

**REPORT OF PROCEEDINGS BEFORE**

**STANDING COMMITTEE ON SOCIAL ISSUES**

**INQUIRY INTO THE INEBRIATES ACT 1912**

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**At Sydney on Thursday 27 November 2003**

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**The Committee met at 9.30 a.m.**

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**PRESENT**

The Hon. J. C. Burnswoods (Chair)

The Hon. Dr A. Chesterfield-Evans

The Hon. C. E. Cusack

The Hon. K. F. Griffin

The Hon. R. M. Parker

The Hon. I. W. West

**JOHN DENNIS BRICE WILLIAMS**, Senior Policy Officer, Aboriginal Health and Medical Research Council, P.O. Box 1565, Strawberry Hills,

**LEONIE GAI JEFFERSON**, Senior Aboriginal Drug and Alcohol Counsellor, Northern Rivers Area Health Service, Locked Mail Bag 11, Lismore, affirmed and examined:

**CHAIR:** Welcome to the committee hearing and thank you for appearing. In particular, I thank you for arranging for Leonie Jefferson to travel from Ballina. We very much appreciate it and look forward to the evidence. Would you like to make an opening statement or say anything in general terms before questioning?

**Mr WILLIAMS:** I will answer the first question, which is about the Aboriginal Health and Medical Research Council, and my colleague, who is a specialist in the area of drug and alcohol treatment, will speak from her perspective and answer questions and then I will answer the latter questions.

**CHAIR:** We normally try to run through the questions and we sometimes ask follow-up questions. However, feel free to stop us if that makes it difficult for you and the way you have prepared your answers to the questions.

**Mr WILLIAMS:** The first question asked us to explain the role of the Aboriginal Health and Medical Research Council. The council is the peak body for the Aboriginal community-controlled health sector in New South Wales and provides supportive services to 43 Aboriginal community-controlled health services—also known as Aboriginal Medical Services—as well as to a number of Aboriginal community-controlled health-related services, which include specialist drug and alcohol service providers. The Council's philosophy is that Aboriginal people themselves are the best equipped to redress the lack of wellbeing that erodes their communities and that the empowerment of local communities to manage their own health services plays a pivotal part in enabling Aboriginal people to seek attention for their health.

The Aboriginal understanding of health is that it is holistic and that the social injustices of the past have contributed considerably to the great disparity in life expectancy of Aboriginal and non-Aboriginal people. With regard to the specific area of drug and alcohol abuse within the Aboriginal community, the Council feels that this cannot be seen in isolation or in a vacuum. It is considered the legacy of years of deprivation, inequality, racism, dislocation from country, family and children and the lasting consequence of being moved to the fringes of society and excluded from the economic stream of this nation. Although much has been done to reverse the injustices and inequalities of the past, the effects of 200 years of negativism must be included in any assessment of the current situation and its success in ameliorating ill health caused by alcohol and drug abuse and will be successful only to the extent that economics, employment, accommodation, education and access to and equity in health services are also addressed.

These issues were alluded to in a paper presented by the chairperson of the Aboriginal Health and Medical Research Council, Sandra Bailey—our lawyer—at the Alcohol Summit. Some of the recommendations in that paper have been incorporated in the summit's recommendations. The Aboriginal Health and Medical Research Council is in partnership with New South Wales Health through the New South Wales Aboriginal Health Partnership. It has a close and positive relationship with area health services and that partnership is replicated at local and area levels. It is within this constructive context of Aboriginal people accessing area health service programs that our other guest is placed.

Ms Leonie Jefferson is an Aboriginal drug and alcohol worker at the Riverlands Drug and Alcohol Centre, a program within the Northern Rivers Area Health Service. Leonie will comment on the questions raised by the Committee from her experience in her work as a drug and alcohol worker, and the challenges it affords. Our other guest, Mr Brian Duncan, an Aboriginal drug and alcohol worker at Roy Thorn House in Moree, an Aboriginal drug and alcoholic rehabilitative centre, apologises; he was unable to obtain a seat on the daily flight from Moree to attend this session. But he

has relayed his response and relevant experiences directly to the Senior Project Officer, for the standing Committee. Ms Leonie Jefferson will first address the Committee. Thank you.

**Ms JEFFERSON:** The first question asks: Under what circumstances are Aboriginal people being placed under the Inebriates Act? My experience is that we in the Northern Rivers Area Health Service do not use the Inebriates Act a terrible lot. The main reasons are that, one, it is outdated; and, two, people are very reluctant to pick up people and do anything about it. In our area, if the police pick somebody up, they take them to the cell or bring them to Riverlands, and then they are assessed, or I am called down to the cells, or one of the other mental health workers or Aboriginal liaison officers work in with the police and helps.

**CHAIR:** Can you tell us a little bit about Riverlands?

**Ms JEFFERSON:** Riverlands is a detoxification unit, not specifically for Aboriginal people. It is a 7 to 14 day detoxification unit. It has been open now for just over three years. It was very difficult to get for the area because a lot of people denied there was a drug and alcohol issue in Northern Rivers. But, as everybody knows, there is a huge problem in every area; we are not unique. We are situated in a sort of central catchment area that enables us to take people from a lot of different places. I have been at Riverlands for two and a half years. I was a senior worker at Grafton before I came to Riverlands. The difference between a detoxification unit and a rehabilitation unit is that people have been more inclined to come to the detoxification unit and go through it. I have taken out the statistics, but I have left them behind.

**CHAIR:** We can get them from you later.

**Ms JEFFERSON:** Some 250 Aboriginal people have gone through the unit. Of course, some of those are returns, as with non-indigenous people. I encourage people to start with education—perhaps only a little bit of education, just to try to break the cycle.

**The Hon. ROBYN PARKER:** I understand that you do not have the actual figures with you, but could you give the Committee an estimate of the division between detoxification for both alcohol and drug abuse?

**Ms JEFFERSON:** No. I have that breakdown in my statistics, but I cannot remember it offhand. I can get it to you.

**CHAIR:** We will need to talk to you later.

**Ms JEFFERSON:** When I first went into drug and alcohol services I seriously believed that Aboriginal people had more sense than to stick a needle in our arm. I really did not believe that we would do that. I knew we had a problem with alcohol, just from growing up with it. But, as an Aboriginal person, I thought, "No, we're not that stupid to stick a needle in our arm; we would not do that." I got the shock of my life to see that we were that stupid.

**CHAIR:** You said that the police pick people up and take them to the cells. Is this a voluntary process? Do the police call Riverlands and you then go to the cells? Can you tell us a little bit about how that works?

**Ms JEFFERSON:** Basically, we work together. We are very fortunate there. A lot of it operates on personality. We could get a person with the wrong personality. At the moment, we have two really good liaison officers up there, and they advise the police a lot on what to do. If I am missing a person, or I am concerned about a person, they go out and look for the person; if they can find the person, they will pick the person up.

**CHAIR:** They pick the person up and take that person to the cells. That is using the Police Force outside the justice system really. There is no arrest or detention.

**Ms JEFFERSON:** No. Very rarely is there an arrest. And if it becomes a serious issue, if it is drugs, we get the Magistrates Early Referral Into Treatment [MERIT] Program involved. MERIT has not taken on alcohol, but it is looking to do that.

**CHAIR:** Yes. We heard from the Chief Magistrate yesterday, and that was one of the things he spoke about. So, as far as you are concerned, our specific questions about the Inebriates Act do not really apply to your area because on the whole you are not using that Act?

**Ms JEFFERSON:** I have a couple of case studies where we requested that a man be picked up under the Inebriates Act. At the time all the funds for transporting people had been used up, and there are only certain places they can transport them to, and by the time they made the decision on whether they would or would not do it, the person had died.

**The Hon. CATHERINE CUSACK:** Was it the police who were making that decision?

**Ms JEFFERSON:** Yes.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** This relates more or less to question 4, but what would you suggest be done? If you had your way, how would alcohol and/or drug problems be dealt with?

**Ms JEFFERSON:** I would have more workers on the ground, for a start—more liaison type people out there working with all sorts of organisations, Aboriginal medical services, area health services, the police and any non-government organisations just to scout about and look for people, and then encourage those people to have treatment—because you cannot force people into treatment. You just cannot do that. You have to constantly discuss with them the options of treatment and give them the choices. We have had people bring them in under the MERIT system, and they have hopped the fence at night, because we cannot keep people forcibly.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** So you would not advocate any compulsory treatment?

**CHAIR:** We are getting a bit ahead of ourselves. We are dealing with question 4. We understand your organisation does support the principle of compulsory treatment.

**Ms JEFFERSON:** We do support the principle of trying to contain people.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** You cannot have compulsory treatment if you do not keep them in.

**Ms JEFFERSON:** No. But you still cannot force people. You can try. How do you force them? People will always get out if they wish to.

**The Hon. ROBYN PARKER:** So you do not believe in custodial rehabilitation or treatment?

**Ms JEFFERSON:** I do, if we could work it in a way that is culturally appropriate and if you could see that it did make a difference.

**CHAIR:** Could you explain to us the extent to which you would go for compulsory treatment, the extent to which you think that should be retained, the circumstances in which it would be appropriate, and how you would see it being used?

**Ms JEFFERSON:** The person we mention in our case study was very ill. We had tried many times to bring him in. This was before the days of the detoxification unit, and we had had him in hospitals under treatment, and he had left. We had then tried to get the police to take him for compulsory treatment under the Inebriates Act, and that is when we could not do that. I believe we should have some way under the Mental Health Act and the Guardianship Act to retain people—but retain them respectfully and culturally appropriately.

**The Hon. CATHERINE CUSACK:** I would like to ask some questions about the case study, because it seems to be instructive on what the procedures are at the moment.

**Ms JEFFERSON:** I have copies, if you want them.

**The Hon. CATHERINE CUSACK:** That is much appreciated. Could you take us through the process by which you arrived at the decision that the person needed compulsory care and led you to make that request? Who in the organisation makes that decision, and how is it communicated to the police? Could you just speak about the procedure?

**Ms JEFFERSON:** This was not my client. This was the case of another worker. He had seen this person over many years, and he had treated this client many times. In that process he had watched him deteriorate. The man had had times when he had been abstinent and had lived quite well, and then he had slipped back. He was told that he was quite unwell and needed treatment. It has to go to our co-ordinator, our manager, and then it goes out to the police and they make a decision.

**The Hon. CATHERINE CUSACK:** Does it need to be court ordered?

**Ms JEFFERSON:** I am not sure.

**The Hon. CATHERINE CUSACK:** So the request goes to the police to detain the person under the Inebriates Act.

**Ms JEFFERSON:** I think when they bring them back, that leads to a court order.

**The Hon. CATHERINE CUSACK:** But the police were unsure about making a decision.

**Ms JEFFERSON:** They said they had used up their budget for transport, and that is why they did not pick up this person. There was toing-and-froing about where they could find the money to transport this person, and he had died in the meantime.

**The Hon. CATHERINE CUSACK:** Was the person in Nimbin?

**Ms JEFFERSON:** Yes.

**Ms JEFFERSON:** And needed to be transported to Lismore?

**Ms JEFFERSON:** No. He needed to be transported to Morisset.

**CHAIR:** We did get quite a lot of information from the Chief Magistrate yesterday, including copies of all of the legal documents that have to be used: the statement from the police, the statement from the medical practitioner, the application to the court, and so on. So now, at least, we are fairly familiar with the legal side of the Inebriates Act, and it is quite complicated.

**Ms JEFFERSON:** It is quite complex, isn't it? I also have a copy of our submission, if you want that.

**CHAIR:** Yes. Do you wish to make that part of your submission to the Committee?

**Ms JEFFERSON:** Yes.

**Document tabled.**

**The Hon. ROBYN PARKER:** Was the person sent to Morisset because under the Act there was not an appropriate referral place near where this person was?

**CHAIR:** That person did not end up going to Morisset.

**The Hon. ROBYN PARKER:** No, but you were going to take the person to Morisset?

**Ms JEFFERSON:** Yes.

**The Hon. ROBYN PARKER:** Is that because there was not an appropriate place?

**Ms JEFFERSON:** No, it was because they have closed all the beds. They only allocate so many beds in certain areas. I have not had time to familiarise myself with everything. My main role is drug and alcohol, treating people on the ground and counselling. I do pharmacotherapy treatment as well. I have not had a lot to do with this for quite some time. I have not bothered with the Inebriates Act for quite some time. The simple fact is that I work in a different system. I simply work with police and liaison officers that the police have, the mental health team we have and my team of DNA workers.

**The Hon. IAN WEST:** And there was no proclaimed place in the Northern Rivers Area Health Service?

**Ms JEFFERSON:** No, and they have closed the beds, I believe, at Morisset.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Do you think it would have been better if you had a place locally that you could take somebody?

**Ms JEFFERSON:** A sobering-up shelter?

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Yes. You need that?

**Ms JEFFERSON:** Yes.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** And if they are stropky, which they sometimes are, generally you can take them to hospital to sober up but they sometimes destroy the place?

**Ms JEFFERSON:** Hospitals are not really a suitable place unless they are extremely ill. A more appropriate place is one that is designed for people to sober up and that has a staff of qualified people to oversee how they are going. Sometimes they might be ill and you are not sure, so you need to monitor that. If they are going to fit, you have to get them to the appropriate care. You have to be able to do all that sort of stuff. You cannot just put them in a place with unskilled or unqualified people and leave them there.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** No. They will die, as they did in police cells.

**Ms JEFFERSON:** Yes.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** If you have that place, people who go into a coma, go out to it or vomit?

**Ms JEFFERSON:** Or choke.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Or fit or be stropky and attack staff as they wake up?

**Ms JEFFERSON:** And that happens.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** So you need a place where the people are savvy about it. You think that place would need to be escape proof in the short term. Once they walk out, it goes back to an outpatient DNA situation, does it?

**Ms JEFFERSON:** At Riverlands, you cannot just walk through the doors. You could hop over the fence and walk out the gates, out the back door, but you have to actually scan your way through the doors.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** It is semi-closed?

**Ms JEFFERSON:** Yes, a semi-closed place. I think that is a very good system because people know they are there voluntarily and they are there for their own good but if they really insist upon leaving, they can.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Do you think that is the maximum confinement there should be in terms of compulsory treatment?

**Ms JEFFERSON:** I am in two minds on that. I see situations where people have become so ill where they need to be put somewhere and treated but I think, then, you need to have all the family and all the appropriate people around to agree to that.

**CHAIR:** What should be the role of the family and other people with any interest in the person? Should they have a right to seek to have someone compulsorily treated?

**Ms JEFFERSON:** I think they do, because we get people coming to us and they are in such a state. When I was in mental health, people would come and they knew the person was about to have a psychotic episode and because there is nothing in the law that states we can take people because a family thinks something—and nobody knows a person better than the family; I defy anybody to know the person better than the family and the family does know—you go back and that person has had an episode.

I will give an instance of a young girl I was working with in the Moree area. I had been contacted and my hands were tied. I could not go and pick her up. Within hours she was lying on the road, on the main highway with no clothes on, having a psychotic episode. She had already been brought in and let go. We had brought her in and the medical officer had deemed that she was not psychotic, it was a behavioural problem, and she was let go. It was not a behavioural problem, as was proved later.

**The Hon. ROBYN PARKER:** There are people who say that if someone is not harming other people we should not intervene. If they want to drink to excess, that is their prerogative and their problem. There are others who think we have a moral obligation to do something for those people. Which view do you subscribe to?

**Ms JEFFERSON:** I believe we have a moral obligation to try but once again we cannot force. We can try, in that we can strongly try and strongly encourage and if they are seriously ill, we can put them into that sort of treatment model where they are kept for a certain length of time, but in the end it is up to them whether they are going to stay sober.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** If they cannot do it, you take the position that rather than lock them up you would let them self-destruct? They would self-destruct in the end.

**Ms JEFFERSON:** I do not believe you can lock someone up indefinitely, no.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** But do you think that locking them up for a period means you have a reasonable chance, at the end of that period, of changing them so that they stop?

**Ms JEFFERSON:** If all the checks and balances were done and it was decided by the family and all the relevant specialist people there that it would be in their best interests to lock them up for a stated period of time, yes, I think it might be of benefit.

**CHAIR:** That is more like the Mental Health Act and the Guardianship Act, moving more into that area rather than the Inebriates Act.

**Ms JEFFERSON:** Yes.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** You would effectively take drug addiction to be a mental illness in that you treat them the same. They could be scheduled and put in an

institution like Riverlands, but without a back gate presumably, and you would have a bash at treating them as you would for a suicidal or psychotic person?

**Ms JEFFERSON:** I guess, yes.

**CHAIR:** John, does the Council have a view on these questions? I know you represent a number of organisations.

**Mr WILLIAMS:** Yes, the Council has a position on this and it is outlined. Also, we have been quite diligent in contacting all or most drug and alcohol rehabilitation service centres that work with Aboriginal Medical Services and we have had case histories given to us anonymously. I have listed a few instances here that might be helpful to the Committee.

**CHAIR:** Yes, very much so. You can speak to that and then leave the document with the Committee, if that suits you.

**Mr WILLIAMS:** I would appreciate that. It is interesting to hear the comments of Leonie because we have not colluded and I know she is going to reflect a position that is not dissimilar to that of the council regarding the treatment of Aboriginal people. The circumstances in which Aboriginal people are being placed under inebriates orders vary. Because of the confidential nature of this work our information is rather scant. However, we have ascertained that the Inebriates Act is being used sparingly and then only as a last resort, particularly in rural and remote areas where access to services is considerably less, less so than what we have just heard described in a rural setting rather than a remote setting.

Revocation is causing some concern amongst those who have found it necessary to use the Act where people are so affected that they are at risk of harming themselves and at risk to others. Upon closer scrutiny it would appear that it is not the Inebriates Act that is considered sacrosanct but, rather, specific provisions that enable involuntary detention at a health detoxification or rehabilitation centre when they are seen as the only measure by which lives can be saved. Whilst there is much in the Act that is anachronistic, reflecting different societal mores and community protocol, it is this capacity to be able to be used in a constructive health context—I think the way the Act is being sparingly used currently similar to the provisions of the Guardianship Act—that make its revocation not an unquestioned action.

Equally important, we have been given anecdotal information that even the mere knowledge of these provisions, even where they are not formally implemented, acts as a catalyst to encourage accessing vital health and counselling services. That is a very important point. It is the use or the implied use of the Act in many cases, where statistically it is not reported, where it has had positive results. One Aboriginal health worker mentioned a case where a man in a remote part of the State facing imminent death due to alcoholism sought in vain to obtain accommodation in an alcohol rehabilitation centre. In desperation he actually solicited the appropriate necessary personnel to have himself placed under an inebriates order through the provisions of the Act and, accordingly, was escorted by police—in spite of what was said a minute ago about transport budgets—to an urban mental hospital in Sydney where he completely recovered after a prolonged stay.

Whilst literature indicates the inappropriateness of mental institutions for this type of therapy, when no other alternative site is available in such circumstances, such criticisms are merely academic. Senior staff of another Aboriginal institution mentioned that whilst the statistics of the Australian Bureau of Statistics indicate that most Aboriginal people do not drink, those that do are more inclined to drink excessively and, accordingly, there is a higher percentage per capita of Aboriginal people who are at risk to themselves and others. The response of colleagues in the remote parts of New South Wales was that if the Act is not repealed, there is nothing that they can turn to in a last-resort situation.

The same staff members mentioned that one of the drug and alcohol workers was trying to assist a man so utterly dependent on alcohol that his health was in serious jeopardy. He hesitated in seeking to have an inebriates order placed upon him due to the negative perception of the Act where there is encroachment upon personal liberty. The next day, as a last resort, he commenced the process to enact the provisions—similar to what we have just heard—only to find the man dead under the local railway bridge.



Their response to me was to convey to this Committee that it might be fine for civil libertarians to do away with the Act but from their hands-on perspective, they would feel totally impotent and would request careful circumspection in any action that would be deleterious to Aboriginal people. Another senior health worker in another Aboriginal organisation stated that they have had several people placed under inebriates orders, and others who realised it would be inevitably sought anyway, agreed to involuntary admission to a State hospital as a precursor to attending their rehabilitation centre. The role of the doctor and the family, as we have just heard, in those situations was instrumental in obtaining orders and a crucial part of the therapeutic process.

A doctor working regularly in this field within an Aboriginal medical service suggested that the Committee look at the 100-odd cases per year that were cited in the 1990s and beyond where inebriates orders were issued and to ascertain why this desperate measure was taken and why other avenues were not sought. She also mentioned that the resultant brain damage in some alcoholics and the role of the Guardianship Act with Aboriginal patients in not being able to make a judgment is a very important process. An urban drug alcohol centre mentioned that there was a real difficulty where access to facilities is drastically restricted and where clients come through detoxification centres, they are then faced with no vacancies in rehabilitation centres. While pharmaceutical advances enable treatment at a community level, there are cases that without some involuntary intervention, lives are at risk. These illustrations all indicate that the Act is not inviolate but rather its intrinsic provisions that enable involuntary health intervention under extreme and drastic circumstances and where life is at risk are seen as indispensable. That is the position of the council.

**CHAIR:** Yesterday the Chief Magistrate gave us a list of cases that were brought under this Act. We were struck by the very small number: 9 in 2001, 19 in 2002 and 11 so far this year. He said the statistics are not complete because some cases would not have been recorded in the appropriate way to be put onto the centralised computer system. They are very small figures. Do you have a comment on that? You suggest that the existence of the Act has a use even when all of its provisions are not followed through. Presumably, the number of people in need of assistance is strikingly higher than the small figures we have been provided with.

**Mr WILLIAMS:** The response we have had is that because of the tedious process and complexity in seeking immediate resolution to a pressing problem, the Act is not implemented as much as it would be otherwise. As I said earlier, the experience in rural and remote areas where facilities are scarce is that the implied use of the Act encourages the participation in programs. The statistics may not reflect that. I spoke to one Area Health Service where the director of a drug and alcohol program said that they had utilised the Act eight times in a year. That seems to conflict with the statistics. They may show the formal results, but it is certainly not the case from his perspective.

