REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO THE INEBRIATES ACT 1912

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At Macquarie Hospital on Thursday 4 March 2004

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The Committee met at 2.45 p.m.

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PRESENT

The Hon. J. C. Burnswoods (Chair)

The Hon. Dr A. Chesterfield-Evans
The Hon. R. M. Parker
The Hon. I. W. West

GLENYS DORE, Senior Staff Specialist Psychiatrist and Deputy Superintendent, Macquarie Hospital, Wicks Road, North Ryde, affirmed and examined:

CHAIR: Thank you for taking us on a tour of the hospital. Do you wish to make an opening statement?

Dr DORE: I felt that going into some case histories might be the best way to start, because it would also illustrate some of the difficulties we have had with particular patients who have come through the hospital under the Inebriates Act. I will start with some studies of patients that I have been involved with directly. Obviously, I do not want to go into too much detail because of the confidentiality of the people concerned. The first case history relates to a male who came into Macquarie Hospital in about the middle of last year under a three-months Inebriates Act order. He was sent to us by one of the magistrates at Hornsby Court. As a hospital, we do not have any say when a person comes in under the Inebriates Act. We get a phone call, usually from the court, saying, "We have got somebody under the Act. We are sending them to your hospital. Please find a bed." So everyone scrambles around trying to find a bed, which is often very difficult because we are dealing with acute psychiatry and we usually try to keep beds for people who are acutely psychotic, or who are at risk of harming themselves or others because of mental illness.

The gentleman was placed under the Act because he was being a repeated public menace. He was drinking heavily, all day every day; he was essentially drunk all day every day. In that context, he was committing petty crimes and making a public nuisance of himself. The police were involved, his family was involved, and he was placed under the Act and sent here for three months. He started out in the Parkview unit, and my team from the Fig Tree unit, were asked to assess him to see if he could be placed in our unit for a three-month period. The other option was to go to Tarban House, the locked ward with the long term mentally ill. We were at pains to avoid that, because we felt it was an extremely inappropriate place for this gentleman, who did not have alcohol-related brain damage and did not have another major mental illness.

After the initial detoxification period, he came to the Fig Tree unit for a three-month period. There were a number of difficulties with that placement. There were a lot of difficulties for him because he was somebody without a mental illness living with essentially 19 young people who were psychotic, had schizophrenia, a number of them were very difficult to talk to, they were extremely thought-disordered, a number of them were hallucinating, and they were generally mentally unwell. He did not feel that he had anything in common with that patient group. He was extremely derogatory of that patient group. He called them morons, and he put them down, which was difficult. He did not feel that he belonged in the programs. All the programs we have were geared up for that patient group, so he had to join them in their programs, which he did not like. We tried to accommodate his needs. We had him go to Alcoholics Anonymous, which was helpful.

He generally did pretty well in the ward in terms of his drinking. He was having leave on weekends; he was going around the corner to the shops. There was a bottle shop next door. He was not drinking; we would breathalyse him when he came back. All of that was going fine, but then the reports came in from a number of the young patients independently, saying that he was dealing drugs on the unit. He was bringing marijuana into the unit and selling it to the young patients with schizophrenia on the unit. Schizophrenia patients' brains are incredibly vulnerable to the effects of marijuana, unlike individuals who do not have schizophrenia. Sometimes even low doses will trigger off a psychotic reaction. We were very distressed to hear this. None of these patients—and there were a number of them—wanted to lay a complaint or to be named. So we could not bring in the police; we could not really do anything about it. We could not remove him from the hospital, because he was under a three-month order. We ended up transferring him to the locked-ward Tarban unit to at least remove him from the environment with our young people who are vulnerable. He was very angry about that, and he denied that he was dealing in drugs.

We ended up taking the case to the magistrate. We had not taken the matter to the police, because we were protecting our other patients. We were not able to say to the magistrate that we wanted him taken out of the hospital because he is dealing drugs to our young vulnerable patients with schizophrenia, but we were able to argue that he had been in the hospital under the Inebriates Act for

about 2½ months, that he had made progress in terms of his alcohol dependency, he had not been drinking, he had leave, he was on Campral, he was attending Alcoholics Anonymous, he was attending drug and alcohol relapse prevention programs, and we argued that it was appropriate for him to be discharged because he was doing well and because we had a treatment plan set up in the community. We were able to get the magistrate to agree to take him off the order, and we discharged him at that point, two weeks early.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you know what happened?

Dr DORE: We do not know what happened.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You do not have any follow-up?

Dr DORE: We handed the case over to the community team and the drug and alcohol services. We have a follow-up study for the Fig Tree unit generally, but not for this particular patient group. So we do not know what has happened to him.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it common practice that you do not find out what happens to people? This is the bane of any proper study, is it not?

Dr DORE: Yes, it is common. Probably most of the units in this hospital do not have a follow-up study. At the Fig Tree unit we have an outcomes study, under which we track all our patients over six months, 12 months, 18 months and two years to see how they are doing. But he was not within the study that we were looking at because he was someone much older than our patient group, so we were not specifically involved in following him up.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you handed over to a community group. Could you not follow up the case with that group?

Dr DORE: We could. But our energy in the hospital is geared towards a specific patient group, and those who are under the Inebriates Act do not fit within our treatment plans and treatment process. We do not have specific treatments for them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In relation to most people who are the subject of some sort of study, you do follow what happens to them?

Dr DORE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But if you are not studying them, once they leave the hospital gates they are not followed up. In a sense, it does not matter that the record is incomplete?

Dr DORE: Unless the case manager has specifically contacted us, we would not have information or feedback about how that person is doing in the community.

CHAIR: Do you have other case studies?

Dr DORE: Yes.

The Hon. ROBYN PARKER: How did you ascertain that the patient you have referred to did not have any brain damage from his alcohol abuse?

Dr DORE: It is possible that he had some subtle cognitive impairment. Our psychologist was involved and doing some psychometric testing to assess that.

The Hon. ROBYN PARKER: So you do that?

Dr DORE: Yes, we do that. Even though he was here and not part of our treatment program per se, we still offered him all the treatment opportunities and the investigations so we were still doing blood tests, checking his brain functions, making sure he was on anti-craving medication for his

alcohol dependence, plugging him into AA and so on. We did our best to try to offer him what we could within the realms of a treatment program that is for people with schizophrenia.

CHAIR: I assume that when someone like him arrives out of the blue under an inebriates order, basically no file comes with them? What sort of information do you get on a person like that?

Dr DORE: We essentially get no information, unless we chase it up.

CHAIR: Basically, you get a phone call to say someone is coming.

Dr DORE: Yes, we get a phone call saying they are coming, they are under an order. We know nothing about them generally but we may be able to gain some information from the community team, if there has been a team involved.

The Hon. ROBYN PARKER: So he would have come already detoxed, or was he under the influence of alcohol when he arrived?

Dr DORE: He came under the influence to the acute unit and had to be detoxified first.

The Hon. ROBYN PARKER: Which ward did you use for that?

Dr DORE: We used the acute unit first and then he came over to Fig Tree once he had detoxified.

The Hon. ROBYN PARKER: After three days?

Dr DORE: It was after about a week. Shall I move on to another brief case study?

CHAIR: Yes, because some of our questions may relate to that.

Dr DORE: This is a young woman in her early twenties who was actually involved in placing herself under the Inebriates Act. Both she and her family felt that this was the best thing to do so she came into Parkview, the acute unit, and needed a brief period of detoxification. We also felt that it was not going to be appropriate to place her in a locked long-stay ward so we negotiated for her to come over to our open ward in Fig Tree, which she did. She was the only female there. There were 19 others who were all male patients with schizophrenia, and she found it very frightening. She felt the patients were freaky and she did not feel that she fitted in with that group of patients. She had a lot of underlying psychological problems which we started to put together ourselves and with her case managers in the community and from the drug and alcohol services. It seemed that she had a lot of problems with depression and anxiety and probably a history of sexual abuse.

She hated going to any of the programs. She did not feel that they were relevant for her and she did not want to mix with the patient group. She was also quite phobic about groups and she started indicating that she might be thinking about running away. In fact, she checked out with me what would happen if she went underground for the rest of the three months and then appeared after the three months were up and the order was over. She wanted to know if we could then lock her up again. I then had to say to her, "No, once your order has expired it has expired." We were preparing to transfer her back to the acute ward because we thought she was going to run away but we could not get a bed in the acute ward quickly enough and she did run away. Essentially, she went underground for the rest of her three months order. She would ring her family from time to time but was not seen or heard from again until that order expired.

CHAIR: Do you know what became of her?

Dr DORE: I know that she was alive and well and that she was in contact with her family but she was trying to keep away from everybody because of the fear that the police would arrest her and bring her straight back to this hospital.

CHAIR: Even though she had essentially placed herself under the Inebriates Act originally?

Dr DORE: Yes. She was not able to tolerate being in a treatment program and being in this kind of environment.

The Hon. ROBYN PARKER: Because she was under that Act your hands were tied in terms of putting her into any other rehabilitation program?

Dr DORE: She was negotiating that with us. She said, "If I am not drinking or using drugs"—she also had a drug problem—and I am attending programs and going to AA will you then look at allowing me to go off to work or some other rehabilitation program?" We said, "Of course we will". We were going to look at setting that up for her but the difficulty was that she absconded before we had a chance to do that.

CHAIR: Would that have meant you making an application to the magistrate to vary the order or would it have been within the terms of the order?

