REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO THE INEBRIATES ACT 1912

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At Sydney on Wednesday 7 April 2004

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The Committee met at 9.30 a.m.

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PRESENT

The Hon. J. C. Burnswoods (Chair)

The Hon. Dr A. Chesterfield-Evans
The Hon. K. F. Griffin
The Hon. R. M. Parker
The Hon. G. Pearce
The Hon. I. W. West

INGRID VAN BEEK, Director, Kirketon Road Centre, Victoria Street, Darlinghurst, and

HESTER WILCE, Medical Officer, Kirketon Road Centre, Victoria Street, Darlinghurst, affirmed and examined:

CHAIR: It would help us if you could provide a brief overview of the services that the Kirketon Road clinic provides and the clients you assist, a bit of a pen picture of who they are or how they break down into different groups.

Dr van BEEK: Kirketon Road Centre is a department of Sydney Hospital located in Kings Cross. It provides a broad-ranging primary health care service targeting the needs of three target populations: at risk youth, sex workers and injecting drug users. We provide a range of medical, nursing and counselling services and we seek to address the various clinical and psychosocial issues that people within these populations may have. As well as providing on-site medical counselling and social welfare services, we provide a needle syringe program from several fixed sites, and a methadone access program for drug users who are opioid dependent who are unable to access other programs due to their chaotic lifestyles. We also have an extensive outreach program in the Darlinghurst, East Sydney, Kings Cross area. Every night of the week a bus goes to those locations. We also conduct clinics at youth centres within the eastern suburbs area extending through to Woolloomooloo and The Rocks targeting young people before they have made the transition to injecting in the hope of preventing that transition. We are also involved in training at a State-level, providing training in primary health care, and outreach. We also conduct special projects which include an Aboriginal project targeting Aboriginal injecting drug users at risk within the area, and a youth project and dental and hepatitis clinics.

CHAIR: How many staff do you have to do all that?

Dr van BEEK: We have a full-time equivalent staff of approximately 45.

CHAIR: Is severe alcohol dependence much of a feature of your work or is it almost totally other drugs?

Dr van BEEK: It is not. Certainly, some clients also have alcohol problems but the predominant issue is illicit drug use.

CHAIR: And as your submission notes, the Inebriates Act actually does cover both, although most of our evidence has focused on alcohol dependence. The Committee would like to focus today on a possible model, given the unanimity of opinion that exists against the Inebriates Act as it stands, but before we get on to the details of the directions in which we might go we want to get on the record your opinions about the whole notion of compulsory treatment and, I guess, the ethical issue but also the issue of effectiveness as well of compulsory treatment for the client group that we are talking about.

Dr WILCE: We do think that compulsory treatment may be necessary and ethically justified, but in perhaps rather exceptional circumstances. I will illustrate this by talking about two cases. The first was referred to in the submission: the 27-year-old cocaine-dependent young lady. She is very well known to Kirketon Road. She has been in Kings Cross area for many years—lots of psychosocial issues, opioid and cocaine dependent. In 2001 she presented to services in the local area including our service, emergency departments and other services a total of 21 times over a three-week period seeking help. There were two issues. The first one was that she was bingeing on cocaine and she was acutely delirious. She was agitated, disoriented and had paranoid delusions—seeing things, hearing things—but very distressed and very unwell.

The other issue was that she had a severe deep laceration on her left wrist which was untreated. When the injury first happened stitches were put in but she had a psychotic episode the following day and pulled the stitches out. So throughout the three weeks when she was seen she had this awful, open, gaping, infected wound that throughout that time was not adequately treated. It was our frustration and her frustration as well that nothing could be effectively done. This was an

individual who came to us seeking help and because of the way she presented and because of the issues around her presentation she was not able to be effectively helped through that period.

The second case involved a young guy who has recently moved into the Kings Cross area and has been seen at Kirketon Road very frequently over the last few months. He is 23, opiate dependent but also benzodiazepine dependent. As well as taking opiates he will take massive amounts of oral benzodiazepines. As you known, benzodiazepines are sleeping tablets and taken in small quantities may help people to sleep and to relax. Taken in large quantities they can actually cause a disinhibited behaviour whereby people act out in extraordinarily odd ways—very different from their natural personality. The other issue is that they do not remember what they have done. They do not know what they are doing. You cannot intervene. You cannot rationalise. They do incredibly stupid things. He would take some opiates and a lot of benzodiazepines, do really silly things, have no memory of it and then people around the streets would say, "Oh, do you remember what you did last night!" He would feel so embarrassed that he would want to be oblivious again so he would do the same things. So there was this ongoing cycle for him.

He is another person who has seen us repeatedly and said, "I don't want to do this; I hate that I'm doing this but I can't stop", and we have been unable to access a model of care that would enable him to make changes to that very destructive and dangerous behaviour. We felt that the Inebriates Act may be useful for those people whose lives are at risk and other people's lives are at risk through their drug use. In the first case the woman was mentally disordered. In the second case the man is not mentally disordered—he does not fit under the Mental Health Act—but he has a dependency that is putting his life at risk. He would wander out onto the road when he was intoxicated, for example, and nearly get run over by cars. He had no rational thought at that time. So people sit in two categories. This can be caused by benzodiazepine use or by other sedatives such as opiates and also the psycho stimulants such as amphetamines and cocaine, and inhalants. We do not tend to see that in Kings Cross, but that is another area.

CHAIR: You say in your submission that the first case—you call her LT—was admitted under the Mental Health Act on one occasion but little was achieved from that admission as she was reassessed 12 hours later and found, quite correctly, to be not mentally ill according to the definition in the Act. For us there is an issue regarding the people who could fall between the current Inebriates Act or some revised legislation and the Mental Health Act. Although you say that, unlike the second case study, she could be assisted under the Mental Health Act, after 12 hours she received no help.

Dr WILCE: That is exactly right. That was part of my frustration, having scheduled her, to find that 12 hours later, quite rightly, the psychiatric registrar said, "You are no longer psychotic so you can leave the hospital." The other thing that happened in the 12 hours that she was in hospital was that the surgical registrar was asked to look at her arm. He looked at her through the door, saw who it was, looked at her behaviour—she was very agitated, very angry and crying out; that kind of thing—and said, "Give her antibiotics it's not safe for me to go near her." So she received no intervention for the laceration at that point.

CHAIR: Was she in a general hospital?

Dr WILCE: She was in the emergency department of St Vincent's.

CHAIR: So she was not in a specific facility under the Mental Health Act?

Dr WILCE: That is right. That is certainly another point that I think is important. Emergency departments are not gazetted hospitals. While generally ambulances and sometimes police will take people to an emergency department, they are not gazetted hospitals. One of the issues for someone like the first case, with acute delirium, is that it is inappropriate for them to be seen in a psychiatric hospital. Some psychiatric hospitals may have the staff to cope with medical problems but the majority do not.

The Hon. IAN WEST: Would I be correct in assuming that in a place like St Vincent's the animosity of which you spoke from the intern, the registrar or whoever saw that person is unfortunately the norm?

Dr WILCE: I have worked in emergency departments and I know that dealing with this group of people is very difficult. There is a feeling out there that they are doing this to themselves; they are just junkies, let them sit in the corner and they will go away—which is what usually happens. It comes from the fact that emergency departments are very busy and emergency staff are not particularly well trained to deal with the issues affecting injecting drug users. They are quite difficult problems to deal with. I know this individual very well and in the state she was in she is very difficult to deal with.

Dr van BEEK: My understanding is that this particular person could only be admitted under the Mental Health Act. She was otherwise banned from being admitted to the emergency department of both hospitals.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you mean that hospitals have decided that she was too disruptive and did not want to see her? So you were inflicting her on the emergency department.

Dr van BEEK: Indeed, because of previous behaviour in the respective hospitals.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It was my medical experience 100 years ago that hospitals never wanted to take psychiatric admissions—even psychiatric hospitals would explain why people were not schedulable. Could you have argued that she was psychotic when you scheduled her and that she had a wound that had gone untreated for several weeks? The fact that she was no longer psychotic after 12 hours did not mean that she was not about to become psychotic again. It was a pattern of behaviour. I think the words in the Act are "not under proper care and control"—that used to be the definition for schedulable. If that is the case you could argue that the hospital was simply not adhering to the existing schedule. I used to schedule people and they would boomerang back all the time. That was exactly the situation that you were in, was it not?

Dr WILCE: Schedulable in the case of a mentally disordered person—she would fit in that category—is "for the person's own protection from physical harm or the protection of others from serious physical harm."

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: She was suffering physical harm because her wound was untreated.

Dr WILCE: That is absolutely right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We are discussing whether the Act should be changed. You have said that hospitals have difficulty with those sorts of patients—everyone knows that. She was specifically and personally banned by the hospital, which means that she had a double barrier. It seems to me—this was also your opinion—that she was meeting the criteria for the Act. Thus the problem may not be the Act but the fact that the hospital chooses not to abide by the Act.

Dr van BEEK: My understanding is that after 12 hours, because the duration of the effect of cocaine is so short, the psychotic symptoms—which were secondary to the cocaine use—had settled down so she no longer met the requirements of the Mental Health Act.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But she was still in danger of physical harm because her arm was festering and she was about to take another dose of cocaine—you knew that and so did hospital from its records of her past behaviour.

Dr van BEEK: That was certainly the pattern of her behaviour, particularly given the location—you are only five short minutes away from cocaine supply. Indeed, that was the frustration: although she was no longer psychotic she was still using cocaine compulsively. So she would leave the hospital and resume her use and then the psychotic symptoms would reoccur.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Could you not argue in both these cases that, while the duration of the effects of the drug was short, the behaviour was long-term and

therefore the people were schedulable under the Mental Health Act and should have been retained by the hospital whether it liked it or not?

Dr van BEEK: It has not been our experience that we have been able to argue that successfully.

CHAIR: So even in relation to cocaine use there is a gap—a hole—between the Mental Health Act and the Inebriates Act. It sounds as if this particular person fell into the gap.

Dr van BEEK: We are not sure whether the Inebriates Act—whether in its current form or modified—could fill that gap. But I suppose that is what motivated us to make a submission to the Committee, in case this was an opportunity to close that gap.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have not argued successfully in practice but you would presumably argue in theory that both these cases were schedulable under the Mental Health Act, whether or not you have successfully argued that in the past and whether or not the effect of the drug wore off after 12 hours.

Dr van BEEK: My understanding—and neither of us is psychiatrically trained—is that previous patterns of behaviour cannot be considered and it is the mental state of the person there and then that is assessed. Indeed, the bar is quite high from that point of view.

CHAIR: You noted the provisos in the Mental Health Act in your submission. Of course, one is that people cannot be scheduled if they have taken alcohol or any other drug unless that use is immediately life threatening. The Mental Health Act almost explicitly excludes LT and the case study.

Dr van BEEK: Usually the reality in these situations is that 12 hours later both the person assessing the patient and the patient are in agreement that there is no problem any more.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: To the benefit of both in the short term.

Dr van BEEK: They have a common interest at that moment.

The Hon. ROBYN PARKER: If we are looking at using compulsion in a mandated way, the key would seem to be that treatment must be added somewhere rather than just a period of time when someone is held against his or her wishes or willingly. There appeared to be absolutely no treatment in the case of that particular young woman. Perhaps there was a short-term advantage; that is, she did not meet a fatal end at that point. However, treatment must be added at some stage.

Dr WILCE: The Inebriates Act makes no mention of treatment; it is simply about containment. With the majority of drugs we are talking about there is no treatment. We do not have treatments for cocaine and amphetamine dependence. Treatment for benzodiazepine dependence in the community is very difficult because we cannot control supply. Methadone and buprenorphine have been very useful in helping people to come to terms with their opiate dependence. However, we do not have easy, first-line pharmacotherapeutic options for these other drugs. That is a real problem.

Dr van BEEK: In the case we are discussing, ceasing the cocaine use will certainly stop the psychosis, and usually quite quickly. However, there is no licensed treatment to prevent its recurrence on the resumption of cocaine use. So, preventing someone from resuming use is the primary aim. However, in a community situation, particularly in such proximity to cocaine suppliers in the Darlinghurst and Kings Cross area, that not feasible. The Mental Health Act works in those situations to remove the immediate risk in the short term, but the problems all recur when and if the drug use resumes.

Dr WILCE: When LT goes into gaol she is contained and when she comes out she has put on weight and is doing well. She is articulate and looks fantastic. People are not put in gaol for those reasons—it is not for treatment—but it is a secondary effect. For her, containment has been very effective in the short term. One of the issues is that she comes out of that containment and moves back into dependency. Since then she has knowingly allowed herself to be infected with HIV.

The Hon. ROBYN PARKER: There is no treatment for cocaine abuse. Would a counselling program make a difference in a gaol-type situation?

Dr WILCE: I do not think gaol is the appropriate place.

The Hon. ROBYN PARKER: I mean in a compulsory detainment environment, not an alternative place, where she would be kept for some time.

Dr WILCE: Individuals like LT need ongoing, intensive psychosocial input. She fulfils the criteria for borderline personality disorder. She has a very damaged personality. She is a very nice woman and very intelligent. When she is straight she is a very interesting person to talk to. She has a lot of potential, but because of her personality disorder and her dependence she cannot realise that potential. People with these personality disorders need intensive, long-term counselling and support.

CHAIR: As I said, we are very anxious to look at how we can come up with a model for the future, whatever legislative form it might take. I refer to question three. Your submission states that of the 150,000 attendances at Kirketon Road in the past three years there were only two cases in which the Inebriates Act may have been useful, and you have provided the two case studies. Is that a comment about the old-fashioned 1912 Act, or are you saying that, given the lack of treatment and the need to address motivational issues rather than compulsory treatment, even a new, greatly improved Act would be of very little relevance to the 150,000 attendances?

Dr WILCE: For the vast majority that is correct. The second case I discussed was not the one referred to in the submission. It is another one since then, so there have been three in the past three and a half years. The dilemma which I face and which you have already referred to is that people do much better if they are ready to make the changes themselves and if they do not feel coerced into treatment. If they come to the point where they decide that they want to make changes and they are empowered, of course, it will be much better. I have a slight anxiety that if the Act were changed people who were not appropriate would be admitted. It must be very carefully worked out and it would apply to a very small proportion of people.

CHAIR: Having clarified that, some of the committee's specific questions will enable honourable members to refine the limited system we are talking about. Keeping in mind a potential model, legislative or otherwise, for compulsory treatment, what in your view should treatment involve?

Dr WILCE: As we have said, in the first instance it should be containment in a safe environment. Containment in a psychiatric locked ward is not appropriate because these people are not mentally ill. It must be a dedicated unit for people dealing with drug and alcohol issues. They need intensive psychosocial support and pharmacotherapy, if it is available for their drug of choice. We need to base that treatment on evidence, but the problem is that we do not have much at the moment.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The staff at the gaol institutions we visit—and I have visited them a couple of times—are very proud of the improvements they achieve in their drug patients. They are sometimes crestfallen that patients come in complete wrecks and they build them up, get them healthy and they put on weight, but they go home and come back much worse than they were. They build their self-esteem, give them activities, teach them to cook and how to garden and so on. The patients have obviously committed a crime deliberately or in concert with a boyfriend or whatever—it is usually women in these situations. It seems odd that we can provide a supportive environment in gaol and a totally unsupportive environment elsewhere. We do not seem able to find the middle course. Do you have anything to say about that? Could there be an Inebriates Act that does not involve locking them up?

Dr WILCE: Residential rehabilitation is that middle ground. It is not compulsory, though it can be a condition of somebody's parole. For want of a better word, it is a contained environment if people choose to stay there.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Under the old-fashioned Inebriates Act people went to a psychiatric ward, and that was it.

Dr WILCE: An asylum for the insane.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And now all the institutions complain that they do not have those sorts of wards anymore. All the disabled support and mental health support groups say that we need graded supports in the community. Would you advocate that type of model? If so, how it would it occur or is that beyond your expertise in the sense that you are merely offering one point of service in a community?

Dr WILCE: I am not sure what you are asking.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What is the suggested model to be included in the Inebriates Act for a schedule to an unlocked community-based place? Presumably if they wanted they could still go out and get cocaine but if they were fed and looked after they would do a bit better.

Dr van BEEK: If something like that were not located in the heart of Kings Cross it would be a good start to make that less likely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you suggest residential rehabilitation so someone would be scheduled to attend there? What order would be given? Everyone in the drug and alcohol field has told the committee that compulsory treatment does poorly and parents who are trying to get their kids rehabilitated are concerned about the MERIT program taking spaces that might have been available to their kids. In other words, court orders eat up the resources that could be used for voluntary patients. It is also said that the compulsory people have a lower success rate than voluntary patients anyway and that they are getting diddled. What type of compulsory model would it be?

CHAIR: The Hon. Dr Arthur Chesterfield-Evans, some of your broader questions are spelled out in our questions. It might be easier for our witnesses to answer those questions.

Dr WILCE: I want to comment on what we consider success is. For me with the case studies that I have talked about, success in a way is keeping them alive and trying to give them a safe breathing space for a short period of time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Short, but even prisoners say they were healthier and happier and weighed 10 kilograms more and they were full of diseases and sores. Physical health is a measure of success.

CHAIR: Most people have said, in answer to questions about the ethical issues of compulsory treatment, that one measure of success is that people are alive after one, three or six months. Currently at Bloomfield in Orange there are three people under Inebriates Orders and as Bloomfield has a knowledge of their history it can talk with some evidence about the likely outcomes for people. Given all of these other questions about the lack of success by other measures there seems to be broad agreement that keeping people alive is one important consideration.