**CHAIR:** When the Chief Magistrate gave the statistics he also named the courts. The spread across New South Wales is not even. Some courts show up more than others and some are not mentioned at all. It could be that some area health services use the Act or attempt to use it more than others.

**The Hon. CATHERINE CUSACK:** That is one of the reasons I was interested in the case study. I wanted to know how the Act is being applied by the area health services and whether it is understood at a local level. People may believe they are using the provisions of the Act but, in fact, it is not the provisions of the Act that are being invoked. That may be why the formal statistics show only nine cases. I would assume there are a number of workers involved, such as police and health workers, and it would be unreasonable to expect all of them to be trained in the proper use of the Act.

**Ms JEFFERSON:** Exactly. It is very complex and there is a lot of paperwork. Many people are daunted by the paperwork and a lot of them do not know how to fill it in. It is as simple as that.

**Mr WILLIAMS:** There is also a perception that we picked up from a number of sources that magistrates are not inclined to implement the Act and take away people's liberty. That is a perception that may act as a deterrent to use the Act.

**The Hon. IAN WEST:** Are the magistrates not inclined to use it or are they unable to because of the lack of facilities?

**Mr WILLIAMS:** We have ascertained that it is a perception. I do not know if it has come out of past experience of declines or rejections. It came through clear that there was a definite disinclination to proceed down that path.

**The Hon. CATHERINE CUSACK:** Would it be fair to say that at the service level there is not a great deal of credibility in the legislation as it stands?

**Ms JEFFERSON:** I would imagine so, yes. In our area we have had very good magistrates. They try to look for alternatives to the Act and try to employ all the other services rather than invoke that Act.

**Mr WILLIAMS:** What you heard yesterday from the Chief Magistrate about the MERIT Program may be one reason why the statistics are not as high as they otherwise would be, and also the credibility of the Act. Its draconian nature, its 1912 Empire setting with inordinate stays in detention and the impression of oppressive judicial involvement rather than using it from a health perspective are all contributing factors that make it an unprofitable instrument. We have other suggestions, which have been alluded to here, that might provide another way. As we said earlier, the provisions are the issue. I have met no-one who has said that the Inebriates Act is the epitome of legislation. We have found that people are very reluctant to see it dispensed with unless something is put in its place. I think that is the basic feeling.

**The Hon. CATHERINE CUSACK:** Is that particularly true for Aboriginal people who have such a negative experience with the criminal justice system?

**Mr WILLIAMS:** I think so. That is a very interesting point. That experience would exacerbate the situation and emphasise the inappropriateness of the particular document and the reservation to go down that path where there are other alternatives. We are seeing from the judicial system and the health system much more positive and constructive alternatives being suggested.

**CHAIR:** You referred to the MERIT Program, as did Judge Price yesterday. We should be clear that at this stage we have only talked about non-offenders. One of the issues about the Act is that there are compulsory treatment provisions relating to people who have not committed an offence. That is the group we have been talking about. Once you refer to the MERIT Program you are talking about offenders.

**Mr WILLIAMS:** We have addressed that, and I am sure that Leonie has as well. We see it as a dual issue. We use the MERIT Program as a model. At this stage it has not been used for drug and alcohol but it is planned to use it for that purpose. There is both an offenders' and a non-offenders' process. In our presentation we have addressed both those issues.

**CHAIR:** Before moving on to specific treatments, particularly for Aboriginal people, which is question 6, do either of you want to say more about the principle of compulsory treatment in questions 4 and 5 and, if you accept that principle, the safeguards that should be applied? We added a question about the actual goals of compulsory treatment. Are they fundamentally about saving lives, protecting the person, giving the family or community respite or all of those things? You have prepared written answers. You can give more detail later or address those issues now.

**Ms JEFFERSON:** In relation to question 4, there would have to be a lot of consultation on the treatment provision with the appropriate people—family, medical practitioners and all those associated with that work. I wrote something on the plane, but I cannot find it. Yesterday I had planned to do a bit of typing, but I was called out. I am a case manager for a pharmacotherapy client who is being cut off. The client came first, I am sorry.

**CHAIR:** We appreciate that. We are very grateful that you have come from Ballina to assist us.

**Mr WILLIAMS:** The council has a position. Why do we think that the provision of compulsory treatment should be retained? The history of alcohol-related legislation being used disproportionately against Aboriginal people is correct, but this reflects an application of such

provisions as punitive, restrictive or correctional measures rather than an enforced health intervention in the interests of Aboriginal people. Comparable action under the Mental Health Act and the Guardianship Act is not seen as an inordinate or inappropriate erosion of civil liberty. In what circumstances do we believe it is warranted? Where it is a diversionary measure from a justice to a health measure—that is an important transition; where it results from a magistrates early referral into treatment, as we have mentioned, as an alternative mandatory incarceration; if the person is causing self-harm or harm to others; where it is a medical opinion that the life of the patient is in jeopardy; and where following an assessment by family, elders, doctors and/or psychiatrists, Aboriginal drug and alcohol and Aboriginal health workers it is so agreed and where the client has had legal and separate medical representation if not in agreement.

Professional advice from psychiatrists working in this field to the Aboriginal Health and Medical Research Council [AHMRC] indicates that the 72-hour detaining of drunken people under the Intoxicated Persons Act does not allow for the deleterious effects of the d.t.'s and that the extended period can take a further 36 hours. When released with the effects of the d.t.'s there is a choice of further drink or the risk of death if left unattended. The length of the involuntary period advised to the AHMRC by professional psychiatrists working in this field to enable safe passage through the d.t.'s and for adequate health and psychiatric diagnosis is an initial assessment period of up to 30 days, after which an informed decision for involuntary rehabilitation can be made or a client can be referred for appropriate health and psychiatric treatment in the event of dual diagnoses.

Whether this provision within the Inebriates Act should be replaced with an amendment in the Mental Health Act, the Public Health Act or the Guardianship Act is a matter for those with expertise, like yourselves and legal jurisprudence. There are already defined categories for substance dependence within the mental health context in DSM4 and substance abuse is considered and categorised as substance use disorders. There should be safeguards to ensure legislation is not discriminatory to Aboriginal people. The community assessment models that we are proposing comprise Aboriginal peers, family, doctors, Aboriginal drug and alcohol and Aboriginal health workers working with the client. Aboriginal Medical Services and drug and alcohol services should be utilised. It is very crucial that necessary services are made available. There is no point proceeding down this line without those services.

Additional Aboriginal community-controlled drug and alcohol centres should be developed. At present they are sparse and in many cases inadequate. The processes should be moved from a judicial context to a health context. There should be liaison with the Aboriginal Health and Medical Research Council health ethics committee. The New South Wales Aboriginal Health Partnership, which is a policy with the New South Wales Health Department, has provisions for workshops at the local level and, perhaps, draft legislation should be workshopped through the Partnership with Aboriginal communities. My colleague works in the mainstream area, but I believe she would support those points. We see the partnership in New South Wales as a bicycle, not a penny-farthing. We have a very good working relationship with the Health Department. The only way we can address these issues is if we work totally in a complementary way to each other, rather than duplicate services.

**Ms JEFFERSON:** We do really need an appropriate assessment model. The model that John was alluding to is the one we would advocate—with the family, the community and the elders, as they have much more knowledge of the person—rather than the medical model.

**The Hon. ROBYN PARKER:** Is there an appropriate model you are aware of elsewhere in Australia that operates effectively?

**Ms JEFFERSON:** I do believe there is. I believe up in the Northern Territory they do have an appropriate model, one that is a better working model than we have, but I have not seen it. I was only just told about it and I just made these hurried inquiries. I was hoping was in the Internet but I could not find it.

**Mr WILLIAMS:** I have got a comment on that, regarding models. I also agree that the Northern Territory do have these shelters, and so does Victoria have appropriate health centres. The honourable gentleman asked the question earlier about that and there are centres in Victoria and the Northern Territory that are required, as Leonie mentioned earlier. So it takes it out of that judicial

system into a healing situation which do have appropriate staff trained for people going through crisis when they are obstreperous and so forth.

For a model, whilst not totally applicable, the MERIT system and circle sentencing—this is very important—circle sentencing in New South Wales, a process between the judicial commission of New South Wales and the New South Wales Aboriginal Justice Advisory Council. That is being modelled right now. And something akin to that, good models need more integration of services rather than disjointed and partial processes such as where you have no Aboriginal detoxification centres but you have Aboriginal rehabilitation centres, then you have the gap where you cannot get access and there is no automatic transition. In the interim period lives are at risk.

To increase the number of centres as a model, to increase the number of centres geographically so that they are all located within our Council regional boundaries which follow Area Health Service boundaries enabling supportive visitation by families or clients within their own country; there is nothing worse than people leaving their country and finding themselves in a judicial situation; we know some of the results of the Royal Commission into Deaths in Custody about that process. The need for a more holistic approach with more facilities for women. We just heard of a case where a rehabilitation centre, an Aboriginal community controlled one, applied for funds for a women's wing and it was declined. At the National conference of our national body last week it was acknowledged that across the State there is a great dearth, there is a shortage of centres for women, family and youth.

Notwithstanding the minority of individuals for whom involuntary detention and treatment is indispensable there is precedent set within the Mental Health Act for community initiated community treatment orders which provide a model for possible comparable treatment of alcohol dependency within local and regional community-based complimentary programs. These are designed for voluntary involvement of inebriates in various pharmacol-dynamic therapies to counteract the effects of alcohol by using drugs which are listed, complemented with appropriate counselling and incorporated into Aboriginal rehabilitation services. This alternative initiative could be augmented into the community assessment panels that we have alluded to, each availing itself of the current medical and drug and alcohol expertise available within each area health service in New South Wales. Each Area Health Service is a resource for a drug and alcohol program.

We think that those specialist services should be accessed by the Aboriginal community and at the present time that is not happening the way it should be because of various problems. I think that is how we would suggest the model be looked at.

**The Hon. CATHERINE CUSACK:** I think you mentioned earlier a case of a man who wanted treatment and could not access treatment and then almost volunteered to be ordered under the Inebriates Act. Is that correct?

**Mr WILLIAMS:** Yes.

**The Hon. CATHERINE CUSACK:** it seems to me that when the States makes something compulsory it then has an obligation to provide it and it is amazing to me that people would have to resort to being charged with an offence to access a certain service or, in this case, double and say, "I should be committed under the Act" and volunteered to be committed under the Act. I guess it comes back to what you are saying about resources: there needs to be the resources to back up any orders that a person should be treated. I am particularly interested in the country issues where there are small communities such as Walgett and Wilcannia and Brewarrina where it is very challenging to provide a holistic service to a town that has got a total population of under 5000 people. Can you comment on that? Is it being done appropriately at the moment?

**Mr WILLIAMS:** We have addressed this in our paper, particularly in some of the towns you have mentioned and others where the police cell unfortunately is the only place where a person in an intoxicated state, who is a danger to himself, can be taken. There are no beds available. There is no appropriate detoxification centre within reasonable time or distance. What we are suggesting is we have 43 Aboriginal Medical Services throughout the State. In each of those 12 regions we think a culturally appropriate community controlled shelter, an appropriate shelter, could be staff under the auspices of the community controlled health sector working with the Area Health Service to provide

such a place in remote areas where people can be taken because you cannot go putting such a place into every community, but you could put such a place in every region within a reasonable distance for people to be taken to.

The immediate problem might have to be a cell if there is no transportation available. These are some of the problems we do have but again, the police are not trained and if they are going to use that as the only recourse then we think that medical people or registered nursing sisters or Aboriginal medically trained staff who would be available to constantly check these people because if they have not being charged there is no obligation to do two hourly checks. That only occurs if they are charged, not necessarily if they are only there to sleep it off. And that is a risk.

**The Hon. CATHERINE CUSACK:** There is a facility in Walgett, formerly a proclaimed place, which is still operating but appears to have no clients. Are you familiar with that issue? The Walgett Aboriginal medical service is auspicing Brewarrina at the moment I think.

**Mr WILLIAMS:** They are about to auspice and to do two years training to help set that organisation back up with the autonomy not eroded for the Aboriginal Medical Service. I am not sure about the service in Walgett.

**The Hon. CATHERINE CUSACK:** In Walgett there is a proclaimed place.

**Mr WILLIAMS:** Weren't they all closed?

**The Hon. CATHERINE CUSACK:** No, it is still operating with no clients and it is through the Department of Community Services that it is funded. I just wondered if you were familiar with that case and what lessons we can learn from that case because they are a lot of resources being put into it for people to be taken to as an alternative to being taken to a call.

**Mr WILLIAMS:** Christine Corby is the chief executive officer there. I will chat with her after this meeting and get a response back to the Committee.

**Ms JEFFERSON:** What we used to do when people were picked up and taken into the police cell when I worked out in the remote areas, we always had a set of Elders of who we would call on, like a list of Elders or responsible people who would go and sit in the cell with the person to keep them safe.

**CHAIR:** Are you talking about non-offenders?

**Ms JEFFERSON:** who were just being a nuisance, non-offenders. They were not charged, they just had to be kept in a place that was deemed appropriately safe and so we just had a list of Elders who we used to call on and they would just go and sit with them and keep them safe.

**CHAIR:** Was that effective?

**Ms JEFFERSON:** Very.

**CHAIR:** What about what happened after the 24-hours or 48 hours that Mr Williams before was going through the psychiatric advice in terms of say 72 hours is not enough and so on. What happened after the initial period in the cell and the assistance of the Elders?

**Ms JEFFERSON:** If they were still ill after that certain time the main places then were hospitals so we put them into the local area hospitals and they were treated then from there. If they were psychotic and had a mental illness they were transported to the local mental health facilities.

**CHAIR:** Once they were transferred from the cell to a hospital did you continue to organise with the Elders to keep sitting with them and keep an eye on them?

**Ms JEFFERSON:** Yes, we kept vigilance while they were there.

**The Hon. IAN WEST:** Leonie and John, when you are dealing with the issue of our last question about what you think should come out of this inquiry—

**Mr WILLIAMS:** Can I just clarify one thing the Chairman mentioned? The advice from the distinguished psychiatrist was not for people who would be just routinely locked up overnight and get up the next morning, it was for specific people who are at the nadir of their demise and on the path to destruction.

**CHAIR:** Yes, that is true. Most of the people that Leonie is talking about were not at that point.

**The Hon. IAN WEST:** I would ask you to give us your thoughts on the possible success of the Aboriginal circle centre sentencing that is being piloted in Nowra in regards to people who have not been charged, whether or not there is some role in that area, especially in trying to ease the burden on families who may be required to cause a family member to come into contact with the police even though they think it might be in their best interests in one respect, that they prefer not to be the people that do that. Does that make sense?

**Mr WILLIAMS:** Yes.

**Ms JEFFERSON:** I have had very little to do with the Nowra situation. John would be better to answer that question.

**Mr WILLIAMS:** We have a medical student working in our office at the present time, James Ward, and he has familiarity with that and he has briefed me on that matter. He would have come today but he is at another function. The advantage of that process is that we are pre-empting, we are forestalling or preventing Aboriginal youth or young people or even older people moving into the criminal or into the judicial system. It is not a confronting situation. They sit in a circle and various family members, there are doctors, maybe psychiatrists, health workers, and it becomes quite evident that there is a consensus, a collective attempt to try to resolve the problem and have the particular client address it themselves.

It is a very positive result of although still on trial. That is the sort of model that we are suggesting could be looked at by this Committee for commencing the process for rehabilitation, especially in drug and alcohol related crimes or problems where people are at a stage where they are no longer able to help themselves. I think what you are saying is a very good alternative. It may need to be fine tuned so that it works in a complimentary way with the Area Health Services because we see that both the Area Health Services expertise in tertiary services and the Aboriginal Medical Services with their primary medical health model is, we think, a ray of hope for this whole problem of stopping that vicious circle that Leonie mentioned.

**CHAIR:** In saying that you are talking about its usefulness for people who have not committed an offence?

**Mr WILLIAMS:** Yes, in a preventative way because once it goes to the next stage it is inevitable that they enter into the criminal setting and then it is very hard to redress.

**CHAIR:** You have talked about useful models and the sorts of things you would like to see, it seems to be implicit in what you are saying that you are not urging Aboriginal communities to be responsible for providing the services themselves. You seem to be talking about partnerships between, say, the Aboriginal Medical Service and the Area Health Service, or between the police. Could you just elaborate on that?

**Mr WILLIAMS:** Yes, I would like to clarify that. Leonie wears two hats: as an Aboriginal person and a worker in mainstream, and she can see the deficiencies in both the community controlled health sector and the mainstream sector.

**CHAIR:** It may be that different models suit different parts of the State.

**Mr WILLIAMS:** That is true. By being involved in a partnership arrangement, rather than intruding upon the autonomy because it is an Aboriginal arrangement, the Area Health Service chief executive officer and the chairman and CEO of the Medical Service are the parties at the highest level of parity. You have asked a very good question: Do Aboriginal communities wish to be responsible for providing these services themselves? The National Aboriginal Health Strategy, signed by every State and the Commonwealth Government in 1989, recommends that such facilities should be within the Aboriginal community. The Aboriginal definition of health, being holistic, naturally places centres within a supportive community context—we have heard about the importance of the family. The Council has member organisations that currently undertake comparable services.

The Aboriginal Health College, which is being built in La Perouse by courtesy of this Government, is designing courses for Aboriginal drug and alcohol workers as well as governance courses for organisations that deliver health services. These services are preferably managed by local community organisations working in close association with Aboriginal Medical Services or under the umbrella of a competently run Aboriginal Medical Service. The most efficient, cost-effective, outcome-oriented and culturally appropriate manner of delivering services is through the community itself, properly resourced and trained. The Council has taken this on board and is working closely with the State Government to start this training of drug and alcohol workers and the governance of these centres so that the outcomes can be positive and taxpayers' money is not wasted.

**Ms JEFFERSON:** We have a lot to do with the elders in our area. There is an elders council and a community council, which advise us about issues. We have regular meetings. They like to take responsibility for their actions but they need to be assisted, they need specialist training and they need to work in partnership with everybody because they cannot do it on their own. It is just not possible. The Aboriginal medical services, the area health services, the elders council and the other community councils must all work together.

**CHAIR:** If it is a matter of setting up a centres such as Riverlands, for instance, in most areas the centre would be mainstream—to use Mr Williams's term—and would not be dedicated for Aboriginal people. It would be for everybody but with input from the Aboriginal community.

**Mr WILLIAMS:** This argument comes up time and time again: The Area Health Service and mainstream organisations are better resourced and financed to carry out such services. Riverlands is a very well run organisation. Some 200 clients have gone through that centre over a considerable period. Our philosophy and the Community feeling is that when the Community and its elders take that responsibility and avail themselves of the expertise within the Area Health Services they have a more permanent and immediate positive result. There must be an identification of that process by the community. It may be appropriate to establish services in certain places but, as to mainstreaming something that is so close to cultural issues, Leonie said earlier that she was amazed that so many people had the stupidity to break the cultural traditions. It is so un-Aboriginal to get involved in these processes and these self-destroying actions. It needs a cultural injection.

We feel strongly that the Aboriginal community should take responsibility and we think the best way to do that would be through community-controlled health services associated with AMSs. But every Aboriginal person has the right to go to mainstream services, and many choose to do so. I do not think the duplication of processes is a good idea; I think they should be complimentary. If a centre is in Riverlands obviously another centre should not be built opposite it. We have seen the Government waste money by putting in programs opposite Aboriginal Medical Services. They are then not utilised and are closed. People feel much more at home with an Aboriginal Medical Service. I think the analogy would be extended to these sorts of centres, not acting in a vacuum but working closely in partnership. Access is the next stage. We must work with the area health service, which has the expertise and the professional workers whom we can tap into and refer issues to. The referral process has been broken; it is not happening. Aboriginal people are not accessing services—they do feel free to go to certain services.

You mentioned a town earlier—we will not name it again—where the Aboriginal people will not go to the local hospital. That has been the traditional understanding and perception for years; it is not the fault of the present staff. It is very difficult to solve that problem. In many places there is a very happy working relationship with the Area Health Service. Let us use commonsense and tap into both areas but we must allow the Aboriginal people to identify and own the process or else it will not

work. It will be seen as extraneous. It is their problem—with due respect to my colleague—for the many reasons that we have outlined, which may not necessarily have been their fault. Nonetheless, it is of their volition and they alone can solve it. They must identify and control the process or it will be a case of putting money into a process that is not utilised. We want to see remedial, therapeutic solutions to this problem. We must not leave it until it is too late and we find people under the bridge in a state when we could have saved them through preventative action much earlier.

**Ms JEFFERSON:** Riverlands was built in conjunction with the Bunjalunj Elders Council, which advised about the appropriateness of its design. From its inception right through to its completion, the Bunjalunj elders were involved. It has been hard getting people to come to the centre mainly because they thought it was a rehabilitation centre. Understanding the difference between a detox centre and a rehab centre is quite hard for many people, not just Aboriginal people. But they did not understand the difference. When I was first employed at the centre my role was to work partly in the community and partly in Riverlands. But for various reasons I had to stay mainly in Riverlands. We are now better staffed and so on so I can get out into the community. We are seeing a greater number of Aboriginal people come through the centre. They are less likely to repeat and go on to rehab. If they are well supported in the community they go on to education. I am addicted to education.

**The Hon. CATHERINE CUSACK:** I want to clarify that Aboriginal medical services see non-Aboriginal people as well. I know that happens in Casino. The service that we visited in Walgett is absolutely outstanding and has really increased the quality of care and the variety of services available to the local non-Aboriginal community. Some Aboriginal medical services, like any organisations that are locally based, will be more successful than others. But Walgett seemed to us to be an outstanding success. Perhaps the Aboriginal medical service in that community can be the main provider of those sorts of health care services.