Dr DORE: We were not sure about that. We were going to look at whether we could do it within the existing order as part of her treatment program. If it was going to be a rehabilitation program outside Macquarie we probably would have had to go back to court and negotiate that with the magistrate, if she was going to be living outside the hospital.

CHAIR: We talked to the people at North Shore this morning. Like a lot of people, they unfavourably compared all of the Inebriates Act provisions in terms of the original orders and the input of clinicians and the advice and the process. Would it be true to say, from your experience here, that the processes, safeguards, input, et cetera under the Mental Health Act are very much better than the processes under the Inebriates Act?

Dr DORE: Much better. They are much better because under the Inebriates Act the clinicians have no say in what happens to the patient and the patient has no say either. There is no review process. The only review process is if the patient asks for the order to be appealed and it is placed back before the magistrate. But nobody else has any control over that order. There is no tribunal. For example, with the Mental Health act we would have a mental health review tribunal that would come in at specified periods and there would be a hearing, the case would be put by both the patient, their legal representative, their family and the treating clinicians about whether it was appropriate for that person to stay in hospital or not stay in hospital. There is no forum to do that under the Inebriates Act unless you specifically request to go back to court.

CHAIR: So you can get someone and you have no information about them and then when you try to scratch your head and work out what to do with them you turn into a bush lawyer and say, "Do I have to go to a magistrate to do this?"

Dr DORE: Yes, and clarify this.

CHAIR: It is very hit and miss, is it not?

Dr DORE: It is very hit and miss.

The Hon. IAN WEST: Do you have any views or ideas as to what facilities can be put in place to assist you? It sounds to me like what you are saying is that, because going back to the magistrate was too much of a legal problem, it just was not done.

Dr DORE: We were prepared to do it. We were going to go back to the magistrate with the second case, the young female, but she stepped in and made her own decision before we had a chance to get to that point and she ran off.

The Hon. IAN WEST: I understood you to say that she came to you about some flexibility, some change in environment, and you said you were unable to do it.

Dr DORE: Yes. We said that if she had a period of time when she was not drinking or using drugs and she was attending the program and everything was going well, she was not running off the ward, then we were very happy to argue in front of the magistrate that her needs would be better met

in a different treatment environment. But we felt to argue that with the magistrate and to have her taken off the order, we would need to indicate that she was sober, she was not drinking and she was actually meeting the treatment requirements within our unit.

The Hon. IAN WEST: So the difficulty was that you could not change the environment quick enough.

Dr DORE: We could not change it quick enough for her.

The Hon. IAN WEST: There was a period of time in which she was not drinking and in that period of time you could not change the environment.

Dr DORE: We could not change the environment, yes. To go to a magistrate, you have got to be able to argue, if you are going to argue that the person should be discharged out of hospital and they have been there for less than three months and they should be discharged to another unit, you have to argue that there is an indication that they have made progress in your own unit but she was not doing that. She was actually leaving the ward, she was drinking, she was not complying with the program.

The Hon. IAN WEST: And on top of that you did not really have the expertise to go before the magistrate. It was not something you do every day anyway.

Dr DORE: I go before magistrates a lot and I have done a lot of court work so it was not so much a matter of expertise; it was a matter of needing to put a case together for the magistrate to say, "Yes, this person is doing well enough to be released off the order and to go into a rehabilitation program off the order." That was the difficulty. We did not have the positive evidence to give the magistrate that she was doing well enough to be released.

CHAIR: If she had been doing well enough and you were about to go before the magistrate to do all this, would you have needed to have a place for her to go to?

Dr DORE: Yes, we would.

CHAIR: That could be quite difficult.

Dr DORE: That could be very difficult.

CHAIR: I assume the magistrate would say, "Well, where is she going tomorrow?"

Dr DORE: We would actually have to present a case of where she is going to, what kind of unit she is going to, there is a bed available, she has been accepted. We would have to get all that set up in advance.

CHAIR: Which, presumably, is not easy?

Dr DORE: Which is not easy.

The Hon. IAN WEST: May I assume that you are saying that you really do not cater for young women?

Dr DORE: No, we do cater for young women, but we cater for young women with schizophrenia. This hospital is primarily a hospital for people with schizophrenia, which is a brain disease. Schizophrenia makes people psychotic, for example they may hear voices, they may feel aliens are invading their brain, they are thought disordered, they have cognitive impairments, difficulty with their thinking and their thoughts are often very disordered. This young woman did not have schizophrenia and all our programs are geared up for schizophrenia; that is the problem.

The Hon. ROBYN PARKER: Tell me why this particular client decided to self-refer to an inebriates order rather than go to one of the community-based rehabilitation places or one of the other hospitals that offer detoxification in a rehabilitation program?

Dr DORE: That is a very good question. The reason why is because she had done that already several times.

The Hon. ROBYN PARKER: She felt that the compulsory nature of it was important?

Dr DORE: Yes, because each time she had gone into a rehabilitation or a detoxification environment she ran away. Then she would be drinking and getting depressed. She had tried to throw herself in front of trains but her friends had grabbed her; she had tried to throw herself off a tall building; she had tried to jump out in front of traffic when she was intoxicated**.** She felt maybe if she was detained somewhere against her will she might actually settle into a treatment program and not run off. But there was not enough to stop her running away either.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So not a success.

Dr DORE: Not a success.

CHAIR: Any more case studies?

Dr DORE: There is one more. Again it is not a happy one. These are not happy stories. I could tell you a lot of happy stories about the patients in the Fig Tree unit but I cannot tell you happy stories about these patients because they were not happy. This was a young woman in probably her mid-twenties who was placed under the Inebriates Act because she was out of control in the community, she was using a lot of drugs, a lot of alcohol, she was prostituting herself, she was becoming angry, violent, threatening, there was a concern that in an intoxicated state she might attack and harm someone.

She came to the hospital—and it was very clear very early on that she had a severe personality disorder underlying all her problems, as well as a severe drug and alcohol dependence—and she was placed in a unit like in Tarban; it was another long-stay ward that she was placed in with a similar patient mix. I think she was on a nine-month order. It became clear very quickly that there was a risk that she might harm the other patients because she would become very angry, very explosive, very threatening and very intimidating.

We ended up going before the magistrate and arguing that we needed to release her from the hospital and from the Act because we were afraid she was going to attack one of the vulnerable long-stay patients. The magistrate agreed to that and she was released off the Act, but not before we had to spend a lot of time looking at an appropriate place in the community for her to go to. We had to make sure—as of course we would—that she had adequate accommodation in the community and that she had follow-up in the community as well. She was someone for whom we felt we did not have treatment programs to manage the complexity of her problems. She did not have schizophrenia; she was locked in a ward with the long-term mentally ill, which was very difficult for her to manage, and she reacted by becoming aggressive and threatening.

CHAIR: In broad terms, from all three cases you have quoted, it sounds as if Macquarie was a totally inappropriate place.

Dr DORE: Totally inappropriate.

CHAIR: Are there other places that would have been reasonably appropriate for these three people and where placing them under an inebriates order was probably quite a good thing to do and might have worked better? I know it is hypothetical.

Dr DORE: That is a very good question. I think something that is in the order of drug and alcohol services: something that provides an inpatient detoxification, followed by an inpatient rehabilitation program would be much more appropriate for this patient group.

CHAIR: Such as the Royal North Shore ones that we have talked about?

Dr DORE: The Herbert Street program and the Phoenix unit program. The difficulty would be getting these particular patients to agree to go into those programs because they would have been offered those programs and some of them may have been through those programs already. At the end of the day those patients would have chosen not to accept those programs or to go into those programs and then leave them. So the difficulty would be getting them to be contained in those treatment programs.

CHAIR: Were they really willing to come here? They might not be willing to go to Herbert Street but did they want to come here?

Dr DORE: No, they did not want to come here. Most of the people who come here under the Inebriates Act do not want to come here. I think the young girl who signed herself up to come here did not realise what it was going to be like once she got here.

The Hon. IAN WEST: The second case, did that young woman go to Royal North Shore or Herbert Street?

Dr DORE: She had been involved in drug and alcohol services. She had had a number of detoxifications. I cannot remember whether she went to Herbert Street or the Phoenix unit. She had gone into a drug and alcohol unit but she had always left them within a few days. She could not commit herself to staying for any longer than a few days.

CHAIR: May I just say welcome to Mr Schmid. You are probably aware we are running a bit late and for that we apologise. We may find that by starting off with the case studies or in our tour earlier some of the questions have been answered.

The Hon. ROBYN PARKER: Dr Dore, we are aware that you worked under the New Zealand health system and we have been comparing different models obviously. I wonder if you could outline the compulsory treatment and legislation program over there and how it works as opposed to the Australian system?

Dr DORE: I brought the Act along. It is called the Alcoholism and Drug Addiction Act, June 1985. It operates in quite a different framework and a different structure, and in my opinion it is set up much more appropriately than the Inebriates Act. It allows for family members, the police or other responsible persons to apply for the patient—the alcoholic or person who has a drug addiction problem—to be placed within a hospital treatment setting. But that application is not the only part of it; the application would go to the court and then two doctors would have to complete certificates saying that they believe the person did have an alcohol problem, did have a drug problem, was probably at risk of harming themselves or others and needed to be placed in a treatment environment. So there would be two medical staff involved in signing off on that before the order went before the magistrate.