Dr WILCE: I guess with the model my thoughts are that it would be good for a period of time, perhaps a months, to be a contained unit where people are not able to access their drugs. So they are not able to wander off and get their drugs.

CHAIR: Why one month?

Dr WILCE: Twelve hours is not long enough. The other thing is that ideally—and am I thinking of both the first case and the case about which I spoke earlier—they would come to us when they were well and rational and say, "I want to stop this." At that point for us to say, "What we can do for you is if you sign this we can put you into a safe place for a month. You will not be allowed to leave that place. There will be times when you feel you want to do that. How about we try this because you, at the moment, know that you are not able to contain your dependency and you do things that you do not wish to do because of your illness? How about you sign this? You make a living will that says that you will attend this place?" That is one option when the person is rational that they be

involved in that decision. The other option is when they actually are unwell that they be scheduled, for want of a better word, under this new Act and taken to that place.

The Hon. ROBYN PARKER: Who should determine that someone should be scheduled? Is it the same sort of people who currently are able to schedule under the Mental Health Act?

Dr WILCE: Anyone should be able to say, "I want this person to be assessed". So a family member, the doctor, the local police officer or whoever but the only people that can do the assessment and that scheduling should be addiction specialists. You may be aware that the College of Physicians has just started a new chapter for addiction specialists. My concern is that if it is broader than that then people's idea of what dependence and safety is could be quite broad, and we do really want to limit it. Addiction specialists are the individuals ideally placed for that. There are only a small number of them so far. How many are there?

Dr van BEEK: I am not sure, but I imagine that their coverage is not so good in rural areas.

CHAIR: Without holding you to one month, particularly in relation to alcohol people have made a point that at least seven days needs to elapse for people to get over the state they are in. Then there is a need for a proper assessment process. Most people include in the compulsory period initial detoxification, assessment and then a period of rehabilitation or whatever it is called in relation to alcohol. When you first mentioned one month starting when people are well, I guess that could be post-assessment. Would you expand on that?

Dr WILCE: Certainly, another important part of the assessment would be to exclude serious mental illness. It may well be that some people would require a psychiatric assessment as well to make sure that that is not in the mix. I strongly believe that people who have a serious mental illness need to be managed through the mental health system. A lot of people who have serious mental illness also have substance dependencies, but they need to be managed through the mental health system.

CHAIR: In relation to who would be involved in the assessment process, you would need various mental health specialists as well as addiction specialists to cope with that overlap in people who have both conditions. Does that have implications for where the assessment would be carried out? How would they be co-located? What would the process be of bringing in different expertise to carry out the assessments?

Dr WILCE: I would imagine that you could bring in a psychiatrist on a consultant basis to assess everybody. I would think that everybody, regardless of whether they appear to have a mental health issue or not, should also be assessed by a psychiatrist. One of the great frustrations within the system is that it is often hard to know whether somebody has an underlying mental health problem while they are using all sorts of drugs in the community. So you get the situation where the psychiatrist says, "I can't assess this person until they cease using drugs." Of course, we have difficulty effecting that in a community situation. If you had a contained environment where people were detoxed across a period of however long that takes, depending on the drug, it is then an ideal opportunity to bring in a psychiatrist to assess whether there is a serious underlying problem or whether the behavioural problems you are seeing are specifically related to the drug use per se.

We have suggested a month, but that is fairly arbitrary. It should be assessed on a case-by-case basis. In the alcohol area there is a lot more research over many more years, so we know more about how long it takes for the brain to recover to get to a stage where you can assess the situation. We know less about that with some of the illicit substances, particularly when used in varying combinations and so on. I would think the order might even need to be reviewed over time as far as how long it should be.

The Hon. ROBYN PARKER: And reviewed by a team of people?

Dr van BEEK: Yes, including addiction medicine specialists. A social worker and a psychologist should also be part of that team.

The Hon. ROBYN PARKER: You do not see a role for the judiciary in this process?

Dr van BEEK: They could chair the meeting.

Dr WILCE: Under the Mental Health Act, if the schedule is upheld it is taken before a magistrate, and the magistrate has the final decision. So perhaps it could be set up in much the same way, where a schedule is written by the addiction specialist for five or seven days, then the person is reassessed at that point by a multidisciplinary team. It is then taken before a magistrate, who is the person who makes the final decision, simply because that is then gives it some kind of binding.

CHAIR: It also addresses the civil liberties concerns that you and others have raised.

Dr van BEEK: Yes.

CHAIR: But that is different from the inebriates order structure, under which the magistrate is the primary decision maker on perhaps a relatively perfunctory statement from a general practitioner, particularly in rural areas.

Dr van BEEK: Yes. I would say that the Inebriates Act is perhaps more directed towards dealing with public nuisance. In that sense, the judiciary has had a role, but it is not there necessarily to institute treatment.

The Hon. ROBYN PARKER: Currently that is the situation. The magistrate makes an order and the person is duly trucked off to wherever, and there is no further contact. Everyone, including the judiciary, has had the same view on where they see their role following the review process.

Dr van BEEK: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: A judicial officer presented the case that he was told that he was doing the eastern suburbs, and that he had to turn up at the Mental Health Tribunal on the Monday so he had better read the Act. His research was to read the Act before he started work, and that was the extent of his knowledge.

CHAIR: Although, in general it would probably be true to say that the Inebriates Act does not allow for any training or specialty amongst magistrates at all. If you are in a particular place and you are brought before the magistrate who happens to be on duty, that is what happens. Whereas, the safeguards under the Mental Health Act at least enable a little specialisation, even though it is not always the case.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The amount of discretion the judicial system is given obviously should relate to the amount of knowledge they have.

CHAIR: We would like to talk about a number of issues, including what people have referred to as community treatment orders, and applying them to alcohol and other drugs. Would it be true to say that you envisage that whatever system might be set up, it would deal with a very small number of people?

Dr van BEEK: Yes.

CHAIR: Given the sort of statistics you have provided, can you quantify that or give us any sort of indication? Do you think it would be a very small percentage of the sort of clients you deal with, for example?

Dr WILCE: When we talked about it we came up with a figure of between two and five a year from our client group.

Dr van BEEK: Which is several hundred.

CHAIR: Those two to five a year would be various drugs, and not alcohol?

Dr WILCE: Most likely, polydrug use. Occasionally we do see people who have an alcohol dependence, but it is much less common. The majority of people we see have polydrug use.

CHAIR: Two to five a year extrapolated from the State is still a very small number, is it not?

Dr WILCE: Yes.

CHAIR: The other issue that is absolutely missing from the Inebriates Act but which people have begun to explore with us is the post-treatment situation, the follow-up mechanisms. The problem with the notion of compulsory treatment is what happens when people simply walk out. What kind of service system is there to make sure that people are supported afterwards?

Dr WILCE: One of the issues for people coming out of any kind of hospital stay is that the doors open, somebody who is a junior doctor or whatever might write a discharge to the local medical officer, and quite often they will be out in the community when nothing has been organised. This is often the case with gaol: the people are let out when nothing has been organised, and they are left to their own devices. If you are someone who has spent a great deal of time on the streets of Kings Cross, you go back to where your supports are: you go back to what you know. After this period of compulsory treatment people are then offered a number of different options. They could go to residential rehabilitation, or they could go to outpatient rehabilitation. But it needs to be formalised, it needs to be discussed before the person leaves, and it needs to be discussed with all the relevant people that might be involved.

One of our concerns, given that we are a service based in the middle of Kings Cross, is that we know these people very well, we are part of their support structure, but by the very fact of their coming back to see us they are coming back to the Kings Cross area, which may not be such a good idea for them. From my point of view, I think it is important that the individual is involved in that decision making and that they decide where they want to continue on from there. It may be that at that point they make a rational decision to move back to Kings Cross and back to using, and that is their choice. In terms of the community treatment orders under the Mental Health Act, one possibility is to compel people to continue with treatment. I do not know how often that would be useful in this group.

Dr van BEEK: I suppose it depends on what treatment and how important we think that is to their being an immediate threat to either themselves or others. In the case of LT, that treatment that we felt was needed across time was medical treatment of a wounded arm. So whilst there is no pharmacological treatment for cocaine dependence, and cessation is the best treatment for that, in her case she needed ongoing treatment of this wounded arm, otherwise she was at risk of developing a disseminated sepsis, which could be life threatening. Again, it varies depending on the situation.

CHAIR: Some of the people who have spoken to us about community treatment orders—such as the health professionals at Bloomfield, where we were a couple of weeks ago, and health professionals in the broad mid-western region—have probably been thinking of a more rural and regional setting where they have envisaged something that would compel someone, for example, to see probably their local GP, given the size of the communities they are talking about, perhaps once or twice a week for a specific period. They are nominating the GP partly because of a lack of anyone else in the community who may be visiting drug and alcohol affected people or who may have access to them, but I guess they are also stressing the need for the kinds of social supports and so on that you are talking about. Kings Cross is very different. You are talking I guess from your expertise in the Kings Cross area. It is very different from dealing with someone from a smallish town in the Mid Western Area Health Service. I would like your comments on whether or not the community treatment order course is much more relevant to a rural and regional setting than it is to an urban setting.

Dr WILCE: I was talking to some GPs from Nowra. They have a community benzodiazepine detoxification service and they have a nurse who actually visits people in their home and doses them with benzodiazepines. There are a limited number of GPs and there are a limited number of pharmacies. The environment can be quite closely controlled because it is a smaller community and that works very well in that area. The issue in Kings Cross is that there is almost a limitless number of GPs and a limitless number of pharmacies. There would be, I would think, an issue of safety for staff first of all with visiting people.

The other issue is that a lot of the people we see do not have homes and they do not have addresses. That is one of the issues with the community treatment order in the mental health system.

While people can get a community treatment order without an address they tend not to because the mental health service is not in a position to go looking for them. Occasionally it can be done through the methadone clinic or they know that they sleep in the lane outside Matthew Talbot and they may go looking for them, but people need to have an address. In Kings Cross it is quite different to rural areas for those reasons.

CHAIR: So you can envisage a service system I guess that would incorporate things like community treatment orders, but that might vary very much across the State of New South Wales.

Dr WILCE: The idea of home visits is fantastic. Seeing people in their own environment is a very different experience than having someone coming to your surgery. You get a lot more information. You see them in their own domain. You pay a visit to their own domain. It can be very useful, but it is not going to be useful for everyone because everybody's situation is different. Ideally it would be great while people were in treatment, if they were in compulsory treatment for a period of time, if housing could be organised so that when they came out of that they had somewhere to go to. The fact is that that is not always possible. The Department of Public Housing lists are long, and people wait years.

The Hon. IAN WEST: In regard to LT, in those times when she was what we would describe as in a rational state such as at a time when you assessed her as being a very bright and intelligent young woman, can you give us some insight into what triggered the relapse? Can you also give us some indication as to her environment in terms of housing and whether or not she ever had any employment?

Dr WILCE: She was first on the streets of Kings Cross at age 13. She has been sex working since her early teens and heroin dependent: first seen at Kirketon Road aged 16. She has a past history of a very troubled family childhood: sexual assault and physical assault as a child. She has sex worked. However, she has had times when she has been good, when she has worked in the construction industry. She has been chronically homeless. She moves around Sydney and she has had times when she has had housing for short periods of time but things generally fall apart fairly quickly for her.

The Hon. IAN WEST: And at that time when there is the trigger and things fall apart, you actually have not had contact with her. Your contact has been after it is too late.

Dr WILCE: The sorts of things that for her would trigger issues would be lots of issues to do with her relationship with her partner. She is actually a perpetrator of domestic violence against her partner. Another thing that she will do when she is feeling very distressed is she will go out into the streets and assault people.

Dr van BEEK: She also has her own physical and sexual abuse history.

Dr WILCE: Yes. We can see her at times when she is doing well and we can see her at times when she is becoming more chaotic, and the triggers quite often are to do with relationship issues.

The Hon. IAN WEST: Am I right in assuming that at the times she is feeling well and you have seen her, she has said, "Yes, I really do need treatment." Is that the case?

Dr WILCE: Absolutely. The last time that I saw her, which was shortly after she came out of gaol when she was doing well, she wanted to actually see a counsellor around her issues with anger and her issues with her inability to trust people, and she actually had some counselling at that stage.

The Hon. IAN WEST: At that point in time, was she working in the construction industry?

Dr WILCE: At that point in time she was doing some gardening work.

Dr van BEEK: We had an outreach program into Mulawa at one stage particularly targeting women who were in on charges related to their cocaine use, so we thought it was a good idea to be able to access them, when they were stable and not using cocaine, to try to look at ways to prevent

their resumption of that use once they came out. The women in those situations usually do have good insight into why they are there and they can themselves trace the history related to their circumstances that have led them there. Certainly they are as motivated as they will ever be in that situation, in our experience.

When we put to people the prospect of never using cocaine again—for example, in the early trial phases there are what are called "vaccines" for cocaine. A medication can be given that will stop cocaine from having any effect subsequently. In that way it works sort of like naltrexone does. It means that even if a person does use cocaine, it is not going to have any effect. When we put to people whether or not they would be interested in such a thing after they had acknowledged that all of their problems are related to their cocaine use, what we found was that in those circumstances people had great confidence that they would not need something like that, that they would be strong enough not to resume their use.

About a third were in that group. Another third actually thought it would be a very good idea and they would be willing to submit for that. Maybe that is the group who has the most insight. And then another third were perhaps the most honest and said that the thought of never injecting cocaine again and not having the psycho-active effects that people report with that was just too much to contemplate.

The Hon. IAN WEST: In terms of that period of heightened rational thought, do you see a role for some sort of living will that gives you the custodial authority to be able to say that when there is a trigger that causes a person to commence a descent on the slippery slope, you are in a position to respond to that trigger. Do you see a role for that?

Dr WILCE: Yes.

Dr van BEEK: I think that would be the time to do it and when you can also be assured that people are of rational mind to be making that sort of informed decision and also they are in a situation where they are contained: For example, what we are proposing would also be a time to get that sort of undertaking.

The Hon. IAN WEST: Has LT ever indicated to you that she really would like some long-term employment opportunities?

Dr WILCE: Yes.

The Hon. ROBYN PARKER: The pilot program, was that a pilot program that you took into Mulawa, or was it just something that you initiated?

Dr van BEEK: That was something that we initiated.

The Hon. ROBYN PARKER: That is fantastic. So there was no proposal from the Government or anything to keep that sort of program going?

Dr van BEEK: There was difficulty with the funding. It was funded from Mulawa. They would actually fund us to go, and it involved their staff as well. There are various logistical issues of course with that sort of thing, with lockdowns occurring, so that you could not always be sure of getting into the prisons and so on. But we were very committed to it. It seemed like a good place to be intervening.

CHAIR: Were you able to follow up anyone afterwards?

Dr van BEEK: These were, by and large, people that we knew, so we followed them up when they came back out.

CHAIR: I follow on from Mr West's questions about the living will and so. Presumably that would need to be in some form of legislative model, because you are saying it would provide a basis of individual choice, and then for some compulsion to be exercised where people move from what I will call the rational phase into another phase. I think it would be fair to say that most people we have

talked to have said that the model of safeguards and so on, the appeals process and the mix of medical and legal people in the Mental Health Act, is not a bad model to apply for the group currently covered by the Inebriates Act. Would you agree? I think you expressed a little bit of concern about the legal side of it before, but do you regard the regime in the Mental Health Act as having defects that would need to be corrected?

Dr van BEEK: Not from that perspective. I did not mean to sound glib about the role of the judiciary.

CHAIR: Not the judiciary, but the broader legal body.

Dr van BEEK: I think we need to include other people to make sure that community standards also are taken into account into that situation. I think that is important.

CHAIR: Would you go for any other sorts of safeguards in order to balance the rights of people regarding civil liberties and such things?

Dr van BEEK: I think you could also have consumer representation, as occurs on the Mental Health Tribunal. You could have advocates from drug user organisations. That might be another safeguard.

CHAIR: In terms of the decision-making process, you have stressed the need for addiction specialists and others to have an input. Presumably, you would also accept that, in the end, it has to have some sort of legal input because of the nature of the decisions being made.

Dr van BEEK: Yes.

CHAIR: Question 6 is a vexed question that we have been dealing with. It is about whether or not a new compulsory treatment regime should be within the mental health system or the alcohol and drug system. It is partly a question of a recognition that there can be very different problems, but the issues that we are grappling with impact a group of as maybe as many as a third of people who overlap the mental health and drug and health side of things. We are also being made very conscious that in rural and regional areas the small number of people makes it much more difficult, outside Sydney and perhaps Wollongong, Newcastle and some coastal areas, to get sufficient numbers of people, including staff, and the facilities necessary to have two separate systems running. Can you give us your feelings about the different aspects of making a choice between the mental health system and the drug and alcohol system?

Dr van BEEK: Our view was that it should be in the alcohol and other drugs system, but that it should be closely aligned and integrated with the mental health system. The reason for that view is that, although there are overlaps, the way things are structured in this country, particularly in regard to the training of medical practitioners—who are quite separate now, with addiction medicine physicians being under the college of physicians, as opposed to the college of psychiatrists, so they are quite separate systems as it is—the only instances in which we think there would be benefits from it being one and the same would be those instances where there is a serious underlying mental illness. It depends on what your definition of that is. But, if we are only including the psychoses schizophrenia and bipolar disorder, then it is actually only a small percentage of people who use drug and alcohol who have those underlying diagnoses.

CHAIR: What sort of percentage do you mean when you say small?