**Mr WILLIAMS:** It is a credit to the community. They did it by themselves. The CEO went through our executive management course with New England university. Fifteen students have now graduated—I think half are in mainstream and half are in the community-controlled health sector. It is the highest degree in hospital administration. We are seeing the results. There was a backlog. I was talking to Leonie in the car about young people being educated and getting degrees who would otherwise have been left on the street corner. We will see the benefits of that education perhaps five or 10 years down the track. There is still a great deficiency at present. Walgett has an exemplary service, which people are modelling. Look at their commitment to help Brewarrina. There was a movement to move Brewarrina into a mainstream hospital combination but the community was incensed. Walgett then stepped in and said, "We'll help you and we'll train you." The expertise is flowing on. It is a steady process and we should not judge the great inroads being made in this area according to the few aberrations that we hear about.

**The Hon. CATHERINE CUSACK:** I guess I am saying that in some communities we should go with what is working—it might be the Aboriginal medical service or it might be a Riverlands-type service.

**Mr WILLIAMS:** Precisely. If a service is working, rather than spending funds unnecessarily in a particular area, there are many other areas within the area health services that are not serviced. I reiterate: There is not one Aboriginal detox centre in the State. All of the people with whom I spoke this week and last week asked me to raise that issue today.

**The Hon. CATHERINE CUSACK:** What facilities are available for young Aboriginal people?

**Ms JEFFERSON:** There are very, very few.

**The Hon. CATHERINE CUSACK:** Are there any in the Northern Rivers?

**Ms JEFFERSON:** No, none. I had a telephone call the other day from a distraught woman who is caring for a very violent 14-year-old girl, who has had a horrific life. That woman was advised by various services simply to give the child back. She did not want to do that and she was ringing everywhere looking for assistance. I have got that girl to see one of my colleagues, who is an



extremely good psychologist. He works for another organisation but he has had a lot of experience with youth, so I channelled her to him to try to get some help. We had nothing else to offer her. Riverlands do not take people under 18 and this girl is 14. She is in a desperate situation. She is putting herself at risk and putting the other children in the home at risk. The lady has been beaten up twice by this child.

**The Hon. CATHERINE CUSACK:** Is she fostering the child?

**Ms JEFFERSON:** Yes.

**The Hon. CATHERINE CUSACK:** There is no service available?

**Ms JEFFERSON:** None. The lady was advised, "Give the child back."

**Mr WILLIAMS:** There are a few beds for families, which sometimes include youth. There is Orana Haven at Moree. Wiegelli at Cowra and Oolong House at Nowra requested funds for youth and women but both were declined. There is a great problem and deficiency in this area. One recommendation we strongly urge in this paper is that appropriate expertise in drug and alcohol be introduced into Juvenile Justice centres. We have a partnership with Corrections health but we have a great need for that expertise in these institutions.

**The Hon. ROBYN PARKER:** Your comment about Juvenile Justice takes me to question No. 10. We have talked a lot about non-offenders. As to offenders with drug and alcohol problems and the Inebriates Act, what is your view on the appropriateness and effectiveness of compulsory treatment for Aboriginal people who have committed a drug- or alcohol-related crime?

**Mr WILLIAMS:** The Council has a position on compulsory treatment for Aboriginal people who have committed drug- or alcohol-related crimes. We think discretionary measures should be offered to offenders—the Magistrates Early Release Into Treatment diversionary program has been mentioned—and later involuntary rehabilitation. To increase the roll-out of this program we need a simultaneous increase in the number of Aboriginal-controlled drug and alcohol rehabilitation centres. As we mentioned earlier, circle sentencing for minor offences is a preventive factor because in many cases people are turning a blind eye to offences that could have been proceeded with. Other measures include drug and alcohol counsellors in correction health services and juvenile justice centres. A culturally appropriate, remedial health context is preferable to a justice alternative. Other measures include resourcing the AH&MRC to provide additional courses for an increased work force in drug and alcohol counselling, which will flow into these organisations, departments and communities; the health context with its complementary counselling, to assist in addressing causative underlying issues; and a practical time frame to enable upskilling for traditional counsellors and Aboriginal drug and alcohol workers.

A lot of people criticise the Aboriginal Land Councils under fire right now for mismanagement. I worked for a Land Council as a senior policy adviser and research officer for a number of years. When they passed the NSW Aboriginal Land Council, without any manual, without any guidance or governance training, they gave 117 Land Councils a budget that would blow the minds of the people who have no expertise in that area. They had no idea what was probity or not, or what was community relevant or not. One module change in Telecom takes two years preparation and guidance. I urge this Committee, before things are enforced upon Aboriginal people, to recommend that appropriate measures in training occur. We urge that our college, and perhaps other colleges, the area health service and our staff, be given work training in these areas prior to seeing something set up to ostensibly fail. We are not knocking back money; we are suggesting an appropriate time frame.

**Ms JEFFERSON:** We do really need the training, and we need the bodies on the ground. Every time we do an Aboriginal health plan we request funding for DNA workers, DNA counsellors, and mental health and youth workers, and they are always knocked back. We very rarely get them. In the whole Northern Area Health Service, which goes from the Queensland border down to Grafton, I am the only trained Aboriginal health counsellor in that service. My role is an area role. We do have another one coming through the Casino ANS, whose name is Hank. He is training, and he is extremely good—actually, his brilliant. I believe the funding is also coming through for another couple to be put in place.

**The Hon. ROBYN PARKER:** I think you have probably answered the last question. In conclusion, we would appreciate hearing your views on what you would like this inquiry to achieve.

**Ms JEFFERSON:** I think the Act itself needs to be looked at and repealed, but something else needs to be put in place. With the provision of amending the Mental Health Act and the Guardianship Board Act, within those two Acts could be incorporated some type of legislation that would assist our people to get treatment and better resources.

**Mr WILLIAMS:** I have nothing to add. In my notes I have about 10 dot points, but they have all been alluded to, by either Leonie or me, or members of the Committee. We would like to thank you for the seriousness with which you have approached this subject. It is a very serious problem in the Aboriginal community. Whilst we seek the repealing of the Inebriates Act, before that occurs we would like to see safeguards to be given to the wider community, but also the Aboriginal community, particularly in remote areas, to ensure there are provisions in place for those situations so we do not continue to find men dead under bridges.

**CHAIR:** Mr Williams, would you mind tabling the answers for the benefit of the Committee? As you said, we have covered those points, but in some cases you have clearly put a lot of time and effort into preparing them. Leonie, if you have documents you would like to leave with us, we would be grateful.

**Ms JEFFERSON:** That would be fine. I would like to prepare the answers and send them to you, along with the statistics. You also have the case studies and our submission.

**CHAIR:** We need a broad resolution to accept the documents you have brought with you, and we would be very appreciative to receive further documents. Similarly, we may well find that after taking other evidence, for example from New South Wales Police, we may want to ask you further questions.

**(The witnesses withdrew)**

**ROBERT JAMES WAITES**, Commander, Greater Metropolitan Region, and Corporate Spokesperson, Alcohol-related Crime, NSW Police, Level 14 Pacific Power Building, Elizabeth Street, Sydney, and

**FRANK ROBERT HANSEN**, Manager, Drug and Alcohol Co-ordination, State Crime Command, NSW Police, 1 Charles Street, Parramatta, sworn examined:

**CHAIR:** The Committee has forwarded to you the questions to be asked and I think you have had time to look at them. Would you prefer to go straight to questions or make an opening statement?

**Mr WAITES:** We would prefer to go straight to questions.

**CHAIR:** Before I ask you to explain the role of NSW Police in relation to the Inebriates Act and your interest in this inquiry, you are probably aware that Judge Price appeared before the Committee yesterday and explained in detail the way the Inebriates Act works, the way applications are made, and a little about the role of police. We are now more familiar with those matters, but we would like to hear about the former role of the police and the police service's problems with the Act.

**Mr WAITES:** I will commence by speaking about our former role. Our role is one of an advocate, rather than an active role. Under the current legislation a police officer of the rank of sergeant is often given the responsibility, on behalf of others, of bringing matters before the court. When I say "on behalf of others", it can be a medical practitioner, it can be at the behest of a relative or guardian of the person so affected, or it can be under the direction of a justice. That is our formal role under the Act. The other responsibility we have under the Act is that where an order is issued and a person absconds from an institution or a person in whose custody they are held under that order, the responsibility falls to us to arrest that person and return him or her to the original custody or a court for the order to be re-enforced. From a formal perspective, that is our only role. From an operational and practical perspective there are many other roles that I will get into as we go through this process.

**CHAIR:** You have told us why your agency is interested in this inquiry. Obviously the police are very much involved not only in the Inebriates Act process but also more broadly in dealing with people affected by alcohol.

**Mr WAITES:** "Suffer" is a hard term, but it is a reality. We suffer a responsibility from the community to fix all and every ill of society when we are available 24 hours a day. Related community members, or in some cases those who have no direct relationship to the person affected, have an expectation of police officers that is lawfully impossible to apply and ineffective in the long term in solving these major problems.

**CHAIR:** Will you expand on that in further questioning?

**Mr WAITES:** I will.

**CHAIR:** A great deal of police work concerns the results of the misuse of alcohol. I refer to assault, domestic violence, drink driving, offensive behaviour and so on. The committee is trying to get a sense of the broader effect of alcohol. How much of your work concerns the people who are the focus of this inquiry—that is, not only the people technically covered by the Inebriates Act but also those at the more severe end of alcohol or drug dependence?

**Mr WAITES:** Recent research in New South Wales indicates that across the State about 70 per cent of all police responses relate to incidents involving alcohol. That is a very large percentage. In fact, it ranges from minor through to major crime. Many crimes that one would not relate to alcohol in fact do involve alcohol. In the western parts of the State, through work we are doing in conjunction with the Hunter Area Health Service on the Linking Project, which is a tool for police to measure alcohol involvement in our work, we have found that in some communities the incidence of alcohol involvement in police calls and police work is more than 95 per cent. That is why we have been led down the path in recent times to things like the Alcohol Summit. In all of those areas, the number of people who would be directly affected by the Inebriates Act if it were enacted, or

could be assisted by it, is impossible to say. Again, it depends on the community and the level of alcohol usage.

In previous years—and the I go back in my own history as a police officer—a number of Acts of Parliament gave police officers the opportunity to deal with the homeless and people with health problems associated with alcohol and so on. Those various Acts have been repealed over the years because of a concern about making people criminals or making crimes out of health issues. Nevertheless, because we provide that 24-hour service to the community across the State, and ours is the only government organisation that is able to do that, the community's expectation is that we will fix these problems. That makes it very difficult. In fact, in some communities in which direct crime is very small and the only crime committed is alcohol related the police spend all their time dealing with those issues.

The effect of the repeal of other Acts of Parliament such as the Vagrancy Act is that we have fewer tools available to manage what I call social problems and what the police tend to see as health problems. Nevertheless, they are left to our officers to solve in some way. This Act was one of the tools we used for some time; that is, until we found that it was both inappropriate and ineffectual. This Act used to be applied by the police in the case of people who were continually arrested for drunkenness. Although people saw the offence of drunkenness as a crime, the police did not. In fact, the legislation simply resulted in a record of the particulars of the person involved. However, it offered the person the opportunity to go before the court and contest the allegation.

People who were continually arrested for drunkenness, and in many cases that was because they came to police stations for shelter, were taken to the drunks' court in the old Central Court in Sydney. The police prosecutor proposed that the magistrate enact the Inebriates Act to give the offender some respite, particularly if he or she was suffering other health conditions. They were put in the corrective system simply to get medical attention and to put more meat on their bones—to use the vernacular. They would stay in care for some time and then come out. Often those people went down to Kenmore at Goulburn.

However, they were offered no treatment. They were treated for other illnesses and clothed and fed, but nothing was done to deal with their alcohol problems. Consequently they ended up in a vicious cycle—back on the streets of Sydney and then back through the process again. The advantage from the police perspective was that at least we were able to regenerate their health. That is why in many cases they voluntarily came to police stations at the onset of winter and the Christmas season. In my experience, many would turn up at the counter late at night and say, "Sergeant, can you put me away. I want a holiday. I need to get better and it is too cold at night." Society did not see that, but it was the way we managed the situation. Because we no longer have legislation covering drunkenness and we no longer take people who are intoxicated under the Intoxicated Person's Act before the courts there is no record of who they are or this continuing problem.

Some officers in the country in recent times have given me examples of trying to use the Inebriates Act to assist homeless people who are living on the proceeds of crime simply because they need to support themselves. They have utilised the Act by coercing these people—or convincing them—to go to court and then getting a doctor's certificate so that they can be placed in care. Those people have been taken to Bloomfield Hospital at Orange. The officers are concerned that that provides very short respite—for four, five or six weeks—on the order of a magistrate. They are given no treatment for their problem and they are allowed to leave the facility to visit local clubs and hotels. Providing they return and behave themselves, the hospital will allow that to happen. They return to the community and slip into the same old cycle. Although we do not see this as our core business, in some cases it is only our business.

**CHAIR:** What percentage of your work involves alcohol to the point that the Inebriates Act is enforced to have someone sent to Bloomfield Hospital? Presumably most alcohol abuse is minor or episodic.

**Mr WAITES:** It is more episodic. The research does not indicate the level of intoxication. The officer is required to estimate the degree of intoxication but no record is kept. Some people might be highly intoxicated, but the officer might see them only once in that state. Although they may have been in conflict or contact with police on several occasions, for all sorts of reasons the research does

not specifically record the level of intoxication against an individual, so we are unable to provide that information. There is no research data to indicate what percentage would be experiencing that level of alcohol or drug-related problems. I can rely only on my own experience, which suggests that it is very small. For example, in Dubbo we are talking three, four or five people.

The local police in some Aboriginal communities will say that their percentages are very high. However, they will never give a number because it is difficult to judge who are the regulars and whether they have a genuine drinking problem or other behaviour issues being exacerbated by alcohol. When I talk to the officers in those locations they say that these people have an ongoing drinking problem. Whether it would be such that they would be classified under this Act is an issue for a doctor to decide. In some Aboriginal communities and in towns in which the population is predominantly Aboriginal the issue for police is alcohol consumption at all levels.

**CHAIR:** Do other pieces of legislation that still exist, such as the Intoxicated Persons Act, provide certainty about these definitions or the extent to which a complex group of problems is involved?

**Mr WAITES:** No. In many respects it is equally as powerless as this legislation. When the Intoxicated Persons Act was invoked it was seen as a good tool to assist with some of the social issues. Unfortunately, the provision of proclaimed places never occurred at the level that was expected—in fact, there are now none. When confronted by people who are intoxicated to such a degree that they are unable to care for themselves or are in danger, the police have two choices. First, the offender can be placed in a police cell. We do not want to do that and we avoid it at all costs because of the potential for self-harm. Secondly, if they are taken to places such as Matthew Talbot Hostel they will not be accepted if they are violent or argumentative. We either take them back to a police cell or ignore the issue. Officers move them on and hope they do not get into trouble. They are the issues we deal with on the street.

**CHAIR:** There is a lot of buck-passing and simply nowhere to go.

**Mr WAITES:** A consequence is that these people, who are very vulnerable, are left on the street. That is a concern because they are very often victims of crime.

**CHAIR:** Do you want to add anything, Superintendent Hansen?

**Mr HANSEN:** I agree entirely with what Mr Waites has said. There is no formal mechanism between the Intoxicated Persons Act and this Act. We rely on the police to bluff—I think that was the word used in one of the reports from Dubbo—in an attempt to overcome the problem of dealing with that degree of intoxication and to get someone within the ambit of the Inebriates Act, but there is no formal mechanism to do so.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** In a sense, you are saying that the police were inappropriately doing a social worker job and the gaols were in fact expensive hostels, in the sense that if you had to take people to Kenmore that was an expensive and logistically difficult procedure.

**Mr WAITES:** It is. But Kenmore no longer exists; it has closed down.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** But even then it obviously was not as good in rehabilitating these people as a centre closer to any family contacts that these people might have had. So, in a sense, that was an inefficiency that has been addressed by leaving these people on the streets.

**Mr WAITES:** That is right.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Presumably, the crime that you spoke of is a crime of subsistence, if you want to put it that way, involving, presumably, a bit of shoplifting and the grabbing some cash or whatever.

**Mr WAITES:** Yes, that type of thing.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** If an officer were to take those events more seriously, or someone were to press charges, the offender would go to gaol, at a cost of \$60,000 a year or whatever, in order to solve that problem.

**Mr WAITES:** That is effectively what happens, particularly with Aboriginal communities. Our officers are often frustrated; where criminality is involved, they have to take action under the criminal law, simply because they have no other option.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** So, in essence, it is a housing and support problem?

**Mr WAITES:** That is right.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** And obviously a treatment issue as well, but it is a housing and support issue primarily, assuming the treatment is not successful.

**Mr WAITES:** Yes.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** But, if the treatment could be added to housing and support, presumably you have the possibility of some resolution of the problem.

**Mr WAITES:** Treatment, for us, is an important issue, because even outside our communities, in metropolitan and urban communities, alcohol issues in the house are just as bad in relation to domestic violence and those sorts of things. Domestic violence is almost 100 per cent alcohol-related or has an alcohol relationship. Therefore housing is not always the issue. In many cases the people have housing and occupations, or there are sufficient funds to support the house or the family. The difficulty then is one of behaviour, and the only way to overcome that behaviour is to have some form of treatment.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** So it is not in essence an economic problem in most cases? Presumably, with some homeless people there is an economic issue.

**Mr WAITES:** Yes.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** But, in the majority of cases, economics is not the problem; the behaviour is the problem.

**Mr WAITES:** Behaviour exacerbated by lack of support to change what creates the behaviour, yes.

**The Hon. ROBYN PARKER:** You touched on rural communities. I would have thought the issue in rural areas is also one of resources being thinly spread. The Committee has had evidence so far about the distances that people must be taken once they come into your care. How much does having to transport people to other services impact on your core role of crime prevention? Is that sometimes a reason for that transportation not occurring?

**Mr WAITES:** That is true. But you ask two questions. The first is the level of resources in those regions. In many cases country towns, compared with city and urban centres, have many more police officers than they would normally need. That is simple because of the issues confronting that community, predominantly involving alcohol-related behaviour. In many cases officers in locations that have more officers than city locations still have insufficient officers to deal with the issues on a day-to-day basis. In fact, they deal with those issues by developing relationships with the community, as opposed to applying the law, if they can do that. It is an easy way of doing it, it is less resource intensive, and it is encouraged from our perspective.

The transport of people in those circumstances is a major issue for country locations. I spoke with the commander of a western part of New South Wales on Tuesday this week, and he told me that on any one day thirty police officers could be engaged in conveying people in various forms of custody, whether they be juveniles in custody, whether they be adult prisoners in custody, or whether,

and more often, they are people with mental problems who have been scheduled at institutions or doctors surgeries. That is the biggest issue. Because we are not applying the Inebriates Act, there is not a lot of use for it. If it was being applied, it would be the same situation.

The great difficulty is that most country towns have virtually one vehicle working at any one time. Obviously, when somebody has to be transferred to a larger centre an immense distance away, you cannot use that vehicle because you would then have no police resources to look after the general issues of concern to the community. So what has to occur is that, when that vehicle is finishing its shift and the next crew start, they dispatch that vehicle on an overtime basis. So we are then paying time and a half and double time to convey people immense distances, sometimes up to six and twelve hours.

That leads to another issue: the fact that conveyances tend to be done late in the evening because there is no facility to keep these people overnight in the local town and they have to be moved. So we then have the issue, particularly in western New South Wales, of native fauna on our roadways creating greater risk of injuries to officers and more damage to vehicles, which means that the conveyances are done at a much slower pace than if they were done in daylight hours. So it becomes an expanding issue. Nevertheless, it is done. But as this commander told me, on some days he could have thirty officers tied up doing these conveyances, and then there is the cost of that.

So obviously there is a reluctance at the local level—whether it be by the sergeant who is running the local station, or the local inspector—to be involved in that if they can avoid it, because of the budgetary cost of it, because of the likelihood of injury to officers and damage to resources, and in some cases the fear of the futility of it because in some cases where people are transported to a centre they are assessed and released and are back in the community two or three days later.

**CHAIR:** If that happens, how do they get back to the community?

**Mr WAITES:** One of the things that we do not do is bring them back. But they all find their way back, usually via public transport systems.

**The Hon. CATHERINE CUSACK:** Is it true that in situations where there is not a police cell in the local town, a police vehicle is used to contain a person overnight, with a police officer sitting inside the vehicle?

**Mr WAITES:** I am certainly not aware of that. It is strictly against our instructions, if it is occurring. In fact, until now I had never heard of that. It would go against everything that we generally want to do. One of the issues that often confront young police officers particularly is that they see their role as helping these people, not punishing them. Unfortunately, in some instances they do not have any choice and they are led down that punishment path because there is no other alternative. The practice you mention is something that I have never heard of before. It is not something we would allow to happen. If it is happening, it would have to be that it is someone who is not doing as they are expected to do, or, alternatively, somebody who felt they had no other option.

**The Hon. CATHERINE CUSACK:** I do not mean any criticism of the police. If they have someone who has been arrested and there is nowhere to take them, surely you could envisage situations where that person would be left in a paddy wagon.

**Mr WAITES:** Even in smaller towns—places like Wilcannia, which was once a big town but is now a fairly small town, and so on—there are cells. They are not designed to keep people in overnight, but if you had that sort of situation you would use them. Even places like Ivanhoe—virtually a single-unit police station—have a room that they use as a custody room. To keep them in a vehicle would only be when they were extremely violent and they could not get them out.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Presumably, if you went to a hospital and the hospital could not take them, you would then be stuck.

**Mr WAITES:** The practice is, even if it is late at night, to take them to the next centre that has enough staff to look after them. But most of our country locations do not have police working night shifts. If you look at the western part of New South Wales, the only towns that have 24-hour

active patrolling are the larger towns like Dubbo, Bathurst and Orange. In most others, the police actually stop work at one o'clock or two o'clock in the morning. Then, if there is an issue, they are called out to attend to it. Certainly, in the smaller Aboriginal communities, the police do not work 24 hours a day, unless there is a major issue.