The individual themselves could also sign themselves up and sign a section 8, I think it is, so they could have themselves placed under this particular Act and access a treatment program. From there the individual would be placed usually in a drug and alcohol treatment setting—not always—but usually they would go and have detoxification in an inpatient unit. In New Zealand there is a broader range of units where they could go for treatment. There are residential rehabilitation programs and under this Act those programs will agree to take them under the Act for longer-term periods of time.

Under the Act if the clinicians who are involved in treating the patient feel that the patient needs to be released early, or if the patient feels he or she needs to be released earlier, then that decision can be taken by the clinician in association with the medical superintendent of the hospital. So once somebody is in a treatment institution they do not necessarily have to stay there for two months, three months, six months or 12 months, they can be released on trial leave at any point it is felt appropriate. The Act can also be continued in the community so that patients can have the compulsory drug and alcohol treatment within a community-based setting, and if they do not meet the conditions of that then they can have their trial leave revoked and they can be readmitted into a drug and alcohol treatment setting.

The Hon. ROBYN PARKER: In your opinion, as opposed to the Australian system would you say that the New Zealand system is much more effective?

Dr DORE: There is more clinician involvement, which I think is appropriate because it means you can negotiate a lot more with the patient about what they need in terms of treatment and how long they need to be in a treatment program, whereas here there is no negotiation; they are sent to you on an order for three months, six months or 12 months. Neither the clinician nor the individual can do anything about that order unless they go back to the magistrate. There are community options and usually they can go into a drug and alcohol treatment environment rather than a long-term psychiatric unit.

The Hon. ROBYN PARKER: What is the review process? Is it just a medical review?

Dr DORE: Yes, just a medical review. It does not have to go before the court.

CHAIR: Often the structure in the legislation or whatever can sound wonderful or sound very bad but essentially it comes down to funding and resources. Does New Zealand have the resources to actually make that system work so that the beds are available, the places are there where someone needs to be placed?

Dr DORE: I was down in the South Island in Dunedin and there did seem to be the resources there. There was a problem in that the stand-alone detoxification unit had been closed and merged with an acute psychiatric ward. That was problematic because it meant individuals under this Act had to fight for a bed in an acute psychiatric ward with people who were homicidal and suicidal. There was a lot of debate about should these patients be placed in this ward where we need those beds for psychiatrically disturbed patients, and should they be placed there anyway. If a person is detoxifying they do not want to be in an acute psychiatric environment; it is the wrong kind of environment. I think generally in terms of the administration of the Act clinicians were not looking at anyone and everyone going under this Act, we were looking specifically at people who were at serious risk of harming themselves and at serious risk of harming others, and nothing else had worked. They had been offered a lot of other treatments, had had a lot of other treatments, and nothing else was working.

The Hon. ROBYN PARKER: Do you believe that that sort of treatment does work? For someone placed in that environment against their will do you think the outcome is a positive one, or can be a positive one for them? We have not heard of any so far in your case studies but do you think under those circumstances that sort of treatment works?

Dr DORE: I think there is more flexibility and more negotiation. It is hard to know because the studies do not really exist in looking at the outcomes for those patient groups. There are some European studies which would indicate some individuals do benefit from having a long-term placement and do make changes, but they have to be in the right kind of treatment setting. There was a young woman I was involved with in New Zealand who had some problems with mental illness. She used to light fires when she was drinking. She came close to burning down her boarding house on a number of occasions. She was somebody we placed under the Act and detoxified. Then we placed her on Antabuse, which is a treatment for alcohol problems; if you drink on it you basically get a terrible reaction like a panic attack. This woman was placed on this medication and she had to take it as part of her outpatient treatment. That was very successful because she knew if she drank on this treatment she would get very sick, so she did not drank and she stopped lighting fires. So that was a good outcome.

The Hon. ROBYN PARKER: We have discussed with almost everyone the ethical questions of whether a person has a right to drink themselves to death, who has the right to intervene, whether there is a point at which people who have substance abuse cannot make those decisions for themselves, and whether family and community rights and responsibilities override that person's decisions. What do you think?

Dr DORE: I think it is a really complicated question. I spent a lot of time thinking about it yesterday, and also talking with some of my clients at a drug and alcohol centre at which I work. I think the answer is probably yes and no. If you look at things like smoking, people smoke themselves to death. A member of Parliament recently came out and said, "I have lung cancer, and it is my own

fault; I have been smoking all my life." We expect that people can make that treatment decision: to do something as part of their lifestyle which could endanger their life. Similarly, there are people in the community who are extremely obese who, we could argue, are eating themselves to death. They are not exercising enough, they are eating a lot of fatty foods, they are just getting bigger and bigger, and they are getting diabetes and cardiovascular disease. As a society we do not expect to lock them up because they are making a lifestyle choice to overeat, with all the health consequences that go with that.

Similarly with drug and alcohol use. I would argue that drug and alcohol dependence is not so much a disease as a disorder, and there are very complicated components to having a drug and alcohol problem. There are certainly biological and brain components. For individuals with an alcohol problem there is often a genetic component, and they may be genetically vulnerable so that their brain chemistry may mean they are prone to abuse something like alcohol. They have a drink, it stimulates their dopamine and their serotonin, they feel fantastic, so they want to do a whole lot more. But there are also a lot of other components. We know that people drink or use drugs because their peers do it, it is a fun thing to do, it makes them feel relaxed, it makes them feel sociable. To a degree, there is always an element of individual choice.

I think that when we are looking at this Act we need to look at a very narrow spectrum of individuals who have lost that capacity to choose or not choose whether they use drugs or alcohol. I am thinking about those who are at a point where they can no longer make an informed decision about using or not using. That may be because they have brain damage, for example from their alcohol abuse. Or it may be a female alcoholic who is so chronically intoxicated she is just lying in a gutter, urinating, incontinent, unable to look after herself. She is so chronically intoxicated that she cannot make a decision. You could not engage in a discussion about the pros and cons of drinking or the benefits of this treatment program over that treatment program.

It may be a person who is mentally ill as well as drinking and using drugs, and is not capable of having an informed discussion about the drug use and treatment options. I feel that that is where we as a society could legitimately intervene. I do not think we should be intervening outside that, because I think it leaves us open. For example, dad is unhappy because Billy is smoking marijuana all day, every day, and not going to school. So dad wants him locked up so he can be under a treatment program under this order. Billy knows there are problems with his marijuana use. He is able to engage in a discussion about the risks and benefits, he is able to engage in a discussion about how to cut down, and he is able to make a choice about the treatment options that are available.

We do not want those kinds of situations arising under the Act whereby anyone, as a heroin user, a stimulant user or an ecstasy user, finds themselves incarcerated in hospital because they have chosen to use a drug and their family are not happy about it. I think we really have to confine the definitions of who we would want to have placed under a compulsory treatment order. I think it is to do with losing that capacity to make an informed decision about whether you use or do not use.

The Hon. IAN WEST: Is there room for compulsory treatment as opposed to compulsory incarceration?

Dr DORE: I think that that is absolutely what it should be. At the moment what we have with this Act is compulsory incarceration and institutions that do not have treatment programs specifically geared up for these individuals. If we are to have compulsory incarceration, we should have incarceration within an appropriate treatment setting.

The Hon. IAN WEST: There may be those who need compulsory incarceration. I understood you to be talking about it in the light of compulsory incarceration only.

Dr DORE: No. I think it should be incarceration with a view to treatment, if treatment is appropriate. If a person is so brain damaged that they cannot engage in any treatment, it may be that they simply need to be in a safe, secure environment to detoxify and get their physical health back on track before a supportive environment is found for them to live in. But that is the extreme end. You have the other end of those who have perhaps some low-grade brain damage which will respond to abstinence, and once they abstain they may be able to engage in a treatment program. So you probably need a range of options available.

CHAIR: With regard to your example of the woman lying in the gutter, unable to enter into any discussions or make decisions, are you suggesting that that is a stage that is not as great as brain damage but nevertheless it is a grey area where you would still willingly use compulsion, or would you start using the definition of brain damage for that sort of case?

Dr DORE: You would obviously want to try to negotiate with that woman to get her into hospital, but if she was refusing and you felt she was in danger—I think you want a broader definition. I was thinking about a definition that involved a seriously diminished capacity to make an informed decision to use drugs or alcohol or to seek treatment for drugs and alcohol. That could involve brain damage or presumed cognitive impairment, or chronic intoxication, such as with that woman. If she is constantly alcohol-affected with high blood alcohol levels it is very difficult for her to engage in an informed discussion. It could also involve a person who is so psychotic or depressed that they cannot appreciate the consequences of their drinking or their drug use. I think you need to have a broad definition of impaired capacity.

The criteria would involve, firstly, a seriously diminished capacity to make an informed decision; secondly, that detainment is necessary for the person's own protection from serious physical harm or the protection of others from serious physical harm, similar to the Mental Health Act; and thirdly, a bed would need to be available for a treatment program. I think that has to be built into it, because at the moment there is no negotiation about the bed. If there is not a gazetted treatment program that is able to appropriately look after that person, I think you need to think seriously about whether they should be placed under the Act.

The Hon. ROBYN PARKER: We have looked at the fact that if we make a decision to repeal the Inebriates Act and design a new "you beaut" piece of legislation, what model or framework that should take. We have had a discussion about the Mental Health Act and various other Acts, and you have mentioned the New Zealand Act. What sort of legislative framework do you believe would work?