Dr van BEEK: My understanding is that in the order of about 5 to 10 per cent would have those serious mental illnesses. If we include borderline personality disorder, of course it is then a very much higher percentage. But the mental health system has, traditionally anyway, offered little to people with borderline personality disorder; in fact, the system often has excluded people with that diagnosis, certainly from acute care—for good reasons mostly, because the acute mental health system has little to offer people with borderline personality disorder. So, yes, we felt that perhaps a co-location would be useful, as obviously would a lot of communication between the two systems, perhaps bringing in psychiatrists to consult with the Alcohol and Drug Unit, and probably the reverse as well could occur, but not necessarily all under the one umbrella.

The Hon. ROBYN PARKER: An underlying theme in your submission—and it may be something that prompted you to make the submission in the first place—is possible abuse or misuse of a reformed Inebriates Act to deal with community morality issues, such as cleaning up the streets, or whatever. Can you expand on what your concerns might be in that regard?

Dr WILCE: I would be very concerned if the legislation was used to punish people for bad behaviour. It should be used for people who are, medically, at a point where they are at significant harm. There may be some in our community who think that injecting once is a terrible thing, and that people should be compelled not to do that again. From my point of view, that may be a community value, and I would be horrified if one of my family members were injecting and I had to deal with that, but from the point of the Act and civil liberties, and the right of people to decide how they are going to live their lives, I think it is very important that it is not used in that way.

The Hon. ROBYN PARKER: If we go down the path of the model that we have been talking about today, as long as there are adequate safeguards in the sense of having community representatives and drug and alcohol specialists and advocates involved, do you think that would be sufficient to prevent the abuse of such an Act?

Dr WILCE: If there is an appeal process available to the individual, and if the addiction specialists are trained and understand what the new Act is about, I think that is sufficient. Do you agree?

Dr van BEEK: I agree, providing the Act is reframed to provide a balance between the need to protect the individual and the community—acknowledging, of course, that harm to the community is something that needs to be dealt with. As long as there has been a reframing as has been discussed, and it is also seen as a therapeutic opportunity, I think that is likely to be sufficient.

The Hon. ROBYN PARKER: So would you see a right of appeal as only being granted to the individual concerned? Probably the majority of your clients would not be necessarily living in a family environment, there are some people that this Act might apply to who are living in a family environment, no doubt not very stable because of their chaotic sort of lifestyle. But do you see that others may have a right of appeal or should it only be confined to the individual?

Dr van BEEK: I would think families should also have a right of appeal.

The Hon. ROBYN PARKER: Or address that appeal?

Dr van BEEK: Yes, I think so, not having giving it previous thought. But it would seem that that would be a good opportunity to flag whether or not there might be a problem there as far as the family's ability to cope with the situation and then maybe alternative arrangements could be made and additional support put in place.

Dr WILCE: And family members may well have additional information that is very useful in enabling a decision to be made.

CHAIR: Could I just clarify, when we talk about these kinds of safeguards, appeal processes and so on in an Act, do you favour a separate Act, given that you are certainly supporting having a separation between the alcohol and other drugs service and the mental health service? Do you see the need for a continuation of a separate Act or do you see the Mental Health Act as covering both?

Dr WILCE: I would think a separate Act; very much based on the template of the Mental Health Act, which is excellent, but a separate Act.

CHAIR: I just wanted to get that on the record because of the differing opinions. Just given what you have said about a separation of the two, when you referred to co-location could you give us any indication of where that might be, because obviously at this stage people at the old hospitals that are gazetted under the Inebriates Act, such as Bloomfield at Orange, Macquarie Hospital and so on, have made comments about how unsatisfactory it is to have someone arrive out of the blue under an inebriates order in a hospital that is set up to deal with the serious end of mental health issues? When

you talk about co-location what kind of facility are you talking about? Are you talking about a general hospital, for instance, or a piece of land that has a variety of different health services operating from it? What have you got in mind?

Dr van BEEK: When I said that I suppose I was thinking of Rozelle Hospital where indeed there are quite large grounds and where an environment might be able to be established which is unlike a correctional facility but, nonetheless, away from some of the cues for drug use and new facilities where there are also mental health services.

CHAIR: So a site like Rozelle?

Dr van BEEK: That is a fairly unique environment. Now that I think about it further there are not many situations like that.

CHAIR: Well, yes and no. Where sites that perhaps have been in the health system for 150 years have developed as sites for all sorts of facilities. We also visited the detoxification unit at Royal North Shore Hospital, which has taken people under the Inebriates Act. It works in co-operation with the general hospital and particularly the accident and emergency sections, but it then has a rehabilitation unit at Manly. So that is a model of co-location on a general hospital site as distinct from the Rozelle Hospital mental health sort of site. But then the mental health system is also in a state of flux as to the continuing use of the old large institutions. You do not see problems about putting people in the drug and alcohol services area, both staff and clients, on the same sites close by—people under the mental health system?

Dr van BEEK: No.

Dr WILCE: I think the benefit of that is that it means that you have a number of different staff with different expertise who can help manage the individual's issues. Ideally I think it would be good if you had mental health staff, drug and alcohol staff, emergency department staff and general hospital staff, so that there are all those kinds of skills that could help you manage the individual's problems.

CHAIR: One huge sort of amorphous health facility.

The Hon. ROBYN PARKER: We have talked mostly about non-offenders today and I noticed in your submission you talk about the Inebriates Act not applying to offenders. When I say "non-offenders" most people in this sort of crisis situation probably offend in some way, whether it be domestic violence or petty crime, but for those currently under the criminal system there are some options available to them. Some of those might be the Magistrates Early Referral Into Treatment Program [MERIT] or the drug courts or the drug gaol. You talked a little bit about gaol and the effectiveness of that, how do you view those programs that currently operate for offenders?

Dr van BEEK: We would be very supportive of those programs. When people come before the criminal justice system that is a time—particularly if it is the first time they have come before the system—which is often a life changing event, and can actually motivate people to address their drug use. So, yes, we would support all efforts like that to address the cause of the crime in the hope of preventing it from happening again. Obviously we need to avoid a situation where people can only get access to drug treatment or rehabilitation services if they have committed a crime. Certainly before the New South Wales Drug Summit I think that was the situation but I do not think that is the situation any more. Access to drug treatment has certainly improved.

To clarify: there is not a lot of hard evidence about the relative merits of compulsory versus non-compulsory treatments, although I suppose it is fairly self-evident that people who are motivated for treatment are going to have better outcomes. But that is not to say that there is absolutely nothing to be gained in compulsory treatment for those who are not motivated, particularly depending on what outcomes you are judging your success on. Hester already referred to that. If the benchmark is being drug-free forever, indeed the success of compulsory treatment is low—the success of any treatment is low on that measure.

But in terms of removing people from immediate danger, I think that is obviously where compulsory treatment does have something to offer. So provided we can have at least equal access to people who voluntarily want to go into treatment, we do not have much to lose by also having a system running alongside that requires treatment in extreme circumstances.

Dr WILCE: The Inebriates Act does mention offenders and non-offenders. It would certainly be my view that a new Act should not include offenders, that they should be dealt with through the criminal justice system.

The Hon. ROBYN PARKER: So you would completely isolate offenders or those caught?

Dr WILCE: There are already programs that assist them anyway.

The Hon. ROBYN PARKER: What do you think of the drug gaol initiative?

Dr van BEEK: That is the drug-free gaol?

The Hon. ROBYN PARKER: Well, the less drugs gaol.

Dr van BEEK: Which they all are of course. From our perspective the more opportunities there are for people to address their drug use the better. So again we would support that initiative as long as it does not take away from resources at the community level for people who are trying to do it without going through the criminal system.

The Hon. ROBYN PARKER: Would you like to see a recommendation in terms of further initiatives, such as your outreach program, into gaols?

Dr van BEEK: I think it would be a great thing if we could have greater continuity of care for this population, who do revolve through the criminal justice system back out into the community, so that we have a shared care arrangement. Again, there are a lot of structural barriers to this at this stage. What we found when we were trying to promote discharge planning from post-release from gaols was that it was almost impossible. Nobody knew when people were going to be released exactly. Sometimes people were given three hours notice that they were going to be released that day and you may not have everything in place at that moment in time.

People get moved around the correctional system at an alarming rate, which interferes a lot with all the therapeutic opportunities. From our perspective in our community and, indeed, it is not your average community, we are seeing the most chaotic, damaged people, who are thankfully not the norm among the drug-using population, but we envy the correctional system in many ways, where they see the same clients as we see in the community and it is a great challenge to try to follow up the multitude of health problems. Then, when they are in a contained, literally captive situation in prison, that would seem a great opportunity to be able to sort out people's dental health and other health problems, yet that seems to be difficult to do, largely for structural reasons.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In your outreach program into the criminal justice system you still have trouble addressing things like that, do you?

Dr van BEEK: Yes, we have, because of the policies in place that involve moving people around. There is a set capacity within the prison system so if someone has to go from Silverwater gaol to Long Bay to be assessed for hepatitis C, for example, which is where the clinic is for that, then another prisoner has to be taken from Long Bay to Silverwater. At any one time—I do not have the number ready to hand—but I gather there are literally hundreds of prisoners being transported on our roads all over New South Wales to the many correctional facilities. Maybe we should have medical clinics in the trucks or mobile treatment units.

CHAIR: Hester has made the comment about keeping offenders separate from the legislative model that may be created. Would it be true to say that most of the people you are dealing with are offenders at some stage or another?

Dr van BEEK: Over 50 per cent have been incarcerated and something like a quarter in the last 12 months, and we are not including time in police cells there; we are talking about convicted persons.

CHAIR: Without being overly pessimistic, would some of the rest of the people be likely to be in gaol later?

Dr van BEEK: Very likely. It is a case of sooner or later.

CHAIR: We need to be conscious of all the issues related to offenders, discharge planning and so on because the people you are talking about, although we might want to regard them as non-offenders, are likely to progress through that system as well.

Dr van BEEK: That is right. But perhaps with initiatives like this, if they could happen upfront we could actually prevent people's progression into the correctional system, which, of course, happens in association with the crime they commit to do with their illicit drug use.

CHAIR: We have covered most of the questions we sent you. However, in your submission you flag a potential conflict between compulsory treatment and harm minimisation. Can you tell us whether you have thought through that potential conflict and do you have more to say?

Dr van BEEK: We have. We have flagged it rather than saying that it is an issue. The harm reduction approach is underpinned by the premise that people are rational and that provided we give them good information about the risks to their health, they will make rational decisions to reduce their risk. We have found overwhelmingly, since harm reduction has been the approach to drug-related problems and HIV since 1985, that the vast majority of people do make rational decisions, even if they are in the midst of injecting drug use and so on. They will use clean needles if those are available and they will take steps to improve their health.

However, of course, the limitation of that approach is in situations where people are not of sound mind and they are not making rational decisions. I think it is very important, particularly for the survival of the harm reduction approach, that we recognise those limitations and the point at which the community has to take over some responsibility. The Kirketon Road Centre, which most certainly operates under the harm minimisation framework, at the same time accepts a duty of care, has the therapeutic approach and believes that, particularly with drugs like cocaine and benzodiazepines, where we do feel that people's ability to make rational decisions is severely impaired some of the time, that there is an onus on us to be able to step in and be our brother's keeper.

CHAIR: Is your fear based on a philosophical conflict, that you think a philosophy of compulsory treatment would go with an abstinence philosophy as distinct from a harm reduction philosophy?

Dr van BEEK: My concern is that sometimes people interpret harm reduction to be the opposite of the abstinence approach, whereas we define abstinence as part of the continuum of harm reduction. Most people who work very close to the coalface, particularly with cocaine users, realise before too long that the only thing that works is abstinence. Obviously, we would prefer that people come to that realisation themselves but in some instances, particularly where there is this bingeing pattern of use, they simply never arrive at a point for long enough to really be able to make that decision and then the compulsion to reuse sometimes overrides all good intentions. In those situations I think, as care givers, we have a duty of care to then try to provide a safe place for people, contained where there can be some time out, where they can then regain their rational thoughts and then we can go back to our belief in self-determination.

CHAIR: What would you like to see come out of this inquiry. This is where you can give us your wish list.

Dr van BEEK: We would like to see either the Inebriates Act reframed in such a way as to make it more focused towards the therapeutic outcomes for people with drug and alcohol problems, at the same time reducing the imminent harms that that sort of lifestyle can create for the rest of the community, not in a punitive framework but in a caring and holistic framework.

CHAIR: Hester, do you want to add anything?

Dr WILCE: The only other thing is that there needs to be adequate funding for this to actually work. The mental health system is straining under the load. Yesterday we wanted to talk to a psychiatrist up at the St Vincent's mental health service but they had no doctors that day. At the moment the system is straining to do what it can and I would be very disappointed if this additional strain was put on without realistic funding, realistic support and realistic training of individuals involved in providing this care.

CHAIR: A couple of devil's advocates or pragmatists cautioned against a complete split from the mental health system on the grounds they fear that if resources were always stretched within the mental health system, they are likely to be even more stretched in a standalone, alcohol and other drug system. Therefore, while ideally there should be the sort of separation you have advocated, a less total separation, pragmatically speaking, may be more likely to produce resources. What is your view between the ideal and pragmatic, which is something this Committee has to grapple with?

Dr van BEEK: Nonetheless there would still be resource implications as far as training people from the mental health system. Another set of skills and so on are required to manage people with drug and alcohol issues. Generally speaking, those people, particularly those who are acutely intoxicated, have been necessarily excluded from the mental health system. So not only would it have training implications and so on but it would possibly require a different approach. It would be fair to say that the mental health system has tended to be more cure oriented, whereas the drug and alcohol system is more care oriented. So there are some philosophical differences in approach, which I think we need to be looked at. I suppose I interpret harm reduction as an approach which is used in the context of drug and alcohol but you do not hear it used in the context of mental health. My definition is that we are aiming for cure, and when we are unable to cure for various reasons we extend care. It seems to me that the mental health system would also benefit from that approach.

CHAIR: Do you have any other comments about the great things that could come out of this inquiry?

Dr van BEEK: The only other aspect, just further to that, would be that you would need to think about the stigmatisation that one can have. That kind of runs both ways.

CHAIR: The stigma in both systems.

Dr van BEEK: Yes. People with drug and alcohol problems do not want to be stigmatised with a mental health diagnosis, and people with psychiatric problems do not want to be tainted with drug and alcohol problems.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: People always talk about dual diagnosis. How big is the overlap?

Dr van BEEK: If you count borderline personality disorder, there is a very significant overlap, but if you do not count that—the psychiatrists themselves do not count that as a serious mental illness—then it is not as large as perhaps is sometimes suggested. Again, I suppose you would need to think about how you define your drug using population but particularly if you include not just those people who are drug dependent but those people who are using a wide range of drugs.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: On the other hand, if it is not disrupting their social functioning, then you are probably not diagnosing them as having a problem. Your group is presumably a relatively extreme group. If we take that group, who would have a mental health problem other than a personality disorder, which the psychiatrists are having trouble defining at the moment?

Dr van BEEK: I would say that no more than 10 per cent of the people we see have an underlying serious mental illness.

(The witnesses withdrew)

ANDREA REESE TAYLOR, Manager, Quality Risk Management Unit, Royal North Shore and Ryde Health Service, affirmed and examined:

CHAIR: In what capacity are you appearing before the Committee today?

Ms TAYLOR: I am representing Northern Sydney Health Mental Health Services, and I do not wish to make a brief opening statement.

CHAIR: Normally our first question enables you to give a bit of an overview, and that is exactly what we have asked you to do, to give us a view of your expertise and experience in relation to people with alcohol and drug dependence and also specifically with the Inebriates Act.

Ms TAYLOR: My experience and expertise lies both within formal qualifications and work experience. I have worked in the non-government sector and I have worked in the public sector in relation to people who would come within the Inebriates Act, as both a nurse/social worker and a manager with various other qualifications. Services I have worked in, approximately 4½ years in a detoxification and short-term drug and alcohol facility. I have worked for three years in a women's refuge that was also a proclaimed place, and I have worked for 11 years in mental health, both on the crisis team and facilitating the management of the mental health service. During the past six years or so I have also been the director of the health care agency in accordance with the Mental Health Act at Ryde Community Mental Health Service. That has a number of obligations attached to it. I have, in conjunction with others, either facilitated or been involved in a number of persons being placed under the Inebriates Act either to protect the substance-abusing individual or to protect others.

CHAIR: We have your submission as part of the broader area health service. You make some specific points about your experience with the Inebriates Act. Because we have had a lot of witnesses previously, it has become clear to us that there is a fair degree of agreement about the inadequacies of the current Inebriates Act and the need for safeguards like in the Mental Health Act, and so on. We have reached the point where we are mostly asking people to talk to us not so much about the problems we have at the moment but what we should do in the future. It is also important for us to get on the record the extent to which you think compulsory treatment is justified, ethically speaking and practically speaking.

Ms TAYLOR: To answer that, one must first ask oneself whether it is ethical to permit continued abuse and neglect on the individual or others. Basically, my response to your question is yes. For what purposes? Again, to reiterate that, to protect the individual, to protect the community and to protect others. I can quickly give you a thumbnail sketch of two people I have put under the Inebriates Act. One was a woman who dressed as a man, lived on the streets, was regularly brought into a proclaimed place, was being raped daily and was coming in with clothes ripped off and obvious trauma associated with rape and would do absolutely nothing about it. She had shocking peripheral neuropathy and was in her late thirties or early forties. It took me seven days to put her under the Inebriates Act. As a worker I could not stand by and watch that. Another was a woman in her early thirties with two young children at home. She was the principal carer for them while dad went to work. She was sitting at home drinking methylated spirits, unable to care for her very, very young children. It progressed over a period of about three months before we got her in under the Inebriates Act. There were quite clear care issues there.