**The Hon. ROBYN PARKER:** Could I talk about the lack of facilities and persons in an intoxicated state going home and perhaps causing an increase in domestic violence in the home. In many towns there has been a crackdown on public drunkenness, with lots of alcohol-free zones and a push out of public places. Would you say that that potentially increases the incidence of violence in the home in some of these communities?

**Mr WAITES:** I could not make that direct relationship. I am not from that area, but my own experience is that the domestic violence issue is one that exists regardless of where the alcohol is consumed. If it is consumed in a park, or in a bar or anywhere else, the issue of domestic violence tends to occur regardless. Domestic violence, whilst it may in some ways be exacerbated by alcohol, tends to be one of a power basis, rather than just the alcohol. Domestic violence exists regardless. You raise a point about alcohol-free zones and those sorts of places. Again, that is a cause of frustration for police officers. We do not instigate those sorts of places. That is usually done by local government and by local citizens who bemoan the incidence of people drinking in public places. In fact, that presents another difficulty for us, because under the current legislation the police have no choice but to enforce those measures, which we see as ineffective. It simply moves the problem. It might suit a local government group or a local community group to get these people out of their sight, but that does not take away the police responsibility or requirement to do something.

**The Hon. ROBYN PARKER:** Police have a very clear role when a crime has been committed and alcohol is involved. There are people who would say that if someone is drinking to excess, that is their problem, and if they are not causing harm to anyone but themselves society should not intervene. There are others who say we have a moral obligation to assist people and save them from themselves. Do you see yourself as having a role in that process?

**Mr WAITES:** Firstly, I should say that the core function of police officers is enforcement of the law. If that were taken to the very end of the line, that is our job, and if someone breaches the law, it is our responsibility to enforce the law. Coupled with that, though, we have the common law discretion to apply the law as best fits the needs of the community and the needs of the individual. Whilst in more recent times the discretion continues to be reduced by the enactment of further legislation that removes that discretion from police officers, that level of discretion enables police to try to avoid confronting the legal system and allows us to try to solve the problem, because this is not a major criminal problem, it is more a health or behavioural problem that we are trying to deal with by using that legislation.

However, what can happen is that police officers are forced, because of the circumstances, or because of complaints from the community about the behaviour of a person, to exercise their real role, which is to enforce the law. In doing that, they have to apply the law as best they can. It is not always a law that is applied to suit the needs of the person, and often it is not applied to suit the person who complains. Police officers often bear the brunt of complaint because they did not apply the law as it is written; they in fact use their discretion to overcome a problem in a much more humane way.

On the question of whether our job is to enforce the law, or our job is to look after the concerns of the person, I could take you to the legislation regarding seat belts. The legislation for the compulsory wearing of seat belts was enacted for no reason other than to protect people from themselves. Research would indicate that the enactment of that legislation—which started in New South Wales and is now worldwide—was a very effective way of reducing the road toll and reducing the incidence and severity of injuries to drivers and passengers, and more importantly reducing the cost to the community of those injuries. If you use that analogy, yes, the implementation of law that looks after the welfare of people often has greater good for the whole of society.

**The Hon. CATHERINE CUSACK:** Can I build on that analogy? It is pretty clear whether or not someone has a seat belt on. Any police officer can make a consistent call on that. It is much harder to make a judgment call in the case of intoxication.



**Mr WAITES:** I would be the first to admit it is almost impossible to get it right every time. It is very, very hard.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Would things be better if you had a comprehensive record? If a sergeant sees a person who is often intoxicated, which could be part of a pattern of behaviour and, indeed, a patterned response, that would be a great advantage, would it not? If someone says, "My name is Fred Bloggs", would the sergeant look up that name on the COPS register?

**Mr WAITES:** He could, and in fact that is what used to happen with the old offence of drunkenness because their records were officially taken. With the current legislation in the Intoxicated Persons Act we do not record that.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Is that not counterproductive, in the sense that removes continuity from the police response?

**Mr WAITES:** Yes, but there is equally the other side of the argument, which is the one we are confronted with. They are not criminals and their actions are not criminal; it is about trying to help them through the issue. They are recorded in our charge management system but they are not recorded under the criminal system and they are not recorded in COPS.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** You cannot look them up because you can only look at COPS.

**Mr WAITES:** That is right.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** So the fear of criminalising is actually stopping a more humane response in many cases, would that be your argument?

**Mr WAITES:** Yes.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** You mentioned that your discretion had been undermined. Do you think that the more prescriptive laws actually stop you solving problems in more humane ways?

**Mr WAITES:** In relation to alcohol issues, yes, because if you go to the theory of policing, which is that police come from the community and their role is to work for the community. If that is prescribed along strict lines, while some may argue that protects the community from overzealous policing, from the point of view of applying the law, we do not have any choice, which is the same argument we use that says zero tolerance cannot apply because every one of us, including myself, on a daily basis breaks some law, unknowingly and without malice but nevertheless there are so many laws it is almost impossible not to do it.

**The Hon. IAN WEST:** Every day?

**Mr WAITES:** Even pedestrian laws. There are so many issues out there. I do not want to get into an argument about zero tolerance, but taking away that discretion leaves police no choice but to apply laws that often makes things criminal that were best dealt with in other locations.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** And that is particularly the case with alcohol, which is why you have asked for this law to be changed?

**Mr WAITES:** That is right.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** If you remove the Intoxicated Persons Act and the offence of drunkenness, surely you have more discretion than you had before, under the Vagrancy Act?

**Mr WAITES:** Yes, we have discretion but that is all we have. We do not have the ability, for those people who are obviously in need of assistance, who ask for assistance and, in many cases,

community members have asked for our assistance with the problem, to actually do anything about the problem. I spoke about the issues of people in Dubbo where police have used bluffing to get people to go to a doctor and then before a magistrate to try to get some treatment, not because they want to make them criminals but they want to give them some protection and some assistance.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** The civil liberties argument has effectively cut police out of the treatment loop when they are a major point in treatment. Is that consistent with your comments?

**Mr WAITES:** Yes, simply because in most cases we are the only service available and although I accept the civil liberties argument, the difficulty for us is that there is nothing else to replace us. There is no-one else to do the things we are left to do.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** The pendulum has gone too far?

**Mr WAITES:** In respect of getting support for those people, yes.

**CHAIR:** You came in at the end of the evidence of the previous witnesses. The Aboriginal council from the northern part of the State spoke about the continuation of a system where they would receive a call saying someone was in a cell. They would organise for an Aboriginal elder to go to the cell, keep an eye on the person and then accompany them to a hospital. That process, which sounds humane, is happening on an unofficial level.

**Mr WAITES:** We encourage it and we have policies that promote that within the service but there is no legal aspect to it.

**CHAIR:** We are talking about non-offenders here.

**Mr WAITES:** That is right.

**CHAIR:** They are in a cell essentially for their own protection?

**Mr WAITES:** But in many cases they are in the cell because they did offend, and that is the difficulty we have. We cannot put somebody in a cell unless they are either intoxicated and we cannot find a place to take them and we need to put them in for their own protection or, alternatively, they have committed some breach of the law. In many cases because police do not want to simply put them in a cell, it is not until they actually breach the law that they end up in the cell. Our policies are then to encourage police visitors from their own community to actually spend time with them for fear of their own safety and propensity for self-harm; and also to go with them and convey them. Now if that person is only intoxicated, we do not keep them there. As soon as a friend or relative is located, we immediately give them into their custody. It is only if they are actually charged with an offence, we have to keep them in custody and we need someone to help them and support them.

**The Hon. CATHERINE CUSACK:** The law is a statewide law, but in reality there are a limited number of places that are hotspots for problems, would you agree?

**Mr WAITES:** Yes.

**The Hon. CATHERINE CUSACK:** Could you identify those areas?

**Mr WAITES:** I do not have current knowledge of exactly where the hotspots are and if I were to identify today four or five locations, tomorrow it could be another four or five locations. I am not suggesting that is because of the movement of these people; it is more a matter of what is occurring in the community at the time. If I talk about Aboriginal communities, some have no problems because of the efforts of their own people and the efforts of other government departments. They are doing some very good work. In others they are episodic, they come and go over a period of time.

You would all be aware of incidents, particularly if there is a media focus, where it becomes a major issue in one town or other for a short period of time, be it Wilcannia or Bourke. To say there

is an issue in one town, no, I cannot do that. I do not think any police officer could because no one police officer has the intimate knowledge of every single location and because we do not record it on the ground of personal privacy and because our systems are designed to record acts that are either criminal in nature or in response to a complaint, there is no way of actually checking where they are.

**The Hon. CATHERINE CUSACK:** We are talking about a relatively small group of people in a small number of communities that is driving the policy. At some point should we not just focus our resources and in a practical sense solve the problem?

**Mr WAITES:** No, my experience is that every town in New South Wales has this issue at some time or another. It depends on seasonal issues and what else is happening in the town. For example, we have just recently had the Aboriginal football competition at Maitland, where there were no problems. It was very well run and very well organised. We are now entering what we consider to be our busiest time for alcohol consumption and street crime, which is the beginning of November until just after Christmas. I am the commander for western, south-western and north-western Sydney. This morning I attended an alcohol crime-related forum at Liverpool before I came here. There is a major issue in the Macquarie Fields and Campbelltown areas because coming into summer alcohol consumption rises. We have major issues now with behaviour, domestic violence and street behaviour, which are alcohol-related.

You would say that those people are not inebriates in the true sense of the definition of this legislation but because of their episodic behaviour, which may go over several months, they would certainly come under this legislation if there was an ability to take them and give them some level of treatment. It moves, depending on what else happens. We are about to have the Tamworth music country festival in late January. We are already planning for the rise in the level of alcohol consumption, not in Tamworth so much itself but in the towns surrounding that area and the effects of that alcohol consumption.

**The Hon. ROBYN PARKER:** We have heard about the broad-ranging problems that you are experiencing. Are you aware of a model in other States perhaps that would assist in moving forward with this? The Alcohol Summit recommended a big roll-out of additional services but from a policing point of view, are you aware of some other model that is better than what we currently have in New South Wales?

**Mr WAITES:** Upfront, no, I am not personally aware of one. Certainly, my knowledge now is that in the early 1990s, because of the movement away from legislative control of alcohol and the enforcement of alcohol laws, every State in Australia reduced its level of enforcement of alcohol-related laws. We are the first State in more recent times to suddenly realise the error of our ways and actually try to turn that around. I have recently been to Victoria and spoken to people in South Australia. They are now heading down the same road simply because we looked at the industry as self-regulating and the legislation was written for self-regulation and in fact the majority of them did, but the numbers that did not are sufficient to create a problem. Every State in Australia and all the police commissioners will now acknowledge that they are not doing as much about control of the disposal or sale of alcohol as they should. I have an understanding of many programs in many States but none of them can effectively make this any easier at the current time.

**Mr HANSEN:** Leading up to the Alcohol Summit we did an audit of projects across the State and there were dozens of them. There are isolated projects, often initiated by the police or in collaboration with other agencies to deal with things ranging from under-age drinking to safe partying, but they are isolated. There are dozens of them to try to prevent the problems arising from alcohol abuse.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Is that audit publicly available?

**Mr HANSEN:** Yes, it is.

**The Hon. CATHERINE CUSACK:** Is it fair to say that the way the policies are being implemented—it is pretty anecdotal across the State—there is not necessarily a focus on particular areas with a particular problem because of a reluctance to identify the area as having a problem?

**Mr WAITES:** What we found from our audit of all government departments is that what is happening across the State was that they were dependent often on local leadership, which either encouraged, promoted or were able to access the funds of an organisation to develop and run the program. That is why in many cases it is run by police, in some cases Health and in some cases the Department of Community Services. It is probably about the power of the community, more than anything. I am not talking about monetary power but the ability of the people to lead and get something done. Some of the programs are quite effective and could be run across the whole of the State or country, but there is a large cost factor involved.

These programs compete for the dollars of a number of government departments, which do not have the excess dollars to run them on a major scale. One program that was trialled and was talked about in the Alcohol Summit is a program started by one of our patrol commanders in the western part of the State to provide meat-based food in hotels on pension days to reduce the level of alcohol effect on people drinking in hotels. The evidence indicates that was effective, but in order to do that the officer himself expended some of his own funds to purchase that food because there were not any funds available. It is about the ability to influence the community to get something done and where they can scratch the money together.

**The Hon. CATHERINE CUSACK:** I am interested in a statewide policy. At a State level you deploy the resources but there seems to be a reluctance to stigmatise a community by saying there is a big problem in, for example, Brewarrina.

**Mr WAITES:** Yes, there probably is a reluctance. but there is also no way that we have used to compare one community to another. We certainly do not do that.

**The Hon. CATHERINE CUSACK:** What it not be useful to do that?

**Mr WAITES:** If you were looking at alcohol consumption, it would be. If you are looking at criminality, we could do that but I go back to where I started; it would indicate that in those towns that have a high percentage of alcohol-related crime at all levels there is a drinking problem. I can certainly get that sort of data, but I cannot say specifically that alcohol is an issue because we do not gather data on how much they consume. In fact, it is very difficult in this State, because alcohol is taxed federally, to even know what alcohol is sold or supplied.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Would you really need an alcohol project to see how much is consumed and where, plus where it is sold, to actually deal with it as a public health problem? If you were selling chemicals and you wanted to know how many people were affected by those chemicals when they were sprayed on crops, you would look at the outlets and how they were used, would you not??

**Mr WAITES:** That is right.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** If you had alcohol-producing crimes you would probably want to do the same thing if you wanted to deal with the matter systematically. Do you advocate that approach?

**Mr WAITES:** It is one of the tools you could use, but it is not available to us at the moment.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Would it make much difference to what you do?

**Mr WAITES:** Not to what we do, but it would give us a better indication of where we put our resources. Again I have to stress that we do this job because nobody-else will or can. We would rather see those who are better able to deal with the health issues doing it.

**CHAIR:** These questions perhaps should be put to other agencies. We talked before about domestic violence. When Judge Price appeared yesterday we went through some changes that could be introduced. He suggested that as part of apprehended violence orders in domestic violence cases where alcohol is clearly identified as a major factor, it may be sensible to introduce a provision for compulsory treatment by the aggressor. Then we discussed the need for a provision that makes failure

to undergo the program an offence and the circle of criminalising this matter. Do you have any comments on apprehended violence orders for domestic violence and the cycle of criminalisation?

**Mr WAITES:** In relation to domestic violence, I was involved in a program on the Central Coast that provided support to the victims. We got together all the groups that were getting various levels of government funding to support the victims of domestic violence. We got the support group a vehicle and they worked out of the police station. They responded as the police left to support the victim. We then tried to instigate a program where the offender had to undergo treatment. There was no legislative base for it. Probation and parole were prepared and wanted to take it on, but they could get no magistrate to make an order to do it because there was no legislative base.

**CHAIR:** Judge Price was raising with us the possibility of implementing a legislative base, and then it would be necessary to amend the Crimes Act to make a breach of such an order an offence. We discussed the extent to which it would address the problem and also the effectiveness of compulsory treatment.

**Mr WAITES:** From our perspective, any system that would try to treat the problem rather than punish it would be a much better option.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Would you advocate a counselling system that was compulsory after domestic violence intervention? Would you support the victim and counsel the perpetrator as a compulsory procedure rather than wait until an offence was committed and then cart him off?

**Mr WAITES:** That is our preferred option. Under the program we tried to instigate on the Central Coast, offenders were actually charged with the offence of assault but were to undergo treatment prior to sentencing by the magistrate. It was a bit like the MERIT Program.

**The Hon. CATHERINE CUSACK:** Was it like a bail condition?

**Mr WAITES:** It was more than that. It was like the MERIT Program. It was a court directive.

**CHAIR:** You are talking about a case where an offence is proven, whereas with Judge Price we discussed people who had not yet committed an offence but were expected to. Perhaps the violence could be seen as an offence in a broader way.

**Mr WAITES:** Again it is about where we go with the law. If there is violence it is an offence, as far as the law is concerned. Certainly we would be strongly behind any proposal that would reduce the incidents of domestic violence by creating some way of compelling an offender to undertake treatment.

**The Hon. IAN WEST:** This may be a question for others. We need to come up with something before an offence is admitted or proven. The police go to the house and the matter first comes before the court. We need to come up with something in that period before the magistrate finds the offender guilty. As we know, only the minority of offenders say they are guilty or have an offence proved against them. Do you have any ideas on a program that could be implemented between the police going to the house and the matter coming before the court?

**Mr WAITES:** As I just indicated, you could do that with the MERIT Program. When the matter gets to court the magistrate can deal with it without proceeding to conviction, provided the offender has undertaken the treatment and has a response from the treating group. That is what happened with the MERIT system. Whilst you can use the bail conditions to do that, the difficulty is that you have to charge someone, put them on bail and they still have to end up in court. Our option was to try to do exactly what your approach is: first of all, and most importantly, provide ongoing support to the victim and the family, and then put the offender in a treatment program prior to the magistrate making any decision about guilt or otherwise. That was our intention. The difficulty was that because probation and parole were offering the service, the courts needed a legislative base, and they did not have it.

**The Hon. CATHERINE CUSACK:** Are they unable to order someone as a condition of bail to attend that type of program?

**Mr WAITES:** Currently under that legislation, yes.

**The Hon. CATHERINE CUSACK:** They can or they cannot?

**Mr WAITES:** They cannot order them. Bail conditions are about exclusion, not direction. People under bail conditions can be told they cannot go somewhere, but they cannot be made to do something.

**The Hon. CATHERINE CUSACK:** If it were possible to order a person to undergo a treatment program as a condition of bail, if they did not turn up would they be put in prison?

**Mr WAITES:** It would be a breach of the bail conditions.

**CHAIR:** Apprehended violence orders are a huge problem but are at the lower level of offences. Some of the options we are talking about would not ever be used at that level. By saying that, I am not underestimating the problem.

**Mr WAITES:** Under the current legislation for apprehended violence orders, with some amendment to the law it could be a condition of the order that the offender gets treatment. The offender has not committed an offence at that stage. There has been a threat or the proposal that there may be a threat.

**CHAIR:** The basis of our discussion yesterday was that although there is no formal offence or charging of an offence, a diversion into compulsory treatment may be in the interests of everyone. The stick would need to be that the failure to turn up for treatment would become an offence.

**Mr WAITES:** That is right.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** I am amazed that meat-based foods on pension days in hotels attract the interest of the police to the point that they fund it. That is a long way down the treatment path, because it is about nutrition. Was there any feedback on that initiative?

**Mr WAITES:** It was felt to be successful because the incidents of criminal behaviour by intoxicated persons reduced whilst it was occurring.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** It was not the fact that it was dietary, it was the fact that people did not get as drunk because they emptied their stomachs of the alcohol?

**Mr WAITES:** That is right.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** There was a less high peak?

**Mr WAITES:** Yes.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** From practical experience, you find out where the alcohol problems are, where the violence is and where people are drinking. Would records of alcohol sales help in your policing? You would still have to know where people buy the alcohol and where they drink it. You would not collect statistics on alcohol sales if you could not use them.

**Mr WAITES:** The value for us and for other government departments, whether it be the Department of Community Services or Health, would be that we would know by the level of consumption those locations that need greater resources. Consistent with what we have found from our own research on crime involving alcohol, those places that had the highest consumption of alcohol tended to have the greatest calls for police service. It is about putting that first. I talked earlier about the single-unit police stations where there is often an Aboriginal community. The police manage by developing relationships with the community rather than enacting the law every time someone does

something wrong. If we were aware of the amount of alcohol that was being dispensed into the community, we would have a better understanding of the resources we need in those places. At the moment we do not measure it, because if the officer does not enact the law he does not record the amount of criminal offences that occurred.

**CHAIR:** This is a long way from the Inebriates Act.

**Mr WAITES:** It certainly is.

**CHAIR:** The Inebriates Act is theoretically meant to deal with people at the very extreme end of alcohol use and misuse. We have dealt with most of the questions. Do you have any other specific problems about the Inebriates Act and, if so, how they should be addressed? What would you like to see come out of this inquiry? For example, should the Act be repealed and, if so, replaced by different legislation, such as the Mental Health Act or the Guardianship Act?

**Mr WAITES:** We have as many issues with the Mental Health Act as we have with the Inebriates Act.

**CHAIR:** Perhaps you could expand on that, because several witnesses and submissions have suggested that the Mental Health Act is a much better way to go.

**Mr WAITES:** The Mental Health Act for us creates the issue of being ineffective in that we are, for want of a better term, picking up the people that no-one else can or will deal with. When people with mental illness have episodic attacks it creates major issues for us, such as officer injury. The safety of our officers dealing with people in this situation is increasingly becoming an issue and is now being reported to WorkCover. Nevertheless, as I say to our officers, if we cannot do it there is not anybody else left. No-one else wants to touch it because those people in those episodes are ill but they are uncontrollable. There are no longer facilities to manage them either on the street or in many cases in institutions. They are simply taken, assessed and re-released into the community. Hopefully they will not have another episode for some time because when they do we go through the same cycle again.

The Mental Health Act creates a huge workload for us, particularly in metropolitan areas. Again, it is one of those Acts where officers feel they are hamstrung because there is no end to the process. Nothing is going to change or make it better. Repealing the Inebriates Act in its current form is probably an option. But our preferred options as a police organisation would be: one, to give police the ability directly to take people before a magistrate rather than having to go through the convincing and controlling process; and, two, the need for the services as described to be provided. That is not something that you as a Committee can put into legislation. Because of the issues I have just talked about in mental health, there has been a watering down of facilities and the desire in those facilities that do exist to effectively treat people. That was the experience of police at Dubbo. People have been committed to Bloomfield and then allowed to wander out each day to the local club or hotel, have a drink, come back and sleep for the night.

**CHAIR:** Many health professionals say that in their experience unless someone wants to be treated the treatment will be ineffective and that that is the problem with compulsory treatment.