Dr DORE: I would like to see it piggy-backed onto the Mental Health Act here or the Mental Health Review Tribunal because that is a framework that already exists. It provides a lot of opportunity for a person's detention under the Act to be reviewed by an independent panel at regular intervals. It means that the clinicians and the individual patients and their families all have a voice at regular periods all the way through. You already have the Mental Health Review Tribunal set up around the country. I do not imagine there would be huge numbers of individuals coming under this Act, and I feel it would probably be structurally easier to manage if it were within that mental health framework, rather than setting up a completely separate framework. I think a lot of the principles will be the same, in terms of those who are placed under the Act, and I would hope that under a new Act there would be a lot of opportunities for reviewing individuals' placement under the Act, in the way that it is done under the Mental Health Act. So I would really like to see it as a parallel process.

CHAIR: Would there be any people in the mental health system who might think, "We don't want to take on drug and alcohol issues"?

Dr DORE: There are probably a lot of people who would think that.

CHAIR: Would they be at the level of the workers at a hospital such as Macquarie Hospital?

Dr DORE: I think it would change. In terms of our work here, when someone comes to the hospital under the Inebriates Act everyone says, "Oh no!" We do not have any control over it. We know that we do not have appropriate treatment programs. We know that we cannot negotiate anything with anyone because there is no negotiation, they are just sent here, and we cannot offer them the things we want to offer them because we are bound by the legislation. Everyone feels really stuck. Other patients are trying to get into a bed. They need that bed for rehabilitation for their schizophrenia, but they cannot get in because somebody who is under the Inebriates Act is in that bed. I think it would change everyone's perspective if there were some sense that clinicians were involved in and had some input into the Act and the running of it, and then we could work with the patients on administering the Act.

CHAIR: I suppose ideally, if you had the Mental Health Act included in these areas, you would still want it either designated in the legislation or organised administratively that certain places would be set aside. Everyone might decide that Macquarie Hospital is totally inappropriate and no-one in that category will come here, but a lot of people might go somewhere else, which might mean it can be staffed accordingly.

Dr DORE: That is right.

CHAIR: But you do not think there is an in-principle position to this serious category of drug and alcohol patients, but mostly alcohol patients, being broadly put within the mental health system?

Dr DORE: I think there would be a lot of opposition in some quarters. The reality is that we try to integrate drug and alcohol and mental health much more, but we are still under different roofs at the moment. Similarly, our policies are geared towards integration, which is a good thing, but there are still a number of individuals who would argue that mental health belongs here.

CHAIR: Is that more of a practical competition for resources, et cetera, or is it a philosophical objection?

Dr DORE: I think often it is philosophical. Often mental health staff feel they are not trained to deal with drug and alcohol issues, and, equally, drug and alcohol staff feel they are not trained to deal with mental health issues. So the patients are often sent from one service to the other.

CHAIR: They need to be linked because there is such a crossover?

Dr DORE: Yes. There is such a crossover that they do need to be linked.

CHAIR: The people we are talking about are excluded from institutional care; they are not captured by community-based services. Do you agree with this observation?

Dr DORE: I do not agree. The services are there. The difficulty is that this patient group do not want those services. They do not want to go to detox, or they do not want to go to rehabilitation, or they do not want to go on methadone programs, or they do not want to go on Campral. They would prefer to be using drugs and alcohol. The services are there, but they either do not want to use them or in some cases they have gone to all those programs and they are still not succeeding. There are some patients for whom we simply do not have treatments that will be successful. There are cases of individuals that we just do not have adequate treatment services for or they do not exist. We do not know when we will have them. We do not have medication that controls everyone's addiction. So there are individuals who will not survive their problems with addiction and who we will not be able to help, unfortunately, with the best treatment services in the world.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are saying that they do not want treatment and then you are saying that treatment does not work. In a sense, when you are saying that treatment does not work you are saying, "We assume that the desirable outcome is that they stop doing the naughty things they are doing and be good little vegemite citizens." That is different from saying that they have chosen to use drugs because that is more fun than whatever else. At what stage are they in control of their situation, and at what stage are you imposing a model on them?

Dr DORE: There are probably both groups. There is the group who have gone into treatment and they are not that particularly interested in the treatment options that are available and they would prefer to continue using drugs and alcohol. That would be a preferred lifestyle choice. Then there is a group who do go into detoxification, go into rehabilitation, go into treatment programs, go on the anti-craving medications that are available and those things just do not work for them. It seems that nothing we have available on offer is effective for that group. I guess what I am saying is that there is a small group of people for whom we do not have successful treatments.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Having done the mental health inquiry, which I was on, the impression that they gave us, almost universally, was that there was not anything like enough resources in the community. This morning at North Shore they were saying that

basically they could increase their resources by four just with the existing demand. Are you saying that there are enough resources in the community? You said there were enough resources in the community for drug and alcohol, is that right?

Dr DORE: No, I am thinking about this particular group we are seeing who are coming in under the Inebriates Act, which is a very extreme end. I am not looking at the whole spectrum. There are certainly not enough resources for the whole spectrum of people with alcohol and drug use. But with the Inebriates Act we are looking at the very extreme, severe end, and for that particular group there are resources, there are rehabilitation programs, treatment programs and detoxification programs.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But they would be eligible on the basis of how bad they are—in a sense, how severe they are.

Dr DORE: Yes, they would.

CHAIR: Taking that division into two groups, the group who have in a sense tried everything and it has not helped, in the end we simply have to allow them to drink themselves to death because there is nothing left that the community can do?

Dr DORE: Unfortunately I think that it is the reality for some individuals, that compulsion. Rennie may be able to talk to those because he has been involved in different cases than I have. But there have been some individuals who have gone through on the Inebriates Act here who have then left and died within a short space of time and they have spent 12 months incarcerated in this hospital.

CHAIR: Given the case studies we talked about before, that may be partly because this was an inappropriate place for them—the treatment being offered and the motivation and so on was such that they were unlikely to make progress.

Dr DORE: And perhaps also because they had so many factors in their situation and that meant no treatment program would make a difference. That is the other option.

The Hon. IAN WEST: Or it might have been a successful outcome. They lived 12 months longer than they would have.

Dr DORE: Yes, that is true. They lived 12 months longer than they would have done otherwise. They would have died a lot earlier, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: A cancer doctor might think that was a good outcome.

Dr DORE: Yes, that is true.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It depends on which profession or specialty you are in.

Dr DORE: Yes. They stayed alive for another 12 months.

CHAIR: With that second group, the group that does not want to try the services that are available, is that where we should bring in compulsion, basically to say, "We have decided that you are sick enough. You may not want to do this but we will make you"?

Dr DORE: I think that is where it goes back to my previous comments. For example, a lot of heroin users do not want to go on methadone or buprenorphine treatment; they would prefer to use heroin. Do we lock them all up because they have made that choice? I would argue that we should only look at compulsory detention of those who are at serious risk of harming themselves or others and who have that seriously diminished capacity to make an informed decision about the appropriateness of using or not using.

The Hon. ROBYN PARKER: What about those who do not have that capacity because they have brain damage from alcohol abuse? What do we do with those people? Can we treat them or can be just provide a place for them to exist? Are there those sorts of places?

Dr DORE: I am probably not in a position to answer that because I am not involved in treating individuals with alcohol-related brain damage unless they are in our hospital setting. But within that group again there is a broad spectrum. There are those who have some mild cognitive impairment from their drinking, which will fully recover if they stop drinking. There are those who have some permanent brain impairment but some reversible brain impairment, and if they stop drinking they may recover enough to be able to engage in a treatment program and make some improvements. Then you have those at the far end who have permanent brain damage, things like Korsakoff's and alcoholic dementia. In those cases it is usually very difficult for them to engage in treatment programs. Sometimes what you are looking at is placement in a supportive environment. I do not know how many places exist in the community. I suspect that there are very few places in the community for those with alcohol-related brain damage. As I said, it is not an area I am very involved with.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably at one time this hospital was a general psychiatric hospital and there were a number of general psychiatric hospitals which drew from various geographical areas of Sydney. Have psychiatric hospitals now specialised to the point that Rozelle does drug and alcohol and North Shore does drug and alcohol but you do schizophrenia? Are you saying that this hospital is not set up to deal with drug and alcohol patients?

Dr DORE: We have a lot of patients with drug and alcohol problems but most of them have a major mental illness so we are very geared up for that. The Fig Tree unit I am involved in running is specifically geared up for young people with a psychotic illness and drug and alcohol problems. We are not specifically geared up for individuals who have drug and alcohol issues but do not have a major mental disorder. We have an acute unit which will admit a broad range of general patients, including patients with drug and alcohol issues, but they can only stay there for a very short amount of time. So patients who tend to go into the extended care and rehabilitation wards tend to be those with a psychotic illness and that is what we are very good at managing. All our treatment programs are geared up for that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It might be a silly question but why are we here?

CHAIR: Because Macquarie is listed in the Inebriates Act.

Dr DORE: Because Macquarie is gazetted. People under the Inebriates Act come here. That is why you are here.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I wondered. I thought that maybe you had put in a submission.

Dr DORE: Yes. We put in submissions because these patients come to us, which is an inappropriate treatment environment for them and it is inappropriate for us.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You do not want them to come anymore?

Dr DORE: We would rather they went somewhere where there is an appropriate treatment program and where they are not filling beds that would be more appropriately used by other patients.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So if someone gave you the resources and the beds to run a program you would put one together, but if they do not you would rather they did not.

Dr DORE: We would be happy to.

