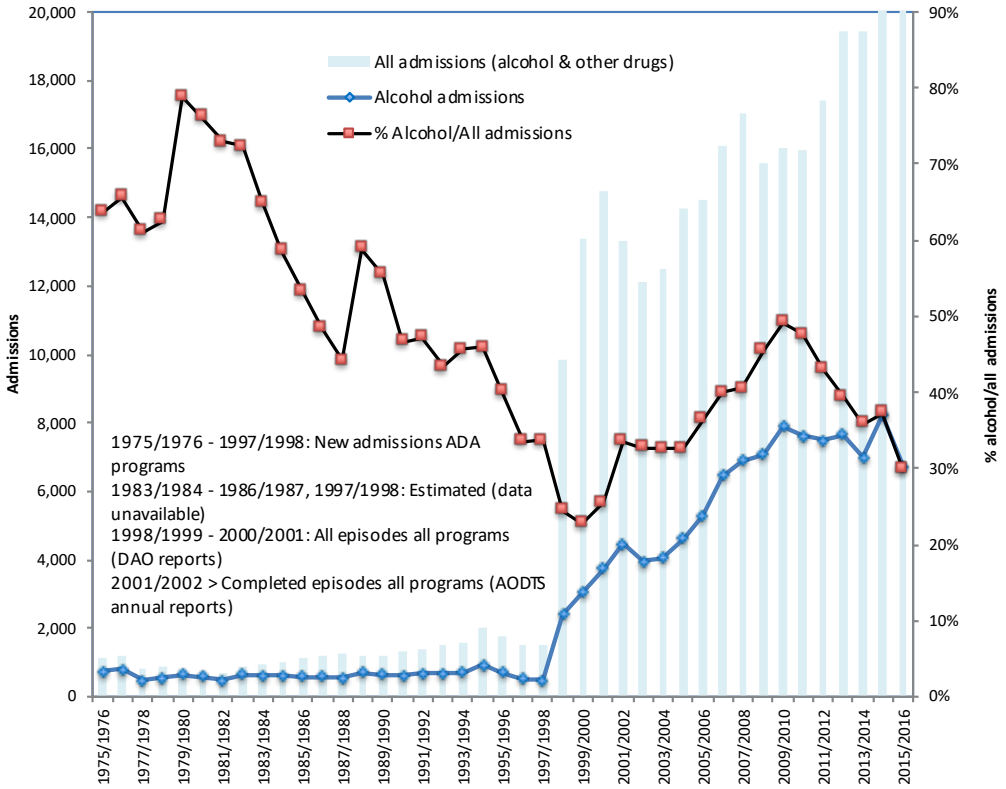

Figure 5: Number of total admissions for treatment for alcohol, all admissions & % of alcohol admissions of total admissions, WA, 1975/1976 – 2015/2016

9 1990s to present: decriminalisation of drunkenness

A shortcoming in the evolution of model of treatment services established and supported by the ADA from the mid 1970s, which progressively devolved the majority of treatment services to non-government bodies through these administrative reforms, was in effect to marginalise the treatment of Indigenous people and others with chronic levels of problematic use of alcohol.

This meant so long as public drunkenness remained an offence, substantial numbers of Indigenous people in particular continued to be caught up in the revolving door of the criminal justice system, ie arrest for public disorder, unable to pay fine, imprisoned and discharged and return to drinking and associated social and health problems.

It was not until April 1990, with the repeal of the *Convicted Inebriates Rehabilitation Act 1963 and* the passing of the *Detention of Drunken Persons Act 1989*, that public drunkenness was decriminalised in WA; a reform which was a key recommendation of the Royal Commission Into Aboriginal Deaths in Custody (RCIADIC).[69]

[69] Aboriginal Affairs Department, *Royal Commission Into Aboriginal Deaths in Custody: Government of Western Australia, implementation report*, Aboriginal Affairs Department (Perth, WA, 2001), www.daa.wa.gov.au/Documents/ReportsPublications/RCIADIC_Implementation_Report2000.pdf; J Brewer, "Public drunkenness - Australian law and practice," in *Deaths in custody: Australia, 1980-1989. Royal Commission Into Aboriginal Deaths in Custody. Research Paper No. 3*, ed. D Biles and D McDonald (Canberra, ACT: Australian Insitute of Criminology, 1992); C Cunneen, "Reflections in criminal justice policy since the Royal Commission into Aboriginal Deaths in Custody," in *Reflections: 40 years on from the 1967 Referendum, Aboriginal legal rights movement*, ed. Gillespie N (Adelaide, SA: 2007); R W Harding et al., *Aboriginal contact with the criminal justice system and the impact of the Royal Commission Into Aboriginal Deaths in Custody* (Annandale, NSW: Hawkins