**Mr WAITES:** I accept that. In fact, I had that conversation prior to coming here. If that is the case, then all of us as a society need to provide something at a local level to support these people and manage their behaviour for their sake, firstly, and then for the sake of their families and the greater community. To simply say if they do not want to be treated we cannot treat them does not solve the problem. The problem continues to exist and in some communities continues to grow, as do the mental health problems.

The wet house issue is one that I am aware of. I have done some recent research overseas on that. Whilst it works for those people, it creates immense problems for others. The experience of the wet house in Canada and in Switzerland is that whilst it takes them off the streets it is creating greater conflict between them. I am aware that with the one in Canada in recent times, because the organising group cannot protect their people, they are now likely to be prosecuted for not providing a safe working environment for the staff.

So there are all those issues that go with that. We are legislating in one area and we are pushing, but we are over legislating in others. It is the same issue I talked about that is now becoming a major issue for us with the safety of our officers in dealing with these people. When I was a constable it was said, "Well, that's what cops do"—you lived with it. Now that the legislation that protects the workers is equally applied to us it is making it almost impossible in some cases for us to do the things we used to do. I am not suggesting you change that, I am simply saying that it makes the law more difficult to apply.

**CHAIR:** So to just get straight your attitude on the issue of involuntary treatment or whatever, you are saying that even if we all accept that compulsory treatment is unlikely to be effective for the majority of cases, you believe there should be an element of compulsion in terms of safety for the persons themselves and some degree of respite and safety for the members of their family or their community? That really means some degree of incarceration for a person's own good and the good of the community even if there is not much in the way of treatment.

**Mr WAITES:** Yes, but I see that the way to do that, from my perspective, is to do it locally, not transport people to centres where they do not have that level of support. Call them halfway houses, call them hospitals, call them whatever you like, there is a real, genuine need in many of those communities for some facility where those people, even if they flatly refuse any treatment, can go and be managed. I am not talking about the locking them up and throwing away the key type of thing here, I am talking about somewhere that becomes part of their practice to attend regularly to undergo counselling, to actually have some sort of level of supervision, even if it is from people who are supervising them in their own environment, someone who actually continually works with them to try to manage the issue.

**Mr HANSEN:** I suppose it depends on the definition of "treatment" too. Compulsory treatment in the sense of sharing a problem with someone is one thing but treatment which provides some respite and some ability to get them back into some healthy condition and respite for the family, that is treatment that is not necessarily curing the alcohol problem as well.

**The Hon. CATHERINE CUSACK:** Did you have any problems with the old system of proclaimed places?

**Mr WAITES:** We had no problem with them except that they do not exist and they never did exist in many places. In fact we encourage proclaimed places and we would like to see them in every town in New South Wales. That is part of our current drive, to actually have them provided simply so that we do not have to put people in police cells and we do not leave them on the streets when they are extremely vulnerable.

**The Hon. CATHERINE CUSACK:** Why do you think that legislative authority was taken away?

**Mr WAITES:** Because they were not being used and therefore there was not seen to be a need. The reasons they were not being used were two things: one is they were not in the places we actually needed them, so it was the issue of bringing someone, for example, from Penrith to the city who was intoxicated and you cannot let your resources out to do that. The other reason they were not used is, again, that issue about the support of workers; they would not take quarrelsome or violent people and most of the intoxicated people we deal with that are brought to our attention are in that situation.

**The Hon. CATHERINE CUSACK:** If the model for proclaimed places were to be restored, you would need a different type of service?

**Mr WAITES:** Only to some degree. They still have a proclaimed place, or the equivalent of such, at Matthew Talbot hostel. The difficulty they have is the difficulty I talked about of managing these people if they are violent. They have no choice but to kick them back out onto the laneway to protect their own workers, for no other reason.

**CHAIR:** We are visiting Matthew Talbot in a couple of weeks, as well as other services.



**Mr WAITES:** And you will see what I am talking about then.

**Mr HANSEN:** The violent ones are the ones that come under our notice. We do not go out deliberately looking for intoxicated people. So it is the ones that come under our notice and they are the ones who will not be accepted in the proclaimed places anyway, and those that might accept them of course have no power to detain them either. So they can walk through the revolving door and be back out causing the same problem that might have attracted the attention of the police in the first place.

**The Hon. CATHERINE CUSACK:** So they go into police cells now?

**Mr WAITES:** Either that or, unfortunately, our younger police just ignore them. As I said, if they are called to an incident they will stop the incident; under the move on legislation they will tell them to move and they will move away and the police will leave, only to have another car called back half an hour later to the same person another kilometre down the street.

**CHAIR:** So what would you like to see come out of the inquiry if you had your wish?

**Mr WAITES:** What I would like to see come out of the inquiry from the policing perspective is at least in your deliberations some acknowledgement that there is an issue that has to be worked with more than just one organisation. I know health do a lot of work; I know the Department of Community Services does a lot of work, but it is isolated to where they are actually set up. From a policing perspective we would like to have a lot more assistance from other government organisations in all centres, including those country centres, so that the only option is not the police.

The other thing is the ability for some treatment of people in that situation. As I say, it is not necessarily incarceration 500 kilometres from home, it is about some facility that provides some safety for them and some respite if they take the option of some ongoing, long-term treatment. The third thing is, again, the police organisation does not have any difficulty with the Inebriates Act if we have the ability for those people who fall outside the system to actually take them to court to have them put into the system.

**Mr HANSEN:** I would suggest not leaving us with the situation at the moment where operational police are either attempting to manipulate existing legislation or trying to get people to fit in with this if they wish to use it, and then exposing police to criticism that might go with that. Or the other unattractive point of that is that police might be catching people in the net for street offences, more substantive offences to resolve a problem that they have come across on the street. Now there is the option of not doing anything, trying to find some legislation that captures that particular issue, and the community expectation and what the police might be able to do to assist that social problem, or resort to a more substantive street offence and put somebody before the court. It needs something that is tailored that the police can actually use.

**Mr WAITES:** Can I just stress, and I think it is something we do not stress often enough as police, whilst our core function is enforcing the law—and at the end of the day that is our role—we are often seen as being overly strong-handed with these issues and certainly my officers and myself from my experience will tell you that that is not our desired outcome. We would rather solve the problem than put someone in the criminal system in any way. In modern policing that is what we try to do but it is very difficult when you have to use the system, and that is suggested by Superintendent Hansen.

**Mr HANSEN:** Certainly, and I think Bob would have to agree that since the time when I joined my experience has been that police are more likely to exercise or want to exercise some discretion and want to exercise some more tolerance in dealing with these issues than perhaps 30 years ago when it was fairly much dealt with in black and white terms: people were processed. I think we are looking for options to be able to accommodate these issues more than we did in the past.

**CHAIR:** Thank you very much for that and for staying well over your time. You have not only helped us a great deal but you have also give us some pointed questions to put to some of the

other agencies that will be coming before us as well. I hope if we need more information from you that we can contact you.

**Mr WAITES:** If we can assist in any way, either provide you with any of our data or come back, we are quite happy to do that. Thank you for the opportunity to present it to the Committee.

**(The witnesses withdrew)**

**PETER KENNETH TUCKER**, Psychiatrist, Clinical Director of Mental Health Services, Western Sydney Area Health Service,

**HAROLD VICTOR STORM**, Psychiatrist, Clinical Director of Mental Health Services, Central Sydney Area Health Service, and

**JOANNE FERGUSON**, Psychiatrist, Drug Health Services, Central Sydney Area Health Service, affirmed and examined:

**CHAIR:** You have each received a copy of our questions, which we hope will be a guide. Do any of you wish to make an opening statement?

**Dr TUCKER:** No.

**Dr STORM:** No.

**Dr FERGUSON:** No.

**CHAIR:** Can you explain the role that the Inebriated Act sets out for the gazetted hospitals?

**Dr TUCKER:** My understanding is that psychiatric hospitals are not specifically nominated in the Act. However, we were advised by the Attorney General's Department early this year that the establishment of institutions for inebriates is notified in the *Government Gazette*, and that seven hospitals are currently gazetted to receive inebriates. You are probably aware of that. It would be possible for a hospital to be removed from the list if it were to apply and give good reasons for its removal. The role of hospitals at present is essentially as a place to which magistrates commit inebriates for lengthy periods of time. This appears also to be largely based on the need or requirement that the inebriate should not abscond.

**CHAIR:** Is there any real concern or conception of appropriate treatment?

**Dr TUCKER:** The Act does not specify anything about treatment; it does not mention treatment. It seems to be concerned mainly with separating the inebriate from alcohol or whatever.

**CHAIR:** Has Health or anyone else laid down any guidelines to govern the role that hospitals should play?

**Dr TUCKER:** I am not aware of any official guidelines.

**CHAIR:** We are not either.

**Dr FERGUSON:** There are none that I know of. In fact, there is no need to write treatment in the Act. However, most people who come to the hospitals have a line in their orders saying, "For the appropriate treatment and containment." Magistrates write that in off their own bat.

**CHAIR:** Can you give us an idea of how many people are presenting to hospitals and the circumstances in which they present? Can you give some examples? We talked to Chief Magistrate Derek Price yesterday, who gave us statistics for the past three years. We were struck—as I suppose most people would be—by how small the numbers are. I think it is 11 so far this year, 19 in 2002 and nine in 2001. He said that there would be a few more people because those figures come through the centralised computer system, which does not pick up all cases. We partly know how many but we need you to tell us about the circumstances and to give examples of the kinds of people who come in under orders.

**Dr STORM:** Those numbers are consistent with our figures. We have had nine come through our service in the past three years. Given that we are one of the larger hospitals, that seems to be the sort of ratio that you would expect. The issue facing us is that there is quite a variety in the mode of presentation and people are sent from a variety of places. So you cannot necessarily draw any

systemic issues from the stories that we relate. We have had people sent to us from country areas, such as Wagga Wagga. A court in Wagga Wagga sent us an individual, who lived further away between Wagga and Deniliquin. That person was taken totally out of their social fabric and context. They knew no-one in our service and were simply sent to Sydney for six months—that was the order.

From the evidence it is clear that there has been a history of chaos and personal tragedy in each episode but the expectation of what can be done is a little unclear. Exporting the problem to Sydney for resolution does not lay the foundations for reintegrating that individual into his or her community, if that is what is intended. Perhaps that is not what is intended: perhaps they want to remove the problem in the hope that the chaos will not return. That is rather sad. We are constantly faced with the fact that there has been little consultation with our service about what we may or may not offer. Someone will just arrive with an order at the front office of the hospital and there has been no consultation about whether it is a good idea.

**CHAIR:** Do you know that they are coming?

**Dr STORM:** No, they just land there. The other thing that often occurs is that people will ring from court to ask whether we will house someone. When I was superintendent of Rozelle hospital I would say that we had drug and alcohol treatment facilities, a detoxification unit and we ran a rehabilitation program and we were quite happy to take people for inpatient treatment but that the thrust of our treatment was that the person should be willing to undertake it. I would usually point out that the evidence is not good that compelling someone to have treatment is successful. Persons are often referred from the courts and they arrive for assessment and treatment off their own bat. They move through our services without having recourse to an inebriates order.

If lawyers and others tell us that people are agreeable to come to hospital, we say, "Well, if they are agreeable, let that happen. Don't use a judicial order to enforce it." If people take it on board that they are part of the process they are much more likely to work at it. If people feel compelled, there is often a tendency to want to resist. Characteristically, when a person presents on an order we usually do not have much warning—the person just arrives. People come from all over New South Wales and they are cut off from their home and support networks. It makes it very hard to integrate any ongoing treatment when they are like a fish out of water.

**Dr TUCKER:** I can offer some thumbnail sketches of the people who have been sent to us. I preface my remarks by saying that we have had five presentations since the beginning of 2002, which is consistent with the relatively small numbers. However, I point out that if people stay four months, six months or something like that they occupy a whole bed in our acute service. That is fine if it is appropriate but many acutely ill people could be receiving active and effective treatment using that bed in the same period. We need to think about the economics of the issue. That is not to say that these people do not have serious problems.

For example, a woman in her thirties came to us who was noted to have abused alcohol in the preceding 12 months in the context of a marital breakdown. There had been aggression, apprehended violence orders, damage to property, rage and violence towards family members. The local community mental health team had also been involved. There was a history of treatment for anxiety and depression over the preceding 10 years but close questioning shortly before admission revealed that she had been drinking since her mid teens, drinking heavily by the age of 20 and drinking very heavily in the preceding year. Her life was clearly very disturbed. There was no doubt about that.

A man in his sixties was given a three-month order. In this case no documentation or affidavits were supplied by the courts. That is a problem: under the operation of the present Act, that sort of information is not sent to us. This person was plausible and denied a serious drinking problem. He was reluctant to take anti-craving medication and felt that he could control his drinking. He normally lived with a close family member, to whom he paid rent. He is an example of somebody who just sat there for three months. He had no insight or motivation to go anywhere with his treatment.

A 66-year-old man was given a three-month order. No affidavits were supplied with him. He had been neglecting eating and drinking. He was living with his wife and had drink-driving charges. He was happy to accept treatment in a private hospital.

In fact, we made an application to the magistrate for a variation of the order so that he could be on his own recognisance and go to the private hospital. The magistrate granted that application and the man went. That sort of flexible application of the Act is good. The last person I want to mention is a man in his early fifties, who received a six-month order. He was a well-known local drunk in the suburb from which he came. He hung around the streets and the community knew him. In fact, upon his committal to our hospital the local newspaper carried a photograph of him accompanied by quite a fond story about him. You may have seen that story. He is still with us. He had two previous admissions last year under an inebriates order and has had a total of 16 admissions to hospital, many under the Inebriates Act. So there are questions about the effectiveness of his treatment.

**CHAIR:** So the figures that we were given by Chief Magistrate Price were individual cases. Therefore, the totals refer not to individuals but to cases. So the number of people could be much smaller.

**Dr TUCKER:** The 16 admissions were over a large number of years up to last year.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** In my experience, it takes about 23 admissions to die of liver failure in the public hospital system. That is the average number of admissions, at vast cost. The present inquiry revealed that many people in gaol—70 per cent or 80 per cent—are affected by alcohol, which is also costing a large amount. If it is an inappropriate use of hospital, gaol and acute care resources, what resources do you think should be allocated and who would look after these people in order to derive maximum benefit for minimum cost? What system should apply? These people are pushed from pillar to post in terms of the system that deals with them.

**Dr FERGUSON:** The difficulties in gaol are caused by a combination of alcohol and other drug problems. Most alcohol problems can be dealt with very effectively using outpatient treatments and brief intervention. Most people respond very well to a small amount of counselling, direction from a doctor and evidence that their life—their health or their relationships—is being impacted. The literature shows that most people with alcohol dependence—which is a little different from what the Act describes—respond quite well to a brief intervention.

The more difficult problems are when people have a chronic, severe alcohol dependence. That group are often quite slow to respond, and do require a lot of admissions. This is a chronic, relapsing condition, and the chance of someone who has a severe dependence resuming drinking is very high; it is a long-term problem. I think we need an integrated approach. There is a role for prisons, there is a role for the health system, and there is a role for outpatient services as well as inpatient services.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** I would not say we have an integrated and co-ordinated approach now. It seems that whichever service you bump into by mishap reneges on responsibility, depending on what it does, and then you bounce to the next level or stay in the gutter.

**Dr FERGUSON:** Yes. And the expansion of the drug health services within the Department of Corrective Services has been quite noticeable in the last two years. That is an important component, not only due to people staying in correctional institutions but also in referral to a community-based drug and alcohol treatment service, particularly for those on methadone but also for counselling, and that has been expanded in the last two years. That sort of integration can happen. I think you are right: they are not completely finished, and quite a lot of creative work needs to be done about how we do it, and it is a part of our service that needs to be looked at.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Mental health is very much starved of beds, and it does not seem to have the outreach that it should have. Having done the mental health report recently, it seems that the dual diagnosis patient had big problems. The mental health people said, "Get rid of your drug problem," and the drug people said, "Get rid of your mental health problem". It was a stand-off. Yesterday Derek Price, the Chief Magistrate, said that he really wanted the mental health people to almost take drug addiction as another mental health aspect and treat it in that medical model rather than get into a criminal model; that was the alternative he was looking at. You are saying that most of them can live at home—which is fine, if they are in functioning households and relationships, which presumably only some of them are—

**The Hon. IAN WEST:** Is this question 3?

**CHAIR:** I think it is question 6. Dr Tucker—

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Please let the witnesses answer my question.

**CHAIR:** That is exactly what question 6 is about.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** I was merely following on from what the witnesses had said.

**Dr STORM:** I think what we are talking about is a small subset of people who cause great havoc—the people who end up facing inebriates orders and the like. I think these people can cause havoc wherever they may appear. In essence, the difficulty for any system is to try to integrate the various needs that these individuals have. The health system in general, apart from the mental health system, usually involves people voluntarily seeking assistance for a problem that is mutually agreed, and the majority of the health system's interventions are based on those sorts of—

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** A cheery little model, which does not apply in a lot of these cases?

**Dr STORM:** Given that, for the most part, that is the culture of the health service delivery, this problem puts up a dilemma right at the start because you are having to develop a model that is different to the general thrust of the culture of the whole service. I think that is one of the problems. In a sense, the correctional service, which is a more compelled service—in other words, you do not have a lot of choice about what you do—can probably deliver components of the intervention at the very severe end, particularly when there are breaches of the criminal code, reasonably effectively.

I suppose the reason that the magistrate you referred to felt that the mental health infrastructure might represent a model is that there is a component in that which is about compulsory treatment for disorders which we know respond to treatment. There are some quite successful examples of what might evolve for an effective treatment for addiction. I think we could perhaps pursue that a little more in some of these discussions, because I think there are models about the process of compelling people for assessment, the possibility of reviewing the treatments and their efficacy, and particularly the process of external review by other agencies under the Mental Health Act, rather than just a referring doctor and treating facilities. I think there are a whole lot of checks and balances that might help us develop a model, or the treatment of a very severe dependency, that might save lives.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** The definition of success depends on where you are. When we used to talk to oncologists about success, they would talk about it in terms of extra life gained, rather than actually winning. You could regard people not going back to gaol as a success, rather than some sort of abstinence or controlled drinking, or non-suicide as being a success over a long period. Is it that your definition of success is compared with highly successful treatments, and therefore you are defining yourself out of the game?

**Dr STORM:** I was not trying to say that we should not have a role. I think the mental health treatment models can give us some examples of the way we may be able to proceed, but I do not think it should be simply handed over to the psychiatric services to administer and manage; I think other specialties are required and are quite necessary to make sure that a range of best-available treatments are offered to the spectrum of people. I suppose you also have to raise the issue of how much effort you need to put into a small subset of the community and what level you go to. That is another issue you need to address in terms of balancing resources.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** If it were a terminal cardiac condition, the answer would be endless resources, would it not?

**Dr STORM:** No. Some people elect not to continue with treatment that is not going to be helpful. If the consumer is actively involved, people can accept that if there is no realistic gain from treatment. They might accept palliative care to make themselves comfortable, but I think people accept that there is a limit. If you cannot get a heart transplant, sometimes people accept that. There is nothing you can do for a terminal cardiac condition.

**CHAIR:** Dr Tucker, with regard to the cases you mentioned you referred to, I would like to know about the outcomes you get and how they compare with the outcomes you might expect from people who come to your service not under the Inebriates Act.

**Dr TUCKER:** I take on board some of the points that have just been made. Some of the outcomes are not followed up because these people are discharged and they are being seen as appropriate for follow-up by a drug and alcohol service. I think there is probably an argument for a greater degree of integration of mental health and drug and alcohol services. I am perhaps speaking for myself now. However, it has been long thought that it would be good to have a greater integration of mental health and drug and alcohol services. I think one could come up with some proposals for treatment programs that would do that, and that would require a good deal of consultation. We have been talking about some of those proposals.

To get back to your question, unfortunately what I know of the outcomes is very little. I can only mention that person who was known to the local community mental health service who had repeated admissions and the answer was repeatedly, "Send him back in under the Inebriates Act." Perhaps there needs to be something better than that for that individual. I am sure it is also true that there may be some individuals for whom there is no easy solution. But, sadly, we do not really know a lot about the outcomes of these people.

**CHAIR:** Is that a weakness in the regime that the Act provides for?

**Dr TUCKER:** I would see it as such. One of the big problems with the Act as such is that it is basically operated and run by the court system and there are no provisions for treatment, which includes follow-up treatment. That is not to say that we should not try to provide treatment: of course, we should if we can. But there are no real follow-up systems that have been set in place at the moment. If there were to be any new legislation, this would be a most important thing to look at: exactly how the services and treatment were going to be delivered, including follow-up and evaluation of that service.

**CHAIR:** How do the people who come to you under an inebriates order compare with the people who come to your service by other means?

**Dr TUCKER:** In terms of follow-up?

**CHAIR:** In terms of provisions for follow-up, provision for knowing their case history, the opportunity to talk to their family or the community to integrate them with other services, and so on.

**Dr TUCKER:** That is all there, and they do have, for example, social work intervention and neuro-psychometric testing and the various resources that are available within the service.

**CHAIR:** But if they come to you out of the blue, presumably a lot of that is very hard to put in place?

**Dr TUCKER:** It is. Although, if they happen to have family that they are still in touch with, we can contact them. Sometimes they are estranged from everybody; I can certainly relate it to a couple of these cases. It is very helpful if we have information sent from the courts. Also, if we know that somebody has been admitted to another hospital or service, we can ask them for information.

**The Hon. ROBYN PARKER:** When we are talking about cases that have been presented to your various institutions under the Inebriates Act, I am assuming from those case studies you have presented that they are all alcohol abuse cases rather than drug abuse cases under the Inebriates Act.

**Dr TUCKER:** Yes, that is by far the predominant type of problem. Although, I do not think the Act precludes those sorts of drugs.

**The Hon. ROBYN PARKER:** Is that because there are other methods of preventing those with drug abuse problems from taking other avenues?