CHAIR: Presumably when Macquarie was first gazetted in the list it was a much more general larger hospital within the mental health system. So perhaps we can assume that it used to be at least more suitable than it is now—I do not know how much more suitable.

Dr DORE: It did. Long before I was here there was a ward that was specifically geared for patients with alcohol problems.

CHAIR: The people at North Shore said to us this morning that Bridgeview—

Dr DORE: Bridgeview used to be, yes.

Reverend SCHMID: It had wards specifically for inebriated people with brain damage.

CHAIR: We intervene to protect family from whatever it is that the person with severe alcohol abuse is doing. Then the other side of it, I guess, is the role of the family and that is probably related to that point you made in your submission about community treatment orders and getting out of the institutional setting and using compulsion perhaps and using it in a community setting. Do you want to say a bit about that? They are two separate things.

Dr DORE: I think having a community treatment order under the alcohol and drug act would be very helpful because it does compel people to follow up with counselling or follow up with specific medications for drug and alcohol problems. Under the Mental Health Act we cannot compel people to go into treatment for their drug and alcohol problems or take medication for their drug and alcohol problems, even though there are some very effective medications these days that double your chances of becoming abstinent. I feel that would be very helpful in that such a community treatment order would be set up in association with families.

I think families are in a real bind because they are often pulled between tough love and kind of pulling back and pulling out and letting the person reach absolute crisis point and hope that things turn around, or feeling that they just had to keep putting more and more into a situation that is becoming incredibly untenable. So I feel that this whole process with the Inebriates Act does not involve families much either. It does not really involve anybody. I think an Act such as we have with the Mental Health Act, where families come in on tribunal hearings, families are involved in developing treatment plans with clinicians. I feel that an Act that allows for all that negotiation with family members would be much more helpful.

CHAIR: Earlier you said that there are a lot of services out there but that there are problems with some of those people using them. Would that be true of regional and rural areas?

Dr DORE: Probably, I would think much less so. More of the treatment rehabilitation centres are located within the greater Sydney area. There are some in specific rural areas.

CHAIR: We are going to Bloomfield in a couple of weeks. We have certainly heard that people were brought into Bloomfield from places in the western two-thirds of the State—I guess, even from Sydney in the past. I am thinking more of community-based services. Simply being a small community or a relatively small town makes it much harder to provide a range of services because of the number of staff you could effectively have on deck in a relatively small community.

Dr DORE: I think it is very much harder in rural areas. I had a lawyer who phoned me last year about a client of his with a drinking problem who had committed a crime. She was wanting to set herself up and go into a rehabilitation program so that she could then say to the courts, "I am going to this rehabilitation program. What about I stay in the program rather than go to gaol?" She was having a lot of trouble accessing an appropriate program where she was based so she was ringing around. She was ringing the Royal North Shore hotline to find out what rehabilitation programs were available in the lower North Shore and central Sydney area. She was determined to go to whatever program, even if it was out west somewhere. I think that is probably often a dilemma for people in rural settings that they have to come into the metropolitan area at times to get appropriate treatment.

CHAIR: Which makes a bit of a mockery of involving the family?

Dr DORE: Yes, because you are away from your family, you are away from your normal environment and your friends.

CHAIR: Question number 9, some people have suggested we are looking to an involuntary system to solve problems that are really associated with inadequate voluntary services. You have said for this small, really extreme group the services are there up to a point and they could get into them if they wanted to or were capable of making that choice. It has been suggested that if we really had a good range of all the sorts of services that are needed maybe we would not need compulsion.

Dr DORE: We would still need compulsion. There are still individuals who would not want to go into any services and who would be getting very very sick.

CHAIR: Sometimes we obviously ask these questions because we want to get you on the record. What would you like to see come out of this inquiry?

Dr DORE: Modify the Act, involve doctors and units in the process, have specialised detoxification and rehabilitation units gazetted to take the patients, and have something like a community treatment order able to be set up through community drug and alcohol centres.

The Hon. ROBYN PARKER: Lots of resources?

Dr DORE: Lots of resources, yes.

CHAIR: And take Macquarie off the list?

Dr DORE: Yes.

CHAIR: Thank you very much, Glenys. Your evidence—which is very clear—has been very valuable, and the earlier tour explained a lot to us as well.

RENNIE SCHMID, Mental Health Chaplain, Uniting Care, New South Wales and the Australian Capital Territory, Pitt Street, Sydney, sworn and examined:

CHAIR: We have your submission. Did you want to start off with any opening statement?

Reverend SCHMID: No, I am quite happy to go to questions.

CHAIR: Glenys gave us three case studies and, as you know, we asked you to start off with the case study of Barry—not his real name. We have read your submission and that was very striking. Can you tell us about other cases as well? Given the small number of them we are trying to get a sense of what is typical of the way the system treats these people or how they treat the system.

Reverend SCHMID: The other case is an American man who came from the northern beaches and was put before a magistrate and placed in Macquarie Hospital. It was questionable whether he had a mental illness as well. He was a very out-of-control person and he was sleeping in a church's premises before he came here; he was being cared for in the community by, it seems, a number of religious organisations who were providing him shelter and probably food as well. I am not sure what the exact mechanism for him coming here was but it was under the Inebriates Act that he was placed here. I do not know the fine details about that. However, he did nothing but try to get out when he was placed here.

He found it very difficult in Tarban House and I think he escaped on at least one occasion. In the end he called upon all his American cultural attributes to bring legal aid to his help—his beck and call—to get himself out of that ward. The ward really suffered greatly. It was horrendous. He split staff; he even split patients on the ward, and when I went and did my work he tried to enlist me to support him in that role. It was a pretty awful situation. In the end he got released back into the community and he disappeared for a while. Then I heard that he was found dead in a bus shelter at St Vincent's hospital. Apparently he had drunk himself so silly that he had caused damage. He ended up in casualty; casualty were going to treat him but he walked out before he got treated. It was one of the staff at St Vincent's who found him on a park bench early in the morning, so it was a night-time thing.

I know that information because one of the people who used to work here works for the Coroner and phoned through to say that this person had died. Often we do not hear of the outcomes because once they leave us they sort of disappear. It is the same with mentally ill people sometimes as well. That was pretty horrific and the outcome, I am sad to say, was not a very good one. He was very different to the case that I used in my submission because it was always touch-and-go whether or not he had a mental illness; you could not tell what was the greater, the mental illness or his addiction to alcohol. It was interesting: he submitted music to be played at the Olympic Games; he had tapes of his submitted music and he was apparently short listed in the process for selecting that music.

The other case that I have had face-to-face experience with I think is the same person that Glenys dealt who was involved in the drug dealing. He ended up in Tarban House because he was not fitting into the Fig Tree unit. I got a report that he was really aggressive about being put back in the Tarban unit. In that unit those people who have not got a mental illness find it extremely confronting to see people around them who are very psychotic and very ill, resistant to treatment, have maximum medication often, and they felt at risk often in that environment. Often the response that I thought we were getting was one about a response to the environment they were in as much as their disorder or their alcoholism. That man had a manipulative behaviour and he was sitting at the front door at Tarban—there is sort of a front door entrance which is like a tunnel and people often sit looking longingly out the glass doors. That is the impression I can give about those cases. I do not know where that man is now, I have not followed through on that.

CHAIR: We spoke to people at the Herbert Street clinic this morning and I think it was from Phoenix House they mentioned the case of someone who kept ringing them from here at Macquarie Hospital saying he was under an order at Macquarie. He kept ringing them and asking if he could go there. I am trying to remember the rest of the details. It could be one of the cases you have mentioned.

Reverend SCHMID: I am not aware of that directly but it does not surprise me that people would ring from Macquarie Hospital.

CHAIR: It was a 60-year-old retired man. I think they said he was found dead eventually.

Reverend SCHMID: The American man would have been no more than 38 to 40 and the person I spoke about in my report was 48 years old when he died.

CHAIR: These people were getting a phone call and the information was sketchy.

Reverend SCHMID: What would happen is because of the freedoms that operate under the Mental Health Act people would be able to access telephones and things to support themselves. As a matter of fact, they would be encouraged to take responsibility for their lives. So if they were able to make a contact to find alternatives for treatment, accommodation or a whole range of things, that is not an unusual thing. It would not be unusual for a mentally ill person to ring a few places a number of times and then that becoming part of their management structure within the hospital they would be limited to the amount of calls they could make because their behaviour would be deemed to be inappropriate. So that is not a surprising story really.

CHAIR: This person was under an inebriates order. Did you want to say any more about Barry?

Reverend SCHMID: Unless people want to ask questions about that, I have kept it general. I worked with Barry for just about the full 12 months and I was quite involved with him on his discharge. I will just say that it is probably one of the most difficult cases that I have dealt with in terms of the amount of energy of care and standing beside him as he tried to plan his way out of the hospital environment. He did not have a presenting mental illness; if anything he would have had a depression that might have developed because of the environment that he found himself in. I suppose this question about what is alcoholism comes in here: I worked with him very closely trying to find what the mechanisms were that sort of sent him over the edge because he was probably minimally brain-damaged, and he responded well to the lack of alcohol being made available to him.

He escaped once, or he went out. A person who he considered one of his best friends had died and he had not heard about it. That was enough to tip him over to drink again, and that was why he went from Hamilton Hostel, which the Committee did not visit—it is a low containment area—into Tarban. His brother and his sister were very strong that he needed to stay in here under the Inebriates Act. They threatened to sue the hospital if he was let free before the end of the term of his incarceration here. It was very difficult to work with because it showed that the mental health system has come right in conflict with the Inebriates Act and there was absolutely no mechanism to bridge that conflict.