CHAIR: Does that imply that you would only use compulsion in very severe circumstances, almost life-and-death circumstances for that person or, in that second case, the young children?

Ms TAYLOR: Life and death, I think, is a bit dramatic. Neglect, I think. If we do not look after the young people and put a lot of work into them—remove probably initially and assist in changing the individual's behaviour pattern—we are then breeding the next generation of people presenting at either mental health services or drug and alcohol facilities. So, not life and death—I think neglect is one of the answers in that equation.

CHAIR: Can you quickly fill us in—you will probably come to it in answer to the next question about potential models for compulsory treatment—given that you have used the Inebriates Act, you mentioned it took you seven days in the first case and three months in the second.

Ms TAYLOR: You are wondering about the time delay?

CHAIR: Given your experience of the Act, clearly difficulties in the process of using it affect the outcome for the people we are talking about. I wonder whether you can quickly sum up for us the difficulties in the process and perhaps, if you know, what were the outcomes for the two people you mentioned?

Ms TAYLOR: A lot of the difficulties in the process are in my submission. Basically, it is very cumbersome. You cannot immediately respond to the issues, and it is that time delay that is the most frustrating. That is, running around getting the statement, getting the case before the magistrate. They are the key issues. In relation to the three-month delay, we tried everything, drug and alcohol services, before putting the individual under the Inebriates Act. We wanted it to be seen that we tried everything and this was the last resort. I know we can probably be criticised because three months is quite a period of time. There was some improvement periodically in that three months, but it would revert back to the previous behaviour.

CHAIR: If you were using the Mental Health Act for different clients, are those process issues much less of a problem?

Ms TAYLOR: I think we are going to the first dot point in question 3.

CHAIR: We can come back to that. I am just trying to get your picture straight at the moment as someone who has experience with both pieces of legislation.

Ms TAYLOR: Over the years I probably would have had a number of other people placed under the Inebriates Act because we certainly came across a vast array of people who would qualify for this. These are quite high-functioning people who drink excessive amounts of alcohol and then have my crisis team up all night with them when they threaten to kill themselves. That is almost a daily event. They can be contained but once they are sober they do not want to kill themselves; they go back to work and the process starts again. There can be nightly calls for weeks on end. It is incredibly problematic. Traditionally drug and alcohol services are not that interested in these people, because they are not interested in changing their behaviour. They do not have a mental illness but they say they are going to kill themselves to get attention.

The mental health service responds, the referral goes to the drug and alcohol service, and very little is done until usually Mental Health calls a coming together of parties. Usually multiple parties are involved by this time including the police who had carted the individual away on multiple occasions. Also the emergency department responds with, "Oh, no, Joe Bloggs is arriving." The ambulance service is running backwards and forwards. If the Inebriates Act in its current format had something to offer and was less cumbersome in getting people to a point of treatment, I am sure it would be used more extensively.

CHAIR: That is interesting. Obviously the Committee will hear more details.

Ms TAYLOR: Yes. I am pleased that I sat in at the end of the earlier session, because I found the drug and alcohol perspectives fascinating.

CHAIR: The Kings Cross perspective is probably different from the perspective of the Northern Sydney Area Health Service.

Ms TAYLOR: The proclaimed place I worked in was Kings Cross, although my information might be a little dated.

The Hon. ROBYN PARKER: You said that the Inebriates Act could be used more extensively. The Committee has heard from many people that this would apply to a small percentage of the population. Do you think that that is not realistic? Do you think a revised Act could apply to a much broader group?

Ms TAYLOR: You need to look at who would be included in that. A whole bevy of people live on the streets, and they periodically end up in proclaimed places. When you look at their history

and exactly what is happening to them, society probably has a duty of care to ensure that they receive some level of treatment. Some people who are drinking can make quite informed decisions but other people cannot. Society has a role in that, whether it is the Big Brother role or not I am not sure. We certainly have role in the care provision. Previously Missionbeat picked up individuals and they had everything from adjustment disorders to benefiting from time out from drinking.

CHAIR: I turn now to question 3. The question contains a number of dot points to guide our discussion about your suggestions for a potential model for compulsory treatment. Would you like to address that question? Committee members will then ask you questions.

Ms TAYLOR: I have prepared a chart, so that you can follow my thought processes.

Chart tabled.

Ms TAYLOR: This is very rudimentary, and is conceptual. It provides some ideas on what is happening. We have to look at this in a number of stages. First, we need to look at the immediate response and that is where the Inebriates Act is problematic. We do not have that immediate response unless the mental health service is involved. The Ryde Community Mental Health Service has always been a crisis team that has picked up a much broader base of issues after hours than just mental health. Routinely it has supported drug and alcohol services along with the Department of Ageing, Disability and Home Care and group homes. We have picked up that huge range. We have been a community resource for a long time and probably have been doing some of that work. Immediate management is the issue.

At the moment the teams involve police, mental health crises or accredited individuals—that is, accredited under the Mental Health Act who can detain people. For our model to work there would need to be an immediate approach. Who does that and whether that is utilised within the Mental Health Act is probably the outcome of this. One of the Committee's questions refers to that. The intoxicated person needs to be detained for their own safety and/or the safety of others. The question is: Where do they go? We have diminishing proclaimed places and basically they are just a facility to sleep it off. We cannot contain some people, and although staff have a lot of experience their skill base and progressing needs to be further addressed. Other issues include medical coverage. The response to an intoxicated person who has vomited and aspirated is quite problematic. The gaol option is problematic, and we would not want to see an intoxicated person end up in gaol, unless that is the last resort. Emergency departments are unable to contain people, they are not really established for that role. I may have jumped over some issues.

The mental health facilities are probably the only resource we currently have that is established to potentially manage people. I understand that in rural areas that will be problematic. Already we have some mental health facilities that have specialist units attached that can be open or closed. Probably in the current situation they are open. The specialist units are able to manage women who need to be in a mental health facility and who have young babies, or have special needs.

CHAIR: Can you give some examples?

Ms TAYLOR: Yes. The east wing at Manly has the ability to take women with small babies. It has separate facilities that can be hived off.

CHAIR: Is that for an initial detoxification assessment?

Ms TAYLOR: It is for the initial stage of containment, if we were to go down the containment process. I tried to think a little laterally around who, what, where, how and what we currently have and what we can utilise. Mental health people probably are not happy, because of the bed crisis, of which everyone is aware. The next step would be the person having to be reassessed. We are not substance affected, so people might present frequently and that might guide the care pathway. That process would be along the lines of needing two psychiatrists to agree that a person is mentally ill or mentally disordered and needs to be contained in the unit. Where they go from there depends on the key issue. There is the criminal justice system, but I have utilised health only within this scope. We then need to look at the short-term management; whether it is a mental health issue, or drug and alcohol—and there is a link between mental health and drug and alcohol—or is it an adjustment issue?

CHAIR: What do you mean by an adjustment issue?

Ms TAYLOR: A large number of people who have had a relationship break-up are brought to emergency departments. Often they are younger people who have drunk to excess and might have tried to jump in front of a train, or something like that. Once they sober up they reflect on what they have done and cannot believe that they were in that situation. They move forward, but they need follow-up, sometimes through the general practitioner and sometimes through brief intervention with a mental health service.

CHAIR: Their situation is quite different from the longer-term dependent person in the other categories?

Ms TAYLOR: I have written this down as being the management of intoxicated persons rather than as long-term treatment. We are seeing people who are intoxicated at the point of assessment. Often you cannot get very much out of them apart from their vital signs. So it will be a stage further down when you assess where they go.

CHAIR: How broadly do you cast your net when you are talking about intoxicated persons at the immediate management phase? You would have to have a broad net, which would narrow as you went through the processes?

Ms TAYLOR: I have. I am coming from a philosophical background of running the service at Ryde. When you are making a phone assessment you are not clear on exactly what are the presenting issues. Often people in the community are unable to articulate the information that we want to know that would indicate long-term mental illness or that a person was acutely psychotic. So it is better to go out and see the individual and get a baseline. I am coming from mental health service with a fairly small catchment area but with an interesting history of Gladesville, Macquarie and Mount St Margaret hospitals, decanting into the local community. I think it is the area in Sydney with the largest percentage of Department of Housing facilities.

The Department of Housing actively moved people with a mental illness into that area because it knows that the services are there. It is quite open about that. That is our model. We manage those people that fall within that scope. We refer on those people that do not. So the net is wide. These people then go to a mental health facility, or they follow the care pathway for mental health. I refer next to adjustment issues. Technically, people go to mental health and they are briefly followed up. Referring to the drug and alcohol stage, I think it is at that stage that we need a comprehensive drug and alcohol assessment. People can be discharged. I write an assertive community follow-up report. I know about the models of enabling and management, but I am a true believer in assertive treatment, so I will refer to assertive treatment and risk management on many occasions.

CHAIR: Does assertive community follow-up equal community treatment orders? In other words, it could be a compulsory aspect?

Ms TAYLOR: No, I do not believe so.

CHAIR: It is a very interventionist pathway.

Ms TAYLOR: We need to be able to follow up people assertively. They do not need to get in to the rehabilitation phase. It just depends on what stage they are at. It really comes down to the drug and alcohol assessment. Those people that need detoxification go to the detoxification units, and the care pathways go on from there. None of our detoxification units are really set up to contain people. That issue would need to be looked at. How do we contain individuals who are under the Inebriates Act and what would be their long-term treatment?

CHAIR: Do we assume that assertive community follow-up also means relatively high resources?

Ms TAYLOR: Yes and no. In all the years that I have been working in the community I could not tell you how many times I have arrived at a client's place and drug and alcohol services are

leaving, or drug and alcohol services are arriving as I am leaving. I am trained in both and quite a lot of mental health staff and drug and alcohol staff have been trained in both. A lot of nurses that came through the old psychiatric training system have been trained in both—maybe not in community treatment—but they still have skills in the provision of mental health and drug and alcohol services. We probably need to upgrade their skills, but they could probably deliver the same services.

In the last 11 years that I have been in the mental health system I have seen an exponential increase in clients with substance abuse issues. The younger generation is coming through. Currently, drug and alcohol services staff do not have the assertive function. They state, "Please come to our offices", whereas we are out seeing people. So we tend to pick up and run with those issues. The people who are happy to come into the offices of drug and alcohol services will be managed by both services and others generally will generally be managed only by one.

CHAIR: Anecdotally, how come you arrive as drug and alcohol services are leaving, or you leave as they are arriving? What is the pathway that would bring the two different services to one home address?

Ms TAYLOR: Care delivery has been delivered separately. Traditionally, mental health staff have focused on mental health issues, and drug and alcohol staff have focused on drug and alcohol issues. To give drug and alcohol services at Ryde credit, there is a good relationship between both services. So we are not actually poles apart, but the models are certainly poles apart. The drug and alcohol counsellor is providing one service and we are providing another. That is where problem arises.

CHAIR: How did both services get to hear about the needs of the client?

Ms TAYLOR: There are a number of care pathways. In relation to mental health being involved, we are usually the first people to pick up the individual. We then refer the individual for specialist drug and alcohol counselling, or we tend to utilise drug and alcohol services a lot for psychometric testing, to look at where those people have challenges and to determine where they have strengths.

CHAIR: That co-ordination occurs partly because people involved on the ground in the area talk to one another?

Ms TAYLOR: That is correct.

CHAIR: So it is not built into the system?

Ms TAYLOR: It is starting to be built into the system. The Department of Health released its policy relating to substance abuse. Some work is being done to move them together, but they are poles apart and they are also cultures apart. One assertive service is delivering one model and you have another model that looks at that and believes that it is enabling behaviour.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said earlier that you were a big fan of assertive behaviour. Some of the mental health support groups are frightened of assertive treatment, being paternalistic and judgmental. You then said that you did not think the legal or judicial system needed to be involved in that either. That would be even more frightening for civil libertarians.

CHAIR: That is the evidence that was given by an earlier witness.

Ms TAYLOR: I did not say anything. I left the legal system out of this. I have looked at the health care pathways.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said perhaps five minutes ago that you were a believer in assertive systems. The Chair then asked you about community treatment orders which, of course, are ordered through the Mental Health Tribunal. You said that that would not be needed. What would then regulate the assertive treatment that you are quietly advocating?

Ms TAYLOR: I think I said that that related to question No. 3. I had not yet got to that. I have that written down under medium-term treatment. Would you like me to refer to it?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I thought it was an issue that needed clarification.

CHAIR: Ms Taylor can finish her discussion in relation to the chart. We will then ask specific questions about issues arising out of that.

Ms TAYLOR: I have almost finished. Basically, it is referring to long-term and medium-term treatment. I have not written down any examples of short-term treatment. We have the drug and alcohol phoenix unit at Manly, which moves from detoxification to a short stint of care. I know that you have questions about how that unit is managed. No matter where the care pathways go, we need to come back to community follow-up. We need to get people reinstated in the community.

CHAIR: Do we take it for granted that you do not support the current system that sends people under inebriates orders to Macquarie hospital?

Ms TAYLOR: I do not support the current system for a number of reasons. The system is set up for mental health clients. There are no programs for people with long-term drug and alcohol issues. We are delivering health care and containment. We are not delivering rehabilitation or treatment; we are basically containing them for the period. I do not think it is productive for the mental health clients being in the unit with someone who is sitting there probably very angry and wanting to go out and continue with their behaviour.

CHAIR: You are aware that we went to Macquarie Hospital, talked to the people there and saw some of the wards where people under inebriates orders go. It seems a pretty self-defeating system or lack of system, whereas you are suggesting that the Royal North Shore detox unit and Phoenix unit at Manly are a better sort of model.

Ms TAYLOR: They are the detox and short-term models. It has taken people a lot of learned behaviour and a lot of practice to come within the scope of the Inebriates Act. We are not going to undo that learning and those practices and skills—however maladaptive they are—that they have acquired to get where they are. I think they are great for a short-term approach but as a long-term approach we need another model.

CHAIR: Do you have any views on mixing together people who are under a compulsory system and people who have chosen to undergo voluntary treatment? Do the two groups work together?

Ms TAYLOR: I can only answer that from a mental health perspective. Providing you have a step-down process so that after people first come in they can step down to where they are more settled and focused on treatment then there is no issue if voluntary people come into that stepped-down process. If it is a supportive, treatment-oriented environment then it should be beneficial.

CHAIR: This point has been raised with us in regard to the MERIT program. For instance, some of the people are there compulsorily because they are there to avoid a gaol sentence and other people are in the same facility quite voluntarily. It is quite problematic combining the two.

Ms TAYLOR: Any person who has been detained involuntarily on an inebriates order, a mental health order or what have you will experience initially a very angry phase. Sometimes people are relieved but usually it takes a while for them to settle down. So you would not want to be putting voluntary people in there and then adopting an acute and subacute model like mental health but on a long-term perspective.

CHAIR: Is there anything else you want to say in addition to what you have said about the chart in relation to the points we asked under question 3?

Ms TAYLOR: Just in relation to the immediate phase, basically you need identification, assessment and transport. They are the key things you need under that phase. You may or may not be

aware but transportation is a huge issue. Whether they are under the Inebriates Act, the Mental Health Act or under the criminal justice system, getting people from A to B is problematic.

CHAIR: If you think it is bad in Ryde you should try going to Orange from Wilcannia or some other places.

Ms TAYLOR: I was recently in Cobar talking to guards transporting individuals from Broken Hill to Sydney. In the short term you probably need containment, assessment and detox.

CHAIR: How would you define short term?

Ms TAYLOR: I would envisage short term as being under a month. The medium term is where you need programs, living skills, a period of time to reflect, nutrition, education, models of abstinence—all that education. Graduation out on a community treatment order or CTO-like model might come in. We need a process of constant review. The long term is probably medium to long term and with similar goals. One of the questions is around what sort of assistance would be required. I think you need people trained up in the bio-psycho-social model, which is looking at the medical, the psychological and the social. In relation to the individuals I mentioned before, one I cannot speak to because I suspect she probably went back to living on the street. I did follow her for a while when she was discharged. I think she had actually forgotten to drink because she was quite unwell—brain-damage probably. Her level of care was a lot higher but I have no doubt that a period of transition would probably have her back then. She might not be alive any more.

In relation to the other individual, there was quite a period of stability after that and then we went on the downhill trend again but there was sufficient stability to probably get the children through to mid-primary school before that happened. I do know where this case is now, and the children are living with dad, completely separate. But mum does have quite prolonged periods of abstinence. She gets on the turps and then she gets off and then she gets on again. I truly believe that had we not intervened she probably would be dead. How long do I believe legal restraint would be necessary? It has taken the individual a very long time to get to this stage. We are not going to undo it overnight. On each occasion I have been involved in the application we have applied for 12 months. We may not have actually thought that 12 months necessarily would be beneficial but not on one occasion have we got 12 months. On the two occasions we got six months and one month.

CHAIR: Is that because magistrates are unwilling to grant such a long period under restraint?

Ms TAYLOR: I think so. I do not know that the magistrates have a lot of experience of putting people under the Inebriates Act because people are not applying. I read the Bloomfield evidence before the inquiry. I would agree with the numbers falling off. It is the process of the application of this order.

CHAIR: And therefore the people involved with the Inebriates Act are very inexpert because they have so few dealings and no training?

Ms TAYLOR: I think so.

CHAIR: On your chart where would you stop legal restraint?

Ms TAYLOR: It would be on an individual-by-individual basis. The system needs to have checks and balances in it to ensure that we are not detaining people for periods longer than what is indicated. I cannot give you a definitive time frame. I do not know.

CHAIR: But you are philosophically comfortable with 12 months, for instance, because that is what you have been involved in applying for?