Curiously, decriminalisation of public drunkenness had been resisted for some years, even being asserted it may deprive problematic users of alcohol who cycled in and out the courts and the prison system of some perceived health and social 'benefits' which they received from being incarcerated:

> 'Alcoholism … is a condition which has always been the cause of many people being imprisoned… In Western Australia this problem has been added to by the propensity of many of the Aboriginal population for alcohol. There is some danger that the optimism generated by the decriminalisation of alcoholic offences will lead to a deterioration in the quality of care provided for alcoholics. …
>
> What prisons have always done for alcoholics is to clean them, feed them and give them a chance to recuperate, if only for a short period. In this respect prison has been an asylum.'[70]

As part of this reform the ADA undertook the progressive funding of sobering up centres (SUCs), one of which was in the Perth metropolitan area and the remainder were based in the North West of the State.[71] The function of SUCs was to provide a low-cost overnight non-medical service almost wholly used by Indigenous people, that provided police with an alternative to lockups as a place for short term protective care of alcohol intoxicated people that they apprehended.

Figure 6 refers to the period 1963/1964 to 2010/2011 and has been included, even though it contains data concerned with the offence of public drunkenness, referring to the period before and after decriminalisation in May 1990. The data in this figure is to demonstrate the impact of decriminalisation of public drunkenness and utilises annual apprehensions by police which resulted in an admission to a sobering up centre, as a proxy measure of public drunkenness since decriminalisation.

In the period post decriminalisation, the annual number of admissions to SUCs increased to 2007/2008, supporting the belief that decriminalisation did have an important impact by providing police with an option to convey intoxicated people to a safe environment other than to a lock up. The rate of charges/apprehensions for drunkenness has remained relatively constant in WA since the early 1990s, though the decline in both the rate and number of admissions to SUCs since 2008/2009 appears to not be related to reductions in alcohol intoxicated people, but possibly due to changes in funding criteria and priorities.

The sharp peak in the annual number of charges over the four-year period up to 1975/1976 requires further research, to determine whether it was a consequence of the effect of the closure of the Karnet Prison Inebriates Section and the establishment of the ADA in the early

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Press, 1995); Royal Commission Into Aboriginal Deaths in Custody, *Regional report of inquiry into individual deaths in custody in Western Australia*, Australian Government Publishing Service (Canberra, ACT, 1991).

[70] J E Thomas and A Stewart, *Imprisonment in Western Australia: Evolution, theory and practice* (Perth, WA: University of Western Australia Press, 1978), 157-58.

[71] G Swensen, *Utilisation of sobering up centres in Western Australia, 1990 - 1997*, WA Drug Abuse Strategy Office (Perth, WA, 1999); G Swensen, *Utilisation of sobering up centres and their impact on detentions for drunkenness in Western Australia, 1990 - 2000*, WA Drug Abuse Strategy Office (Perth, WA, 2001); G Swensen, *Utilisation of sobering up centres, 1990 - 2002*, Drug and Alcohol Office (Perth, WA, 2003); G Swensen, *Utilisation of sobering up centres, 1990 - 2003*, Drug and Alcohol Office (Perth, WA, 2004); G Swensen, *Utilisation of sobering up centres, 1990 - 2004*, Drug and Alcohol Office (Perth, WA, 2005); G Swensen, *Utilisation of sobering up centres, 1990 - 2005*, Drug and Alcohol Office (Perth, WA, 2007); G Swensen, *Utilisation of sobering up centres, 1990 - 2007*, Drug and Alcohol Office (Perth, WA, 2008).

1970s, or other reasons, such as increased alcohol consumption following the lowering of the drinking age in WA from 21 to 18 in 1971 following the commencement of the Liquor Act 1970.