Then it became a human rights issue because when he was sober and he was as normal as we are here he was able to articulate the difficulty of being an alcoholic—he owned his alcoholism—but we did not have the ability to provide the treatment for him that would go one-to-one to work out some of the probably psychological therapeutic issues that were going on within himself so that he could take control over his life. The frustration was that we could see there was a possibility of a really strong program for walking with this person in the community, but none of the resources in Macquarie Hospital could step beyond his discharge date—except for me, because my role is in between being an employee of the hospital and an employee of the church. That lets me stand in advocacy roles that are built into the mental health system. One of the strengths of the mental health system is that I can advocate free of the administration side of the hospitals I work in.

The Hon. IAN WEST: Is that a training issue or a resource issue?

Reverend SCHMID: Because he was put in the hospital under the Inebriates Act, there was no way that anybody could fill that gap after that, other than in the goodwill of the staff who were working here, who went beyond their duty to make sure that this person had care. The social worker worked outside the model of mental health to make sure that accommodation was in place. We had an enormous amount of trouble with the Department of Housing with regard to the accommodation because they would only see people from Macquarie Hospital under the mental health umbrella. They had different criteria for housing. I had to write independently of the social worker so that they had

another document to show that it was case managed in some way. I actually did some of the case management so that we could bridge that gap.

Drug and alcohol staff would not come to hospital to see him at the moment when the family was trying to make sure he did not get out of hospital. So to get to drug and alcohol counselling under the drug and alcohol model, he needed to take responsibility and catch a bus from here to Ryde hospital so he could see his drug and alcohol counsellor. However, drug and alcohol counselling would not come to Tarban House to do the work.

CHAIR: Why not?

Reverend SCHMID: Because the model they work under means that the person takes responsibility for their alcoholism. Until the person takes responsibility for their alcoholism, you cannot do a whole lot of counselling with them that is going to change anything in their lives. He was willing to go to the clinic, but we could not get there.

CHAIR: We have a very old, extremely inflexible Act. In a sense, because so few people dealt with it—such as drug and alcohol services, the Department of Housing, the magistrates—it is too specialised, people do not understand it, and therefore the people who end up being trapped within it do not get a very good deal. Would that be a fair summary?

Reverend SCHMID: I think the inflexibility is on both sides of the fence here; all the systems could not find ways to address the issues. I think it got passed on to the mental health research group, the overall think tank for mental health. It got put there, but it never got dealt with in the time that he was here. So from three months to 12 months the system could not come up with what I would consider to be an adequate human rights response to the position that this person was finding himself in. The other side is that the Commonwealth Rehabilitation Service was involved, and it was very difficult for him to get any training that would give him some sense of stepping from here into the work force. He had the ability to train. In fact, he had enough computer training in his background to build upon to work in the community. However, he was still an alcoholic, and he still needed a support mechanism in the community that would be beyond most people, even beyond what people need in a mental health scenario, I would think.

CHAIR: Clearly, there was considerable tension with his brother and sister. I suppose that tension arose also out of the fact that they wanted him locked up until something was solved. But if he were locked up, Macquarie Hospital could not do anything to solve its problems.

Reverend SCHMID: There was a mindset that you could fix it. There was a mindset that it was an embarrassment, that the professional position of his brother and his sister—and I believe that the family background was also involved, because we ought to also realise that alcoholism involves family structures and that questions about family involvement in alcoholism is not to be underestimated. They really did want him out of their face. They had actually prepared for him to be dead already, because they were told that he would not come out of Hornsby hospital intensive care. When he came through, it was a shock. It was then that they sought to use the Inebriates Act. They understood how they could use it. I am very clear about that. They did it in a way that he had no say: "I have read the Act, and the Act says that there has to be space for a person to negotiate." He was not offered that opportunity at all in the process before the magistrate. In fact, he did not go back to the magistrate after six months because the hospital said that because he had that lapse they would not support a release before six months. But he did not go before the magistrate in person.

He came here after nearly dying after being under severe intensive care support, so physically he was weak. He woke up in this hospital, I suppose as much a result of the interventions of intensive care as, one could argue, his condition was caused through his drinking. He was an alcoholic who would go into this blackout area and drink anything. The reason he nearly died was that he drank chemicals from under the kitchen sink. The police told me that when he died, he died from drinking three bottles of methylated spirits. Although I did not see the Coroner's report, it appears he died from a ruptured stomach, which is consistent with alcohol abuse.

Although I am trained in psychology and behavioural skill techniques, and I operate in a way that enables people to take responsibility for their lives, it affected me because I saw the human side

of the person. On the one hand he had one year and three months of what I believe to be quality living, because we could provide him with shelter and distance from alcohol for that period. On the other hand there was a whole lifetime of potential that was not there, and that is what made this case different. I think it was a good case of where the Inebriates Act fell down.

CHAIR: But a case where a good Inebriates Act, with proper services available, would have a good chance of saving him?

Reverend SCHMID: Yes. He would have said, and said a number of times, that the thing that he appreciated was that alcohol was kept away from him. The thing that he was frustrated about—which became a management model of dealing with his anger and frustration, rather than his alcoholism—was the fact that he did not have any movement in the system. It was not that the staff were stopping him; it was that the staff did not have anything to provide for him, and that our models are not models for alcoholics but models for people with mental illness. We could go two steps forward and one step back in mental illness treatment just because of psychosis, whereas I believe the alcoholic program is a very strong, rigid program that has a reward system in place that people must comply with.

If a person is five minutes late for the program, the consequences are quite severe. We cannot do that in mental health because the mental illness itself is what is variable. That is why they are here. They are not being managed in a way that we can contain people very much. We are slowly bringing them to be accountable and responsible for their mental illness, and we manage it for the rest of their days. Whereas, I think the alcohol and drug addiction model has very strong boundaries to cope with the manipulative behaviour that is part of it. It is only after years and years of hiding alcoholism that it becomes visible in the community.

Family structure needs to be part of the treatment. I have never seen an alcoholic case that does not have a link back to the family. I could be realistic and say that society itself has to take responsibility, but it seems to me from the work and reading I have done that alcoholism is often in a family setting and that the family's role in relation to alcohol needs to move as much as the individual's role.

CHAIR: You are not talking about causation but about relationships?

Reverend SCHMID: In order to cope with alcoholism in the family, different members of the family take on different roles, and the role in that cycle is no different to the violence cycle but is often involved in it. Working the system is often the way to make a difference. The tough love statement is an important one, but you cannot get to the tough love unless people are prepared to own the reality of the situation and get out of the magic thinking that we can fix this.

The Inebriates Act allows people to take people out of their face without dealing with the underlying issues that are there. In this case I believe that the family had huge issues. Indeed, my case approach in putting the picture together showed that the generation before had alcoholism as well. His mother and father and he grew up as part of a family that took the blame for the alcoholism, which was surely part of his problem. He had difficulty holding his head up and being confident that he could move forward.

It is not just an individual thing; it is a systemic thing. It belongs to individuals in family structures, and it also belongs to the community because of the availability of alcohol in our community. I say that not from a wowser position, because I drink alcohol and I am not an alcoholic. I can manage it and I take responsibility for it. But people with alcoholism are not able to put in that boundary to stop themselves reaching out for it. Whatever function it is within their lives, I do not think any alcoholic is the same as the next one because they are unique human beings with unique lives and different families behind them.

CHAIR: Assuming we had the right kind of legislation and the right kind of settings for people to go to, good detoxification facilities and particularly rehabilitation places, we would have to find out an enormous amount about the background, try to work closely with the family, try to bring in support services, and link up to the services in the community. Hopefully the person will go back to where they came from, or perhaps they will go somewhere else because that may be part of the

solution. The system would need to be extremely sensitive and detailed, and have a lot of information and a lot of ancillary workers.

Reverend SCHMID: That is right, and truly case managed and truly interdisciplinary in nature. The different skills of the different professions, including spiritual dimensions, need to be looked at, so that the program is agreed and people follow it. I think the containment is really important, but the containment does not need to be in an environment that is going to reabuse somebody. That is the issue here. It is not the containment; it is the context of the containment that causes the difficulty.

A rehabilitation program must also have a continuity of care. From the moment the person is placed under whatever Act is in place, to the setting up of the initial detox program, to the setting up of the rehabilitation program, the rehabilitation program continues into the community. They need the same amount of support to be as strong in the community setting. Similarly, mental health needed a mental health model. But the cohort of people and the numbers we are talking about here may be small enough to put the resources into modelling it. We are not talking about hundreds of beds; it sounds like we are talking about a maximum of 20 beds in that sort of model—unless, of course, the inebriates who have been hidden in our society all of a sudden come out. I actually think society, especially urban settings, hide it. I think there are community organisations of people who provide support without addressing the underlying issues. It is welfare without walking beside to give the person a sense of independence in their life. If you keep giving out they are going to take; they are not going to address the issues.

They do not like compulsory programs because they know that they have worked the city enough to know where it is. The person named in my report, Barry, can tell you everywhere in the street, right up and down Paddington, exactly where it is that you could do it. He could tell me the network of alcoholics, how they looked after each other and giving each other drinks and sharing what they had. He said he could walk up there and be sober at the beginning of the walk and be an alcoholic at the end because of the social framework and setting that he was involved in. He had a very good understanding of how it operated.