Ms TAYLOR: As long as the checks and balances are in place I am, yes.

The Hon. IAN WEST: Do you see the restraint as being defined as incarceration in bricks and mortar or do you see legal restraint as something that may incorporate something else?

Ms TAYLOR: If the care can be delivered in the community I would support that model, with the legal restraint like a community treatment order, I suppose, if that was applicable.

The Hon. IAN WEST: What do you envisage that legal restraint for up to 12 months to be?

Ms TAYLOR: I suspect that it would have to be some sort of containment facility. It depends on what the Act is. I think you would need to risk management the process. You will have those individuals who you know have nowhere to go and who will potentially stay here or the individuals who are doing brilliantly in the treatment model who will stay. Then you have those individuals who are off to the hotel for the next drink. It will probably come back to some sort of step-down process. By the sound of it I have now built a whole new Macquarie Hospital or a like facility.

CHAIR: That is an issue in terms of the groups that the system that you propose would target. I guess another way of asking the question is: How many people might benefit from or be subject to this treatment in a year? I know it is hard to pluck out a figure. At the moment we know that the Inebriates Act is dealing with very few people. We know also that probably many people might benefit from a system that is workable. But it is important for us to get a sense, in some sort of number or percentage terms or whatever, of how much greater that need is than the number of people currently being catered for. Can you give us any hints?

Ms TAYLOR: As a stand-alone mental health service we would probably see in excess of a dozen people a year. We manage some of those people long term. The figure is probably higher than that.

CHAIR: So you would apply a good Inebriates Act, if you had one, to at least a dozen people?

Ms TAYLOR: I think so. These are people with co-morbidities who also have a mental illness. In the case of the individual who I spoke with before who has been doing that to our service, every single year that I have been there we have had peaks of activity. That is not from trying absolutely everything.

CHAIR: I am looking at the areas you have covered under question No. 3. What differences, if any, would there be between clients who use alcohol and those who use other drugs?

Ms TAYLOR: I do not feel able to answer that question as it has been quite a while since I have been in drug and alcohol services and the behaviours are often quite different. I do not think I am in a position to answer that question.

CHAIR: Are the people to whom you refer in your experience mostly severely alcohol affected rather than affected by other drugs?

Ms TAYLOR: They tend to be because it is a bit more difficult to get together to organise to get illegal substances whereas it is very easy to walk past a hotel.

CHAIR: Or not walk past as the case may be.

Ms TAYLOR: Indeed. That is more difficult when you have a mental illness or an active psychosis.

CHAIR: Is alcohol more of a problem in the area in which you are based and other drugs are more of a problem in King's Cross, for example?

Ms TAYLOR: No. I think King's Cross is on its own. We have a lot of people with drug issues and mental health issues who end up in the criminal justice system or with forensic orders attached. They tend to follow different care pathways in mental health.

CHAIR: Whereas the people whose major issue is alcohol do not end up in the criminal justice system to anywhere near the same extent.

Ms TAYLOR: We certainly have a program at Macquarie in relation to that. I do not whether Glenys Dore has appeared before the Committee.

CHAIR: Yes.

Ms TAYLOR: So I do not need to say anything about it. It is Glenys's program.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: With the adjustment issues and general practitioners, I spoke to Hester Wilce after she gave evidence about personality disorders. Is that what you mean by "adjustment issues" or does it also involve social problems?

Ms TAYLOR: You would not put adjustment issues under personality disorders. Any one of us could be subject to adjustment disorders. When we witness major trauma we have an adjustment phase. For young people often the end of a relationship is an adjustment phase. They have experienced what they considered to be a major trauma and they need to go through a period of adjustment before they move on.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are general practitioners [GPs] well positioned to do that? Everyone says that GPs can do everything but everyone else says that GPs do not have the time to do mental health under the current system. They certainly do not have time for it under Medicare—they would go broke. Do they have time in general?

Ms TAYLOR: We would look to the GP following it up in conjunction with normal care delivery. People with adjustment issues—this comes down to your assessment phase; this is the process in the adjustment—are often horrified that they have ended up in this situation and then move on. At times you just link in services. I have a question mark in that area because I tried to think of this model very generally and to think of rural and urban applications. There might be an appropriate service to follow up or there might be no service need to follow up. Mental health might follow up briefly. A raft of things sit there.

CHAIR: You have probably covered question No. 4 with your chart and your comments. Do you have any comments about bricks and mortar facilities and their specific geographical locations? Do you have a question mark on the chart because those issues are difficult to pin down?

Ms TAYLOR: Even with mental health facilities dotted all over the State there are still huge transportation issues. I think it is easy to go back to what we know, and that is probably appropriate care delivery on sites such as Bloomfield, Rozelle or Macquarie, where there were programs and where we have existing infrastructure. I guess Health is moving down a slightly different track in that they want to maintain people on supra sites. Certainly for the medical management of individuals in this long-term treatment—people often arrive with a myriad physical ailments—the site location could be general psychiatric. I do not know where you would place them.

CHAIR: Do you mean a super site? For instance, you might have all sorts of things at Royal North Shore, Concord, RPA and so on, but then that intensifies the transportation issues.

Ms TAYLOR: When you are talking about people living in a facility potentially for up to 12 months you cannot place them on any site in any ward. It needs to be scoped and liveable for 12 months, if you are looking at that time frame. Many of those sites do not have the land mass on which to locate a specialist unit like this. That is my opinion. Basically, you would need to review the site to consider the appropriateness and placement of the unit.

CHAIR: What about the issues of social support, family links, relationships and so on?

Ms TAYLOR: They are phenomenal. We have problems transporting clients so we will have even more problems with families. However, in my experience by the time people come under the Inebriates Act they do not have those social supports. That is not to say that everyone does not have them but people have usually burnt a lot of bridges. I would hate to see people dislocated from their families but we are a big State. I do not have an easy answer for you, I am sorry.

CHAIR: I do not think anyone does. If we have a compulsory system, at least in part, for those people who need it, what safeguards should be built into the model? Who should be ultimately responsible for the decision about compulsory treatment? We have asked people specifically whether the sort of regime, safeguards and processes that exist under the Mental Health Act are the kind of processes that should exist for the people currently covered by the Inebriates Act.

Ms TAYLOR: I have looked at it in the immediate model and walked through it. We need a process behind the immediate sanctioning of the individual. What do we utilise to pick up the person from the street and take him or her to care? That is the first check and balance. We also need a check and balance for when they arrive at the facility, or wherever. Are they appropriate for that facility? Do they meet the requirements and, if not, where can we send them, and so on? We need a process involving assessment when they are sober and a formal reassessment within three days or so. One often sees a very different picture. A magistrate needs to be involved in the delivery of a detention-like model. We need a person or a system outside the inebriates system to sanction what is going on. There must be some process and agreement to determine how long we can contain people. I am not sure about the criteria behind that, but it is probably removed from drug and alcohol services. There must also be a compulsory reassessment at two-monthly or three-monthly intervals post containment to ensure that we are following a model of least restrictive care and that we are reassessing the option of the care being delivered in the community. It is very expensive to keep people in hospital.

I consulted with Dr Nick O'Connor, the director of the Area Mental Health service at North Sydney Area Health Service, about this question. He referred to a subset of the Mental Health Act that relates to detention and compulsory treatment. Inebriates orders could be brought within that so we would have the necessary checks and balances. We have an existing system; whether it is right for inebriates orders, I am not sure. However, bringing it under that umbrella seems to have a lot of credence.

CHAIR: Are you suggesting an overarching Mental Health Act that would deal with people currently covered by the Inebriates Act? The alternative suggestion is a system like the mental health process, but in a separate piece of legislation.

Ms TAYLOR: I understand that the Mental Health Act is being reviewed. There is no reason that it should retain reference to the Mental Health Act. It could refer to something like "persons detained for reasons of health", or it could be some sort of health detention Act. We could go down the mental health pathway or the Inebriates Act pathway. If the committee decides that the Inebriates Act should apply only to alcohol and members want to include detention for other drug-related issues it could be slotted in. It would be easy to slot additional measures into one piece of legislation rather than create all these other Acts.

CHAIR: You said you have read the Bloomfield transcript.

Ms TAYLOR: I have.

CHAIR: You would have seen the model suggested by Dr Martyn Patfield, which contained a number of aspects. He stressed the fundamental need for well-qualified medical assessment. In effect, that would be ticked off by a magistrate. That would be different from the existing Inebriates Act system, in which the power to decide resides with the family or the police. The magistrate makes the decision technically on the basis of medical and police evidence. Do you see that as the preferred system, with the magistrate having a role in ensuring that the medical profession does not suddenly decide to lock up everyone?

Ms TAYLOR: I read the Bloomfield transcript and spoke with Merrin Thompson. Because there was no model it was very hard to follow the exact proposal. The magistrate system works, but it is person dependent, not system dependent. It comes down very much to personalities. There are no checks and balances. There is no avenue for customer feedback in relation to the judicial system in this area, which could be examined. The person applying for an order, the person providing evidence about detainment and the subject of the order are all customers of the judicial system. Therefore, there must be checks and balances.

CHAIR: Other people would argue that there should be checks and balances on the different areas of the medical profession too.

Ms TAYLOR: I certainly agree. The medical profession is starting to head that way.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you saying that the magistrates are just as capricious as the doctors? Are you saying that there are no checks and balances and it is personality dependent? The myth is that the judicial system, because it has advocates and someone making a decision on the basis of that advocacy, has checks and balances, whereas the doctors' treatment regime does not. You also appear to be saying that it has much the same effect and that it is personality dependent in both cases.

Ms TAYLOR: I have had good and not so good experiences with magistrates. It has generally been person dependent and based on their interpretation of the Act.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So the advocacy process has not had a huge influence on the outcome.

Ms TAYLOR: That is person dependent, not system dependent. That is where the problems occur.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would a specialised mental health tribunal for these cases combine the advantages of both?

Ms TAYLOR: The mental health tribunal model has some definite benefits in that there would be a panel with a minimum of three members making decisions. They would all have different hats and different philosophical and professional backgrounds. That decision-making process certainly has merit.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is more or less what Dr Patfield advocated, so you agree with him.

Ms TAYLOR: Getting a tribunal together and hearing a case can be done in two or three weeks. I am not sure that we have a model at the moment that would enable a tribunal hearing to be conducted in sufficient time to ensure the least restrictive care program to be implemented. If people are to be detained under an inebriates order or whatever, someone must be able to say whether they should continue to be detained. We would then get a more formal, longer-term process. That is what happens with the Mental Health Act. The person concerned is seen within x days of being admitted and the decision is made that they either stay or go, or a variety of other options is pursued.

CHAIR: Could a tribunal be brought together in enough time to make that fair and to provide safeguards for the client?

Ms TAYLOR: If a tribunal could be brought together that would probably be a very good system.

CHAIR: The more decentralised the system, the harder it is to operate.

The Hon. IAN WEST: Would it be possible to establish some form of two-tiered system, for lack of a better term, with the legal system able to do its bit at the initial stage, and then some other more user-friendly, tribunal-type arrangement for the participant, who must be receptive to treatment otherwise the chances of success are minimal?

CHAIR: Do you mean that something like the existing system might lock up the person while they are in the intoxicated state, and when they are ready to be assessed after their detoxification a tribunal system makes that judgment?

The Hon. IAN WEST: Yes.

CHAIR: But there might be a simpler and quicker compulsory in-you-go type thing at the beginning.

Ms TAYLOR: That is exactly what I am advocating. If any one of us or our children went out and had a huge night on alcohol and accidentally fell into the system somehow or another there needs to be that check and balance so that we can get them out of the system immediately.

The Hon. IAN WEST: Not only get them out, but a person needs to be receptive to treatment to have a better chance of success?

Ms TAYLOR: That is right.

CHAIR: At the moment while the Mental Health Act applies the police might pick up someone who might in the first stages be locked up for 12 hours or whatever. It may not be long enough and certainly Dr van Beek and Dr Wilce talked about how short 12 hours is for drug and alcohol affected people, but it is a similar sort of issue. Do you have any comments on the legislative model, and question five?

Ms TAYLOR: No, I do not.

CHAIR: I assume in terms of discharge you would stick to a tribunal model because you have committed to an ongoing assessment process and there may be decisions made.

Ms TAYLOR: The tribunal is very good with engaging family and relevant others in hearing from them in relation to the care of people.

CHAIR: Do we situate the new compulsory treatment regime within the mental health system, within the alcohol and other drug system, or a mixture of the two or does it not matter?

Ms TAYLOR: Even though I understand that politics apply, we are starting to see the mental health and drug and alcohol services come together. We have Southern Area Health Service that has both, led under the same leader, so it is one service, and that has got to break down some of those barriers. Dr O'Connor also indicates the Greater Murray Area Health Service has gone like that with drug and alcohol and mental health. Just to put it on the table, I am actually working in general health so at the moment I do not really have a stake in any camp but I do see the benefits. We have got a lot more extensive resources in mental health. We have got the facilities. We are a lot further down the track with a different care delivery model, as you have heard earlier, that I support. I do see that the two coming together would probably be beneficial.

Rather than people having a mental illness and a drug alcohol problem they do not go to the mental health clinician for mental health delivery and the drug and alcohol clinician for the drug and alcohol delivery. We bring those staff together. We have got a lot larger resource base. We cross-train people in the delivery of care of both. We have got social workers and psychologists and OTs and registered nurses working, and a variety of other disciplines, teachers and that, working in both facilities. The only reason they are in those separate health care delivery streams is that they have applied for a job in it.

The Hon. IAN WEST: They are clinicians, but are there difficulties when you put the clients together?

Ms TAYLOR: Having built a mental health model which brought the aged care mental health service in to general mental health service, and I have been down this track with similar things in that the aged care staff did not want the adults and the young people to be sitting out in the waiting room altogether. We looked at how we designed our facility and five years later it is frequently visited because of it being an excellent model that demonstrates how people can be brought together. What the facility is named will be interesting because drug and alcohol clients might not like to be getting services from something called Ryde Community Mental Health Service.

The Hon. IAN WEST: The comfort of clients will have a very big bearing on the success rates as their attitude towards treatment is vital.

Ms TAYLOR: But it depends on how care is delivered. We are supposed to be delivering care in the community and not operating on an outpatient model where people come to us. We deliver care to people in the community. What we call ourselves is only an issue when people come in to get care in that facility, providing we are not running around with cars with "Drug and Alcohol Service" or whatever written on them. If we look at community care I say anecdotally that we have a problem in that there is an increasing level of violence in the community. I can also pull all the incident records from Ryde community. The community services are starting to withdraw into the facilities for safety reasons so we have that paradigm. But if we put safe work places in place when doing community visits then I think it is maintainable.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that the major problem?

Ms TAYLOR: It is starting to become. Certainly in rural areas we are seeing care deliveries pulling back out of the community into the facility.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that because society is becoming more and more violent?

Ms TAYLOR: You are probably better off getting an epidemiologist or someone like that to say.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I would have thought it was better to ask someone at the coalface?

Ms TAYLOR: I am saying anecdotally that in the 11 years I was at Ryde Mental Health Service I saw a huge change in the population that was coming to us. There were a lot more younger people, a lot more people utilising drugs ending up with drug-induced psychosis and a high level of violence.

CHAIR: You said earlier you heard the end of the evidence of Dr van Beek and Dr Wilce. Dr van Beek particularly mentioned the issue of the different training of drug and alcohol people compared to mental health. The Hon. Ian West made a point about whether the two lots of clients can successfully be placed together. We talked earlier about mixing people under the Inebriates Act and the Mental Health Act at Macquarie hospital. We have the client's point of view and then issues of training of staff and the stigmas that applies to both, as mentioned by Dr van Beek. Also in rural and regional areas of more scattered population there is the sheer practical difficulties of operating separate systems because the number of people is so small. Depending on whether one focuses on the training of the staff, workplaces or the needs of clients the question is probably answered slightly differently.

Ms TAYLOR: I have been in my new job for nine weeks but I still feel I own the previous one because I held it for so long. Staff at Ryde Community Health are cross-trained in a huge variety of things, as are a lot of the drug and alcohol staff. A lot of drug and alcohol staff have worked in mental health; you already have a vast skill base there. Yes, you will have to upgrade some people's skills, or standardise the training to be delivered to both in both areas.

CHAIR: Is it possible that the Ryde area is particularly fortunate in having that mix of skills and training, and that in other areas the available staff are much less multiskilled?

Ms TAYLOR: I would say there is probably a good chance that that is possible. There is a very low turnover of staff at Ryde and people tend to skill up, even during their training.

CHAIR: Certainly in rural areas where there is a very high turnover of staff and a preponderance of newly trained staff, they would not have the good fortune that you are describing?

Ms TAYLOR: No. But if you put drug and alcohol and mental health resources together you have a slightly bigger pool of people. There may be people with extensive experience, and it may be possible to a skill then using a mentor shift supervision or otherwise model. But it then stops the delivery of care, like two cars two cars driving to X and two cars driving to Y.

The Hon. IAN WEST: What is the practical position with regard to training in those two areas? At the moment you have a certain skill base, but the training of the young ones coming through is more in drug and alcohol than mental health, is it not?

Ms TAYLOR: Probably, yes. Certainly we are having to do a lot of legwork with these first presenters who are there for drug-induced psychoses.

The Hon. IAN WEST: Would I be correct in saying that the training in mental health at this point in time is probably subject to some discussion amongst the profession as to its adequacy?

Ms TAYLOR: Yes, and no. If you look at the psychiatric registrar rotation, I am pretty sure that one of their rotations is that they must go through drug and alcohol facilities. As a component of the training they must do six months in a drug and alcohol facility. So we already have a pool of doctors who have the training.