**Dr TUCKER:** I do not think so. I think it is just what has grown to be the case.

**Dr FERGUSON:** I have some people come in with referrals for other dependencies. I am particularly thinking of a woman who has chronic schizophrenia and benzodiazepine dependency who came from the Central Coast. She really came because the services had reached the end of their tether, and her family were really angry with her for not stopping taking her benzodiazepine despite having repeated admissions to the mental health services up there. I have never seen anybody come in with heroin dependence under an inebriates order. I think that in magistrates minds inebriates orders are associated with alcohol, and there are other diversion programs that have been developed that are more appropriate for people who are heroin dependent, and they are more likely to be referred into those systems. They are also then likely to be sent for mandatory treatment or to have rehabilitation written into their adjournment notices or whatever.

I would like to talk about some of the cases that came to Rozelle. They have some common themes. The common theme I have found is that the patients create difficulties for their families. A 38-year-old mother of two who ran her own business and used to get drunk a couple of times a week would continually fight with her relatives and her ex-husband. They were embarrassed by her performance. She stopped drinking about eight months prior to her presentation. They had been taking her to see a psychiatrist, and the psychiatrist suggested an inebriates order, then the family worked on statements. When she came to the hospital she did not have an alcohol problem and I could not make a diagnosis of alcohol dependence. She was comfortable and happy to stay. It was useful for her but it was not an effective treatment.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** So it was a holiday.

**Dr FERGUSON:** There is a theme of chaos. Another patient this year had conflict within her family related to issues in addition to alcohol use. She did not want to be there but agreed to the order. As a result she would not engage with me in a conversation about it. She went into rehabilitation and we went back to the magistrate to get the order changed and there was recognisance to the court, but that was not effective. Because she felt forced into treatment she took a long time to get over her feelings of resentment. That is an important component. People will come to treatment—they reach the point at which the consequences force them into treatment—but when it is imposed they take a long time to get over the resentment and they feel a loss of autonomy.

Another case involved someone bothering a magistrate by repeatedly presenting as drunk and disorderly in a park and so on. That person came without a doctor's note from the magistrate. She was Aboriginal and homeless and had multiple other problems. She had some cognitive impairment, but I think that was due to alcohol abuse. She had a nice stay in hospital for three months but would not discuss her alcohol problems and did not want to go into rehabilitation. It was a good intervention in that she looked a lot better at the end of three months, but it did not address her real problems—homelessness, isolation from her family and so on. We could not touch the real problems because she did not want to be there.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** It may have been cheaper than the alternatives.

**Dr FERGUSON:** That is the common theme. People coming to me under the Inebriates Act are those who are creating a problem for someone else. They are few and are confined under a very rigorous and indefensible order. They cannot work their way out or appeal to the court. It is difficult to believe that the right to appeal is protected.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Are you saying that the only people being subjected to this law are those who are inconveniencing someone, that is, no-one bothers about a drunk under a bridge?



**Dr FERGUSON:** I have never seen homeless people come through that system. Homeless people are effective in accessing detoxification services. They will go to a homeless service and access drug and alcohol services.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Are they more effective than someone who has a home?

**Dr FERGUSON:** They are effective.

**The Hon. CATHERINE CUSACK:** Is it possible that the magistrate is genuinely concerned about a person's welfare? Does the magistrate resort to the Inebriates Act not as the preferred option but as the best of a bad lot?

**Dr FERGUSON:** That is probably a strong feeling on the part of many magistrates who are frustrated with repeat offenders and who want them treated.

**The Hon. CATHERINE CUSACK:** Do you regard alcohol addiction as a mental health issue?

**Dr FERGUSON:** Alcohol dependence—that is, physical, mental and social dependence—is a mental health disorder. It is also a social problem; it has significant social consequences. It is both.

**The Hon. CATHERINE CUSACK:** Would it be would appropriate for a person with alcohol dependency to be treated in a mental health context?

**Dr FERGUSON:** Many people with alcohol dependency problems do not need mental health interventions; they need health interventions. Often they can be helped significantly by their general practitioner and outpatient drug and alcohol services staffed by a range of people, including social workers, psychologists and general nurses.

**The Hon. CATHERINE CUSACK:** I am talking about people at the severe end of the scale. Are they a mental health responsibility?

**Dr STORM:** These people have addictions. Our drug health services specialise in that area. It is a subspecialty in the health sector. The primary health sector addresses most people's problems. The next level is addictions medicine, which is an integration of psychological, mental health and other health expertise to provide specialist treatment. Dr Tucker, Dr Ferguson and I would all agree that one of the systemic problems in New South Wales is that drug and alcohol services have become somewhat divorced from speciality mental health services across the State, although our services are working closely together. Dr Ferguson and I are an example of that. Dr Tucker worked in our service some years ago and knows that there is close collaboration. However, it varies in different parts of New South Wales.

**The Hon. CATHERINE CUSACK:** You have many residential services that are required by people who are likely to be subjected to an Inebriates Act order. Is that why mental health services are being asked to take responsibility for this or is it genuinely a mental health services responsibility? I understand that there are different levels—the quit-smoking level and the level we are talking about today. Is that appropriate at this level, given that for historical reasons mental health provides many residential care services?

**Dr FERGUSON:** Dr Storm's comments capture the core of the issue. Addiction treatment has developed a separate identity. It is a new chapter in the Royal Australasian College of Physicians—the Addiction Medicine chapter. It includes public health physicians, rehabilitation specialists, psychiatrists and so on. It is a unique field in that it requires input from everyone in that area. It is a stream of its own. Historically beds have been provided in scheduled hospitals. That is partly why there is ongoing psychiatric expertise in this area as well emerging expertise in physicians.

**CHAIR:** What do you see as the way forward? Do you see a role for compulsory treatment? If so, where and in what speciality? I want to ensure that we have covered your criticism of the Act and your views on current approaches to treatment of alcohol and other drug misuse.

**Dr FERGUSON:** I have a couple of criticisms of the Act. The rights of the patients referred under the Act are not well described. In fact, there is great potential for abuse. In addition, the rights of staff are not defined. The Mental Health Act requires staff to contain patients, which means they can, if necessary, physically restrain them. That is not provided for in the Inebriates Act. Therefore, staff believe that they could be deemed to have acted inappropriately if they try to restrain someone. Further, this process is conducted in a public court. That can be humiliating for people who do not normally go to court. That does not protect rights. The Act does provide that the proceedings can be held in a magistrate's chambers, but that happens at the discretion of the magistrate. There is no privacy. This is a medical problem being dealt in a public legal situation.

We have had extensive discussions with colleagues over the past few weeks and have discovered a consensus about the role of compulsory treatment in this field. There is a bit of debate about the extent, but not about 12 months being far too long. We do not need any longer than a month. That is the most time that would be required to set up a process or to establish that the process will not work. If it is going to work, we need a very short period to undertake an assessment, to provide help during physiological withdrawal and to set up an engagement process for treatment. That can be done in seven days, and would certainly not require any longer than a month.

We could make outpatient assessment mandatory at a recognised drug and alcohol treatment service. That would have to be a medical assessment, because it would involve a medico-legal report for the court discussing the treatment options available and the outcomes. I am not sure that we need mandatory inpatient treatment. However, if it were appropriate, mandatory assessment and mandatory inpatient treatment would work. However, it would not work to engage someone if he or she did not want to be engaged. People have to want to do something about their problem. Legal and social problems in people's lives force them into treatment.

**CHAIR:** You and your colleagues have discussed this issue before and after the Alcohol Summit. There is consensus, but presumably there is also a wide range of views about the degree of compulsion.

**Dr FERGUSON:** There is a developing consensus about the role of compulsory treatment.

**CHAIR:** What is the best setting for inpatient or outpatient treatment? Should it be done in the mental health system, local centres or mainstream multipurpose centres?

**Dr FERGUSON:** I suspect that we need all levels of involvement. Mandatory outpatient assessment should happen at a local drug and alcohol service so that a local facility is involved in the care. Sending someone from Deniliquin to Sydney for treatment would be a waste of time because it would not be effective when they returned home. When someone needs medical withdrawal management that should happen at a drug and alcohol service. If it is done in either a general hospital or a psychiatric facility, a drug and alcohol service should do it. Someone staying for slightly longer needs a facility that is used to long-term patients. That may or may not be a government service; it may be an appropriately organised non-government drug and alcohol service or rehabilitation unit. That is usually a residential service. The options need to be fairly wide; treatment does not necessarily need to be supplied by one service. It should not be provided in an acute mental health bed; these people need a drug and alcohol treatment program bed.

**CHAIR:** How do you make the decision and who makes the decision about who receives involuntary treatment? You said that patients go back to the court following assessment or treatment. The key question is who decides and the criteria applied to people subjected to involuntary treatment.

**Dr FERGUSON:** Many people develop cognitive impairment due to alcohol abuse. Often their judgment is poor and they behave in such a way that they get into trouble with the police or socially; that is, they are homeless or vagrant. They would probably require long-term treatment. I think a lot of the social pressure to have people treated will still come from families who are very distressed about their relatives. I think there will continue to be that pressure. And it is not

unreasonable to have some response at the community and health level to that degree of concern. I think where there is a degree of concern from relatives, that should be taken seriously.

**CHAIR:** So might we have a revamped Inebriates Act or move everything off into the Mental Health Act? I guess you are not the people who would necessarily answer a question on the exact legislative framework, but we are trying to get your views on balancing people's rights. Dr Ferguson stressed the rights of the family and the degree of harm that people cause themselves or their community.

**Dr STORM:** Our feeling is that it probably should not be under the Mental Health Act, although it may be of a very similar model to that of the Mental Health Act. Therefore, there need to be the appropriate checks and balances. The current Act, which is nearly 100 years old, was set up in a way that was consistent with the manner in which business was done at that time. I think now we would expect some appropriate mechanisms for review so that independent opinion can be brought to bear on decisions that are made. Admittedly it is under extreme pressure that a family would go to that extent, because I do not think any family takes the decision lightly. It is usually the family that drives applications under the Act. But, having said that, I think someone external needs to be involved in the process of reviewing whether the decision made stands up to scrutiny.

**CHAIR:** Yesterday Judge Price said that he basically saw the role of the justice system as being one of review, like there is under the Mental Health Act—not an initiating role but a reviewing role.

**Dr STORM:** Or whether you have a tribunal, as under the Mental Health Act, which is a body of a less adversarial nature and allows for a reasonable decision process so that people can be heard and evidence can be considered appropriately.

**Dr TUCKER:** Section 33 of the Mental Health (Criminal Procedure) Act enables magistrates to refer people for mental health assessment. There may be a role for that sort of process regarding inebriates. What is often frustrating for people working in our positions is that a patient's stay is prescribed by a magistrate, whether or not we think it is appropriate.

**The Hon. CATHERINE CUSACK:** So there needs to be assessment before that step?

**Dr TUCKER:** Exactly.

**CHAIR:** I have two final questions. I think we have all been struck by the very small number of people being dealt with under the Inebriates Act. I do not think we have any sense of how many should be dealt under either that Act or under legislation of that kind. Given the definitional problems that exist, what level of need is there? How many people need the fairly draconian system that the Inebriates Act provides? Do we have any idea of the number?

**Dr STORM:** I think we could be staring into a black hole here. In our discussions prior to coming to meet with you we did express some agitation and concern that if a new Act was established there was the potential that for people who were just drunk and disorderly this would become a new default option to solve this common social problem. I am not telling anyone here anything particularly surprising when I say that we know there is a huge problem with alcohol abuse and quite a significant problem with alcohol dependency in our community. As you say, the number of individuals who end up in our services for compulsory treatment is quite small. But then, of course, quite a large number of people who are being treated in our services voluntarily attend for those services. That gives a sense of the scope of the problem that exists in the community.

**CHAIR:** Presumably you are saying that a large number of people are not getting the kind of service they need. The next question is: How do you deliver that service?

**Dr STORM:** Frequently, because they have no desire for the service.

**The Hon. CATHERINE CUSACK:** We have heard from the police about people who tried to get service and could not, and then used the Inebriates Act as a way of getting themselves ordered

into treatment—specifically they self-referred because they could not get access to a service. Does that surprise you?

**Dr TUCKER:** It surprises me. I am not aware of that. As you say, the numbers of inebriates are very small anyway, let alone the number who would fit into that category.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Certainly, in the mental health inquiry, we heard that a lot of people could not get mental health services that they needed. Surely this is merely a subset of those. If more mental health services were available, presumably from that increased number of models and services, options based on Dr Ferguson's model would be able to be worked out for people who were seeking treatment or needed support.

**The Hon. CATHERINE CUSACK:** Are you satisfied that the health system is meeting the demand for services for people with alcohol dependency?

**Dr FERGUSON:** I think a considerable number of people with alcohol dependency problems are not getting treatment that might be helpful. Sometimes that is because they do not want to have treatment, and sometimes people have a significant range of problems apart from dependency itself, such as homelessness and the sorts of physical health problems that derive from that situation. So there is a need for not just isolated drug and alcohol services but services across many fields, often involving the Department of Housing, the Department of Community Services and so on. An integrated whole-of-government approach is often needed for a particular subset.

Another group that is not well serviced—although there are good programs in place, and they need to be improved—are the people, mentioned earlier, with both substance abuse and mental illness problems. That group requires ongoing input into the services, and there is quite creative service development for them. So there are some specific subgroups that require focus.

**The Hon. CATHERINE CUSACK:** To help meet that demand?

**Dr FERGUSON:** Yes.

**Dr TUCKER:** You are talking about whether people with drug and alcohol problems are having their demands met, and not anyone else?

**The Hon. CATHERINE CUSACK:** Yes.

**Dr TUCKER:** If we do try to integrate treatment programs for mental health and drug and alcohol problems, then we would have to take them together I suppose. It is well known that about 50 per cent of people with serious mental illness will have drug and alcohol disorders, and that an almost equal percentage of people with primary drug and alcohol disorders will have mental health problems, such as anxiety and depression. Earlier I was saying that some of the people in our mental health rehabilitation service who are being detained under the Mental Health Act for quite lengthy periods as continuous treatment patients have major problems related to substance abuse. If given complete freedom, they will repeatedly abuse substances, and they will relapse. At the end of the day, the big problem is that their lives fall apart. Now, whether somebody has schizophrenia or not, if they relapse into very heavy substance abuse and drinking, their lives will fall apart. So, to that extent, I see the problems of inebriates and people with chronic mental health problems as being very similar and perhaps requiring similar sorts of approaches. I think there is quite a lot of room for integration.

**The Hon. ROBYN PARKER:** This inquiry is specifically into the Inebriates Act but more broadly into drug and alcohol treatment programs. The three of you are from the metropolitan area. Other people that we have spoken with, and will speak with, raise concerns about those outside the metropolitan area. They raise access issues, and taking people away from their communities. You spoke about someone from Wagga Wagga. In the general context of the treatment programs that we have for drug and alcohol abusers in New South Wales, what could we be doing better across the board?

**Dr FERGUSON:** In rural areas?

**The Hon. ROBYN PARKER:** The inadequacies of the Act include that people are referred, as I understand it, to a specific number of institutions and that those institutions do not necessarily meet the needs of people in rural and regional communities. You have spoken about community-based treatment. Do you have a model that you think would work well, and do you have an answer to trying to cover the broader New South Wales community on some of these issues?

**Dr FERGUSON:** There are drug and alcohol counselling services in most area health services. There are staff shortages in most rural areas in those positions, and sometimes the mental health worker is the drug and alcohol worker. I have met with a few of those over the years, and they have usually said they do not really have the capacity to meet the need that exists in their communities. Under the mandatory assessment and containment provisions of the Inebriates Act, placement in local institutions would be really difficult. Perhaps outpatient assessment might be able to be obtained, but even that would require some resourcing, I suspect, particularly if it requires a medical report. Mandatory inpatient treatment would still require, I suspect, movement to localities like Bloomfield and hospitals in certain areas, but they service vast areas and people are a long way from their communities. I think it is a very difficult issue. Rural servicing was one area that the Alcohol Summit identified as an area of concern.

**The Hon. ROBYN PARKER:** You would say we are not doing well in dealing with drug and alcohol issues across New South Wales?

**Dr FERGUSON:** Across rural New South Wales we are not, no.

**The Hon. CATHERINE CUSACK:** The Act says that there will be a supervising board. I take it there is not such a board.

**Dr FERGUSON:** I inquired about that. I understand it has never been established.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Not since 1912?

**Dr FERGUSON:** Correct.

**The Hon. CATHERINE CUSACK:** It says the board would have the power to direct the removal of people and their transfer from one institution to another. Alternatively, the Minister has the power to direct the transfer. Has it ever occurred that someone who has presented to one of your hospitals and been assessed has been recommended for transfer to a more appropriate facility?

**Dr FERGUSON:** Not via a mechanism like that. I have made several representations to courts asking that orders be changed and that people be referred to a drug and alcohol rehabilitation service that might appropriately fulfil their requirements.

**The Hon. CATHERINE CUSACK:** Was that to a residential facility?

**Dr FERGUSON:** Yes, it has been.

**The Hon. CATHERINE CUSACK:** It seems to me that some provisions in the Act could make your life a little easier, but that they have just never been used.

**Dr FERGUSON:** They are certainly not used now.

**Dr TUCKER:** The provisions relating to sending people back to the magistrate for variations of orders are used as we have described. But they are not very easy to use. It is a quite cumbersome process for us to use. That, again, is part of the problem.

**The Hon. CATHERINE CUSACK:** This has a mechanism by which you could ask the Minister to exercise his or her power to transfer someone from your hospital to another health facility—another "institution", I think is the term used.

**Dr TUCKER:** I have never asked the Minister to do that.

**The Hon. CATHERINE CUSACK:** I am thinking that he might be more compliant than a magistrate.

**Dr FERGUSON:** I suspect it would still be a fairly cumbersome system. How do you get a Minister's attention for something like this?

**The Hon. ROBYN PARKER:** Just expanding a little on your ideas on community-based treatment and how we can deal with these issues more broadly, obviously the ways of treating people with substance and alcohol dependency have advanced since the Act was implemented. I wonder what treatment models you would suggest to get away from the current regime, which requires compulsory rehabilitation in a centre.

**Dr FERGUSON:** There is good evidence in the literature that various psychological approaches and some medical approaches make a significant difference. Motivational interviewing is a technique that has been widely taken up within drug and alcohol services and has repeatedly been shown to make a difference to people's outcome in that they are much more likely to engage in treatment and to reduce and stop their intake.

Brief interventions have been developed for alcohol and for many other substances and these have been shown to be quite effective. There are relapse prevention programs, which could be run as an outpatient or inpatient service. Some things have been clearly shown to not work and they have been documented. There is quite a good body of literature to show what works and what is useful. There are also some anti-craving medications for alcohol dependence, which, although they do not work by themselves, they work if someone engages in a therapy and they do make a significant difference to outcome.

**The Hon. ROBYN PARKER:** So you think that pharmacotherapy is an answer to retaining people in their communities?

**Dr FERGUSON:** They work in conjunction with an ongoing therapeutic relationship with a counsellor. That is how they have been licensed and that is how they work. They are in addition to a good counselling relationship, so they help.

**Dr STORM:** They are adjuncts.

**The Hon. ROBYN PARKER:** After this process, if we were to design new legislation and a new framework, which is very much the direction recommended by witnesses and submissions, how do you see that developing? Should we be looking at a framework that only deals with alcohol dependency as opposed to drug dependency separately or should it be a combined framework? How do you see that working well, from your point of view?

**Dr FERGUSON:** The inclusion of people who have other drug dependencies into mandatory treatment was put into the Act quite a long time ago. There is no reason to think that the dependency issues are any different. Most people engage voluntarily in treatment and that is when most people change—when they want to be engaged in the treatment process. This is obviously for people who are not prepared to engage at the moment and it is really about assessing and trying to engage them in that process of change. If that is not going to work at the moment, there should also be a mechanism where they come back later when they are ready to consider working with somebody about their behaviour.

**Dr STORM:** It is important to add that to do it by substance is probably not particularly helpful. The experience is that most people, even if they start off with one agent, they will often use or abuse another agent if that agent is not available. It needs to be broad-based rather than agent-based legislation.

**Dr TUCKER:** We are looking at legislation to deal with this matter. Of course, there are vast amounts of treatment that can be delivered without the need for any legislation and we need to keep that in mind. We are talking about what is, at the moment, an extraordinarily small number of referrals and the fact that there must be a much better way of dealing with those cases. There seem to be two main reasons why one might use coercion, having distilled our discussions. One is to bring someone into assessment and treatment who may lack insight but who may very rapidly develop some insight

and engagement with a service. The length of time for which they need to be coercively managed would be very brief, hopefully. It might need to be repeated later but treatment can be initiated. That is one group. There is, unfortunately, a small group who would be fairly intractable and we need to think about what we will do with those people. We may need to think about whether longer-term coercive management of that group is needed. So there are two main groups that I can think of. The numbers of the latter certainly would be extremely small and even of the former, probably not that large.

**The Hon. ROBYN PARKER:** Do you think we should be catering to that group?

**Dr TUCKER:** The latter?

**The Hon. ROBYN PARKER:** Yes.

**Dr TUCKER:** My feeling is that there is a duty of care.

**Dr FERGUSON:** I feel that the duty of care cuts in when people's cognitive impairment is such that they can no longer make judgments about their own behaviour. That, actually, is a fair way down the track in terms of alcohol-related brain damage, I suspect, in my opinion.

**The Hon. CATHERINE CUSACK:** Would that constitute the people who have been referred to you? Would that be generally true of people referred to you?

**Dr FERGUSON:** No.

**The Hon. ROBYN PARKER:** In an ideal world what are you hoping that this inquiry will ultimately achieve?

**Dr FERGUSON:** I think there is a role for compulsory assessment and short-term treatment. Withdrawal management and engagement in treatment or the attempt to engage in treatment services constitute a duty of care. I think that the rights of people who come in under the service need to be protected; that it needs to be reviewed and as a service we need to follow this group and see whether it is going to be effective. We need to expand the service if it does work and to provide appropriate locations where the service is provided by qualified, well-trained staff, so that we do it well when we choose to do it. If it does not work, that we come back and look at it in some specified time period and we know what the outcomes are.