CHAIR: When you say "Paddington" I gather—he had started off, he came here effectively from Hornsby hospital and talked a bit about his family, and he was in the work force as well.

Reverend SCHMID: Like most alcoholics, he had been in lots and lots of jobs. He had been in jobs with some responsibility, government jobs, and he would be drinking in order to cope with being in those jobs. Then when the drinking got out of control he found himself on the street out of those jobs. He had been to a number of rehabilitation centres. He could name them. He had been to Christian ones, he had been to gestalt therapy ones. He had been to all the different networks. If we put before him the possibility of going to one again, it just was not an option for him. In the sense of what we are talking about, he fitted the bill of the Inebriates Act but where it was different he did not seem to have as many complicating factors. His brain had not been destroyed as much as some peoples, through some miracle—nobody could understand why he was still alive, when you read the medical stuff.

The rehabilitation needs to extend into the community because it is in the community that he was his weakest. He did not fall down in Macquarie Hospital in containment; he fell down when I went on leave and when one night for some reason or other he slipped into that dark abyss—I tried a number of times to work out what that was like—and it was so quick, it was shorter than a slippery dip ride. It was as sudden as that and he would be in that alcoholic state and he had no power over that. You could talk to him when he was not in that state and he felt supported and he would appear to be normal. He was not manipulative in the same way as some of the other people I have dealt with so there was not that sense of "make me responsible for your life". Some part of him really wanted independence, wanted to be in control. So he set up his flat with his own furniture and he was very proud of it. It was immaculate. The police could not believe how immaculate it was, except for the mess of his dying.

CHAIR: If he had survived what sort of regime would he have needed? Would he have been best with an element of compulsion continuing on? We talked before about community treatment orders, for instance, and we have also talked to a number of our witnesses about, on the whole, a

glaring gap in post discharge. There may be an order and then one day it comes to a stop and there is very little set up to go on caring for people after that. I am just wondering about your view on someone like Barry. Let us say we have a system where there is a relatively short, say three months, or whatever order, as is usually the case, and things are going okay and that person is then discharged. What sort of regime do we need after that? Does it need to be voluntary or compulsory? Does Barry need to work everything out for himself? Does he need to keep having people involving him? Who does it? How do they look after him? How do they help him look after himself?

Reverend SCHMID: By looking at his particular cases. The indicators are that he has reached a certain point in independence and able to look after that, to test out what happens if this happens and how there is support, where does it come from. The three months, six months or 12 months is not the issue. It is that the criteria for that person to live as wholesome a life as possible, that then identify the points where the support is needed, and that may be for the rest of the days, just like medication may be for the rest of the days. It may be that someone needs to be on 24-hour call for these people to connect with at two o'clock in the morning because that is the time that they do it, or the long weekend or the Christmas break.

Each individual will be different in what they require, depending on the complex world which they come from. There is no cure perhaps but there is a way that we can prevent them from dying by making sure that the resources are there. One of the questions is: Should a person be able to die or not? A person is in charge of their own life. I think that is the bottom line to survive in any of this work. If a person decides that they will take themselves out then they will and nothing anybody can do can often stop that. It may delay it but we are not necessarily talking about suicidal ideation with an alcoholic; we are talking about someone who drinks so much that they are destroying their body. Sure, some may be drinking to destroy themselves; Barry was not.

Barry just happened to get into that spot. There may have been some black spot in the centre of his world that was, "I can only see darkness, therefore why keep living? I will keep drinking." I could not get to that but maybe there was something there. The responsibility we have, I believe, is to provide the best possible resources to a group of people who are defined. Then if they are ordered to have treatment then we actually look at what the treatment is and what it is that we are measuring. Then when we feel they are ready to survive in the community, there will always be that risk that they will not survive but it might be five years, not three months, after discharge. I suppose it is about quality of living as well.

If he is trapped, locked up in a hospital that is close to a prison, that is not quality of living. However, if he is able to live with the freedoms that we are all supposed to be living with, within the limitations of his illness—and there will be limitations—then we have to provide that maximum possible and in his case I can truly say that we did not offer him the freedoms that were necessary for his ability while he was here. We were not able to contain the other person I spoke about. So even with the Inebriates Act we were not able to contain him because of personality, because of his intelligence perhaps as well. He needed containment because he was a disaster happening.

CHAIR: Would he have been able to be contained if he had been in a more appropriate setting?

Reverend SCHMID: I would hope that the management principles in a rehabilitation setting would be just like a mental health setting in terms of where we have drug-affected people. We would have mechanisms under which to contain them until such time that they are able to take more responsibility for themselves. I actually think yes, he would have tried to escape no matter where he was, but he was a danger to himself. If he was a danger to everybody else around him, which he was not, containment would have been tighter because it was him. I think people give up on alcoholics. It is almost like they come around and around and go, "It is too hard". And it is. You have to have a boundary. You cannot go into their lives and be the alcoholic with them. But I actually think it is necessary to understand some of the dynamics that are there in order to put in place behavioural techniques that address those.

If someone has a phobia about bridges, you break down the regime into little bits and take the person closer to facing that phobia and it works. They come through the other side. People say, "I can do amazing things. I can cross bridges. I can climb mountains." You reduce the effect on their lives,

but to get there you have to be with them to understand the nature of their fear. I think you can do that with a combination of therapeutic frameworks, psychological behavioural frameworks, cognitive therapeutic frameworks. Definitely challenge the frameworks. You do not have to belong to that family any more. You do not have to go back to that same place. Your pattern of friends does not need to be in this broad Sydney area. You should go and build your life in another place. That sort of thing.

Some of these overlap with mental illness but need tighter control because mental illness is more fragmented, it seems to me, by its nature. Disordered thoughts are disordered thoughts. You cannot expect somebody to be logical if they are disordered. But somebody who is not disordered and understands alcoholism can actually understand when they overstep the boundary. I think that is a difference.

CHAIR: There might be a few of these questions. A lot of what you have said has thrown a lot of light on them. You mentioned before the specific question of whether people have the right to drink themselves to death and you said, "Yes, basically, in certain circumstances".

Reverend SCHMID: I think it is an ethical framework that says that every human being is responsible for their own lives. When we are doing any treatment with any human being, the aim is to make them responsible for their own lives, not to make them welfare cases, not to take responsibility for the decisions they make. When we treat them we walk with them. It is like if somebody had two broken legs—we walk with them, we give them the supports until they can walk by themselves. A hip replacement operation has a rehabilitation program with an outcome. When a person can walk by themselves they no longer need physiotherapy or care.

Paraplegics need care all the time but what we do need is for them to actually own that and live with that as a whole as they can within that framework. I think that a similar model is here. We cannot take responsibility away from an individual and some part of me says—and this is because I have worked six years in mental health—we cannot take, I suppose, a person's decision to kill themselves because of the torments of the schizophrenia or demons in their lives or whatever. At the end of the day there is some part of me that can accept that decision. It does not mean that I condone it but I have to give that responsibility back to them, otherwise I would own every single client that I see in the place.

CHAIR: Obviously you have given our questions a lot of thought. Are there any others where we are trying to pin down people's views on some of these difficult issues where you want to be on the record giving a specific answer to some of these questions? Is there a situation where the rights of the family or community take precedence over the rights of the person?

Reverend SCHMID: If the person is a danger to themselves or to anybody else in the community I think there is a clear responsibility to make it safe for the community or to help that person so that they are not damaging themselves.

CHAIR: When you say "responsibility" do you mean compulsory treatment?

Reverend SCHMID: Yes, I think so, if a set of criteria is set up. I am in the same place as Glenys on this. If criteria are set up that define that this person fits this cohort because of this, this and this. I think it should also be done in a team approach so that not one person is responsible for that, which I think is a problem with the Act at the moment. It comes down to a lawyer in a magistrate's position.

CHAIR: So when you say "team" you also mean a multidisciplinary team.

Reverend SCHMID: A multidisciplinary team, yes, and some of those criteria. Some parts of the team are more able to make an assessment than others but at the end of the day the protections we have in the Mental Health Act—in six years I have not seen anybody under the Mental Health Act who did not need to be hospitalised. I mean, people have viewed the system; it seems to be working to say this person needs it. Resources meant that some people might not be treated that needed to be treated or people might be released before they are probably at an optimum stage but the process of the Mental Health Act does protect the rights of the individual and the community to the extent that it takes it away from an individual but places it in a systemic approach that is accountable.

It also allows for human rights to flow through through a number of places where an individual can access support from outside the mental health system and model. I believe in that. I believe we can fine-tune it, and we are. I believe this section is doing something on mental health as well, and that is something that has to happen all the time; we go back over and re-look at it and see how it works or where it does not work. Ultimately I think representatives of society should be allowed to protect society, and the individuals in society, from individuals and as long as we are putting in place the options for that individual to remain human and remain whole or work towards being whole is probably the way I would like to put it.

CHAIR: In question 3 concerning the role for compulsory treatment you have probably broadly answered some of that question in the circumstances that we have talked about. Do you have a view on the length of time that someone should be subject to a compulsory regime?

Reverend SCHMID: That is an individual question again because you do not know. I cannot predict how long it is going to take for a mental health person to come through the system. Some people amazingly go through quite quickly and get their lives together and other people take longer. Sometimes issues do not present themselves until later on in the treatment process. So the answer is not in a specific time but rather in the order that comes around again to be reviewed on a regular basis.