CHAIR: What about mixing the clients? When we talked to people under Inebriates Act orders at Bloomfield, for example, they said they were totally bored with the programs, and that they did not want to be with the people who work there, who were psychotic, schizophrenic, or whatever. For example, the staff at Macquarie Hospital spoke about how incredibly difficult and perhaps violent the people who came under Inebriates Act orders were and how badly they mixed with the other people in the wards. Let us assume that the staff are all trained and skilled sufficiently to cope with both groups. Are there other insuperable problems in putting the two groups together?

Ms TAYLOR: I think that medium term there are problems in their being contained together. It is not a specialist model. There are no programs, and they are bored. Whether they are violent, or it is high-level expressed frustration or cabin fever, being locked in a facility for a month, there is no outlet. Often the mental health facilities that they are contained in are for shorter-term stays than what the Inebriates Act people are. There is nothing for them to do, and it is very frustrating. It is probably an acting out expression of their frustration.

CHAIR: That may be worse, because there are so few of them. But if the Inebriates Act is hardly being used at all, and perhaps should be used somewhat more, it may be possible to devise better programs and set-ups.

Ms TAYLOR: We have seen those facilities at Rozelle. I think resources had not been put in there for a while, but it was a specialist treatment care delivery model and there were some reasonable outcomes.

CHAIR: You are speaking about the units you referred to in your submission that provide care for people with long-term alcohol-related brain damage?

Ms TAYLOR: That is where we ended up placing people under the Inebriates Act orders. To be placed under an Inebriates Act order, they would usually come within the scope of those units.

CHAIR: So they had specialist care?

Ms TAYLOR: Retraining and relearning. A lot of them had forgotten the basic skills of daily living: how to cook and the maintenance of personal hygiene. It is starting from scratch and relearning basically, and teaching them better coping mechanisms. We certainly have seen a model that had some reasonable outcomes.

CHAIR: If you must have a relatively small number of people at, for example, Rozelle, those other problems of transportation, the continuation of community links, outcomes after discharge, and so on, become somewhat more difficult if you are talking about one or two places in the entire State.

Ms TAYLOR: Yes. Alternatively, if you house them in the mental health facility and you have these wonderfully skilled mental health and drug and alcohol clinicians, there is no reason why that community service education cannot be delivered in the inpatient facility. If you do end up with the poor inebriates outlier in a mental health facility in respect of which transportation to an inebriate-

specific facility is inappropriate for whatever reason, there is absolutely no reason why community facilities cannot deliver care in that model.

CHAIR: What would you like to come out of this inquiry?

Ms TAYLOR: Better care delivered to persons within the scope of the Inebriates Act, more appropriate placement, and ongoing rehabilitation and assertive follow-up.

CHAIR: Would you like to expand on any of those?

Ms TAYLOR: I think I already have.

(The witness withdrew)

(Luncheon adjournment)

GRAEME JOHN SMITH, Director, Office of the Public Guardian, L16, 133 Castlereagh Street, Sydney, and

FRANCES RUSH, Regional Manager, Sydney Met South East, Office of the Public Guardian, 133 Castlereagh Street, Sydney, sworn and examined:

CHAIR: In what capacity are you appearing before the Committee?

Mr SMITH: I am appearing on behalf of the Public Guardian.

Ms RUSH: I am appearing in the capacity of representing the Office of the Public Guardian.

CHAIR: Does either of you wish to make an opening statement, or are you happy to go into questions that you have been sent and have discussed with Merrin? We may become slightly sidetracked or ask questions out of order, but we will keep on eye on getting through the things that we want to ask you. Commencing with a really general question, could you briefly tell us about the role of the Public Guardian, especially in relation to clients who have a disability relating to drug and alcohol dependence? We have noted your submission and the case studies in it.

Mr SMITH: In general terms, the role of the Office of the Public Guardian is to perform the duties of a guardian for those people for whom we are appointed by the Guardianship Tribunal. You have had a submission from the Guardianship Tribunal so you know the circumstances under which the Public Guardian might be appointed as the guardian for a person with a disability. Primarily our role is to make decisions with respect to those functions that are included in the order from the Guardianship Tribunal. Typically we are required to make decisions about where a person should reside, to make health care decisions on a person's behalf, to make decisions with respect to a person's medical and dental treatment, and to make decisions with respect to those services that a person should receive.

From time to time we are given additional functions, such as an access function, where the guardian is required to make decisions concerning who the person under guardianship can have contact with, or who can have contact with the person under guardianship. At times we are provided with additional or an expanded accommodation function. In those circumstances the tribunal will specify that the guardian may authorise others to take a person to a place determined to be appropriate by the guardian, to keep the person at that place, and to retrieve the person should the person leave that place, and to authorise others to do that, such as the police or the Ambulance Service, et cetera.

The other function which is inherently located within the guardianship functions is an advocacy function. That advocacy function is typically directed towards facilitating access to service provision with a range of Government and non-government agencies. The Office of the Public Guardian also provides a community education function with respect to the nature and effect of guardianship. The Office of the Public Guardian also provides a support service to private guardian and enduring guardians.

CHAIR: Did you want to say anything specifically regarding drug or alcohol dependence?

Mr SMITH: The guardianship orders are not necessarily any different for a person with drug or alcohol dependence. As you will have noted from the submission by the President of the Guardianship Tribunal, in the first instance, the person would have to be regarded as a person with a disability and an incapacity with respect to decision making. A drug and alcohol dependency may be in addition to that underlying disability, but the functions would normally be the same. The functions normally would relate to aspects of accommodation, health care, medical and dental treatment, et cetera.

CHAIR: The second question relates to the way your submission focuses not so much on compulsory treatment—which is an issue we have addressed substantially—but on the need for long-term care and support. We are interested in your views on how the service system needs to be improved to support those clients. Then there is the subsidiary question: Who should be responsible for funding the services that you think are needed?

Mr SMITH: I think the area of greatest concern for the Public Guardian is access to appropriate supported accommodation services for people who have acquired a disability as a result of long-term dependence on alcohol or drugs. Typically, those will be people who have acquired a brain injury as a result of long-term abuse of alcohol, and sometimes they will be younger people who have acquired a brain injury as a result of taking other forms of drugs.

There is a real problem in gaining access to appropriate long-term supported accommodation services for people with brain injury, particularly people whose brain injuries acquired as a result of the abuse of alcohol. They are a group of people who typically fall between the gaps, so to speak. They are people for whom health services generally have nothing to offer. They are not long-term providers of supported accommodation. The State disability agencies do not provide direct services for people with brain injury. They do fund non-government agencies in some circumstances to provide services for people with a brain injury, but, historically, people with a brain injury associated with long-term alcohol abuse have fallen into the area of responsibility of the State health authorities, and therefore the State disability agencies are reluctant to provide designated funds for that group of people. So it is an area of what might be termed dispute between the two agencies.

Typically, the Commonwealth funded agencies, such as nursing homes, often are called upon to provide that long-term supported accommodation. There are some nursing homes that have tended to specialise somewhat in that field, but very few, and they have far less resources than there is demand for those services. So, from the Public Guardian's perspective, being able to facilitate access to appropriate long-term supported accommodation is a huge problem for that group of people.

In addition to that, for people who require urgent intervention with respect to breaking the cycle of intoxication and compromised health status and exposure to other risks associated with their intoxication and their lifestyle, the Public Guardian finds it extremely difficult to get access to appropriate services. So we are frequently confronted with situations where persons are homeless, living on the street, continuously intoxicated, have a health status that is extremely comprised, require urgent medical treatment, and are required to stop drinking in order to return their health to an acceptable situation, and it is very difficult for us to get those people admitted to a hospital, or have mental health services intervene, and basically we have to use our best endeavours to get whatever service we can for those people.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How do you keep track of them?

Mr SMITH: If they are homeless, it is with some difficulty. But usually there are agencies available. Sometimes they are health agencies, and sometimes they are non-government agencies.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you subcontract them?

Mr SMITH: We do not subcontract them, but they provide us with a source of information and intelligence about the movements and circumstances of those people.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you have case managers chasing them?

Mr SMITH: Normally, we would attempt to have a person within that sort of agency nominated to be the case manager for our particular client.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are they paid to do that by you?

Mr SMITH: No, they are not paid by us, but they are paid by either the Department of Health or—

Ms RUSH: A number of non-government agencies. For people who are homeless in the inner city, there are a lot of informal support networks. Normally, if somebody is not turning up, we can ring a number of the support networks and find out where that person is. So it is informal tracking. But we are not funded to do that, and we have no funds to employ anyone. We request a case manager, but it is a very difficult group of people to have a case manager provided for.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes. And that is why I wondered how your agency dealt with it. Every other agency seems to have a lot of difficulties doing that.

Ms RUSH: We share that difficulty in terms of trying to do it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am sure you do.

Ms RUSH: Really, for some of the non-government agencies, it is a matter of goodwill, and the fact that they get to know people quite personally, and also share that concern or exasperation that there are not services available.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I understand—and I am not an expert in this—that they bounce their way around various shelters and agencies in the central city. But how do you find one of those agencies that has latched onto that person and think of themselves as a primary carer, knows the names of the person and follows the persons through their perambulations, catching up with them, and how good is that feedback to you, and how good is your feedback to them?

Ms RUSH: Sometimes it can be, and is, a case of hit and miss. It depends on when we get appointed and we can even meet the person. Once we try to do that, and we try to find out from the person who made the application in the first place to the tribunal who knows them and what is their network, and do as much investigation as we can on that, then we try to track that person informally—whether that is because they received their money from the Office of the Protective Commission, so they go to the customer service centre at a certain time of day. We might track it through Missionbeat who often knows people around the inner-city. There is a variety of ways, but it is extremely difficult.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you have field officers doing this or do you sit it in your offices and let your fingers do the walking, as it were?

Ms RUSH: We have guardians, senior guardians or liaison officers and they would be out in the field, as well as being in an office, making contact. Because we are not direct care providers and we are not case managers we are looking for the people who know them and who have the main relationship with them to feed that information back.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But there must be a fair few who have no main relationship carers and the non-government organisations must be so stretched that they cannot become case managers or write reports on people who may drift in through their agency once every so often?

Ms RUSH: That is true.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So there are a lot of people presumably out there who do not have any case management?

Mr SMITH: There would be, but there are not a lot of those people that we would be responsible for. In other words, those people for whom we are the guardians we are able to keep track of. But there is a much broader group of people, many of whom are not under our guardianship.

CHAIR: You say you have 56 people who have a disability arising from drug and alcohol use currently under your guardianship?

Mr SMITH: That is right.

CHAIR: I notice in your submission you give a percentage breakdown of where your current clients live. Is it possible to indicate where those 56 people live? For instance, are they overwhelmingly concentrated at the homeless end? I assume they are not overwhelmingly concentrated in the 63 per cent of your total clients who live in nursing homes and aged care hostels?

Ms RUSH: That is right. The numbers are not huge when you say 56, and that was at the time of writing this report. Bear in mind that we go back before a tribunal with reviews, so that number can vary.

CHAIR: It is 56 out of 1,500.

Ms RUSH: That is right. The people who generally come under guardianship are at the severe end of people who would be seen as even being suitable, say, for an inebriates order. So it is people with a severe alcohol or drugs dependency and with another disability. So the figure of 63 per cent reflects the people of perhaps an older age group or even a younger age group, but because their needs are so complex and high-level they have required aged care facility service. That does not mean that the aged care service is the appropriate service for them because we have got too many young people in nursing homes. The figure of 4 per cent homeless is reflective of what we were saying earlier, which is that there are a lot of homeless people and a lot of homeless people with drug and alcohol dependence, but very few of them come under guardianship. So in terms of who is coming under guardianship, that is reflected in these kinds of figures.

CHAIR: Could you say roughly where those 56 are concentrated in terms of their accommodation?

Mr SMITH: The bulk of them would be in aged care facilities

Ms RUSH: And the bulk of them would be in Sydney metropolitan. There is not a lot in rural who are in aged care facilities or who even come to the attention of the Guardianship Tribunal and then virtually by that to us.

CHAIR: Why do non-metropolitan people not come to the attention of the tribunal and yourselves?

Mr SMITH: I am not too sure. I think the number generally under guardianship in rural areas is slightly smaller. I think that is probably a reflection of the fact that service providers in rural areas tend to be somewhat more self-reliant and do not necessarily seek guardianship as a necessary safeguard. But, having said that, there are people with an acquired brain injury, associated with particularly alcohol abuse, who do come from rural areas. They would probably end up quite frequently being located in aged care facilities in the broader metropolitan area because those sorts of facilities are not available in the rural areas.

Ms RUSH: I think that is very true. That is reflected in, say, Sydney metropolitan where there are people who unfortunately, by the lack of service, have to go out of area and remove themselves from community and their own informal networks because there is no provision. So someone from Broken Hill might end up in South Australia or they might end up in more of a Sydney-based or a regional-based area which has got nothing to do with their own community, and that is a reflection of the lack of service and a lack of creative and flexible services to meet people's needs across the State.

The Hon. ROBYN PARKER: Or is it because they just want to get away from something? Is there a honey-pot effect with the city as opposed to the sort of lifestyle that they lead?

Ms RUSH: I would not necessarily say so. We looked at some of the Aboriginal people in terms of more tailored aged care facilities. If you look at a place in Kempsey—Booroongen Djarngun—which is purpose-built. I am not sure of the exact figures but they have a huge number of people with alcohol-related brain damage [ARBD] who are relatively young—under 60—who are in that facility. That is because it is probably the best and most purpose-built place for people with, say, an alcohol-related brain damage. That is not ideal because an Aboriginal person will leave their own community and networks, even if they are slightly marginalised or not, to come to a facility that can cater for them which is not available in their own area. So I do not know that it is so much of a honey-pot effect.

Mr SMITH: In relation to the second part of the question, which government agency should be responsible for funding the services that would provide acute intervention to deal with the

immediate effects of continued intoxication, I think the health department should be funding those agencies. At that end of the spectrum it is very much a health issue. Nevertheless, at the other end of the spectrum where you are dealing with the effects of long-term disability, the needs are going to be more in relation to long-term support and care, and particularly accommodation. I think the State disability services providers should be funding those agencies. So there is a distinction between acute intervention and long-term care.

One of the problems that we have with respect to people who have both a disability and who are intoxicated and need to stop drinking, is that whilst you may be able to get access to detoxification services, you cannot necessarily get the follow-through to ensure the person's health is protected, and you certainly cannot get access to long-term care. Part of the reason for that is because health will not take responsibility for long-term care and the disability services agency will not take responsibility for long-term care. In other words, they take the view that the person's disability is associated with an acute health issue, therefore it is a health responsibility. I think that is an issue that needs to be resolved in the interests of this group of people.

CHAIR: We should move on to the third question. There is this long lead-in partly about the president of the tribunal saying that people who are simply intoxicated are not really within the jurisdiction of the tribunal, and that is related to the issue of compulsory treatment. Then the definition of "disability". Is that the way that you interpret the legislation as well?

Ms RUSH: In short, yes, it is. Having read the submission from the president of the Guardianship Tribunal, the Public Guardian's view is that we would definitely support that. The Act is clear in itself. However, the Public Guardian's point of view and experience is that when someone is drinking to that level, say if you are looking at alcohol and/or drugs, the intoxication can actually mask the disability. So given that the tribunal would have been satisfied that the person's alcohol or drug dependence combined with an underlying impairment in some way satisfies the need under the Act to prove a disability and appoint the Public Guardian, our experience can be that the presenting issues for that person is alcohol dependence. So once you get into a position where they are detoxified by whatever means, whether that is a hospital admission or something else, what we often see is that that person's capacity has increased.

CHAIR: Their decision-making capacity?

Ms RUSH: Because they have enforced sobriety and they have access to nutrition, good rest and other support services. When a Public Guardian is appointed and we meet with that person and we see a significant improvement in their capacity, that will lead us down different paths. If that is able to be sustained, we may take the existing guardianship order back to the tribunal and say that we have new evidence, because whilst the person may have been in enforced sobriety, we might have had proper assessment undertaken to actually look at their capacity. If we have that kind of evidence and the person is able to sustain it, we may go back to the tribunal and say, "Is there now a need or is there new evidence before the tribunal that the person needs a guardian?" If not, we will look at weighting that person's view very differently in terms of what they would want. I think that has some informing, in the sense of whether you try to compel treatment or how long we may detain someone when the capacity has been regained. There are issues around that and that provides a lot of dilemmas for the Public Guardian.

CHAIR: Evidence from people in the health field is that even on regaining of capacity after a period of detoxification, there may soon be a relapse as well.

Ms RUSH: Unfortunately, that is the cycle that we get. We may take it back to the Guardianship Tribunal and the person may have capacity as such, but they say, "I do not want to stay here", or they do not meet the grounds in terms of the schedule for mental health—they are too young for an aged care facility—then there are not the options or service provision in the community to assist them. Even while often they are just being humanely contained in a place to regain their health, they end up basically back on the street or back in some accommodation that breaks down, and you go through the cycle again.

That is a dilemma for the Public Guardian and a great concern to us, service providers and family members, because who can make the difference there? We can often be ineffectual in the lack

of services provided to us to consent to and what difference does the guardian make? Even if you were going to use a coercive function, where do you actually consent to that person to stay when there is not a place that is going to meet their needs?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We had evidence from the rehabilitation people at North Shore that neuropsychiatric assessments measured long-term ability to have any insight to make decisions. If your neuropsychiatric test was no good, then you could never learn. In a sense, you would then be unable to make a decision. Does that sort of testing then kick back into question 3, that you would have to do compulsory treatment in the sense that they are no longer responsible—mind you, the suggestion is that the treatment would not work either?