9.1 Statistical summary

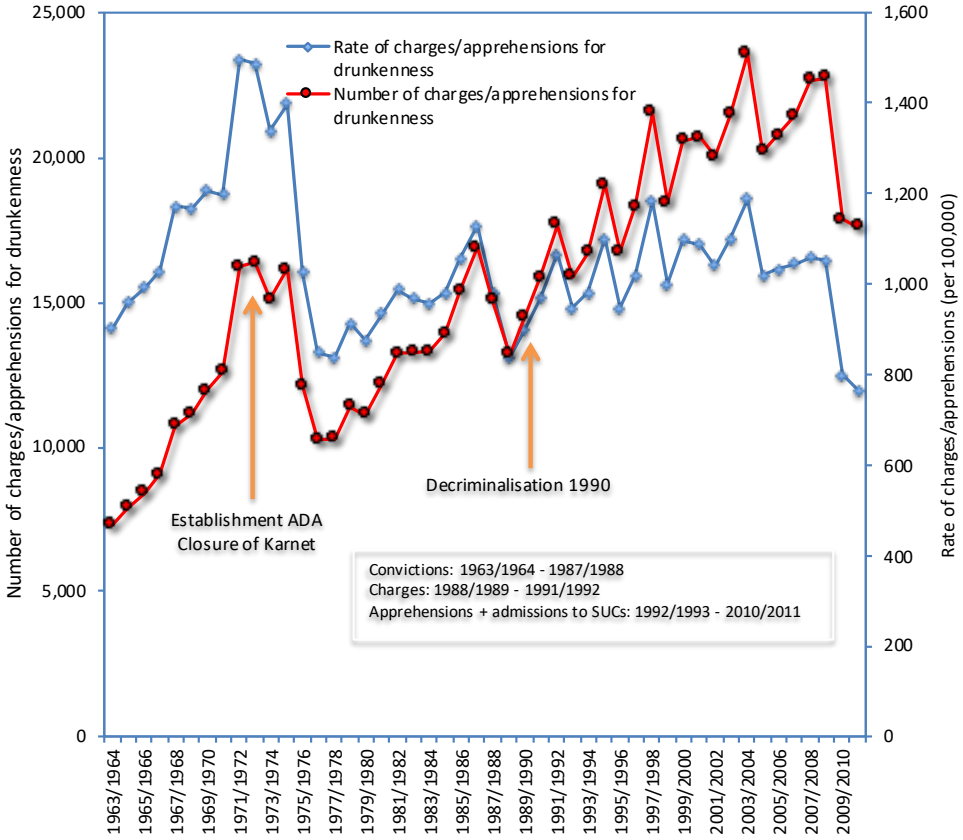

Figure 6: Number & rate of charges/apprehensions for drunkenness, WA, 1963/1964 – 2010/2011

In April 2013 the government announced the DAO would become part of the Mental Health Commission and that the *Alcohol and Drug Authority Act 1974* would be repealed so as to dissolve the Board of the ADA. In a ministerial statement, the Minister for Mental Health stated:

> '"The Stokes Report highlighted the need for improved liaison between mental health and drug and alcohol services to co-operatively provide care and intervention for patients with dual conditions," she said.
>
> "The new arrangement will encourage culture change, reduce the incidence of 'silos' in-service delivery and improve the delivery of mental health and drug and alcohol services across the State."
>
> Ms Morton said the amalgamation would also ensure integration of professional education and training and research activities in the drug and alcohol and mental health sectors.

She said the MHC and DAO currently operated primarily as the purchaser of services across government, and the proposal would strengthen the ability of the departments to negotiate and manage contracts."[72]

10 Discussion and conclusion

The research presented here indicates the principles of governmentality has the potential to assist in understanding with respect to the use of alcohol, of how at different time periods, policies operated which defined and prioritised the regulation of the use of alcohol, to minimise its harms and to maintain social order.

The sort of information required to identify the shifts over an extended time period posed some challenges, such as determining implementation of legislative provisions in a State which covered an enormous geographical area and small dispersed communities, reliability of and consistency in time series data concerning utilisation of services and impact of constant cycles of departmental and administrative change on quality of records.

The emphasis on social order underpinned the necessity for systems of compliance and observance of rules about appropriate behaviour was able to be implemented the mental system through the concept of the inebriate, which was supported by the existence of a broader framework which at different times involved a range of departments and legislation.

This means that the mental health system should not be seen as acting in isolation, but that it functioned as a component of a broader framework of controls, including the criminal justice system which enforced a spectrum of offences such as public drunkenness and other offences which criminalised public order consequences associated with alcohol, restrictions on access to alcohol in liquor licensing laws and prohibitions that targetted Indigenous people in native welfare legislation.

Of particular interest in this regard is how the framework of provisions in inebriate and mental legislation that operated over the period up to the 1970s enabled the alcohol industry to be lightly regulated. This occurred as the causes of alcohol-related mental disorders, as well as public drunkenness and other consequences from problematic alcohol use were seen to be a function of individual shortcomings.