CHAIR: The time could be extended as long as the process is there to ensure that it is not abused? If someone needs an extension of time then the team goes through the process of extending it?

Reverend SCHMID: That is correct.

CHAIR: You are philosophically content for that to be the case in relation to severe alcohol dependence?

Reverend SCHMID: Yes, because I think there is a real issue here and that real issue has the capacity to destroy other parts of our society and the individual themselves. I think if we can put in place something that protects both society and the rights of the person as best we possibly can. It seems to me the Mental Health Act is like a revelation; it was a very good thing to come into place. I am very much for the changes that took place in the Mental Health Act. If that can be applied into the inebriates side of things that is fine. There are people who would say the mental health system should not be the place that is just extended to use the assessment process and the tribunal process. I do not think the system will cope the way it is at the moment because the system is very stretched with resources.

It is not just a simple matter of tagging it onto mental health. I agree that the Mental Health Act has already been set up and we have worked with it for a number of years, so the prototype and the model is there, but to add it in in a system that is down this path of mental illness—and alcoholism is still in a separate place—is not a realistic short-term ask. It may be a step towards that, but the more I thought about it the more I thought that yes, ideally that would be where it goes, but practically I am not sure we would be doing a great service to the people on that because there is a reframing going on.

CHAIR: From the evidence we have taken I think we have found almost unanimity on the Mental Health Act as a model in terms of the administration of the system, the checks and balances. But there is quite a considerable diversion of opinion on the extent to which the drug and alcohol side of things and the mental health side of things should be treated as two separate systems or one system, or as two separate but related systems.

Reverend SCHMID: Like all these things I think it comes down to a resource question. I am surprised how few there have been—we must have got them all or a lot of them—but given the numbers it is a brilliant opportunity to set up a systemic approach, a model that could be world's best practice. The other thing that crossed my mind: when I used to work in Canberra a member of my parish was the chairperson of the faculty of epidemiology at Australian National University [ANU]. That focused on multidiscipline approaches to social issues. That was the group that first put up the model heroin trial to measure all aspects of it. In Canberra they never ever dreamed it would go on—it was not Sydney—but because of the containment in Canberra they thought they could measure what a

difference a trial could make there. What was impressive about that organisation was that they used a multidiscipline approach, the best research; they travelled the world and communicated with the world to put it in place. I think this lends itself to doing that because if you talk about 20 people in New South Wales—

CHAIR: The people at Royal North Shore this morning thought that if we had a workable system we might be talking about 100 to 200 people a year because the reason we have got fewer than 20 is because people are not using the Act because it is an awful Act and the places are not available.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is a figure plucked out of the air though.

CHAIR: It is probably logical to think that if everyone says it is not working and people are not using it because people are being sent to inappropriate places, et cetera, we might have to think that the pool is a bit larger. But it is still very small. For the population of New South Wales it is minute.

Reverend SCHMID: You are not going to get any government in New South Wales at this time putting 200 beds in a place, but you are more likely to get 20 beds with a framework of how our acute stuff works now; there are just so many beds and you have to have criteria to go through. That is a model that could work and if it is seen to be working and the outcomes are seen to be better then it allows it to be extended.

CHAIR: Even 100 to 200 a year at any one time, that is not all that many beds.

Reverend SCHMID: No. At any one moment? 200 alcoholics in one ward!

CHAIR: No, per year I think. But, as Arthur said, it was very much plucked out of the air because we are seeking some sort of expert guidance on this. It is a question obviously that no one knows the answer to.

Reverend SCHMID: I think the research component of it is important. In a modern setting we need to keep feeding in and using our resources to better inform us about what we are dealing with. So if we had some it would need to have that as part of it I would think.

CHAIR: Should your role as a patient advocate be formally incorporated into the system?

Reverend SCHMID: Yes, but it would be if you followed that anyway. In mental illness they have official visitors, they have the consumer consultants and they have chaplaincy. Chaplaincy deals with the spiritual aspects of people's lives. The most difficult thing is to be the advocate. It is a very difficult role within the system to stand before case management meetings on behalf of people, but there is something about that independence there that means that we have sometimes relationships—even mentally ill people—where they tell us aspects of their lives that they do not tell others. The doctors are seen as like the judges, the nurses are seen like the guards, yet there is this group of people that we can trust to do that. So there are confidentiality issues there. We do not always report back the details of conversations. We certainly report back behaviour that might be dangerous to the person and anybody else.

CHAIR: Would you agree with that, Glenys?

Dr DORE: I think you really do need advocates who are independent. I guess the other side of that is that certainly the model that I work with is a model that involves spending a lot of time with patients individually and in group settings and trying to develop a lot of rapport and a really close therapeutic alliance. So that even though you are in the role of judge you are also seen as an advocate or a parental figure who can come in and advocate on behalf of that person where necessary. It is just a more complicated role for doctors and nurses to get their heads around and more complicated for the patients, and it is often just easy having somebody who is completely independent. Having said that, cleaners also are often seen as advocates because patients see them every day and develop a relationship with them, and they are not part of the treating team.

CHAIR: Reverend Schmid, what would you like to see come out of this inquiry?

Reverend SCHMID: I think the Act needs to be repealed. I think it would be a brave thing to try to rewrite it, given that it was already rewritten, from what I can gather, back at some point. I think a new Act needs to be in place. I think that is what I was hearing was happening when I came in. There needs to be a specialised alcohol unit for North Sydney or for New South Wales that really does look at this cohort of people and follows it through.

CHAIR: Are you talking about a research unit?

Reverend SCHMID: No, an actual treatment unit. There needs to be a place for them to go so that if there is going to be forced treatment then the model has to be in place for it to take place. It has to be resourced for that, probably alongside the implementation of the Act.

CHAIR: Is it a problem with a State the size of New South Wales—its population and geographical extent—to think of all those people coming into one place?

Reverend SCHMID: The question about the rural aspect: I do have experience with people in the country. My wife's family comes from the country and I have been requested to find support for members of that family.

CHAIR: You worked in Canberra, which is almost country.

Reverend SCHMID: Canberra is different altogether. In actual fact for the Wagga Wagga area Canberra was the only place we could get the sort of support for a rural situation. It was not alcoholism—it could develop into that I suspect—but I phoned around everywhere to get legitimate support for a person who was a farmer. The issues there were about the community being intolerant. So the anonymity of a city setting, even for people living in the city, is a positive because it allows a person to get treatment independently of their friends and sometimes with some members of their family being part of it, yet if it was done in a rural setting then people would know and it could become a stigma issue, a label. Again it is a resources issue. A big rural centre like Wagga Wagga is perhaps big enough to be able to do that. I think Wagga Wagga is the largest centre inland.

CHAIR: Wagga, Bathurst, Dubbo, they are all a fair size.

Reverend SCHMID: I am not sure whether community resources for holding a person when they leave an institutional setting are as easy to bring together as they would be in, say, a city setting because if you are in a suburb of the city two suburbs away you can get a resource person, whereas in a rural community there is no other next suburb to get it from. I have also worked in a mining community in Western Australia where alcoholism was a huge issue and violence was a huge issue. They just let it happen, if you know what I mean. It was just very difficult in Western Australia. There were no mechanisms in mining communities to deal with that other than lock a person up in the general hospital or lock them up in the lock-up until they sobered up.

CHAIR: Do you mean violence as in miners brawling with one another or also beating up women?

Reverend SCHMID: Miners with each other, miners with their partners, miners with their children. There is a large Vietnam veteran contingent in Tom Price, which prepared me for mental health in that way, and they are often had great binge drinking sessions. In those days, 15, 16 years ago, they did not have the mechanisms in place. The Vietnam Veterans Association was only just getting its counselling and post trauma work in place. That was in Canberra, interestingly. So they had to do their networks that way.

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

Reverend SCHMID: The opportunity to lead the world, a specialised unit, a repeal of the Act, and to stop sending them to mental health hospitals. I do not think Macquarie Hospital will be alone in saying that it cannot cope with it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you stressing there is a lot of difference in mental health and drug and alcohol?

Reverend SCHMID: Yes, I think there is a difference.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think they should be kept as separate specialties? Is there not a pretty big overlap?

Reverend SCHMID: There may be an overlap in terms of the mechanics of rehabilitation programs and behavioural programs. But the boundaries under which you operate with a group of mentally ill patients are very different from the boundaries for drug-addicted and alcohol-addicted people.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are telling me that there are two poles, but is there not quite a large merger in the middle?

Reverend SCHMID: Not in terms of managing group programs, I would not think. You cannot have a mental health program operator who is given flexibility to move within their illness capabilities, which is what the people there are measuring, and at the same time jump onto somebody whose alcoholism has not moved an inch from where the program is. I run a group in a day program area here, and we have to allow for the restlessness that comes with mental illness. We have to make judgments all the time about people moving in and out of the group because they are not able to sit for extended periods of time. If you put an alcoholic in that same sort of group, they will use that flexibility against the group.

If you have a group of five or six alcoholics in the rehabilitation program and they know what the rules are, they might work hard at manipulating those rules, but the facilitator of the team running that program will know exactly where the boundary is and the consequences of that outcome. That is as big as the difference is. You are still using behaviourism, and you are still using boundary setting, but you are setting the boundary in a different place. But it is absolutely too hard to get a coherent group and achieve the outcomes of the group if everything is speaking management.

(The witness withdrew)

(The Committee adjourned at 5.03 p.m.)