Ms RUSH: That is what I was going to say because what do you call compulsory treatment? If we look at the components of that and say that we need to do detoxification and have enforced sobriety, what are you going to do? What is the treatment that will be provided? Our experience is that you cannot force someone to change their ways.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In a sense, there is no point giving the treatment because they have now said that the treatment will not work, by definition?

Ms RUSH: And even in terms of our understanding of the Inebriates Act when people did try to have it invoked, often facilities would say, "It is a short-term stay because we cannot provide them with treatment. There is no treatment whilst they are in a hospital", so it becomes a vicious cycle in terms of what action do you take. Even if you had the option to consent or provide consent, if there is not the service there, it is very limited.

Mr SMITH: In reality, I think that whether it is the Inebriates Act or whether someone is detained pursuant to the Mental Health Act or under the authority of the guardian, treatment as such is arguable. What they are getting is detoxification and enforced sobriety. That is not to say that that does not have a positive effect, but whether it is sustainable in the long term is another issue. That goes to the question about the effectiveness of interventions with this group of people anyway.

The issue of capacity is a relatively vexed issue in the sense that it is both, on one level, a psychological and medical standard and, on the other hand, it is a legal standard. It becomes, in a sense, a medicolegal issue. There is a lot of evidence to suggest that it is not an absolute thing. It tends to fluctuate, depending on the circumstances. For example, you may well have a person who has been diagnosed with minor early stage dementia but who, for the most part, continues to have capacity with respect to decisions in a large proportion of their life. They may not be able to make decisions regarding complex financial issues, but they can decide where they need to live, what services they need to have, and so forth.

But if the person becomes ill, if they have an acute illness on top of that, for example, pneumonia or a urinary tract infection, their confusion levels rise and their capacity diminishes. Once that is treated, their capacity may stabilise again, so it is certainly not an absolute. The same thing occurs with respect to people with drug and alcohol dependence in the sense that intoxication can lower a person's capacity. That presents problems for the tribunal because they can only appoint a guardian if they believe that the person has an underlying disability, but they may well be confronted with evidence that suggests the person has, to all intents and purposes, an acute brain syndrome.

There is a real question about whether or not there is an underlying chronic brain syndrome. Until you deal with the issue of intoxication, you may not be able to make an effective evaluation of whether or not they have a disability. I think what Frances is saying is that the Public Guardian is often confronted with circumstances where we are appointed as a guardian for a person and the tribunal has made a determination that the person has a decision-making incapacity. Once the issue of intoxication has been dealt with, their capacity seems to return. That impacts on our capacity to make decisions on their behalf. It is certainly means that we are required, by law, to give greater weight to their view with respect to what needs to happen to them.

Ms RUSH: And being mindful of the invasiveness of guardianship, so it is trying to be that respectful line between saying, "There is a role for a guardian" and you are advocating in the best

interests of that person, often in that kind of circumstance, but if that person regains capacity, you are also mindful of that—and that is the weighting it differently and the appropriateness of intervention.

The Hon. GREG PEARCE: Do the majority of people under your care have assets?

Mr SMITH: Some. No, some do not.

The Hon. GREG PEARCE: The vast majority would though, I suppose?

Mr SMITH: Other than income security. But a lot do.

The Hon. IAN WEST: Guardianship is about financial arrangements and effectively becoming the person and acting as the person. That is my understanding of the role.

Mr SMITH: Yes, there are two types of guardianship.

CHAIR: We all received this chart at the beginning, explaining the role of the Protective Commissioner.

Mr SMITH: The Protective Commissioner provides financial guardianship and the Public Guardian provides personal guardianship. Personal guardianship includes those things such is where the person lives, their health care, et cetera.

Ms RUSH: We are separate to anyone who would manage the person's finances or assets. That is the Office of the Protective Commissioner.

Mr SMITH: The Protective Commissioner and the Public Guardian is the same natural person. He has the Office of the Public Guardian to fulfil his duties as the Public Guardian and he has the Office of the Protective Commissioner to fulfil his duties as the Protective Commissioner, but it is the same person.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does that mean there is one person heading the two agencies?

Ms RUSH: Yes.

Mr SMITH: The Public Guardian and the Protective Commissioner is the same person.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And that is you?

Mr SMITH: No. He has two offices. He has an Office of the Protective Commissioner and an Office of the Public Guardian. I am the head of the Office of the Public Guardian. There is another person who is the head of the Office of the Protective Commissioner.

Ms RUSH: There is one commissioner.

The Hon. IAN WEST: And you are both under him.

Mr SMITH: That is right.

Ms RUSH: But we are public guardians and we are looking at the lifestyles.

CHAIR: In terms of what you were saying about fluctuating decision-making capacity, does the Guardianship Act need more flexibility so that people can come under it and perhaps depart from it, or do we need some other legislative set up that enables the group of people you are talking about to be catered for in their fluctuating circumstances?

Mr SMITH: It is fairly flexible now to the extent that the Guardianship Act provides for the tribunal to make a decision with respect to whether or not to appoint a guardian and to determine what functions that guardian should have. In circumstances, for example, where the issue about whether a

guardian should have been appointed because of a person's fluctuating capacity, there is already provision in the legislation for that matter to be returned to the tribunal and for the tribunal to review its decision. In other words, if evidence could be brought forward to indicate that a person's capacity was not as it appeared when the tribunal appointed a guardian, they can undo that. Where they have appointed a guardian and they have provided that guardian with certain functions, how the guardian then exercises those functions will be influenced by the person's level of capacity to participate in decision making affecting them. So at both levels there is already a fair degree of flexibility.

Ms RUSH: At times the public guardian may be provided with certain functions that we will not use unless we have evidence that we need to use them.

Mr SMITH: Both decisions—those of the tribunal and those of the guardian—are reviewable by the Administrative Decisions Tribunal.

The Hon. IAN WEST: In example 3 on page 5 of your submission you talk about the public guardian making a decision on behalf of this particular individual that he be accommodated in a nursing home, and the placement was unsuccessful due to lack of supervision. You go on effectively to indicate that you are currently seeking to have Mr S placed under the Inebriates Act. Can you go through that example 3 in more detail for us?

Ms RUSH: This is an example of a person coming before the Guardianship Tribunal seen to be having an underlying mental illness and having a long history of being on the street and increasingly all concerned were extremely concerned that he would die on the street because he was being beaten up more regularly and was less able to fend for himself. His health had deteriorated to the point that he needed to have major health issues addressed, including an ileostomy bag. That meant that he was then admitted in and out of hospitals. His health deteriorated to the point that we got him into a nursing home. He was too young in a sense for that aged care facility. But he said he needed help for a period of about three months, until some of the operations required could be reversed.

That aged care facility, the nursing home, did everything it could to try to contain him. It was actually a secure dementia-specific nursing home and once he was detoxified for a certain period of time he said that that was greatly distressing for him. He did not want to be there. He had nothing in common with people and with the detoxification he became healthier and he would scale the secure unit and go out every day.

The Hon. IAN WEST: What was the name of the unit?

Ms RUSH: Sorry?

The Hon. IAN WEST: Where was this?

Ms RUSH: This was in Sydney. It was a Sydney aged care facility. It is a nursing home with a dementia specific wing to it.

Mr SMITH: The reference in the final paragraph where it says, "the Public Guardian is currently seeking to have Mr S placed under the Inebriates Act" is more a reflection of the fact that there are no available facilities for a person in these circumstances. It is not a reflection of the fact that the Public Guardian does not have adequate authority to confine a person where such a facility can be located. In other words, this is simply a means of trying to find a person's way into a psychiatric hospital, which was the only place we could potentially locate a bed and to keep the person in one place long enough to deal with his health issues.

CHAIR: We know from our visits and talking to people at Bloomfield, Macquarie hospital, et cetera, and the people there would mostly say that psychiatric hospitals are wildly unsuitable.

Mr SMITH: Absolutely.

CHAIR: Particularly when someone has been through detoxification and is in better physical health.

Mr SMITH: I think we would be wanting very strongly to make the point that issues about appropriate mechanisms and authorities to contain and confine people where necessary in their interests is not as much of an issue as there being no places that are appropriate to provide care for these people.

Ms RUSH: That is exactly what this example gets to because that unit, while it tried everything, it could not contain him and his health was at risk. We were looking at what authority we could exercise because of the lack of services there. It was trying to look at whether we could get him into a hospital. In fact, the hospital could not take him. That is an example of a complete breakdown of trying to use this Act. They were not able to take him because they could not provide the treatment for him and they felt he would be more at risk at that very point in a psychiatric hospital than he would be in a general hospital.

CHAIR: This example is in your submission stated last December. Are you able to give us an update on Mr S and what has happened to him since?

Ms RUSH: I can. He is actually in hospital again. The thing that has probably made the biggest impact on him was that he was run over by a car. So all the issues about being mobile and being able to get away from facilities that could at least address him means that that has been addressed. So in fact he is receiving treatment in that context and he is being contained because his health has deteriorated but he is suffering from fractures of both legs.

CHAIR: So he is now contained because of the fractures, not because anyone has found appropriate accommodation for him.

Ms RUSH: That is right. There is an irony in that in a sense.

The Hon. IAN WEST: Can you confirm that the Public Guardian has control of this person's financial affairs?

Ms RUSH: The protective commissioner did.

The Hon. IAN WEST: Your protective commissioner has his financial affairs in his hands. He has no control over that.

Ms RUSH: No.

The Hon. IAN WEST: And the Office of the Protective Commissioner, under the guardian, has also had yourselves appointed as looking after this person.

Ms RUSH: That is right.

Mr SMITH: In relation to the second dot point in question three, "in what circumstances are coercion and restrictive practices exercised by the Office of the Public Guardian", it would only be in circumstances where we felt the person's health or wellbeing was compromised to such an extent that a failure to do so would be in a sense tantamount to neglect. In other words, it would be in extreme circumstances where we felt the person needed urgent medical treatment, urgent detoxification and a degree of enforced sobriety that we would authorise their confinement.

Ms RUSH: That leads into question 4, "Do you think it is ever necessary and ethically justified to compel someone …" That would only be in those same circumstances of when their life is at risk and we have the evidence provided before us to demonstrate that that we would exercise a coercive function in that way.

Mr SMITH: And that would only be where your reference to treatment included detoxification and enforced sobriety. Beyond those two elements, treatment may represent a whole range of different initiatives.

CHAIR: So you would not define treatment for instance to include a rehabilitation period in a specific rehabilitation unit.

Mr SMITH: Not necessarily. I suppose if it was designed to sustain a level of wellness over a long period and we clearly saw it as being in that person's best interests we would certainly consider it and we may well consent to it.

Ms RUSH: It is the problem, is it not? If you look at treatment holistically you would always say there will be a move away from just humane containment. Different services or different treatment models will be provided that will be able to work with the person. So, it is not even coming into the context of forcing them. You are looking more in the environment of putting it in such a way that it is offered to meet their needs and, while that person is contained, to be available in the community wherever they are. But we know they do not exist. So in the minimal time you would take to get a person into a safe position for their health to be restored at least in a minimal way, you would look at our coercive function in that context.

CHAIR: Would you define containment to include, for instance, a community treatment order or are you really using the word containment as being locked up in a bricks and mortar facility?

Ms RUSH: I think in a broader sense the aspects of a community treatment order or a community counselling order are part of a more holistic sense of treatment because it looks at a person living back in the community.

CHAIR: But a sanction is implied.

Ms RUSH: Yes, that is true.

CHAIR: If you continue to breach a community treatment order, where do you go then and who has the right to compel you to go where it is decided you should go?

Ms RUSH: It has that component of a safety net for someone. Your earlier point about who can locate them if there is a community treatment order in place, there is an onus on whether in that context a mental health provider at least meeting with that person or saying they are participating in the order or they will be breached, there is a safety component there which is quite healthy in that way. It has its checks and balances to make sure it is not going to be used inappropriately.

CHAIR: In the case studies you have given us, the place where, say, the second and third people were, failed one way or another. So, for instance, number two, supported community accommodation is unsuccessful and he ended up homeless and number three, you have said, basically got over the wall and presumably the end result of that was the car accident. In those cases we are not talking treatment, we are talking about coerced, safe containment?

Mr SMITH: Yes.

CHAIR: The treatment is only part of what is happening in those two cases. It is more a matter of physical safety?

Ms RUSH: I think that was Graeme's earlier point about different models of supported accommodation for all people. In the third example, that man was out of his normal area but he would get himself back every night to that aged care facility because he knew they would help clean him up, not in a dissimilar way to a proclaimed place, but he had a little more flexibility in staying, rather than at a proclaimed place, having to leave at a certain point and only being allowed back into it. It is a different model completely when someone with that history of dependence on or abuse of drugs or alcohol, they are unable or unwilling or lack the capacity to enter into treatment. It is looking at different models that still meet their needs and looking at the dignity of the person still being maintained.

The Hon. GREG PEARCE: In your submission you said the numbers of those disabilities that related to drug and alcohol abuse have remained relatively consistent since 1989 in relation to the

guardianship appointments. How do these people come to your attention or how have you come to be appointed? There is an application of some description to the tribunal, I assume, is there?

Mr SMITH: Usually it will be an application brought forward by the sorts of people we discussed earlier. There are a number of agencies that specifically deal with, particularly, people who are homeless, hospitals where people are constantly presenting in an intoxicated state. There is a wide variety of people likely to make an application to the tribunal.

The Hon. GREG PEARCE: So, mostly professionals but not so much relatives?

Ms RUSH: Sometimes but not so much. A relative could but in these cases it is more professionals.

The Hon. GREG PEARCE: Police?

Mr SMITH: It could be the police, if the police feel that a person they are aware of is continuously intoxicated and is placing himself at risk of a motor vehicle accident or assault. It is fairly unusual for the police to make an application. They would probably liaise with hospitals, social workers or some sort of government agency or non-government agency and it would be that agency that would end up making the application.

The Hon. GREG PEARCE: Would there be people placed in guardianship with relatives or friends who have a disability with drugs or alcohol?

Mr SMITH: There is. The legislation requires that where the tribunal can identify a person who is related to or closely associated with a person to whom the application relates, who is either willing or able to act as the person's guardian, they should appoint that person rather than the Public Guardian. The Public Guardian is regarded as the guardian of last resort. Having said that, the test for whether a person is able to be guardian is pretty broad and it is subjective. It is subjective to the extent that it is a decision made by members of the tribunal at that time and place. So we are frequently appointed when there are close family members or close friends involved with the person but there will also be conflict between those persons with respect to whether or not a guardian should be appointed, who the guardian should be or what should happen with that person. We are often appointed in those circumstances as an independent guardian.

The Hon. ROBYN PARKER: I was wondering if we go down the path of providing a different model, firstly how would you see your role fitting into that and, secondly, do you think if the end result was that we had more options available do you think the number of referrals to you would increase?

Mr SMITH: In a sense that related to the question about the legislative requirement. There are two elements I suppose we want to emphasise. One is that there is currently a dearth in appropriate care facilities for people when they require them. The second issue is that the mechanism through which people can access those facilities were they to exist currently falls into probably three different areas: the Inebriates Act, which is rarely if ever used these days; the Mental Health Act, which is sometimes used, albeit inappropriately because these people are not necessarily mentally ill; and guardianship legislation. There is a similar debate currently within the disability sector with respect to the respective merits of guardianship versus civil detention legislation for people with a disability.

At the present time civil detention legislation exists only in relation to the Inebriates Act or the Mental Health Act in New South Wales. For example, a person with an intellectual disability is not a person with a mental illness and therefore that does not fall within the provisions of the Mental Health Act. So, there are no civil detention provisions for, say, a person who needs confinement for care and support, where the person has a disability other than a mental illness. There is a view that New South Wales needs such legislation as they have in Victoria. Equally, there is a view that guardianship is a preferable mechanism to civil detention legislation. Civil detention legislation would normally be constructed in a manner similar to the Mental Health Act, that is to say, that it is dual-purpose legislation.

It has one focus on the needs of the individual and one focus on the public interest. The advantage of guardianship over that legislation is arguably that it is confined strictly to the person's best interests; in other words you could not make a decision to confine a person unless it was in their interests. That is, you would not take into account the public interest in making that decision. People who were at the civil libertarian end of the spectrum would argue that guardianship provides the necessary checks and balances in those circumstances. Obviously the Mental Health Act requires both those elements, because quite clearly there are times when people with a mental illness represent a threat to the public. That is why the legislation exists in that way.

For a person with a drug and alcohol dependence, whose overall wellbeing is compromised as a result of that, I believe guardianship would probably be a more effective and less threatening mechanism. That is simply because if you have a magistrate who makes an order to confine someone for the purpose of treatment, for their own good or whatever, unless you appoint essentially a guardian-type of person to monitor what is happening to that person, their rights may well be overridden in those circumstances. When the guardian is appointed with authority to make those decisions, the guardian retains responsibility for ensuring that the person's best interests are maintained at all times. Their interests are paramount and are focused on to the exclusion of anyone else's interests. That is a safer way of doing it for the individual.

The Hon. IAN WEST: I have difficulty coming to grips with the issue of the financial control. We are talking about acting in the best interests of the person. At the same time, you appear to have a dual role of being the person's appointed financial controller as well as acting in that person's best interests.

Ms RUSH: The Public Guardian is not appointed as the financial manager.

Mr SMITH: The Protective Commissioner will be appointed.

Ms RUSH: Or a private financial manager.

The Hon. IAN WEST: Is it not one and the same thing, with two different names?