> 'It was largely a matter of temperament with the individual, (which) became a disease. This is an early example of the way in which individualistic basis of the disease concept fitted well with the interests of the liquor trade, unlike the prevention-oriented, consumption control aims of the nineteenth century Temperance movement, and of the public health lobby of the 1980s.'[73]

There were also limited interest in reducing the consumption of alcohol over the period from 1900 to the 1940s, as over this period military regulations were applied to the two periods associated with both World Wars I and II in relation to opening hours of hotels near ports and railway stations and restricted serving of alcohol to service men. Policy makers in Australia were well aware of the experience in the United Kingdom in the World War I period when

[72] Morton, "DAO joins Mental Health Commission (Media statement)."

[73] M Lewis, "The early alcoholism treatment movement in Australia, 1859 - 1939," *Drug and Alcohol Review* 11 (1992): 79.

access to alcohol was heavily regulated to ensure production and efficiency was not adversely by problematic use of alcohol which had undermined the war effort.[74]

However, over the period after World War II the consumption of alcohol in WA substantially increased, from 6.3 litres of absolute alcohol per capita in 1945/1946 to 10.8 litres of absolute alcohol per capita in 1977/1978, followed by a levelling off since. This longer term of increasing alcohol consumption is mirrored in the increase in the rates of alcohol-related hospital admissions increased to the late 1970s, then decreased to the early 1990s and since then have increased markedly (Figure 4).

The perceptions of the value of appropriate behaviour towards others has been embodied in the concept of manners, which has a long pedigree and can be traced from the use of sumptuary laws which utilised external controls and punishments for the effect as necessary, which at their heart were concerned with consumption and regulation of impulses.[75]

More recently governance has evolved to an expectation the individual should be self-regulating, evidenced by assuming and maintaining responsibility for their own health and to make considered choices to rationally reduce risks, such as to drink alcohol 'responsibility' in accordance of recommended safe limits.[76] Nudge theory has also been advocated as a mechanism for policy makers to effect behavioural changes for the adoption a healthier lifestyle involving a range of health issues, including the use alcohol.[77]

This shift to self-governance is reliant on a rational consumer, as part of a broader goal to create a neo-liberal open market. The open market extolls a reduced regularly role of the state vis a vis the reliance of self-regulation by industry, for instance the adoption of industry

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[74] H Carter, *The control of the drink trade: A contribution to national efficiency 1915-1917* (London: Longmans, Green & Co, 1918).

[75] C I Dick, "Sumptuary law by any other name: manifestations of sumptuary regulation in Australia, 1901-1927 (PhD thesis)" (University of Wollongong, 2015), http://ro.uow.edu.au/theses/4490; A Hunt, *Governance of the consuming passions: a history of sumptuary regulation* (London, UK: Hutchinson, 1996); Hunt, "The governance of consumption: sumptuary laws and shifting forms of regulation."; A Hunt, *Governance of the consumping passions: a history of sumptuary law* (London, UK: Macmillan Press, 1996).

[76] Home Office, *The Government's alcohol strategy*, The Stationery Office (London, UK, 2012), http://www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/alcohol-strategy. National Health and Medical Research Council, *Australian guidelines to reduce health risks from drinking alcohol*, National Health and Medical Research Council (Canberra, ACT, 2009), https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/ds10-alcohol.pdf; National Health and Medical Research Council, "Revision of the Australian guidelines to reduce health risks from drinking alcohol 2009."; Health Department of Western Australia, *Alcohol use and social disruption: An alcohol education campaign for Western Australia*, Health Department of Western Australia (Perth, WA, 1993); Health Department of Western Australia, *Western Australian Health Promotion Strategic Framework 2007-2011*, Health Department of Western Australia (Perth, WA, 2007); Health Department of Western Australia, "Western Australian Health Promotion Straegic Framework 2012 - 2016," (2012). www.public.health.wa.gov.au/2/1588/2/health_promotion_strategic_framework.pm.

[77] A Arno and S Thomas, "The efficacy of nudge theory strategies in influencing adult dietary behaviour: a systematic review and meta-analysis," *BMC Public Health* 16 (2016), https://doi.org/10.1186/s12889-016-3272-x, http://download.springer.com/static/pdf/787/art%253A10.1186%252Fs12889-016-3272-x.pdf; N Biddle and K Curchin, "The promise and perils of giving the public a policy 'nudge'," (1 May 2014). http://theconversation.com/the-promise-and-perils-of-giving-the-public-a-policy-nudge-24887; H T Meyer, "'Responsibility deal' announced as health group withdraw," (15 March 2011). http://www.alcoholpolicy.net/2011/03/respsonsibilty-deals-announced-but-health-groups-withdraw-.html; R H Thaler and C R Sunstein, *Nudge: improving decisions about health, wealth and happiness* (Harmondsworth, England: Penguin, 2009).

overseen codes for alcohol advertising.[78] This has been a paradigm shift in how health is viewed and understood by as the 'New public health', [79] which