I think there is a need for a service. That is a consensus across all psychiatrists and other addiction specialists that I have talked to. I think if we going to do it, we need to do it well, protecting the interests of staff, clients and the community. And in a short period of time, like 10 years, come back and say, "Well, it worked for this group" or "It didn't work here. We need to change this", as a community not as a small site—but overall.

**Dr STORM:** I support all the things that Dr Ferguson has just said. One issue that has come through in the discussion this afternoon is that many of our service elements are somewhat fragmented and really what needs to develop is a more integrated service framework. I do not think we can say that it is Corrections' responsibility or the responsibility of mental health. Some new partnerships need to be forged that better serve this community. I suppose the reason we are having this inquiry is because there is a group of people in our society that we have not been assisting all that well and we need to try to determine how we can best use the resources that we have available to assess those people in a better way. Clearly, just trying to shovel it into one area of responsibility has not worked. There needs to be a systemic development of using all the elements of the service, which can play a collaborative role together rather than a warring role.

**The Hon. CATHERINE CUSACK:** It does seem to me to be hard for legislation to achieve that. It requires the Health Department to come to grips with that issue, would you agree, because the services that need to integrate are all internally managed by the Health Department?

**Dr STORM:** It is not just about health. There are other elements that we need to take on board such as housing and other support services. If you fix up someone who is chronically homeless—for example, with mental health services the Department of Housing has been very

supportive in helping provide accommodation services as a component for people who are recovering from mental illness. If you are homeless it often prevents recovery in quite a significant way, even when all the other medical treatments are in place. I think the same would be true of people with alcohol and other drug dependence problems. There is not much future if you have nowhere to live, even if you deal with all your addiction problems. There are other elements that are part of the social infrastructure that are required to assist people who have had a pretty disastrous period in their life and we need to integrate all those in the recovery.

**The Hon. ROBYN PARKER:** Is it being done well elsewhere that you are aware of? It would be great to pick up a model from somewhere and say that we should do that because it has been proved to work.

**Dr STORM:** We are not aware that somewhere has done it so well that you would be jumping from the roof tops to say that they have solved the problem. We are dealing with a fundamental problem of human behaviour: There are these substances out there that our brains get addicted to—and I do not shy away from that term—and it results in a whole lot of psychosocial consequences and legal consequences. We probably need to trawl what we can from other people's experiences and beg, borrow and steal. It may be that we will develop the best system possible over the next decade.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** The evidence in a number of our inquiries, where people end up in gaol with social problems, mental health and disability, have suggested that what is really needed in society is a graded support system in the community rather than an institutionally based system. Do you think many of these problems would be solved if, as a by-product, we had a better graded support system?

**Dr STORM:** Yes. One of the core problems that most of our services face is that we have very intensive high tech—and hospitals are high tech—intervention and the next level down and the full spectrum for whatever services we offer are not there. Islands are quite useful services, but the full spectrum does not exist to enable them to function as best they might.

**The Hon. CATHERINE CUSACK:** I wanted to ask about adolescents. Are you aware of any services that specifically assist young people?

**Dr STORM:** I am aware, although I do not have the details, of a couple of programs that exist for young people. There is one run by the Wayside Chapel in the eastern suburbs and there is also a service out at West Parramatta—I cannot remember the exact suburb—but that is a problem where we probably need a fair amount of investment. As a child adolescent psychiatrist, whenever I see people from the juvenile justice arena, they often come to me basically having committed an offence while intoxicated and that is why they have got caught—they were intoxicated and were silly enough to stay where they were and got caught. It is a big problem.

**Dr TUCKER:** Of course, if we look at the mental health services for young people and the early intervention services, a very large proportion of those are abusing substances such that it becomes very difficult to work out sometimes what is the primary problem, whether it is substance abuse or a mental illness—at least early on in the piece.

**The Hon. ROBYN PARKER:** Dr Tucker, we heard from Dr Ferguson and Dr Storm about what they want out of this inquiry. Do you have anything specifically you would like to add to that?

**Dr TUCKER:** I concur with what has been said. First of all, we feel that the current legislation is not satisfactory and not effective, but that there is some role probably for some sort of coercive treatment, which will, of course, require legislation and a system to support it. I agree that something along the lines of the system that is used for the current Mental Health Act seems to work reasonably well and could be used to deal with inebriates. Again, my feeling is that the distinction between mental health problems and drug and alcohol problems is more than it should be; it is perhaps, in fact, not as true a distinction as is made out to be and I would like to see a rapprochement of those two areas in terms of treatment programs.



**The Hon. CATHERINE CUSACK:** Why do some people seem to have addictive personalities? Two children in different families with similar circumstances, one child is able to cope while the other's life falls apart. Is that a mental health issue or a behavioural problem?

**Dr FERGUSON:** Dependence on substances seems to arise from a multifactorial input. There are some genetic components. Children of parents who are dependent on substances are more likely to use substances, not often the same substance. There are some situations or components from childhood that seem to be consistent. If you have a disorganised childhood with parents not providing appropriate structure and care, you are more likely to run into situations where you are involved in risk-taking activities as a youngster and therefore become exposed to substances and take more risks. There are also some personality traits perhaps. There is not an addictive personality as such. There are people who are perhaps more impulsive and people who are perhaps more anxious and they may be more likely to use substances. None of these things contribute 100 per cent. They are more gradual.

**Dr STORM:** There is ample evidence that the earlier you start using whatever substances you do, the more likely it is to impact on your development in some way. Some people might have a lot of vulnerabilities but they do not expose themselves to marijuana or amphetamines at a young age, say, 12, 13 or 14. That gives them a chance to develop a range of other skills and attitudes. They might be exposed at 21 or 22 but they are more mature and do not go down that track. Maturity is also an issue, apart from the other vulnerabilities that people might have.

**Dr FERGUSON:** There is also true physiological dependence. Your body comes to depend on the substance. The cells demand that you place that level in your blood. There is a physical addiction that is a strong component as to why people keep using it.

**The Hon. CATHERINE CUSACK:** Is that with alcohol?

**Dr FERGUSON:** Alcohol and other substances.

**The Hon. ROBYN PARKER:** Thank you for coming. We appreciate your time and your submissions. Would you be available to answer further questions in the future, if required?

**Dr TUCKER:** Yes, certainly.

**(The witnesses withdrew)**

**LARRY JOHN PIERCE**, Executive Director, Network of Alcohol and Drugs Agencies, 295 Cleveland Street, Surry Hills, affirmed and examined:

**ACTING CHAIR (The Hon. Robyn Parker):** In what official capacity are you appearing before the Committee?

**Mr PIERCE:** As a representative of the Network of Alcohol and Drugs Agencies.

**ACTING CHAIR:** Do want to make an opening statement?

**Mr PIERCE:** I do not think so. If I made an opening statement I would repeat myself when I answered questions. We have provided a submission to the inquiry and I will refer to that.

**ACTING CHAIR:** Thank you, it is a comprehensive submission and we appreciate the attention you have paid to it. Would you explain the role of the Network of Alcohol and Drugs Agencies and give an overview of alcohol and drug treatment in New South Wales?

**Mr PIERCE:** The Network of Alcohol and Drug Agencies—or NADA for short—is the peak organisation representing the non-government service throughout New South Wales that provides alcohol and drug treatment, education and prevention services. We have been around for about 25 years. We are funded under the New South Wales Health's non-government organisation [NGO] grants program and we are funded centrally from the Health Department itself as a peak organisation. They fund a number of other peaks in the non-government sector. We have that role. We have about 102 member agencies ranging from the Salvation Army right down through to very small two- and three-person counselling and support services in the suburbs and all sorts of agencies in between.

In terms of membership we represent all of the 52-odd direct NGO treatment services funded by the New South Wales Health NGO grant program and managed through the Drug Programs Bureau. Those include all of the major residential rehabilitation services, some detoxification services, counselling and community development services, as well as assessment and referral type services. The rest of the other half of the membership come from various funding sources, including the Department of Community Services, the Department of Ageing, Disability and Home Care, Commonwealth funding, Corrections funding, and a lot of self-funding.

We have a specific set of criteria in relation to membership to the network. They have to be a non-government organisation properly incorporated. They have to have alcohol and drug service delivery as a principal purpose of their service delivery. Their service delivery must have some evidence base and be supported by literature. Their staff must have appropriate qualifications and their board of directors or management committee similarly must be appropriate persons. They must be able to demonstrate that they comply with the relevant occupational health and safety legislation, local government legislation and State regulatory requirements for the non-government sector, as outlined under the Department of Fair Trading guidelines. They have to have bona fides.

**Mr PIERCE:** What we do as an organisation at NADA, as a secretariat we have four staff, we have two specialist workers who run programs for our membership in relation to information technology and information management, including compulsory or mandated sort of reporting like minimum dataset reporting—which I must say has improved since the 1999 Drug Summit—as well as information management in terms of their own treatment population statistics and data. We also have a workforce development program and we focus on management, managers and organisational development issues for the non-government sector. The reason we do that is because the sectors faced, in the last decade, a huge amount of changes in relation to professionalism, accountability, performance reporting, the tax system, accreditation, quality improvement and all those sorts of things. The other core functions that we have relate to advocacy and we are involved with the support for planning, providing advice both to government and to the membership, and instead of talking to 100-odd services health likes to talk to us. So we have that sort of central pit of files. That is essentially what we are.

**ACTING CHAIR:** Since this Act was introduced obviously things have moved on in terms of our treatment of drug and alcohol related issues. This Act looks at one way of treating severe inebriates. With your overall peak body organisation I wonder whether you have a view on it? I gathered from your submission you had a view that we should be treating inebriates as a social issue rather than as a justice issue. Could you expand a little bit on that please?

**Mr PIERCE:** You mentioned this, and we go to it to some extent in our submission, that the world is quite different in terms of the alcohol and drug services system. In terms of health service system delivery in general we were much better in the latter part of the 20th century and certainly in the first decade of this century we have a very sophisticated, professional response to alcohol and drug problems in a general sense more so than we did even in the 1960s and 1970s. Certainly the Hon. Dr Arthur Chesterfield-Evans would understand that the public health approach, if you like, has been developing since the 1970s in a very specific professional systems oriented way, looking at the integration of public policy, the legal system, the health system, and so forth. Obviously that was not the case when this legislation was developed in a just post-Victorian world.

As a general tenet of policy, if you like, government sees drug and alcohol addiction as a health and social problem. That was reinforced very clearly in the 1999 Drug Summit and reaffirmed in this year's 2003 Alcohol Summit. Certainly from the 1999 Drug Summit addiction or drug dependency, including alcohol dependence, was seen as a chronic recurring condition and, as a matter of policy, is addressed that way in a whole of government response. So the principal response, if you like, in terms of dealing with people who are affected tends to be a health and social approach. What we have become quite good at, and I think getting better at since 1999, and since the shift in both national and State drug policy to look at the diversion of people away from the criminal justice system and into the health system, is a formalised expression of something that has been informally happening for a long time anyway.

Drug and alcohol as a sector, whether it is non-government or government, has a long history of working with probation and parole, magistrates and the police on offenders' drug issues and treatment in a general sense and how those episodes and engagements with treatment and treatment providers might go to mitigate or alleviate or in some way reduce the impact that the criminal justice system has on their offending behaviour in relation to how the magistrates might view the sentencing options if they have been involved in treatment as well. That stuff has been happening for ever really. It was clearly happening when I first started in this field back in the mid-1980s. Diversion is a formal shift in government policy in the past five years to doing something about that interface between policing the criminal justice system and drug treatment. We are getting quite good at working that system. I was going to make some specific statements about compulsory treatment in one of the questions that you have asked but I think I will leave that until then.

**ACTING CHAIR:** When you talk about the philosophical approach to drug and alcohol problems, and you have talked in a general philosophical way, should we, as a society, be taking a role in protecting people from themselves? I guess we are talking about the civil liberty approach as opposed to the moral obligation where some people feel a duty of care to take people away from a situation where they are harming themselves.

**Mr PIERCE:** Can I just clarify, we are referring to people who have not committed an offence?

**ACTING CHAIR:** Yes.

**Mr PIERCE:** So quite differently from diversion programs. Just to note, there is a fair degree of agency and decision by the clients in diversion programs. They get read their rights and told what the program is going to be about; they get assessed by a team, including court people and health people; and then they go before a magistrate and decision is made. There is as much agency by the offender as there is by the magistrate in relation to what actually will happen to that person: will they go to the treatment service recommended or will they—

**ACTING CHAIR:** Is that the MERIT Program?

**Mr PIERCE:** Yes.

**ACTING CHAIR:** That is a specific treatment program for offenders and more likely to be for substance abuse?

**Mr PIERCE:** I am just raising the point that there is some agency going on, even in mandated clients. What we are talking about here is people who have not committed an offence, who are drinking themselves into a dangerous, disturbing state that is worrying family and probably threatening their lives, drinking themselves to death, as it were, and they are not making choices other than that. We are talking about us as the drug treatment system and the criminal justice system making a decision that says, "We are going to save you from yourself".

**ACTING CHAIR:** So do you agree with that approach?

**Mr PIERCE:** No, yet I have said in our submission that we would support appropriate changes to the Intoxicated Persons Act that would at least see the establishment of an intoxicated persons type service that does give a power under that Act for police—who already have the power to stick them in a gaol cell—to stick them in this service. We have a whole lot of issues and a whole lot of caveats around that so I am kind of saying two things at the same time: principally, no, but then yes in relation to the Intoxicated Persons Act.

**The Hon. IAN WEST:** Can I clarify, are we not also talking about people who have not yet been convicted?

**Mr PIERCE:** Can you clarify that?

**The Hon. IAN WEST:** Those who may have committed an offence but have not been found guilty?

**Mr PIERCE:** Possibly.

**The Hon. CATHERINE CUSACK:** Can I give an example: someone who has been picked up for drink driving three times and then clearly they are going to be let go; someone is going to die because they are very addicted to alcohol. Is any intervention appropriate in that situation?

**Mr PIERCE:** I would imagine if it is a third offence before the courts the magistrate has an option to impose a custodial sentence and perhaps with some conditions that, say, the corrections health service should assess this person for treatment. I do not see any problems with that.

**The Hon. CATHERINE CUSACK:** That is taking the problem back into the criminal justice system again, is it not?

**Mr PIERCE:** Although there is an offence that has occurred. It is a crime to drink and drive.

**ACTING CHAIR:** So what do you see are the specific problems associated with the Inebriates Act?

**Mr PIERCE:** I have summarised them very briefly in my report. Basically, a good historical examination of it shows that it is often of little benefit to the community, and in particular those who are chronically alcohol or substance addicted. Most of the provisions of the Act are rarely used, which is one of the big problems with it, that the provisions for putting somebody into a specific purpose-built place and to have some sort of set of interventions and also have the benefit of the support scrutiny of the situation by an official visitor, were never implemented. They are the sorts of things we recommended in relation to the review of the Intoxicated Persons Act, that those sorts of things were a big problem with the Act.

Basically, sticking people in psychiatric institutions has never worked and there have been a number of studies, as we pointed out, over the past 100 years, and a number of reviews where very senior New South Wales medical people said as much. Psychiatric hospitals do not provide the appropriate kind of drug and alcohol assessment and treatment intervention and they are also ill-equipped for that sort of work. The Act has been used in a discriminatory manner so who has it

impacted on? It has impacted on men, largely, the Aboriginal and homeless sort of population; it infringes civil rights in the way it has been enacted, without providing appropriate checks and balances; the official visitor's program does not relate to the Inebriates Act itself and we do not think it can be amended in a way which would allow it to be consistent with current legislation or practice, that is, the sort of interaction between the judicial criminal system and the drug and alcohol and health services system and the interaction between both mental health and drug and alcohol.

The other problem with the Act is also the definition of "intoxication", and that is also an issue with the Intoxicated Persons Act. Clearly outlined in the Alcohol Summit were the broad, vague definitions in both Acts. I think in the Intoxicated Persons Act "intoxication" is identified as a person who appears to be seriously affected by alcohol or another drug, or a combination of drugs. It is very vague and it is hard to understand what that means. Under the old Inebriates Act an inebriate was someone who was habitually using intoxicating liquor or intoxicating or narcotic drugs to excess. Both of those definitions try to operationalise how you identify an intoxicated person who is at the level of need or in such a condition to consider some sort of intervention, such as police intervention. That is too vague. The Alcohol Summit made specific recommendations about that, to which I refer in my paper. I guess they are the main problems with the Inebriates Act.

**ACTING CHAIR:** Do you believe there is any role for compulsory treatment of people with severe drug and alcohol dependency?

**Mr PIERCE:** To be clear, we are saying in this paper that we do not think the intervention that might be appropriately required under a review of the Intoxicated Persons Act is treatment. We see it as harm reduction or a harm management type approach. Clearly, if somebody needs to be saved from asphyxiation as a result of acute alcoholic poisoning, yes, you need to intervene. But that is harm reduction or harm management. If a person needs to be held for 24 or 48 hours under some amended Intoxicated Persons Act it should be for the purposes of assessing and managing the harm and then making some decision about whether that person is treated and moved into a treatment services system or whether he or she moves into some sort of medical or social arrangements that may be determined after assessment.

If it is about saving lives and if the Intoxicated Persons Act is to be used in such a way, and defined appropriately, that the condition and the level of intoxication of the person in question is deemed to be such that if an intervention is not made that person may die, the intervention is about harm management or reduction. I do not think it is about treatment at that stage. I think treatment comes after that when there is some cognitive relationship between that person and the treatment system or the treatment episode that they get introduced to.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Is your position compulsory detox but, once they are detoxed, no compulsory treatment?

**Mr PIERCE:** It is not as simple as that. I am saying that it is not compulsory detox, it is compulsory assessment and intervention, which will probably include a requirement for detoxification.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** If a person is in danger of asphyxiation from alcoholic poisoning, you cannot conduct a rational assessment until that person has detoxed. Once they have detoxed they will presumably be rational—arguably, at least. Are you saying that at that point compulsory treatment probably does not work? You did not say that immediately preceding my question but you said it in your earlier evidence.

**Mr PIERCE:** Yes, I think I agree with that. Basically, I am saying that the compulsory treatment order ought to be conceptualised more as a harm management or harm reduction intervention. As to compulsory detox assessment, a wealth of physical and medical issues may need to be assessed so you can say, "This person is now stable." Some cognitive interaction between that person and what happens next should occur in order to protect their civil liberties.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** If they then say, "Look, mate, I'm not going to stop drinking and I don't want to talk to you", you do not reply, "You have to sit here for six

months or so in this hospital and get fed. Presumably whatever else we do to you will make you better. We'll see who lasts the longest"—if they are sticking with a non-treatment model at that point.

**Mr PIERCE:** Yes, I agree. I do not think that sort of compulsory treatment model would have the desired effect. In fact, history shows that interventions such as that have an almost 100 per cent relapse rate. Even after six weeks, six months or whatever, a person will go back to drinking because they have not engaged with their treatment—they did not want to change. We would not advocate that. However, that is not to say that mandated treatment does not have an effect. But there must be some cognitive interaction and some agency with which to engage at some level on behalf of the client. That approach works quite well with the Drug Court and the MERIT Program. Those people have made a choice—on balance, it might be a coerced choice but it is a choice. We are talking about a situation where we say, "You have no choice: like it or lump it". The drinker might be forced to dry out in detox but they may not want to stop being a drinker. We have seen the evidence: when inebriates orders have been enacted there is invariably an almost 100 per cent relapse rate.

**ACTING CHAIR:** My question relates to the issue we are discussing and also jumps to question No. 8. In talking about harm management, we recognise that family members, for example, might seek an order under the Inebriates Act to gain respite for themselves. Do you think there is a harm management role for respite and assisting family and community members in dealing with the problem?

**Mr PIERCE:** Yes. I have prepared a response to that question but I will make some brief points. I will relate to the experience of the woman who described at the Alcohol Summit how she had lost her husband to alcohol poisoning and overdose. It was a very moving and poignant story. Essentially, her point was that the Inebriates Act did not work because there were no facilities or arrangements and the system had let her and her husband down. If only some treatment service, a hospital or someone had taken her husband and made him stay there, he would not have drunk himself to death. If we look at that example dispassionately, we can see that the probability is that, even if he had been stuck in a hospital bed for one or two weeks and made to stay there in detox, he may not have changed his behaviour.

The pattern was such that the inevitability of his quest to drink himself to death would have been only put off. In the drug and alcohol field we see such cases fairly regularly. Despite numerous best efforts and in some cases hundreds of attempts—literally hundreds of different individual treatment episodes—people succeed in their quest for oblivion. I do not think anything—any system, any policy or any piece of legislation—will ever stop that happening. Having said that, there is a big need to support families. Anybody who knows the drug and alcohol field will know that the inclusion of families and family-oriented programs is a pretty recent arrival to drug and alcohol treatment. After the 1999 summit—it was reaffirmed at the Alcohol Summit—government made it a very clear statement of policy, saying, "Families are a target group; families are important to support.

Drug and alcohol services ought to be more family friendly, they ought to interact and engage with families and offer family support." More work must be done to reorient drug and alcohol services to be family friendly, and probably more dedicated resources are needed for specific family support interventions. For example, Tony Trimmingham's Family Drug Support service provides counselling and a range of other supports to families who are dealing with drug addiction, and in this case alcohol addiction. I think some of the Alcohol Summit's recommendations in that area should be examined closely, resourced, developed and put out there. Yes to your question about family services: It is a health system service response priority and it is just good drug and alcohol and public health policy to engage the affected groups in relation to the service system.

**The Hon. IAN WEST:** I may have missed this information in your submission but could you explain the different levels of assessment? If we are looking at introducing some form of mandatory or compulsory assessment, can you provide some definitions of the various levels of assessment?