Mr SMITH: No, the tribunal can make separate orders. It is required to make separate orders with respect to the person's guardianship and the person's financial management. When a tribunal decides that they guardian needs to be appointed, the Public Guardian is appointed; but where the tribunal believes that the person lacks the capacity to manage their financial affairs the tribunal will appoint a financial manager.

The Hon. IAN WEST: How are you paid for anything that you do on behalf of, say, Mr S, who is now in hospital with a broken leg?

Ms RUSH: In the case of Mr S, we can only decide on his behalf where he can live, according to his resources. He is on a pension only.

The Hon. IAN WEST: Who gets his pension?

Mr SMITH: In that case, the Protective Commissioner.

The Hon. IAN WEST: Who pays you?

Mr SMITH: Nobody, the Government pays us.

The Hon. KAYEE GRIFFIN: As the guardian, the Protective Commissioner has control over the use of the pension of Mr S, to use him as an example. Presumably you made the decision for him to go into a nursing home that has dementia patients who can be confined, given his medical condition and underlying issues with alcohol. Obviously the payment of his pension is handed over to the Protective Commissioner. So there is contact between the two of you from that point of view. Otherwise, if you have accommodation for that person within the community the Protective Commissioner would be dealing with the financial aspects separately, unless the two go together as part of providing accommodation in a nursing home, or something like that.

Mr SMITH: Therein lies the logic of having the commissioner and the Public Guardian as the same person. Clearly if we make a decision with respect to a person going into a particular facility, the person needs to be able to pay the fees of that facility. If the Protective Commissioner is the financial manager for that person and believes the person does not have the resources to pay the fees, that influences our decision. We would have to find a place where the Protective Commissioner can afford to pay the fees.

Ms RUSH: A lot of clients would not have the Protective Commissioner as their financial manager, they would have a private financial manager. In any decision we make we would liaise with their financial manager, whether private or the Protective Commissioner, to ask whether the person can afford to pay the nursing home entry fee, rent, or whatever. We can make the decision, but we make it in the context of the person's resources and we would liaise with the person's financial manager, whether a government department or a person.

The Hon. KAYEE GRIFFIN: What if a person is living within the community and his financial management is controlled by the Protective Commissioner or a private person and his health is deteriorating? From the guardian's point of view he needs to be confined in a nursing home that relates to dementia patients as well because that is the only type of accommodation that confines people. If you had to make that decision is there some contact with the Protective Commissioner in relation to how up to that point he was basically drinking himself to death but was not responsible for paying for his accommodation? That person would have had some money to spend. Do you contact the Protective Commission or the financial manager to totally change the way that he is going to live?

Ms RUSH: Yes.

The Hon. KAYEE GRIFFIN: The money that he was receiving was spent on himself, as opposed to accommodation. The money was being misused. Is that your responsibility?

Mr SMITH: Yes. The decision of the guardian with respect to where a person should live is deemed to be a decision of the person himself. The decision of the financial manager in a sense has to follow the decision of the person. They have control of the person's financial estates, so if, for example, we say that the person should be allowed to live at home but they need services to come in and look after them 24 hours a day, that could be a very expensive model of care. Our decision to do that is dependent on their ability to pay. Where the resources are available within the estate, the financial manager has to make the payment. In other words their decision has to follow our decision, because our decision is regarded as a decision made by the person himself. In other words, we stand in their shoes and make the decision for them.

Ms RUSH: Is another component of what you are asking whether they might spend all their money on alcohol instead of accommodation and food?

The Hon. KAYEE GRIFFIN: How the person is struggling?

Ms RUSH: Yes. We try to organise meetings with people. In some circumstances a person who receives their pension on a Wednesday might spend it all on drink by Thursday of Friday. Lots of arrangements are put in place where someone may be able to access $10 day and in a sense that controls their access to money to spend on alcohol. Other money would be controlled to make sure they have food and that their rent is paid. There are lots of combinations and it is all about us working closely with the financial manager to try to deal with that informally as well.

CHAIR: Graeme, I refer to what you said earlier. If I understood you correctly, you said that when we replace the Inebriates Act with something that might cover the group of people about whom we are concerned we could get by essentially by including them under the guardianship legislation.

Mr SMITH: The limitation would be that the group of people you might want to deal with might be smaller under guardianship, in the sense that they would have to have a disability before they were placed under guardianship.

CHAIR: It would probably be true to say that most of the witnesses that have spoken to us about any model at which we might look have said that the safeguards, the civil liberties, the protective aspects would be catered for to their satisfaction by a piece of legislation that mirrored the protective aspects of the Mental Health Act, or by bringing the group of inebriates under the Mental Health Act. There is a considerable divergence of opinion as to whether the people we are talking about should be dealt with by drug and alcohol services and kept separate from mental health services. There is a degree of agreement that the Mental Health Act, as such, or a piece of legislation that is closely modelled on it, with its tribunal, its procedures and safeguards, would be a fair enough model. You have said something different to what other witnesses have said so far.

Mr SMITH: There are two issues in relation to that. I think that is a reasonable perspective if a decision to detain a person is made purely in that person's interests and not in the public interest. If you look at the way in which the Inebriates Act may have been used in days gone by, it was frequently used more in the public interest to remove the drunks from the streets than it was in the interests of the person.

CHAIR: People are telling us that it is being used in that way today. We have heard about cases that have made that pretty clear.

Mr SMITH: If the legislation were constructed so that it mirrored the principles of the Guardianship Act to that extent—that it has to be in the person's interests and for no other reason—I would accept that as being a reasonable proposition. The other point I was making is that when a person is placed under guardianship, a guardian is appointed to protect his or her interests.

CHAIR: Under the Mental Health Act that does not happen.

Mr SMITH: No that does not happen. Obviously a magistrate makes that decision in the first instance. A tribunal reviews that decision at some point somewhere down the track. You also have the added protection of official visitors if a person happens to be in hospital and so forth. But the advantage of guardianship is that you have a guardian appointed for that person at all times. It is the duty of that guardian to constantly monitor whatever is happening in relation to that person and to ensure that it is in his or her best interests.

CHAIR: That goes beyond a case manager within the health system. Someone has a brief to look at the overall interests of that person.

Mr SMITH: Yes.

CHAIR: You referred earlier to "public interest". In some ways this inquiry came about as a result of a speech at the Alcohol Summit relating to the interests of the family. Where does the family fit in, in particular, a partner of someone with a degree of alcohol dependence?

Mr SMITH: In relation to the Mental Health Act, quite clearly the family will often have an interest. Their interests will be taken into account when decisions are made in respect of a mentally ill person. The difference between that and guardianship is that a guardian's decision-making with respect to that person would exclude the interests of family members. It would be based exclusively on the interests of the person under guardianship. That is not to say that we do not take into account the views of family members. When making decisions with respect to a person under guardianship we always consult family members and we seek their views. It forms part of the information base upon which we make our decisions. But we do not ever make a decision that affects the person under guardianship when the interest is purely with the family and not with the person.

CHAIR: In relation to question No. 5, you have given us a new answer to a legislative model. In relation to who would be responsible for making decisions about whether a person receives treatment, where it occurs and when he or she is to be discharged, would you see that as a matter for people with expertise in the health or treatment area, or would you see that as a matter for people in the guardianship area?

Mr SMITH: It depends on which model you go for in response to your question. If you go for a civil detention model, which is similar to the Mental Health Act, people with drug and alcohol

expertise would be centrally located as decision-makers within that model. If you go for the guardianship model, the guardian would make those decisions.

CHAIR: What sort of input would the health professionals make?

Mr SMITH: At present we make decisions in relation to people with a wide range of disabilities—people with Huntington's chorea, multiple sclerosis, intellectual disability, brain injury, senile dementia, et cetera. The decision-making process requires us to gather information from appropriate experts in the field upon which we can formulate our decisions. In this case, if the legislative mechanism was to be guardianship and the guardian was making these decisions, the same principles would apply. We would have to seek the advice of appropriate experts in order to make those decisions.

The Hon. ROBYN PARKER: Is that an absolute requirement, or is that just the practice that you adopt? Are you compelled to do that, or do you just choose to do that?

Mr SMITH: Our decisions are reviewable, obviously. In answer to your question, it is not a requirement under the legislation that we do that, so it is a practice issue. The duty that is imposed on the guardian is a fairly broad duty. You need to be able to exercise that duty prudently. In so doing you would need to be able to demonstrate whether your decision was based on the evaluation of evidence that you had collected.

The Hon. ROBYN PARKER: Is there an appeals process?

Mr SMITH: There is. The decisions of the public guardian can be appealed to the Administrative Decisions Tribunal.

The Hon. ROBYN PARKER: What body reviews the efficacy of your decision-making apart from that body?

Mr SMITH: The Guardianship Tribunal does when it reviews the order. So part of our responsibility is to report to the tribunal what we have done pursuant to that order.

The Hon. ROBYN PARKER: I am trying to work out what are the checks and balances.

Mr SMITH: The Guardianship Tribunal is one review body and the Administrative Decisions Tribunal is the other review body.

CHAIR: What happens if a private guardian is appointed?

Mr SMITH: The same review provisions apply.

Ms RUSH: We also have internal reviews. Those are the end points. Family members can request an internal review. We have internal mechanisms in addition to that.

The Hon. ROBYN PARKER: If the decision is made wholly and solely on the basis of what is best for the individual and it does not take into account the family over the individual, what sort of ranking is an appeal from a family member given as opposed to an individual?

Ms RUSH: A family member's views are sought. His or her views are weighted quite heavily as well. We are not doing it in isolation. We recognise that, for a lot of people, the family is important and integral to them. Some people might not see their families for five or 10 years and they have different agendas or issues. So it depends on the nature of the relationship as well. It is never done just in isolation.

The Hon. ROBYN PARKER: A person who has brain damage from alcohol abuse possibly is not in a position to appeal.

Ms RUSH: A person under guardianship?

The Hon. ROBYN PARKER: Yes.

Mr SMITH: The person may not but a member of the family could—anyone affected by the decision or anyone who is able to demonstrate that they have a genuine interest.

The Hon. ROBYN PARKER: If a person was sent to an inappropriate place—be it a home or something like that—could they appeal as well?

Mr SMITH: They could appeal or their family could appeal. It would be rare that the person under guardianship would appeal. It would normally be a family member.

The Hon. ROBYN PARKER: If they are climbing the walls is that because they do not understand that they have the right to appeal, they do not have the intellectual capacity, or—

Mr SMITH: My point was that it related to their lack of capacity.

Ms RUSH: In terms of climbing a wall or something it is getting out and then getting back in again. That example highlights the complexity of it. The person might climb the wall in the morning but get back at 5 o'clock. It is very interesting. Once members of the client group we are talking about are operating from an addiction or dependence in relation to need—it is an insight into that.

Mr SMITH: There is an analogy with children placed in out-of-home care. As you would be aware, under recent legislation controlling that situation there is now a children's guardian who is appointed to regulate those arrangements and to protect the interests of children in those situations.

CHAIR: I return to the point at the beginning of question 3. People who are simply intoxicated, albeit regularly and seriously, are not within the jurisdiction. This morning the people from the Kirketon Road clinic gave the example of a woman who was admitted under the Mental Health Act but very briefly and, they thought quite properly, discharged after 12 hours. The major problem was cocaine. She had come out of the intoxication or whatever you call it during that period. From what we can gather this one would not have fitted within your rules but clearly would have fitted within the Inebriates Act. So, in terms of the models that we are talking about, what should we do with people like that where the mental health part was really a relatively minor part of this young woman's problem?

Mr SMITH: I am assuming that she did not fit within the Mental Health Act because she was not mentally ill.

CHAIR: That is right.

Mr SMITH: And I am assuming she would not have met the requirements of having a disability under the Guardianship Act because no-one could give evidence to say that she clearly had a disability.

CHAIR: And the people talking to us this morning were pretty confident that in fact she did not have a disability.

Mr SMITH: You are then dealing with a situation where a person is apparently, in the absence of mental illness and disability, exercising their free will to consume alcohol.

CHAIR: Or cocaine or whatever it may be.

Mr SMITH: Or a particular drug. Notwithstanding that presumably they have a capacity to make some informed decisions about consequences, the question is whether it is appropriate in those circumstances for the State to intervene through the use of some mechanism, and what does it do when it does intervene? It is unlikely that someone can provide effective treatment to someone who has elected to indulge in this behaviour in the absence of a mental illness or any other decision-making incapacity.

CHAIR: At least two complicating factors in that case were that the young woman, from memory, had presented 21 times in a relatively short period. She was seeking help but ceased to feel that way once she was again under the influence of cocaine. She had also been treated in a general hospital because of a major injury to her harm which required treatment to avoid serious infection and so on. There was a whole complex of issues.

Mr SMITH: I am assuming that many people take heroin and so forth who do not have a disability or mental illness: they elect to take heroin as an exercise of free will. They will suffer consequences from that related to health and the lifestyle they lead, which will place them at risk of a range of things such as arrest and incarceration, assault and battery, and contracting hepatitis et cetera. At the end of the day they are still making an informed choice.

CHAIR: So you would see her as not properly subject to compulsory treatment or incarceration?

Mr SMITH: It goes back to the point that I was making before: In whose interest are you going to compel someone to have treatment in those circumstances? The provisions under guardianship that relate to whether a person has a decision-making incapacity are fairly broad. If it can be demonstrated through the provision of evidence that the person is not making an informed decision with respect to the lifestyle that they are leading then clearly they fall within the provisions of the legislation. But in circumstances where that cannot be demonstrated, where the person is clearly acting in the exercise of their free will, notwithstanding that they know the consequences, my question would be: In whose interest are you making the decision to compel them to have treatment?

Ms RUSH: I remember reading the submission from Kirketon Road and that example and the real dilemma of the multiple admissions and being caught in the throes of that dependency cycle. It is not that she regained a choice ability in the sense of being able to clearly distinguish that her mind was clear enough. There were queries about whether her mind was clear enough to say that she was choosing to have her next hit; or was it the cycle of that dependence and addiction that was taking over? If you have the evidence and the medical background to look at that kind of absolute concentration of dependence you might make a different decision.

Mr SMITH: You may be able to mount an argument that a person who is suffering the effects of withdrawal from a drug is in a sense compelled to continue to take that drug. But notwithstanding that they know that it is just locking them into the cycle of intoxication and withdrawal, the physical effects of withdrawal are so severe that in a sense they have no choice: they have to do it.

Ms RUSH: That was very much the case. There was not an element of a freedom of choice at all; it was desperation by all parties involved.

The Hon. IAN WEST: Lack of freedom to choose as opposed to free choice.

Ms RUSH: That was more evident in that.

CHAIR: Can you give us any information about the work in New South Wales along the lines of the Victorian Human Services (Complex Needs) Act? It would also be good if you could point us in the right direction in relation to the civil detention legislation that you were talking about.

Mr SMITH: What I was referring to was a debate rather than there actually being any sort of draft legislation. We may have misled you somewhat in relation to question 6 when we suggested that there was a similar model. What we were referring to was collaborative work being done between the departments of health, ageing, disability and home care, the public guardian, housing, juvenile justice, criminal justice and disability units. That work was essentially about creating service models rather than legislative provisions. Nevertheless, as I said earlier, there is a current debate within the sector about whether civil detention legislation is needed for people with disabilities.

This arises for a number of reasons. One is that there has been—as you will probably be aware—an ongoing issue in relation to people with disabilities in the criminal justice system. A view widely expressed within the disabilities sector is that people in those circumstances would be better

diverted away from the criminal justice system and into specialist service arrangements. The debate is about whether in those circumstances people could be detained under the authority of a guardian or under the authority of some special legislation. There are proponents of both arguments. Some people believe it is important to have a legislative base if you want to detain people and other people argue that it is better to have a guardian who will make those decisions. I refer you to situations such as children in out-of-home care. It was decided that they should have a children's guardian to protect the interests of children in out-of-home care. That decision was made initially by the court but subsequently the guardian was appointed to protect children's interests thereafter.

CHAIR: Do you currently cater for people with an intellectual disability?

Mr SMITH: We do. The tribunal, within the context of the order it makes, will frequently provide us with the necessary authority to detain people. We have a bit of a dispute at the moment with the Department of Ageing and Disability, which for some reason after 12 years or so has suddenly decided that it is not sure whether our authority will hold up. That has fed into this debate about whether there needs to be special legislation.

CHAIR: Where do you detain the people we are talking about?

Mr SMITH: They can be detained in a variety of different places, such as group homes and sometimes in larger residential services like Rydalmere, for example.

CHAIR: That is interesting because you have opened more avenues for the debate about compulsion. What would you like to see come out of this inquiry?

Ms RUSH: I think you have had this in a number of submissions. I think you can have all the Acts in the world but if the services are not there and creative, flexible models across the State, as much in rural and regional as in inner-city areas, are not funded, those Acts will not make a difference. We can have the Acts but they will be ineffectual. I would like to see come out of this inquiry—I know that it is a bit outside the Committee's brief—a big push and great advocacy for these services to be provided.

CHAIR: The Committee is certainly grappling with that issue.

Ms RUSH: I am sure it is.

Mr SMITH: In addition, funding must be injected into the development of treatment options. We are frequently told by the Department of Health that there is no point in invoking the Inebriates Act because it requires us to provide treatment that we cannot provide.

CHAIR: In some cases it is because there is no treatment and in other cases it is because the resources, facilities and so on are not set up to provide treatment.

Ms RUSH: In that sense it is about a web of care. It is not just a case of containing someone and then releasing them. It is trying to provide an integrated service across where they live, their communities and families and creating a model. That is just not there.

CHAIR: Thank you very much for your evidence.

(The witnesses withdrew)