> '(w)hile the emphasis is shifted to social aspects, the strategy also focuses on individuals: in effect, the basis assumption of the new public health is to increase citizens' responsibility for risks and possibilities concerning their bodies and health.'[80]

This retreat by government from direct service provision in favour of a regulatory role was crystallised in the adoption and implementation of the National Competition Policy in Australia over the period 1995 to 2005:

> 'The National Competition Policy was Australia's landmark microeconomic reform program. A key principle of the program was that competitive markets will generally best serve the interests of consumers and the wider community.'[81]

In addition to the mental health system, repressive mechanisms were exercised by the criminal justice system from offences in the *Police Act 1892,* which imposed fixed terms of imprisonment for repeat offenders for public drunkenness. In effect this meant the powers available through the criminal justice and the mental health systems from the early 1900s established a framework of coercive and punitive measures which targeted problematic users of alcohol. This system was predicated on the belief that without strict controls, the unfettered use of alcohol posed a serious risk to social order and the stability of the family.

In addition to the repressive provisions in both mental health and police legislation, provisions were also present in other legislation, which sustained an environment of control over alcohol, such as restrictions on Sunday trading hours of hotels, the closure of hotels on holidays in the Christian calendar, the creation of extended opening hours in mining regions and specified hours of trading through special classes of licenses.

Other examples of the perceived threat of alcohol to social order were in matrimonial matters, where alcoholism was a ground for divorce under the State's *Matrimonial Causes and Personal Status Code* 1948. There were also restrictive provisions in 'native welfare' legislation, which targeted Indigenous people by excluding them from gazetted towns and prohibition of alcohol use in prescribed zones in the State, as they were regarded as being incapable of using alcohol safely due to supposed racial and genetic-based factors such as aldehyde dehydrogenase deficiency,[82] justifying prohibition use.

All of these measures established a pervasive system of controls over the use of alcohol, which shared a premise the genesis of problematic use of alcohol was located in the person. This perception was used to justify the use of an array of punitive, coercive and persuasive measures to reform, correct, educate, treat and rehabilitate such individuals.

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[78] G Swensen, "Public space and alcohol advertising: exploratory role of local government," *International Journal of Alcohol and Drug Research* 5(3) (2016).

[79] A Petersen and D Lupton, *The new public health: health and self in the age of risk* (London: Sage, 1996).

[80] C Tigerstedt, "Alcohol policy, public health and Kettil Bruun," *Contemporary Drug Problems* 26 (1999): 212.

[81] National Competition Policy. <http://ncp.ncc.gov.au/pages/overview>

[82] J Greeley and W Gladstone, "Alcohol and human behaviour (Research paper No. 14)," in *Deaths in custody Australia, 1980 - 1989: Resarch papers of the Criminology Unit of the Royal Commission into Aboriginal Deaths in Custody*, ed. D Biles and D McDonald (Canberra, ACT: Australian Institute of Criminology, 1992).

> 'The effects of alcoholic behaviour on the body have come to be considered as 'symptoms' of a 'disease', but if alcoholism is conceived as a way of life, the 'symptoms' would be better regarded as the side effects of the excessive consumption of alcohol.' [83]

This understanding creates a pervasive ideology that everyone has a freedom to drink, except that those who are problematic users of alcohol, for whom treatment may be required due to an inability to self-regulate, in spite of the existence of adverse social and other circumstances. This perspective was recognised nearly three decades ago in a landmark report by the American Institute of Medicine published in 1990:

> 'Alcohol is a drug, and its direct, relatively predictable, and uniform actions on the human organism have been well documented. Yet alcohol problems are experienced by specific individuals, who live and move and have their being within very different social, psychological, and cultural environments. [84]

The resurgence in establishing court adjudicated processes to compel problematic users of alcohol, as well as other drugs, to undergo a regime of abstinence focussed 'treatment' in custodial settings can be traced from the growth of Drug Courts in the United States. The use of drug courts and other court-overseen coercive measures have since proliferated in a number of jurisdictions, including in Australia.

Given the recency of statements by the government it has been difficult to identify the types of institutions, arrangements and supervisory structures that would be needed to produce the outcomes expected. However, in the light of little evidence to support similar approaches in the past, it is argued these reforms may be mostly about punishment and not much about treatment.

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[83] M Sargent, "Heavy drinking and its relation to alcoholism - with special reference to Australia," *Australian & New Zealand Journal of Sociology* 4 (1968): 146.

[84] Institute of Medicine, *Broadening the base of treatment for alcohol problems* (Washington, DC: National Academy Press, 1990), 20.

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