**Mr PIERCE:** Certainly. When somebody has been placed by the police in an intoxicated persons service—since we are thinking in those terms, and that is certainly what we are recommending—the assessment should be very comprehensive. It should obviously be a medical and physical assessment as to the level of alcohol damage that the individual has sustained. There should certainly be a psychosocial assessment in relation to cognitive psychological orientation and the

person's social and welfare issues, including family. It should be a broad-ranging medical, psychosocial assessment, covering all major aspects. It should also look into things such as homelessness.

**The Hon. IAN WEST:** What are the time frames of these assessments?

**Mr PIERCE:** How long is a piece of string? If we are talking about an intoxicated persons service—which we advocate in our submission—we would be looking at a definite time frame of between 48 hours and five to seven days. It would be 48 hours for the acute assessment and then perhaps an entire health, medical and social assessment could take place over five or seven days.

**The Hon. CATHERINE CUSACK:** Returning to the issue of rights, during the Alcohol Summit some of us visited some towns in north-western New South Wales. In two towns in particular the Aboriginal community said, "Alcohol is out of control. We cannot cope as a community. We need help to deal with this." They were referring to huge drinking parties at home, domestic violence, widespread sexual abuse and abuse of children, children who could not sleep and were trying to go to school and a range of other problems triggered by alcohol abuse. The police said that conviction rates for domestic violence were incredibly low because the alleged offender would plead not guilty and by the time the case came up the witnesses would have withdrawn their statements and the case would fall in a hole. Turning to issue of compulsory treatment for non-offenders, the group that I have described are technically non-offenders but we have evidence of children living in disgraceful conditions. We must be mindful of the rights not just of the person who is drinking but of the victims created when we fail to assist that person.

**Mr PIERCE:** Yes, absolutely—the rights of the members of that person's household, the children and the spouse. But is the Inebriates Act the vehicle for doing that? What drives it? What fuels it?

**The Hon. CATHERINE CUSACK:** It is fuelled by cultural disempowerment but I cannot go out to Walgett and fix that problem.

**Mr PIERCE:** Exactly.

**The Hon. CATHERINE CUSACK:** We must acknowledge as a community that this behaviour will happen tonight. The communities to which I referred told us, "We need something done." You are clearly correct: the Inebriates Act is not working. Do you view compulsory treatment as an option in those circumstances?

**Mr PIERCE:** Do you mean using the existing Inebriates Act to collar a drunken male, who is wreaking havoc in a household?

**The Hon. CATHERINE CUSACK:** You mentioned earlier a modified version of the Intoxicated Persons Act, which would involve removing the person even though they have not committed an offence.

**Mr PIERCE:** That is correct.

**The Hon. CATHERINE CUSACK:** We have experimented with the Proclaimed Places Act. Are you familiar with the strengths and weaknesses there?

**Mr PIERCE:** Yes. Some of our member agencies—and we worked closely with them when we were doing the submission—identified the fact that prior to the amendment of the Proclaimed Places Act and a review of the Intoxicated Persons Act a number of years ago, the real problem was that although the staff at proclaimed places had the same houses as police to detain people, unlike police they were not trained to do that, and they were not resourced or quipped to do that. There were all sorts of occupational health and safety problems for those staff to do that, and in a general sense it made the mood, if you like, in the proclaimed places much darker and more dangerous, given that the aim of the proclaimed place is to provide safety and overnight accommodation for intoxicated people.

Since that shift away from the staff having the power to detain people, most of the proclaimed places are now turning to a focus on the client. We give them a bed and pyjamas, and we give them a bit of food before they leave, but what else can we do? Can we provide a level of assessment? Can we provide alternative activities? Can we look at moving these people towards a decision to engage in treatment? Can we have a look at the primary health care issues of these people? So they are moving to that sort of approach, which is much better.

**The Hon. CATHERINE CUSACK:** Do they have any clients? We have heard about the very low occupancy rates.

**Mr PIERCE:** The same people turned up night after night at the Albion Street lodge. There is a definite clientele. But there is some choice about them turning up and what they are doing there, and they want to work with them closely.

**The Hon. CATHERINE CUSACK:** In terms of removing a person who has been violent in the home but not going back to proclaimed places, what would you do?

**Mr PIERCE:** The current option is a lock-up. That is the only option that currently exists.

**The Hon. CATHERINE CUSACK:** But we are trying to develop a better option.

**Mr PIERCE:** We are. The problem with lock-ups is that police have to use staff resources to physically monitor somebody who is overly intoxicated in a cell. It takes them away from other duties, so it is a resource drag, and they are not trained or equipped to have a health role; they are police. That is why we are arguing that specific intoxicated persons facilities need to be established where there can be some assessment and intervention. In terms of the scenario you raised earlier, for a raging, violent, drunken male in a household, perhaps a cell is appropriate for 24 hours. But is that the intervention that is going to stop it happening the next night or the next week?

**The Hon. CATHERINE CUSACK:** You are saying that they need to volunteer for that kind of intervention, that we as a community should not compel them to try to get treatment?

**Mr PIERCE:** I was trying to outline the difference between treatment and the intervention you would use under an amended version of the Intoxicated Persons Act, which is a harm-prevention, harm-management intervention, including harm to others around that intoxicated person.

**ACTING CHAIR:** There is uniform agreement that the Inebriates Act needs to be repealed. I have not heard anyone, in either their submissions or their presentations to us, suggest that the Inebriates Act should be retained in its current form. There is a difference of opinion about how the Act should be repealed and the legislation that should be brought in. You have suggested that the Intoxicated Persons Act could be amended. Are you able to suggest how we could use that Act to address the needs of people with severe drug and alcohol problems? What problems do you see with both Acts, and how can we come up with a model that is going to work?

**Mr PIERCE:** I have outlined the problems with the Inebriates Act. I think the issue about having a look at the Intoxicated Persons Act is an opportunity for a more thoughtful and more expertly guarded set of discussions that lead to good policy and translate into good law amendment. In my paper I have not said, "With the Intoxicated Persons Act, you do this, this, this and that." I think we need to have a more thoughtful approach to that. I cannot answer some of the questions you have raised, because the answers are so difficult. I think we need to address that.

That is why we have recommended that health care professionals, law enforcement people, representatives from indigenous communities, people with expertise in the management of chronic addictions, and also people involved in legal and social rights issues, need to be brought together to really work through these questions. I do not think it is possible for an organisation like us to throw the answers out neatly and simply. When we talk about what ought to happen with intoxicated persons services, I think it needs to be done in a health or medical setting. It probably needs to be attached to a hospital; it needs to have appropriate staff and a mix of staff, and there needs to be procedures, protocols and agreements between police and the service, as well as the other services that that articulates to. That would be the key.



**The Hon. IAN WEST:** I am trying to visualise a practical example where police officers go to a house and decide that a particular person needs to be taken to hospital for assessment.

**Mr PIERCE:** Most likely, it would probably be a neighbour or relative or an immediate family member who will alert police to the direness of the situation of the intoxicated person.

**The Hon. IAN WEST:** The police get a phone call and go to a house.

**Mr PIERCE:** That is right, they respond. When we talked earlier about the definitions of intoxication, it rests on there being a lot more clarity in what we mean by that and how it is observed and assessed by police officers. That is a prerequisite to that, because there are a whole lot of reasons why somebody would ring the police and say, "Come and pick up so and so." There needs to be more clarity around the definition of intoxication, the level of it, and there needs to be more support training and skilling of police so that they are able to make a judgment based on an assessment that has some science or a logic behind it.

**The Hon. IAN WEST:** Assuming that police went to a house, they had a feeling that there was a possibility of violence, and they decided that the individual needed to be taken to a hospital. Let us assume that the hospital had facilities to enable some form of assessment, and the individual was taken to the hospital for assessment and kept there for a period, say, 24 or 48 hours. Then what would happen?

**ACTING CHAIR:** What if the person is violent when he gets to the hospital?

**Mr PIERCE:** In New South Wales there are very clear protocols and guidelines for health professionals to deal with patient violence. I think Minister Knowles, the former health Minister, after a number of fairly spectacular incidents in New South Wales hospitals, led a process to address the issue of the management of violent patients.

**ACTING CHAIR:** What safeguards do you see being put in place to protect the rights of consumers? You spoke about needing to consult legal and social rights professionals. Do you have any idea about the safeguards that need to be introduced?

**Mr PIERCE:** If this is in terms of reviewing the Intoxicated Persons Act, obviously the safeguards would be a clear relationship between the official visitors program and this legislation and the processes set up around it; that resources are identified and provided to assessed; that the official visitor or a guardian be appointed to act as the check and balance in relation to the civil liberty issue of how that person is being managed, and also be able to assess that person's access to an appropriate judicial review in relation to the order that is placed on them. That is clearly one of the things that need to happen. I think that is probably the major thing that was wrong with the Inebriates Act, but that was never put into place.

**ACTING CHAIR:** Various people have suggested that the Mental Health Act should be amended. Do you have a view on that?

**Mr PIERCE:** We did not go to the Mental Health Act in another submission, because being from the alcohol and drug field we felt that, in relation to the Mental Health Act, it was probably already strong enough to be invoked and used where the person clearly has a mental health issue or a diagnosis and they also have concurrent substance or alcohol abuse. We were thinking more about those who are not dually diagnosed or who do not have a psychiatric diagnosis, and that is why we did not go to the Mental Health Act. We were mainly looking at the non-psychiatric population.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** It is a very interesting answer, in the sense that yesterday the Chief Magistrate, Derek Price, in effect said that the mental health system will not acknowledge drug and alcohol dependence as a diagnosis, and thus will not make available facilities that they would have made available for mental health, and that this is unhelpful. You are also making a distinction between drug and alcohol and mental health?

**Mr PIERCE:** Yes.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** It seems that these two fields might have to achieve some sort of rapprochement, in that they overlap and the type of facilities needed are similar. What would you say to that?

**Mr PIERCE:** In relation to an intoxicated persons service, if you like, where somebody was going to be placed under an order, there would have to be very strong similarities in the way in which psychological and health and addiction problems were assessed and reviewed. But, while there is a lot of overlap between people who have psychological and psychiatric issues and concurrent substance abuse, they are not always the same.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** But they often need family support when they do not really want it, accommodation when they do not have it, and community support of a number of specialisations who have to work from a central point and talk to each other. So, in an administrative sense, rather than a diagnostic sense, they may be similar.

**Mr PIERCE:** Yes.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** From the point of view of someone designing a system, where the option is often the medical system or the legal system, both drug and alcohol and mental issues are very much in the medical system rather than the legal system?

**Mr PIERCE:** Yes.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Can the two of you get your houses in order, and get both issues in the medical system rather than the legal system or the prison system, because if you could it would be very helpful to the resolution of this issue?

**Mr PIERCE:** I could not agree more.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** But you did not answer from a mental health point of view; you drew the distinction in your non-submission, I think you said?

**Mr PIERCE:** That is correct. We have tended to focus on that when looking at how the Mental Health Act has been assessed in relation to the Inebriates Act and the many attempts to repeal it. It appears that the Mental Health Act is perfectly appropriate if it is dealing with a person who has a diagnosed psychiatric condition. That is why we chose to focus on the Intoxicated Persons Act in our response to the Inebriates Act. I agree that the drug and alcohol services and mental health services systems have a long way to go and need to move more quickly towards services alignment so that there can be a more seamless transition between services for clients with a concurrent mental health and drug and alcohol problems. While there is talk of it shifting, the demarcation is still very much in place.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** That has been our experience. You argued about the Inebriates Act, which is fine in terms of this inquiry. However, when you talked about Aborigines you referred to a more holistic approach. Inebriates as defined in the Act are only the tip of the iceberg of drug-dependent people. I am talking about the integration of mental health and drug and alcohol across the broad spectrum of those disciplines, not only the extremes; that is, those who do not have a medical problem but are suffering acute toxicity.

**ACTING CHAIR:** A number of participants have suggested the existence of broader problems in dealing with drug and alcohol abuse. Do you have a framework that you think might work well? If you do, can you outline it and how other services could be improved, such as police services, to fit into that framework?

**Mr PIERCE:** If you look at what has been happening in New South Wales since the 1999 Drug Summit you will see that a framework is very much in place. The overall policy deems that alcohol and drug problems are a whole-of-government issue that affects not only the police or the Attorney General's Department but also housing, social welfare, education, family services and so on. There is already a clear framework for the way forward. Clearly, the recommendations from the drug

and the alcohol summits demonstrate the way in which the Government sees the interaction and interplay between government departments, the community-based sector, the non-government sector, local government, corrections and police services and, in the case of alcohol, the producers and distributors.

The plan of action that emerged from the 1999 summit was a good blueprint for an integrated system. What has not happened and what needs to happen is the implementation of an integrated planning process between NSW Health, DOCS, DADAHC, juvenile justice, the police and the Attorney General's Department, just to name the major players. In many ways, particularly from a non-government point of view looking in, those agencies are still silos that have their turf, and within that there is turf within turf—for example, the alcohol and drug system and the mental health system. In reality, practice and organisational changes are not up with this very good government policy and framework. The framework is there and we know what the policy and plans should look like. The Government should be congratulated for tipping many extra resources into this field since 1999. That has been a considerable boost. However, we need more than that; we must get people to change the way they do business in NSW Health, DOCS, Attorney General's, police and corrections.

**The Hon. IAN WEST:** Well said.

**ACTING CHAIR:** Do you have any comments to make about the appropriateness of compulsory treatment of offenders with drug and alcohol problems and how the New South Wales Government acts in this arena?

**Mr PIERCE:** Diversion is an ongoing experiment. We are having some success in showing that that system can be set up and run well. MERIT and the Drug Court are good examples of the way everyone plays together well. In terms of the efficacy and success of treatment of mandated clients, there is very strong evidence to suggest that the treatment outcomes can be just as good as for voluntary treatment. The same factors kick in; that is, it depends on the quality and depth of the assessment and the appropriateness of the treatment regime or system provided, coupled with good case management and care following the major intensive treatment phase. If those things are provided, it probably does not make much difference whether a client has had a lot of compulsion from the Drug Court or MERIT or the other compulsions that drive people to treatment, such as not being able to get drugs, the threat of family break-up or gaol. There is all sorts of coercion behind the choices people make to go into treatment.

**ACTING CHAIR:** Do you see a way forward by expanding MERIT and the Drug Court concept to include alcohol offenders?

**Mr PIERCE:** Absolutely. In my service delivery days a number of years at Manly we ran compulsory education and intervention sessions for drink drivers on their last strike. It was surprising the lack of any involvement with health or drug treatment programs and even the lack of information they had about the cumulative damage their drinking could cause. I do not know whether they re-offended because I have not been involved in direct service delivery since. However, it surprised me that the average alcohol-dependent person was not as savvy about the health issues as illicit-drug or heroin users in Sydney. Illicit drug users tend to seek treatment at various crisis junctures, and they tend to know better how to do it. They tend to be better informed about the treatment services system. We should redouble our efforts in focusing on alcohol treatment, particularly early identification and intervention, and providing good education and family support. General practitioners have stacks of involvement in this area, but we need more coordination in terms of early intervention. We should make a greater effort to divert alcohol offenders to treatment programs.

**ACTING CHAIR:** Are you saying that there is no recognition that alcohol is such a problem in society generally?

**Mr PIERCE:** We think the Alcohol Summit was great for positioning alcohol at centre stage, which is where it should be. Anyone who attended the summit or read the transcript would know that the summit clearly dealt with the huge cultural difference between alcohol and illicit drugs. Community perceptions and attitudes to alcohol use are quite sympathetic. I have done a lot of radio interviews in the past week about schoolies week and kids binge drinking. One of the good parts of the summit was the early presentations about the cultural history of alcohol and the role it has played

in this country. We must address that issue. The Alcohol Summit was good in that respect. However, if we are thinking about the diversion question, we should consider the expansion of diversion programs for alcohol offenders.

**ACTING CHAIR:** As you know, this inquiry came out of the Alcohol Summit. The Inebriates Act looks at drug and alcohol dependence. To what extent to due do you think severe dependence on drugs and alcohol is similar or different?

**Mr PIERCE:** In terms of dependency and treatment approaches, there are many similarities. Alcoholics Anonymous and Narcotics Anonymous say that an addict is an addict, regardless of the substance. Many drug-free treatment programs, including residential therapeutic community-style programs, focus on the person, not the drug. In pharmacotherapy the reverse is true; the focus is on substance replacement, not the person. We are trying to fill that gap. I am not advocating one form of treatment over the other; they are both valuable and have a place. In terms of the differences, we need to look at the client. Those who are severely alcohol dependent are a little different in the treatment sense because they are generally less involved in deviance. They have not been out on the street scamming, stealing, prostituting and sticking a gun in someone's face and demanding money like the average heroin user.

When mixing primary alcohol clients and illicit drug clients, particularly heroin and amphetamine clients, in treatment programs the alcohol clients tend to be older and less involved in deviance. They are not punks and although their connections to family are tenuous they are still a lot better. Some of us in the field tend to think that residential programs for primary alcohol dependent people should have a slightly different emphasis. Perhaps they need less emphasis on confrontation and harm reduction than the heroin population. Their programs should be more relaxed and focused on family, integration, career and so on. I am not suggesting that programs for illicit drug clients should not do that. However, one would have a slightly different emphasis when treating an older population of alcohol-dependent clients.

**ACTING CHAIR:** You mentioned schoolies week. I have a personal issue about advertising alcohol, but that is not relevant today. You mentioned older alcohol abusers. What programs do you think we should have for young people? Surely they must be presenting somewhere in the cycle.

**Mr PIERCE:** They are. The doctors alluded to that earlier. We know that the outcomes are much worse for 12, 13 and 14-year-olds starting to use alcohol or other drugs. We know that the degree of physical damage is worse and that is a real issue. We need to do more work in relation to youth services. Again, it is a bit like mental health services—many youth services do not want to touch those issues. Some do, but they tend to be specialist services. The school drug and alcohol education system, particularly the alcohol education system, needs a big rocket under it because it is not very effective despite the rhetoric of the Department of Education and Training and the state and national school drug education programs. Those of us who have been involved in school drug education know that it has minimal effect. It needs a good overhaul. Parent and family education is also important. Most young people get their modelling for drinking and tobacco use at home.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Do you think school drug education is, rather, education about all the facts about drugs that make them exciting? That criticism has certainly been levelled at the services that I have seen in eastern Sydney. If you say, "All these exciting things can happen, this is what they are, and we are not going to be judgmental if you use them," that is almost saying, "Hey! This is the menu of what you can have today."

**Mr PIERCE:** That is right. Interestingly, at the Alcohol Summit a lot of very interesting initiatives in relation to alcohol prevention and early prevention for youth were proposed, even to the extent of the educative safe-drinking concept that was put up. To be honest, we are plagued by ideology and morality when it comes to decisions about how we will do education and prevention work with young people when it comes to alcohol and substance abuse.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** You mean we are not using an evidence base?

**Mr PIERCE:** I do not believe we are.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** It is do-goodism gone wrong, is it?

**Mr PIERCE:** I think so. If you look at the national campaigns that have been run by the Commonwealth over the last few years in relation to illicit drugs, they have been demonstrated to have failed to have any impact whatever. However, there is a belief in politicians and leaders that it is imperative first to send the right message and that that usually supersedes the evidence base. I think that is a problem.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Just say no.

**Mr PIERCE:** It is ineffective.

**ACTING-CHAIR:** You have recommended revision of the Intoxicated Persons Act. If the Inebriates Act looks at drug and alcohol dependent persons, do you see an amendment to the Intoxicated Persons Act to include substance abusers as well?

**Mr PIERCE:** It would have to, because alcohol and substance use is ubiquitous. There are very few people who take an illicit substance who would not also drink. Poly drug use is the norm. So, yes, it has to.

**ACTING-CHAIR:** What do you want this inquiry to achieve in an ideal world?

**Mr PIERCE:** In an ideal world, obviously one outcome should be repeal of the legislation. Another outcome we would like would be review of the Intoxicated Persons Act and its redevelopment to address some of the concerns that will arise from the repeal of the Inebriates Act because, yes, we think there probably is a need for an intoxicated persons service and that kind of harm management and harm reduction intervention in some spectacular cases. We would like to see the adoption of our recommendations on consultation on those measures and how they should be thought through before being put into place.

I would also like reinforcement of the message about continued systems change and practice change within and across government departments in relation to getting our act together a little bit better. As I said before, we agree with the Government's overall drug and alcohol policy and its service system plan. But the reality is that departments and program areas are still too siloed.

**The Hon. CATHERINE CUSACK:** Is there a diversity of opinion among your members about these issues?

**Mr PIERCE:** Yes, there is.

**The Hon. CATHERINE CUSACK:** In which areas?

**Mr PIERCE:** The diversity of opinion would mainly be on the civil liberties issues. Some member agencies and workers in those agencies believe it would be perfectly fine to use the Inebriates Act as it is currently structured. They are in the minority. Interestingly, those who used to run proclaimed places type of services do not ever want to go back to those days, because they do not feel those services were adequate. They were just like services for psychiatric hospitals: they were not adequately staffed and supported to enable those people to undertake a custodial management type of role. They heavily advocate the establishment of alternative intoxicated persons services that may take on that role. Similarly there is diversity in our membership agency between those who are from the Salvation Army sort of framework who think that harm reduction is a bit off, and that safe injecting rooms are not a good thing and send the wrong message, right through to people who would prefer to see us experimenting with heroin trials. So there is a big diversity of opinion, yes.

**The Hon. CATHERINE CUSACK:** But basically not a lot of support for the Inebriates Act?

**Mr PIERCE:** No.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Thankfully, you have a unanimous view on that.

**Mr PIERCE:** Pretty much—and we consulted with the broad range of membership. Also, we were involved with the New South Wales Council of Social Services in consulting across the health and welfare sector. The general consensus we have is that there is not a lot of support for it, no.

**ACTING-CHAIR:** Thank you, Mr Pierce. We really appreciate your giving us so much time, and we thank you for your comprehensive submission. Do we have your permission to contact you further on any other questions that might arise over time?

**Mr PIERCE:** Absolutely.

**ACTING-CHAIR:** We appreciate that. Thank you so much.

**(The Committee adjourned at 4.21 p.m.)**

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